PERTH AMBOY BOARD OF EDUCATION Aetna Open Access[®] Managed Choice[®]

Coverage for: Individual + Family | **Plan Type:** POS



The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, https://www.aetna.com/sbcsearch/getpolicydocs?u=081300-050020-012003 or by calling 1-800-370-4526. For general definitions of common terms, such as

<u>allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined</u> terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-800-370-4526 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	In- <u>Network</u> : Individual \$400 / Family \$800. Out-of-Network: Individual \$600 / Family \$1,200.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. Emergency care; plus in- <u>network</u> office visits & <u>preventive care</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <u>https://www.healthcare.gov/coverage/preventive-care-benefits</u> /.
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet deductibles for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	In- <u>Network</u> : Individual \$1,000 / Family \$2,000. Out-of-Network: Individual \$2,000 / Family \$4,000.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket</u> <u>limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billing charges, health care this plan doesn't cover & penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a <u>network provider</u> ?	Yes. See http://www.aetna.com/docfind or call 1-800-370-4526 for a list of in- <u>network providers</u> .	This <u>plan</u> uses a <u>provider</u> <u>network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's</u> <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



		What You V	Will Pay		
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out–of–Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
	Primary care visit to treat an injury or illness	\$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply	40% coinsurance	None	
	<u>Specialist</u> visit	\$30 <u>copay</u> /visit, <u>deductible</u> doesn't apply	40% coinsurance	None	
If you visit a health care <u>provider's</u> office or clinic	<u>Preventive care</u> / <u>screening</u> /immunization	No charge	40% <u>coinsurance;</u> <u>deductible</u> doesn't apply to child immunizations; no charge for mammograms	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.	
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	40% coinsurance	None	
n you nave a test	Imaging (CT/PET scans, MRIs)	10% coinsurance	40% coinsurance	None	
If you need drugs to treat	Generic drugs	Not covered	Not covered		
your illness or condition	Preferred brand drugs	Not covered	Not covered	Not covered.	
More information about	Non-preferred brand drugs	Not covered	Not covered		
prescription drug coverage is available at www.aetna.com/pharmacy-insu rance/individuals-families	<u>Specialty drugs</u>	Not covered	Not covered	Not covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	40% coinsurance	None	
curgory	Physician/surgeon fees	10% coinsurance	40% coinsurance	None	
If you need immediate	Emergency room care	\$50 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$50 <u>copay</u> /visit, <u>deductible</u> doesn't apply	No coverage for non-emergency use.	
medical attention	Emergency medical transportation	0% coinsurance	0% coinsurance	40% coinsurance for non-emergency transport.	
	<u>Urgent care</u>	\$25 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$25 <u>copay</u> /visit, <u>deductible</u> doesn't apply	No coverage for non-urgent use in- <u>network,</u> 40% <u>coinsurance</u> for non-urgent use out-of-network.	

		What You Will Pay		
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out–of–Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
lf you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	40% coinsurance	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
noopital otay	Physician/surgeon fees	10% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or	Outpatient services	Office: \$30 <u>copay</u> /visit, <u>deductible</u> doesn't apply; other outpatient services: no charge	Office & other outpatient services: 40% <u>coinsurance</u>	None
substance abuse services	Inpatient services	10% coinsurance	40% <u>coinsurance</u>	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	Office visits	No charge	40% coinsurance	Cost sharing does not apply for preventive
If you are pregnant	Childbirth/delivery professional services	10% coinsurance	40% coinsurance	<u>services</u> . Maternity care may include tests and services described elsewhere in the SBC
	Childbirth/delivery facility services	10% coinsurance	40% coinsurance	(i.e. ultrasound.) Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care may apply.
	Home health care	10% coinsurance	40% <u>coinsurance</u>	60 visits/calendar year combined with private-duty nursing. Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	Rehabilitation services	\$20 <u>copay</u> /visit, <u>deductible</u> doesn't apply	40% coinsurance	None
If you need help recovering or have other	Habilitation services	\$20 <u>copay</u> /visit, <u>deductible</u> doesn't apply	40% coinsurance	None
special health needs	Skilled nursing care	10% coinsurance	40% coinsurance	60 days/calendar year. Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	Durable medical equipment	10% coinsurance	40% coinsurance	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	10% coinsurance	40% coinsurance	Penalty of \$400 for failure to obtain pre-authorization for out-of-network care.

		What You Will Pay			
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out–of–Network Provider (You will pay the most)	Limitations, Exceptions, & Other Importan Information	
lf vour child noode dontel	Children's eye exam	Not covered	Not covered	Not covered.	
 If your child needs dental or eye care	Children's glasses	Not covered	Not covered	Not covered.	
	Children's dental check-up	Not covered	Not covered	Not covered.	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT	Cover (Check your policy or plan document for more informatio	n and a list of any other <u>excluded services</u> .)
Cosmetic surgery	 Non-emergency care when traveling outside the 	Routine foot care
Dental care (Adult & Child)	U.S.	 Weight loss programs
Glasses (Adult)	 Prescription drugs 	
Long-term care	 Routine eye care (Adult & Child) 	
Othern Courses of Complete (1) inside times and	u anglu ta thaan asmuisan. This isgut a samulata list. Diasan asau	
Other Covered Services (Limitations ma	y apply to these services. This isn't a complete list. Please see y	our <u>pian</u> document.)
Acupuncture	 Infertility treatment - Limited to the diagnosis & 	 Private-duty nursing - Included as part of home

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Bariatric surgery	treatment of underlying medical condition, artificial	health care.		
Chiropractic care	insemination & ovulation induction. Advanced			
 Hearing aids - 1 hearing aid to \$1,000 maximum per 	reproductive technology: 4 complete egg			
ear/24 months for children up to age 16.	retrievals/lifetime.			

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Office of Managed Care, Consumer Protection Services, NJ Department of Banking and Insurance, Phone: 1-888-393-1062 or Consumer Hotline: 1-800-446-7467,

https://www.state.nj.us/dobi/division insurance/managedcare/mcfaqs.htm.

- For more information on your rights to continue coverage, contact the <u>plan</u> at 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa.
- For non-federal governmental group health <u>plans</u>, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or <u>www.cciio.cms.gov</u>.
- If your coverage is a church <u>plan</u>, church <u>plans</u> are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-800-370-4526.
- Office of Managed Care, Consumer Protection Services, NJ Department of Banking and Insurance, Phone: 1-888-393-1062 or Consumer Hotline: 1-800-446-7467, https://www.state.nj.us/dobi/division_insurance/managedcare/mcfaqs.htm.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.doi.gov/agencies/ebsa.
- For non-federal governmental group health <u>plans</u>, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or <u>www.cciio.cms.gov</u>.
- Additionally, a consumer assistance program can help you file your <u>appeal</u>. Contact The Office of the Insurance Ombudsman, NJ Department of Banking and Insurance, 20 West State Street, PO Box 472, Trenton, NJ 08625-0472, 1-800-446-7467, Fax: 609-292-2431, <u>http://www.state.nj.us/dobi/consumer.htm</u>, ombudsman@dobi.state.nj.us

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have <u>Minimum Essential Coverage</u> for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? No.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

-----To see examples of how this plan might cover costs for a sample medical situation, see the next section.-----

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)

The <u>plan's</u> overall <u>deductible</u>	\$400
Specialist copayment	\$30
Hospital (facility) <u>coinsurance</u>	10%
Other <u>coinsurance</u>	10%
This EXAMPLE event includes services	ike:
Specialist office visits (prenatal care)	
Childbirth/Delivery Professional Services	
Childbirth/Delivery Facility Services	
Diagnostic tests (ultrasounds and blood wo	rk)
Specialist visit (anesthesia)	,

Total Example Cost	\$12,800	
In this example, Peg would pay:		
Cost Sharing		
Deductibles	\$400	
Copayments	\$0	
Coinsurance	\$600	
What isn't covered		
Limits or exclusions	\$100	
The total Peg would pay is	\$1,100	

Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)

 The plan's overall <u>deductible</u> <u>Specialist copayment</u> 	\$400 \$30
Hospital (facility) <u>coinsurance</u>	10%
Other <u>coinsurance</u>	10%
This EXAMPLE event includes services	like:
Primary care physician office visits (include disease education)	ing
Diagnostic tests (blood work)	
Prescription drugs	
Durable medical equipment (glucose mete	r)

Total Example Cost	\$7,400	
In this example, Joe would pay:		
Cost Sharing		
Deductibles	\$100	
Copayments	\$200	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$6,000	
The total Joe would pay is	\$6,300	

Mia's Simple Fracture (in-network emergency room visit and follow up care)

The plan's overall deductible	\$400
Specialist copayment	\$30
Hospital (facility) <u>coinsurance</u>	10%
Other <u>coinsurance</u>	10%
This EXAMPLE event includes service	s like:
Emergency room care (including medical	supplies)
Diagnostic test (x-ray)	
Durable medical equipment (crutches)	
Rehabilitation services (physical therapy)	

Total Example Cost	\$1,900
In this example, Mia would pay:	
Cost Sharing	
Deductibles	\$400
Copayments	\$200
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$600

The <u>plan</u> would be responsible for the other costs of these EXAMPLE covered services.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-800-370-4526.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030, Fresno, CA 93779)

1-800-648-7817, TTY: 711, Fax: 859-425-3379 (CA HMO customers: 1-860-262-7705)

Email: CRCoordinator@aetna.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates.

TTY: 711

Language Assistance:

For language assistance in your language call 1-800-370-4526 at no cost.

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-800-370-4526.
Amharic -	ለቋንቋ እንዛ በ አማርኛ በ ነ-800-370-4526 በነጻ ይደውሉ
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 4526-370-4801
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-800-370-4526 առանց գնով։
Bahasa-Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-370-4526 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-800-370-4526 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বনিামুল্য(1–800–370–4526–ত(কল করুন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-370-4526 nga walay bayad.
Burmese -	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် ¹⁻⁸⁰⁰⁻³⁷⁰⁻⁴⁵²⁶ ကို ခေါ်ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-800-370-4526.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-800-370-4526 sin gåstu.
Cherokee -	ፀወሃፀ s ৩ክብወቭ Jhወspወy ፀቲፐ (CWY) obwምi s 1-800-370-4526 ውፀፐ ር AГወJ JEGPJ hՒRፀ.
Chinese -	欲取得繁體中文語言協助,請撥打 1-800-370-4526,無需付費。
Choctaw -	(Chahta) anumpa ya apela a chi I paya hinla 1-800-370-4526.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-800-370-4526 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-370-4526.
French -	Pour une assistance linguistique en français appeler le 1-800-370-4526 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-800-370-4526 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-370-4526 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-370-4526 χωρίς χρέωση.
Gujarati -	ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-800-370-4526 પર કૉલ કરો.

Hawaiian -	No ke kōkua ma ka 'ōlelo Hawai'i, e kahea aku i ka helu kelepona 1-800-370-4526. Kāki 'ole 'ia kēia kōkua nei.
Hindi -	हनि्दी में भाषा सहायता के लएि, 1-800-370-4526 पर मुफ्त कॉल करें।
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-800-370-4526.
lbo -	Maka enyemaka asụsụ na Igbo kpọọ 1-800-370-4526 na akwụghị ụgwọ ọ bụla
llocano -	Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-370-4526 nga awan ti bayadanyo.
Italian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-800-370-4526.
Japanese -	日本語で援助をご希望の方は、1-800-370-4526 まで無料でお電話ください。
Karen -	လ၊တၢ်မာ့စားတၢ်ကတိးကျိဉ်အဂီ၊ ကျိဉ် ကိုး 1-800-370-4526 လ၊တအိဉ်ဒီးတၢ်လ၊ဉ်ဘူဉ်လ၊ဉ်စု့းဘာ
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-370-4526 번으로 전화해 주십시오.
Kru-Bassa -	Ɓɛ´m`ké gbo-kpá-kpá dyé pidyi dé Ɓašɔɔ́-̀wùdุùùň wɛ̃ɛ, dá 1-800-370-4526
Kurdish -	براي راهنمايي به زبان فارسي با شمار ه 370-370-800 به خۆړايي پهيوهندي بکهن.
Laotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-800-370-4526 ໂດຍບໍ່ເສຍຄ່າໂທ.
Marathi -	तीलभाषा(मराठी)सहाय्यासाठी 1-800-370-4526 क्रमांकावरकोणत्याहीखर्चाशविायकॉलकरा.
Marshallese -	Ñan bōk jipañ ilo Kajin Majol, kallok 1-800-370-4526 ilo ejjelok wōnān.
Micronesian - Pohnpeyan	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-800-370-4526 ni sohte isais.
Mon-Khmer, Cambodian -	សម្ភរាប់ជំនួយភាសាជា ភាសាខ្មមរែ សូមទូរស័ព្ ទទ ៅកាន់លខេ 1-800-370-4526ដ ោយឥតគិតថ្ ល។ៃ
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-800-370-4526
Nepali -	(नेपाली) मा नन्शिुल्क भाषा सहायता पाउनका लाग 1-800-370-4526 मा फोन गर्नुहोस् ।
Nilotic-Dinka -	Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-800-370-4526 kecïn aɣöc.
Norwegian -	For språkassistanse på norsk, ring 1-800-370-4526 kostnadsfritt.
Panjabi -	ਪੰਜਾਬੀ ਵੱਚਿ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-800-370-4526 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-800-370-4526 aa. Es Aaruf koschtet nix.

Persian -	برای راهنمایی به زبان فارسی با شماره 370-4526 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Polish -	Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-800-370-4526.
Portuguese -	Para obter assistência linguística em português ligue para o 1-800-370-4526 gratuitamente.
Romanian -	Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-800-370-4526
Russian -	Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-800-370-4526.
Samoan -	Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-800-370-4526 e aunoa ma se totogi.
Serbo-Croatian -	Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-800-370-4526.
Spanish -	Para obtener asistencia lingüística en español, llame sin cargo al 1-800-370-4526.
Sudanic-Fulfude -	Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-800-370-4526 Njodi woo fawaaki on.
Swahili -	Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-800-370-4526 bila malipo.
Syriac -	к эск к a pari, abr sle, к vai, к m ly iopr ibl, sa, 1-800-370-4526 apr .
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-800-370-4526 nang walang bayad.
Telugu -	భషతో సయం కొరకు ఎలెంటి ఖర్చు లేకుండా 1-800-370-4526 కు శల్ చేయండి. (తిలుగు)
Thai -	สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-800-370-4526 ฟรีไม่มีค่าใช้จ่าย
Tongan -	Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-800-370-4526 'o 'ikai hā tōtōngi.
Trukese -	Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-800-370-4526 nge esapw kamé ngonuk.
Turkish -	(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-800-370-4526.
Ukrainian -	Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-800-370-4526.
Urdu -	ا رورک ل کتف م رپ 1-800-370-4526 محال کتن و اعمین اس و در
Vietnamese -	Đê được hố trợ ngôn ngự băng (ngôn ngự), haỹ gọi miến phi đên số 1-800-370-4526.
Yiddish -	פאר שפראך הילף אין אידיש רופט 1-800-370-4526 פריי פון אפצאל.
Yoruba -	Fún ìrànlowo nípa èdè (Yorùbá) pe 1-800-370-4526 lái san owó kankan rárá.