Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period: 01/01/2021-12/31/2021

BAPTIST HEALTH SOUTH FLORIDA, INC.: Aetna Choice® POS II - Pineapple Premier Plan

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

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) 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, www.HealthReformPlanSBC.com or by calling 1-866-456-3120. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-866-456-3120 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	BHSF: Individual $1,000 / Family $2,000. Aetna: Individual $1,000 / Family $2,000. Out-of-Network: Individual $3,000 / Family $6,000.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network preventive care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	BHSF: Individual $2,000 / Family $4,000. Aetna: Individual $2,000 / Family $4,000. Out-of-Network: Individual $4,000 / Family $8,000.	The out–of–pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out–of–pocket limits until the overall family out–of–pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover, OON Deductible & 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 network provider?	Yes. See www.aetna.com/despublic/#/bhsf or call 1-800-231-7729 for a list of BHSF providers.	You pay the least if you use a provider in BHSF Provider Network. You pay more if you use a provider in Aetna Provider Network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		BHSF Provider (You will pay the least)	Aetna Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance after deductible	$20 copay/visit after deductible	50% coinsurance after deductible	None
	Specialist visit	$15 copay/visit after deductible	$40 copay/visit after deductible	50% coinsurance after deductible	None
	Preventive care /screening /immunization	No charge	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge for laboratory; $0 after deductible for x-ray	No charge for laboratory; $25 copay/visit after deductible for x-ray	50% coinsurance after deductible	None
	Imaging (CT/PET scans, MRIs)	$150 copay/visit, deductible doesn't apply	$750 copay/visit after deductible	50% coinsurance after deductible	None
If you need drugs to treat your illness or condition Prescription drug coverage is provided through CVS/Caremark.	Generic drugs	$15 copay	$15 copay	Not covered	Generic & Brand drugs: Covers up to 90-day supply at retail pharmacies and a 60-90-day supply via mail order. Certain drugs in all tiers require prior authorization. Brand additional charges may apply.
	Preferred brand drugs	$30 copay	$30 copay	Not covered	
	Non-preferred brand drugs	$50 copay	$50 copay	Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		BHSF Provider (You will pay the least)	Aetna Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
More information is available at: www.caremark.com or by calling 1-844-345-1255	Specialty drugs	$75 copay	$75 copay	Not covered	Call 1-800-237-2767 or visit CVSspecialty.com for assistance with specialty medications. Specialty medications can also be filled at the Baptist Specialty Pharmacy located in the Miami Cancer Institute. For more information, call 786-527-8200 or toll free at 1-855-527-MEDS.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 copay/visit	$750 copay/visit after deductible	50% coinsurance after deductible	Diagnostic colonoscopies are covered at No charge.
	Physician/surgeon fees	0% coinsurance	0% coinsurance	50% coinsurance after deductible	None
If you need immediate medical attention	Emergency room care	$200 copay/visit after deductible	$200 copay/visit after deductible	$200 copay/visit after deductible	No coverage for non-emergency use.
	Emergency medical transportation	$100 copay/trip after deductible	$100 copay/trip after deductible	$100 copay/trip after deductible	Non-emergency transport: not covered, except if pre-authorized.
	Urgent care	$75 copay/visit after deductible	$100 copay/visit after deductible	50% coinsurance after deductible	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	$75 copay/day first 5 days per stay after deductible; 0% coinsurance thereafter	$150 copay/day first 5 days per stay after deductible; 0% coinsurance thereafter	50% coinsurance after deductible	Penalty of 50% of allowed amount for failure to obtain pre-authorization for out-of-network care.
	Physician/surgeon fees	0% coinsurance	0% coinsurance	50% coinsurance after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	No charge	50% coinsurance after deductible	None
	Inpatient services	$75 copay/day first 5 days per stay after deductible; 0% coinsurance thereafter	$150 copay/day first 5 days per stay after deductible; 0% coinsurance thereafter	50% coinsurance after deductible	Penalty of 50% of allowed amount for failure to obtain pre-authorization for out-of-network care.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		BHSF Provider (You will pay the least)	Aetna Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	No charge	No charge	50% coinsurance after deductible	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Penalty of 50% of allowed amount for failure to obtain pre-authorization for out-of-network care may apply.
	Childbirth/delivery professional services	0% coinsurance	0% coinsurance	50% coinsurance after deductible	
	Childbirth/delivery facility services	$75 copay/day first 5 days per stay after deductible; 0% coinsurance thereafter	$150 copay/day first 5 days per stay after deductible; 0% coinsurance thereafter	50% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	0% coinsurance after deductible	0% coinsurance after deductible	50% coinsurance after deductible	60 visits/calendar year. Penalty of 50% of allowed amount for failure to obtain pre-authorization for out-of-network care.
	Rehabilitation services	0% coinsurance after deductible	$20 copay/visit after deductible	50% coinsurance after deductible	90 visits /calendar year for Physical, Occupational & Speech Therapy combined.
	Habilitation services	0% coinsurance after deductible	$20 copay/visit after deductible	Not covered	None
	Skilled nursing care	0% coinsurance after deductible	0% coinsurance after deductible	50% coinsurance after deductible	90 days/calendar year. Penalty of 50% of allowed amount for failure to obtain pre-authorization for out-of-network care.
	Durable medical equipment	10% coinsurance after deductible	10% coinsurance after deductible	50% coinsurance after deductible	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	0% coinsurance after deductible	0% coinsurance after deductible	50% coinsurance after deductible	Penalty of 50% of allowed amount for failure to obtain pre-authorization for out-of-network care.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	Not covered.
	Children's glasses	Not covered	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	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 information and a list of any other excluded services.)		
• Cosmetic surgery • Dental care (Adult & Child) • Glasses (Child) • Hearing aids	• Long-term care • Non-emergency care when traveling outside the U.S. • Private-duty nursing	• Routine eye care (Adult & Child) • Routine foot care • Weight loss programs - Except for required preventive services.
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture - 20 visits/calendar year. • Bariatric surgery - Limited to BHSF providers.	• Chiropractic care - 20 visits/calendar year.	• Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.

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:

- For more information on your rights to continue coverage, contact the plan at 1-866-456-3120.
- 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 plans, 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 www.cciio.cms.gov.
- If your coverage is a church plan, church plans 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 plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. 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 1-866-456-3120.
- 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 plans, 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 www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your appeal. Contact information is at: http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html.

Does this plan provide Minimum Essential Coverage? **Yes.**
If you don't have Minimum Essential Coverage 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? **Yes.**
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 plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. 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 plan's overall deductible	**$1,000**
Specialist copayment	**$15**
Hospital (facility) copayment	**$75**
Other coinsurance	**0%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,000
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$100
The total Peg would pay is	**$1,300**

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

The plan's overall deductible	**$1,000**
Specialist copayment	**$15**
Hospital (facility) copayment	**$75**
Other coinsurance	**0%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$1,000
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$200
The total Joe would pay is	**$2,200**

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

The plan's overall deductible	**$1,000**
Specialist copayment	**$15**
Hospital (facility) copayment	**$75**
Other coinsurance	**0%**

This EXAMPLE event includes services 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	$1,000
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,200**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-866-456-3120.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-866-456-3120.

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).

TTY: 711

Language Assistance:

For language assistance in your language call 1-866-456-3120 at no cost.

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-866-456-3120.
Amharic -	ለቋንቋ እገዛ በ አማርኛ በ 1-866-456-3120 በነጻ ይደውሉ
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-866-456-3120
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-866-456-3120 առանց զնով:
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-866-456-3120 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-866-456-3120 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-866-456-3120-তে কল করুন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-866-456-3120 nga walay bayad.
Burmese -	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-866-456-3120 ကို ခေါ်ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-866-456-3120.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-866-456-3120 sin gåstu.
Cherokee -	ᎾᏍᎩᎾ ᏕᏲᏂᎯᏍᏗ ᏗᏂᏍᏕᎵᏍᎩ ᎾᏋᎢ (ᏣᎳᎩ) ᏫᏓᏔᏅᎢᏕ 1-866-456-3120 ᎤᎾᎢ ᏝᎪᎱᏍᏗ ᏧᎬᏩᏢᏗ ᏂᎨᏒᎾ.
Chinese -	欲取得繁體中文語言協助，請撥打 1-866-456-3120，無需付費。
Choctaw -	(Chahta) anumpa ya apela a chi I paya hinla 1-866-456-3120.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-866-456-3120 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-866-456-3120.
French -	Pour une assistance linguistique en français appeler le 1-866-456-3120 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-866-456-3120 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-866-456-3120 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-866-456-3120 χωρίς χρέωση.
Gujarati -	ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-866-456-3120 પર કૉલ કરો.

Hawaiian -	No ke kōkua ma ka ʻōlelo Hawaiʻi, e kahea aku i ka helu kelepona 1-866-456-3120. Kāki ʻole ʻia kēia kōkua nei.
Hindi -	हिन्दी में भाषा सहायता के लिए, 1-866-456-3120 पर मुफ्त कॉल करें।
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-866-456-3120.
Ibo -	Maka enyemaka asụsụ na Igbo kpọọ 1-866-456-3120 na akwụghị ụgwọ ọ bụla
Ilocano -	Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-866-456-3120 nga awan ti bayadanyo.
Italian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-866-456-3120.
Japanese -	日本語で援助をご希望の方は、1-866-456-3120 まで無料でお電話ください。
Karen -	လာတ်မၤစၢၤတ်ကတိၤကျိာ်အဂီၢ် ကျိာ် ကိး 1-866-456-3120 လာတအိာ်ဒီးတ်လၢာ်ဘျာ်လၢာ်စုၤဘာ်
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-866-456-3120 번으로 전화해 주십시오.
Kru-Bassa -	Bɛ´m`ké gbo-kpá-kpá dyé pídyi ɖé Bǎsɔ́ɔ̀-wùɖùǔn wɛ̃ɛ, ɖá 1-866-456-3120
Kurdish -	برای راهنمایی به زبان فارسی با شماره 1-866-456-3120 به خۆرایی پەیوەندی بکەن.
Laotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ1-866-456-3120 ໂດຍບໍ່ເສຍຄ່າໂທ.
Marathi -	तीलभाषा (मराठी) सहाय्यासाठी 1-866-456-3120 क्रमांकावरकोणत्याहीखर्चाशिवायकॉलकरा.
Marshallese -	Ñan bōk jipañ ilo Kajin Majol, kallok 1-866-456-3120 ilo ejjelok wōnān.
Micronesian-Pohnpeyan -	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-866-456-3120 ni sohte isais.
Mon-Khmer, Cambodian -	សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-866-456-3120 ដោយឥតគិតថ្លៃ។
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-866-456-3120
Nepali -	(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-866-456-3120 मा फोन गर्नुहोस् ।
Nilotic-Dinka -	Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-866-456-3120 kecïn aɣöc.
Norwegian -	For språkassistanse på norsk, ring 1-866-456-3120 kostnadsfritt.
Panjabi -	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-866-456-3120 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-866-456-3120 aa. Es Aaruf koschtet nix.
Persian -	برای راهنمایی به زبان فارسی با شماره 1-866-456-3120 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Polish -	Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-866-456-3120.

Portuguese - Para obter assistência linguística em português ligue para o 1-866-456-3120 gratuitamente.

Romanian - Pentru asistenţă lingvistică în româneşte telefonaţi la numărul gratuit 1-866-456-3120

Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-866-456-3120.

Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-866-456-3120 e aunoa ma se totogi.

Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-866-456-3120.

Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-866-456-3120.

Sudanic-Fulfude - Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-866-456-3120. Njodi woo fawaaki on.

Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-866-456-3120 bila malipo.

Syriac - [illegible] 1-866-456-3120 [illegible].

Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-866-456-3120 nang walang bayad.

Telugu - భాషతో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 1-866-456-3120 కు కాల్ చేయండి. (తెలుగు)

Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-866-456-3120 ฟรีไม่มีค่าใช้จ่าย

Tongan - Kapau ‘oku fiema'u hā tokoni ‘i he lea faka-Tonga telefoni 1-866-456-3120 ‘o ‘ikai hā ōtōngi.

Trukese - Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-866-456-3120 nge esapw kamé ngonuk.

Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-866-456-3120.

Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-866-456-3120.

Urdu - اردو میں لسانی معاونت کے لئے 1-866-456-3120 پر مفت کال کریں

Vietnamese - Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-866-456-3120.

Yiddish - פאר שפראך הילף אין אידיש רופט 1-866-456-3120 פריי פון אפצאל.

Yoruba - Fún ìrànlọwọ nípa èdè (Yorùbá) pe 1-866-456-3120 lái san owó kankan rárá.