



: ADOBE SYSTEMS INCORPORATED: Aetna Choice® POS II –
(HealthSave HSA Plan)

Coverage for: EE Only; EE+ 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 1-888-982-3862. 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 1-888-982-3862 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|--|---|
| What is the overall deductible? | Network: EE Only \$1,350; EE+ Family \$2,700. Out-of-Network: EE Only \$2,700; EE+ Family \$5,400. | 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 policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay. |
| Are there services covered before you meet your deductible? | Yes. In-network preventive care is covered before you meet your deductible. | 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 https://www.healthcare.gov/coverage/preventive-care-benefits/ |
| Are there other deductibles for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services. |
| What is the out-of-pocket limit for this plan? | Network: EE Only \$2,800; EE+ Family \$6,500. Out-of-Network: EE Only \$5,400; EE+ Family \$10,800. | 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> , the overall family <u>out-of-pocket limit</u> must be met. |
| What is not included in the out-of-pocket limit? | 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 <u>out-of-pocket limit</u> . |
| Will you pay less if you use a network provider? | Yes. See www.aetna.com/docfind or call 1-888-982-3862 for a list of network providers. | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's 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 charge</u> 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 referral to see a specialist? | No. | You can see the <u>specialist</u> you choose without a <u>referral</u> . |



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 |
|---|--|--|---|--|
| | | Network Provider (You will pay the least) | 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 | 10% coinsurance | 30% coinsurance | None |
| If you visit a health care provider's office or clinic | Specialist visit | 10% coinsurance | 30% coinsurance | None |
| If you visit a health care provider's office or clinic | Preventive care /screening /immunization | No charge | 0% coinsurance | 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) | 10% coinsurance | 30% coinsurance | None |
| If you have a test | Imaging (CT/PET scans, MRIs) | 10% coinsurance | 30% coinsurance | None |
| <p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.aetnapharmacy.com/premierplus</p> <p>Premier Plus Formulary</p> | Generic drugs | Copay/prescription: \$15 (retail), \$30 (mail order) | 50% coinsurance after copay/prescription: \$15 (retail) | Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral & injectable fertility drugs to \$20,000 maximum/lifetime. No charge for preferred generic FDA-approved women's contraceptives in-network. Deductible doesn't apply to preventive medications. Maintenance drugs- no refill restrictions or penalties apply. Members save with lower copays at Aetna Rx Home Delivery or CVS Pharmacy. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|---------------------------|---|---|--|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| <p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.aetnapharmacy.com/premierplus</p> <p>Premier Plus Formulary</p> | Preferred brand drugs | Copay/prescription: \$45 (retail), \$90 (mail order) | 50% coinsurance after copay/prescription: \$45 (retail) | Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral & injectable fertility drugs to \$20,000 maximum/lifetime. No charge for preferred generic FDA-approved women's contraceptives in-network. Deductible doesn't apply to preventive medications. Maintenance drugs- no refill restrictions or penalties apply. Members save with lower copays at Aetna Rx Home Delivery or CVS Pharmacy. |
| <p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.aetnapharmacy.com/premierplus</p> <p>Premier Plus Formulary</p> | Non-preferred brand drugs | Copay/prescription: \$65 (retail), \$130 (mail order) | 50% coinsurance after copay/prescription: \$65 (retail) | Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral & injectable fertility drugs to \$20,000 maximum/lifetime. No charge for preferred generic FDA-approved women's contraceptives in-network. Deductible doesn't apply to preventive medications. Maintenance drugs- no refill restrictions or penalties apply. Members save with lower copays at Aetna Rx Home Delivery or CVS Pharmacy. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|--|---|--|--|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| <p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.aetnapharmacy.com/premierplus</p> <p>Premier Plus Formulary</p> | Specialty drugs | Applicable cost as noted above for generic or brand drugs | Not covered | First prescription fill at a retail pharmacy or specialty pharmacy. Subsequent fills must be through the Aetna Specialty Pharmacy Network. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance | 30% coinsurance | None |
| If you have outpatient surgery | Physician/surgeon fees | 10% coinsurance | 30% coinsurance | None |
| If you need immediate medical attention | Emergency room care | 10% coinsurance | 10% coinsurance | 50% coinsurance for non-emergency use. |
| If you need immediate medical attention | Emergency medical transportation | 10% coinsurance | 10% coinsurance | 50% coinsurance for non-emergency transport. |
| If you need immediate medical attention | Urgent care | 10% coinsurance | 30% coinsurance | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 10% coinsurance | 30% coinsurance | Penalty of \$400 for failure to obtain pre-authorization for out-of-network care. |
| If you have a hospital stay | Physician/surgeon fees | 10% coinsurance | 30% coinsurance | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|---|--|--|--|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Office & other outpatient services: 10% coinsurance | Office & other outpatient services: 30% coinsurance | None |
| If you need mental health, behavioral health, or substance abuse services | Inpatient services | 10% coinsurance | 30% coinsurance | Penalty of \$400 for failure to obtain pre-authorization for out-of-network care. |
| If you are pregnant | Office visits | No charge | 30% coinsurance | 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 \$400 for failure to obtain pre-authorization for out-of-network care may apply. |
| If you are pregnant | Childbirth/delivery professional services | 10% coinsurance | 30% coinsurance | 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 \$400 for failure to obtain pre-authorization for out-of-network care may apply. |
| If you are pregnant | Childbirth/delivery facility services | 10% coinsurance | 30% coinsurance | 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 \$400 for failure to obtain pre-authorization for out-of-network care may apply. |
| If you need help recovering or have other special health needs | Home health care | 10% coinsurance | 30% coinsurance | 120 visits/calendar year. Penalty of \$400 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 |
|---|----------------------------|--|--|--|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you need help recovering or have other special health needs | Rehabilitation services | 10% coinsurance | 30% coinsurance | 60 visits/calendar year for Physical & Occupational Therapy combined, 60 visits/calendar year for Speech Therapy. Includes treatment of Autism & developmental delays. |
| If you need help recovering or have other special health needs | Habilitation services | 10% coinsurance | 30% coinsurance | 60 visits/calendar year for Physical & Occupational Therapy combined, 60 visits/calendar year for Speech Therapy. Includes treatment of Autism & developmental delays. |
| If you need help recovering or have other special health needs | Skilled nursing care | 10% coinsurance | 30% coinsurance | 120 visits/calendar year. Penalty of \$400 for failure to obtain pre-authorization for out-of-network care. |
| If you need help recovering or have other special health needs | Durable medical equipment | 10% coinsurance | 30% coinsurance | Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse. |
| If you need help recovering or have other special health needs | Hospice services | 0% coinsurance | 0% coinsurance | Penalty of \$400 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. |
| If your child needs dental or eye care | Children's glasses | Not covered | Not covered | Not covered. |
| If your child needs dental or eye care | 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 information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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 - 45 visits/calendar year.
- Bariatric surgery
- Chiropractic care - 45 visits/calendar year.
- Hearing aids - 2 hearing aids/24 months.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition. Artificial insemination & ovulation induction: 6 combined attempts/lifetime. Advanced reproductive technology: 3 cycles/lifetime.
- Private-duty nursing – 70- 8 hour shifts/calendar year.

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 1-888-982-3862.
- 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 www.dol.gov/ebsa/healthreform.
- 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 1-888-982-3862.
- 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 www.dol.gov/ebsa/healthreform.
- 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 Standard? 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** \$1,350
- **Specialist coinsurance** 10%
- **Hospital (facility) coinsurance** 10%
- **Other coinsurance** 10%

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$1,350 |
| Copayments | \$40 |
| Coinsurance | \$1,100 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$2,550 |

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

- The **plan's** overall **deductible** \$1,350
- **Specialist coinsurance** 10%
- **Hospital (facility) coinsurance** 10%
- **Other coinsurance** 10%

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$1,350 |
| Copayments | \$1,300 |
| Coinsurance | \$70 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$2,740 |

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

- The **plan's** overall **deductible** \$1,350
- **Specialist coinsurance** 10%
- **Hospital (facility) coinsurance** 10%
- **Other coinsurance** 10%

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$1,350 |
| Copayments | \$0 |
| Coinsurance | \$60 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,410 |

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: 1-888-982-3862.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-888-982-3862.

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 (Aetna).

- Hawaiian - No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-888-982-3862. Kāki ‘ole ‘ia kēia kōkua nei.
- Hindi - हनिदी में भाषा सहायता के लिए, 1-888-982-3862 पर मुफ्त कॉल करें।
- Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-888-982-3862.
- Ibo - Maka enyemaka asụsụ na Igbo kpọọ 1-888-982-3862 na akwụghị ụgwọ ọ bụla
- Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-888-982-3862 nga awan ti bayadanyo.
- Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-888-982-3862.
- Japanese - 日本語で援助をご希望の方は、1-888-982-3862 まで無料でお電話ください。
- Karen - လာဝတ်စကားတော်ကတိကုန်အင်္ဂါ ကျိန် ကိး 1-888-982-3862 လာဝတ်အိန်ဒီးတော်လာဝတ်ကျိန်လာဝတ်စကားတော်
- Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862번으로 전화해 주십시오.
- Kru-Bassa - Ɓe m'ké gbo-kpá-kpá dyé pídyi dé Ɓáwó-wuḍuŋ wɛɛ, dǎ 1-888-982-3862
- Kurdish - برآی راهنمایی به زبان فارسی با شماره 1-888-982-3862 به خورایی یه یومندی بکن.
- Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-888-982-3862 ໂດຍບໍ່ເສຍຄ່າໂທ.
- Marathi - तीलभाषा (मराठी) सहाय्यासाठी 1-888-982-3862 क्रमांकावरकोणत्याहीखर्चाशिवायकॉलकरा.
- Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-888-982-3862 ilo ejjelok wōnān.
- Micronesian-Pohnpeyan - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-888-982-3862 ni sohte isais.
- Mon-Khmer, Cambodian - សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-888-982-3862 ដោយឥតគិតថ្លៃ។
- Navajo - T'áá shi shizaad k'ehjí bee shík'a a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-888-982-3862
- Nepali - (नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1- 888-982-3862 मा फोन गर्नुहोस् ।
- Nilotic-Dinka - Tèn kuwoɲy è thok è Thuwoɲjäɲ cɔl 1-888-982-3862 kec'in ayöc.
- Norwegian - For språkassistanse på norsk, ring 1-888-982-3862 kostnadsfritt.
- Panjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-888-982-3862 'ਤੇ ਮੁਫਤ ਕਾਲ ਕਰੋ।
- Pennsylvania Dutch - Fer Hefte in Deitsch, ruf: 1-888-982-3862 aa. Es Aaruf koschtet nix.
- Persian - برآی راهنمایی به زبان فارسی با شماره 1-888-982-3862 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
- Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-888-982-3862.

- Portuguese - Para obter assistência linguística em português ligue para o 1-888-982-3862 gratuitamente.
- Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-888-982-3862
- Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-888-982-3862.
- Samoaan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-888-982-3862 e aunoa ma se totogi.
- Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-888-982-3862.
- Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-888-982-3862.
- Sudanic-Fulfude - Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-888-982-3862. Njodi woo fawaaki on.
- Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-888-982-3862 bila malipo.
- Syriac - ܠܟܘܢܘܢ ܠܫܘܠܘܬܘܢܝܢ ܕܡܘܨܝܘܢܝܢ ܕܡܘܨܝܘܢܝܢ ܕܡܘܨܝܘܢܝܢ ܕܡܘܨܝܘܢܝܢ ܕܡܘܨܝܘܢܝܢ 1-888-982-3862 ܕܡܘܨܝܘܢܝܢ.
- Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-888-982-3862 nang walang bayad.
- Telugu - భాషలో సాయం కోరకు ఎలాంటి ఖర్చు లేకుండా 1-888-982-3862 కు కాల్ చేయండి. (తెలుగు)
- Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-888-982-3862 ฟรีไม่มีค่าใช้จ่าย
- Tongan - Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-888-982-3862 'o 'ikai hā ʻōtōngi.
- Trukese - Ren ánnisinisn chiakú ren (Kapasen Chuuk) kopwe kékkéeri 1-888-982-3862 nge esapw kamé ngonuk.
- Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemedi 1-888-982-3862.
- Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-888-982-3862.
- Urdu - اگر کسی کو اردو کی زبان کی مدد کی ضرورت ہے تو براہ کرم 1-888-982-3862 پر کال کریں۔
- Vietnamese - Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-888-982-3862.
- Yiddish - פאר שפראך הילף אין אידיש רופט 1-888-982-3862 פון אפצאל.
- Yoruba - Fún ìrànlọwọ nípa èdè (Yorùbá) pe 1-888-982-3862 láí san owó kankan rárá.