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, visit www.ih-aetna.com/fcps or call 1-888-236-6249. 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 1-888-236-6249 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: Individual $250 / Family $500 Out-of-Network: Individual $500 / Family $1,000	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?	Network: Individual $2,000 / Family $4,000 Out-of-Network: Individual $4,000 / Family $8,000 Pharmacy: Individual $1,500 / Family $3,000	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 limit 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, penalties for failure to obtain pre-authorization for services. Coinsurance and copayments for covered prescriptions apply to a separate pharmacy out-of-pocket maximum.	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.ih-aetna.com/fcps or call 1-888-236-6249 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's 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
		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	$20 copay/visit	40% coinsurance	No visit limits.
If you visit a health care provider's office or clinic	Specialist visit	$20 copay/visit	40% coinsurance	Therapeutic services limited to 90 visit max per therapy, per calendar year.
If you visit a health care provider's office or clinic	Preventive care /screening /immunization	No charge. Deductible does not apply.	40% coinsurance	Age & frequency limits may apply. 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	40% coinsurance	Refer to www.ih-aetna.com/fcps for participating laboratories/radiology facilities. Copay applies to complex radiology services.
	Imaging (CT/PET scans, MRIs)	$75 copay/visit	40% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://info.caremark.com/fcps	Generic drugs	Retail: $7/$14/$21 (30/60/90-day supply) Mail Order: $14 (up to 90-day supply)	Pay in full, then file claim for reimbursement. Reimbursement limited to amount plan would have paid if network pharmacy was used.	Participants using a CVS retail pharmacy for maintenance medications may receive a 90-day supply for two retail copays. For plan details, see http://info.caremark.com/fcps (employees and non-Medicare retirees). Your plan uses a network of participating pharmacies and a formulary (a list of preferred covered medications). Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered. Deductible does not apply to prescription coverage. Certain preventive medications covered for $0 copay.
	Preferred brand drugs	20% of cost of drug; maximum copay: Retail: $50/$100/$150 (30/60/90-day supply) Mail Order: $100 (up to 90-day supply)		
	Non-preferred brand drugs	Not covered	Not covered	
	Specialty drugs	20% of cost of drug, $50 max (up to 30-day supply)	Must use CVS Specialty Pharmacy after first fill	

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	40% coinsurance	Pre-authorization may be required depending on type of service rendered.
	Physician/surgeon fees	10% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	10% coinsurance plus $150 copay/visit	10% coinsurance plus $150 copay/visit	$150 copay waived if admitted. No coverage for non-emergency use; prudent layperson rules & definitions apply.
	Emergency medical transportation	10% coinsurance	40% coinsurance	Must be medically necessary.
	Urgent care	10% coinsurance	10% coinsurance	If using a non-participating provider, may be required to pay in full & file for reimbursement.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance plus $150 copay/stay	40% coinsurance plus $150 copay/stay	Pre-authorization required for all inpatient hospital stays.
	Physician/surgeon fees	10% coinsurance	40% coinsurance	Pre-authorization may be required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/office visit 10% coinsurance outpatient facility	40% coinsurance	Pre-authorization is not required for Outpatient Therapy. Pre-authorization required for Psychological Testing, Neuropsychological Testing, Outpatient ECT, Biofeedback, Outpatient Detoxification & Home Health Care.
	Inpatient services	10% coinsurance plus $150 copay/stay	40% coinsurance plus $150 copay/stay	Pre-authorization required for all inpatient hospital & treatment facility stays, in addition to care received in Intensive Outpatient, Partial Hospitalization & Residential Treatment settings.

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 are pregnant	Office visits	No charge	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of service, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Pre-authorization required for maternity & newborn confinements that exceed the standard length of stay for normal vaginal delivery or C-Section. Pre-authorization may be required for out-of-network care.
	Childbirth/delivery professional services	10% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	10% coinsurance plus $150 copay/stay	40% coinsurance plus $150 copay/stay	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	40% coinsurance	90 visits/calendar year. Pre-authorization required for certain services.
	Rehabilitation services	$20 copay/visit	40% coinsurance	90 visits/therapy/calendar year. Pre-authorization & Utilization Management review required.
	Habilitation services	$20 copay/visit	40% coinsurance	Prior authorization required. Coverage for Autism & Pervasive Development Disorder limited to ages 2-10. Other habilitative services covered as part of Early Intervention Program (birth to age 3).
	Skilled nursing care	10% coinsurance plus $150 copay/stay	40% coinsurance plus $150 copay/stay	120 days max/confinement. Days renewed when out of facility for 60 consecutive days; prior authorization required. $150 copay waived if directly transferred from inpatient facility.
	Durable medical equipment	10% coinsurance	40% coinsurance	Pre-authorization required for certain durable medical equipment (i.e. motorized wheelchairs, customized braces).
	Hospice services	10% coinsurance plus $150 copay/stay for inpatient; 10% coinsurance for outpatient	40% coinsurance plus $150 copay/stay for inpatient; 40% coinsurance for outpatient	Pre-authorization required. Per admission copay waived if transferred directly from inpatient or skilled nursing facility.

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 your child needs dental or eye care	Children's eye exam	$20 copay/visit, not subject to deductible.	Reimbursement up to $40/visit	Once every 12 months. Routine vision services not subject to deductible.
	Children's glasses	Standard glasses covered in full up to $130 allowance	Reimbursement $40 - $80	Lenses once per 12 months; frames once per 24 months; max $130 allowance
	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) • Long-term care	• Non-emergency care when traveling outside the U.S. • 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.)		
• Accupuncture – only if used by physician in lieu of anesthesia • Bariatric surgery – subject to Utilization Management approval • Chiropractic care – subject to Utilization Management	• Hearing aids – Only if result of injury. • Infertility treatment – subject to Utilization Management approval.	• Private-duty nursing – outpatient only- limited to 120 days per plan year • Routine eye care (Adult & Child)

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 www.fcps.edu or 571-423-3200, Option 3.
- 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.

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 1-888-236-6249.
- 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.

For grievances and appeals regarding your drug coverage, contact:

- CVS Caremark at 1-888-217-4161 or visit http://info.caremark.com/fcps (active employees/non-Medicare retirees)

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**.**

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----------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	**$250**
Specialist copayment	**$20**
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	**$12,840**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$250
Copayments	$220
Coinsurance	$900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,430**

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

The plan's overall deductible	**$250**
Specialist copayment	**$20**
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	**$7,460**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$250
Copayments	$420
Coinsurance	$1,060
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,790**

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

The plan's overall deductible	**$250**
Specialist copayment	**$20**
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	**$1,970**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$250
Copayments	$290
Coinsurance	$140
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$680**

Note: If your plan has a wellness program and you choose to participate, you may be able to reduce your costs.

The plan 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 1-888-236-6249. TTY: 711.

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/Innovation Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Aetna/Innovation Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Aetna/Innovation Health 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 1-888-236-6249.

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: 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 1-888-236-6249 at no cost.

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-888-236-6249.
Amharic -	ለቋንቋ እገዛ በ አማርኛ በ 1-888-236-6249 በነጻ ይደውሉ
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-888-236-6249
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-888-236-6249 առանց գնով:
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-236-6249 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-888-236-6249 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-888-236-6249-তে কল করুন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-888-236-6249 nga walay bayad.
Burmese -	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-888-236-6249 ကို ခေါ်ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-888-236-6249.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-888-236-6249 sin gåstu.
Cherokee -	ᎾᏍᎩᎾ ᎦᏬᏂᎯᏍᏗ ᏗᏂᏍᏕᏢᏍᎩ ᎾᏛᎢ (ᏣᎳᎩ) ᏫᏏᏔᏅᎢᎦ 1-888-236-6249 ᎤᎾᎢ Ꮭ ᎪᎱᏍᏗ ᏧᎬᏩᏢᏗ ᏂᎨᏒᎾ.
Chinese -	欲取得繁體中文語言協助，請撥打 1-888-236-6249，無需付費。
Choctaw -	(Chahta) anumpa ya apela a chi I paya hinla 1-888-236-6249.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-888-236-6249 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-888-236-6249.
French -	Pour une assistance linguistique en français appeler le 1-888-236-6249 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-888-236-6249 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-888-236-6249 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-888-236-6249 χωρίς χρέωση.
Gujarati -	ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-888-236-6249 પર કૉલ કરો.

Hawaiian -	No ke kōkua ma ka ʻōlelo Hawaiʻi, e kahea aku i ka helu kelepona 1-888-236-6249. Kāki ʻole ʻia kēia kōkua nei.
Hindi -	हिन्दी में भाषा सहायता के लिए, 1-888-236-6249 पर मुफ्त कॉल करें।
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-888-236-6249.
Ibo -	Maka enyemaka asụsụ na Igbo kpọọ 1-888-236-6249 na akwụghị ụgwọ ọ bụla
Ilocano -	Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-888-236-6249 nga awan ti bayadanyo.
Italian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-888-236-6249.
Japanese -	日本語で援助をご希望の方は、1-888-236-6249 まで無料でお電話ください。
Karen -	လာတၢ်မၤစၢၤတၢ်ကတိၤကျိာ်အဂီၢ် ကျိာ် ကိး 1-888-236-6249 လာတအိဉ်ဒီးတၢ်လၢာ်ဘျာ်လၢာ်စုဘဉ်
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-236-6249 번으로 전화해 주십시오.
Kru-Bassa -	Bɛ´m`ké gbo-kpá-kpá dyé pídyi ɖé Baˇsɔɔ̀-wuɖuùn wɛ̃ɛ, ɖá 1-888-236-6249
Kurdish -	برای راهنمایی به زبان فارسی با شماره 1-888-236-6249 به خۆرایی پەیوەندی بکەن.
Laotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ1-888-236-6249 ໂດຍບໍ່ເສຍຄ່າໂທ.
Marathi -	तीलभाषा (मराठी) सहाय्यासाठी 1-888-236-6249 क्रमांकावरकोणत्याहीखर्चाशिवायकॉलकरा.
Marshallese -	Ñan bōk jipañ ilo Kajin Majol, kallok 1-888-236-6249 ilo ejjelok wōnān.
Micronesian-Pohnpeyan -	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-888-236-6249 ni sohte isais.
Mon-Khmer, Cambodian -	សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-888-236-6249 ដោយឥតគិតថ្លៃ។
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-888-236-6249
Nepali -	(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1- 888-236-6249 मा फोन गर्नुहोस् ।
Nilotic-Dinka -	Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-888-236-6249 kecïn aɣöc.
Norwegian -	For språkassistanse på norsk, ring 1-888-236-6249 kostnadsfritt.
Panjabi -	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-888-236-6249 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-888-236-6249 aa. Es Aaruf koschtet nix.
Persian -	برای راهنمایی به زبان فارسی با شماره 1-888-236-6249 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Polish -	Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-888-236-6249.

Portuguese -	Para obter assistência linguística em português ligue para o 1-888-236-6249 gratuitamente.
Romanian -	Pentru asistenţă lingvistică în româneşte telefonaţi la numărul gratuit 1-888-236-6249
Russian -	Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-888-236-6249.
Samoan -	Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-888-236-6249 e aunoa ma se totogi.
Serbo-Croatian -	Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-888-236-6249.
Spanish -	Para obtener asistencia lingüística en español, llame sin cargo al 1-888-236-6249.
Sudanic-Fulfude -	Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-888-236-6249. Njodi woo fawaaki on.
Swahili -	Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-888-236-6249 bila malipo.
Syriac -	[illegible] 1-888-236-6249 [illegible]
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-888-236-6249 nang walang bayad.
Telugu -	భాషతో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 1-888-236-6249 కు కాల్ చేయండి. (తెలుగు)
Thai -	สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-888-236-6249 ฟรีไม่มีค่าใช้จ่าย
Tongan -	Kapau ‘oku fiema'u hā tokoni ‘i he lea faka-Tonga telefoni 1-888-236-6249 ‘o ‘ikai hā ōtōngi.
Trukese -	Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-888-236-6249 nge esapw kamé ngonuk.
Turkish -	(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-888-236-6249.
Ukrainian -	Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-888-236-6249.
Urdu -	[illegible] 1-888-236-6249 [illegible]
Vietnamese -	Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-888-236-6249.
Yiddish -	פאר שפראך הילף אין אידיש רופט 1-888-236-6249 פריי פון אפצאל.
Yoruba -	Fún ìrànlọwọ nípa èdè (Yorùbá) pe 1-888-236-6249 lái san owó kankan rárá.