aetna® : THE UNIVERSITY OF VIRGINIA
Open Choice® - UVA J1 Visa Health Plan

Coverage Period: 01/01/2020 - 12/31/2020

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

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 1-800-231-7729. 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 1-800-231-7729 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Outside the U.S.: Individual $500 / Family $1,000. Preferred Benefits: Individual $500 / Family $1,000. Non-Preferred Benefits: Individual $1,500 / Family $3,000.	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 office visits, prescription drugs & preventive care are 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?	Outside the U.S.: Individual $2,500 / Family $5,000. Preferred Benefits: Individual $5,500 / Family $11,000. Non-Preferred Benefits: Individual $11,000 / Family $22,000.	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, penalties for failure to obtain pre-authorization for services & health care this plan doesn't cover.	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 http://www.aetna.com/docfind or call 1-800-231-7729 for a list of Outside the U.S. providers.	You pay the least if you use a provider in Outside the U.S.. You pay more if you use a provider in Preferred Benefits. 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
		Outside the U.S. Provider (You will pay the least)	Preferred Benefits Provider (You will pay more)	Non-Preferred Benefits 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% coinsurance	$30 copay/visit, deductible doesn't apply	50% coinsurance	None
	Specialist visit	20% coinsurance	$50 copay/visit, deductible doesn't apply	50% coinsurance	None
	Preventive care/ screening/ immunization	20% coinsurance	No charge	50% 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)	20% coinsurance	20% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance	50% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetnapharmacy.com/valueplus	Preferred generic drugs	20% coinsurance (retail)	Copay/prescription, deductible doesn't apply: $20 (retail & mail order)	50% coinsurance (retail)	Covers 365 day supply (retail & mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral & injectable fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in-network. Review your formulary for prescriptions requiring precertification or step therapy for coverage. Your cost will be higher for choosing Brand over Generics.
	Preferred brand drugs	20% coinsurance (retail)	Copay/prescription, deductible doesn't apply: $40 (retail & mail order)	50% coinsurance (retail)	
	Non-preferred generic/brand drugs	20% coinsurance (retail)	Copay/prescription, deductible doesn't apply: $70 (retail & mail order)	50% coinsurance (retail)	
	Specialty drugs	Not covered	Applicable cost as noted above for generic or brand drugs	Not covered	All prescriptions must be filled through the UVA Specialty Pharmacy only. Covers 365 day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	20% coinsurance	50% coinsurance	None
	Physician/surgeon fees	20% coinsurance	20% coinsurance	50% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Outside the U.S. Provider (You will pay the least)	Preferred Benefits Provider (You will pay more)	Non-Preferred Benefits Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	25% coinsurance	25% coinsurance	25% coinsurance	50% coinsurance for non-emergency use, except 25% coinsurance for outside the U.S.
	Emergency medical transportation	20% coinsurance	20% coinsurance	20% coinsurance	Non-emergency transport: not covered, except 50% coinsurance in-network & out-of-network if pre-authorized.
	Urgent care	20% coinsurance	20% coinsurance	20% coinsurance	50% coinsurance for non-urgent use, except 20% coinsurance for outside the U.S.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	20% coinsurance	50% coinsurance	Penalty of $400 for failure to obtain pre-authorization for out-of-network care.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: 20% coinsurance	Office: $50 copay/visit, deductible doesn't apply; other outpatient services: 20% coinsurance	Office & other outpatient services: 50% coinsurance	None
	Inpatient services	20% coinsurance	20% coinsurance	50% coinsurance	Penalty of $400 for failure to obtain pre-authorization for out-of-network care.
If you are pregnant	Office visits	20% coinsurance	No charge	50% 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.
	Childbirth/delivery professional services	20% coinsurance	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	20% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Outside the U.S. Provider (You will pay the least)	Preferred Benefits Provider (You will pay more)	Non-Preferred Benefits Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	50% coinsurance	120 visits/calendar year combined with private-duty nursing. Penalty of $400 for failure to obtain pre-authorization for out-of-network care.
	Rehabilitation services	20% coinsurance	$50 copay/visit, deductible doesn't apply	50% coinsurance	60 visits/calendar year for Physical, Occupational & Speech Therapy combined.
	Habilitation services	20% coinsurance	$50 copay/visit, deductible doesn't apply	50% coinsurance	None
	Skilled nursing care	20% coinsurance	20% coinsurance	50% coinsurance	120 days/calendar year. Penalty of $400 for failure to obtain pre-authorization for out-of-network care.
	Durable medical equipment	20% coinsurance	20% coinsurance	50% coinsurance	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	20% coinsurance	20% coinsurance	50% coinsurance	30 days/lifetime inpatient. 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	20% coinsurance	No charge	Not covered	1 routine eye exam/24 months.
	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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Long-term care
- 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.)		
• Chiropractic care • Hearing aids - 1 hearing aid to $1,000 maximum per ear/3 years for children up to age 26.	• Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition, embryo transfers & cryopreservation. Artificial insemination, ovulation induction & advanced reproductive technology: 6 cycles/lifetime.	• Non-emergency care when traveling outside the U.S. - Most coverage provided outside of United States. See www.aetnainternational.com • Private-duty nursing - 120 visits/calendar year combined with home health care. • Routine eye care (Adult) - 1 routine eye exam/24 months for in-network & outside the U.S.

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: Insurance Commissioner and Department of Insurance, 302-674-7300, http://www.delawareinsurance.gov.

- For more information on your rights to continue coverage, contact the plan at 1-800-231-7729.
- 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 1-800-231-7729.
- Insurance Commissioner and Department of Insurance, 302-674-7300, http://www.delawareinsurance.gov.
- 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.

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** **$500**
- **Specialist coinsurance** **20%**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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	$500
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,560**

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

- **The plan's overall deductible** **$500**
- **Specialist coinsurance** **20%**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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	$500
Copayments	$0
Coinsurance	$1,400
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,920**

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

- **The plan's overall deductible** **$500**
- **Specialist coinsurance** **20%**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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	$500
Copayments	$0
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$800**

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 1-800-231-7729.

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 1-800-231-7729 at no cost.

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-800-231-7729.
Amharic -	ለቋንቋ እገዛ በ አማርኛ በ 1-800-231-7729 በነጻ ይደውሉ
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-800-231-7729
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-800-231-7729 առանց գնով:
Bahasa-Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-231-7729 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-800-231-7729 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-800-231-7729-তে কল করুন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-231-7729 nga walay bayad.
Burmese -	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-800-231-7729 ကို ခေါ်ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-800-231-7729.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-800-231-7729 sin gåstu.
Cherokee -	ᎾᏍᎩᏃ ᎦᏬᏂᎯᏍᏗ ᏚᏂᏙᎢᏍᏗᎩ ᎾᏋᎢ (ᏣᎳᎩ) ᏫᏓᎳᏛᎢᏍ 1-800-231-7729 ᏅᏗᎢ Ꮯ ᎪᎱᏍᏗ ᏧᎬᏩᎶᏗ ᏂᎨᏒᎾ.
Chinese -	欲取得繁體中文語言協助，請撥打 1-800-231-7729，無需付費。
Choctaw -	(Chahta) anumpa ya apela a chi I paya hinla 1-800-231-7729.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-800-231-7729 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-231-7729.
French -	Pour une assistance linguistique en français appeler le 1-800-231-7729 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-800-231-7729 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-231-7729 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-231-7729 χωρίς χρέωση.
Gujarati -	ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-800-231-7729 પર કૉલ કરો.

Hawaiian -	No ke kōkua ma ka ʻōlelo Hawaiʻi, e kahea aku i ka helu kelepona 1-800-231-7729. Kāki ʻole ʻia kēia kōkua nei.
Hindi -	हन्दिी में भाषा सहायता के लएि, 1-800-231-7729 पर मुफ्त कॉल करें।
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-800-231-7729.
Ibo -	Maka enyemaka asụsụ na Igbo kpọọ 1-800-231-7729 na akwụghị ụgwọ ọ bụla
Ilocano -	Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-231-7729 nga awan ti bayadanyo.
Italian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-800-231-7729.
Japanese -	日本語で援助をご希望の方は、1-800-231-7729 まで無料でお電話ください。
Karen -	လၢတၢ်မၤစၢၤတၢ်ကတိၤကျိဉ်အဂီၤ် ကျိဉ် ကိး 1-800-231-7729 လၢတအိဉ်ဒီးတၢ်လၢာ်ဘူဉ်လၢာ်စ့ၤဘဉ
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-231-7729 번으로 전화해 주십시오.
Kru-Bassa -	Ɓɛ́m`ké gbo-kpá-kpá dyé piɗyi ɖé Ɓaǎɔɔ̀-wuɖuǔn wɛ̃ɛ, ɖá 1-800-231-7729
Kurdish -	برای راهنمایی به زبان فارسی با شماره 1-800-231-7729 به خۆرایی پەیوەندی بکەن.
Laotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ **1-800-231-7729** ໂດຍບໍ່ເສຍຄ່າໂທ.
Marathi -	तीलभाषा(मराठी)सहाय्यासाठी 1-800-231-7729 क्रमांकावरकोणत्याहीखर्चाशवियकॉलकरा.
Marshallese -	Ñan bōk jipañ ilo Kajin Majol, kallok 1-800-231-7729 ilo ejjelok wōnān.
Micronesian - Pohnpeyan	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-800-231-7729 ni sohte isais.
Mon-Khmer, Cambodian -	សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-800-231-7729 ដោយឥតគិតថ្លៃ។
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-800-231-7729
Nepali -	(नेपाली) मा नःिशुल्क भाषा सहायता पाउनका लागि 1-800-231-7729 मा फोन गर्नुहोस् ।
Nilotic-Dinka -	Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-800-231-7729 kecïn aɣöc.
Norwegian -	For språkassistanse på norsk, ring 1-800-231-7729 kostnadsfritt.
Panjabi -	ਪੰਜਾਬੀ ਵੱਚਿ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-800-231-7729 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-800-231-7729 aa. Es Aaruf koschtet nix.

Persian -	برای راهنمایی به زبان فارسی با شماره 1-800-231-7729 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Polish -	Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-800-231-7729.
Portuguese -	Para obter assistência linguística em português ligue para o 1-800-231-7729 gratuitamente.
Romanian -	Pentru asistenţă lingvistică în româneşte telefonaţi la numărul gratuit 1-800-231-7729
Russian -	Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-800-231-7729.
Samoan -	Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-800-231-7729 e aunoa ma se totogi.
Serbo-Croatian -	Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-800-231-7729.
Spanish -	Para obtener asistencia lingüística en español, llame sin cargo al 1-800-231-7729.
Sudanic-Fulfude -	Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-800-231-7729 Njodi woo fawaaki on.
Swahili -	Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-800-231-7729 bila malipo.
Syriac -	[illegible] 1-800-231-7729 [illegible].
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-800-231-7729 nang walang bayad.
Telugu -	భషతో సయంకొరకు ఎలాంటి ఖర్చు లేకుండా **1-800-231-7729** కు కల్ చేయండి. (తెలుగు)
Thai -	สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-800-231-7729 ฟรีไม่มีค่าใช้จ่าย
Tongan -	Kapau ‘oku fiema'u hā tokoni ‘i he lea faka-Tonga telefoni 1-800-231-7729 ‘o ‘ikai hā tōtōngi.
Trukese -	Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-800-231-7729 nge esapw kamé ngonuk.
Turkish -	(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-800-231-7729.
Ukrainian -	Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-800-231-7729.
Urdu -	ا ریرک ل گتفم رپ 1-800-231-7729 ےعلےکتنو اعمینللل ریم ودر
Vietnamese -	Để đươc̣ hỗ trợ ngôn ngữ băǹg (ngôn ngữ), haỹ goị miễn phí đêń sô´ 1-800-231-7729.
Yiddish -	פאר שפראך הילף אין אידיש רופט 1-800-231-7729 פריי פון אפצאל.
Yoruba -	Fún ìrànlọ́wọ́ nípa èdè (Yorùbá) pe 1-800-231-7729 lái san owó kankan rárá.