



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 <u>deductible</u> ? | In- <u>Network</u> : Individual \$2,500; Family \$5,000 | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> . |
| Are there services covered before you meet your <u>deductible</u> ? | Yes. In- <u>network</u> office visits & <u>preventive care</u> are covered before you meet your <u>deductible</u> . Copays do not apply to 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 <u>deductibles</u> for specific services? | Yes | There is a separate \$50 per person annual deductible that needs to be satisfied for pharmacy benefits under Express Scripts. |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u> ? | In- <u>Network</u> : Individual \$6,900; Family \$13,800 | 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> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met. |
| What is not included in the <u>out-of-pocket limit</u> ? | <u>Premiums</u> , <u>balance-billing</u> charges & health care this <u>plan</u> doesn't cover. | 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 <u>network provider</u> ? | Yes. See www.aetna.com/docfind or call 1-888-982-3862 for a list of in- <u>network</u> designated <u>providers</u> . | 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> . Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| Do you need a <u>referral</u> to see a <u>specialist</u> ? | No | You can see the <u>specialist</u> you choose without a <u>referral</u> . |



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 |
|--|---|--|--|---|
| | | In-Network Designated Provider (You will pay the least) | Non-Designated 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 | \$30 <u>copay</u> /visit, <u>deductible</u> doesn't apply | Not covered | None |
| If you visit a health care provider's office or clinic | <u>Specialist</u> visit | \$65 <u>copay</u> /visit, <u>deductible</u> doesn't apply | Not covered | None |
| If you visit a health care provider's office or clinic | <u>Preventive care</u> / <u>screening</u> /immunization | No charge | Not covered | You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | 25% <u>coinsurance</u> | Not covered | None |
| If you have a test | Imaging (CT/PET scans, MRIs) | 25% <u>coinsurance</u> | Not covered | None |
| If you need drugs to treat your illness or condition If you need drugs to treat your illness or condition. More information about <u>prescription drug coverage</u> is available at www.express-scripts.com | Generic drugs | \$20 Retail \$50 Mail Order High Performance Formulary | Not covered | Covers up to a 30-day supply (retail prescription); 84-90-day supply maintenance medications available via an Express Scripts Smart90 retail pharmacy or through Express Scripts Home Delivery Service. There is a separate deductible that needs to be satisfied for pharmacy benefits. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|---------------------------|---|--|--|
| | | In-Network Designated Provider (You will pay the least) | Non-Designated Provider (You will pay the most) | |
| <p>If you need drugs to treat your illness or condition</p> <p>If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.express-scripts.com</p> | Preferred brand drugs | \$50 Retail \$125 Mail Order High Performance Formulary | Not covered | <p>Covers up to a 30-day supply (retail prescription); 84-90-day supply maintenance medications available via an Express Scripts Smart90 retail pharmacy or through Express Scripts Home Delivery Service Not covered.</p> <p>There is a separate deductible that needs to be satisfied for pharmacy benefits.</p> |
| <p>If you need drugs to treat your illness or condition</p> <p>If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.express-scripts.com</p> | Non-preferred brand drugs | \$70 Retail \$175 Mail Order High Performance Formulary | Not covered | <p>Covers up to a 30-day supply (retail prescription); 84-90-day supply maintenance medications available via an Express Scripts Smart90 retail pharmacy or through Express Scripts Home Delivery Service Not covered.</p> <p>There is a separate deductible that needs to be satisfied for pharmacy benefits.</p> |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|--|--|--|--|
| | | In-Network Designated Provider (You will pay the least) | Non-Designated Provider (You will pay the most) | |
| <p>If you need drugs to treat your illness or condition</p> <p>If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.express-scripts.com</p> | <u>Specialty drugs</u> | \$150 | Not covered | <p>Prescriptions are limited to a 30-day supply. There is limited retail access for a small subset of specialty medications.</p> <p>There is a separate deductible that needs to be satisfied for pharmacy benefits.</p> |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 25% <u>coinsurance</u> | Not covered | None |
| If you have outpatient surgery | Physician/surgeon fees | 25% <u>coinsurance</u> | Not covered | None |
| If you need immediate medical attention | <u>Emergency room care</u> | 25% <u>coinsurance</u> after \$300 <u>copay</u> /visit; waived if admitted | 25% <u>coinsurance</u> after \$300 <u>copay</u> /visit; waived if admitted | <p>No coverage for non-emergency use. Covered only for true emergency or HAIRPENS.</p> <p>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>).</p> |
| If you need immediate medical attention | <u>Emergency medical transportation</u> | 25% <u>coinsurance</u> | 25% <u>coinsurance</u> | Non-emergency transport: not covered, except if pre-authorized. |
| If you need immediate medical attention | <u>Urgent care</u> | 25% <u>coinsurance</u> | Not covered | No coverage for non-urgent use. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 25% <u>coinsurance</u> per stay | Not covered | None |

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| | | In-Network Designated Provider (You will pay the least) | Non-Designated Provider (You will pay the most) | |
| If you have a hospital stay | Physician/surgeon fees | 25% <u>coinsurance</u> | Not covered | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Office: \$65 <u>copay</u> /visit, <u>deductible</u> doesn't apply; other outpatient services: 25% <u>coinsurance</u> | Not covered | None |
| If you need mental health, behavioral health, or substance abuse services | Inpatient services | 25% <u>coinsurance</u> per stay | Not covered | None |
| If you are pregnant | Office visits | No charge; except \$65 <u>copay</u> for initial visit to confirm pregnancy, <u>deductible</u> doesn't apply | Not covered | <u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) |
| If you are pregnant | Childbirth/delivery professional services | 25% <u>coinsurance</u> | Not covered | <u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) |
| If you are pregnant | Childbirth/delivery facility services | 25% <u>coinsurance</u> per stay | Not covered | <u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) |
| If you need help recovering or have other special health needs | <u>Home health care</u> | 25% <u>coinsurance</u> | Not covered | 100 visits/calendar year |
| If you need help recovering or have other special health needs | <u>Rehabilitation services</u> | \$65 <u>copay</u> /visit. <u>deductible</u> doesn't apply | Not covered | 60 visits/calendar year for Physical, Occupational & Speech Therapy combined. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|----------------------------------|--|--|--|
| | | In-Network Designated Provider (You will pay the least) | Non-Designated Provider (You will pay the most) | |
| If you need help recovering or have other special health needs | <u>Habilitation services</u> | \$65 <u>copay</u> /visit. <u>deductible</u> doesn't apply | Not covered | None |
| If you need help recovering or have other special health needs | <u>Skilled nursing facility</u> | 25% <u>coinsurance</u> per stay | Not covered | 60 days/calendar year. |
| If you need help recovering or have other special health needs | <u>Durable medical equipment</u> | 25% <u>coinsurance</u> | Not covered | Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse. |
| If you need help recovering or have other special health needs | <u>Hospice services</u> | 25% <u>coinsurance</u> | Not covered | None |
| 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.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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.)

- Bariatric surgery - \$10,000 maximum/lifetime.
- Chiropractic care - 20 visits/calendar year.
- Hearing aids - 2 devices/36 months for children up to age 17.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.
- Prescription drugs – covered through Express Scripts

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 : <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 1-888-982-3862.
- 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 <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? No.

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

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

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this 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 **\$2,500**
- Specialist copayment **\$65**
- Hospital (facility) coinsurance **25%**
- Other coinsurance **25%**

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 | \$2,500 |
| Copayments | \$60 |
| Coinsurance | \$2,500 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$100 |
| The total Peg would pay is | \$5,160 |

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

- The plan's overall deductible **\$2,500**
- Specialist copayment **\$65**
- Hospital (facility) coinsurance **25%**
- Other coinsurance **25%**

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 | \$100 |
| Copayments | \$400 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$6,000 |
| The total Joe would pay is | \$6,500 |

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

- The plan's overall deductible **\$2,500**
- Specialist copayment **\$65**
- Hospital (facility) coinsurance **25%**
- Other coinsurance **25%**

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 | \$600 |
| Copayments | \$300 |
| Coinsurance | \$200 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,100 |

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).

TTY: 711

Language Assistance:

For language assistance in your language call 1-888-982-3862 at no cost.

- Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-888-982-3862.
- Amharic - ለቋንቋ እገዛ በ አማርኛ በ 1-888-982-3862 በነጻ ይደውሉ
- Arabic - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-888-982-3862
- Armenian - Լեզվի ցուցաբերած աջակցության (հայերեն) գանգի 1-888-982-3862 ամանց գնով:
- Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-982-3862 tanpa dikenakan biaya.
- Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-888-982-3862 ku busa
- Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-888-982-3862-তে কল করুন।
- Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-888-982-3862 nga walay bayad.
- Burmese - ငွေတန်ကျခံရမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-888-982-3862 ကို ခေါ်ဆိုပါ။
- Catalan - Per rebre assistència en (català), truqui al número gratuït 1-888-982-3862.
- Chamorro - Para ayuda gi fino' (Chamoru), ágang 1-888-982-3862 sin gástu.
- Cherokee - ᎠᎩᎠᎵ ᎠᎵᎠᎵᎠᎵ ᎠᎵᎠᎵᎠᎵ ᎠᎵᎠᎵᎠᎵ (GWY) ᎠᎵᎠᎵᎠᎵ 1-888-982-3862 ᎠᎵᎠᎵ ᎠᎵᎠᎵᎠᎵ ᎠᎵᎠᎵᎠᎵ ᎠᎵᎠᎵᎠᎵ.
- Chinese - 欲取得繁體中文語言協助，請撥打1-888-982-3862，無需付費。
- Choctaw - (Chahta) anumpa ya apela a chi l paya hinla 1-888-982-3862.
- Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-888-982-3862 irratti bilisaan bilbilaa.
- Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-888-982-3862.
- French - Pour une assistance linguistique en français appeler le 1-888-982-3862 sans frais.
- French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-888-982-3862 gratis.
- German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-888-982-3862 an.
- Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-888-982-3862 χωρίς χρέωση.
- Gujarati - ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-888-982-3862 પર કોલ કરો.
- 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.

- Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-888-982-3862.
- Samoan - 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 - ܠܗܘܠܐ ܠܗܘܠܐ ܠܗܘܠܐ ܠܗܘܠܐ ܠܗܘܠܐ ܠܗܘܠܐ ܠܗܘܠܐ ܠܗܘܠܐ ܠܗܘܠܐ ܠܗܘܠܐ ܠܗܘܠܐ ܠܗܘܠܐ ܠܗܘܠܐ 1-888-982-3862 ܠܗܘܠܐ.
- Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-888-982-3862 nang walang bayad.
- Telugu - భాషతో 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 ánninnisin 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 - اے ری کال کسٹم رپ 1-888-982-3862 سے مل سکتے ہیں اور اس میں کوئی بھی رقم نہیں ہوتی۔
- Vietnamese - **Đê 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 iràn጗ọ nípa èdè (Yorùbá) pe 1-888-982-3862 láí san owó kankan rárá.