Coverage for: Individual + Family | Plan Type: POS



The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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, <u>www.HealthReformPlanSBC.com</u> or by calling 1-855-223-8791. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-855-223-8791 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$0. Out-of-Network: Individual \$350 / Family \$700.	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 deductible?	Yes. Emergency care is covered before you meet your <u>deductible</u> .	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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	In- <u>Network</u> : Individual \$500 / Family \$1,000. Out-of-Network: Individual \$2,000 / Family \$5,000. Rx: Individual \$1,600 / Family \$3,200.	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 out-of-pocket limit?	<u>Premium</u> s, balance-billing 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 network provider?	Yes. See http://www.aetna.com/docfind or call 1-855-223-8791 for a list of in-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</u> charge 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 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.

	What You Will Pay			
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	\$10 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% coinsurance	None
If you visit a health	<u>Specialist</u> visit	\$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% coinsurance	None
care <u>provider</u> 's office or clinic	Preventive care /screening /immunization	No charge	Not covered, except 30% coinsurance for mammograms & gynecological exams; deductible doesn't apply for child immunizations	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 toot	Diagnostic test (x-ray, blood work)	No charge	30% coinsurance	None
If you have a test	Imaging (CT/PET scans, MRIs)	No charge	30% coinsurance	None
	Generic drugs	\$5 copay/ retail prescription (up to 34-day supply) \$10 copay / retail prescription (35 – 90-day supply) and \$10/prescription mail order	\$5 copay/ retail prescription (up to 34-day supply) \$10 copay / retail prescription (35 – 90-day supply)	Covers up to a 90-day supply (retail prescription); 31-90-day supply (mail order prescription) Your plan uses a preferred drug list which identifies the status of covered drugs. Some drugs may require preauthorization, if the necessary preauthorization is not obtained, the drug may not be covered.

Common Medical Event	Services You May Need	What You In-Network Provider (You will pay the least)	Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your	Preferred brand drugs	\$10 copay/ retail prescription (up to 34-day supply) \$20 copay / retail prescription (up to 90-day supply) and \$20/ prescription mail order	\$10 copay/ retail prescription (up to 34-day supply) \$20 copay / retail prescription (up to 90-day supply)	Covers up to a 90-day supply (retail prescription); 31-90-day supply (mail order prescription) Your plan uses a preferred drug list which identifies the status of covered drugs. Some drugs may require preauthorization, if the necessary preauthorization is not obtained, the drug may not be covered.
illness or condition  More information about prescription drug coverage is available at www.expressscripts	Non-preferred brand drugs	\$10 copay/ retail prescription (up to 34-day supply) \$20 copay / retail prescription (up to 90-day supply) and \$20/ prescription mail order	\$10 copay/ retail prescription (up to 34-day supply) \$20 copay / retail prescription (up to 90-day supply)	Covers up to a 90-day supply (retail prescription); 31-90-day supply (mail order prescription) Your plan uses a preferred drug list which identifies the status of covered drugs. Some drugs may require preauthorization, if the necessary preauthorization is not obtained, the drug may not be covered.
<u>.com</u>	Specialty drugs	\$20 copay (up to 30-day supply) \$40 copay (31-60-day supply) \$60 copay (61-90-day supply)	Not covered	Covers up to a 90-day supply (retail prescription); 31–90-day supply (mail order prescription)
If you have	Facility fee (e.g., ambulatory surgery center)	No charge	30% coinsurance	None
outpatient surgery	Physician/surgeon fees	No charge	30% coinsurance	None
	Emergency room care	\$125 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$125 <u>copay</u> /visit <u>deductible</u> doesn't apply	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> . No coverage for non-emergency use.
If you need immediate medical attention	Emergency medical transportation	10% <u>coinsurance,</u> <u>deductible</u> doesn't apply	10% <u>coinsurance,</u> <u>deductible</u> doesn't apply	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> . Non-emergency transport: not covered, except 30% <u>coinsurance</u> if preauthorized.
	<u>Urgent care</u>	\$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% coinsurance	No coverage for non-urgent use.

Common Medical Event	Services You May Need	What You In-Network Provider (You will pay the least)	u Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	30% <u>coinsurance</u>	Pre-authorization required for out-of-network care.
1105pital Stay	Physician/surgeon fees	No charge	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse	Outpatient services	Office: \$15 copay/visit, deductible doesn't apply; other outpatient services: no charge	Office & other outpatient services: 30% coinsurance	None
services	Inpatient services	No charge	30% coinsurance	Pre-authorization required for out-of-network care.
	Office visits	No charge	30% coinsurance	Cost sharing does not apply for preventive
	Childbirth/delivery professional services	No charge	30% coinsurance	services. Maternity care may include tests and
If you are pregnant	Childbirth/delivery facility services	No charge	30% coinsurance	services described elsewhere in the SBC (i.e., ultrasound.) <u>Pre-authorization</u> for out-of-network care may apply.
	Home health care	No charge	30% coinsurance	Pre-authorization required for out-of-network care.
	Rehabilitation services	\$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% coinsurance	Out-of- <u>network</u> maximum: 75% of in- <u>network</u> cost up to \$52/visit for Physical Therapy.
If you need help	Habilitation services	No charge	30% coinsurance	None
recovering or have other special health needs	Skilled nursing care	No charge	30% coinsurance	120 days/calendar year in-network & 60 days out-of-network/calendar year. Pre-authorization required for out-of-network care.
	Durable medical equipment	10% <u>coinsurance,</u> <u>deductible</u> doesn't apply	30% coinsurance	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	No charge	30% coinsurance	<u>Pre-authorization</u> required for out-of-network care.
If your child needs dental or eye care	Children's eye exam	\$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Not covered	1 routine eye exam/calendar year.

ſ		Services You May Need	What You Will Pay			
	Common Medical Event		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
١		Children's glasses	Not covered	Not covered	Not covered.	
		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 foot care
- Weight loss programs Except for required <u>preventive</u> <u>services</u>.

# Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture Limited to disease, injury & chronic pain. Out-of-<u>Network</u> Maximum: 75% of in-<u>Network</u> cost up to \$60/visit.
- Bariatric surgery
- Chiropractic care 30 visits/calendar year.
- Hearing aids 1 hearing aid to \$1,000 maximum per ear/24 months for children up to age 16.
- Infertility treatment For more information & exceptions, see policy document provided by your employer or call the number on your ID card.
- Private-duty nursing
- Routine eye care (Adult) 1 routine eye exam/calendar year for in-network only.

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 <u>plan</u> at 1-855-223-8791.
- 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 <a href="http://www.dol/gov/ebsa/healthreform">http://www.dol/gov/ebsa/healthreform</a>
- For non-federal governmental group health <u>plans</u>, 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 <u>www.cciio.cms.gov</u>.
- If your coverage is a church <u>plan</u>, church <u>plans</u> 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 on how 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:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general number at 1-855-223-8791. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <a href="http://www.dol/gov/ebsa/healthreform">http://www.dol/gov/ebsa/healthreform</a>
- For non-federal governmental group health <u>plans</u>, 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 <u>www.cciio.cms.gov</u>.
- Additionally, a consumer assistance program can help you file your <u>appeal</u>. Contact information is at: <a href="http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html">http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html</a>.

## Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

## 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 <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost-sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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 <u>plan's</u> overall <u>deductible</u>	\$0
■ Specialist copayment	\$15
■ Hospital (facility) <u>copayment</u>	\$0
Other <u>copayment</u>	\$0

#### This EXAMPLE event includes services like:

Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost	\$12,700
In this example, Peg would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$70
The total Peg would pay is	\$70

# Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$0
Specialist copayment	\$15
■ Hospital (facility) copayment	\$0
Other <u>copayment</u>	\$0

#### This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits (including disease education)

Diagnostic tests (blood work)

Prescription drugs

Durable medical equipment (glucose meter)

Total Example Cost	\$5,600	
In this example, Joe would pay:		
Cost Sharing		
<u>Deductibles</u>	\$0	
Copayments	\$100	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$4,300	
The total Joe would pay is	\$4,400	

## **Mia's Simple Fracture**

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ Specialist copayment	\$15
■ Hospital (facility) copayment	\$0
■ Other <u>copayment</u>	\$0

#### This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

Diagnostic test (x-ray)

<u>Durable medical equipment</u> (crutches)

Rehabilitation services (physical therapy)

Total Example Cost	\$2,800	
In this example, Mia would pay:		
Cost Sharing		
<u>Deductibles</u>	\$0	
<u>Copayments</u>	\$200	
<u>Coinsurance</u>	\$90	
What isn't covered		
Limits or exclusions	\$10	
The total Mia would pay is	\$300	

## **Assistive Technology**

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 866-393-0002.

## **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 unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, disability, gender identity or sexual orientation.

We provide 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: P.O. Box 24030, Fresno, CA 93779),

1-800-648-7817, TTY: 711,

Fax: 859-425-3379 (CA HMO customers: 860-262-7705), 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 <a href="https://ocrportal.hhs.gov/ocr/portal/lobby.jsf">https://ocrportal.hhs.gov/ocr/portal/lobby.jsf</a>, 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 companies, including Aetna Life Insurance Company and its affiliates (Aetna).

#### TTY: 711

## Language Assistance:

For language assistance in your language call 1-855-223-8791 at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-855-223-8791.

Amharic - ለቋንቋ እንዛ በ አማርኛ በ 1-855-223-8791 በነጻ ይደውሉ

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-855-223-8791 الرجاء الاتصال على الرقم المجاني

Armenian - Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-855-223-8791 առանց գնով։

Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-855-223-8791 tanpa dikenakan biaya.

Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-855-223-8791 ku busa

Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বিনামুল্যে 1-855-223-8791-তে কল করুন।

Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-855-223-8791 nga walay bayad.

Burmese - ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-855-223-8791 ကို ခေါ် ဆိုပါ။

Catalan - Per rebre assistència en (català), truqui al número gratuït 1-855-223-8791.

Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-855-223-8791 sin gåstu.

Cherokee -  $\theta \circ DY \theta \circ SOh \mathcal{A} \circ J \mathcal{A} h \circ DSP \circ DY \theta \mathcal{A} T (GWY) \circ DSWO^{1}S 1-855-223-8791 O' \text{OT } L \text{A} \Gamma \circ D \mathcal{A} J \text{EGPA} h \text{PR} \text{O}.$ 

Chinese - 欲取得繁體中文語言協助, 請撥打1-855-223-8791, 無需付費。

Choctaw - (Chahta) anumpa ya apela a chi I paya hinla 1-855-223-8791.

Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-855-223-8791 irratti bilisaan bilbilaa.

Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-855-223-8791.

French - Pour une assistance linguistique en français appeler le 1-855-223-8791 sans frais.

French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-855-223-8791 gratis.

German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-855-223-8791 an.

Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-855-223-8791 χωρίς χρέωση.

Gujarati - ગુજરાતીમાં ભાષામાં સહ્ય માટે કોઈ પણ ખર્ચ વગર 1-855-223-8791 પર કૉલ કરો.

Hawaiian - No ke kōkua ma ka 'ōlelo Hawai'i, e kahea aku i ka helu kelepona 1-855-223-8791. Kāki 'ole 'ia kēia kōkua nei.

Hindi - हिन्दी में भाषा सहायता के लिए, 1-855-223-8791 पर मुफ्त कॉल करें।

Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-855-223-8791.

lbo - Maka enyemaka asusu na Igbo kpoo 1-855-223-8791 na akwughi ugwo o bula

llocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-855-223-8791 nga awan ti bayadanyo.

Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-855-223-8791.

Japanese - 日本語で援助をご希望の方は、1-855-223-8791 まで無料でお電話ください。

Karen - လာတစ်မာစားတစ်ကတိုးကျို့ခ်အင်္ဂါ ကျို့ခ် 🛱 855-223-8791 လာတအိုခ်ိုဒီးတစ်လာခ်ဘူဉ်လာခ်စ္ခာဘဉ်

Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-855-223-8791 번으로 전화해 주십시오.

Kru-Bassa - Be´m`ké gbo-kpá-kpá dyé pidyi dé Bašsɔɔ́-wuduùň wẽe, dá 1-855-223-8791

برای راهنمایی به زبان فارسی با شماره 8791-855-223 به خورایی پهیوهندی بکهن.

Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລນາໂທຫາ-855-223-8791 ໂດຍບໍ່ເສຍຄ່າໂທ.

Marathi - कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-855-223-8791 वर फोन करा.

Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-855-223-8791 ilo ejjelok wōnān.

Micronesian-

Pohnpeyan - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-855-223-8791 ni sohte isais.

Mon-Khmer, សម្សាប់ជំនួយភាសាជា ភាសាខ្មមរៃ សូមទូរស័ព្ទទទៅកាន់លខេ 1-855-223-8791 ដោយឥតគិតថ្លាំ។

Cambodian -

Navajo - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-855-223-8791

Nepali - (नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-855-223-8791 मा फोन गर्नुहोस् ।

Nilotic-Dinka - Tën kupony ë thok ë Thuonjan col 1-855-223-8791 kecin ayöc.

Norwegian - For språkassistanse på norsk, ring 1-855-223-8791 kostnadsfritt.

Panjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-855-223-8791 'ਤੇ ਮਫ਼ਤ ਕਾਲ ਕਰੋ।

Pennsylvania Dutch - Fer Helfe in Deitsch, ruf: 1-855-223-8791 aa. Es Aaruf koschtet nix.

برای راهنمایی به زبان فارسی با شماره 8791-855-1-1 بدون هیچ هزینه ای تماس بگیرید. انگلیسی Persian -

Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-855-223-8791.

Portuguese - Para obter assistência linguística em português ligue para o 1-855-223-8791 gratuitamente.

Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-855-223-8791

Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-855-223-8791.

Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-855-223-8791 e aunoa ma se totogi.

Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-855-223-8791.

Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-855-223-8791.

Sudanic-Fulfude - Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-855-223-8791. Njodi woo fawaaki on.

Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-855-223-8791 bila malipo.

Syriac - אבת א שבאו מאר שלב א שמו, אר שמו ו-855-223-8791 משל ב א אין וששר זאל, שמ ב 1-855-223-8791 משל ב .

Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-855-223-8791 nang walang bayad.

Telugu - భాషతో సాయం కొరకు ఎలాంటి ఖర్పు లేకుండా 1-855-223-8791 కు కాల్ చేయండి. (తెలుగు)

Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-855-223-8791 ฟรีไม่มีค่าใช้จ่าย

Tongan - Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-855-223-8791 'o 'ikai hā ōtōngi.

Trukese - Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-855-223-8791 nge esapw kamé ngonuk.

Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-855-223-8791.

Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-855-223-8791.

بلاقیمت زیان سے متعلقہ خدمات حاصل کرنے کے لیے ، 8791-855-223 یر بات کریں۔

Vietnamese - Đê 'được hố trở ngôn ngư bằng (ngôn ngư), hấy gọi miến phi 'đên số 1-855-223-8791.

Yiddish - פאר שפראך הילף אין אידיש רופט 1-855-223-8791 פריי פון אפצאל.

Yoruba - Fún ìrànlowo nípa èdè (Yorùbá) pe 1-855-223-8791 lái san owó kankan rárá.