Coverage Period: 01/01/2024-12/31/2024

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Coverage for: All Tiers | 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 1-877-371-2007. 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 1-877-371-2007 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	In- <u>Network</u> : Individual \$100 / Family \$200. Out- of-Network: Individual \$400 / Family \$800.	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. Prescription drugs; plus in-network office visits & preventive care are covered before you meet your deductible.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <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 limit</u> for this <u>plan</u> ?	In- <u>Network</u> : Individual \$2,000 / Family \$4,000. Out-of-Network: Individual \$3,500 / Family \$7,000.	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</u> <u>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>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover & penalties for failure to obtain <u>pre-authorization</u> for services.	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 <u>www.aetna.com/docfind</u> or call 1-877-371-2007 for a list of in- <u>network 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> . 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	ı 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
If you visit a health care <u>provider</u> 's office or clinic	Primary care visit to treat an injury or illness	\$20 <u>copay</u> /visit, <u>deductible</u> doesn't apply	20% coinsurance	Includes virtual visits by designated virtual network provider.
If you visit a health care <u>provider</u> 's office or clinic	<u>Specialist</u> visit	\$20 <u>copay</u> /visit, <u>deductible</u> doesn't apply	20% coinsurance	Includes virtual visits by designated virtual network provider.
If you visit a health care <u>provider</u> 's office or clinic	Preventive care /screening /immunization	No charge	20% <u>coinsurance</u>	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	Diagnostic test (x-ray, blood work)	10% coinsurance	20% coinsurance	None
If you have a test	Imaging (CT/PET scans, MRIs)	10% coinsurance	20% coinsurance	None
If you need drugs to treat your illness or condition  Prescription drug coverage is administered by OptumRX  More information about prescription drug coverage is available at https://www.optumrx.com/public/landing	Generic drugs	Copay/prescription, deductible doesn't apply: \$5 (retail), \$10 (mail order)	Reimbursed 100% of contract rate less copay, deductible doesn't apply	Covers 30 day supply (retail), 31-90 day supply (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. Precertification & step therapy required.

	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	
If you need drugs to treat your illness or condition  Prescription drug coverage is administered by OptumRX  More information about prescription drug coverage is available at https://www.optumrx.com/public/landing	Preferred brand drugs	Copay/prescription, deductible doesn't apply: \$30 (retail), \$60 (mail order)	Reimbursed 100% of contract rate less copay, deductible doesn't apply	Covers 30 day supply (retail), 31-90 day supply (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. Precertification & step therapy required.	
If you need drugs to treat your illness or condition  Prescription drug coverage is administered by OptumRX  More information about prescription drug coverage is available at https://www.optumrx.com/public/landing	Non-preferred brand drugs	Copay/prescription, deductible doesn't apply: \$50 (retail), \$90 (mail order)	Reimbursed 100% of contract rate less copay, deductible doesn't apply	Covers 30 day supply (retail), 31-90 day supply (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. Precertification & step therapy required.	

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 need drugs to treat your illness or condition  Prescription drug coverage is administered by OptumRX  More information about prescription drug coverage is available at https://www.optumrx.com/public/landing	Specialty drugs	Applicable cost as noted above for generic or brand drugs	Applicable cost as noted above for generic or brand drugs	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	20% coinsurance	None
If you have outpatient surgery	Physician/surgeon fees	10% coinsurance	20% coinsurance	None
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> . 50% <u>coinsurance</u> for non-emergency use.
If you need immediate medical attention	Emergency medical transportation	10% coinsurance	10% coinsurance	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> .
If you need immediate medical attention	<u>Urgent care</u>	10% <u>coinsurance</u>	20% coinsurance	50% <u>coinsurance</u> for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	20% coinsurance	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.

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	Physician/surgeon fees	10% coinsurance	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$20 copay/visit, deductible doesn't apply; other outpatient services: no charge	Office & other outpatient services: 20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Inpatient services	10% coinsurance	20% coinsurance	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
If you are pregnant	Office visits	No charge	20% <u>coinsurance</u>	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Penalty of \$400 for failure to obtain pre-authorization for out-of-network care may apply.
If you are pregnant	Childbirth/delivery professional services	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Penalty of \$400 for failure to obtain pre-authorization for out-of-network care may apply.
If you are pregnant	Childbirth/delivery facility services	10% <u>coinsurance</u>	20% <u>coinsurance</u>	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.

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 need help recovering or have other special health needs	Home health care	10% <u>coinsurance</u>	20% coinsurance	120 visits/calendar year. Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
If you need help recovering or have other special health needs	Rehabilitation services	10% <u>coinsurance</u>	20% coinsurance	None
If you need help recovering or have other special health needs	Habilitation services	No charge	20% <u>coinsurance</u>	None
If you need help recovering or have other special health needs	Skilled nursing care	10% <u>coinsurance</u>	20% coinsurance	120 days/calendar year. Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
If you need help recovering or have other special health needs	Durable medical equipment	10% <u>coinsurance</u>	20% coinsurance	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	Hospice services	No charge	20% coinsurance	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
If your child needs dental or eye care	Children's eye exam	\$20 <u>copay</u> /visit, <u>deductible</u> doesn't apply	20% coinsurance	1 routine eye exam/calendar year.
If your child needs dental or eye care	Children's glasses	Not covered	Not covered	Not covered.
If your child needs dental or eye care	Children's dental check-up	Not covered	Not covered	Not covered.

#### **Excluded Services & Other Covered Services:**

# Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult & Child)

- Glasses (Adult & Child)
- Long-term care

- 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 Only when administered by an MD.
- Bariatric surgery
- Chiropractic care
- Hearing aids 1 hearing aid to \$3,000 maximum per ear/2 years for children to age 13 & \$3,000 maximum per ear/3 years thereafter.
- Infertility treatment Limited to the diagnosis & treatment of underlying medical condition.
   Artificial insemination, ovulation induction & advanced reproductive technology: \$30,000 maximum/lifetime.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing 70- 8 hour shifts/calendar year.
- Routine eye care (Adult) 1 routine eye exam/calendar year.
- Transgender surgery

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 1-877-371-2007.
- 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 www.cciio.cms.gov.
- 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 <u>Health Insurance Marketplace</u>. For more information about the <u>Marketplace</u>, visit <u>www.HealthCare.gov</u> 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 1-877-371-2007. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform

- 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: http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html.

## 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 <u>plan</u> doesn't meet the <u>Minimum Value Standards</u>, you may be eligible for a <u>premium tax credit</u> to help you pay for a <u>plan</u> through the <u>Marketplace</u>.

To see examples of how this <u>plan</u> 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>	\$100
■ 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	\$12,700
In this example, Peg would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$20
Coinsurance	\$1,100
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$1,280

# Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$100
Specialist copayment	\$20
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

#### This EXAMPLE event includes services like:

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

Diagnostic tests (blood work)

Prescription drugs

Diabetic supplies (glucose meter)

Total Example Cost	\$5,600
In this example, Joe would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$800
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$920

# **Mia's Simple Fracture**

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

■ The <u>plan's</u> overall <u>deductible</u>	\$100
■ 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)

<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>	\$100	
<u>Copayments</u>	\$50	
Coinsurance	\$200	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$350	

## **Assistive Technology**

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-877-371-2007.

## **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:

To access language services at no cost to you, call 1-877-371-2007.

Albanian - Për shërbime përkthimi falas për ju, telefononi 1-877-371-2007.

Amharic - የቋንቋ አባልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-877-371-2007 ይደውሉ።

للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء االتصال على الرقم 371-2007 -1-877

Armenian - Անվձար լեզվական ծառալություններից օգտվելու համար զանգահարեք 1-877-371-2007 հեռախոսահամարով։

Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-877-371-2007 tanpa dikenakan biaya.

Bantu-Kirundi - Kugira uronke serivisi z'indimi atakiguzi, hamagara 1-877-371-2007.

Bengali-Bangala - আপনাকে বিনামৃক্যে ভাষা পবিক্ষাি পপকে হক্য এই নম্বকি পেব্যক ান েরুন: 1-888-982-386।

Bisayan-Visayan - Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-877-371-2007.

Burmese - သင့္အေနျဖင့္ အခေၾကးေငြ မေပးရပဲ ဘာသာစကားဝန္ေဆာင္မႈမ်ား ရရွိႏုိင္ရန္ 1-877-371-2007 သို႕ ဖုန္းေခၚဆုိပါ။

Catalan - Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-877-371-2007.

Chamorro - Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-877-371-2007.

Cherokee - GYOJA SOPHOOJA OGOLOGIJA C ALOJA JGEGWIJA JAY, OFOLOGIJA 1-877-371-2007.

Chinese - 如欲使用免費語言服務, 請致電 1-877-371-2007.

Choctaw - Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-877-371-2007.

Cushite - Tajaajiiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-877-371-2007.

Dutch - Voor gratis toegang tot taaldiensten, bell 1-877-371-2007.

French - Afin d'accéder aux services langagiers sans frais, composez le 1-877-371-2007.

French Creole - Pou jwenn sèvis lang gratis, rele 1-877-371-2007.

German - Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-877-371-2007 an.

Greek - Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό

1-877-371-2007.

Gujarati - તમારેકોઇ જાતના ખર્ચવિના ભાષાની સેિાઓની પહોોર્ માટે, કોલ કરો1-877-371-2007.

Hawaiian - No ka wala'au 'ana me ka lawelawe 'ōlelo e kahea aku i kēia helu kelepona 1-877-371-2007. Kāki 'ole 'ia kēia kōkua nei.

Hindi - आपकेलिए बिना ककसी कीमत केभाषा सेवाओंका उपयोग करनेकेलिए,1-877-371-2007 पर कॉल करें।

Hmong - Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-877-371-2007.

lgbo - Iji nwetaòhèrè na oru gasi asusu n'efu, kpoo 1-877-371-2007

llocano - Tapno maaksesyo dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti 1-877-371-2007.

Indonesian - Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi 1-877-371-2007.

Italian - Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-877-371-2007.

Japanese - 言語サービスを無料でご利用いただくには、1-877-371-2007 までお電話ください。

Karen - လာတ်ကမန္နာ်ကိုဉ်အတာ်မာစားအတာ်ဖုံးတာ်မာတဖဉ်လာတအိဉ်ဒီးအပူးလာကဘဉ်ဟူဉ်အီးအဂ်ီးဘဉ်နှဉ် ကိုး 1-877-371-2007 တက္၏.

Korean - 무료 언어 서비스를 이용하려면 1-877-371-2007 번으로 전화해 주십시오.

Kru-Bassa - Μ dyi wudu-dù kà kò dò bě dyi moú ń nì Pídyi ní, nìí, dá nòbà nìà kε: 1-877-371-2007

بۆ دەسىپىراگەيشتن بە خزمەتگوزارى زمان بەبئى تېچوون بۆ تۆ، يەيوەندى بكە بە ژمارەي 2007-371-877-1-1-877

Laotian - ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ. ໃຫ້ໂທຫາເບີ1-888-982-3862

Marathi - कोणत्याही शल्ुकालशवाय भाषा सेवा प्राप्त करण्यासाठी,, 1-877-371-2007 वर फोन करा.

Marshallese - Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlok 1-877-371-2007.

Micronesian-

Pohnpeyan - Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1-877-371-2007.

Mon-Khmer, ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-888- 982-3862។

Cambodian -

Navajo - T'áá ni nizaad k'ehjí bee níká a'doowoł doo bááh ílínígóó kojj' hólne' 1-877-371-2007.

Nepali - निःश्ल्क भाषा सेवा प्राप्त गर्न 1-877-371-2007 मा टेलिफोन गर्न्होस्।

Nilotic-Dinka - Të koor yin weër de thokic ke cin wëu kor keek tënon yin. Ke col koc ye koc kuony ne nomba 1-877-371-2007.

Norwegian - For tilgang til kostnadsfri språktjenester, ring 1-877-371-2007.

Pennsylvania Dutch - Um Schprooch Services zu griege mitaus Koscht, ruff 1-877-371-2007.

برای دسترسی به خدمات زبان به طور رایگان، با شماره 2007-371-877-1 تماس بگیرید.

Polish - Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-877-371-2007.

Portuguese - Para acessar os serviços de idiomas sem custo para você, ligue para 1-877-371-2007.

Punjabi - ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1-877-371-2007 'ਤੇ ਫ਼ੋਨ ਕਰੋ।

Romanian - Pentru a accesa gratuit serviciile de limbă, apelați 1-877-371-2007.

Russian - Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-877-371-2007.

Samoan - Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala'au le 1-877-371-2007.

Serbo-Croatian - Za besplatne prevodilačke usluge pozovite 1-877-371-2007.

Spanish - Para acceder a los servicios de idiomas sin costo, llame al 1-877-371-2007.

Sudanic-Fulfude - Heeba a nasta jangirde djey wolde wola chede bo apelou lamba 1-877-371-2007.

Swahili - Kupata huduma za lugha bila malipo kwako, piga 1-877-371-2007.

Syriac - جل سلخه نوندیک در این این در کینی در ۱-877-371-2007 کی معبقی منابع کی این در ۱-877-371-2007 کی در این در کینی در این د

Tagalog - Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-877-371-2007.

Telugu - మీరు భాష్ణ సేవలను ఉచితంగా అందుకునందుకు, 1-877-371-2007 కు కాల్ చేయండి.

Thai - หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-877-371-2007.

Tongan - Kapau 'oku ke fiema'u ta'etōtōngi 'a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he 1-877-371-2007.

Trukese - Ren omw kopwe angei aninisin eman chon awewei (ese kamo), kopwe kori 1-877-371-2007.

Turkish - Sizin için ücretsiz dil hizmetlerine erişebilmek için, 1-877-371-2007 numarayı arayın.

Ukrainian - Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-877-371-2007.

بالقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 3862-982-988-1 پر بات کریں۔

Vietnamese - Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-877-371-2007.

Yiddish - 1-877-371-2007 צו צוטריט שּפרַאך בַאדינונגען אין קיין פרייַז צו איר, רופן

Yoruba - Lati wonú awon ise èdè l'ofe fun o, pe 1-877-371-2007.