

Coverage for: Employee + Family | Plan Type: POS

Coverage Period: 11/01/2020 - 10/31/2021



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, https://www.aetna.com/sbcsearch/getpolicydocs?u=082000-040020-122000 or by calling 1-888-802-3862. 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 1-888-802-3862 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In- <u>network</u> : Individual \$1,500 / Family \$3,000. Out-of-network: Individual \$5,000 / Family \$10,000.	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. Certain office visits, <u>preventive care</u> , emergency care, <u>urgent care</u> and <u>prescription drugs</u> in- <u>network</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 deductibles 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 \$5,000 / Family \$10,000. Out-of-Network: Individual \$10,000 / Family \$20,000.	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 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>	Premiums, balance-billing charges, penalties for failure to obtain pre-authorization for services, and health care this plan 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 http://www.aetna.com/docfind or call 1-888-802-3862 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 before</u> 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	\$20 <u>copay</u> /visit, <u>deductible</u> does not apply	40% coinsurance	None
If you visit a health care provider's office or clinic	Specialist visit	\$50 <u>copay</u> /visit, <u>deductible</u> does not apply	40% coinsurance	None
	Preventive care /screening /immunization	No charge	40% coinsurance	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.
	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
If you have a test	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Out-of-network precertification required or \$400 penalty applies per occurrence.

		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  More information about prescription drug coverage is available at	Preferred generic drugs	Tier 1A: \$3 copay/ prescription for up to a 30 day supply, \$7.50 copay/ prescription for up to a 90 day supply; Tier 1: \$20 copay/ prescription for up to a 30 day supply, \$45 copay/ prescription for up to a 90 day supply	50% <u>coinsurance</u> for up to a 90 day supply, <u>deductible</u> does not apply	Covers up to a 30 day supply (retail prescription), 31-90 day supply (retail & mail order prescription). Your cost will be higher for choosing Brand over Generics; cost difference penalty doesn't apply to <a href="https://doi.org/10.25">out-of-pocket-limit</a> . No charge for preferred generic FDA-approved women's contraceptives in- <a href="https://doi.org/10.25">network</a> . Precertification and step therapy may be required.	
	Preferred brand drugs	\$40 copay/ prescription for up to a 30 day supply, \$100 copay/ prescription for up to a 90 day supply	50% coinsurance for up to a 90 day supply, deductible does not apply		
http://client.formularynavigat or.com/Search.aspx?siteCo de=4331114517	Non-preferred generic/brand drugs	\$90 copay/ prescription for up to a 30 day supply, \$225 copay/ prescription for up to a 90 day supply	50% <u>coinsurance</u> for up to a 90 day supply, <u>deductible</u> does not apply		
	Specialty drugs	Preferred: 20% coinsurance up to a \$250 maximum/ prescription for up to a 30 day supply; Non-preferred: 20% coinsurance up to a \$400 maximum/ prescription for up to a 30 day supply	50% <u>coinsurance</u> for up to a 30 day supply, <u>deductible</u> does not apply	None	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None	
34.7	Physician/surgeon fees	20% coinsurance	40% coinsurance	None	

		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 immediate	Emergency room care	\$250 <u>copay</u> /visit, <u>deductible</u> does not apply	\$250 <u>copay</u> /visit, <u>deductible</u> does not apply	<u>Copay</u> waived if admitted. Out-of-network <u>emergency room care</u> cost-share same as in- <u>network</u> . No coverage for non-emergency care.
medical attention	Emergency medical transportation	20% coinsurance	20% coinsurance	Out-of-network cost-share same as in-network.
	<u>Urgent care</u>	\$75 copay/visit, deductible does not apply	40% coinsurance	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Out-of-network precertification required or \$400 penalty applies per occurrence.
noopital otay	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Outpatient office visits: \$50 copay/visit, deductible does not apply; All other outpatient services: 20% coinsurance	Office visits and all other outpatient services: 40% coinsurance	None
	Inpatient services	20% coinsurance	40% coinsurance	Out-of-network precertification required or \$400 penalty applies per occurrence.
If you are pregnant	Office visits	No charge	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	None
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	Out-of-network precertification required or \$400 penalty applies per occurrence.

	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	
	Home health care	20% coinsurance	40% coinsurance	Coverage is limited to 60 visits.	
	Rehabilitation services	\$50 copay/visit, deductible does not apply	40% coinsurance	None	
	Habilitation services	20% coinsurance	40% coinsurance	None	
If you need help recovering or have other	Skilled nursing care	20% coinsurance, deductible does not apply	40% coinsurance	Coverage is limited to 60 days. Out-of-network precertification required or \$400 penalty applies per occurrence.	
special health needs	Durable medical equipment	20% coinsurance	40% coinsurance	Coverage is limited to 1 <u>durable medical</u> <u>equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse. Excludes vehicle modifications, home modifications & exercise equipment.	
	Hospice services	20% coinsurance	40% coinsurance	Out-of-network precertification required or \$400 penalty applies per occurrence.	
If your child needs dental	Children's eye exam	\$50 copay/visit, deductible does not apply	40% coinsurance	Coverage is limited to one exam every 12 months.	
or eye care	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.)

- 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

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

- Bariatric surgery
- Chiropractic care Coverage is limited to 12 visits applicable to spinal manipulation services only by any provider type.
- Hearing aids Coverage is limited to 1 per ear every 36 months age 0-18.
- Infertility treatment Benefit limitations may apply.
- Routine eye care (Adult) Coverage is limited to one exam every 12 months.

## **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: Illinois Department of Insurance, Office of Consumer Health Insurance, 1-877-527-9431 toll free, 1-866-323-5321 (TDD), <a href="https://insurance.illinois.gov/">https://insurance.illinois.gov/</a>.

- For more information on your rights to continue coverage, contact the plan at 1-888-802-3862.
- 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 <a href="https://www.dol.gov/agencies/ebsa">https://www.dol.gov/agencies/ebsa</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 <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. 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 1-888-802-3862.
- Illinois Department of Insurance, Office of Consumer Health Insurance, 1-877-527-9431 toll free, 1-866-323-5321 (TDD), http://insurance.illinois.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 <a href="https://www.dol.gov/agencies/ebsa">https://www.dol.gov/agencies/ebsa</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 Office of Consumer Health Insurance, Consumer Services Section, 122 South Michigan Avenue, 19th floor, Chicago, IL 60603, Or 320 W. Washington Street, Springfield, IL 62767-0001, 877-527-9431, 1-866-323-5321 (TDD), <a href="http://insurance.illinois.gov/">http://insurance.illinois.gov/</a>

## 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 <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 plan's overall deductible	\$1,500
<ul><li>Specialist copayment</li></ul>	\$50
<ul><li>Hospital (facility) coinsurance</li></ul>	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)

<b>Total Example Cost</b>	\$12,800	
In this example, Peg would pay:		
Cost Sharing		
Deductibles	\$1,500	
Copayments	\$50	
Coinsurance	\$2,200	
What isn't covered		
Limits or exclusions	\$60	
The total Peg would pay is	\$3,810	

# 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>	\$1,500
<ul><li>Specialist copayment</li></ul>	\$50
<ul><li>Hospital (facility) coinsurance</li></ul>	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	\$100	
Copayments	\$1,000	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions \$20		
The total Joe would pay is	\$1,120	

## Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$1,500
<ul><li>Specialist copayment</li></ul>	\$50
<ul><li>Hospital (facility) coinsurance</li></ul>	20%
<ul><li>Other coinsurance</li></ul>	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	\$600	
Copayments	\$500	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions \$0		
The total Mia would pay is	\$1,100	

Note: These numbers assume the patient does not participate in the <u>plan's</u> wellness program. If you participate in the <u>plan's</u> wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-888-802-3862.

## **Assistive Technology**

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-888-802-3862.

## **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 1-888-802-3862.

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 <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 subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates.

### TTY: 711

## **Language Assistance:**

For language assistance in your language call 1-888-802-3862 at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-888-802-3862.

Amharic - ለቋንቋ እንዛ በ አማርኛ በ 1-888-802-3862 በነጻ ይደውሉ

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 3862-802-888-1

Armenian - Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-888-802-3862 առանց գնով։

Bahasa-Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-802-3862 tanpa dikenakan biaya.

Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-888-802-3862 ku busa

Bengali-Bangala - বাংলাম ভাষা সহায়তার জন্য বিনামূল্য( 1-888-802-3862-ত( কল কর্ন।

Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-888-802-3862 nga walay bayad.

Burmese - ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-888-802-3862 ကို ခေါ် ဆိုပါ။

Catalan - Per rebre assistència en (català), truqui al número gratuït 1-888-802-3862.

Chamorro - Para ayuda gi fino' (Chamoru), agang 1-888-802-3862 sin gastu.

Chinese - 欲取得繁體中文語言協助,請撥打 1-888-802-3862,無需付費。

Choctaw - (Chahta) anumpa ya apela a chi I paya hinla 1-888-802-3862.

Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-888-802-3862 irratti bilisaan bilbilaa.

Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-888-802-3862.

French - Pour une assistance linguistique en français appeler le 1-888-802-3862 sans frais.

French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-888-802-3862 gratis.

German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-888-802-3862 an.

Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-888-802-3862 χωρίς χρέωση.

Gujarati - ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-888-802-3862 પર કૉલ કરો.

Hawaiian - No ke kōkua ma ka 'ōlelo Hawai'i, e kahea aku i ka helu kelepona 1-888-802-3862. Kāki 'ole 'ia kēia kōkua nei.

Hindi - हिन्दी में भाषा सहायता के लिए, 1-888-802-3862 पर मुफ्त कॉल करें।

Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-888-802-3862.

lbo - Maka enyemaka asusu na Igbo kpoo 1-888-802-3862 na akwughi ugwo o bula

llocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-888-802-3862 nga awan ti bayadanyo.

Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-888-802-3862.

Japanese - 日本語で援助をご希望の方は、1-888-802-3862 まで無料でお電話ください。

Karen - လာတာ်မာစားတာ်ကတိာကျိန်အင်္ဂ ကျိန် ကိုး 1-888-802-3862 လာတအိန်ဒီးတာ်လာ၁်ဘူန်လာ၁်စုးသာ

Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-802-3862 번으로 전화해 주십시오.

Kru-Bassa - Be´m`ké gbo-kpá-kpá dyé pidyi dé Bašsoó-wuduun wee, dá 1-888-802-3862

برای راهنمایی به زبان فارسی با شماره 3862-802-88-1 به خورایی پهیومندی بکهن. - Kurdish

Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-888-802-3862 ໂດຍບໍ່ເສຍຄ່າໂທ.

Marathi - तीलभाषा(मराठी)सहाययासाठी 1-888-802-3862 क्रमांकावरकोणत्याहीखर्चाशविायकॉलकरा.

Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-888-802-3862 ilo ejjelok wōnān.

Micronesian - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-888-802-3862 ni sohte isais.

Mon-Khmer, Cambodian - សម្រាប់ជំនួយភាសាជា ភាសាខ្**មរ៉ែ សូមទូរស័ព្**ទទ**ៅកាន់លខេ 1-888-802-3862 ដ**ោយឥតគិតថ្លាំ។

Navajo - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-888-802-3862

Nepali - (नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-888-802-3862 मा फोन गर्नुहोस् ।

Nilotic-Dinka - Tën kuoony ë thok ë Thuonjän col 1-888-802-3862 kecin ayöc.

Norwegian - For språkassistanse på norsk, ring 1-888-802-3862 kostnadsfritt.

Panjabi - ਪੰਜਾਬੀ ਵੱਚਿ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-888-802-3862 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।

Pennsylvania Dutch - Fer Helfe in Deitsch, ruf: 1-888-802-3862 aa. Es Aaruf koschtet nix.

برای راهنمایی به زبان فارسی با شماره 3862-802-188-1 بدون هیچ هزینه ای تماس بگیرید. انگلیسی Persian -

Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-888-802-3862.

Portuguese - Para obter assistência linguística em português ligue para o 1-888-802-3862 gratuitamente.

Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-888-802-3862

Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-888-802-3862.

Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-888-802-3862 e aunoa ma se totogi.

Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-888-802-3862.

Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-888-802-3862.

Sudanic-Fulfude - Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-888-802-3862 Njodi woo fawaaki on.

Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-888-802-3862 bila malipo.

Syriac - אב שבאיב מאר שבאיב מאר שלאי הר שה 1-888-802-3862 מביל ב . בער האלא שלאי הר שה ביל ב ביל ב א שבאים מאר שלאי הר שה שלאי הר שה אלא היא לא מיים לא היא שלא הר של הר שלא הר של הר של הר שלא הר של הר

Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-888-802-3862 nang walang bayad.

Telugu - భషతో నయంకొరకు ఎలంటి ఖర్చు లేకుండా **1-888-802-3862** కు శల్ చేయండి. (తెలుగు)

Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-888-802-3862 ฟรีไม่มีค่าใช้จ่าย

Tongan - Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-888-802-3862 'o 'ikai hā tōtōngi.

Trukese - Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-888-802-3862 nge esapw kamé ngonuk.

Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-888-802-3862.

Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-888-802-3862.

ا رورک ل کستف م رب 288-802-3862 <u>معال کستن و اعم عن الل رق م و در</u>

Vietnamese - Đê 'được hố trợ ngôn ngư bằng (ngôn ngư), hấy gọi miến phi 'đên số 1-888-802-3862.

Yiddish - פאר שפראך הילף אין אידיש רופט 1-888-802-3862 פריי פון אפצאל.

Yoruba - Fún ìrànlowo nípa èdè (Yorùbá) pe 1-888-802-3862 lái san owó kankan rárá.