



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](http://www.HealthReformPlanSBC.com) or by calling 1-866-760-0836. 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 1-866-760-0836 to request a copy.

| Important Questions  | Answers   | Why This Matters:   |
|--|---|---|
| <b>What is the overall deductible?</b>                             | In-Network: Individual \$300 / Family \$900. Out-of-Network: Individual \$300 / Family \$900.   | 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> .   |
| <b>Are there services covered before you meet your deductible?</b> | Yes. <u>Prescription drugs</u> , office visits & <u>preventive care</u> are 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>  |
| <b>Are there other deductibles for specific services?</b>          | No.   | You don't have to meet <u>deductibles</u> for specific services.  |
| <b>What is the out-of-pocket limit for this plan?</b>              | In-Network: Individual \$2,500 / Family \$7,500. Out-of-Network: Individual \$3,000 / Family \$9,000.   | 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.   |
| <b>What is not included in the out-of-pocket limit?</b>            | <u>Premiums</u> , 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> .  |
| <b>Will you pay less if you use a network provider?</b>            | Yes. See <a href="http://www.aetna.com/docfind">www.aetna.com/docfind</a> or call 1-866-760-0836 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 charge</u> 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</u> before you get services. |
| <b>Do you need a referral to see a specialist?</b>                 | 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 Provider<br>(You will pay the least)   | Out-of-Network Provider<br>(You will pay the most)  |   |
| If you visit a health care <b>provider's</b> office or clinic   | Primary care visit to treat an injury or illness        | \$25 <b>copay</b> /visit, <b>deductible</b> doesn't apply                                     | 40% <b>coinsurance</b> after \$25 <b>copay</b> /visit, <b>deductible</b> doesn't apply                  | None  |
|   | <u>Specialist</u> visit                                 | \$25 <b>copay</b> /visit, <b>deductible</b> doesn't apply                                     | 40% <b>coinsurance</b> after \$25 <b>copay</b> /visit, <b>deductible</b> doesn't apply                  | None  |
|   | <u>Preventive care</u> / <u>screening</u> /immunization | No charge   | 40% <b>coinsurance</b> , <b>deductible</b> doesn't apply  | You may have to pay for services that aren't preventive. Ask your <b>provider</b> if the services needed are preventive. Then check what your <b>plan</b> will pay for.   |
| If you have a test  | <u>Diagnostic test</u> (x-ray, blood work)              | 10% <b>coinsurance</b>  | 40% <b>coinsurance</b>  | None  |
|   | Imaging (CT/PET scans, MRIs)                            | 10% <b>coinsurance</b>  | 40% <b>coinsurance</b>  | None  |
| If you need drugs to treat your illness or condition<br><br>More information about <b>prescription drug coverage</b> is available at <a href="http://www.aetnapharmac">www.aetnapharmac</a> | Generic drugs   | <u>Copay</u> /prescription, <b>deductible</b> doesn't apply: \$10 (retail), \$20 (mail order) | 40% <b>coinsurance</b> after <u>copay</u> /prescription, <b>deductible</b> doesn't apply: \$10 (retail) | Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives <u>in-network</u> . Review your <u>formulary</u> for prescriptions requiring step therapy for coverage. Your cost will be higher for choosing Brand over Generics; cost difference penalty doesn't apply to <u>out-of-pocket limit</u> . Maintenance drugs- no refill restrictions or penalties apply. |
|   | Preferred brand drugs                                   | <u>Copay</u> /prescription, <b>deductible</b> doesn't apply: \$30 (retail), \$60 (mail order) | 40% <b>coinsurance</b> after <u>copay</u> /prescription, <b>deductible</b> doesn't apply: \$30 (retail) |   |

| Common Medical Event   | Services You May Need                          | What You Will Pay   |  | Limitations, Exceptions, & Other Important Information   |
|--|--|---|--|--|
|  |  | In-Network Provider<br>(You will pay the least)   | Out-of-Network Provider<br>(You will pay the most)   |  |
| y.com/standard   | Non-preferred brand drugs                      | <u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$50 (retail), \$100 (mail order)          | 40% <u>coinsurance</u> after <u>copay</u> /prescription, <u>deductible</u> doesn't apply: \$50 (retail)                    | Members save with lower <u>copays</u> at CVS Caremark® Mail Service Pharmacy or CVS Pharmacy.  |
|  | <u>Specialty drugs</u>                         | Applicable cost as noted above for generic or brand drugs   | Not covered  | First prescription fill at a retail pharmacy or specialty pharmacy. Subsequent fills must be through the Aetna Specialty Pharmacy <u>Network</u> . Precertification required for coverage. Covers 30 day supply. |
| <b>If you have outpatient surgery</b>  | Facility fee (e.g., ambulatory surgery center) | 10% <u>coinsurance</u>  | 40% <u>coinsurance</u>   | None   |
|  | Physician/surgeon fees                         | 10% <u>coinsurance</u>  | 40% <u>coinsurance</u>   | None   |
| <b>If you need immediate medical attention</b>                                   | <u>Emergency room care</u>                     | 10% <u>coinsurance</u> after \$125 <u>copay</u> /visit  | 10% <u>coinsurance</u> after \$125 <u>copay</u> /visit   | Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> .   |
|  | <u>Emergency medical transportation</u>        | 20% <u>coinsurance</u>  | 20% <u>coinsurance</u>   | Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> . Non-emergency transport: not covered, except if pre-authorized.   |
|  | <u>Urgent care</u>                             | \$25 <u>copay</u> /visit, <u>deductible</u> doesn't apply   | 40% <u>coinsurance</u>   | No coverage for non-urgent use.  |
| <b>If you have a hospital stay</b>   | Facility fee (e.g., hospital room)             | 10% <u>coinsurance</u>  | 40% <u>coinsurance</u>   | <u>Pre-authorization</u> required for out-of-network care.   |
|  | Physician/surgeon fees                         | 10% <u>coinsurance</u>  | 40% <u>coinsurance</u>   | None   |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                            | Office: \$25 <u>copay</u> /visit, <u>deductible</u> doesn't apply; other outpatient services: no charge | Office & other outpatient services: 40% <u>coinsurance</u> after \$25 <u>copay</u> /visit, <u>deductible</u> doesn't apply | None   |
|  | Inpatient services                             | 10% <u>coinsurance</u>  | 40% <u>coinsurance</u>   | <u>Pre-authorization</u> required for out-of-network care.   |

| Common Medical Event   | Services You May Need                     | What You Will Pay   |   | Limitations, Exceptions, & Other Important Information   |
|--|---|---|---|--|
|  |   | In-Network Provider<br>(You will pay the least)           | Out-of-Network Provider<br>(You will pay the most)  |  |
| If you are pregnant  | Office visits                             | No charge   | 40% <u>coinsurance</u>  | Cost sharing does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) <u>Pre-authorization</u> for out-of-network care may apply. |
|  | Childbirth/delivery professional services | 10% <u>coinsurance</u>                                    | 40% <u>coinsurance</u>  |  |
|  | Childbirth/delivery facility services     | 10% <u>coinsurance</u>                                    | 40% <u>coinsurance</u>  |  |
| If you need help recovering or have other special health needs | <u>Home health care</u>                   | 10% <u>coinsurance</u>                                    | 40% <u>coinsurance</u>  | 130 visits/calendar year. <u>Pre-authorization</u> required for out-of-network care.   |
|  | <u>Rehabilitation services</u>            | 10% <u>coinsurance</u>                                    | 40% <u>coinsurance</u>  | 35 visits/calendar year for Physical, Occupational, Speech & Massage Therapy combined, including outpatient hospital services.   |
|  | <u>Habilitation services</u>              | No charge, except 10% <u>coinsurance</u> for Autism       | 40% <u>coinsurance</u> after \$25 <u>copay/visit</u> , <u>deductible</u> doesn't apply; 40% <u>coinsurance</u> for Autism | None   |
|  | <u>Skilled nursing care</u>               | 10% <u>coinsurance</u>                                    | 40% <u>coinsurance</u>  | 60 days/calendar year. <u>Pre-authorization</u> required for out-of-network care.  |
|  | <u>Durable medical equipment</u>          | 10% <u>coinsurance</u>                                    | 40% <u>coinsurance</u>  | Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.   |
|  | <u>Hospice services</u>                   | 10% <u>coinsurance</u>                                    | 40% <u>coinsurance</u>  | <u>Pre-authorization</u> required for out-of-network care.   |
| If your child needs dental or eye care                         | Children's eye exam                       | \$25 <u>copay/visit</u> , <u>deductible</u> doesn't apply | Not covered   | 1 routine eye exam/calendar year.  |
|  | 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.
- 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.)

- Acupuncture - 12 visits/calendar year for disease, injury & chronic pain.
- Bariatric surgery - Limited to Institutes of Quality contracted facility only.
- Chiropractic care - 20 visits/calendar year.
- Hearing aids - \$1,000 maximum/36 months.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.
- 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 plan at 1-866-760-0836.
- 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 <http://www.dol.gov/ebsa/healthreform>
- 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](http://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](http://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 1-866-760-0836. 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 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](http://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.**

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 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 **\$300**
- Specialist copayment **\$25**
- 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <u>Cost Sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$300          |
| <u>Copayments</u>                 | \$10           |
| <u>Coinsurance</u>                | \$1,100        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$1,470</b> |

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

- The plan's overall deductible **\$300**
- Specialist copayment **\$25**
- Hospital (facility) coinsurance **10%**
- Other coinsurance **10%**

**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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| <u>Cost Sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$100          |
| <u>Copayments</u>                 | \$1,000        |
| <u>Coinsurance</u>                | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,120</b> |

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

- The plan's overall deductible **\$300**
- Specialist copayment **\$25**
- Hospital (facility) coinsurance **10%**
- Other coinsurance **10%**

**This EXAMPLE event includes services like:**

- Emergency room care (*including medical supplies*)
- Diagnostic test (*x-ray*)
- Durable medical equipment (*crutches*)
- Rehabilitation services (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| <u>Cost Sharing</u>               |              |
|-----------------------------------|--------------|
| <u>Deductibles</u>                | \$300        |
| <u>Copayments</u>                 | \$60         |
| <u>Coinsurance</u>                | \$300        |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$660</b> |

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: 1-866-760-0836.

### 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](mailto: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 companies, including Aetna Life Insurance Company and its affiliates (Aetna).**





- Hindi - हन्दिी में भाषा सहायता के लएि, 1-866-760-0836 पर मुफ्त कॉल करें।
- Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-866-760-0836.
- Ibo - Maka enyemaka asụsụ na Igbo kpọọ 1-866-760-0836 na akwughị ugwo ọ bụla
- Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-866-760-0836 nga awan ti bayadanyo.
- Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-866-760-0836.
- Japanese - 日本語で援助をご希望の方は、1-866-760-0836 まで無料でお電話ください。
- Karen - လာဝံၢ်မၤစၢၤလာဝံၢ်ကၤလိၤကၢ်အိၣ်အိၣ် ၈-866-760-0836 လာဝံၢ်အိၣ်ဒီးတၢ်လာဝံၢ်သ့ၣ်လာဝံၢ်စ့ၣ်
- Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-866-760-0836 번으로 전화해 주십시오.
- Kru-Bassa - Be´m`ké gbo-kpá-kpá dyé pídyi dé Baśwó-wuḍuūñ wěɛ, dá 1-866-760-0836
- Kurdish - برای راهنمایی به زبان فارسی با شماره 1-866-760-0836 به خۆرای یه یو مندێ بکهن.
- Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ-866-760-0836 ໂດຍບໍ່ເສຍຄ່າໂທ.
- Marathi - कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-866-760-0836 वर फोन करा.
- Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-866-760-0836 ilo ejjelok wōnān.
- Micronesian - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-866-760-0836 ni sohte isais.
- Pohnpeyan - ສຍຸກບໍ່ຕີ່ຊຸຍກາສາຕາ ກາສາອຸຮັ່ ສຍຸຮຸສັຕຸອອາຕາກຸສ່ລາຂ 1-866-760-0836 ຜເດຍສັຕຸສັຕຸຮຸດໍ່
- Mon-Khmer, Cambodian - សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទទា ៧កាន់លេខ 1-866-760-0836 ដោយឥតគិតថ្លៃ។
- Navajo - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-866-760-0836
- Nepali - (नेपाली) मा नि:शुल्क भाषा सहायता पाउनका लागि 1-866-760-0836 मा फोन गर्नुहोस् ।
- Nilotic-Dinka - Tën kuwoɗy è thok è Thuonjäŋ cɔl 1-866-760-0836 kecïn ayöc.
- Norwegian - For språkassistanse på norsk, ring 1-866-760-0836 kostnadsfritt.
- Panjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਮਦਦ ਲਈ, 1-866-760-0836 'ਤੇ ਮੁਫਤ ਕਾਲ ਕਰੋ।
- Pennsylvania Dutch - Fer Hefte in Deutsch, ruf: 1-866-760-0836 aa. Es Aaruf koschtet nix.
- Persian - برای راهنمایی به زبان فارسی با شماره 1-866-760-0836 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
- Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-866-760-0836.
- Portuguese - Para obter assistência linguística em português ligue para o 1-866-760-0836 gratuitamente.
- Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-866-760-0836

- Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-866-760-0836.
- Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-866-760-0836 e aunoa ma se totogi.
- Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-866-760-0836.
- Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-866-760-0836.
- Sudanic-Fulfude - Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-866-760-0836. Njodi woo fawaaki on.
- Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-866-760-0836 bila malipo.
- Syriac - ܟܠ ܥܘܪܟܐ ܟܠ ܗܐ ܡܫܘܟܐ ܡܠܟܐ ܟܠ ܗܐ ܡܫܘܟܐ ܟܠ ܗܐ ܡܫܘܟܐ ܟܠ ܗܐ ܡܫܘܟܐ ܟܠ ܗܐ ܡܫܘܟܐ 1-866-760-0836 ܡܫܘܟܐ.
- Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-866-760-0836 nang walang bayad.
- Telugu - భాషతో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 1-866-760-0836 కు కాల్ చేయండి. (తెలుగు)
- Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-866-760-0836 ฟรีไม่มีค่าใช้จ่าย
- Tongan - Kapau ‘oku fiema'u hā tokoni ‘i he lea faka-Tonga telefoni 1-866-760-0836 ‘o ‘ikai hā ʻōtōngi.
- Trukese - Ren ánninnisin chiakú ren (Kapasen Chuuk) kopwe kékkéeri 1-866-760-0836 nge esapw kamé ngonuk.
- Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemedен 1-866-760-0836.
- Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-866-760-0836.
- Urdu - بلا قیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-866-760-0836 پر بات کریں۔
- Vietnamese - Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-866-760-0836.
- Yiddish - פאר שפראך הילף אין אידיש רופט 1-866-760-0836 פון אפצאל.
- Yoruba - Fún ìrànlowọ nípa èdè (Yorùbá) pe 1-866-760-0836 láí san owó kankan rárá.