

KANSAS STATE EMPLOYEES HEALTH CARE COMMISSION (DBA STATE OF KANSAS): Aetna Choice® POS II - Plan A

Coverage for: Individual + Family | Plan Type: POS

Coverage Period: 01/01/2021-12/31/2021



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, <u>www.HealthReformPlanSBC.com</u> or by calling 1-866-851-0754. 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 1-866-851-0754 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: \$1,000 individual / \$2,000 family. Out-of-Network: \$1,200 individual / \$2,400 family.	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. In- <u>network</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>
Are there other <u>deductibles</u> for specific services?	No. There are no other specific deductibles.	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> ?	Medical and Pharmacy combined Out of Pocket: In-Network: Individual \$6,250 / Family \$12,500. Out-of-Network: Individual \$6,250 / Family \$12,500.	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?	Premiums, balance-billing charges & 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 network provider?	Yes. For a list of in-network providers, see www.aetnastateofkansas.com or call 1-866-851-0754.	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> .

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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 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
	Primary care visit to treat an injury or illness	\$40 <u>copay</u> /visit	Deductible plus 50% coinsurance	None
	Specialist visit	\$60 <u>copay</u> /visit	Deductible plus 50% coinsurance	None
If you visit a health care <u>provider</u> 's office or clinic	Preventive care /screening /immunization	\$0 <u>copayment</u>	Deductible plus 50% 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. Colonoscopies, Mammograms and Pap Smears - Not limited to once per year / in <u>network</u> 100% regardless of diagnosis. Immunizations with Non <u>Network providers</u> covered in full up to age 6 only.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Lab services paid at 100% when using preferred labs (Quest, Stormont Vail or University of KS).
If you have a test	Imaging (CT/PET scans, MRIs)	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	None
If you need drugs to treat your illness or	Generic drugs	20% <u>coinsurance</u> (retail or mail order)	20% <u>coinsurance</u> on the <u>plan</u> s allowed charge	First fill is a 30 day supply at retail and mail. A 90 day supply is allowed at retail and mail for subsequent refills.
condition  Prescription drug	Preferred brand drugs	40% <u>coinsurance</u> (retail or mail order)	40% <u>coinsurance</u> on the <u>plan</u> s allowed charge	Diabetics and Asthma medications that are considered generic or preferred brans with the following copays:

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Common Medical Event	Services You May Need	What You Will Pay In-Network Out-of-Network Provider Provider		Limitations, Exceptions, & Other Important Information	
		(You will pay the least)	(You will pay the most)		
coverage is administered by CVS Caremark  More information about prescription drug coverage is available at www.caremark.com	Non-preferred brand drugs	65% <u>coinsurance</u> (retail or mail order)	65% <u>coinsurance</u> on the <u>plan</u> s allowed charge	Generic: 10% coinsurance with a \$20 maximum per 30 day supply. Preferred brand: 20% coinsurance with a \$40 maximum per 30 day supply.  Contraceptives: Covered with 0% member coinsurance. Non Preferred Contraceptives: Covered subject to 65% coinsurance.  Compound Medications covered only at a Network Pharmacy.	
	Specialty drugs	40% <u>coinsurance</u> (with a \$100 maximum) per 30 day supply	None	All fills must be filled through CVS Caremark Specialty (1-800-237-2767)	
If you have	Facility fee (e.g., ambulatory surgery center)	Deductible plus 20% coinsurance	<u>Deductible</u> plus 50% <u>coinsurance</u>	Prior Authorization is required.	
outpatient surgery	Physician/surgeon fees	Deductible plus 20% coinsurance	<u>Deductible</u> plus 50% <u>coinsurance</u>	Prior Authorization is required.	
If you need	Emergency room care	\$100 <u>copayment</u> plus <u>deductible</u> and 20% <u>coinsurance</u>	\$100 <u>copayment</u> plus <u>deductible</u> and 20% <u>coinsurance</u>	Must meet emergency criteria. Copay waived if admitted within 24 hours.	
immediate medical attention	Emergency medical transportation	Deductible plus 20% coinsurance	Deductible plus 20% coinsurance	Must meet emergency criteria.	
	<u>Urgent care</u>	\$50 <u>copay</u> /visit	<u>Deductible</u> plus 50% <u>coinsurance</u>	None	
If you have a	Facility fee (e.g., hospital room)	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Prior Authorization is required.	
hospital stay	Physician/surgeon fees	Deductible plus 20% coinsurance	<u>Deductible</u> plus 50% <u>coinsurance</u>	Prior Authorization is required.	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: \$40 copay/visit, deductible doesn't apply	Office & other outpatient services: Deductible plus 50% coinsurance	\$20 <u>copayment</u> for group therapy sessions	

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Common Medical Event	Services You May Need	What You In-Network Provider (You will pay the	u Will Pay Out-of-Network Provider (You will pay the	Limitations, Exceptions, & Other Important Information	
	Inpatient services	least)  Deductible plus	most)  Deductible plus	Prior authorization is required for inpatient	
	Office visits	\$0 copayment	50% coinsurance  Deductible plus 50% coinsurance	Services.  Cost sharing does not apply for preventive	
If you are pregnant	Childbirth/delivery professional services	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	services. Maternity care may include tests and services described elsewhere in the SBC (i.e.	
	Childbirth/delivery facility services	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	ultrasound.) Prior authorization required for stays longer than 48/96 hours.	
	Home health care	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Prior authorization may be required.	
	Rehabilitation services	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Prior authorization required.	
If you need help recovering or have	Habilitation services	Not covered	Not covered	Unless under Autism rider of the policy.	
other special	Skilled nursing care	Not covered	Not covered	Not covered.	
health needs	Durable medical equipment	<u>Deductible</u> plus 20% <u>coinsurance</u>	<u>Deductible</u> plus 50% <u>coinsurance</u>	Prior authorization required.	
	Hospice services	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Prior authorization may be required. Inpatient Hospice care limited to 180 days maximum/lifetime.	
If your child needs dental or eye care	Children's eye exam	\$0 <u>copayment</u> for first annual visit, then \$60 <u>copayment</u> per visit	Deductible plus 50% coinsurance	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.)

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- Acupuncture
- Cosmetic surgery (to improve appearance of normal body structure)
- Dental care (Adult & Child)
- Glasses (Child)

- Habilitation services
- Hearing aids
- Long-term care
- Private-duty nursing

- Routine foot care
- Skilled nursing
- Weight loss programs Except for required <u>preventive</u> services.

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

- Bariatric surgery Limited to in-<u>network</u> <u>providers</u>. (for qualified patients)
- Chiropractic care 30 visits/calendar year.
- Hearing exam

- Infertility treatment Limited to the diagnosis & treatment of underlying medical condition. 3 cycles/calendar year for artificial insemination & ovulation induction combined.
- Non-emergency care when traveling outside the U.S. - Most coverage provided outside of United States. See www.aetnainternational.com
- Nutritional Evaluation and Diabetes Management
- Routine eye care (Adult) 1 routine eye exam/calendar year.

### **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 1-866-851-0754.
- 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 <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 <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 <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 on how 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 1-866-851-0754.
- 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

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

## 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 plan might cover costs for a sample medical situation, see the next section.

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# **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>	\$1,000
■ Specialist copayment	\$60
■ Hospital (facility) coinsurance	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)

Total Example Cost	\$12,700	
In this example, Peg would pay:		
<u>Cost Sharing</u>		
<u>Deductibles</u>	\$1,000	
<u>Copayments</u>	\$80	
Coinsurance	\$2,300	
What isn't covered		
Limits or exclusions	\$60	
The total Peg would pay is	\$3,440	

# Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$1,000
■ Specialist copayment	\$60
■ Hospital (facility) coinsurance	20%
Other coinsurance	20%

### 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:		
<u>Cost Sharing</u>		
<u>Deductibles</u>	\$1,000	
<u>Copayments</u>	\$400	
Coinsurance	\$1,700	
What isn't covered		
Limits or exclusions	\$20	
The total Joe would pay is	\$3,120	

# **Mia's Simple Fracture**

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

■ The <u>plan's</u> overall <u>deductible</u>	\$1,000
Specialist copayment	\$60
■ Hospital (facility) coinsurance	20%
Other coinsurance	20%

#### 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>	\$1,000		
<u>Copayments</u>	\$100		
<u>Coinsurance</u>	\$100		
What isn't covered			
Limits or exclusions	\$0		
The total Mia would pay is	\$1,200		

### **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, or disability.

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 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 1-866-851-0754 at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-866-851-0754.

Amharic - ለቋንቋ እንዛ በ አማርኛ በ 1-866-851-0754 በነጻ ይደውሉ

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-866-851-0754

Armenian - Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-866-851-0754 առանց գնով։

Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-866-851-0754 tanpa dikenakan biaya.

Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-866-851-0754 ku busa

Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বিনামুল্যে 1-866-851-0754-তে কল করুন।

Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-866-851-0754 nga walay bayad.

Burmese - ငွေကုန်ကျစံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-866-851-0754 ကို ခေါ် ဆိုပါ။

Catalan - Per rebre assistència en (català), truqui al número gratuït 1-866-851-0754.

Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-866-851-0754 sin gåstu.

Chinese - 欲取得繁體中文語言協助, 請撥打1-866-851-0754, 無需付費。

Choctaw - (Chahta) anumpa ya apela a chi I paya hinla 1-866-851-0754.

Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-866-851-0754 irratti bilisaan bilbilaa.

Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-866-851-0754.

French - Pour une assistance linguistique en français appeler le 1-866-851-0754 sans frais.

French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-866-851-0754 gratis.

German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-866-851-0754 an.

Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-866-851-0754 χωρίς χρέωση.

Gujarati - ગુજરાતીમાં ભાષામાં સહ્ય માટે કોઈ પણ ખર્ચ વગર 1-866-851-0754 પર કૉલ કરો.

Hawaiian - No ke kōkua ma ka 'ōlelo Hawai'i, e kahea aku i ka helu kelepona 1-866-851-0754. Kāki 'ole 'ia kēia kōkua nei.

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Hindi - हिन्दी में भाषा सहायता के लिए, 1-866-851-0754 पर मुफ्त कॉल करें।

Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-866-851-0754.

lbo - Maka enyemaka asusu na Igbo kpoo 1-866-851-0754 na akwughi ugwo o bula

llocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-866-851-0754 nga awan ti bayadanyo.

Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-866-851-0754.

Japanese - 日本語で援助をご希望の方は、1-866-851-0754 まで無料でお電話ください。

Karen - လာတာမောေလာက်ကတိုးကျိုဘဲအင်္ဂါ ကျိုင္ငံ 🕰 866-851-0754 လာတအို ၁ ဒီးတာ်လာဘ်ဘူဉ်လာဘ်စ္ခုဘာဉ်

Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-866-851-0754 번으로 전화해 주십시오.

Kru-Bassa - Be´m`ké gbo-kpá-kpá dyé pidyi dé Bašsoó-wuduùn wee, dá 1-866-851-0754

برای راهنمایی به زبان فارسی با شماره 470-851-866 به خورایی پهیوهندی بکهن.

Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລນາໂທຫາ-866-851-0754 ໂດຍບໍ່ເສຍຄ່າໂທ.

Marathi - कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-866-851-0754 वर फोन करा.

Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-866-851-0754 ilo ejjelok wōnān.

Micronesian-

Pohnpeyan - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-866-851-0754 ni sohte isais.

Mon-Khmer, សម្រាប់ជំនួយភាសាជា ភាសាខុមរៃ សូមទូរស័ព្ទទទៅកាន់លខេ 1-866-851-0754 ដំោយឥតគិតថ្លប់។

Cambodian -

Navajo - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-866-851-0754

Nepali - (नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-866-851-0754 मा फोन गर्नुहोस् ।

Nilotic-Dinka - Tën kupony ë thok ë Thuonjan col 1-866-851-0754 kecin ayöc.

Norwegian - For språkassistanse på norsk, ring 1-866-851-0754 kostnadsfritt.

Panjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-866-851-0754 'ਤੇ ਮਫ਼ਤ ਕਾਲ ਕਰੋ।

Pennsylvania Dutch - Fer Helfe in Deitsch, ruf: 1-866-851-0754 aa. Es Aaruf koschtet nix.

برای راهنمایی به زبان فارسی با شماره 470-851-866 بدون هیچ هزینه ای تماس بگیرید. انگلیسی Persian -

Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-866-851-0754.

Portuguese - Para obter assistência linguística em português ligue para o 1-866-851-0754 gratuitamente.

Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-866-851-0754

Proprietary

Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-866-851-0754.

Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-866-851-0754 e aunoa ma se totogi.

Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-866-851-0754.

Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-866-851-0754.

Sudanic-Fulfude - Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-866-851-0754. Njodi woo fawaaki on.

Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-866-851-0754 bila malipo.

Syriac - K - 32 K K & 22 i abk - 21 x C adi, or dy iapk 181, 20 1-866-851-0754 ap

Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-866-851-0754 nang walang bayad.

Telugu - భాషతో సాయం కొరకు ఎలాంటి ఖర్పు లేకుండా 1-866-851-0754 కు కాల్ చేయండి. (తెలుగు)

Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-866-851-0754 ฟรีไม่มีค่าใช้จ่าย

Tongan - Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-866-851-0754 'o 'ikai hā ōtōngi.

Trukese - Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-866-851-0754 nge esapw kamé ngonuk.

Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-866-851-0754.

Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-866-851-0754.

بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 866-851-0754 . پر بات کریں۔

Vietnamese - Đê 'được hố trở ngôn ngư bằng (ngôn ngư), hấy gọi miến phi 'đên số 1-866-851-0754.

Yiddish - פאר שפראך הילף אין אידיש רופט 1-866-851-0754 פריי פון אפצאל.

Yoruba - Fún ìrànlowo nípa èdè (Yorùbá) pe 1-866-851-0754 lái san owó kankan rárá.