Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

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

Coverage Period: 01/01/2023-12/31/2023

Coverage for: EE Only; EE+ Family | Plan Type: POS

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** or by calling 1-866-851-0754. 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 1-866-851-0754 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-**Network**: $500 per Individual / $1,000 per Family. Out-of-Network: $1,000 per Individual / $2,000 per Family.	Generally, you must pay all of the costs from **providers** up to the **deductible** amount before this **plan** begins to pay. If you have other family members on the **plan**, each family member must meet their own individual **deductible** until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-**network preventive care** is covered before you meet your **deductible**.	This **plan** covers some items and services even if you haven't yet met the **deductible** amount. But a **copayment** or **coinsurance** may apply. For example, this **plan** covers certain **preventive services** without **cost sharing** and before you meet your **deductible**. See a list of covered **preventive services** at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No. There are no other specific **deductibles.**	You don't have to meet **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	Medical and Pharmacy combined Out-of-Pocket: **Network**: $7,350 Individual / $14,700 Family. Out-of-Network: $10,000 Individual / $20,000 Family.	The **out–of–pocket limit** is the most you could pay in a year for covered services. If you have other family members in this **plan**, they have to meet their own **out–of–pocket limits** until the overall family **out–of–pocket limit** 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 **out–of–pocket limit**.
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 **plan** uses a **provider network**. You will pay less if you use a **provider** in the **plan's network**. You will pay the most if you use an **out-of-network provider**, and you might receive a bill from a **provider** for the difference between the **provider's** charge and what your **plan** pays (**balance billing**). Be aware, your **network provider** might use an **out-of-network provider** for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the **specialist** you choose without a **referral**.

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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	**Deductible** plus 25% **coinsurance**	**Deductible** plus 50% **coinsurance**	None
	Specialist visit	**Deductible** plus 25% **coinsurance**	**Deductible** plus 50% **coinsurance**	None
	Preventive care /screening /immunization	$0 **copayment**	**Deductible** plus 50% **coinsurance**; no charge for child immunizations to age 6	You may have to pay for services that aren't preventive. Ask your **provider** if the services needed are preventive. Then check what your **plan** will pay for. Colonoscopies, Mammograms, and Pap Smears - Not limited to once per year / in **network** 100% regardless of diagnosis. Immunizations with Non Network **providers** covered in full up to age 6 only.
If you have a test	**Diagnostic test** (x-ray, blood work)	**Deductible** plus 25% **coinsurance**	**Deductible** plus 50% **coinsurance**	Discount to member when using preferred labs (Quest, Stormont Vail or University of KS).
	Imaging (CT/PET scans, MRIs)	**Deductible** plus 25% **coinsurance**	**Deductible** plus 50% **coinsurance**	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.caremark.com**	Generic drugs	**Deductible** plus 20% **coinsurance** (retail or mail order)	**Deductible** plus 20% **coinsurance** on the **plans** 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. **Deductible**: $500 Individual /$1,000 Family. Out-Of-Pocket Maximum: $7,350 Individual/ $14,700 Family Contraceptives: Covered with $0 member **coinsurance** Non-Preferred Contraceptives: Covered subject to 60% member **coinsurance**. Compound medications covered only at a **Network** Pharmacy.
	Preferred brand drugs	**Deductible** plus 35% **coinsurance** (retail or mail order)	**Deductible** plus 35% **coinsurance** on the **plans** allowed charge	
	Non-preferred brand drugs	**Deductible** plus 60% **coinsurance** (retail or mail order)	**Deductible** plus 60% coinsurance on the **plans** allowed charge	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Specialty drugs	**Deductible** plus 40% **coinsurance** per 30 day supply	None	All fills must be filled through CVS Caremark Specialty (1-800-237-2767)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**Deductible** plus 25% **coinsurance**	**Deductible** plus 50% **coinsurance**	Prior authorization is required.
	Physician/surgeon fees	**Deductible** plus 25% **coinsurance**	**Deductible** plus 50% **coinsurance**	Prior authorization is required.
If you need immediate medical attention	**Emergency room care**	**Deductible** plus 25% **coinsurance**	**Deductible** plus 25% **coinsurance**	Out-of-**network** emergency use paid the same as in-network. Must meet emergency criteria.
	Emergency medical transportation	**Deductible** plus 25% **coinsurance**	**Deductible** plus 25% **coinsurance**	Out-of-**network** emergency use paid the same as in-**network**. Non-emergency transport: not covered, except if pre-authorized. Must meet emergency criteria.
	Urgent care	**Deductible** plus 25% **coinsurance**	**Deductible** plus 50% **coinsurance**	None
If you have a hospital stay	Facility fee (e.g., hospital room)	**Deductible** plus 25% **coinsurance**	**Deductible** plus 50% **coinsurance**	Prior authorization is required.
	Physician/surgeon fees	**Deductible** plus 25% **coinsurance**	**Deductible** plus 50% **coinsurance**	Prior authorization is required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: **Deductible** plus 25% **coinsurance**	Office & other outpatient services: **Deductible** plus 50% **coinsurance**	None
	Inpatient services	**Deductible** plus 25% **coinsurance**	**Deductible** plus 50% **coinsurance**	Prior authorization is required for inpatient services.
If you are pregnant	Office visits	**Deductible** plus 25% **coinsurance**	**Deductible** plus 50% **coinsurance**	**Cost sharing** does not apply for **preventive services**. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Prior authorization required for stays longer than 48/96 hours.
	Childbirth/delivery professional services	**Deductible** plus 25% **coinsurance**	**Deductible** plus 50% coinsurance	
	Childbirth/delivery facility services	**Deductible** plus 25% **coinsurance**	**Deductible** plus 50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	**Home health care**	**Deductible** plus 25% **coinsurance**	**Deductible** plus 50% **coinsurance**	Prior authorization may be required.
	Rehabilitation services	**Deductible** plus 25% **coinsurance**	**Deductible** plus 50% **coinsurance**	Prior authorization required.
	Habilitation services	Not covered	Not covered	Limited to treatment of Autism.
	Skilled nursing care	Not covered	Not covered	Not covered.
	Durable medical equipment	**Deductible** plus 25% **coinsurance**	**Deductible** plus 50% **coinsurance**	Prior authorization required.
	Hospice services	**Deductible** plus 25% **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 **copayment** for first annual visit, then **deductible** plus 25% **coinsurance**	**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 under Medical **Plan**	Not covered under Medical **Plan**	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)
- Hearing aids
- Long-term care
- 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.)		
• Bariatric surgery - Limited to in-**network providers**. (for qualified patients) • Chiropractic care - 30 visits/calendar year.	• Infertility treatment - For more information & exceptions, see policy document provided by your employer or call the number on your ID card. • Non-emergency care when traveling outside the U.S. - Most coverage provided outside of United States. See www.aetnainternational.com	• Routine eye care (Adult) - 1 routine 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 **plan** 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 **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**.
- 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** 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 1-866-851-0754. 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.**
- 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	**$500**
Specialist coinsurance	**25%**
Hospital (facility) coinsurance	**25%**
Other coinsurance	**25%**

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:	
Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$3,000
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$3,570**

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

The plan's overall deductible	**$500**
Specialist coinsurance	**25%**
Hospital (facility) coinsurance	**25%**
Other coinsurance	**25%**

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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$400
What isn't covered	
Limits or exclusions	$3,500
The total Joe would pay is	**$4,400**

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

The plan's overall deductible	**$500**
Specialist coinsurance	**25%**
Hospital (facility) coinsurance	**25%**
Other coinsurance	**25%**

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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$600
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$1,100**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

Assistive Technology

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

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, disability, gender identity or sexual orientation.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: P.O. Box 24030, Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at 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).

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 እገዛ በ አማርኛ በ 1-866-851-0754 በነጻ ይደውሉ
Arabic -	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 বিনামূল্যে 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 -	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-866-851-0754 ကို ခေါ်ဆိုပါ။
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.
Cherokee -	ᎾᏍᎩᎾ ᏕᏬᏂᎯᏍᏗ ᏗᏂᏍᏕᎵᏍᎩ ᎾᏛᎢ (ᏣᎳᎩ) ᏫᏓᏔᏅᎯᏍ 1-866-851-0754 ᎤᎾᎢ Ꮭ ᎠᎱᏍᏗ ᏧᎬᏩᎶᏗ ᏂᎨᏒᎾ.
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 સહાય માટે કોઈ પણ ખર્ચ વગર 1-866-851-0754 પર કૉલ કરો.
Hawaiian -	No ke kōkua ma ka ʻōlelo Hawaiʻi, e kahea aku i ka helu kelepona 1-866-851-0754. Kāki ʻole ʻia kēia kōkua nei.

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.
Ibo -	Maka enyemaka asụsụ na Igbo kpọọ 1-866-851-0754 na akwụghị ụgwọ ọ bụla
Ilocano -	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 -	လၢတက်မၤစၢးတက်ကတိၤကျိာ်အဂီၢ် ကျိာ် 1-866-851-0754 လၢတအိဉ်ဒီးတက်လၢာ်ဘျုာ်လၢာ်စုၤဟဉ်
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-866-851-0754 번으로 전화해 주십시오.
Kru-Bassa -	Bɛ́m̀ké gbo-kpá-kpá dyé pídyi dé Bǎsɔ́ɔ̀-wùdùǔn wɛ̃ɛ, dá 1-866-851-0754
Kurdish -	برای راهنمایی به زبان فارسی با شماره 1-866-851-0754 به خۆرایی پەیوەندی بکەن.
Laotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ1-866-851-0754 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, Cambodian -	សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-866-851-0754 ដោយឥតគិតថ្លៃ។
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 kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-866-851-0754 kecïn ayöc.
Norwegian -	For språkassistanse på norsk, ring 1-866-851-0754 kostnadsfritt.
Panjabi -	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-866-851-0754 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-866-851-0754 aa. Es Aaruf koschtet nix.
Persian -	برای راهنمایی به زبان فارسی با شماره 1-866-851-0754 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
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 asistenţă lingvistică în româneşte telefonaţi la numărul gratuit 1-866-851-0754

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 - [illegible] 1-866-851-0754 [illegible].

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

Telugu - భాషతో సాయం కొరకు ఎలాంటి ఖర్చు 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.

Urdu - بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-866-851-0754 . پر بات کریں-

Vietnamese - Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-866-851-0754.

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

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