

Coverage for: Employee + Family | Plan Type: EPO



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, https://www.aetna.com/sbcsearch/getpolicydocs?u=082000-070020-032149 or by calling 1-855-885-3289. 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 1-855-885-3289 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For each <u>Plan</u> Year, In- <u>network</u> : Individual \$3,000 / Family \$6,000.	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. <u>Preventive care</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 \$6,900 / Family \$13,800.	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 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 1-855-885-3289 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 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.

		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	0% coinsurance	Not covered	None
If you visit a health care	Specialist visit	0% coinsurance	Not covered	None
provider's office or clinic	Preventive care /screening /immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	0% coinsurance	Not covered	Applies to services received in office or in outpatient setting.
ii you nave a test	Imaging (CT/PET scans, MRIs)	0% coinsurance	Not covered	Applies to services received in office or in outpatient setting.
	Preferred generic drugs	\$12 <u>copay/</u> prescription for up to a 30 day supply, \$30 <u>copay/</u> prescription for up to a 90 day supply	Not covered	Covers up to a 30 day supply (retail prescription), 31-90 day supply (retail & mail
If you need drugs to treat your illness or condition	Preferred brand drugs	\$55 <u>copay/</u> prescription for up to a 30 day supply, \$137.50 <u>copay/</u> prescription for up to a 90 day supply	Not covered	order prescription). Your cost will be higher for choosing Brand over Generics; cost difference penalty doesn't apply to overall deductible or out-of-pocket limit. No charge for preferred
More information about prescription drug coverage is available at http://aet.na/dcsg	Non-preferred generic/brand drugs	\$95 copay/ prescription for up to a 30 day supply, \$237.50 copay/ prescription for up to a 90 day supply	Not covered	generic FDA-approved women's contraceptives in- <u>network</u> .
	Specialty drugs	Preferred: 40% coinsurance up to a \$150 maximum/ prescription for up to a 30 day supply; Non-preferred: 50% coinsurance up to a \$150 maximum/ prescription for up to a 30 day supply	Not covered	All specialty <u>prescription drug</u> fills on initial fill must be filled at a <u>network</u> specialty pharmacy except for urgent situations. Your <u>plan</u> may include access to CVS retail pharmacies for certain <u>specialty drugs</u> .

		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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not covered	None	
ourgery	Physician/surgeon fees	10% coinsurance	Not covered	None	
If you need immediate medical attention	Emergency room care	\$750 <u>copay</u> /visit	\$750 <u>copay</u> /visit	Copay waived if admitted. Out-of-network emergency room care cost-share same as in-network. No coverage for non-emergency care.	
	Emergency medical transportation	0% coinsurance	0% coinsurance	Out-of-network cost-share same as in-network.	
	<u>Urgent care</u>	\$60 <u>copay</u> /visit	Not covered	No coverage for non-urgent use.	
If you have a	Facility fee (e.g., hospital room)	10% coinsurance	Not covered	None	
hospital stay	Physician/surgeon fees	0% coinsurance	Not covered	None	
If you need mental health, behavioral health, or	Outpatient services	Office visits and all other outpatient services: 0% coinsurance	Not covered	None	
substance abuse services	Inpatient services	10% coinsurance	Not covered	None	
	Office visits	No charge	Not covered	Cost sharing does not apply for preventive	
If you are pregnant	Childbirth/delivery professional services	0% coinsurance	Not covered	services. Maternity care may include tests and services described elsewhere in the SBC	
	Childbirth/delivery facility services	10% coinsurance	Not covered	(i.e. ultrasound).	
	Home health care	0% coinsurance	Not covered	Coverage is limited to 90 visits per episode.	
	Rehabilitation services	\$75 copay/visit	Not covered	None	
	Habilitation services	0% coinsurance	Not covered	None	
If you need help	Skilled nursing care	10% coinsurance	Not covered	Coverage is limited to 60 days.	
recovering or have other special health needs	Durable medical equipment	50% coinsurance	Not covered	Coverage is limited to 1 <u>durable medical</u> <u>equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.	
	Hospice services	Inpatient: 10% <a href="mailto:coinsurance">coinsurance</a> ; Outpatient: 0% <a href="mailto:coinsurance">coinsurance</a>	Not covered	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	
	Children's eye exam	50% coinsurance	Not covered	Coverage is limited to 1 exam per <u>plan</u> year up to age 19.	
If your child needs dental or eye care	Children's glasses	50% coinsurance	Not covered	Coverage is limited to 1 set of frames and 1 set of contact lenses or eyeglass lenses per <u>plan</u> year. Includes contact lens fitting up to age 19.	
	Children's dental check-up	0% coinsurance	Not covered	Coverage is limited to 2 exams per <u>plan</u> year up to age 19.	

### **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.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids

- Infertility treatment
- 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.)

- Acupuncture Coverage is limited to 10 visits.
- Chiropractic care
- Routine eye care (Adult) Coverage is limited to 1 exam.

# **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: The District of Columbia Department of Insurance, Securities and Banking, (202) 727-8000, TTY: 711, <a href="http://disb.dc.gov/">http://disb.dc.gov/</a>.

- For more information on your rights to continue coverage, contact the plan at 1-855-885-3289.
- 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/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a>.
- For non-federal governmental group health <u>plans</u>, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or <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</u> <u>Marketplace</u>. 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 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 1-855-885-3289.
- The District of Columbia Department of Insurance, Securities and Banking, (202) 727-8000, TTY: 711, http://disb.dc.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 www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health <u>plans</u>, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or <u>www.cciio.cms.gov</u>.
- Additionally, a consumer assistance program can help you file your <u>appeal</u>. Contact Office of Health Care Ombudsman, One Judiciary Square, 441 4th Street, NW, 250 North Washington, DC 20001, Phone: (202) 724-7491, TTY: 711, <a href="https://healthcareombudsman.dc.gov/">https://healthcareombudsman.dc.gov/</a>, healthcareombudsman@dc.gov

## 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 <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>	\$3,000
<ul><li>Specialist coinsurance</li></ul>	0%
■ Hospital (facility) coinsurance	10%
Other coinsurance	0%

### 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>	\$12,700	
In this example, Peg would pay:		
Cost Sharing		
<u>Deductibles</u>	\$3,000	
<u>Copayments</u>	\$10	
<u>Coinsurance</u>	\$800	
What isn't covered		
Limits or exclusions	\$60	
The total Peg would pay is	\$3,870	

# 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>	\$3,000
Specialist coinsurance	0%
■ Hospital (facility) coinsurance	10%
Other coinsurance	0%

### This EXAMPLE event includes services like:

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

Diagnostic tests (blood work)

Prescription drugs

<u>Durable medical equipment</u> (glucose meter)

Total Example Cost	\$5,600	
In this example, Joe would pay:		
Cost Sharing		
<u>Deductibles</u>	\$3,000	
<u>Copayments</u>	\$600	
<u>Coinsurance</u>	\$0	
What isn't covered		
Limits or exclusions	\$20	
The total Joe would pay is	\$3,620	

# **Mia's Simple Fracture**

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

■ The <u>plan's</u> overall <u>deductible</u>	\$3,000
<ul><li>Specialist coinsurance</li></ul>	0%
<ul><li>Hospital (facility) coinsurance</li></ul>	10%
Other coinsurance	0%

### 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		
<u>Deductibles</u>	\$2,800	
<u>Copayments</u>	\$0	
<u>Coinsurance</u>	\$0	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$2,800	

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: 1-855-885-3289.

# **Assistive Technology**

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-855-885-3289.

# **Smartphone or Tablet**

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

# **Non-Discrimination**

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

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

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

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: P.O. Box 24030, Fresno, CA 93779),

1-800-648-7817, TTY: 711,

Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <a href="https://ocrportal.hhs.gov/ocr/portal/lobby.jsf">https://ocrportal.hhs.gov/ocr/portal/lobby.jsf</a>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of 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 1-855-885-3289 at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-855-885-3289.

Amharic - ለቋንቋ እንዛ በ አማርኛ በ 1-855-885-3289 በነጻ ይደውሉ

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 289-885-885-1-85.

Armenian - Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-855-885-3289 առանց գնով։

Bahasa-Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-855-885-3289 tanpa dikenakan biaya.

Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-855-885-3289 ku busa

Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বিনামূল্য( 1-855-885-3289-ত( কল করুন।

Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-855-885-3289 nga walay bayad.

Burmese - ငွေကုန်ကျစံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-855-885-3289 ကို ခေါ် ဆိုပါ။

Catalan - Per rebre assistència en (català), trugui al número gratuït 1-855-885-3289.

Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-855-885-3289 sin gåstu.

Chinese - 欲取得繁體中文語言協助,請撥打 1-855-885-3289,無需付費。

Choctaw - (Chahta) anumpa ya apela a chi I paya hinla 1-855-885-3289.

Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-855-885-3289 irratti bilisaan bilbilaa.

Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-855-885-3289.

French - Pour une assistance linguistique en français appeler le 1-855-885-3289 sans frais.

French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-855-885-3289 gratis.

German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-855-885-3289 an.

Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-855-885-3289 χωρίς χρέωση.

Gujarati - ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ય વગર 1-855-885-3289 પર કૉલ કરો.

Hawaiian - No ke kōkua ma ka 'ōlelo Hawai'i, e kahea aku i ka helu kelepona 1-855-885-3289. Kāki 'ole 'ia kēia kōkua nei.

Hindi - हिन्दी में भाषा सहायता के लिए, 1-855-885-3289 पर मुफ्त कॉल करें।

Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-855-885-3289.

lbo - Maka enyemaka asusu na Igbo kpoo 1-855-885-3289 na akwughi ugwo o bula

llocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-855-885-3289 nga awan ti bayadanyo.

Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-855-885-3289.

Japanese - 日本語で援助をご希望の方は、1-855-885-3289 まで無料でお電話ください。

Karen - လာတာမ်ာစားတာ်ကတိုးကျိုာ်အင်္ဂ ကျိုာ် ကိုး 1-855-885-3289 လာတအိနာ်ခီးတာ်လာဘွဲ့နာလာခဲ့စာသာ

Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-855-885-3289 번으로 전화해 주십시오.

Kru-Bassa - Be´m`ké gbo-kpá-kpá dyé pidyi dé Bašsoó-wuduun wee, dá 1-855-885-3289

برای راهنمایی به زبان فارسی با شماره 3289-885-1-1 به خورایی پهیومندی بکهن. - Kurdish

Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-855-885-3289 ໂດຍບໍ່ເສຍຄ່າໂທ.

Marathi - कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-855-885-3289 वर फोन करा.

Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-855-885-3289 ilo ejjelok wōnān.

Micronesian - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-855-885-3289 ni sohte isais.

Mon-Khmer, Cambodian - សម្ភាប់ជំនួយភាសាជា ភាសាខ្មមរៃ សូមទូរស័ព្**ទទ**ៅកាន់លខេ 1-855-885-3289 ដ**ោយឥតគិតថ្**ល។ៃ

Navajo - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-855-885-3289

Nepali - (नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-855-885-3289 मा फोन गर्नुहोस् ।

Nilotic-Dinka - Tën kuoony ë thok ë Thuonjän col 1-855-885-3289 kecin ayöc.

Norwegian - For språkassistanse på norsk, ring 1-855-885-3289 kostnadsfritt.

Panjabi - ਪੰਜਾਬੀ ਵੀੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-855-885-3289 'ਤੇ ਮਫ਼ਤ ਕਾਲ ਕਰੋ।

Pennsylvania Dutch - Fer Helfe in Deitsch, ruf: 1-855-885-3289 aa. Es Aaruf koschtet nix.

برای راهنمایی به زبان فارسی با شماره 3289-885-1 بدون هیچ هزینه ای تماس بگیرید. انگلیسی Persian -

Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-855-885-3289.

Portuguese - Para obter assistência linguística em português ligue para o 1-855-885-3289 gratuitamente.

Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-855-885-3289

Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-855-885-3289.

Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-855-885-3289 e aunoa ma se totogi.

Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-855-885-3289.

Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-855-885-3289.

Sudanic-Fulfude - Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-855-885-3289 Njodi woo fawaaki on.

Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-855-885-3289 bila malipo.

Syriac - K ser of b pear able of wain on Ly ispor abl, so 1-855-885-3289 apel.

Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-855-885-3289 nang walang bayad.

Telugu - భషతో సయంకోరకు ఎలెంటి ఖర్చు లేకుండా 1-855-885-3289 కు శల్ చేయండి. (తెలుగు)

Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-855-885-3289 ฟรีไม่มีค่าใช้จ่าย

Tongan - Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-855-885-3289 'o 'ikai hā tōtōngi.

Trukese - Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-855-885-3289 nge esapw kamé ngonuk.

Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-855-885-3289.

Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-855-885-3289.

بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 3289-885-1-85. پر بات کریں

Vietnamese - Đê 'được hố 'trợ ngôn ngư băng (ngôn ngư), hấy gọi miến phi 'đên số '1-855-885-3289.

Yiddish - פאר שפראך הילף אין אידיש רופט 1-855-885-3289 פריי פון אפצאל

Yoruba - Fún ìrànlowo nípa èdè (Yorùbá) pe 1-855-885-3289 lái san owó kankan rárá.