

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

Coverage for: Individual + Family | Plan Type: POS



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- <u>Network</u> and Out-of-Network for Single Policies: <u>Deductible</u> \$2,750. In- <u>Network</u> and Out-of-Network for other <u>Plan</u> s: Individual <u>Deductible</u> \$2,800/ Family <u>Deductible</u> \$5,500.	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 preventive care</u> is 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 https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other <u>deductibles</u> 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> ?	Medical and Pharmacy combined Out of Pocket: In-Network: \$6,650 Individual / \$13,300 Family. Out-of-Network: \$6,650 Individual / \$13,300 Family.	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?	<u>Premium</u> s, balance-billing charges & health care this <u>plan</u> 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 <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 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	<u>Deductible</u> plus 35% <u>coinsurance</u>	Deductible plus 50% coinsurance	None	
	<u>Specialist</u> visit	Deductible plus 35% coinsurance	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; no charge for child immunizations to age 6	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.	
Khava a taat	Diagnostic test (x-ray, blood work)	Deductible plus 35% coinsurance	Deductible plus 50% coinsurance	Discount to member when using preferred labs (Quest, Stormont Vail or University of KS).	
If you have a test	Imaging (CT/PET scans, MRIs)	<u>Deductible</u> plus 35% <u>coinsurance</u>	Deductible plus 50% coinsurance	None	
If you need drugs to treat your illness or condition	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: \$2,750 Individual /\$5,500 Family.	
Prescription drug coverage is administered by CVS Caremark More information about prescription	Preferred brand drugs	Deductible plus 40% coinsurance (retail or mail order)	Deductible plus 40% coinsurance on the plans allowed charge	Out-Of-Pocket Maximum: \$6,650 Individual/ \$13,300 Family Contraceptives: Covered with \$0 member coinsurance	
	Non-preferred brand drugs	Deductible plus 65% coinsurance (retail or mail order)	Deductible plus 65% coinsurance on the plans allowed charge	Non Preferred Contraceptives: Covered subject to 65% member <u>coinsurance</u> . Compound medications covered only at a <u>Network</u> Pharmacy.	

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	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
drug coverage is available at www.caremark.com	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	Facility fee (e.g., ambulatory surgery center)	Deductible plus 35% coinsurance	<u>Deductible</u> plus 50% <u>coinsurance</u>	Prior authorization is required.
outpatient surgery	Physician/surgeon fees	Deductible plus 35% coinsurance	<u>Deductible</u> plus 50% <u>coinsurance</u>	Prior authorization is required.
lfd	Emergency room care	Deductible plus 35% coinsurance	<u>Deductible</u> plus 35% <u>coinsurance</u>	Must meet emergency criteria
If you need immediate medical attention	Emergency medical transportation	Deductible plus 35% coinsurance	<u>Deductible</u> plus 35% <u>coinsurance</u>	Must meet emergency criteria
attention	<u>Urgent care</u>	Deductible plus 35% coinsurance	<u>Deductible</u> plus 50% <u>coinsurance</u>	None
If you have a	Facility fee (e.g., hospital room)	<u>Deductible</u> plus 35% <u>coinsurance</u>	<u>Deductible</u> plus 50% <u>coinsurance</u>	Prior authorization is required.
hospital stay	Physician/surgeon fees	Deductible plus 35% coinsurance	<u>Deductible</u> plus 50% <u>coinsurance</u>	Prior authorization is required.
If you need mental health, behavioral health, or	Outpatient services	Office & other outpatient services: Deductible plus 35% coinsurance	Office & other outpatient services: Deductible plus 50% coinsurance	None
substance abuse services	Inpatient services	Deductible plus 35% coinsurance	<u>Deductible</u> plus 50% <u>coinsurance</u>	Prior authorization is required for inpatient services.
If you are pregnant	Office visits	Deductible plus 35% coinsurance	Deductible plus 50% coinsurance	Cost sharing does not apply for preventive
	Childbirth/delivery professional services	Deductible plus 35% coinsurance	Deductible plus 50% coinsurance	services. Maternity care may include tests and services described elsewhere in the SBC (i.e.
	Childbirth/delivery facility services	<u>Deductible</u> plus 35% <u>coinsurance</u>	Deductible plus 50% coinsurance	ultrasound.) Prior authorization required for stays longer than 48/96 hours.
If you need help recovering or have	Home health care	<u>Deductible</u> plus 35% coinsurance	<u>Deductible</u> plus 50% coinsurance	Prior authorization may be required.

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		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	
other special health needs	Rehabilitation services	Deductible plus 35% coinsurance	Deductible plus 50% coinsurance	Prior authorization required.	
	<u>Habilitation services</u>	Not covered	Not covered	Unless under Autism rider of the policy.	
	Skilled nursing care	Not covered	Not covered	Not covered.	
	<u>Durable medical equipment</u>	Deductible plus 35% coinsurance	Deductible plus 50% coinsurance	Prior authorization required.	
	Hospice services	Deductible plus 35% coinsurance	Deductible plus 50% coinsurance	Prior authorization may be required. Inpatient Hospice care limited to 180 days maximum/lifetime.	
If your child needs	Children's eye exam	\$0 <u>copayment</u> for first annual visit, then <u>deductible</u> plus 35% <u>coinsurance</u>	<u>Deductible</u> plus 50% <u>coinsurance</u>	1 routine eye exam/calendar year.	
dental or eye care	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)
- 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> <u>services</u>.

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

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- 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.

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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 <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> Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information 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
- 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 www.cciio.cms.gov.
- 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 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.

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Does this plan meet Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this <u>plan</u> might cover costs for a sample medical situation, see the next section.

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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>	\$2,750
■ Specialist coinsurance	35%
■ Hospital (facility) <u>coinsurance</u>	35%
Other coinsurance	35%

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		
<u>Deductibles</u>	\$2,750	
Copayments	\$0	
Coinsurance	\$3,500	
What isn't covered		
Limits or exclusions	\$60	
The total Peg would pay is	\$6,310	

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>	\$2,750
■ Specialist coinsurance	35%
■ Hospital (facility) coinsurance	35%
Other coinsurance	35%

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:		
Cost Sharing		
<u>Deductibles</u>	\$2,750	
Copayments	\$0	
Coinsurance	\$1,500	
What isn't covered		
Limits or exclusions	\$20	
The total Joe would pay is	\$4,270	

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$2,750
■ Specialist coinsurance	35%
■ Hospital (facility) coinsurance	35%
■ Other coinsurance	35%

This EXAMPLE event includes services like:

<u>Emergency room care</u> (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>	\$1,900	
Copayments	\$0	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$1,900	

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 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 subsidiary companies, in cluding 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.

Cherokee - $\theta \partial \mathcal{Y} \theta \mathcal{S} \mathcal{O} h \mathcal{A} \partial \mathcal{J} \mathcal{J} h \partial \mathcal{S} \mathcal{F} \partial \mathcal{Y} \theta \mathcal{T} (GWY) \mathcal{O} b W \mathcal{O} \mathcal{I} \mathcal{S} 1-866-851-0754 \mathcal{O} \theta \mathcal{T} \mathcal{L} A \Gamma \partial \mathcal{J} \mathcal{J} E G \mathcal{F} \mathcal{J} h \mathcal{F} R \theta.$

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 'ōlelo Hawai'i, e kahea aku i ka helu kelepona 1-866-851-0754. Kāki 'ole 'ia kēia kōkua nei.

Proprietary

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.

ltalian - 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 - လာတာမောက်တတိုးကျိုင်အင်္ဂါ ကျိုင် 🕰 866-851-0754 လာတအိုင်ခ်ိဳးတာ်လာဝ်ဘူင်လာဝ်စူးဘင်

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

Kru-Bassa - Bɛ´m`ké gbo-kpá-kpá dyé pidyi dé Bašsɔɔ´-wuduùň wɛ̃ɛ, dá 1-866-851-0754

برای راهنمایی به زبان فارسی با شماره ۰٫۶۶۱-۵۶۵-۱-۱-۹۶۵ به خورایی پهیومندی بکهن.

Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລນາໂທຫາ1-866-851-0754 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.

Microne sian -

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

Mon-Khmer, សម្រាប់ជំនួយភាសាជា ភាសាខុមរៃ សូមទូសេ័ពទទៅកាន់លខេ 1-866-851-0754 ដោយឥតគិតថ្លាំ។

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 Thuonjën 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 ۵۶۱-۵۶۱-۱-۱-۵۵۵ 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 & D241 abK 2 Le K coi, m or Ly iopk 161,20 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 زیان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-866-851-0754 یر 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.