### Important Questions

<table>
<thead>
<tr>
<th>Questions</th>
<th>Answers</th>
<th>Why this Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>In-Network: Individual $0 / Family $0. Out–of–Network: Individual $200 / Family $600. Does not apply to prescription drugs and emergency care in-network.</td>
<td>You must pay all the costs up to the <strong>deductible</strong> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <strong>deductible</strong> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <strong>deductible</strong>.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>No.</td>
<td>You don't have to meet <strong>deductibles</strong> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.</td>
</tr>
<tr>
<td><strong>Is there an out-of-pocket limit on my expenses?</strong></td>
<td>Yes. In-Network: Individual $2,000 / Family $4,000. Out–of–Network: Individual $2,000 / Family $4,000.</td>
<td>The <strong>out-of-pocket limit</strong> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Premiums, balance-billed charges, penalties for failure to obtain pre-authorization for service, and health care this plan does not cover.</td>
<td>Even though you pay these expenses, they don't count toward the <strong>out-of-pocket limit</strong>.</td>
</tr>
<tr>
<td><strong>Is there an overall annual limit on what the plan pays?</strong></td>
<td>No.</td>
<td>The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.</td>
</tr>
<tr>
<td><strong>Does this plan use a network of providers?</strong></td>
<td>Yes. See <a href="http://www.aetna.com">www.aetna.com</a> or call 1-888-982-3862 for a list of in-network providers.</td>
<td>If you use an in-network doctor or other health care <strong>provider</strong>, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <strong>provider</strong> for some services. Plans use the term in-network, <strong>preferred</strong>, or participating for <strong>providers</strong> in their <strong>network</strong>. See the chart starting on page 2 for how this plan pays different kinds of <strong>providers</strong>.</td>
</tr>
<tr>
<td><strong>Do I need a referral to see a specialist?</strong></td>
<td>No.</td>
<td>You can see the <strong>specialist</strong> you choose without permission from this plan.</td>
</tr>
<tr>
<td><strong>Are there services this plan doesn't cover?</strong></td>
<td>Yes.</td>
<td>Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about <strong>excluded services</strong>.</td>
</tr>
</tbody>
</table>

**Questions:** Call 1-888-982-3862 or visit us at [www.HealthReformPlanSBC.com](http://www.HealthReformPlanSBC.com). If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.HealthReformPlanSBC.com](http://www.HealthReformPlanSBC.com) or call 1-888-982-3862 to request a copy.
Limitations & Exceptions

Your Cost If You Use an Out—of—Network Provider

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use an In-Network Provider</th>
<th>Your Cost If You Use an Out—of—Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>No charge</td>
<td>30% coinsurance</td>
<td>Includes Internist, General Physician, Family Practitioner or Pediatrician.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>No charge</td>
<td>30% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>No charge</td>
<td>30% coinsurance</td>
<td>Coverage is limited to 20 visits for Chiropractic care and 20 visits for acupuncture per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Preventive care /screening /immunization</td>
<td>No charge</td>
<td>30% coinsurance</td>
<td>Age and frequency schedules may apply.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge</td>
<td>30% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>No charge</td>
<td>30% coinsurance</td>
<td>none</td>
</tr>
</tbody>
</table>

Copayments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service. Coinurance is your share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is $1,000, your coinsurance payment of 20% would be $200. This may change if you haven't met your deductible.

The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)

This plan may encourage you to use in-network providers by charging you lower deductibles, copayments, and coinsurance amounts.

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# Summary of Benefits and Coverage: What this Plan Covers & What it Costs

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use an In-Network Provider</th>
<th>Your Cost If You Use an Out-of-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td><strong>Generic drugs</strong></td>
<td>Copay/prescription: $10 (retail), $20 (mail order)</td>
<td>Copay/prescription: $10 (retail)</td>
<td>Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs &amp; devices obtainable from a pharmacy, oral &amp; injectable fertility drugs 30% copayment limited to $2,000 maximum benefit per individual per lifetime. Review your formulary for prescriptions requiring precertification or step therapy for coverage. Your cost will be higher for choosing Brand over Generics unless prescribed Dispense as Written.</td>
</tr>
<tr>
<td><strong>Prescription drug coverage</strong> is administered by OptumRx</td>
<td><strong>Preferred brand drugs</strong></td>
<td>Copay/prescription: $35 (retail), $70 (mail order)</td>
<td>Copay/prescription: $35 (retail)</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Non-preferred brand drugs</strong></td>
<td>Copay/prescription: $60 (retail), $120 (mail order)</td>
<td>Copay/prescription: $60 (retail)</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Specialty drugs</strong></td>
<td>Copay/prescription: $60</td>
<td>Copay/prescription: $60</td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>No charge</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>No charge</td>
<td>No charge</td>
<td>30% coinsurance for non-emergency use out-of-network.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>No charge</td>
<td>No charge</td>
<td>No coverage for non-emergency transport.</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>No charge</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>No charge</td>
<td>30% coinsurance</td>
<td>Pre-authorization required for out-of-network care.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>No charge</td>
<td>30% coinsurance</td>
<td></td>
</tr>
</tbody>
</table>

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## Summary of Benefits and Coverage: What this Plan Covers & What it Costs

<table>
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<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use an In-Network Provider</th>
<th>Your Cost If You Use an Out-of-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental/Behavioral health outpatient services</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Mental/Behavioral health inpatient services</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Substance use disorder outpatient services</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Substance use disorder inpatient services</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered.</td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prenatal and postnatal care</td>
<td>No charge</td>
<td>30% coinsurance</td>
<td></td>
<td>Includes outpatient postnatal care. Pre-authorization may be required for out-of-network care.</td>
</tr>
<tr>
<td>Delivery and all inpatient services</td>
<td>No charge</td>
<td>30% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home health care</td>
<td>No charge</td>
<td>30% coinsurance</td>
<td></td>
<td>Coverage is limited to 100 visits per calendar year. Pre-authorization required for out-of-network care.</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>No charge</td>
<td>30% coinsurance</td>
<td></td>
<td>Coverage is limited to 39 visits per calendar year for Occupational &amp; Speech Therapy combined, 39 visits per calendar year for Physical Therapy.</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>Not covered</td>
<td>Not covered</td>
<td></td>
<td>Not covered.</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>No charge</td>
<td>30% coinsurance</td>
<td></td>
<td>Coverage is limited to 90 days per calendar year. Pre-authorization required for out-of-network care.</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>No charge</td>
<td>30% coinsurance</td>
<td></td>
<td>none</td>
</tr>
<tr>
<td>Hospice service</td>
<td>No charge</td>
<td>30% coinsurance</td>
<td></td>
<td>Pre-authorization required for out-of-network care.</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye exam</td>
<td>Not covered</td>
<td>Not covered</td>
<td></td>
<td>Not covered.</td>
</tr>
<tr>
<td>Glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered.</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Questions
Call 1-888-982-3862 or visit us at www.HealthReformPlanSBC.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.HealthReformPlanSBC.com or call 1-888-982-3862 to request a copy.
### Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover** (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Habilitation services
- Hearing aids
- Long-term care
- Mental/Behavioral health and Substance use disorder
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult & Child)
- Routine foot care
- Weight loss programs - Except for required preventive services.
- Infertility treatment - Coverage is limited to the diagnosis and treatment of underlying medical condition and artificial insemination.

**Other Covered Services** (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture - Coverage is limited to 20 visits per calendar year.
- Chiropractic care - Coverage is limited to 20 visits per calendar year.
- Agriculture - Coverage is limited to 20 visits per calendar year.

### Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-982-3862. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

### Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact us by calling the toll free number on your Medical ID Card. If your group health plan 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](http://www.dol.gov/ebsa/healthreform).

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](http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html)

### Questions:

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The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". **This plan or policy does provide** minimum essential coverage.

**Does this Coverage Meet Minimum Value Standard?**
The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does not meet** the minimum value standard for the benefits it provides.
About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

No. Treatments shown are just examples. The care you would receive for this condition could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.
Assistive Technology
Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-888-982-3862.

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 discriminate on the basis of race, color, national origin, age, disability, or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Aetna:
- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 14462, Lexington, KY 40512, 1-800-648-7817, TTY 711, Fax 859-425-3379, CRCordinator@aetna.com.
California HMO/HNO Members: Civil Rights Coordinator, PO Box 24030 Fresno CA, 93779, 1-800-648-7817, TTY 711, Fax 860-262-7705, CRCoordinator@aetna.com.
You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (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.
Language Assistance:

For language assistance in your language call 1-888-982-3862 at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-888-982-3862.

Amharic - እንወ እገዛ በ አማርኛ በ 1-888-982-3862 ያስቀል ይደውሉ.

Arabic - للمساعدة في اللغة العربية، الرجاء الاتصال على الرقم المجاني 1-888-982-3862.

Armenian - Անվտանգության համար կատարեք հազարը 1-888-982-3862 առանց գնով:

Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-982-3862 tanpa dikenakan biaya.

Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-888-982-3862 ku busa.

Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-888-982-3862-তে কল করুন।

Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-888-982-3862 nga walay bayad.

Burmese - ေငြကုန္က်ခံစရာမလိုဘဲ (ျမန္မာဘာသာစကား)ျဖင့္ ဘာသာစကားအကူအညီရယူရန္ 1-888-982-3862 ကို ေခၚဆိုပါ။

Catalan - Per rebre assistència en (català), truqui al número gratuït 1-888-982-3862.

Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-888-982-3862 sin gåstu.

Cherokee - ፟ᏲᏭᏬᏲᏲᏲ (ᏣᎳᎩ) ᏫᏏᏲᏲ 1-888-982-3862 ከ ᏗᏪreleased.

Chinese - 欲取得繁體中文語言協助，請撥打 1-888-982-3862，無需付費。

Choctaw - (Chahta) anumpa ya apela a chi ! paya hina 1-888-982-3862.

Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-888-982-3862 irratti bilisaan bilbilaa.

Dutch - Bel voor tolk-en vertaaldiensten in het Nederlands gratis naar 1-888-982-3862.

French - Pour une assistance linguistique en français appeler le 1-888-982-3862 sans frais.

French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-888-982-3862 gratis.

German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-888-982-3862 an.

Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-888-982-3862 χωρίς χρέωση.

Gujarati - ગુજરાતીમાં ભાષાની સહાય માટે કોઈ પ્લાંટ અંદર 1-888-982-3862 પર કોલ કરો.
No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-888-982-3862. Kāki ‘ole ‘ia kēia kōkua nei.

Hindi - हैदराबाद में भाषा सहायता के लिए, 1-888-982-3862 पर मुफ्त कॉल करें।

Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-888-982-3862.

Ibo - Maka enyema asusu na Igbo kpọ 1-888-982-3862 na akwụghị ugwọ ọ bu la

Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-888-982-3862 nga awan ti bayadanyo.

Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-888-982-3862.

Japanese - 日本語で援助をご希望の方は、1-888-982-3862 まで無料でお電話ください。

Karen - သောအခါသည် ဗီရိုင်း အဆက်ဆံဖုံး 1-888-982-3862 ကြည့်ရှုဖို့လိုက်ပါ။

Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862번으로 전화해 주십시오.

Kru-Bassa - Bec`m`ke gbo-kpá-kpá dyé piyi dyé Baçoó-wuquuùn wee, dà 1-888-982-3862

Kurdish - 1-888-982-3862

Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-888-982-3862 ໄດ້ບໍ່ເສຍຄ່າໂທ.

Marathi - तील भाषा (मराठी) सहाय्यासाठी 1-888-982-3862 कर्मांकावरकोणात्याविंचकित्वकाळकरा.

Marshallese - Ñan bòk jipa ilo Kajin Majol, kallok 1-888-982-3862 ilo eijelok wônän.

Micronesian-Pohnpeyan - Ohng palien sawas en sou kawewe ni omw loka Ponape koahl 1-888-982-3862 ni sohte isais.

Mon-Khmer, Cambodian - ប្រតិបត្តិការពន្ធទូទៅ ប្រាប់ប្រែវិញ ទៅមករស់មក 1-888-982-3862 រុក្សាន់កិច្ចឃ្លាខ្លាត។

Navajo - T'áá shi shiisaad k'ehjí bee shíká a'doowol ninízingo Diné k'ehjí koj'i t'áá jíík'e hólne' 1-888-982-3862

Nepali - (नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-888-982-3862 मा फोन गरुन्छो।

Nilotic-Dinka - Tën koony ē thok ē Thuonjän col 1-888-982-3862 kecin ayoc.

Norwegian - For språkassistanse på norsk, ring 1-888-982-3862 kostnadsfritt.


Persian - برای راهنمایی به زبان فارسی با شماره 1-888-982-3862 یک همیشه آماده تمرکز در انگلیسی

Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-888-982-3862.

Portuguese - Para obter assistência linguística em português ligue para o 1-888-982-3862 gratuitamente.
Punjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-888-982-3862 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-888-982-3862
Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-888-982-3862.
Samoan - Mo fesoasoani tau gagana le Gagana Samoa vala'au le 1-888-982-3862 e aunoa ma se totogi.
Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatni broj 1-888-982-3862.
Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-888-982-3862.
Sudanic-Fulfude - Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-888-982-3862. Njodi woo fawaaki on.
Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-888-982-3862 bila malipo.
Syriac - ܢܰܐ ܐܶܥܳܒ ܢܶܐ ܢܘܦܝܠܬܕ ܐܳܡܩܰܪ ܟܳܠ ܐܳܗ ܐܳܿܝܳܝܪܽܘܣ ܐܳܢܫܶܠܒ ܐܬܽܘܢܪܕܰܥܡ ܬ 1-888-982-3862 .ܢܳܓܰܡܘ
Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-888-982-3862 nang walang bayad.
Telugu - భాషతో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 1-888-982-3862 కు కాల్ చేయండి.
Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-888-982-3862 ฟรีไม่มีค่าใช้จ่าย
Tongan - Kapau ‘oku fiema’u hā tokoni ‘i he lea faka-Tonga telefoni 1-888-982-3862 ‘o ‘ikai hā tōtōngi.
Turkese-Chuukese - Ren áninnisin chiaku ren (Kapasen Chuuk) kopwe kékkééri 1-888-982-3862 nge esapw kamé ngonuk.
Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-888-982-3862.
Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-888-982-3862.
Urdu - ارکائیل کھٹم رپ 882-982-3862-888-982-3862 ہے میں طلب ریم و دی
Vietnamese - Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-888-982-3862.
Yiddish - 1-888-982-3862
Yoruba - Fún irànlowọ nípa èdè (Yorùbá) pe 1-888-982-3862 lái san owó kankan rará.