Coverage for: Individual + Family | Plan Type: POS



SEGAL: Aetna Choice® POS II - \$1,000 Deductible Plan



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 1-888-982-3862. 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 1-888-982-3862 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In- <u>Network:</u> Individual \$1,000 / Family \$2,000. Out-of-Network: 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 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> ?	In- <u>Network:</u> Individual \$8,700 / Family \$17,400. Out-of-Network: Individual \$9,500 / Family \$19,000.	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</u> <u>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?	Copayments on certain services, <u>premiums</u> , balance-billing charges, health care this <u>plan</u> doesn't cover & penalties for failure to obtain <u>pre-authorization</u> for services.	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. See www.aetna.com/docfind or call 1-888-982-3862 for a list of in-network providers. See www.optumrx.com for a list of in-network providers for prescription drug coverage	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
If you visit a health care <u>provider</u> 's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	None
If you visit a health care <u>provider</u> 's office or clinic	<u>Specialist</u> visit	20% coinsurance	40% coinsurance	None
If you visit a health care <u>provider</u> 's office or clinic	Preventive care /screening /immunization	No charge	40% coinsurance	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
If you have a test	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% <u>coinsurance</u>	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
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.optumrx.com Visit https://specialty.opt umrx.com/ for information about specialty drugs	Generic drugs	10% coinsurance Retail and Mail subject to: Retail: \$7.50/Minimum, \$30/Maximum; Mail and Retail 90: \$15/Minimum, \$60/Maximum	Not covered	30-day supply retail and 31-90 day supply for mail order. 90-day retail ("Retail 90") at Walgreens/Duane Reade only. Certain medications are subject to step therapy and/or require preauthorization. If Brand drug is purchased when Generic is available, participant pays the applicable cost
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.aetna.com/phar macy-insurance/individuals-families	Preferred brand drugs	20% coinsurance Retail and Mail subject to: Retail: \$20/Minimum, \$100/Maximum; Mail and Retail 90: \$40/Minimum, \$200/Maximum	Not covered	sharing plus the difference between the Brand and Generic price. No charge for FDA-approved Generic contraceptives (or Brand contraceptives if Generic is medically inappropriate).

	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 need drugs to treat your illness or condition More information about prescription drug coverage is available at www.aetna.com/phar macy-insurance/individuals-families	Non-preferred brand drugs	30% coinsurance Retail and Mail subject to: Retail: \$40/Minimum, \$200/Maximum; Mail and Retail 90: \$80/Minimum, \$400/Maximum	Not covered	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.aetna.com/phar macy-insurance/individuals-families	Specialty drugs	Optum Specialty only 30-day supply Generic: 10% coinsurance with \$15/Minimum, \$60/Maximum Preferred Brand Drug: 20% coinsurance with \$40/Minimum, \$200/Maximum Non-Preferred Brand Drug: 30% coinsurance with \$80/Minimum; \$400/Maximum; For more than 30-day supply, Generic: 10% coinsurance with \$30/minimum \$120/maximum Preferred Brand Drug: 20% coinsurance with \$80/minimum \$400/maximum Non-Preferred Brand drug: 30% coinsurance with \$160/minimum \$800/maximum	Not covered	Preauthorization Required. Optum Specialty drug Smart Fill or Split Fill program can provide specialty drugs for 30-day supply or less than or more than 30-day supply. For a Split Fill (one half month's supply) for certain conditions minimums and maximum may be reduced.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
If you have outpatient surgery	Physician/surgeon fees	20% coinsurance	40% coinsurance	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
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> . No coverage for non-emergency use.
If you need immediate medical attention	Emergency medical transportation	20% coinsurance	20% coinsurance	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> . No coverage for non-emergency transport.
If you need immediate medical attention	<u>Urgent care</u>	20% coinsurance	40% coinsurance	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 <u>copay</u> /day first 5 days per stay; 0% <u>coinsurance</u> thereafter	\$500 copay/day first 5 days per stay; 40% coinsurance thereafter	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
If you have a hospital stay	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: 20% coinsurance	Office & other outpatient services: 40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Inpatient services	\$250 <u>copay</u> /day first 5 days per stay; 0% <u>coinsurance</u> thereafter	\$500 copay/day first 5 days per stay; 40% coinsurance thereafter	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
If you are pregnant	Office visits	No charge	40% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Penalty of \$400 for failure to obtain pre-authorization for out-of-network care may apply.

	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 are pregnant	Childbirth/delivery professional services	0% <u>coinsurance</u>	40% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Penalty of \$400 for failure to obtain pre-authorization for out-of-network care may apply.
If you are pregnant	Childbirth/delivery facility services	\$250 <u>copay</u> /day first 5 days per stay; 0% <u>coinsurance</u> thereafter	\$500 <u>copay</u> /day first 5 days per stay; 40% <u>coinsurance</u> thereafter	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Penalty of \$400 for failure to obtain pre-authorization for out-of-network care may apply.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	None
If you need help recovering or have other special health needs	Rehabilitation services	20% coinsurance	40% coinsurance	60 visits/calendar year for Physical, Occupational & Speech Therapy combined.
If you need help recovering or have other special health needs	Habilitation services	20% coinsurance	40% coinsurance	None
If you need help recovering or have other special health needs	Skilled nursing care	\$250 <u>copay</u> /day first 5 days per stay; 0% <u>coinsurance</u> thereafter	\$500 <u>copay</u> /day first 5 days per stay; 40% <u>coinsurance</u> thereafter	120 days/calendar year. Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
If you need help recovering or have other special health needs	Durable medical equipment	20% coinsurance	40% coinsurance	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.

		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 need help recovering or have other special health needs	Hospice services	\$250 <u>copay</u> /day first 5 days per stay; 0% <u>coinsurance</u> thereafter for inpatient; 20% <u>coinsurance</u> for outpatient	\$500 copay/day first 5 days per stay; 40% coinsurance thereafter for inpatient; 40% coinsurance for outpatient	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
If your child needs dental or eye care	Children's eye exam	No charge	40% coinsurance	1 routine eye exam/24 months.
If your child needs dental or eye care	Children's glasses	Not covered	Not covered	Not covered.
If your child needs dental or eye care	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)

- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs Except for required <u>preventive</u> <u>services</u>.

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

- Acupuncture 10 visits/calendar year for disease, injury & chronic pain.
- Bariatric surgery

- Chiropractic care
- Infertility treatment For more information & exceptions, see policy document provided by your employer or call the number on your ID card.
- Private-duty nursing 70- 8 hour shifts/calendar year.
- Routine eye care (Adult) 1 routine eye exam/24 months.

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 1-888-982-3862.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health <u>plans</u>, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or <u>www.cciio.cms.gov</u>.
- If your coverage is a church <u>plan</u>, church <u>plans</u> are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the <u>Health Insurance Marketplace</u>. For more information about the 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 1-888-982-3862. 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>.
- 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.

Does this plan meet Minimum Value Standards? Yes.

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

To see examples of how this plan might cover costs for a sample medical situation, see the next section

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost-sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,000
■ Specialist coinsurance	20%
■ Hospital (facility) copayment	\$250
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)

Total Example Cost	\$12,700
In this example, Peg would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,000
Copayments	\$780
Coinsurance	\$230
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,070

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>	\$1,00
■ Specialist coinsurance	20%
■ Hospital (facility) copayment	\$25
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

Durable medical equipment (glucose meter)

Total Example Cost	\$5,600
In this example, Joe would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$0
Coinsurance	\$1,010
What isn't covered	
Limits or exclusions	\$690
The total Joe would pay is	\$2,700

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$1,000
■ Specialist coinsurance	20%
■ Hospital (facility) <u>copayment</u>	\$250
■ Other coinsurance	0%

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

Diagnostic test (x-ray)

<u>Durable medical equipment</u> (crutches)

Rehabilitation services (physical therapy)

Total Example Cost	\$2,800
In this example, Mia would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$360
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,360

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).

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 1-888-982-3862 at no cost.

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

Amharic - $(i \text{ TM} \int \frac{3}{A}x \mu; \text{ Mox } 1\text{-888-982-3862 } x \cdot t' \cdot , €)$

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-888-982-3862 الرجاء الاتصال على الرقم المجاني

Armenian - Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 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 nomero 1-888-982-3862 ku busa

Bengali-Bangala - a Ike It ĎIĕ LĹĺ It č IE ĞĂĕ la ĂId'ãe ĕ 1-888-982-3862-ĕ ¹ e ¹ ½ Ă]

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

Burmese - ငွေကုန်ကျစံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-888-982-3862 ကို ခေါ် ဆိုပါ။

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 - $\ ^-$ Ľ Þ $^-$ ð ε Å 3 Ľ Ŕ ŔAĽ Őğ Ľ Þ $^-$ · Ž (ŹF Þ) δ LF T Đờ 1-888-982-3862 $\ ^+$ Ž Ť þ ½Ľ Ŕ $\Gamma \times \Phi$ ğ Ŕ Åý ń $^-$.

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 I paya hinla 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 - χ là { $\ddot{\psi}$ ày $\ddot{\textbf{UR}}$ $\ddot{\textbf{UA}}\ddot{\textbf{U}}$ $\ddot{\textbf{UR}}$ $\ddot{\textbf{E}}\ddot{\textbf{U}}$ y $\ddot{\textbf{U}}$ koæ $\ddot{\textbf{e}}$ Wu o b f \leftarrow c { 1-888-982-3862 u { a \ref{a} a { $\ref{e}}$

Hawaiian - 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 - हिन्दी 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.

lbo - Maka enyemaka asusu na Igbo kpoo 1-888-982-3862 na akwughi ugwo o bula

llocano - 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 - လာတာမြာစားတာကတိုးကျိုဘ်အင်္ဂါ ကျိုဘ် ကိုန်888-982-3862 လာတအိုဘိုဒီးတာ်လာဘ်ဘူဉ်လာဘ်စူးဘဉ်

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

Kru-Bassa - Be´m`ké qbo-kpá-kpá dyé pidyi dé Bašsoó-wuduùn wee, dá 1-888-982-3862

برای راهنمایی به زبان فارسی با شماره 3862-982-1-888 به خورایی پهیومندی بکن.

Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ-888-982-3862 ໂດຍບໍ່ເສຍຄ່າໂທ.

Marathi - $\hat{u} \hat{v} \sim \sum_{\rho \in \mathcal{V}} v^{\rho} \hat{s} \hat{u} \rho^{Q} \hat{s} \hat{u} \rho^{Q} \hat{s} \hat{u} \rho^{Q} \hat{s} \hat{u} \rho^{Q} \hat{u} \rho \neq \hat{u} \prod \sum_{\rho \in \mathcal{V}} p e^{\rho \mathcal{C}_{\mathcal{V}}} 1-888-982-3862 \stackrel{a}{=} \square \geq \text{$^{\pm}$ \hat{u} \square} \hat{b}$

Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-888-982-3862 ilo ejjelok wōnān.

Micronesian-

Pohnpeyan - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-888-982-3862 ni sohte isais.

Mon-Khmer, សម្រាប់ជំនួយភាសាជា ភាសាខុមរៃ សូមទូសេ័ពុទទៅកាន់លខេ 1-888-982-3862 ដោយឥតគិតថ្លាំ។

Cambodian -

Navajo - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-888-982-3862

Nepali - $(\pm \underline{\leqslant} \rho \pi \, v) \, \partial \, \rho \, \hat{\Psi} \, \ddot{\mathbb{E}} \, \hat{\mathfrak{f}} \, \hat{\mathfrak{u}} \, \mu \, \rho \Omega \rho \& \sigma \rho \Sigma \neq \rho \leq \rho \rbrace \pm \hat{\mathfrak{u}} \, \rho \pi \, \rho \, \tilde{\tau} \, 1 - 888 - 982 - 3862 \, \partial \, \rho \geq v \pm \, \hat{\tau} \pm \hat{\mathfrak{g}} \, \hat{\mathsf{u}} \, \hat{\mathfrak{e}} \, \hat{\mathfrak{g}} \,$

Nilotic-Dinka - Tën kupony ë thok ë Thuonjan col 1-888-982-3862 kecin ayöc.

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

Panjabi - $p \sim A \ddot{k} \sim V$ { | $T \sim WU$, 1-888-982-3862 $\dot{k} \sim V \dot{U}$

Pennsylvania Dutch - Fer Helfe in Deitsch, ruf: 1-888-982-3862 aa. Es Aaruf koschtet nix.

برای راهنمایی به زبان فارسی با شماره 3862-982-982 بدون هیچ هزینه ای تماس بگیرید. انگلیسی Persian -

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

Portuguese - Para obter assistência linguística em português ligue para o 1-888-982-3862 gratuitamente.

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 I le Gagana Samoa vala'au le 1-888-982-3862 e aunoa ma se totogi.

Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan 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 - K - 22 K K & 2241 abk 2122 K oai, K or Ly io 2 188-982-3862 ap .

Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-888-982-3862 nang walang bayad.

Telugu - !! $\not c$ Å $\alpha \ e\ddot{i} \ \tilde{N}$ $P \ U \ z \ \omega Z \ e^{2} \ | \hat{i} \ \omega P \ e^{2} \ | 1-888-982-3862 \ \omega \ U \ \tilde{N} \ z \ e^{2} \ P \ e^{2} \ | \omega P \ e^{2$

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 ōtōngi.

Trukese - Ren áninnisin chiakú 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.

بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 3862-982-1888 یر بات کریں۔

Vietnamese - Đê 'được hố trở ngôn ngư bằng (ngôn ngư), hấy gọi miễn phi 'đên số 1-888-982-3862.

Yiddish - פאר שפראך הילף אין אידיש רופט 1-888-982-3862 פריי פון אפצאל.

Yoruba - Fún ìrànlowo nípa èdè (Yorùbá) pe 1-888-982-3862 lái san owó kankan rárá.