



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, www.HealthReformPlanSBC.com or by calling 1-833-821-0849. 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 1-833-821-0849 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 \$0 / Family \$0.	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your deductible?	No.	You do not have to meet a <u>deductible</u> before services are covered under this plan, but a <u>copayment</u> may apply.
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 limit</u> for this <u>plan</u> ?	In- <u>Network</u> Medical: Individual \$4,500 / Family \$9,000. In- <u>Network</u> Prescription drugs: Individual \$2,100 / Family \$4,200. Out-of- <u>Network</u> : Not applicable.	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> ?	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover, <u>copayments</u> & <u>coinsurance</u> on certain services & penalties for failure to obtain precertification.	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 www.aetna.com/docfind or call 1-833-821-0849 for a list of <u>in-network providers</u> .	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</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$15 <u>copay</u> /visit	Not covered	None <u>Referrals</u> are required for most <u>specialist</u> visits. If you don't get <u>referral</u> , benefits will be denied. 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.
	<u>Specialist</u> visit	\$25 <u>copay</u> /visit	Not covered	
	<u>Preventive care</u> / <u>screening</u> /immunization	No charge	Not covered	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	X-ray: \$50 <u>copay</u> /visit for hospital facility & No charge for freestanding facility; Laboratory: \$50 <u>copay</u> /visit except \$10 <u>copay</u> /visit for Quest Diagnostics/Labcorp	Not covered	Preferred laboratories: Quest Diagnostic or Labcorp.
	Imaging (CT/PET scans, MRIs)	\$100 <u>copay</u> /visit for hospital; no charge for non-hospital freestanding facility	Not covered	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition <u>Prescription drug coverage is administered by CVS Caremark</u> More information about <u>prescription drug coverage</u> is available at www.caremark.com	Generic drugs	\$10 <u>copay</u> /prescription for 30-day supply (retail or mail order); \$20 <u>copay</u> /prescription for 90-day supply (participating retail or mail order)	Reimbursement limited to in- <u>network</u> allowable amount minus applicable <u>copay</u>	Up to 30-day fills at retail or mail order for non-maintenance drugs; 90-day fills for maintenance drugs available at participating pharmacies or mail order only, maintenance drugs filled as 30-day supply incur penalty at fourth fill; under Choice Program, you pay applicable <u>copay</u> plus difference between generic and brand when preferred generic equivalent is available. Erectile dysfunction (ED) drugs are not covered unless <u>medically necessary</u> for conditions other than ED. <u>Prescription drugs</u> with an over-the-counter equivalent are not covered, except for emergency contraception. Qualified members ages 40 - 75 receive generic low to moderate dose statins at no cost. No charge for diabetic supplies purchased through the prescription <u>plan</u>. One <u>copay</u> applies for multiple diabetic medications filled at a 90-day participating retail pharmacy or mail order pharmacy, if purchased at the same time.
	Preferred brand drugs	\$32 <u>copay</u> /prescription for 30-day supply (retail or mail order); \$64 <u>copay</u> /prescription for 90-day supply (participating retail or mail order)	Reimbursement limited to in- <u>network</u> allowable amount minus applicable <u>copay</u>	
	Non-preferred brand drugs	\$60 <u>copay</u> /prescription for 30-day supply (retail or mail order); \$120 <u>copay</u> /prescription for 90-day supply (participating retail or mail order)	Reimbursement limited to in- <u>network</u> allowable amount minus applicable <u>copay</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<u>Specialty drugs</u>	No charge if enrolled in the PrudentRx program; 30% <u>coinsurance</u> if not enrolled in the PrudentRx program	Not covered	<u>Specialty drugs</u> must be filled by CVS Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$150 <u>copay</u> /visit for hospital facility; except \$50 <u>copay</u> /visit for freestanding facility	Not covered	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied. Additional benefits for non-emergency, planned surgeries are available through Lantern.
	Physician/surgeon fees	No charge	Not covered	None
If you need immediate medical attention	<u>Emergency room care</u>	\$200 <u>copay</u> /visit	\$200 <u>copay</u> /visit	<u>Out-of-network</u> emergency use paid the same as <u>in-network</u> . No coverage for non-emergency use, except certain services. Refer to <u>plan</u> document for coverage details of non-emergency use.
	<u>Emergency medical transportation</u>	\$50 <u>copay</u> /trip	\$50 <u>copay</u> /trip	<u>Out-of-network</u> emergency use paid the same as <u>in-network</u> . Non-emergency transport: not covered, except if pre-authorized.
	<u>Urgent care</u>	\$15 <u>copay</u> /visit	Not covered	No coverage for non-urgent use.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$100 <u>copay</u> /day; \$200 maximum/admission for elective orthopedic & spine procedures performed at preferred Institutes of Quality (IOQ) or \$500 <u>copay</u> /admission at other facilities No charge for bariatric surgery through Lantern	Not covered	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied. Additional benefits for non-emergency, planned surgeries are available through Lantern.
	Physician/surgeon fees	No charge	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: \$15 <u>copay</u> /visit	Not covered	None
	Inpatient services	\$100 <u>copay</u> /day; \$200 maximum/admission	Not covered	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied.
If you are pregnant	Office visits	No charge	Not covered	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	\$25 <u>copay</u> /pregnancy	Not covered	
	Childbirth/delivery facility services	\$100 <u>copay</u> /day; \$200 maximum/admission	Not covered	
If you need help recovering or have	<u>Home health care</u>	No charge	Not covered	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
other special health needs	<u>Rehabilitation services</u>	20% <u>coinsurance</u> or lesser of \$15 copay or 20% coinsurance per visit for mental health and substance abuse disorder diagnosis	Not covered	Limited to 45 visits per condition for physical and occupational therapy combined. No visit-limit on physical therapy for treatment of back pain. Coverage is limited to 45 visits per condition for speech therapy. Subject to medical necessity review at 25 visits. No visit limit for Physical, Occupational and Speech Therapy for mental health and substance abuse disorder diagnosis.
	<u>Habilitation services</u>	\$15 <u>copay</u> /visit	Not covered	Limited to treatment of Autism.
	<u>Skilled nursing care</u>	No charge	Not covered	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	Not covered	None.
	<u>Hospice services</u>	No charge	Not covered	None
If your child needs dental or eye care	Children's eye exam	\$15 <u>copay</u> /visit	Not covered	1 routine eye exam/24 months.
	Children's glasses	Not covered	Not covered	Coverage may be available through National Vision Administrators (NVA).
	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 (Adult & Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care

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

- Acupuncture - Covered in lieu of anesthesia.
- Bariatric surgery
- Chiropractic care
- Hearing aids - 3 hearing aids per ear/36 months for children up to age 24; 1 initial replacement & 1 additional if needed due to growth.
- Infertility treatment - For more information & exceptions, see policy document provided by your employer or call the number on your ID card.
- Private-duty nursing
- 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 1-833-821-0849.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <http://www.dol.gov/ebsa/healthreform>
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general number at 1-833-821-0849. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <http://www.dol.gov/ebsa/healthreform>
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your appeal. Contact information is at: <http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html>.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Yes.

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

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

About these Coverage Examples:



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

Peg is Having a Baby

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

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$25
■ Hospital (facility) <u>copayment</u>	\$100
■ Other <u>copayment</u>	\$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>	\$0
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$60
The total Peg would pay is	\$460

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>	\$0
■ <u>Specialist copayment</u>	\$25
■ Hospital (facility) <u>copayment</u>	\$100
■ Other <u>copayment</u>	\$0

This EXAMPLE event includes services like:

Primary care provider office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Diabetic supplies (*glucose meter*)

Total Example Cost	\$5,600
In this example, Joe would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$700
<u>Coinsurance</u>	\$200
<u>What isn't covered</u>	
Limits or exclusions	\$20
The total Joe would pay is	\$920

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$25
■ Hospital (facility) <u>copayment</u>	\$100
■ Other <u>copayment</u>	\$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:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$600
<u>Coinsurance</u>	\$100
<u>What isn't covered</u>	
Limits or exclusions	\$0
The total Mia would pay is	\$700

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-833-821-0849.

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 companies, including Aetna Life Insurance Company and its affiliates (Aetna).

TTY: 711

Language Assistance:

To access language services at no cost to you, call 1-833-821-0849.

Albanian -	Për shërbime përkthimi falas për ju, telefononi 1-833-821-0849.
Amharic -	የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-833-821-0849 ይደውሉ።
Arabic -	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-833-821-0849
Armenian -	Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-833-821-0849 հեռախոսահամարով:
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-833-821-0849 tanpa dikenakan biaya.
Bantu-Kirundi -	Kugira uronke serivisi z'indimi atakiguzi, hamagara 1-833-821-0849.
Bengali-Bangala -	আপনাকে বিনামূল্যে ভাষা পবিকষিা পপকে হকয এই নম্বকি পেবযক ান েরন: 1-833-821-0849।
Bisayan-Visayan -	Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-833-821-0849.
Burmese -	သင့်အရှေ့ဖို့ အခမဲ့ကမ်းငြဲ မေးရပဲ ဘာသာစကားဝန်ဆောင်ခွဲမ်း ရရှိဖို့ငွ်န့် 1-833-821-0849 သို့ငှ ဖုန်းခေငှဆုိပါ။
Catalan -	Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-833-821-0849.
Chamorro -	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-833-821-0849.
Cherokee -	Ⴀႃ႗ႃ Ⴑ႗႗႗႗႗ Ⴑ႗႗႗႗႗ Ⴑ႗႗႗႗႗ Ⴑ႗႗႗ Ⴑ႗႗႗႗႗ Ⴑ႗, Ⴑ႗႗႗႗႗႗ 1-833-821-0849.
Chinese -	如欲使用免費語言服務，請致電 1-833-821-0849.
Choctaw -	Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-833-821-0849.
Cushite -	Tajaajiiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-833-821-0849.
Dutch -	Voor gratis toegang tot taaldiensten, bell 1-833-821-0849.
French -	Afin d'accéder aux services langagiers sans frais, composez le 1-833-821-0849.
French Creole -	Pou jwenn sèvis lang gratis, rele 1-833-821-0849.
German -	Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-833-821-0849 an.
Greek -	Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-833-821-0849.
Gujarati -	તમારેકોઇ જાતના ખર્ચવિના ભાષાની સેવિઓની પહોંર માટે, કોલ કરો1-833-821-0849.

Hawaiian -	No ka wala‘au ‘ana me ka lawelawe ‘ōlelo e kahea aku i kēia helu kelepona 1-833-821-0849. Kāki ‘ole ‘ia kēia kōkua nei.
Hindi -	आपकेलिए बिना ककसी कीमत केभाषा सेवाओंका उपयोग करनेकेलिए,1-833-821-0849 पर कॉल करें।
Hmong -	Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-833-821-0849.
Igbo -	Iji nwetaòhèrè na ọrụ gasị asụsụ n'efu, kpọọ 1-833-821-0849
Ilocano -	Tapno maaksesyô dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti 1-833-821-0849.
Indonesian -	Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi 1-833-821-0849.
Italian -	Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-833-821-0849.
Japanese -	言語サービスを無料でご利用いただくには、1-833-821-0849 までお電話ください。
Karen -	လၢတၢ်ကမၤန့ၢ်ကျိၢ်အတၢ်မၤစၢၤအတၢ်ဖဲတၢ်မၤတဖၣ်လၢတအိၣ်ဒီးအပူၤလၢကဘၣ်ဟ့ၣ်အိၣ်အဂီၢ်ဘၣ်န့ၣ် ကိး 1-833-821-0849 တက့ၢ်.
Korean -	무료 언어 서비스를 이용하려면 1-833-821-0849 번으로 전화해 주십시오.
Kru-Bassa -	M̈ dyi wuḍu-dù kà kò ḍò b̈ě dyi m̈oú n̈ ní Pídyi ní, níí, ḍá nòbà n̈ià k̈e: 1-833-821-0849
Kurdish -	1-833-821-0849 بۆ دەسپێرێ گەشتن بە خزمەتگوزاری زمان بەی تێچوون بۆ تۆ، پەیوەندی بکە بە ژمارە
Laotian -	ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ 1-833-821-0849
Marathi -	कोणत्याही शल्ुकालशवाय भाषा सेवा प्राप्त करण्यासाठी,, 1-833-821-0849 वर फोन करा.
Marshallese -	Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlok 1-833-821-0849.
Micronesian-	
Pohnpeyan -	Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1-833-821-0849.
Mon-Khmer, Cambodian -	ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-833-821-0849 ។
Navajo -	T'áá ni nizaad k'ehjí bee níká a'doowoł doo báąh ílínígóó koji' hólne' 1-833-821-0849.
Nepali -	निःशुल्क भाषा सेवा प्राप्त गर्न 1-833-821-0849 मा टेलिफोन गर्नुहोस् ।
Nilotic-Dinka -	Të koor yin wëër de thokic ke cîn wëu k̈or keek ẗen̈ɔŋ yin. Ke c̈ol k̈oc ye k̈oc kuony ne nomba 1-833-821-0849.
Norwegian -	For tilgang til kostnadsfri språktjenester, ring 1-833-821-0849.
Pennsylvania Dutch -	Um Schprooch Services zu griege mitaus Koscht, ruff 1-833-821-0849.
Persian -	برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-833-821-0849 تماس بگیرید .
Polish -	Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-833-821-0849.
Portuguese -	Para acessar os serviços de idiomas sem custo para você, ligue para 1-833-821-0849.

Punjabi -	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1-833-821-0849 'ਤੇ ਫ਼ੋਨ ਕਰੋ।
Romanian -	Pentru a accesa gratuit serviciile de limbă, apălați 1-833-821-0849.
Russian -	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-833-821-0849.
Samoan -	Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala'au le 1-833-821-0849.
Serbo-Croatian -	Za besplatne prevodilačke usluge pozovite 1-833-821-0849.
Spanish -	Para acceder a los servicios de idiomas sin costo, llame al 1-833-821-0849.
Sudanese-Fulfulde -	Heeba a nasta jangirde djey wolde wola chede bo apelou lamba 1-833-821-0849.
Swahili -	Kupata huduma za lugha bila malipo kwako, piga 1-833-821-0849.
Syriac -	ܝܥܢ ܫܒܩܐ, ܕܠ ܝܠܝܚܝܐ ܠܥܝܢܐ ܕܠܝܩܬܐ ܕܝܠܝܬܐ, ܡܢ ܒܚܢܐ: 1-833-821-0849
Tagalog -	Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-833-821-0849.
Telugu -	మీరు భాష సేవలను ఉచితంగా అందుకునందుకు, 1-833-821-0849 కు కాల్ చేయండి.
Thai -	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-833-821-0849.
Tongan -	Kapau ‘oku ke fiema’u ta’etōtōngi ‘a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he 1-833-821-0849.
Trukese -	Ren omw kopwe angei aninisin eman chon awewei (ese kamo), kopwe kori 1-833-821-0849.
Turkish -	Sizin için ücretsiz dil hizmetlerine erişebilmek için, 1-833-821-0849 numarayı arayın.
Ukrainian -	Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-833-821-0849.
Urdu -	بالقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-833-821-0849 پر بات کریں۔
Vietnamese -	Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-833-821-0849.
Yiddish -	1-833-821-0849 צו צוטריט שפראך באדינונגען אין קיין פרייז צו איר, רופן
Yoruba -	Lati wọnú awọn isẹ èdè l’ọfẹ fun ọ, pe 1-833-821-0849.