

NUVANCE HQ: Aetna Open Access® Aetna SelectSM - EPO

Coverage for: All Tiers | Plan Type: EPO

Coverage Period: 01/01/2023-12/31/2023



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 1-877-272-6374. 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 1-877-272-6374 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Tier 1a: \$0 person / \$0 person + 1 / \$0 family; Tier 1b: \$250 person / \$500 person + 1 / \$625 family; Tier 2: \$500 person / \$1,000 person + 1 / \$1,250 family.	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. Emergency care; plus Tier 1b & Tier 2 preventive care are covered before you meet your deductible.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
Are there other <u>deductibles</u> for specific services?	Yes. \$50 person / \$150 family for Prescription Drugs.	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	Tier 1a: \$1,250 person / \$2,000 person + 1/ \$2,625 family; Tier 1b: \$1,250 person / \$2,000 person + 1/ \$2,625 family; Tier 2: \$1,750 person / \$2,500 person + 1/ \$3,250 family; Prescription Drugs: \$3,000 person / \$6,000 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. See www.aetnaresource.com/n/Nuvance-Health or call (877) 272-6374 for a list of in-network providers.	You pay the least if you use a <u>provider</u> in Tier 1a. You pay more if you use a <u>provider</u> in Tier 1b or Tier 2. 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</u> 's 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> ?	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.

Common Medical Event	Services You May Need	Tier 1a Provider (You will pay the least)	(You will pay the (You will pay (You will pay		Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
	Primary care visit to treat an injury or illness	No charge	0% coinsurance; 20% coinsurance after \$100 copay/visit for office surgery	Not covered	Not covered	None	
If you visit a health care <u>provider</u> 's office or clinic	Specialist visit	No charge	\$35 copay/visit; 20% coinsurance after \$100 copay/visit for office surgery	Not covered	Not covered	None	
	Preventive care /screening /immunization	No charge	No charge	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.	
If you have a test	Diagnostic test (x-ray, blood work)	No charge	\$10 copay/visit for laboratory; 0% coinsurance for x-ray	\$10 copay/visit for laboratory; not covered for x-ray	Not covered	None	
	Imaging (CT/PET scans, MRIs)	No charge	\$75 <u>copay</u> /visit	Not covered	Not covered	None	
If you need drugs to treat your illness or	Generic drugs	15% <u>coinsurance</u> after specific <u>deductible</u>	15% <u>coinsurance</u> after specific <u>deductible</u>	15% <u>coinsurance</u> after specific <u>deductible</u>	Not covered	Under limitations, exceptions and other	
condition	Preferred brand drugs	15% <u>coinsurance</u> after specific <u>deductible</u>	15% <u>coinsurance</u> after specific <u>deductible</u>	15% <u>coinsurance</u> after specific <u>deductible</u>	Not covered	important information : Covers 30 day supply	

	Common Medical Event	Services You May Need	Tier 1a Provider (You will pay the least)	Tier 1b Provider (You will pay more)	Tier 2 Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
		Non-preferred brand drugs	15% coinsurance after specific deductible	15% <u>coinsurance</u> after specific <u>deductible</u>	15% <u>coinsurance</u> after specific <u>deductible</u>	Not covered	(retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral & injectable fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in-network. Review your formulary for prescriptions requiring precertification or step therapy for coverage. Your cost will be higher for choosing Brand over Generics.
		Specialty drugs	Applicable cost as noted above for generic or brand drugs	Applicable cost as noted above for generic or brand drugs	Applicable cost as noted above for generic or brand drugs	Not covered	Precertification required for coverage.
	If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance after \$100 copay/visit	Not covered	Not covered	None
		Physician/surgeon fees	No charge	20% coinsurance	Not covered	Not covered	None
		Emergency room care	\$50 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> .			
in	If you need immediate medical attention	Emergency medical transportation	No charge	No charge	No charge	No charge	Out-of-network emergency use paid the same as in-network. Non- emergency transport: not covered, except if pre- authorized.

Common Medical Event	Services You May Need	Tier 1a Provider (You will pay the least)	Tier 1b Provider (You will pay more)	Tier 2 Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
	Urgent care	No charge	\$50 copay/visit after specific deductible	\$50 copay/visit after specific deductible	Not covered	None	
If you have a	Facility fee (e.g., hospital room)	No charge	20% <u>coinsurance</u> after \$500 <u>copay</u> /stay	Not covered	Not covered	None	
hospital stay	Physician/surgeon fees	No charge	Deductible, then no charge0% coinsurance	Not covered	Not covered	None	
If you need mental health, behavioral health, or	Outpatient services	Office & other outpatient services: no charge	Office: \$35 copay/visit; other outpatient services: no charge	Office: \$35 copay/visit; other outpatient services: no charge	Not covered	None	
substance abuse services	Inpatient services	No charge	10% coinsurance after \$250 copay/stay	10% coinsurance after \$250 copay/stay	Not covered	None	
	Office visits	No charge	No charge \$35 copay for initial visit only then no charge	Not covered	Not covered	Cost sharing does not apply for preventive	
If you are pregnant	Childbirth/delivery professional services	No charge	Deductible, then no charge0% coinsurance	Not covered	Not covered	services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)	
	Childbirth/delivery facility services	No charge	20% coinsurance after \$500 copay/stay	Not covered	Not covered		
	Home health care	No charge	Deductible, then no charge0% coinsurance	Deductible, then no charge0% coinsurance	Not covered	200 visits/calendar year.	
If you need help recovering or have other special health needs	Rehabilitation services	No charge	Not covered	Not covered	Not covered	90 visits/calendar year for Physical & Occupational Therapy combined, 60 visits/calendar year for Speech Therapy, including outpatient hospital services.	

Common Medical Event	Services You May Need	Tier 1a Provider (You will pay the least)	Tier 1b Provider (You will pay more)	Tier 2 Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Habilitation services	No charge	Not covered	Not covered	Not covered	None
	Skilled nursing care	No charge	\$500 copay/stay	Not covered	Not covered	120 days/calendar year.
	Durable medical equipment	20% <u>coinsurance</u> , <u>deductible</u> doesn't apply	20% coinsurance	20% coinsurance	Not covered	Limited to 1 <u>durable</u> medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	No charge	Deductible, then no charge0% coinsurance	Deductible, then no charge0% coinsurance	Not covered	None
If your child needs	Children's eye exam	Not covered	Not covered	Not covered	Not covered	Not covered.
dental or eye care	Children's glasses	Not covered	Not covered	Not covered	Not covered	Not covered.
dental of eye care	Children's dental check-up	Not covered	Not covered	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.)

•	Acupuncture	•	Long-term care	•	Routine eye care (Adult & Child)
•	Cosmetic surgery	•	Non-emergency care when traveling outside	•	Routine foot care
•	Dental care (Adult & Child)		the U.S.	•	Weight loss programs - Except for required preventive
•	Glasses (Child)	•	Private-duty nursing		services.

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

- Bariatric surgery
- Chiropractic care

- Hearing aids \$2,500 maximum/3 years.
- Infertility treatment For more information & exceptions, see policy document provided by your employer or call the number on your ID card.

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 <u>plan</u> at 1-877-272-6374.

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

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

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your 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 1-877-272-6374. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <a href="http://www.dol/gov/ebsa/healthreform">http://www.dol/gov/ebsa/healthreform</a>
- For non-federal governmental group health <u>plans</u>, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or <u>www.cciio.cms.gov</u>.
- Additionally, a consumer assistance program can help you file your <u>appeal</u>. Contact information is at: <a href="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</a>.

## 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 <u>plan</u> 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>	\$0
■ Specialist copayment	\$0
■ Hospital (facility) copayment	\$0
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> *	\$10
<u>Copayments</u>	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$70

# 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
■ Specialist copayment	\$0
■ Hospital (facility) copayment	\$0
Other copayment	\$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:	
Cost Sharing	
<u>Deductibles</u> *	\$50
Copayments	\$0
Coinsurance	\$600
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$670

# **Mia's Simple Fracture**

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

■ The <u>plan's</u> overall <u>deductible</u>	\$0
Specialist copayment	\$0
Hospital (facility) copayment	\$0
Other consyment	\$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:				
Cost Sharing				
<u>Deductibles</u> *	\$10			
<u>Copayments</u>	\$50			
<u>Coinsurance</u>	\$0			
What isn't covered				
Limits or exclusions	\$0			
The total Mia would pay is	\$60			

Note: These numbers assume the patient does not participate in the <u>plan's</u> wellness program. If you participate in the <u>plan's</u> wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-877-272-6374.

\*Note: This <u>plan</u> has other <u>deductibles</u> for specific services included in this coverage example. See "Are there other <u>deductibles</u> for specific services?" row above.

## **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 <a href="https://ocrportal.hhs.gov/ocr/portal/lobby.jsf">https://ocrportal.hhs.gov/ocr/portal/lobby.jsf</a>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates.

#### TTY: 711

## **Language Assistance:**

For language assistance in your language call 1-877-272-6374 at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-877-272-6374.

Amharic - ለቋንቋ እንዛ በ አማርኛ በ 1-877-272-6374 በነጻ ይደውሉ

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-877-272-6374

Armenian - Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-877-272-6374 առանց գնով։

Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-877-272-6374 tanpa dikenakan biaya.

Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-877-272-6374 ku busa

Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বিনামুল্যে 1-877-272-6374-তে কল করুন।

Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-877-272-6374 nga walay bayad.

Burmese - ငွေကုန်ကျစံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-877-272-6374 ကို ခေါ် ဆိုပါ။

Catalan - Per rebre assistència en (català), truqui al número gratuït 1-877-272-6374.

Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-877-272-6374 sin gåstu.

Cherokee -  $\theta \circ D Y \theta S \circ D h \mathcal{A} \circ D J J h \circ D S P \circ D Y \theta \mathcal{A} \Gamma (GWY) O D W \circ S 1-877-272-6374 O' \theta T C A G O J J E G P J h P R \theta$ .

Chinese - 欲取得繁體中文語言協助, 請撥打1-877-272-6374, 無需付費。

Choctaw - (Chahta) anumpa ya apela a chi I paya hinla 1-877-272-6374.

Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-877-272-6374 irratti bilisaan bilbilaa.

Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-877-272-6374.

French - Pour une assistance linguistique en français appeler le 1-877-272-6374 sans frais.

French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-877-272-6374 gratis.

German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-877-272-6374 an.

Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-877-272-6374 χωρίς χρέωση.

Gujarati - ગુજરાતીમાં ભાષામાં સહ્ય માટે કોઈ પણ ખર્ચ વગર 1-877-272-6374 પર કૉલ કરો.

Hawaiian - No ke kōkua ma ka 'ōlelo Hawai'i, e kahea aku i ka helu kelepona 1-877-272-6374. Kāki 'ole 'ia kēia kōkua nei.

Hindi - हिन्दी में भाषा सहायता के लिए, 1-877-272-6374 पर मुफ्त कॉल करें।

Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-877-272-6374.

lbo - Maka enyemaka asusu na Igbo kpoo 1-877-272-6374 na akwughi ugwo o bula

llocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-877-272-6374 nga awan ti bayadanyo.

Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-877-272-6374.

Japanese - 日本語で援助をご希望の方は、1-877-272-6374 まで無料でお電話ください。

Karen - လာတာ်မာစားတာ်ကတိုးကျိုဉ်အင်္ဂါ ကျိုဉ် 🗗 877-272-6374 လာတအိုဉ်ဒီးတာ်လာ၁်ဘူဉ်လာ၁်စ္ခာဘဉ်

Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-877-272-6374 번으로 전화해 주십시오.

Kru-Bassa - Be´m`ké gbo-kpá-kpá dyé pidyi dé Bašsoó-wuduùn wee, dá 1-877-272-6374

برای راهنمایی به زبان فارسی با شماره 6374-272-877 به خورایی پهیومندی بکهن.

Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລນາໂທຫາ-877-272-6374 ໂດຍບໍ່ເສຍຄ່າໂທ.

Marathi - कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-877-272-6374 वर फोन करा.

Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-877-272-6374 ilo ejjelok wōnān.

Micronesian-

Pohnpeyan - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-877-272-6374 ni sohte isais.

Mon-Khmer, សម្ភាប់ជំនួយភាសាជា ភាសាខុមរៃ សូមទូសេ័ពុទទៅកាន់លខេ 1-877-272-6374 ដោយឥតគិតថ្លាំ។

Cambodian -

Navajo - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-877-272-6374

Nepali - (नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि १-८७७-२७७४ मा फोन गर्नुहोस् ।

Nilotic-Dinka - Tën kuoony ë thok ë Thuonjän col 1-877-272-6374 kecïn ayöc.

Norwegian - For språkassistanse på norsk, ring 1-877-272-6374 kostnadsfritt.

Panjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-877-272-6374 'ਤੇ ਮਫ਼ਤ ਕਾਲ ਕਰੋ।

Pennsylvania Dutch - Fer Helfe in Deitsch, ruf: 1-877-272-6374 aa. Es Aaruf koschtet nix.

برای راهنمایی به زبان فارسی با شماره 6374-272-471 بدون هیچ هزینه ای تماس بگیرید. انگلیسی Persian -

Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-877-272-6374.

Portuguese - Para obter assistência linguística em português ligue para o 1-877-272-6374 gratuitamente.

Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-877-272-6374

Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-877-272-6374.

Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-877-272-6374 e aunoa ma se totogi.

Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-877-272-6374.

Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-877-272-6374.

Sudanic-Fulfude - Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-877-272-6374. Njodi woo fawaaki on.

Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-877-272-6374 bila malipo.

Syriac - אבת א שבאו מאר שלב א שבאו מאר שלב א זהבת ושם או ושם או ושם אולם בי ו-877-272-6374 משב .

Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-877-272-6374 nang walang bayad.

Telugu - భాషతో సాయం కొరకు ఎలాంటి ఖర్పు లేకుండా 1-877-272-6374 కు కాల్ చేయండి. (తెలుగు)

Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-877-272-6374 ฟรีไม่มีค่าใช้จ่าย

Tongan - Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-877-272-6374 'o 'ikai hā ōtōngi.

Trukese - Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-877-272-6374 nge esapw kamé ngonuk.

Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-877-272-6374.

Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкопітовним номером 1-877-272-6374.

بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 6374-6372 ۔ پر بات کریں۔

Vietnamese - Đê 'được hố trở ngôn ngư bằng (ngôn ngư), hấy gọi miến phi 'đên số 1-877-272-6374.

Yiddish - פאר שפראך הילף אין אידיש רופט 1-877-272-6374 פריי פון אפצאל.

Yoruba - Fún ìrànlowo nípa èdè (Yorùbá) pe 1-877-272-6374 lái san owó kankan rárá.