

BUCKEYE OHIO RISK MANAGEMENT ASSOCIATION BENEFITS POOL,INC.: Aetna Choice® POS II - Standard Plan 2

Coverage for: Individual + Family | Plan Type: POS

Coverage Period: 01/01/2022-12/31/2022



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 1-800-370-4526. 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 1-800-370-4526 to request a copy.

| Important Questions | Answers | Why This Matters: |
|--|---|--|
| What is the overall deductible? | In- <u>Network</u> : Individual \$250 / Family \$500. Out- of-Network: Individual \$500 / Family \$1,000. | 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. Emergency care; plus in- <u>network</u> office visits, <u>prescription drugs</u> & <u>preventive care</u> are 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 \$600 / Family \$1,200. Out-of-Network: Individual \$1,200 / Family \$2,400. <u>Prescription drugs</u> : Individual \$6,250 / Family \$12,500. | 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? | Premiums, balance-billing charges, health care this plan doesn't cover & penalties for failure to obtain pre-authorization for services. | 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 network provider? | Yes. See www.aetna.com/docfind or call 1-800-370-4526 for a list of in-network providers. | 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 | u Will Pay | | |
|---|--|---|--|---|--|
| Common Medical Event | Services You May Need | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information | |
| | Primary care visit to treat an injury or illness | \$10 copay/visit, deductible doesn't apply, except 10% coinsurance for office surgery | 30% coinsurance | None | |
| If you visit a health care <u>provider</u> 's office or clinic | <u>Specialist</u> visit | \$25 <u>copay</u> /visit, <u>deductible</u> doesn't apply, except 10% <u>coinsurance</u> for office surgery | 30% coinsurance | None | |
| | Preventive care /screening /immunization | No charge | 30% <u>coinsurance</u> | 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) | 10% coinsurance | 30% coinsurance | None | |
| ii you nave a test | Imaging (CT/PET scans, MRIs) | 10% coinsurance | 30% coinsurance | None | |
| If you need drugs to treat your illness or condition | Generic drugs | Copay/prescription, deductible doesn't apply: \$5 (retail), \$12.50 (mail order) | Not covered | Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge | |
| More information about prescription drug coverage is available at www.aetnapharmac y.com/standard | Preferred brand drugs | Copay/prescription, deductible doesn't apply: \$15 (retail), \$37.50 (mail order) | Not covered | for formulary generic FDA-approved women's contraceptives in-network. Review your formula for prescriptions requiring precertification or ste therapy for coverage. Your cost will be higher for choosing Brand over Generics. Maintenance drugs- after two retail fills, members are require to fill a 90-day supply at CVS Caremark® Mail Service Pharmacy or CVS Pharmacy. | |
| | Non-preferred brand drugs | Copay/prescription, deductible doesn't apply: \$30 (retail), \$75 (mail order) | Not covered | | |

| | What You Will Pay | | | | |
|---|---|--|--|---|--|
| Common Medical | | In-Network | Out-of-Network | Limitations, Exceptions, & Other Important | |
| Event | Services You May Need | Provider | Provider | Information | |
| | | (You will pay the | (You will pay the | | |
| | | least) | most) | | |
| | Specialty drugs | Copay/prescription, deductible doesn't apply: \$125 | Not covered | All prescriptions must be filled through the Aetna Specialty Pharmacy Network. | |
| If you have | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance | 30% coinsurance | None | |
| outpatient surgery | Physician/surgeon fees | 10% coinsurance | 30% coinsurance | None | |
| If you need | Emergency room care | \$250 <u>copay</u> /visit, <u>deductible</u> doesn't apply | \$250 <u>copay</u> /visit, <u>deductible</u> doesn't apply | 10% <u>coinsurance</u> after \$250 <u>copay</u> /visit, <u>deductible</u> doesn't apply for in- <u>network</u> & 30% <u>coinsurance</u> for out-of-network non-emergency use. | |
| immediate medical attention | Emergency medical transportation | 10% coinsurance | 10% coinsurance | Non-emergency transport: not covered, except 30% coinsurance if pre-authorized. | |
| | <u>Urgent care</u> | \$40 <u>copay</u> /visit, <u>deductible</u> doesn't apply | 30% coinsurance | None | |
| If you have a | Facility fee (e.g., hospital room) | 10% coinsurance | 30% coinsurance | Penalty of 50% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care. | |
| hospital stay | Physician/surgeon fees | 10% coinsurance | 30% coinsurance | None | |
| If you need mental health, behavioral health, or substance abuse | Outpatient services | Office: \$25 copay/visit, deductible doesn't apply; other outpatient services: no charge | Office & other outpatient services: 30% coinsurance | None | |
| services | Inpatient services | 10% coinsurance | 30% coinsurance | Penalty of 50% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care. | |
| | Office visits | No charge | 30% coinsurance | Cost sharing does not apply for preventive | |
| If you are pregnant | Childbirth/delivery professional services Childbirth/delivery facility services | 10% coinsurance 10% coinsurance | 30% coinsurance 30% coinsurance | services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Penalty of 50% of allowed amount for failure to obtain pre-authorization for out-of-network care may apply. | |

| | | | ı 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 |
| | Home health care | 10% coinsurance | 30% coinsurance | 50 visits/calendar year. Penalty of 50% of allowed amount for failure to obtain preauthorization for out-of-network care. |
| | Rehabilitation services | \$25 <u>copay</u> /visit, <u>deductible</u> doesn't apply | 30% coinsurance | 30 visits/calendar year for Physical, Occupational & Speech Therapy combined, including outpatient hospital/facility services. |
| If you need help | Habilitation services | \$25 <u>copay</u> /visit, <u>deductible</u> doesn't apply | 30% coinsurance | 20 visits/calendar year each for Physical, Occupational & Speech Therapy, including outpatient hospital/facility services. |
| recovering or have other special health needs | Skilled nursing care | 10% coinsurance | 30% coinsurance | 100 days/calendar year. Penalty of 50% of allowed amount for failure to obtain preauthorization for out-of-network care. |
| | Durable medical equipment | 10% coinsurance | 30% coinsurance | Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse. |
| | Hospice services | 10% coinsurance | 30% coinsurance | 180 days/lifetime for inpatient & outpatient combined. Penalty of 50% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care. |
| If your obild peeds | Children's eye exam | Not covered | Not covered | Not covered. |
| If your child needs dental or eye care | Children's glasses | Not covered | Not covered | Not covered. |
| dental of eye cale | 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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult & Child)

- Glasses (Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult & Child)
- 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.)

- Chiropractic care 24 visits/calendar year.
- Hearing aids \$2,500 maximum/36 months.
- Infertility treatment Limited to the diagnosis & treatment of underlying medical condition.
- Private-duty nursing \$2,500 maximum/calendar year.

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 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health <u>plans</u>, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- 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 <u>Marketplace</u>, visit <u>www.HealthCare.gov</u> or call 1-800-318-2596.

Your Grievance and Appeals Rights:

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

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-800-370-4526.
- 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>.
- 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 <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> | \$250 |
|---|-------|
| ■ Specialist copayment | \$25 |
| ■ Hospital (facility) coinsurance | 10% |
| Other coinsurance | 10% |

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> | \$250 | |
| <u>Copayments</u> | \$10 | |
| Coinsurance | \$1,100 | |
| What isn't covered | | |
| Limits or exclusions | \$60 | |
| The total Peg would pay is | \$1,420 | |

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

| ■ The plan's overall deductible | \$250 |
|-----------------------------------|-------|
| Specialist copayment | \$25 |
| ■ Hospital (facility) coinsurance | 10% |
| ■ Other coinsurance | 10% |

This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits (including disease education)

Diagnostic tests (blood work)

Prescription drugs

<u>Durable medical equipment</u> (glucose meter)

| Total Example Cost | \$5,600 | |
|---------------------------------|---------|--|
| In this example, Joe would pay: | | |
| <u>Cost Sharing</u> | | |
| <u>Deductibles</u> | \$100 | |
| <u>Copayments</u> | \$600 | |
| Coinsurance | \$0 | |
| What isn't covered | | |
| Limits or exclusions | \$20 | |
| The total Joe would pay is | \$720 | |

Mia's Simple Fracture

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

| ■ The <u>plan's</u> overall <u>deductible</u> | \$250 |
|---|-------|
| ■ Specialist copayment | \$25 |
| ■ Hospital (facility) coinsurance | 10% |
| ■ Other coinsurance | 10% |

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> | \$250 | |
| <u>Copayments</u> | \$400 | |
| <u>Coinsurance</u> | \$70 | |
| What isn't covered | | |
| Limits or exclusions | \$0 | |
| The total Mia would pay is | \$720 | |

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 866-393-0002.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: P.O. Box 24030, Fresno, CA 93779),

1-800-648-7817, TTY: 711,

Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

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

TTY: 711

Language Assistance:

For language assistance in your language call 1-800-370-4526 at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-800-370-4526.

Amharic - ለቋንቋ እንዛ በ አማርኛ በ 1-800-370-4526 በነጻ ይደውሉ

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-800-370-4526 الرجاء الاتصال على الرقم المجاني

Armenian - Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-800-370-4526 առանց գնով։

Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-370-4526 tanpa dikenakan biaya.

Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-800-370-4526 ku busa

Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বিনামুল্যে 1-800-370-4526-তে কল করুন।

Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-370-4526 nga walay bayad.

Burmese - ငွေကုန်ကျစံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-800-370-4526 ကို ခေါ် ဆိုပါ။

Catalan - Per rebre assistència en (català), truqui al número gratuït 1-800-370-4526.

Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-800-370-4526 sin gåstu.

Cherokee - $\theta \circ DY \theta \circ SOh \mathcal{A} \circ J A h \circ DS P \circ DY \theta \circ T (GWY) \circ DSWO^2 is 1-800-370-4526 OPT LAF odd JEGPJ hord.$

Chinese - 欲取得繁體中文語言協助, 請撥打1-800-370-4526, 無需付費。

Choctaw - (Chahta) anumpa ya apela a chi I paya hinla 1-800-370-4526.

Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-800-370-4526 irratti bilisaan bilbilaa.

Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-370-4526.

French - Pour une assistance linguistique en français appeler le 1-800-370-4526 sans frais.

French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-800-370-4526 gratis.

German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-370-4526 an.

Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-370-4526 χωρίς χρέωση.

Gujarati - ગુજરાતીમાં ભાષામાં સહ્ય માટે કોઈ પણ ખર્ચ વગર 1-800-370-4526 પર કૉલ કરો.

Hawaiian - No ke kōkua ma ka 'ōlelo Hawai'i, e kahea aku i ka helu kelepona 1-800-370-4526. Kāki 'ole 'ia kēia kōkua nei.

Hindi - हिन्दी में भाषा सहायता के लिए, 1-800-370-4526 पर मुफ्त कॉल करें।

Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-800-370-4526.

lbo - Maka enyemaka asusu na Igbo kpoo 1-800-370-4526 na akwughi ugwo o bula

llocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-370-4526 nga awan ti bayadanyo.

Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-800-370-4526.

Japanese - 日本語で援助をご希望の方は、1-800-370-4526 まで無料でお電話ください。

Karen - လာတါမာစားတါကတိုးကျိုင်အင်္ဂါ ကျိုင် 🗗 800-370-4526 လာတအိုင်ဒီးတါလာဝိဘူဉ်လာဝိစ္စာဘဉ်

Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-370-4526 번으로 전화해 주십시오.

Kru-Bassa - Be´m`ké qbo-kpá-kpá dyé pidyi dé Bašsoó-wuduun wee, dá 1-800-370-4526

برای راهنمایی به زبان فارسی با شماره 4526-370-4526 به خورایی پهیومندی بکن.

Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລນາໂທຫາ-800-370-4526 ໂດຍບໍ່ເສຍຄ່າໂທ.

Marathi - कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-800-370-4526 वर फोन करा.

Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-800-370-4526 ilo ejjelok wōnān.

Micronesian-

Pohnpeyan - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-800-370-4526 ni sohte isais.

Mon-Khmer, សម្រាប់ជំនួយភាសាជា ភាសាខ្ទមរំ សូមទូរស័ព្ទទេៅកាន់លខេ 1-800-370-4526 ដំោយឥតគិតថ្លប់។

Cambodian -

Navajo - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-800-370-4526

Nepali - (नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-800-370-4526 मा फोन गर्नुहोस् ।

Nilotic-Dinka - Tën kupony ë thok ë Thuonjan col 1-800-370-4526 kecin ayöc.

Norwegian - For språkassistanse på norsk, ring 1-800-370-4526 kostnadsfritt.

Panjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-800-370-4526 'ਤੇ ਮਫ਼ਤ ਕਾਲ ਕਰੋ।

Pennsylvania Dutch - Fer Helfe in Deitsch, ruf: 1-800-370-4526 aa. Es Aaruf koschtet nix.

برای راهنمایی به زبان فارسی با شماره 4526-370-4526 بدون هیچ هزینه ای تماس بگیرید. انگلیسی Persian -

Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezplatnie pod numer 1-800-370-4526.

Portuguese - Para obter assistência linguística em português ligue para o 1-800-370-4526 gratuitamente.

Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-800-370-4526

Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-800-370-4526.

Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-800-370-4526 e aunoa ma se totogi.

Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-800-370-4526.

Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-800-370-4526.

Sudanic-Fulfude - Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-800-370-4526. Njodi woo fawaaki on.

Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-800-370-4526 bila malipo.

Syriac - K - 32K K & D241 abk - 21e K wain on Ly isper 161, 30 1-800-370-4526 apl

Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-800-370-4526 nang walang bayad.

Telugu - భాషతో సాయం కొరకు ఎలాంటి ఖర్పు లేకుండా 1-800-370-4526 కు కాల్ చేయండి. (తెలుగు)

Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-800-370-4526 ฟรีไม่มีค่าใช้จ่าย

Tongan - Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-800-370-4526 'o 'ikai hā ōtōngi.

Trukese - Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-800-370-4526 nge esapw kamé ngonuk.

Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-800-370-4526.

Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкопітовним номером 1-800-370-4526.

بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-800-370-4526 . پر بات کریں۔

Vietnamese - Đê 'được hố 'trợ ngôn ngư bằng (ngôn ngư), hấy gọi miến phi 'đên số 1-800-370-4526.

Yiddish - פאר שפראך הילף אין אידיש רופט 1-800-370-4526 פריי פון אפצאל.

Yoruba - Fún ìrànlowo nípa èdè (Yorùbá) pe 1-800-370-4526 lái san owó kankan rárá.