

TEXAS PROFESSIONAL SERVICE PROVIDERS BENEFITS TRUST :

Aetna Choice® POS II - Gold 1500

Coverage for: Individual + Family | Plan Type: POS

Coverage Period: 07/01/2023-06/30/2024



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 1-866-252-3559. 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 1-866-252-3559 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In- <u>Network:</u> Individual \$1,500 / Family \$3,000. Out-of-Network: Individual \$4,000 / Family \$8,000.	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</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 \$6,850 / Family \$13,700. Out-of-Network: Individual \$14,000 / Family \$38,000.	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?	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 out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind or call 1-866-252-3559 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 <u>specialist</u> you choose without a <u>referral</u> .



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

		.	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
If you visit a health care provider's	Primary care visit to treat an injury or illness	\$30 <u>copay</u> /visit, <u>deductible</u> doesn't apply; except 20% <u>coinsurance</u> for office surgery	25% <u>coinsurance;</u> 40% <u>coinsurance</u> for office surgery	None
	<u>Specialist</u> visit	\$60 copay/visit, deductible doesn't apply; except 20% coinsurance for office surgery	25% <u>coinsurance;</u> 40% <u>coinsurance</u> for office surgery	None
office or clinic	Preventive care /screening /immunization	No charge	25% coinsurance; deductible doesn't apply to mammograms, prostate specific antigen tests & digital rectal exams; no charge for immunizations	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
ii you nave a test	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	None

		What You	ı Will Pay	
Common Medical Event	Services You May Need	In-Network Provider (You will pay the	Out-of-Network Provider (You will pay the	Limitations, Exceptions, & Other Important Information
		least)	most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.aetnapharmac y.com/standard	Generic drugs	Copay/prescription: RX1, deductible doesn't apply: \$10 (retail), \$25 (mail order); RX2, deductible doesn't apply: \$20 (retail), \$50 (mail order); RX4, deductible doesn't apply: \$20 (retail), \$50 (mail order)	Not covered	Covers 30 day supply (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. RX1 & RX2 - Your cost will be higher for choosing Brand over Generics; cost difference penalty doesn't apply to out-of-pocket limit. Maintenance drugs- after three retail fills, members are required to fill a 90-day supply at CVS Caremark® Mail Service Pharmacy or CVS Pharmacy.
	Preferred brand drugs	Copay/prescription: RX1, deductible doesn't apply: \$40 (retail), \$100 (mail order); RX2, deductible doesn't apply: \$60 (retail), \$150 (mail order); RX4 NOT COVERED (retail & mail order)	Not covered	
	Non-preferred brand drugs	Copay/prescription: RX1, deductible doesn't apply: \$100 (retail), \$250 (mail order); RX2, deductible doesn't apply: \$150 (retail), \$375 (mail order); RX4 NOT COVERED (retail & mail order)	Not covered	

Common Medical Event	Services You May Need	What You In-Network Provider (You will pay the	u Will Pay Out-of-Network Provider (You will pay the	Limitations, Exceptions, & Other Important Information
		least)	most)	
	Specialty drugs	Copay/prescription, deductible doesn't apply: RX1, RX2 & RX4: 30%	Not covered	All prescriptions must be filled through the Aetna Specialty Performance Pharmacy Network. Precertification required for coverage. RX4: Brand is not covered, Specialty only covered if generic.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% coinsurance	\$1,000 maximum/surgery for out-of-network freestanding facility.
outpatient surgery	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
	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> . Non-emergency transport: not covered, except 40% <u>coinsurance</u> if preauthorized.
	<u>Urgent care</u>	\$75 <u>copay</u> /visit, <u>deductible</u> doesn't apply	25% <u>coinsurance</u>	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Penalty of 50% of <u>allowed amount</u> (\$10,000 maximum) for failure to obtain <u>pre-authorization</u> for out-of-network care.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse	Outpatient services	Office or freestanding facility: \$30 copay/visit, deductible doesn't apply; other outpatient services: 20% coinsurance	Office or freestanding facility: 25% coinsurance; other outpatient services: 40% coinsurance	None
services	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Penalty of 50% of <u>allowed amount</u> (\$10,000 maximum) for failure to obtain <u>pre-authorization</u> for out-of-network care.

Common Medical Event	Services You May Need	In-Network Provider (You will pay the	Out-of-Network Provider (You will pay the	Limitations, Exceptions, & Other Important Information
If you are pregnant	Office visits	least) No charge; except \$30 copay for initial visit to confirm pregnancy, deductible doesn't apply	most) 25% 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 50% of allowed amount (\$10,000 maximum) for failure to obtain pre-
	Childbirth/delivery professional services Childbirth/delivery facility services	20% <u>coinsurance</u> 20% <u>coinsurance</u>	40% <u>coinsurance</u> 40% <u>coinsurance</u>	authorization for out-of-network care may apply.
	Home health care	20% coinsurance	40% coinsurance	60 visits/calendar year. Penalty of 50% of allowed amount (\$10,000 maximum) for failure to obtain pre-authorization for out-of-network care.
If you need help recovering or have other special health needs	Rehabilitation services	Office/freestanding: \$30 copay/visit, deductible doesn't apply; hospital/ facility: 20% coinsurance	Office/ freestanding facility: 25% coinsurance; hospital/ facility: 40% coinsurance	60 visits/calendar year for Physical, Occupational & Speech Therapy combined, including outpatient hospital services.
	Habilitation services	Office/freestanding: \$30 copay/visit, deductible doesn't apply; hospital/ facility/Autism: 20% coinsurance	Office/ freestanding facility: 25% coinsurance; hospital/ facility/Autism: 40% coinsurance	None
	Skilled nursing care	20% coinsurance	40% coinsurance	60 days/calendar year. Penalty of 50% of <u>allowed</u> <u>amount</u> (\$10,000 maximum) for failure to obtain <u>pre-authorization</u> for out-of-network care.
	Durable medical equipment	20% <u>coinsurance</u>	40% coinsurance	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	20% coinsurance	40% coinsurance	Penalty of 50% of <u>allowed amount</u> (\$10,000 maximum) for failure to obtain <u>pre-authorization</u> for out-of-network care.

Common Medical Event	Services You May Need	What You In-Network Provider (You will pay the least)	u Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If your child needs dental or eye care	Children's eye exam	No charge up to age 19; \$60 copay/visit thereafter, deductible doesn't apply	25% <u>coinsurance</u> up to age 19, 50% <u>coinsurance</u> thereafter	1 routine eye exam/calendar year.
	Children's glasses	50% coinsurance	50% coinsurance	1 pair/calendar year up to age 19.
	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.)

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

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

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

- Acupuncture Limited to disease, injury & chronic pain.
- Chiropractic care 30 visits/calendar year for age 18 & older.
- Glasses (Child)

- Hearing aids 1 hearing aid per ear/2 years.
- 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/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 <u>plan</u> at 1-866-252-3559.
- 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 <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 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 1-866-252-3559. 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 <u>plans</u>, <u>health insurance</u> available through the <u>Marketplace</u> or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of <u>Minimum Essential Coverage</u>, you may not be eligible for the <u>premium tax credit</u>.

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>	\$1,500
■ Specialist copayment	\$60
■ Hospital (facility) coinsurance	20%
Other coinsurance	20%

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)

\$12,700
\$1,500
\$10
\$2,000
\$60
\$3,570

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>	\$1,500
■ Specialist copayment	\$60
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

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>	\$100
<u>Copayments</u>	\$1,300
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,420

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$1,500
■ Specialist copayment	\$60
■ Hospital (facility) coinsurance	20%
Other coinsurance	20%

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>	\$1,500		
<u>Copayments</u>	\$200		
<u>Coinsurance</u>	\$90		
What isn't covered			
Limits or exclusions	\$0		
The total Mia would pay is	\$1,790		

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 1-866-252-3559 at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-866-252-3559.

Amharic - ለቋንቋ እንዛ በ አማርኛ በ 1-866-252-3559 በነጻ ይደውሉ

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-866-252-3559

Armenian - Lեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-866-252-3559 առանց գնով։

Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-866-252-3559 tanpa dikenakan biaya.

Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-866-252-3559 ku busa

Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বিনামুল্যে 1-866-252-3559-তে কল করুন।

Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-866-252-3559 nga walay bayad.

Burmese - ငွေကုန်ကျစံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-866-252-3559 ကို ခေါ် ဆိုပါ။

Catalan - Per rebre assistència en (català), truqui al número gratuït 1-866-252-3559.

Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-866-252-3559 sin gåstu.

Cherokee - $\theta \circ DY \theta \circ SOh \mathcal{A} \circ J \mathcal{A} h \circ DSP \circ DY \theta \mathcal{A} T (GWY) \circ DSWO^{1}S 1-866-252-3559 O' \theta \mathcal{A} T \mathcal{A} \Gamma \circ D \mathcal{A} \mathcal{A} E GP \mathcal{A} h \mathbb{P} R \theta$.

Chinese - 欲取得繁體中文語言協助,請撥打1-866-252-3559,無需付費。

Choctaw - (Chahta) anumpa ya apela a chi I paya hinla 1-866-252-3559.

Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-866-252-3559 irratti bilisaan bilbilaa.

Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-866-252-3559.

French - Pour une assistance linguistique en français appeler le 1-866-252-3559 sans frais.

French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-866-252-3559 gratis.

German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-866-252-3559 an.

Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-866-252-3559 χωρίς χρέωση.

Gujarati - ગુજરાતીમાં ભાષામાં સહ્યય માટે કોઈ પણ ખર્ચ વગર 1-866-252-3559 પર કૉલ કરો.

Hawaiian - No ke kōkua ma ka 'ōlelo Hawai'i, e kahea aku i ka helu kelepona 1-866-252-3559. Kāki 'ole 'ia kēia kōkua nei.

Hindi - हिन्दी में भाषा सहायता के लिए, 1-866-252-3559 पर मुफ्त कॉल करें।

Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-866-252-3559.

lbo - Maka enyemaka asusu na Igbo kpoo 1-866-252-3559 na akwughi ugwo o bula

llocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-866-252-3559 nga awan ti bayadanyo.

Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-866-252-3559.

Japanese - 日本語で援助をご希望の方は、1-866-252-3559 まで無料でお電話ください。

Karen - လာတာမြာစားတာကတိုးကျိုဘ်အင်္ဂါ ကျိုာ် ကိုနေ66-252-3559 လာတအိုဉ်ဒီးတာ်လာဘ်ဘူဉ်လာဘ်စူးဘဉ်

Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-866-252-3559 번으로 전화해 주십시오.

Kru-Bassa - Be´m`ké gbo-kpá-kpá dyé pidyi dé Bašsoó-wuduun wee, dá 1-866-252-3559

برای راهنمایی به زبان فارسی با شماره و 355-252-1-866 به خورایی پهیومندی بکن.

Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລນາໂທຫາ-866-252-3559 ໂດຍບໍ່ເສຍຄ່າໂທ.

Marathi - कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-866-252-3559 वर फोन करा.

Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-866-252-3559 ilo ejjelok wōnān.

Micronesian-

Pohnpeyan - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-866-252-3559 ni sohte isais.

Mon-Khmer, សមរាប់ជំនួយភាសាជា ភាសាខមរៃ សូមទូសេ័ពទទ**ៅកាន់លខេ 1-866-252-3559 ដ**ោយឥតគិតថ្**ល**។

Cambodian -

Navajo - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-866-252-3559

Nepali - (नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-866-252-3559 मा फोन गर्नुहोस् ।

Nilotic-Dinka - Tën kupony ë thok ë Thuonjän col 1-866-252-3559 kecin ayöc.

Norwegian - For språkassistanse på norsk, ring 1-866-252-3559 kostnadsfritt.

Panjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-866-252-3559 'ਤੇ ਮਫ਼ਤ ਕਾਲ ਕਰੋ।

Pennsylvania Dutch - Fer Helfe in Deitsch, ruf: 1-866-252-3559 aa. Es Aaruf koschtet nix.

برای راهنمایی به زبان فارسی با شماره و 355-252-1-866 بدون هیچ هزینه ای تماس بگیرید. انگلیسی Persian -

Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezplatnie pod numer 1-866-252-3559.

Portuguese - Para obter assistência linguística em português ligue para o 1-866-252-3559 gratuitamente.

Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-866-252-3559

Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-866-252-3559.

Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-866-252-3559 e aunoa ma se totogi.

Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-866-252-3559.

Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-866-252-3559.

Sudanic-Fulfude - Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-866-252-3559. Njodi woo fawaaki on.

Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-866-252-3559 bila malipo.

Syriac - K - 254 K & p241 abk 2122 K oai, K or Ly iopk 161,202 1-866-252-3559 apel .

Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-866-252-3559 nang walang bayad.

Telugu - భాషతో సాయం కొరకు ఎలాంటి ఖర్పు లేకుండా 1-866-252-3559 కు కాల్ చేయండి. (తెలుగు)

Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-866-252-3559 ฟรีไม่มีค่าใช้จ่าย

Tongan - Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-866-252-3559 'o 'ikai hā ōtōngi.

Trukese - Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-866-252-3559 nge esapw kamé ngonuk.

Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-866-252-3559.

Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-866-252-3559.

بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، و355-252-1-866 یر بات کریں۔

Vietnamese - Đê 'được hố trở ngôn ngư bằng (ngôn ngư), hấy gọi miến phi 'đên số 1-866-252-3559.

Yiddish - פאר שפראך הילף אין אידיש רופט 1-866-252-3559 פריי פון אפצאל.

Yoruba - Fún ìrànlowo nípa èdè (Yorùbá) pe 1-866-252-3559 lái san owó kankan rárá.