Coverage for: Individual + Family | Plan Type: POS

CITY OF ROCKY MOUNT: Aetna Choice® POS II - HealthMapRx



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?	For each <u>Plan</u> Year, In- <u>Network</u> : Individual \$3,000 / Family \$5,500. Out-of-Network: Individual \$6,000 / Family \$11,000.	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. <u>Prescription drugs</u> ; plus in- <u>network</u> primary care office visits & <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>deductible</u> s for specific services?	Yes. For <u>prescription drugs</u> - Individual \$150 / Family \$450. There are no other specific <u>deductible</u> s.	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> ?	In- <u>Network</u> : Individual \$6,000 / Family \$11,500. Out-of-Network: Individual \$12,000 / Family \$23,000.	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 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>Premiums</u> , balance-billing charges, health care this <u>plan</u> doesn't cover & penalties for failure to obtain <u>pre-authorization</u> for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind or call 1-800-370-4526 for a list of 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.

			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 basith	Primary care visit to treat an injury or illness	\$40 <u>copay</u> /visit, <u>deductible</u> doesn't apply	40% coinsurance	None
If you visit a health care provider's	Specialist visit	30% coinsurance	40% coinsurance	None
office or clinic	Preventive care /screening /immunization	No charge	40% coinsurance	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	40% coinsurance	None
If you have a test	Imaging (CT/PET scans, MRIs)	30% coinsurance	40% coinsurance	Prior Authorization required.
If you need drugs to treat your illness or condition	Generic drugs	Copay/prescription, after specific deductible: \$4 for 30 day supply (retail), \$8 for 31-90 day supply (retail & mail order)	30% coinsurance after copay/ prescription, after specific deductible: \$4 for 30 day supply (retail), \$8 for 31-90 day supply (retail)	Covers 30 day supply (retail), 31-90 day supply (retail & participating mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral fertility drugs. No charge for
about <u>prescription</u> drug coverage is available at www.aetnapharmac y.com/standard	Preferred brand drugs	Copay/prescription, after specific deductible: \$45 for 30 day supply (retail), \$90 for 31- 90 day supply (retail & mail order)	30% coinsurance after copay/ prescription, after specific deductible: \$45 for 30 day supply (retail), \$90 for 31-90 day supply (retail)	preferred generic FDA-approved women's contraceptives in- <u>network</u> . Your cost will be higher for choosing Brand over Generics unless prescribed Dispense as Written; cost difference penalty doesn't apply to <u>out-of-pocket limit</u> .

Common Medical Event	Services You May Need	In-Network Provider (You will pay the	Will Pay Out-of-Network Provider (You will pay the	Limitations, Exceptions, & Other Important Information
	Non-preferred brand drugs	least) Copay/prescription, after specific deductible: \$60 for 30 day supply (retail), \$120 for 31-90 day supply (retail & mail order)	most) 30% coinsurance after copay/ prescription, after specific deductible: \$60 for 30 day supply (retail), \$120 for 31-90 day supply (retail)	
	Specialty drugs	25% copay with \$50 minimum & \$100 maximum/ prescription, after specific deductible	Not covered	First prescription fill at a retail pharmacy or specialty pharmacy. Subsequent fills must be through the Aetna Specialty Pharmacy Network. Precertification required for coverage.
If you have	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	40% coinsurance	None
outpatient surgery	Physician/surgeon fees	30% <u>coinsurance</u>	40% coinsurance	None
If you need immediate medical	Emergency room care Emergency medical transportation	30% coinsurance 30% coinsurance	30% coinsurance 30% coinsurance	No coverage for non-emergency use. Non-emergency transport: not covered, except if pre-authorized.
attention	Urgent care	30% coinsurance	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	40% coinsurance	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
nospital stay	Physician/surgeon fees	30% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse	Outpatient services	Office: \$40 copay/visit, deductible doesn't apply; other outpatient services: no charge	Office & other outpatient services: 40% coinsurance	None
services	Inpatient services	30% coinsurance	40% coinsurance	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
If you are pregnant	Office visits	No charge	40% coinsurance	Cost sharing does not apply for preventive
ii you are pregnant	Childbirth/delivery professional services	30% coinsurance	40% coinsurance	services. Maternity care may include tests and

		What You Will Pay			
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
	Childbirth/delivery facility services	30% coinsurance	40% coinsurance	services described elsewhere in the SBC (i.e. ultrasound.) Penalty of \$400 for failure to obtain pre-authorization for out-of-network care may apply.	
	Home health care	30% coinsurance	40% coinsurance	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.	
	Rehabilitation services	\$40 <u>copay</u> /visit, <u>deductible</u> doesn't apply	40% coinsurance	30 visits/ <u>plan</u> year for Physical, Occupational Therapy & Chiropractic care combined, 30 visits/ <u>plan</u> year for Speech Therapy.	
If you need help recovering or have other special	Habilitation services	\$40 <u>copay</u> /visit, <u>deductible</u> doesn't apply	40% coinsurance	None	
health needs	Skilled nursing care	30% coinsurance	40% coinsurance	60 days/ <u>plan</u> year. Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.	
	Durable medical equipment	30% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.	
	Hospice services	30% <u>coinsurance</u>	40% coinsurance	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.	
If your child needs	Children's eye exam	No charge	40% coinsurance	1 routine eye exam/ <u>plan</u> year.	
dental or eye care	Children's glasses	Not covered	Not covered	Not covered.	
delital of cyc dale	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
- Cosmetic surgery
- Dental care (Adult & Child)

- Glasses (Child)
- Hearing aids
- Long-term care

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

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

- Bariatric surgery
- Chiropractic care 30 visits/<u>plan</u> year combined with rehabilitation services.
- Infertility treatment Limited to the diagnosis & treatment of underlying medical condition.
- Private-duty nursing

• Routine eye care (Adult) - 1 routine eye exam/<u>plan</u> 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 <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 <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 <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. 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.

<u>Minimum Essential Coverage</u> 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.
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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>	\$3,000
■ Specialist coinsurance	30%
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

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
\$3,000
\$0
\$2,100
\$60
\$5,160

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>	\$3,000
Specialist coinsurance	30%
■ Hospital (facility) coinsurance	30%
Other coinsurance	30%

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>	
Deductibles*	\$500
<u>Copayments</u>	\$1,100
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,620

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$3,000
■ Specialist coinsurance	30%
■ Hospital (facility) coinsurance	30%
Other coinsurance	30%

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> *	\$2,400	
<u>Copayments</u>	\$100	
<u>Coinsurance</u>	\$0	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$2,500	

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: 1-800-370-4526.

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles 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, 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 - $(i \text{ TM} \int \frac{3}{A}x \mu; \text{ Mox } 1\text{-800-370-4526 } x \cdot t' \cdot , €)$

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 - a Ike It ĎIĕ LĹĺ It č IE ĞĂĕla ĂId'őe ĕ1-800-370-4526-ĕ¹e¹z Ă]

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 - $\ ^-$ Ľ Þ $^-$ ð ε Å 3 Ľ Ŕ ŔAĽ Őğ Ľ Þ $^-$ · Ž (ŹF Þ) δ LF T Đờ 1-800-370-4526 $\ ^+$ Ž Ť b ½Ľ Ŕ $\Gamma \times \Phi$ ğ Ŕ Åý ń $^-$.

Chinese - 欲取得繁體中文語言協助, 請撥打1-800-370-4526, 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 - χ là { $\ddot{\psi}$ ày $\ddot{\mathbf{U}}$ R $\ddot{\mathbf{U}}$ A $\ddot{\mathbf{U}}$ V $\ddot{\mathbf{U}}$ CÉ $\ddot{\mathbf{U}}$ Y $\ddot{\mathbf{U}}$ Koz $\ddot{\mathbf{e}}$ Wu o b f \leftarrow c { 1-800-370-4526 u { a $\hat{\mathbf{e}}$ a { $\ddot{\mathbf{e}}$

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。

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

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

برای راهنمایی به زبان فارسی با شماره 4526-370-800 به خورایی پهیومندی بکهن.

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

Marathi - $\hat{\mathbf{u}} \hat{\mathbf{v}} \sim \sum \rho \delta \mathbf{v}^{\circ} \hat{\mathbf{s}} \hat{\mathbf{u}} \rho^{\circ} \hat{\mathbf{u}} \hat{\mathbf{u}} \rho^{\circ} \hat{\mathbf{u}} \hat{\mathbf$

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, សមរាប់ជំនួយភាសាជា ភាសាខមរៃ សូមទូសេ័ពទទ**ៅកាន់លខេ 1-800-370-4526** ដ**ោយឥតគិតថ្**លេំ។

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 - $(\pm \underline{\leqslant} \rho \pi \ v) \ \partial \ \rho \hat{\ \ } \pm \hat{\ \ } \hat{\ \ } \hat{\ \ } \hat{\ \ } \mu \ \rho \Omega \rho \varpi \varnothing \rho \underline{\gt} \neq \rho \leq \rho + \hat{\ \ } \hat{\ \ } \pm \hat{\ \ } \hat{\ \ } \rho \pi \ \rho \exists \quad 1-800-370-4526 \ \partial \ \rho \geq v \pm \ \dagger \pm \delta \hat{\ \ } \hat{\ \ } \pm \delta \hat{\ \ } \hat$

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.

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

برای راهنمایی به زبان فارسی با شماره 4526-370-4520 بدون هیچ هزینه ای تماس بگیرید. انگلیسی Persian -

Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie 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 - 22 K K & p241 abk 2 Le K oai, K or Ly iopk 161, 20 1-800-370-4526 apel .

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

Telugu - $\| \phi \hat{A} \alpha \tilde{e} \tilde{l} \tilde{N} P \tilde{U}_{Z} \tilde{o} Z \|^{\circ} P_{1} \neq a z \approx \| \hat{I} \omega P \Theta^{\dagger} 1-800-370-4526 \tilde{o} \tilde{U} \tilde{N} \tilde{I} \tilde{c} \approx P \Theta^{\dagger} (4 \tilde{a} \omega b^{\circ})$

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 ، 4526-370-370 ۔ پر بات کریں۔

Vietnamese - Đê 'được hố trơ 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.