

CITIGROUP-ACTIVE & COBRA : Aetna Choice® POS II - ACTIVE & COBRA - HDHP

Coverage for: EE Only; EE+ Family | Plan Type: POS

Coverage Period: 01/01/2021-12/31/2021

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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 1-888-982-3862. 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 1-888-982-3862 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In- <u>Network</u> : EE Only \$1,800; EE+ Family \$3,600. Out-of-Network: EE Only \$2,800; EE+ Family \$5,600.	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 policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> services 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 <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?	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> : EE Only \$5,000; EE+ Family: Individual \$6,850/ Family \$10,000. Out-of- Network: EE Only \$7,500; EE+ Family: Individual \$15,000/ Family \$15,000.	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>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 <u>out–of–pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind or call 1-888-982-3862 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> .

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

	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
If you visit a health	Primary care visit to treat an injury or illness Specialist visit	20% <u>coinsurance</u> 20% <u>coinsurance</u>	40% <u>coinsurance</u> 40% <u>coinsurance</u>	None None
care <u>provider</u> 's office or clinic	Preventive care /screening /immunization	No charge	No charge	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
If you need drugs to treat your illness or condition  More information about prescription drug coverage is available at www.caremark.com	Generic drugs	\$10 (retail), \$20 (mail order), after deductible	Reimbursed at contracted rate after deductible is met and \$10 copay is paid (retail)	
	Preferred brand drugs	\$30 (retail), \$75 (mail order), after <u>deductible</u>	Reimbursed at contracted rate after deductible is met and \$30 copay is paid (retail)	Covers 31-day supply (retail), Up to 90-day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral fertility drugs. No charge for preferred generic
	Non-preferred brand drugs	50% coinsurance, \$50 min & \$150 max (retail), \$125 min & \$375 max (mail order), after deductible	Reimbursed at contracted rate after deductible is met and 50% coinsurance (\$50 min/\$150max) is paid (retail)	FDA-approved women's contraceptives in-network.

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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
	Specialty drugs	\$20 (generic), 25% coinsurance to \$50 min & \$150 max (formulary), 50% coinsurance to \$100 min & \$250 max (nonformulary), after deductible (retail & mail order)	Not covered	Covers 31 day supply.
If you have	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
outpatient surgery	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need	Emergency room care	20% coinsurance	20% coinsurance	No coverage for non-emergency use.
immediate medical	Emergency medical transportation	20% coinsurance	20% <u>coinsurance</u>	Non-emergency transport: not covered, except if pre-authorized.
attention	<u>Urgent care</u>	20% coinsurance	20% coinsurance	None
If you have a	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Pre-authorization required for out-of-network care.
hospital stay	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or	Outpatient services	Office & other outpatient services: 20% coinsurance	Office & other outpatient services: 40% coinsurance	None
substance abuse services	Inpatient services	20% coinsurance	40% coinsurance	Pre-authorization required for out-of-network care.
If you are pregnant	Office visits Childbirth/delivery professional services Childbirth/delivery facility services	No charge 20% coinsurance 20% coinsurance	40% coinsurance 40% coinsurance 40% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Pre-authorization required for out-of-network care may apply.
If you need help recovering or have	Home health care	20% coinsurance	40% <u>coinsurance</u>	200 visits/calendar year combined with private- duty nursing. Pre-authorization required for out- of-network care.

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	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
other special health needs	Rehabilitation services	20% coinsurance 1st 60 visits, 30% coinsurance, deductible doesn't apply, for Physical & Occupational Therapy thereafter; 20% coinsurance 1st 90 visits, 30% coinsurance, deductible doesn't apply, for Speech Therapy thereafter	40% coinsurance 1st 60 visits, 50% coinsurance, deductible doesn't apply, for Physical & Occupational Therapy thereafter; 40% coinsurance 1st 90 visits, 50% coinsurance, deductible doesn't apply, for Speech Therapy thereafter	60 visits/calendar year for Physical & Occupational Therapy combined, 90 visits/calendar year for Speech Therapy.
	Habilitation services	20% coinsurance	40% coinsurance	None
	Skilled nursing care	20% coinsurance	40% coinsurance	120 days/calendar year. Pre-authorization required for out-of-network care.
	Durable medical equipment	20% coinsurance	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	Pre-authorization required for out-of-network care.
If your obild poods	Children's eye exam	No charge	No charge	1 routine eye exam/calendar year.
If your child needs dental or eye care	Children's glasses	Not covered	Not covered	Not covered.
delital of cyc date	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.)

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- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (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> <u>services</u>.

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

- Acupuncture
- Bariatric surgery Limited to Institutes of Quality contracted facility for in-<u>network</u> only.
- Chiropractic care 20 visits/calendar year.
- Hearing aids 1 hearing aid per ear/2 years up to age 19, every 3 years thereafter.
- Infertility treatment Limited to the diagnosis & treatment of underlying medical condition.
   Artificial insemination, ovulation induction & advanced reproductive technology: \$24,000 Medical maximum/lifetime and \$7,500 Rx maximum/lifetime.
- Private-duty nursing 200 visits/calendar year combined with home health care.
- 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 1-888-982-3862.
- 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</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 <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 1-888-982-3862.
- 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 plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance

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- Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- 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? No.

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.

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## **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>	\$1,800
■ Specialist coinsurance	20%
■ 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)

Total Example Cost	\$12,700	
In this example, Peg would pay:		
<u>Cost Sharing</u>		
<u>Deductibles</u>	\$1,800	
<u>Copayments</u>	\$0	
Coinsurance	\$1,900	
What isn't covered		
Limits or exclusions	\$60	
The total Peg would pay is	\$3,760	

# 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>	\$1,800
■ Specialist coinsurance	20%
■ 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

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

Total Example Cost	\$5,600	
In this example, Joe would pay:		
Cost Sharing		
<u>Deductibles</u>	\$1,100	
<u>Copayments</u>	\$0	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$20	
The total Joe would pay is	\$1,120	

# **Mia's Simple Fracture**

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

■ The <u>plan's</u> overall <u>deductible</u>	\$1,800
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other <u>coinsurance</u>	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>	\$1,800		
<u>Copayments</u>	\$0		
Coinsurance	\$200		
What isn't covered			
Limits or exclusions	\$0		
The total Mia would pay is	\$2,000		

## **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 <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 1-888-982-3862 at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-888-982-3862.

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-888-982-3862

Armenian - Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-888-982-3862 առանց գնով։

Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-982-3862 tanpa dikenakan biaya.

Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-888-982-3862 ku busa

Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-888-982-3862 nga walay bayad.

Burmese - ငွေကုန်ကျစံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-888-982-3862 ကို ခေါ် ဆိုပါ။

Catalan - Per rebre assistència en (català), truqui al número gratuït 1-888-982-3862.

Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-888-982-3862 sin gåstu.

Cherokee - PAYO SUHARU JHRSPAY OFT (CWY) OFMO! 1-888-982-3862 OFT CALRY DECLY HERO.

Chinese - 欲取得繁體中文語言協助,請撥打1-888-982-3862,無需付費。

Choctaw - (Chahta) anumpa ya apela a chi I paya hinla 1-888-982-3862.

Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-888-982-3862 irratti bilisaan bilbilaa.

Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-888-982-3862.

French - Pour une assistance linguistique en français appeler le 1-888-982-3862 sans frais.

French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-888-982-3862 gratis.

German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-888-982-3862 an.

Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-888-982-3862 χωρίς χρέωση.

Hawaiian - No ke kōkua ma ka 'ōlelo Hawai'i, e kahea aku i ka helu kelepona 1-888-982-3862. Kāki 'ole 'ia kēia kōkua nei.

हिन्दी में भाषा सहायता के लिए, <sub>1-888-982-3862</sub> पर मुफ्त कॉल करें। Hindi -Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-888-982-3862. Hmong -Maka enyemaka asusu na lgbo kpoo 1-888-982-3862 na akwughi ugwo o bula lbo -Ilocano -Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-888-982-3862 nga awan ti bayadanyo. Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-888-982-3862. Italian -日本語で援助をご希望の方は、1-888-982-3862 まで無料でお電話ください。 Japanese -Karen -한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862 번으로 전화해 주십시오. Korean -'Bε'm'ké gbo-kpá-kpá dyé pidyi dé 'Ba'sɔɔ̂-wuduùn wε̃ε, dá 1-888-982-3862 Kru-Bassa -براي راهنمايي په زيان فارسي يا شماره 3862-982-1-888 به خور ايي پهيو مندي بكهن Kurdish -ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫືອໃນການແປພາສາລາວ, ກະລນາໂທຫາ-888-982-3862 ໂດຍບໍ່ເສຍຄ່າໂທ. Laotian -Marathi - $\Pi\Pi\Pi$ . Marshallese -Ñan bōk jipañ ilo Kajin Majol, kallok 1-888-982-3862 ilo ejjelok wōnān. Micronesian-Pohnpeyan -Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-888-982-3862 ni sohte isais. សមរាប់ជំនួយភាសាជា ភាសាខមរៃ សូមទូរស័ពទទ ៅកាន់លខេ 1-888-982-3862 ដំោយឥតគិតថ្មលំ។ Mon-Khmer. Cambodian -Navajo -T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-888-982-3862 Nepali -Nilotic-Dinka -Tën kupony ë thok ë Thuonjan col 1-888-982-3862 kecin ayöc. Norwegian -For språkassistanse på norsk, ring 1-888-982-3862 kostnadsfritt. Panjabi -Pennsylvania Dutch - Fer Helfe in Deitsch, ruf: 1-888-982-3862 aa. Es Aaruf koschtet nix. برای راهنمایی به زبان فارسی با شماره 3862-982-1888 بدون هیچ هزینه ای تماس بگیرید انگلیسی Persian -Polish -Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-888-982-3862. Portuguese -Para obter assistência linguística em português ligue para o 1-888-982-3862 gratuitamente.

Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-888-982-3862

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Romanian -

Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-888-982-3862.

Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-888-982-3862 e aunoa ma se totogi.

Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-888-982-3862.

Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-888-982-3862.

Sudanic-Fulfude - Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-888-982-3862. Njodi woo fawaaki on.

Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-888-982-3862 bila malipo.

Syriac - K - 22 K K & 2241 abk 212 K oai, m or Ly io pr 161, 20 1-888-982-3862 ap

Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-888-982-3862 nang walang bayad.

Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-888-982-3862 ฟรีไม่มีค่าใช้จ่าย

Tongan - Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-888-982-3862 'o 'ikai hā ōtōngi.

Trukese - Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-888-982-3862 nge esapw kamé ngonuk.

Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-888-982-3862.

Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-888-982-3862.

بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 2862-982-1888 یر بات کریں۔

Vietnamese - Để được hố trợ ngôn ngư bằng (ngôn ngư), hấy gọi miến phi đến số 1-888-982-3862.

Yiddish - פאר שפראך הילף אין אידיש רופט 1-888-982-3862 פריי פון אפצאל.

Yoruba - Fún ìrànlowo nípa èdè (Yorùbá) pe 1-888-982-3862 lái san owó kankan rárá.