Coverage for: Individual + Family | Plan Type: POS

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STATE OF IL – Open Access Plan



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, by calling 1-855-856-0038. 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 1-855-856-0038 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Tier 1: Individual \$0 per person. Tier 2: Individual \$300 per person. Tier 3: Individual \$400 per person.	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 is 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?	Yes. \$150 for <u>prescription drugs</u> . There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	Tier 1: Individual \$3,000 / Family \$6,000. Tier 2: Individual \$3,000 / Family \$6,000 Tier 3: Individual NONE / Family NONE.	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, penalties for failure to obtain pre-authorization for services & health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind or call 1-800-370-4526 for a list of Tier 1 Provider providers?	You pay the least if you use a <u>provider</u> in Tier 1 <u>Provider</u> . You pay more if you use a <u>provider</u> in Tier 2 <u>Provider</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</u> 's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <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.

		What You Will Pay			
Common Medical Event	Services You May Need	Tier 1 Provider (You will pay the least)	Tier 2 Provider (You will pay more)	Tier 3 Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you visit a health care <u>provider</u> 's office or clinic	Primary care visit to treat an injury or illness	\$30 <u>copay</u> /visit, <u>deductible</u> doesn't apply	10% coinsurance	40% coinsurance	None
	<u>Specialist</u> visit	\$35 <u>copay</u> /visit, <u>deductible</u> doesn't apply	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Preventive care /screening /immunization	No charge	No charge	Not covered	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.
	Diagnostic test (x-ray, blood work)	No charge	10% coinsurance	40% coinsurance	None
If you have a test	Imaging (CT/PET scans, MRIs)	\$30 <u>copay</u> /visit, <u>deductible</u> doesn't' apply	10% coinsurance	40% <u>coinsurance</u>	Requires pre-authorization. If necessary pre-authorization is not obtained, benefits may be reduced or not covered.
If you need drugs to treat your illness or condition More information about prescription	Tier 1 – Typically Generic drugs	\$16 copay/prescription (retail) and \$40.00 copay/prescription (mail order) \$20.00 copay/prescription (Maintenance Choice*)	\$16 copay/prescription (retail) and \$40.00 copay/prescription (mail order) \$20.00 copay/prescription (Maintenance Choice*)	\$16 copay/prescription (retail) and \$40.00 copay/prescription (mail order) \$20.00 copay/prescription (Maintenance Choice*)	Retail is 30 day supply. Mail order is 90 day supply. See Summary Plan description. *90 day supply

		What You Will Pay			
Common Medical Event	Services You May Need	Tier 1 Provider (You will pay the	Tier 2 Provider (You will pay	Tier 3 Provider (You will pay the	Limitations, Exceptions & Other Important Information
Lveiit		least)	more)	most)	important information
drug coverage is available at		\$33 copay/prescription	\$33 copay/prescription	\$33 copay/prescription	
www.caremark.com or call 1-877-232- 8128	Tier 2 – Typically Preferred/Brand drugs	(retail) and \$82.50 copay/prescription (mail order) \$41.25	(retail) and \$82.50 <u>copay</u> /prescription (mail order) \$41.25	(retail) and \$82.50 copay/prescription (mail order) \$41.25	
· · · ·		copay/prescription (Maintenance Choice*)	copay/prescription (Maintenance Choice*)	copay/prescription (Maintenance Choice*)	
	Tier 3 – Typically Non- Preferred/ <u>Specialty drugs</u>	\$57 copay/prescription (retail) and \$142.50 copay/prescription (mail order) \$71.25 copay/prescription (Maintenance Choice*)	\$57 copay/prescription (retail) and \$142.50 copay/prescription (mail order) \$71.25 copay/prescription (Maintenance Choice*)	\$57 copay/prescription (retail) and \$142.50 copay/prescription (mail order) \$71.25 copay/prescription (Maintenance Choice*)	
	Tier 4 – Typically Specialty drugs	Not applicable	Not applicable	Not applicable	See Summary Plan description
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$300 <u>copay</u> /visit, <u>deductible</u> doesn't apply	10% <u>coinsurance</u> after \$300 <u>copay</u> /visit	40% <u>coinsurance</u> after \$300 <u>copay</u> /visit	None
	Physician/surgeon fees	No charge	10% coinsurance	40% coinsurance	None
	Emergency room care	\$275 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$275 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$275 <u>copay</u> /visit, <u>deductible</u> doesn't apply	No coverage for non-emergency use.
If you need immediate medical attention	Emergency medical transportation	No charge	No charge	No charge	10% <u>coinsurance</u> for Tier 2 & 40% <u>coinsurance</u> for Tier 3 non- emergency transport.
	<u>Urgent care</u>	\$35 <u>copay</u> /visit, <u>deductible</u> doesn't apply	10% <u>coinsurance</u>	40% coinsurance	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$425 <u>copay</u> /stay, <u>deductible</u> doesn't apply	10% <u>coinsurance</u> after \$475 <u>copay</u> /stay	40% <u>coinsurance</u> after \$575 <u>copay</u> /stay	<u>Pre-authorization</u> required for out-of- network care. If pre-authorization is not obtained, benefits will be reduced or not covered.
	Physician/surgeon fees	No charge	10% coinsurance	40% coinsurance	None

		What You Will Pay			
Common Medical Event	Services You May Need	Tier 1 Provider (You will pay the least)	Tier 2 Provider (You will pay more)	Tier 3 Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need mental health, behavioral health, or	Outpatient services	Office & other outpatient services: \$30/\$35 copay/visit, deductible doesn't apply	Office & other outpatient services: 10% coinsurance	Office & other outpatient services: 40% coinsurance	None
substance abuse services	Inpatient services	\$425 <u>copay</u> /stay, <u>deductible</u> doesn't apply	10% <u>coinsurance</u> after \$475 <u>copay</u> /stay	40% <u>coinsurance</u> after \$575 <u>copay</u> /stay	Pre-authorization required for out-of-network care.
	Office visits	No charge	No charge	40% coinsurance	Cost sharing does not apply for
	Childbirth/delivery professional services	No charge	10% <u>coinsurance</u>	40% coinsurance	preventive services. Maternity care may include tests and services
If you are pregnant	Childbirth/delivery facility services	\$425 <u>copay</u> /stay, <u>deductible</u> doesn't apply	10% <u>coinsurance</u> after \$475 <u>copay</u> /stay	40% <u>coinsurance</u> after \$575 <u>copay</u> /stay	described elsewhere in the SBC (i.e. ultrasound.) <u>Pre-authorization</u> required for out-of-network care may apply.
If you need help recovering or have other special health needs	Home health care	\$35 <u>copay</u> /visit, <u>deductible</u> doesn't apply	10% <u>coinsurance</u>	Not covered	Pre-authorization required for out-of-network care.
	Rehabilitation services	\$35 <u>copay</u> /visit, <u>deductible</u> doesn't apply	10% <u>coinsurance</u>	Not covered	Limited to treatment for 60 consecutive days/condition for Physical, Occupational & Speech Therapy combined.
	Habilitation services	\$35 <u>copay</u> /visit, <u>deductible</u> doesn't apply	10% <u>coinsurance</u>	Not covered	20 visits/ <u>plan</u> year for Speech Therapy for pervasive developmental delay.
	Skilled nursing care	No charge	10% coinsurance	Not covered	<u>Pre-authorization</u> required for out-of-network care.
	Durable medical equipment	20% <u>coinsurance,</u> <u>deductible</u> doesn't apply	20% <u>coinsurance</u>	40% coinsurance	Limited to 1 <u>durable medical</u> <u>equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	No charge	10% coinsurance	40% coinsurance	<u>Pre-authorization</u> required for out-of-network care.
If your child poods	Children's eye exam	Not covered	Not covered	Not covered	None
If your child needs dental or eye care	Children's glasses	Not covered	Not covered	Not covered	None
uental of eye care	Children's dental check-up	Not covered	Not covered	Not covered	None

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
- Custodial care
- Routine dental care

- Glasses
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Prescription drugs

- Private-duty nursing
- Routine eye care
- Routine foot care
- Weight loss programs Except for required preventive services.

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

- Chiropractic care Limited to in-network providers.
- Hearing aids

 Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.

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:

Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. 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 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 by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-855-856-0038.
- Illinois Department of Central Management Services, Group Insurance Division, at 1-800-442-1300 or by email at CMS.Ben.BCS@illinois.gov.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have <u>Minimum Essential Coverage</u> for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan Meet Minimum Value Standard? 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 plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ Specialist Copayment	\$35
■ Hospital (facility) Copayment	\$425
Other <u>Copayment</u>	\$0

This EXAMPLE event includes services like:

Specialist office visits (prenatal care) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (ultrasounds and blood work) Specialist visit (anesthesia)

\$12,800
\$0
\$460
\$0
\$100
\$560

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a wellcontrolled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$0
Specialist Copayment	\$35
■ Hospital (facility) Copayment	\$425
Other <u>Copayment</u>	\$0

This EXAMPLE event includes services like:

Primary care physician office visits (including disease education) Diagnostic tests (blood work)

Prescription drugs

Durable medical equipment (glucose meter)

Total Example Cost	\$7,400	
In this example, Joe would pay:		
Cost Sharing		
Deductibles*	\$0	
Copayments	\$455	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$0	
The total Joe would pay is	\$455	

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ Specialist Copayment	\$35
■ Hospital (facility) Copayment	\$425
Other Conavment	\$0

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

Diagnostic test (x-ray)

Durable medical equipment (crutches)

Rehabilitation services (physical therapy)

Total Example Cost	\$1,900	
In this example, Mia would pay:		
Cost Sharing		
Deductibles*	\$0	
Copayments	\$275	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$275	

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-855-856-0038.

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

The plan would be responsible for the other costs of these EXAMPLE covered services.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-855-856-0038.

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 discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides 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: PO Box 24030 Fresno, CA 93779),

1-800-648-7817, TTY: 711, Fax: 859-425-3379 (CA HMO customers: 1-860-262-7705),

Email: <u>CRCoordinator@aetna.com</u>.

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 (Aetna).

TTY: 711

Language Assistance:

For language assistance in your language call 1-855-856-0038 at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-855-856-0038.

Amharic - ለቋንቋ እንዛ በ አማርኛ በ 1-855-856-0038 በነጻ ይደውሉ

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-855-856-0038

Armenian - Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-855-856-0038 առանց գնով։

Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-855-856-0038 tanpa dikenakan biaya.

Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-855-856-0038 ku busa

Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-855-856-0038-তে কল করুন।

Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-855-856-0038 nga walay bayad.

Burmese - ငွေကုန်ကျစံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-855-856-0038 ကို ခေါ် ဆိုပါ။

Catalan - Per rebre assistència en (català), truqui al número gratuït 1-855-856-0038.

Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-855-856-0038 sin gåstu.

Cherokee - $\theta \circ \partial \mathcal{Y} \theta \circ \mathcal{Y$

Chinese - 欲取得繁體中文語言協助, 請撥打 1-855-856-0038, 無需付費。

Choctaw - (Chahta) anumpa ya apela a chi I paya hinla 1-855-856-0038.

Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-855-856-0038 irratti bilisaan bilbilaa.

Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-855-856-0038.

French - Pour une assistance linguistique en français appeler le 1-855-856-0038 sans frais.

French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-855-856-0038 gratis.

German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-855-856-0038 an.

Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-855-856-0038 χωρίς χρέωση.

Gujarati - ગુજરાતીમાં ભાષામાં સહ્યય માટે કોઈ પણ ખર્ચ વગર 1-855-856-0038 પર કૉલ કરો.

Hawaiian - No ke kōkua ma ka 'ōlelo Hawai'i, e kahea aku i ka helu kelepona 1-855-856-0038. Kāki 'ole 'ia kēia kōkua nei.

Hindi - हिन्दी में भाषा सहायता के लिए, 1-855-856-0038 पर मुफ्त कॉल करें।

Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-855-856-0038.

lbo - Maka enyemaka asusu na Igbo kpoo 1-855-856-0038 na akwughi ugwo o bula

llocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-855-856-0038 nga awan ti bayadanyo.

Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-855-856-0038.

Japanese - 日本語で援助をご希望の方は、1-855-856-0038 まで無料でお電話ください。

Karen - လာတါမာစားတါကတိုးကျိုဉ်အင်္ဂါ ကျိုဉ် ကိုး 1-855-856-0038 လာတအိုဉ်ဒီးတါလာ၁ိဘူဉ်လာ၁ိစ္စာဘဉ်

Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862번으로 전화해 주십시오.

Kru-Bassa - Be´m`ké gbo-kpá-kpá dyé pidyi dé Bašsoó-wuduùn wee, dá 1-855-856-0038

برای راهنمایی به زبان فارسی با شماره 0038-855-1-4 به خورایی پهیومندی بکهن.

Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ-855-856-0038 ໂດຍບໍ່ເສຍຄ່າໂທ.

Marathi - तीलभाषा (मराठी) सहाय्यासाठी 1-855-856-0038 क्रमांकावरकोणत्याहीखर्चाशिवायकॉलकरा.

Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-855-856-0038 ilo ejjelok wōnān.

Micronesian-Pohnpeyan - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-855-856-0038 ni sohte isais.

Mon-Khmer, សម្ចាប់ជំនួយភាសាជា ភាសាខ្មមរែ សូមទូរស័ព្ទទទៅកាន់លខេ 1-855-856-0038 ដោយឥតគិតថ្លប់។

Cambodian -

Navajo - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-855-856-0038

Nepali - (नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1- 855-856-0038 मा फोन गर्नुहोस् ।

Nilotic-Dinka - Tën kuoony ë thok ë Thuonjän col 1-855-856-0038 kecin ayöc.

Norwegian - For språkassistanse på norsk, ring 1-855-856-0038 kostnadsfritt.

Panjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-855-856-0038 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।

Pennsylvania Dutch - Fer Helfe in Deitsch, ruf: 1-855-856-0038 aa. Es Aaruf koschtet nix.

برای راهنمایی به زبان فارسی با شماره 0038-855-1 بدون هیچ هزینه ای تماس بگیرید. انگلیسی Persian -

Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-855-856-0038.

Portuguese - Para obter assistência linguística em português ligue para o 1-855-856-0038 gratuitamente.

Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-855-856-0038

Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-855-856-0038.

Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-855-856-0038 e aunoa ma se totogi.

Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-855-856-0038.

Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-855-856-0038.

Sudanic-Fulfude - Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-855-856-0038. Njodi woo fawaaki on.

Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-855-856-0038 bila malipo.

Syriac - K = 22K K & D21 and 21 22 K wain on Ly ispr 1812, 20 1-855-856-0038 apr 2.

Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-855-856-0038 nang walang bayad.

Telugu - భాషతో సాయం కొరకు ఎలాంటి ఖర్పు లేకుండా 1-855-856-0038 కు కాల్ చేయండి. (తెలుగు)

Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-855-856-0038 ฟรีไม่มีค่าใช้จ่าย

Tongan - Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-855-856-0038 'o 'ikai hā ōtōngi.

Trukese - Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-855-856-0038 nge esapw kamé ngonuk.

Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-855-856-0038.

Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-855-856-0038.

ا رورک ل کتف م رب 1-855-856-0038 <u>عال کتن و اعمان الل رق م و در</u>

Vietnamese - Đê 'được hố 'trợ ngôn ngư bằng (ngôn ngư), hấy gọi miến phi 'đên số 1-855-856-0038.

Yiddish - פאר שפראך הילף אין אידיש רופט 1-855-856-0038 פריי פון אפצאל.

Yoruba - Fún ìrànlowo nípa èdè (Yorùbá) pe 1-855-856-0038 lái san owó kankan rárá.