

Aetna Choice® POS II - TRS-ActiveCare 1-HD

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



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, visit <u>www.trsactivecareaetna.com</u> or call 1-800-222-9205. 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 1-800-222-9205 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> : EE Only \$2,750; EE+ Family \$5,500. Out-of-Network: EE Only \$5,500; EE+ 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 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. In- <u>network preventive care</u> 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 <u>www.trsactivecareaetna.com</u>
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> ?	Network: EE Only \$6,750; EE+ Family: Individual \$6,750/ Family \$13,500. Out-of-Network: EE Only \$20,250; EE+ Family: Individual \$20,250/ Family \$40,500.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> 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 <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See <u>www.trsactivecareaetna.com</u> or call 1-800-222-9205 for a list of in- <u>network providers</u> .	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.

556963-476278-139001 1 of 9



All $\underline{\textbf{copayment}}$ and $\underline{\textbf{coinsurance}}$ costs shown in this chart are after your $\underline{\textbf{deductible}}$ has been met, if a $\underline{\textbf{deductible}}$ 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 care <u>provider</u> 's office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Includes Internist, General Physician, Family Practitioner or Pediatrician.
If you visit a health care <u>provider</u> 's office or clinic	Specialist visit	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you visit a health care <u>provider</u> 's office or clinic	Preventive care /screening /immunization	No charge	40% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
If you have a TRS Virtual Health visit	TRS Virtual Health video/phone consult	\$30 fee per consult, applies to <u>deductible</u> . After <u>deductible</u> , plan pays 80%; you pay 20% <u>coinsurance</u>	NA	
If you have a test	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% <u>coinsurance</u>	Pre-authorization may be required.

556963-476278-139001

2 of 9

		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 need drugs to treat your illness or condition Prescription drug coverage is administered by CVS/Caremark More information about prescription drug coverage is available at www.cvscaremark.com	Generic drugs	20% <u>coinsurance/</u> prescription (Retail & Mail Order or Retail- Plus)	20% <u>coinsurance/</u> prescription (Retail & Mail Order or Retail-Plus)	Covers 31-day supply (Retail), 60-90 day supply (Mail Order or Retail-Plus). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives in-network. Precertification & step therapy required. Your cost will be higher for choosing Brand over Generics unless prescribed Dispense as Written. Deductible doesn't apply to specific preventive medications. Out-of-Network: reimbursement is the allowed amount for what would have been charged by a network pharmacy less the copay after the drug deductible is met.
If you need drugs to treat your illness or condition Prescription drug coverage is administered by CVS/Caremark More information about prescription drug coverage is available at www.cvscaremark.com	Preferred brand drugs	25% <u>coinsurance/</u> prescription (Retail & Mail Order or Retail- Plus)	25% <u>coinsurance/</u> prescription (Retail & Mail Order or Retail-Plus)	Covers 31-day supply (Retail), 60-90 day supply (Mail Order or Retail-Plus). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives in-network. Precertification & step therapy required. Your cost will be higher for choosing Brand over Generics unless prescribed Dispense as Written. Deductible doesn't apply to specific preventive medications. Out-of-Network: reimbursement is the allowed amount for what would have been charged by a network pharmacy less the copay after the drug deductible is met.

3 of 9

Common Medical Event Services You May Need In-Network Provider (You will pay the least) Limitations, Exceptions, & Other Information Covers 31-day supply (Retail), 60-9 (Mail Order or Retail-Plus). Includes contraceptive drugs & devices obtain the most of the most o	r Important
(Mail Order or Retail-Plus). Includes contraceptive drugs & devices obtain	
Prescription drug coverage is administered by CVS/Caremark More information about prescription drug coverage is available at www.cvscaremark.com Non-preferred brand drugs Sow coinsurance/ prescription (Retail & Mail Order or Retail-Plus) Sow coinsurance/ prescription (Retail & Mail Order or Retail-Plus) Sow coinsurance/ prescription (Retail & Mail Order or Retail-Plus) Precertification & step therapy requirements cost will be higher for choosing Brand Generics unless prescribed Dispension (Retail & Mail Order or Retail-Plus) More information about prescription drug coverage is available at www.cvscaremark.com	nable from a generic FDA-n-network. red. Your nd over se as Written. preventive ursement is nave been
If you need drugs to treat your illness or condition Prescription drug coverage is administered by CVS/Caremark More information about prescription drug coverage is available at www.cvscaremark.com All Specialty drugs must be filled at Pharmacy. Retail not covered. 31-d limit.	
If you have outpatient surgery Facility fee (e.g., ambulatory surgery center) 20% coinsurance 40% coinsurance None	
If you have outpatient surgery Physician/surgeon fees 20% coinsurance 40% coinsurance None	
Emergency room care (hospital affiliated facility) 20% coinsurance 20% coinsurance 20% coinsurance 40% coinsur	y use out-of-

		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 need immediate medical attention	Emergency medical transportation	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Non-emergency transport: not covered, except if pre-authorized.
If you need immediate medical attention	<u>Urgent care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% coinsurance; Member pays the balance of covered charge in excess of \$500 per day after deductible	Penalty of \$250 for failure to obtain <u>pre-authorization</u> for out-of-network care.
If you have a hospital stay	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient visits: 20% coinsurance	Office & other outpatient visits: 40% coinsurance	Pre-authorization may be required for out-of-network care.
If you need mental health, behavioral health, or substance abuse services	TRS Virtual Health video consult	Consult fee: \$185 psychiatrist (initial visit) \$95 psychiatrist (ongoing visits) \$85 therapy visits*, Consult fee applies to deductible. After deductible, plan pays 80%; you pay 20% coinsurance	NA	*Therapy visits can be with a psychologist, licensed clinical social worker, counselor or therapist
If you need mental health, behavioral health, or substance abuse services	Inpatient services	20% <u>coinsurance</u>	40% coinsurance; Member pays the balance of charge in excess of \$500 per day after deductible	Penalty of \$250 for failure to obtain <u>pre-authorization</u> for out-of-network care.

		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 are pregnant	Office visits	No charge	40% <u>coinsurance</u>	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
If you are pregnant	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
If you are pregnant	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% coinsurance; Member pays the balance of charge in excess of \$500 per day after deductible	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 \$250 for failure to obtain pre-authorization for out-of-network care may apply.
If you need help recovering or have other special health needs	Home health care	20% <u>coinsurance</u>	40% <u>coinsurance</u>	60 visits/ <u>plan</u> year. <u>Pre-authorization</u> may be required for in and out-of-network care.
If you need help recovering or have other special health needs	Rehabilitation services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need help recovering or have other special health needs	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to treatment of autism and to speech therapy for developmental delay.

		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 need help recovering or have other special health needs	Skilled nursing care	20% <u>coinsurance</u>	40% <u>coinsurance</u>	25 days/ <u>plan</u> year. Penalty of \$250 for failure to obtain <u>pre-authorization</u> for out-of-network care.	
If you need help recovering or have other special health needs	Durable medical equipment	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.	
If you need help recovering or have other special health needs	Hospice services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Penalty of \$250 may apply for failure to obtain pre-authorization for out-of-network care.	
If your child needs dental or eye care	Children's eye exam	20% <u>coinsurance</u>	40% <u>coinsurance</u>	1 routine eye exam/ <u>plan</u> year if performed by an ophthalmologist or optometrist.	
If your child needs dental or eye care	Children's glasses	Not covered	Not covered	Not covered.	
If your child needs dental or eye care	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)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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.)

- Bariatric surgery Limited to Institutes of Quality facility only in-network. \$5000 copay.
- Chiropractic care 35 visits/plan year.
- Hearing aids \$1,000 maximum/36 months.
- Infertility treatment Limited to the diagnosis & treatment of underlying medical condition.
- Routine eye care (Adult) 1 routine eye exam/plan 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 1-800-222-9205.
- 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: https://www.dol.gov/agencies/ebsa
- 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 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 directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-800-222-9205.
- 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 https://www.dol.gov/agencies/ebsa
- For non-federal governmental group health <u>plans</u>, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- 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.

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 Standards? Yes.

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.-----

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>	\$2,750
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)

\$12,800
\$2,750
\$0
\$2,000
\$60
\$4,810

Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$2,750
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	\$2,750	
Copayments	\$0	
Coinsurance	\$1,000	
What isn't covered		
Limits or exclusions	\$20	
The total Joe would pay is	\$3,770	

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$2,750
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)
Durable medical equipment (crutches)

Rehabilitation services (physical therapy)

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

Note: If your plan has a wellness program and you choose to participate, you may be able to reduce your costs.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-800-222-9205.

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: 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 (Aetna).

TTY: 711

Language Assistance:

For language assistance in your language call 1-800-222-9205 at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-800-222-9205.

Amharic - ለቋንቋ እንዛ በ አማርኛ በ 1-800-222-9205 በነጻ ይደውሉ

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-800-222-9205

Armenian - Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-800-222-9205 առանց գնով։

Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-222-9205 tanpa dikenakan biaya.

Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-800-222-9205 ku busa

Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-800-222-9205-তে কল করুন।

Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-222-9205 nga walay bayad.

Burmese - ငွေကုန်ကျစံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-800-222-9205 ကို ခေါ် ဆိုပါ။

Catalan - Per rebre assistència en (català), truqui al número gratuït 1-800-222-9205.

Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-800-222-9205 sin gåstu.

Cherokee - OOYO SOHAOL JHOSPOY OLT (GWY) OBWO'IS 1-800-222-9205 OOT LATOL JEGPL HERO.

Chinese - 欲取得繁體中文語言協助, 請撥打 1-800-222-9205, 無需付費。

Choctaw - (Chahta) anumpa ya apela a chi I paya hinla 1-800-222-9205.

Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-800-222-9205 irratti bilisaan bilbilaa.

Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-222-9205.

French - Pour une assistance linguistique en français appeler le 1-800-222-9205 sans frais.

French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-800-222-9205 gratis.

German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-222-9205 an.

Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-222-9205 χωρίς χρέωση.

Gujarati - ગુજરાતીમાં ભાષામાં સહ્યય માટે કોઈ પણ ખર્ચ વગર 1-800-222-9205 પર ક્રૉલ કરો.

Hawaiian - No ke kōkua ma ka 'ōlelo Hawai'i, e kahea aku i ka helu kelepona 1-800-222-9205. Kāki 'ole 'ia kēia kōkua nei.

Hindi - हिन्दी में भाषा सहायता के लिए, 1-800-222-9205 पर मुफ्त कॉल करें।

Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-800-222-9205.

lbo - Maka enyemaka asusu na Igbo kpoo 1-800-222-9205 na akwughi ugwo o bula

llocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-222-9205 nga awan ti bayadanyo.

Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-800-222-9205.

Japanese - 日本語で援助をご希望の方は、1-800-222-9205 まで無料でお電話ください。

Karen - လာတၢ်မာစားတၢ်ကတိုးကျိုဉ်အင်္ဂ ကျိုဉ် ကိုး 1-800-222-9205 လာတအိုဉ်ဒီးတၢ်လာ၁်ဘူဉ်လာ၁်စ္ခာဘဉ်

Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-222-9205 번으로 전화해 주십시오.

Kru-Bassa - Be´m`ké gbo-kpá-kpá dyé pidyi dé Bašsɔɔ́-wuduùn wẽe, dá 1-800-222-9205

برای راهنمایی به زبان فارسی با شماره 9205-222-920 به خورایی پهیوهندی بکهن.

Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ-800-222-9205 ໂດຍບໍ່ເສຍຄ່າໂທ.

Marathi - तीलभाषा (मराठी) सहाय्यासाठी 1-800-222-9205 क्रमांकावरकोणत्याहीखर्चाशिवायकॉलकरा.

Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-800-222-9205 ilo ejjelok wōnān.

Micronesian-Pohnpeyan - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-800-222-9205 ni sohte isais.

Mon-Khmer, សម្ចាប់ជំនួយភាសាជា ភាសាខ្មមរៃ សូមទូរស័ព្ទទទ**ៅកាន់លខេ 1-800-222-9205 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' 1-800-222-9205

Nepali - (नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-800-222-9205 मा फोन गर्नुहोस् ।

Nilotic-Dinka - Tën kuoony ë thok ë Thuonjän col 1-800-222-9205 kecin ayöc.

Norwegian - For språkassistanse på norsk, ring 1-800-222-9205 kostnadsfritt.

Panjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-800-222-9205 'ਤੇ ਮਫ਼ਤ ਕਾਲ ਕਰੋ।

Pennsylvania Dutch - Fer Helfe in Deitsch, ruf: 1-800-222-9205 aa. Es Aaruf koschtet nix.

برای راهنمایی به زبان فارسی با شماره 9205-222-1-800 بدون هیچ هزینه ای تماس بگیرید. انگلیسی Persian -

Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezplatnie pod numer 1-800-222-9205.

Portuguese - Para obter assistência linguística em português ligue para o 1-800-222-9205 gratuitamente.

Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-800-222-9205

Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-800-222-9205.

Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-800-222-9205 e aunoa ma se totogi.

Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-800-222-9205.

Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-800-222-9205.

Sudanic-Fulfude - Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-800-222-9205. Njodi woo fawaaki on.

Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-800-222-9205 bila malipo.

Syriac - K = 32 K K & pari abk = 122 K wain on Ly ippk : 181,90 1-800-222-9205 apl

Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-800-222-9205 nang walang bayad.

Telugu - భాషతో సాయం కొరకు ఎలాంటి ఖర్పు లేకుండా 1-800-222-9205 కు కాల్ చేయండి. (తెలుగు)

Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-800-222-9205 ฟรีไม่มีค่าใช้จ่าย

Tongan - Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-800-222-9205 'o 'ikai hā ōtōngi.

Trukese - Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-800-222-9205 nge esapw kamé ngonuk.

Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-800-222-9205.

Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-800-222-9205.

ا رورک ل کتف م رب 9205-222-1-800 <u>ک تن و اعمین الی رق م و در</u>

Vietnamese - Đê được hố trợ ngôn ngư bằng (ngôn ngư), hấy gọi miến phi đến số 1-800-222-9205.

Yiddish - פאר שפראך הילף אין אידיש רופט 1-800-222-9205 פריי פון אפצאל.

Yoruba - Fún ìrànlowo nípa èdè (Yorùbá) pe 1-800-222-9205 lái san owó kankan rárá.