

DEPARTMENT OF DEFENSE - NONAPPROPRIATED FUND HEALTH
BENEFITS PROGRAM: Aetna Choice® POS II - Medical Plan without Dental

Coverage Period: 01/01/2025-12/31/2025

Coverage for: All Tiers | 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, <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?	Preferred (In-Network) (INN): EE Only (EO) \$600; EE+ Family (EE+FAM) (employee+ 1 or more dependents) \$1,800. Non-Preferred (Out-of-Network) (OON): EO \$1,800; EE+FAM (employee+ 1 or more dependents) \$5,400.	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. Emergency care; plus in-network office visits, prescription drugs & preventive care are covered before you meet your deductible.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	Preferred (INN): EO \$5,000; EE+FAM (employee+ 1 or more dependents) \$10,000. Non-Preferred (ONN): EO \$10,000; EE+FAM (employee+ 1 or more dependents) \$20,000.	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> , the overall family <u>out–of–pocket limit</u> must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover & penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the <u>out–of–pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See <u>www.aetna.com/docfind</u> or call 1-800-370-4526 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.



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	Preferred (In- Network) (You will pay the least)	Non-Preferred (Out-of-Network) (You will pay the most)	Limitations, Exceptions, & Other Important Information
	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 <u>provider</u> 's office or clinic	<u>Specialist</u> visit	\$60 <u>copay</u> /visit, <u>deductible</u> doesn't apply	40% coinsurance	None
office of chilic	Preventive care /screening /immunization	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.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
If you have a test	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	None
If you need drugs to treat your illness or	Generic drugs	Copay/prescription, deductible doesn't apply: \$10 (retail), \$20 (mail order)	Not covered	Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral & injectable fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in-network. Your cost will be higher for choosing Brand over Generics; cost difference penalty doesn't apply to out-of-pocket limit. Maintenance drugs- after two retail fills, members are require to fill a 90-day supply at CVS Caremark® Mail Service Pharmacy or CVS Pharmacy. For overseas pharmacies 0% coinsurance for general drugs & 20% coinsurance for brand drugs.
More information about prescription drug coverage is available at www.aetnapharmac y.com/standard	Preferred brand drugs	25% copay with minimum & maximum/ prescription, deductible doesn't apply: \$45 minimum & \$70 maximum (retail), \$90 minimum & \$140 maximum (mail order)	Not covered	

Common Medical Event	Services You May Need	What You Preferred (In- Network) (You will pay the least)	u Will Pay Non-Preferred (Out-of-Network) (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Non-preferred brand drugs	35% copay with minimum & maximum/ prescription, deductible doesn't apply: \$75 minimum & \$200 maximum (retail), \$150 minimum & \$400 maximum (mail order)	Not covered	
	Specialty drugs	40% copay with \$60 minimum & \$125 maximum/prescripti on, deductible doesn't apply	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)	20% coinsurance	40% coinsurance	None
outpatient surgery	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
	Emergency room care	20% coinsurance after \$500 copay/ visit, deductible doesn't apply	20% coinsurance after \$500 copay/ visit, deductible doesn't apply	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> . 50% <u>coinsurance</u> after \$350 <u>copay</u> /visit for non-emergency use.
If you need immediate medical attention	Emergency medical transportation	20% <u>coinsurance</u> after \$500 <u>copay/</u> trip, <u>deductible</u> doesn't apply	20% <u>coinsurance</u> after \$500 <u>copay/</u> trip, <u>deductible</u> doesn't apply	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> . Non-emergency transport: not covered, except if pre-authorized.
	<u>Urgent care</u>	\$40 <u>copay</u> /visit, <u>deductible</u> doesn't apply	40% coinsurance	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u> after \$200 <u>copay</u> /stay	40% <u>coinsurance</u> after \$400 <u>copay</u> /stay	Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None

Common Medical Event	Services You May Need	What You Preferred (In- Network) (You will pay the least)	Will Pay Non-Preferred (Out-of-Network) (You will pay the most)	Limitations, Exceptions, & Other Important Information	
If you need mental health, behavioral health, or	Outpatient services	Office: \$60 copay/ visit, deductible doesn't apply; other outpatient services: 20% coinsurance	Office & other outpatient services: 40% coinsurance	None	
substance abuse services	Inpatient services	20% <u>coinsurance</u> after \$200 <u>copay</u> /stay	40% <u>coinsurance</u> after \$400 <u>copay</u> /stay	Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care.	
	Office visits	No charge	40% coinsurance		
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	Cost sharing does not apply for preventive	
If you are pregnant	Childbirth/delivery facility services	20% coinsurance after \$200 copay/stay, except copay doesn't apply for newborn hospital expenses	40% coinsurance after \$400 copay/stay, except copay doesn't apply for newborn hospital expenses	services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Penalty of \$500 for failure to obtain pre-authorization for out-of-network care may apply.	
	Home health care	20% <u>coinsurance</u>	40% coinsurance	90 visits/calendar year. Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care.	
	Rehabilitation services	20% coinsurance	20% coinsurance	60 visits/calendar year for Physical, Occupational & Speech Therapy combined.	
If you need help recovering or have	Habilitation services	\$60 <u>copay</u> /visit, <u>deductible</u> doesn't apply	20% coinsurance	None	
other special health needs	Skilled nursing care	20% coinsurance	40% coinsurance	90 days/calendar year. Penalty of \$400 for failure to obtain pre-authorization for out-of-network care.	
	Durable medical equipment	20% coinsurance	20% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.	
	Hospice services	No charge	No charge	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.	
	Children's eye exam	No charge	Not covered	1 routine eye exam/calendar year.	

Common Medical Event	Services You May Need	What You Preferred (In- Network) (You will pay the least)	Will Pay Non-Preferred (Out-of-Network) (You will pay the most)	Limitations, Exceptions, & Other Important Information
f your child needs	Children's glasses	No charge	No charge	\$150 maximum/calendar year.
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.)

- Cosmetic surgery
- Dental care (Adult & Child)

- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs

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

- Acupuncture 10 visits/calendar year for disease, injury & chronic pain.
- Bariatric surgery Limited to in-<u>network</u> <u>providers</u>.
- Chiropractic care 20 visits/calendar year.
- Hearing aids \$3,000 maximum/3 years.
- Infertility treatment For more information & exceptions, see policy document provided by your employer or call the number on your ID card.
- Private-duty nursing 70- 8 hour shifts/calendar year.
- Routine eye care (Adult) 1 routine eye exam/calendar year in-network only.

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 plan 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 plan 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:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general number at 1-800-370-4526. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health <u>plans</u>, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or <u>www.cciio.cms.gov</u>.
- Additionally, a consumer assistance program can help you file your <u>appeal</u>. Contact information is at: http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes <u>plans</u>, <u>health insurance</u> available through the <u>Marketplace</u> or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of <u>Minimum Essential Coverage</u>, you may not be eligible for the <u>premium tax credit</u>.

Does this plan meet Minimum Value Standards? Yes.

If your <u>plan</u> doesn't meet the <u>Minimum Value Standards</u>, you may be eligible for a <u>premium tax credit</u> to help you pay for a <u>plan</u> through the <u>Marketplace</u>.

To see examples of how this plan might cover costs for a sample medical situation, see the next section

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost-sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

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

■ The <u>plan's</u> overall <u>deductible</u>	\$600
■ Specialist copayment	\$60
■ Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:

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

Total Example Cost	\$12,700
In this example, Peg would pay:	
Cost Sharing	
<u>Deductibles</u>	\$600
Copayments	\$10
Coinsurance	\$2,200
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,870

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>	\$600
■ Specialist copayment	\$60
■ Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits (including disease education)

Diagnostic tests (blood work)

Prescription drugs

Diabetic supplies (glucose meter)

Total Example Cost	\$5,600	
In this example, Joe would pay:		
<u>Cost Sharing</u>		
<u>Deductibles</u>	\$100	
<u>Copayments</u>	\$1,400	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$20	
The total Joe would pay is	\$1,520	

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$600
■ Specialist copayment	\$60
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

Diagnostic test (x-ray)

<u>Durable medical equipment</u> (crutches)

Rehabilitation services (physical therapy)

Total Example Cost	\$2,800	
In this example, Mia would pay:		
Cost Sharing		
<u>Deductibles</u>	\$400	
<u>Copayments</u>	\$100	
<u>Coinsurance</u>	\$400	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$900	

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-800-370-4526.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, disability, gender identity or sexual orientation.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: P.O. Box 24030, Fresno, CA 93779),

1-800-648-7817, TTY: 711,

Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies, including Aetna Life Insurance Company and its affiliates (Aetna).

TTY: 711

Language Assistance:

To access language services at no cost to you, call 1-800-370-4526.

Albanian - Për shërbime përkthimi falas për ju, telefononi 1-800-370-4526.

Amharic - የቋንቋ አንልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-800-370-4526 ይደውሉ።

للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء االتصال على الرقم 4526-370-4526 اللغوية دون أي تكلفة، الرجاء التصال على الرقم 4526-370-4526

Armenian - Անվձար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-800-370-4526 հեռախոսահամարով։

Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-370-4526 tanpa dikenakan biaya.

Bantu-Kirundi - Kugira uronke serivisi z'indimi atakiguzi, hamagara 1-800-370-4526.

Bengali-Bangala - আপনাকে বিনামূক্যে ভাষা পৰিক্ষিা পপকে হক্ষ এই নম্বকি পেব্যক ান েরুন: 1-800-370-4526 |

Bisayan-Visayan - Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-800-370-4526.

Burmese - သင့္အေနျဖင့္ အခေၾကးေငြ မေပးရပဲ ဘာသာစကားဝန္ေဆာင္မႈမ်ား ရရွိႏုိင္ရန္ 1-800-370-4526 သို႕ ဖုန္းေခၚဆုိပါ။

Catalan - Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-800-370-4526.

Chamorro - Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-800-370-4526.

Cherokee - GYOJ SOHAOJ OGOLONA L ALON IGEGMUN PAPAROL 1-800-370-4526.

Chinese - 如欲使用免費語言服務, 請致電 1-800-370-4526.

Choctaw - Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-800-370-4526.

Cushite - Tajaajiiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-800-370-4526.

Dutch - Voor gratis toegang tot taaldiensten, bell 1-800-370-4526.

French - Afin d'accéder aux services langagiers sans frais, composez le 1-800-370-4526.

French Creole - Pou jwenn sèvis lang gratis, rele 1-800-370-4526.

German - Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-800-370-4526 an.

Greek - Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό

1-800-370-4526.

Gujarati - તમારેકોઇ જાતના ખર્ચવિના ભાષાની સેિાઓની પહોોર્ માટે, કોલ કરો1-800-370-4526.

Hawaiian - No ka wala'au 'ana me ka lawelawe 'ōlelo e kahea aku i kēia helu kelepona 1-800-370-4526. Kāki 'ole 'ia kēia kōkua nei.

Hindi - आपकेलिए बिना ककसी कीमत केभाषा सेवाओंका उपयोग करनेकेलिए,1-800-370-4526 पर कॉल करें।

Hmong - Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-800-370-4526.

lgbo - lji nwetaòhèrè na oru gasi asusu n'efu, kpoo 1-800-370-4526

llocano - Tapno maaksesyo dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti 1-800-370-4526.

Indonesian - Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi 1-800-370-4526.

Italian - Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-800-370-4526.

Japanese - 言語サービスを無料でご利用いただくには、1-800-370-4526 までお電話ください。

Karen - လာတါကမၤနှါ်ကိုဉ်အတါမၢစာၤအတါဖီးတါမာတဗဉ်လာတအိဉ်ဒီးအပူးလာကဘဉ်ဟုဉ်အီးအဂ်ီးဘဉ်နှဉ် ကိုး 1-800-370-4526 တက္၊

Korean - 무료 언어 서비스를 이용하려면 1-800-370-4526 번으로 전화해 주십시오.

Kru-Bassa - Mì dyi wudu-dù kà kò dò bě dyi moú ń nì Pídyi ní, nìí, dá nòbà nìà kε: 1-800-370-4526

بۆ دەسىيىر اگەيىشتن بە خزمەتگوز ارى زمان بەبئى تىچوون بۆ تۆ، پەيوەندى بكە بە ژمارەى 4526-370-370-1-800

Laotian - ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ. ໃຫ້ໂທຫາເບີ 1-800-370-4526

Marathi - कोणत्याही शल्ुकालशवाय भाषा सेवा प्राप्त करण्यासाठी,, 1-800-370-4526 वर फोन करा.

Marshallese - Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlok 1-800-370-4526.

Micronesian-

Pohnpeyan - Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1-800-370-4526.

Mon-Khmer, ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-800-370-4526 ។

Cambodian -

Navajo - T'áá ni nizaad k'ehjí bee níká a'doowoł doo bááh ílínígóó kojj' hólne' 1-800-370-4526.

Nepali - निःश्ल्क भाषा सेवा प्राप्त गर्न 1-800-370-4526 मा टेलिफोन गर्न्होस्।

Nilotic-Dinka - Të koor yin weër de thokic ke cin wëu kor keek tënon yin. Ke col koc ye koc kuony ne nomba 1-800-370-4526.

Norwegian - For tilgang til kostnadsfri språktjenester, ring 1-800-370-4526.

Pennsylvania Dutch - Um Schprooch Services zu griege mitaus Koscht, ruff 1-800-370-4526.

برای دسترسی به خدمات زبان به طور رایگان، با شماره 4526-370-4520 تماس بگیرید.

Polish - Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-800-370-4526.

Portuguese - Para acessar os serviços de idiomas sem custo para você, ligue para 1-800-370-4526.

Punjabi - ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1-800-370-4526 'ਤੇ ਫ਼ੋਨ ਕਰੋ।

Romanian - Pentru a accesa gratuit serviciile de limbă, apelați 1-800-370-4526.

Russian - Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-800-370-4526.

Samoan - Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala'au le 1-800-370-4526.

Serbo-Croatian - Za besplatne prevodilačke usluge pozovite 1-800-370-4526.

Spanish - Para acceder a los servicios de idiomas sin costo, llame al 1-800-370-4526.

Sudanic-Fulfude - Heeba a nasta jangirde djey wolde wola chede bo apelou lamba 1-800-370-4526.

Swahili - Kupata huduma za lugha bila malipo kwako, piga 1-800-370-4526.

Syriac - جل بيلخين جهنبة منبخ حلية به منبق عنب منبق منبخ منب ا-800-370-4526

Tagalog - Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-800-370-4526.

Telugu - మీరు బాప్ల సేవలను ఉచితంగా అందుకునందుకు, 1-800-370-4526 కు కాల్ చేయండి.

Thai - หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-800-370-4526.

Tongan - Kapau 'oku ke fiema'u ta'etōtōngi 'a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he 1-800-370-4526.

Trukese - Ren omw kopwe angei aninisin eman chon awewei (ese kamo), kopwe kori 1-800-370-4526.

Turkish - Sizin için ücretsiz dil hizmetlerine erişebilmek için, 1-800-370-4526 numarayı arayın.

Ukrainian - Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-800-370-4526.

بالقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 4526-370-4520 پر بات کریں۔

Vietnamese - Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-800-370-4526.

Yiddish - 1-800-370-4526 צו צוטריט שַּפרַאך בַאדינונגען אין קיין פרייַז צו איר, רופן

Yoruba - Lati wonú awon ise èdè l'ofe fun o, pe 1-800-370-4526.