

THE CITY OF SEATTLE: Aexcel® Plus Open Choice® - Local 77-Most Traditional

Coverage for: Individual + Family | Plan Type: PPO



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?	In- <u>Network:</u> Individual \$400 / Family \$1,200. Out-of-Network: Individual \$1,000 / Family \$3,000.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. Emergency care & inpatient hospital services; plus in-network 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> ?	In- <u>Network:</u> Individual \$1,400 / Family \$4,200. Out-of-Network: Individual \$3,000 / Family \$9,000.	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</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 & 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 ID card for phone number to call for a list of Aexcel designated <u>providers</u> .	You pay the least if you use a <u>provider</u> in Aexcel Designated. You pay more if you use a <u>provider</u> in <u>Network</u> or Aexcel Non-Designated. 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</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	ı Will Pay		
Common Medical Event	Services You May Need	Aexcel Designated Provider (You will pay the least)	Network Provider (You will pay more)	Aexcel Non- Designated Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	20% coinsurance	20% coinsurance	30% coinsurance	40% coinsurance	None
	Specialist visit	20% coinsurance	20% coinsurance	30% coinsurance	40% coinsurance	None
If you visit a health care <u>provider</u> 's office or clinic	Preventive care /screening /immunization	No charge	No charge	No charge	Not covered, except 40% <u>coinsurance</u> for mammograms	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If b a 44	<u>Diagnostic test</u> (x-ray, blood work)	Not applicable	20% coinsurance	Not applicable	40% coinsurance	None
If you have a test	Imaging (CT/PET scans, MRIs)	Not applicable	20% coinsurance	Not applicable	40% coinsurance	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at	Generic drugs	Not applicable	30% coinsurance with minimum & maximum/prescripti on: \$10 minimum & \$100 maximum (retail), \$20 minimum & \$200 maximum (mail order)	Not applicable	Not covered	Covers 31 day supply (retail), 32-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives in-network.

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Common Medical Event	Services You May Need	Aexcel Designated Provider (You will pay the least)	Network Provider (You will pay more)	Aexcel Non- Designated Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
www.aetnapharmac y.com/premierplus	Preferred brand drugs	Not applicable	40% coinsurance with minimum & maximum/prescripti on: \$10 minimum & \$100 maximum (retail), \$20 minimum & \$200 maximum (mail order)	Not applicable	Not covered	
	Non-preferred brand drugs	Not applicable	40% coinsurance with minimum & maximum/prescripti on: \$10 minimum & \$100 maximum (retail), \$20 minimum & \$200 maximum (mail order)	Not applicable	Not covered	
	Specialty drugs	Not applicable	Applicable cost as noted above for generic or brand drugs	Not applicable	Not covered	Precertification required for coverage.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not applicable	20% coinsurance	Not applicable	40% <u>coinsurance</u>	None
	Physician/surgeon fees	20% coinsurance	20% coinsurance	30% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	Not applicable	20% <u>coinsurance</u> after \$150 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Not applicable	20% <u>coinsurance</u> after \$150 <u>copay</u> /visit, <u>deductible</u> doesn't apply	40% coinsurance after \$150 copay/visit, deductible doesn't apply for non-emergency use.

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Common Medical Event	Services You May Need	Aexcel Designated Provider (You will pay the least)	Network Provider (You will pay more)	Aexcel Non- Designated Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Emergency medical transportation	Not applicable	20% coinsurance	Not applicable	20% coinsurance	Non-emergency transport: not covered, except if pre- authorized.
	<u>Urgent care</u>	Not applicable	20% coinsurance	Not applicable	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Not applicable	20% <u>coinsurance</u> after \$200 <u>copay</u> /stay, <u>deductible</u> doesn't apply	Not applicable	40% <u>coinsurance</u> after \$200 <u>copay</u> /stay, <u>deductible</u> doesn't apply	Pre-authorization required for out-of-network care.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	30% coinsurance	40% coinsurance	None
If you need mental health, behavioral	Outpatient services	Not applicable	Office & other outpatient services: 20% coinsurance	Not applicable	Office & other outpatient services: 40% coinsurance	None
health, or substance abuse services	Inpatient services	Not applicable	20% <u>coinsurance</u> after \$200 <u>copay</u> /stay, <u>deductible</u> doesn't apply	Not applicable	40% <u>coinsurance</u> after \$200 <u>copay</u> /stay, <u>deductible</u> doesn't apply	Pre-authorization required for out-of-network care.
	Office visits	Not applicable	No charge	Not applicable	40% coinsurance	Cost sharing does not
	Childbirth/delivery professional services	20% coinsurance	20% coinsurance	30% coinsurance	40% coinsurance	apply for preventive services.
If you are pregnant	Childbirth/delivery facility services	Not applicable	20% coinsurance after \$200 copay/stay, deductible doesn't apply; copay waived for newborn hospital expenses	Not applicable	40% coinsurance after \$200 copay/stay, deductible doesn't apply; copay waived for newborn hospital expenses	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 other special	Home health care	Not applicable	20% <u>coinsurance</u>	Not applicable	40% coinsurance	130 visits/calendar year. <u>Pre-authorization</u> required for out-of-network care.
health needs	Rehabilitation services	Not applicable	20% coinsurance	Not applicable	40% coinsurance	None

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Common Medical Event	Services You May Need	Aexcel Designated Provider (You will pay the least)	Network Provider (You will pay more)	Aexcel Non- Designated Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Habilitation services	Not covered	20% coinsurance	Not covered	40% coinsurance	None
	Skilled nursing care	Not applicable	20% <u>coinsurance</u> after \$200 <u>copay</u> /stay, <u>deductible</u> doesn't apply	Not applicable	40% <u>coinsurance</u> after \$200 <u>copay</u> /stay, <u>deductible</u> doesn't apply	90 days/calendar year. Pre-authorization required for out-of-network care.
	Durable medical equipment	Not applicable	20% <u>coinsurance</u>	Not applicable	40% <u>coinsurance</u>	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	Not applicable	20% coinsurance	Not applicable	40% coinsurance	Pre-authorization required for out-of-network care.
If your shild poods	Children's eye exam	Not covered	Not covered	Not covered	Not covered	Not covered.
If your child needs dental or eye care	Children's glasses	Not covered	Not covered	Not covered	Not covered	Not covered.
dental of eye cale	Children's dental check-up	Not covered	Not covered	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)
- Glasses (Child)

- Long-term care
- Routine eye care (Adult & Child)

- 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.)

- Acupuncture 12 visits/calendar year.
- Bariatric surgery Limited to Institutes of Quality contracted facility for in-network only.
- Chiropractic care 10 visits/calendar year.
- Hearing aids 1 hearing aid to \$1,000 maximum per ear/36 months.
- Infertility treatment Limited to the diagnosis & treatment of underlying medical condition.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

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: 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.
- 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 1-800-370-4526.
- 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 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 Minimum Essential Coverage 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>	\$400
■ 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	\$12,800
In this example, Peg would pay:	
Cost Sharing	
Deductibles	\$400
Copayments	\$0
Coinsurance	\$1,000
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$1,460

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>	\$400
■ 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	\$400
Copayments	\$700
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,320

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$400
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	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	\$400
Copayments	\$0
Coinsurance	\$300
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$700

Note: These numbers assume the patient does not participate in the <u>plan's</u> wellness program. If you participate in the <u>plan's</u> wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-370-4526.

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 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 1-800-370-4526 at no cost.

Albanian -Për asistencë në gjuhën shqipe telefononi falas në 1-800-370-4526.

Amharic -ለቋንቋ እንዛ በ አማርኛ በ 1-800-370-4526 በነጻ ይደውሉ

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 4526-370-1-800 Arabic -

Լեզվի ցուցաբերած աջակցության (հայերեն) ցանգի 1-800-370-4526 առանց գնով։ Armenian -

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

Bantu-Kirundi -Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-800-370-4526 ku busa

বাংলায় ভাষা সহায়তার জন্য বিনামুল্যে 1-800-370-4526-তেকল করুন। Bengali-Bangala -

Bisayan-Visayan -Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-370-4526 nga walay bayad.

ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-800-370-4526 ကို ခေါ် ဆိုပါ။ Burmese -

Catalan -Per rebre assistència en (català), truqui al número gratuït 1-800-370-4526.

Chamorro -Para ayuda gi fino' (Chamoru), ågang 1-800-370-4526 sin gåstu.

ΘΘΥΘ SOPPOY OF LALON OPEN OF 1-800-340-4250 OF CALON GERN PAGE. Cherokee -

欲取得繁體中文語言協助, 請撥打1-800-370-4526, 無需付費。 Chinese -

Choctaw -(Chahta) anumpa ya apela a chi I paya hinla 1-800-370-4526.

Cushite -Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-800-370-4526 irratti bilisaan bilbilaa.

Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-370-4526. Dutch -

Pour une assistance linguistique en français appeler le 1-800-370-4526 sans frais. French -

French Creole -Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-800-370-4526 gratis.

German -Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-370-4526 an.

Greek -Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-370-4526 γωρίς γρέωση.

ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-800-370-4526 પર કૉલ કરો. Gujarati -

Hawaiian -No ke kōkua ma ka 'ōlelo Hawai'i, e kahea aku i ka helu kelepona 1-800-370-4526. Kāki 'ole 'ia kēia kōkua nei. निदी में भाषा सहायता के लिए, पर मुफ्त कॉल करें।

Hindi - 1-800-370-4526

Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-800-370-4526.

lbo - Maka enyemaka asusu na Igbo kpoo 1-800-370-4526 na akwughi ugwo o bula

llocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-370-4526 nga awan ti bayadanyo.

Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-800-370-4526.

Japanese - 日本語で援助をご希望の方は、1-800-370-4526 まで無料でお電話ください。

Karen - လာတါ်မာစားတါကတိုးကျိုဉ်အင်္ဂါ ကျိုဉ် ကိုး 1-800-370-4526 လာတအိုဉ်ဒီးတါလာဝ်ဘူဉ်လာဝ်စွာဘဉ်

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

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

برای راهنمایی به زبان فارسی با شماره 4526-370-4520 به خورایی پهیومندی بکهن.

Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ1-800-370-4526 ໂດຍບໍ່ເສຍຄ່າໂທ.

Marathi - तीलभाषा (मराठी) सहाय्यासाठी 1-800-370-4526 क्रमांकावरकोणत्याहीखर्चाशिवायकॉलकरा.

Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-800-370-4526 ilo ejjelok wōnān.

Microne sian -

Pohnpeyan - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-800-682-9020 ni sohte isais.

Mon-Khmer. សម្រាប់ជំនួយភាសាជា ភាសាខុមរៃ សូមទូសេ័ពទទ**ៅកាន់លខេ 1-800-370-4526** ដ**ោយឥតគិត**ថ្**ល**។

Cambodian -

Navajo - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-800-370-4526

Nepali - (नेपाली) मा निःश्ल्क भाषा सहायता पाउनका लागि 1-800-370-4526 मा फोन गर्न्होस् ।

Nilotic-Dinka - Tën kupony ë thok ë Thuonjën col 1-800-370-4526 kecin ayöc.

Norwegian - For språkassistanse på norsk, ring 1-800-370-4526 kostnadsfritt.

Panjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-800-370-4526 'ਤੇ ਮਫ਼ਤ ਕਾਲ ਕਰੋ।

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

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

Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-800-370-4526.

Portuguese - Para obter assistência linguística em português ligue para o 1-800-370-4526 gratuitamente.

Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-800-370-4526

Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-800-370-4526.

Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-800-370-4526 e aunoa ma se totogi.

Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-800-370-4526.

Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-800-370-4526.

Sudanic-Fulfude - Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-800-370-4526. Njodi woo fawaaki on.

Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-800-370-4526 bila malipo.

Syriac - K - 32K K & D21 and 2 22 K wain or 24 ison 180-370-4526 april .

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

Telugu - భాషతో సాయం కొరకు ఎలాంటి ఖర్పు లేకుండా 1-800-370-4526 కు కాల్ చేయండి. (తెలుగు)

Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-800-370-4526 ฟรีไม่มีค่าใช้จ่าย

Tongan - Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-800-370-4526 'o 'ikai hā ōtōngi.

Trukese - Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-800-370-4526 nge esapw kamé ngonuk.

Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-800-370-4526.

Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-800-370-4526.

ا ری رک ل کتف م رب 1-800-370-4526 یک تن و اعمین الل رق م و در

Vietnamese - Đê 'được hố trợ ngôn ngư bằng (ngôn ngư), hấy gọi miến phi 'đên số '1-800-370-4526.

Yiddish- פאר שפראך הילף אין אידיש רופט 1-800-370-4526 פריי פון אפצאל.

Yoruba - Fún ìrànlowo nípa èdè (Yorùbá) pe 1-800-370-4526 lái san owó kankan rárá.