aetna : **AWH Southern CA HMO Gold CA $25/50 500**

Coverage Period: 01/01/2024 - 12/31/2024

Coverage for: Employee + Family | Plan Type: HMO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) 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, https://www.aetna.com/sbcsearch/getpolicydocs?u=082500-090020-172310 or by calling 1-866-529-2517. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-866-529-2517 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: Individual $500 / Family $1,000.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Certain office visits, preventive care, urgent care and prescription drugs in-network.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: Individual $8,200 / Family $16,400.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums and 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 http://www.aetna.com/docfind or call 1-866-529-2517 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out–of–Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit, deductible does not apply	Not covered	None
	Specialist visit	$50 copay/visit, deductible does not apply	Not covered	None
	Preventive care /screening /immunization	No charge	Not covered	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 you have a test	Diagnostic test (x-ray, blood work)	Lab: $25 copay/visit, deductible does not apply; X-ray: $60 copay/visit, deductible does not apply	Not covered	None
	Imaging (CT/PET scans, MRIs)	$300 copay/visit, deductible does not apply	Not covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://aet.na/casgppo24	Preferred/non-preferred generic drugs (Tier 1)	$15 copay/ prescription (retail), $30 copay/ prescription (mail order), deductible does not apply	Not covered	Covers up to a 30 day supply (retail prescription), 31-90 day supply (mail order prescription). Applicable cost share plus difference (brand minus generic cost) applies for brand when generic available. No charge for preferred generic FDA-approved women's contraceptives in-network. Maintenance drugs-after two retail fills, you are required to fill a 90-day supply at CVS Caremark® Mail Service Pharmacy or CVS Pharmacy.
	Preferred brand drugs (Tier 2)	$50 copay/ prescription (retail), $100 copay/ prescription (mail order), deductible does not apply	Not covered	
	Non-preferred brand drugs (Tier 3)	$80 copay/ prescription (retail), $160 copay/ prescription (mail order), deductible does not apply	Not covered	
	Preferred/non-preferred specialty drugs (Tier 4)	30% coinsurance up to a $250 maximum/ prescription for up to a 30 day supply, deductible does not apply	Not covered	All specialty prescription drug fills on initial fill must be filled at a network specialty pharmacy except for urgent situations. Your plan may include access to CVS retail pharmacies for certain specialty drugs.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out–of–Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	None
	Physician/surgeon fees	20% coinsurance	Not covered	None
If you need immediate medical attention	Emergency room care	$500 copay/visit	$500 copay/visit	Copay waived if admitted. No coverage for non-emergency care.
	Emergency medical transportation	$500 copay/trip	$500 copay/trip	Precertification is required for certain services.
	Urgent care	$50 copay/visit, deductible does not apply	Not covered	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	None
	Physician/surgeon fees	20% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Outpatient office visits: $25 copay/visit, deductible does not apply; All other outpatient services: 20% coinsurance	Not covered	None
	Inpatient services	20% coinsurance	Not covered	None
If you are pregnant	Office visits	No charge	Not covered	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% coinsurance	Not covered	
	Childbirth/delivery facility services	20% coinsurance	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out–of–Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	Coverage is limited to 100 visits per year.
	Rehabilitation services	$50 copay/visit, deductible does not apply	Not covered	None
	Habilitation services	$50 copay/visit, deductible does not apply	Not covered	None
	Skilled nursing care	20% coinsurance	Not covered	Coverage is limited to 100 days per benefit period.
	Durable medical equipment	20% coinsurance	Not covered	Coverage is limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	20% coinsurance	Not covered	None
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Coverage is limited to up to age 19.
	Children's glasses	No charge	Not covered	Coverage is limited to 1 pair of glasses (lenses and frames) or a one-year supply of contact lenses up to age 19.
	Children's dental check-up	0% coinsurance	Not covered	Coverage is limited to 2 prophylaxis (cleanings) and 2 fluoride applications a year up to age 19.

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)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- 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
- Bariatric surgery
- Chiropractic care - Coverage is limited to 20 visits.
- Infertility treatment - Benefit limitations may apply.

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: California Department of Managed Health Care, 1-888-466-2219 (toll-free), 1-877-688-9891 (TDD), http://www.dmhc.ca.gov.

- 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 www.dol.gov/ebsa/healthreform.

- For more information on your rights to continue coverage, contact the plan at 1-866-529-2517.
- For non-federal governmental group health plans, 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 plan, church plans 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 plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. 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 toll free number at 1-866-529-2517. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- California Department of Managed Health Care, 1-888-466-2219 (toll-free), 1-877-688-9891 (TDD), http://www.dmhc.ca.gov.
- For non-federal governmental group health plans, 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 appeal. Contact California Consumer Assistance Program, Operated by the California Department of Managed Health Care, 980 9th Street, Suite 500, Sacramento, CA 95814-2725, 1-888-466-2219 (toll-free), 1-877-688-9891 (TDD), Fax: 916-255-5241, http://www.dmhc.ca.gov, helpline@dmhc.ca.gov

Does this plan provide Minimum Essential Coverage? Yes.

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

Does this plan meet Minimum Value Standards? 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 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 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 plan's overall deductible	$500
Specialist copayment	$50
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	
Deductibles	$500
Copayments	$200
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,660**

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

The plan's overall deductible	$500
Specialist copayment	$50
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
Diabetic supplies *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$1,500
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 plan's overall deductible	$500
Specialist copayment	$50
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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,700**

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: 1-866-529-2517.

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 1-866-529-2517.

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 California and Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, ancestry, religion, sex, marital status, age, gender, gender identity, sexual orientation 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 race, color, national origin, ancestry, religion, sex, marital status, age, gender, gender identity, sexual orientation or disability, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator, Non-HMO,
P.O. Box 14462, Lexington, KY 40512,
1-800-648-7817, TTY: 711, Fax: 859-425-3379,
CRCoordinator@aetna.com.

Civil Rights Coordinator, HMO,
P.O. Box 24030, Fresno, CA 93779,
1-800-648-7817, TTY: 711, Fax: 860-262-7705,
CRCoordinator@aetna.com.

You can also file a complaint with the California Department of Insurance at www.insurance.ca.gov, or at: Consumer Services Division, 300 Spring Street South Tower, Los Angeles CA 90013, or at 1-800-927-HELP (4357), TDD: 1-800-482-4TDD (4833).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights if there is a concern of discrimination based on the federal protected classes which include race, color, national origin, age, disability, or sex. You can 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).

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TTY: 711

Language Assistance:

For language assistance in your language call 1-866-529-2517 at no cost.

Albanian -	Për shërbime përkthimi falas për ju, telefononi 1-866-529-2517.
Amharic -	የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-866-529-2517 ይደውሉ።
Arabic -	1-866-529-2517 للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم
Armenian -	Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-866-529-2517 հեռախոսահամարով:
Bahasa-Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-866-529-2517 tanpa dikenakan biaya.
Bantu-Kirundi -	Kugira uronke serivisi z’indimi atakiguzi, hamagara 1-866-529-2517.
Bengali-Bangala -	আপনাকে বিনামূকযে ভাষা পবকিষাি পপকে হকয এই নম্বকি পবেযক ান ্রেুন: 1−866−529−2517।
Bisayan-Visayan -	Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-866-529-2517.
Burmese -	သင့်အနေဖြင့် အခကြေးငွေ မပေးရပဲ ဘာသာစကားဝန်ဆောင်မှုများ ရရှိနိုင်ရန် 1-866-529-2517 သို့ ဖုန်းခေါ်ဆိုပါ။
Catalan -	Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-866-529-2517.
Chamorro -	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-866-529-2517.
Cherokee -	ᏩᎩᏍᏗ ᏚᏬᏂᎯᏍᏗ ᏅᏩᎾᏓᏛᏁᏗ Ꮭ ᎪᎱᏍᏗ ᏧᎬᏋᏩᏁᏗ ᏣᎩ, ᏫᏚᎯᏏᏔᏛᏏ 1-866-529-2517.
Chinese -	如欲使用免費語言服務，請致電 1-866-529-2517。
Choctaw -	Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-866-529-2517.
Cushite -	Tajaajiiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-866-529-2517.
Dutch -	Voor gratis toegang tot taaldiensten, bell 1-866-529-2517.
French -	Afin d'accéder aux services langagiers sans frais, composez le 1-866-529-2517.
French Creole -	Pou jwenn sèvis lang gratis, rele 1-866-529-2517.
German -	Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-866-529-2517 an.
Greek -	Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-866-529-2517.

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Gujarati -	તમારે કોઇ જાતના ખર્ચ વિના ભાષાની સેવાઓની પહોંચ માટે, કોલ કરો 1-866-529-2517.
Hawaiian -	No ka wala‘au ‘ana me ka lawelawe ‘ōlelo e kahea aku i kēia helu kelepona 1-866-529-2517 Kāki ‘ole ‘ia kēia kōkua nei.
Hindi -	आपके लिए बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, 1-866-529-2517 पर कॉल करें।
Hmong -	Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-866-529-2517.
Igbo -	Iji nwetaòhèrè na ọrụ gasị asụsụ n'efu, kpọọ 1-866-529-2517.
Ilocano -	Tapno maaksesyo dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti 1-866-529-2517.
Indonesian -	Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi 1-866-529-2517.
Italian -	Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-866-529-2517.
Japanese -	言語サービスを無料でご利用いただくには、1-866-529-2517 までお電話ください
Karen -	လၢတၢ်ကမၤန့ၢ်ကျိာ်အတၢ်မၤစၢၤအတၢ်ဖံးတၢ်မၤတဖၣ်လၢတအိၣ်ဒီးအပှၤလၢကဘၣ်ဟ့ၣ်အီၤအဂီၢ်ဘၣ်န့ၣ် ကိး 1-866-529-2517 တက့ၢ်.
Korean -	무료 언어 서비스를 이용하려면 1-866-529-2517 번으로 전화해 주십시오.
Kru-Bassa -	M̀ dyi wuɖu-dù kà kò ɖò ɓě dyi mɔ́uń nì Pídyi ní, nìí, ɖá nɔ̀ɓà nìà kɛ: 1-866-529-2517.
Kurdish -	بۆ دەسپێڕاگەيشتن بە خزمەتگوزاری زمان بەبێ تێچوون بۆ تۆ، پەیوەندی بکە بە ژمارەی 1-866-529-2517
Laotian -	ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ 1-866-529-2517.
Marathi -	कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी 1-866-529-2517 वर फोन करा.
Marshallese -	Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlok 1-866-529-2517.
Micronesian Pohnpeyan -	Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1-866-529-2517.
Mon-Khmer Cambodian -	ដើម្បីទទួលបានសេវាកម្មភាសាដោយឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមទូរស័ព្ទទៅកាន់លេខ 1-866-529-2517។.
Navajo -	T'áá ni nizaad k'ehjí bee níká a'doowol doo bą́ą́h ílínígóó kojį' hólne' 1-866-529-2517.
Nepali -	निःशुल्क भाषा सेवा प्राप्त गनन 1-866-529-2517 मा टेलिफोन गनुनहोस् ।
Nilotic-Dinka -	Të kɔɔr yïn wëër de thokic ke cïn wëu kɔr keek tënɔŋ yïn. Ke cɔl kɔc ye kɔc kuɔny ne nɔmba 1-866-529-2517.
Norwegian -	For tilgang til kostnadsfri språktjenester, ring 1-866-529-2517.

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Pennsylvania Dutch - Um Schprooch Services zu griege mitaus Koscht, ruff 1-866-529-2517.

Persian - برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-866-529-2517 تماس بگیرید

Polish - Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-866-529-2517.

Portuguese - Para acessar os serviços de idiomas sem custo para você, ligue para 1-866-529-2517.

Punjabi - ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1-866-529-2517 'ਤੇ ਫ਼ੋਨ ਕਰੋ।

Romanian - Pentru a accesa gratuit serviciile de limbă, apelați 1-866-529-2517.

Russian - Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-866-529-2517.

Samoan - Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala’au le 1-866-529-2517.

Serbo-Croatian - Za besplatne prevodilačke usluge pozovite 1-866-529-2517.

Spanish - Para acceder a los servicios de idiomas sin costo, llame al 1-866-529-2517.

Sudanic-Fulfulde - Heeba a nasta jangirde djey wolde wola chede bo apelou lamba 1-866-529-2517.

Swahili - Kupata huduma za lugha bila malipo kwako, piga 1-866-529-2517.

Syriac - ܐܢܬ، ܡܨܝܬܘܢ ܐܡ ܠܝ ܠ ܐ ܒܠܫܢ ܬܪ، ܬܐ ܕܗ ܠܝܫܠ ܡ ܐ ܬܘܗ ܠ ܒܝ ܐ ܦܡ ܡܘ : ܠ 1-866-529-2517 .

Tagalog - Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-866-529-2517.

Telugu - మీరు భాష సేవలను ఉచితంగా అందుకునేందుకు, 1-866-529-2517 కు కాల్ చేయండి.

Thai - หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-866-529-2517.

Tongan - Kapau ‘oku ke fiema’u ta’etōtōngi ‘a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he 1-866-529-2517.

Trukese - Ren omw kopwe angei aninisin eman chon awewei (ese kamo), kopwe kori 1-866-529-2517.

Turkish - Sizin için ücretsiz dil hizmetlerine erişebilmek için, 1-866-529-2517 numarayı arayın.

Ukrainian - Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-866-529-2517.

Urdu - بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے 1-866-529-2517 پر بات کریں۔

Vietnamese - Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-866-529-2517.

Yiddish - צו צוטריט ךארפש באַדינונגען אין קיין פרייַז צו איר, רופן 1-866-529-2517

Yoruba - Lati wọnú awọn isẹ èdè l’ọfẹ fun ọ, pe 1-866-529-2517.

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