

THE DOW CHEMICAL COMPANY : Aetna Choice® POS II - Low Deductible Medical Plan - In Area

Coverage for: EE+ 1 | Plan Type: POS

Coverage Period: 01/01/2023-12/31/2023



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 1-888-982-3862. 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 1-888-982-3862 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network (INN): EE+ 1 Dependent (DEP): Individual (IND) \$125/ Family (FAM) \$250. Out-of-Network (OON): EE+ 1 DEP: IND \$500/ FAM \$1,000.	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. <u>Preventive care;</u> plus INN office visits are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other <u>deductibles</u> for specific services?	Yes. Pharmacy EE only \$100; EE +1 \$200; (Not combined with Medical)	Separate pharmacy deductible is required for prescriptions. Excludes mail claims. A copayment or coinsurance may also apply.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	INN: EO 4% of Annual (ANN) Salary \$9,100 Max; EE+ FAM: IND 4% of ANN Salary \$9,100 Max/FAM 8% of ANN Salary \$18,200 Max. OON: EO 8% of ANN Salary; EE+ FAM: IND 8% of ANN Salary/FAM 12% of ANN Salary.	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. Includes prescription drugs.
What is not included in the out-of-pocket limit?	<u>Premium</u> s, balance-billing 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 www.aetna.com/docfind or call 1-888-982-3862 for a list of Dow Family Health Center providers.	You pay the least if you use a <u>provider</u> in Dow Family Health Center. You pay more if you use a <u>provider</u> in In- <u>Network Provider</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider</u> 's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.

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Important Questions	Answers	Why This Matters:
Do you need a <u>referral</u> to see a <u>specialist?</u>	No.	You can see the specialist you choose without a referral.

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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	Dow Family Health Center (You will pay the least)	In-Network Provider (You will pay more)	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	\$10 copay/visit, deductible doesn't apply; no charge for office laboratory	\$20 copay/visit, deductible doesn't apply; no charge for office laboratory; 15% coinsurance for all other services	30% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$10 copay/visit, deductible doesn't apply; no charge for office laboratory	\$50 copay/visit, deductible doesn't apply; no charge for office laboratory; 15% coinsurance for all other services	30% <u>coinsurance</u>	None
	Preventive care /screening /immunization	No charge	No charge	No charge	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	<u>Diagnostic test</u> (x-ray, blood work)	No charge for laboratory; \$10 copay/visit for x-ray, deductible doesn't apply	No charge for laboratory; 15% coinsurance for x-ray	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	Not applicable	15% <u>coinsurance</u>	30% coinsurance	None
If you need drugs to treat your illness or condition	Generic drugs	\$2 (bypasses deductible)	20% coinsurance	20% via Paper Claims	Prescription drugs are subject to a Deductible EE only \$100; EE + 1 \$200; (Not combined with Medical) Excludes Mail Claims

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			What You Will Pay		
Common Medical Event	Services You May Need	Dow Family Health Center (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
More information about prescription drug coverage is available at www.caremark.com	Preferred brand drugs	\$2 (bypasses deductible)	20% coinsurance	20% via Paper Claims	Prescription drugs are subject to a Deductible EE only \$100; EE + 1 \$200; (Not combined with Medical) Excludes Mail Claims
	Non-preferred brand drugs	\$2 (bypasses deductible)	30% coinsurance	30% via Paper Claims	Prescription drugs are subject to a Deductible EE only \$100; EE + 1 \$200; (Not combined with Medical) Excludes Mail Claims. Brand penalty when Non-Preferred brand filled over generic Plus brand coinsurance.
	Specialty drugs	Not covered	20% coinsurance Max \$200	20% via Paper Claims	Must fill through CVS Specialty Pharmacy
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not applicable	15% <u>coinsurance</u>	30% coinsurance	None
outpatient surgery	Physician/surgeon fees	Not applicable	15% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	Not applicable	15% <u>coinsurance</u> after \$100 <u>copay</u> /visit	15% <u>coinsurance</u> after \$100 <u>copay</u> /visit	Out-of-network emergency use paid the same as in-network. 30% coinsurance after \$100 copay/visit for non-emergency use out-of-network.
	Emergency medical transportation	Not applicable	15% <u>coinsurance</u>	15% <u>coinsurance</u>	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> . Non-emergency transport: not covered, except 30% <u>coinsurance</u> if preauthorized.
	<u>Urgent care</u>	Not applicable	\$20 <u>copay</u> /visit, after <u>deductible</u>	30% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Not applicable	15% <u>coinsurance</u> after \$250 <u>copay</u> /stay	30% coinsurance	Max <u>copay</u> /calendar year: \$500. Penalty of 20% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care.
	Physician/surgeon fees	Not applicable	15% <u>coinsurance</u>	30% coinsurance	None

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		What You Will Pay			
Common Medical Event	Services You May Need	Dow Family Health Center (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not applicable	Office: \$20 copay/visit, deductible doesn't apply; other outpatient services: 15% coinsurance	Office & other outpatient services: 30% coinsurance	None
	Inpatient services	Not applicable	15% <u>coinsurance</u> after \$250 <u>copay</u> /stay	30% coinsurance	Max <u>copay</u> /calendar year: \$500. Penalty of 20% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care.
	Office visits	Not applicable	No charge	No charge	Cost sharing does not apply for
	Childbirth/delivery professional services	Not applicable	15% <u>coinsurance</u>	30% coinsurance	preventive services. Maternity care may include tests and services
If you are pregnant	Childbirth/delivery facility services	Not applicable	15% coinsurance after \$250 copay/stay; deductible waived for newborn hospital expenses	30% <u>coinsurance;</u> <u>deductible</u> waived for newborn hospital expenses	described elsewhere in the SBC (i.e. ultrasound.) Max <u>copay</u> /calendar year: \$500. Penalty of 20% of <u>allowed amount</u> for failure to obtain <u>preauthorization</u> for out-of-network care may apply.
	Home health care	Not applicable	15% coinsurance	30% coinsurance	Penalty of 20% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care.
If you need help recovering or have other special health needs	Rehabilitation services	\$10 copay/visit, deductible doesn't apply; Occupational & Speech Therapy not applicable	15% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Habilitation services	\$10 copay/visit, deductible doesn't apply; Occupational & Speech Therapy not applicable	15% <u>coinsurance</u>	30% <u>coinsurance</u>	None

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			What You Will Pay		
Common Medical Event	Services You May Need	Dow Family Health Center (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Skilled nursing care	Not applicable	15% <u>coinsurance</u> after \$250 <u>copay</u> /stay	30% <u>coinsurance</u>	180 days/calendar year for out-of- network care. Max <u>copay</u> /calendar year: \$500. Penalty of 20% of <u>allowed</u> <u>amount</u> for failure to obtain <u>pre-</u> <u>authorization</u> for out-of-network care.
	Durable medical equipment	\$10 <u>copay</u> /visit, <u>deductible</u> doesn't apply	15% <u>coinsurance</u>	30% coinsurance	Limited to 1 <u>durable medical</u> <u>equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	Not applicable	No charge	No charge	Penalty of 20% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care.
If your shild poods	Children's eye exam	Not applicable	No charge	No charge	1 routine eye exam/calendar year.
If your child needs dental or eye care	Children's glasses	Not applicable	Not covered	Not covered	Not covered.
defital of cyc care	Children's dental check-up	Not applicable	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

- Routine foot care
- Weight loss programs Except for required <u>preventive</u> <u>services</u>.

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

- Bariatric surgery Travel and Lodging limited to \$10,000 maximum for Institutes of Quality contracted facility.
- Chiropractic care 30 visits/calendar year.
- Hearing aids \$3,000 maximum/36 months.
- Infertility treatment For more information & exceptions, see policy document provided by your employer or call the number on your ID card.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing 120-8 hour shifts/calendar year.
- Routine eye care (Adult) 1 routine eye exam/calendar year.

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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 1-888-982-3862.
- 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 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 number at 1-888-982-3862. 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 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? No.

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

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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>	\$125
■ Specialist copayment	\$10
■ Hospital (facility) coinsurance	15%
■ Other coinsurance	15%

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:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$20
Coinsurance	\$1,500
What isn't covered	
Limits or exclusions	\$70
The total Peg would pay is	\$1,690

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>	\$125
■ Specialist copayment	\$10
■ Hospital (facility) coinsurance	15%
Other coinsurance	15%

This EXAMPLE event includes services like:

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

Diagnostic tests (blood work)

Prescription drugs

Durable medical equipment (glucose meter)

Total Example Cost	\$5,600
In this example, Joe would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$100
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$4,300
The total Joe would pay is	\$4,400

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$125
Specialist copayment	\$10
■ Hospital (facility) coinsurance	15%
■ Other coinsurance	15%

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:		
<u>Cost Sharing</u>		
<u>Deductibles</u>	\$100	
<u>Copayments</u>	\$50	
<u>Coinsurance</u>	\$300	
What isn't covered		
Limits or exclusions	\$10	
The total Mia would pay is	\$460	

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 866-393-0002.

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:

For language assistance in your language call 1-888-982-3862 at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-888-982-3862.

Amharic - ለቋንቋ እንዛ በ አማርኛ በ 1-888-982-3862 በነጻ ይደውሉ

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-888-982-3862 الرجاء الاتصال على الرقم المجاني

Armenian - Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-888-982-3862 առանց գնով։

Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-982-3862 tanpa dikenakan biaya.

Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-888-982-3862 ku busa

Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-888-982-3862-তে কল করুন।

Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-888-982-3862 nga walay bayad.

Burmese - ငွေကုန်ကျစံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-888-982-3862 ကို ခေါ် ဆိုပါ။

Catalan - Per rebre assistència en (català), truqui al número gratuït 1-888-982-3862.

Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-888-982-3862 sin gåstu.

Cherokee - $\theta \circ DY \theta \circ SOh \mathcal{A} \circ J A h \circ DS P \circ DY \theta \circ T (GWY) \circ DSWO^2 is 1-888-982-3862 O' \theta T C A F \circ DJ DEGPJ H PRO.$

Chinese - 欲取得繁體中文語言協助, 請撥打1-888-982-3862, 無需付費。

Choctaw - (Chahta) anumpa ya apela a chi I paya hinla 1-888-982-3862.

Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-888-982-3862 irratti bilisaan bilbilaa.

Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-888-982-3862.

French - Pour une assistance linguistique en français appeler le 1-888-982-3862 sans frais.

French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-888-982-3862 gratis.

German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-888-982-3862 an.

Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-888-982-3862 χωρίς χρέωση.

Gujarati - ગુજરાતીમાં ભાષામાં સહ્ય માટે કોઈ પણ ખર્ચ વગર 1-888-982-3862 પર કૉલ કરો.

Hawaiian - No ke kōkua ma ka 'ōlelo Hawai'i, e kahea aku i ka helu kelepona 1-888-982-3862. Kāki 'ole 'ia kēia kōkua nei.

General Business

Hindi - हिन्दी में भाषा सहायता के लिए, 1-888-982-3862 पर मुफ्त कॉल करें।

Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-888-982-3862.

lbo - Maka enyemaka asusu na Igbo kpoo 1-888-982-3862 na akwughi ugwo o bula

llocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-888-982-3862 nga awan ti bayadanyo.

Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-888-982-3862.

Japanese - 日本語で援助をご希望の方は、1-888-982-3862 まで無料でお電話ください。

Karen - လာတာမ်ာစားတာကတိုးကျိုဘ်အင်္ဂါ ကျိုဉ် ကို 888-982-3862 လာတအို ၁ ဒီးတာလာဘ်ဘူဉ်လာဘ်စားဘဉ်

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

Kru-Bassa - Bɛ´m`ké gbo-kpá-kpá dyé pidyi dé Bašsɔɔ́-wuduùň wɛ̃ɛ, dá 1-888-982-3862

برای راهنمایی به زبان فارسی با شماره 3862-982-988-1 به خورایی پهیوهندی بکهن.

Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລນາໂທຫາ-888-982-3862 ໂດຍບໍ່ເສຍຄ່າໂທ.

Marathi - कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-888-982-3862 वर फोन करा.

Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-888-982-3862 ilo ejjelok wōnān.

Micronesian-

Pohnpeyan - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-888-982-3862 ni sohte isais.

Mon-Khmer, សមរាប់ជំនួយភាសាជា ភាសាខមរៃ សូមទូសេ័ពទទ**ៅកាន់លខេ 1-888-982-3862** ដ**ោយឥតគិតថ្**លេំ។

Cambodian -

Navajo - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-888-982-3862

Nepali - (नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-888-982-3862 मा फोन गर्नुहोस् ।

Nilotic-Dinka - Tën kupony ë thok ë Thuonjan col 1-888-982-3862 kecin ayöc.

Norwegian - For språkassistanse på norsk, ring 1-888-982-3862 kostnadsfritt.

Panjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-888-982-3862 'ਤੇ ਮਫ਼ਤ ਕਾਲ ਕਰੋ।

Pennsylvania Dutch - Fer Helfe in Deitsch, ruf: 1-888-982-3862 aa. Es Aaruf koschtet nix.

برای راهنمایی به زبان فارسی با شماره 3862-982-1888 بدون هیچ هزینه ای تماس بگیرید. انگلیسی Persian -

Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-888-982-3862.

Portuguese - Para obter assistência linguística em português ligue para o 1-888-982-3862 gratuitamente.

Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-888-982-3862

General Business

Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-888-982-3862.

Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-888-982-3862 e aunoa ma se totogi.

Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-888-982-3862.

Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-888-982-3862.

Sudanic-Fulfude - Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-888-982-3862. Njodi woo fawaaki on.

Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-888-982-3862 bila malipo.

Syriac - K - 32 K K & D241 abk 3/22 K wain or Ly ippk 161,20 1-888-982-3862 ap

Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-888-982-3862 nang walang bayad.

Telugu - భాషతో సాయం కొరకు ఎలాంటి ఖర్పు లేకుండా 1-888-982-3862 కు కాల్ చేయండి. (తెలుగు)

Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-888-982-3862 ฟรีไม่มีค่าใช้จ่าย

Tongan - Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-888-982-3862 'o 'ikai hā ōtōngi.

Trukese - Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-888-982-3862 nge esapw kamé ngonuk.

Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-888-982-3862.

Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-888-982-3862.

بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 2862-982-1862 . پر بات کریں۔

Vietnamese - Đê 'được hố trở ngôn ngư bằng (ngôn ngư), hấy gọi miến phi 'đên số 1-888-982-3862.

Yiddish - פאר שפראך הילף אין אידיש רופט 1-888-982-3862 פריי פון אפצאל.

Yoruba - Fún ìrànlowo nípa èdè (Yorùbá) pe 1-888-982-3862 lái san owó kankan rárá.