Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

aetna® DELAWARE VALLEY HEALTH TRUST: Open Choice® - City of Milford
PPO $20/$30 with RX $10/$32/$60

Coverage Period: 07/01/2025-06/30/2026

Coverage for: Individual + Family | Plan Type: PPO

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, www.HealthReformPlanSBC.com or by calling 1-833-821-0849. 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 1-833-821-0849 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network(INN): None. Out-of- Network (OON): IND $300/FAM $600.	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
Are there services covered before you meet your deductible?	Yes. Emergency care is covered before you meet your deductible.	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?	INN Medical: IND $4,500/FAM $9,000. INN Prescription (RX) drugs: IND $2,100/FAM $4,200. OON: IND $7,500/FAM $15,000.	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, balance billing charges, health care this plan does not cover, coinsurance on certain services, & penalties for failure to obtain preauthorization.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind or call 1-833-821-0849 for a list of INN 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?	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.

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	$20 copay/visit; no charge for office surgery	20% coinsurance	None
	Specialist visit	$30 copay/visit; no charge for office surgery	20% coinsurance	None
	Preventive care /screening /immunization	No charge	20% coinsurance	Age and frequency limits may apply. 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)	X-ray: $50 copay/visit for hospital facility & No charge for freestanding facility; Laboratory: $50 copay/visit except $10 copay/visit for freestanding facility	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	$100 copay/visit for hospital; No charge for non-hospital freestanding facility	20% coinsurance	None

If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetnapharmacy.com Aetna Standard Plan Formulary	Generic drugs	$10 copay/prescription for 30-day supply (retail or mail order); $20 copay/prescription for 90-day supply (participating retail or mail order)	20% coinsurance after copay/prescription, deductible doesn't apply: $10 (retail)	Up to 30-day fills at retail or mail order for non-maintenance drugs; 90-day fills for maintenance drugs available at participating pharmacies or mail order only, maintenance drugs filled as 30-day supply incur penalty at fourth fill; under Choice Program, you pay applicable copay plus difference between generic and brand when preferred generic equivalent is available. Includes contraceptive drugs & devices obtainable from a pharmacy, oral fertility drugs. Qualified members ages 40 - 75 receive generic low to moderate dose statins at no cost. No charge for preferred generic FDA-approved women's contraceptives in-network.
	Preferred brand drugs	$32 copay/prescription for 30-day supply (retail or mail order); $64 copay/prescription for 90-day supply (participating retail or mail order)	20% coinsurance after copay/prescription, deductible doesn't apply: $32 (retail)	

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)	
	Non-preferred brand drugs	$60 copay/prescription for 30-day supply (retail or mail order); $120 copay/prescription for 90-day supply (participating retail or mail order)	20% coinsurance after copay/prescription, deductible doesn't apply: $60 (retail)	
	Specialty drugs	No charge if enrolled in the PrudentRx program; 30% coinsurance if not enrolled in the PrudentRx program	Not covered	Specialty drugs must be filled by CVS Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 copay/visit for hospital facility; except $50 copay/visit for freestanding facility	20% coinsurance	Preauthorization is required for certain outpatient surgical procedures and other outpatient services. If you don't get preauthorization, benefits will be denied.
	Physician/surgeon fees	No charge	20% coinsurance	Preauthorization is required for certain outpatient surgical procedures and other outpatient services. If you don't get preauthorization, benefits will be denied.
If you need immediate medical attention	Emergency room care	$200 copay/visit	$200 copay/visit	Out-of-network emergency use paid the same as in-network. No coverage for non-emergency use, except for certain services. Refer to plan document for coverage details of non-emergency use.

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)	
	Emergency medical transportation	No charge	No charge	Out-of-network emergency use paid the same as in-network. Non-emergency transport: not covered.
	Urgent care	$20 copay/visit	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copay per day, maximum 2 copays per admission	20% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits will be denied.
	Physician/surgeon fees	No charge	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: $20 copay/visit	Office & other outpatient services: 20% coinsurance	None
	Inpatient services	$100 copay per day, maximum 2 copays per admission	20% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits will be denied.
If you are pregnant	Office visits	No charge; except applicable office visit copay for initial visit to confirm pregnancy	20% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Preauthorization is required. If you don't get preauthorization, benefits will be denied. Initial visit to diagnose pregnancy will have member cost share based on where services are rendered.
	Childbirth/delivery professional services	No charge	20% coinsurance	
	Childbirth/delivery facility services	$100 copay per day, maximum 2 copays per admission	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	240 visits/plan year combined with private-duty nursing. Preauthorization is required. If you don't get preauthorization, benefits will be denied.
	Rehabilitation services	15% coinsurance	20% coinsurance	Coverage for Outpatient Physical, Occupational, and Speech Therapy subject to medical necessity review at 25 visits. Preauthorization is required. If you don't get preauthorization, benefits will be denied. No medical necessity review for Physical, Occupational and Speech Therapy for mental health/substance abuse disorder diagnosis.

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)	
	Habilitation services	No charge	20% coinsurance	None.
	Skilled nursing care	No charge	20% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits will be denied.
	Durable medical equipment	No charge	20% coinsurance	None.
	Hospice services	No charge	20% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits will be denied.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered.	Not covered.
	Children's glasses	Not covered	Not covered	Not covered.
	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)
- Glasses (Adult & Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult & Child)
- Routine foot care

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

- Acupuncture - 10 visits/year for disease, injury & chronic pain.
- Bariatric surgery
- Chiropractic care
- Hearing aids - 1 hearing aid per ear/3 years for children up to age 24.
- Infertility treatment - For more information & exceptions, see policy document provided by your employer or call the number on your ID card.
- Private-duty nursing - 240 visits per year, combined with home health care; 8 hours equals one shift; preauthorization required.

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 1-833-821-0849.
- 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 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 number at 1-833-821-0849. 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 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 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? **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** **$0**
- **Specialist copayment** **$30**
- **Hospital (facility) copayment** **$100**
- **Other copayment** **$0**

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	$0
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$760**

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$30**
- **Hospital (facility) copayment** **$100**
- **Other copayment** **$0**

This EXAMPLE event includes services like:
Primary care provider 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	$1300
Coinsurance	$0
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 plan's overall deductible** **$0**
- **Specialist copayment** **$30**
- **Hospital (facility) copayment** **$100**
- **Other copayment** **$0**

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	$0
Copayments	$400
Coinsurance	$50
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$450**

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 1-833-821-0849.

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).

TTY: 711

Language Assistance:

To access language services at no cost to you, call 1-833-821-0849.

Albanian -	Për shërbime përkthimi falas për ju, telefononi 1-833-821-0849.
Amharic -	የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-833-821-0849 ይደውሉ።
Arabic -	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء االتصال على الرقم 1-833-821-0849
Armenian -	Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-833-821-0849 հեռախոսահամարով:
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-833-821-0849 tanpa dikenakan biaya.
Bantu-Kirundi -	Kugira uronke serivisi z'indimi atakiguzi, hamagara 1-833-821-0849.
Bengali-Bangala -	আপনাের িবনামূেকয ভাষা পিবকিষা পপেক হকয এই ন িক েপবযক ান েরু傳ন: 1-833-821-0849 ।
Bisayan-Visayan -	Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-833-821-0849.
Burmese -	သင့္ေအျဖင့္ အေခၚကားေြင ေမပးရပဲ ဘာသာစကားဝန္ေဆာင&#xFFFD;းမ်ား ရရွိႏုိင&#xFFFD;နဲ 1-833-821-0849 သုိ၀
ဖုန္းေခၚဆုိပါ။ Catalan -	Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-833-821-0849.
Chamorro -	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-833-821-0849.
Cherokee -	ᏩᎩᏯᏗ ᏚᎾᏂᎯᏯᏗ ᎤᏣᎾᏓᏁᏗ ᏧᎪᏯᏗ ᏗᏣᎬᏩᎳᏁᏗ ᎯᎩ, ᎾᏍᎯᏰᎳᏅᏎ 1-833-821-0849.
Chinese -	如欲使用免費語言服務，請致電 1-833-821-0849.
Choctaw -	Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-833-821-0849.
Cushite -	Tajaajiiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-833-821-0849.
Dutch -	Voor gratis toegang tot taaldiensten, bell 1-833-821-0849.
French -	Afin d'accéder aux services langagiers sans frais, composez le 1-833-821-0849.
French Creole -	Pou jwenn sèvis lang gratis, rele 1-833-821-0849.
German -	Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-833-821-0849 an.
Greek -	Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-833-821-0849.
Gujarati -	તમારેકોઇ &#xFFFD;ના ખચર્િવના ભાષાની સેિ◌◌ાઓની પહોંચ માટે, કોલ કરો1-833-821-0849.

Hawaiian -	No ka wala‘au ‘ana me ka lawelawe ‘ōlelo e kahea aku i kēia helu kelepona 1-833-821-0849. Kāki ‘ole ‘ia kēia kōkua nei.
Hindi -	आपके लए बना ककसी क मत केभाषा सेवाओंका उपयोग करनेके लए,1-833-821-0849 पर कॉल करें।
Hmong -	Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-833-821-0849.
Igbo -	Iji nwetaòhèrè na ọrụ gasị asụsụ n'efu, kpọọ 1-833-821-0849
Ilocano -	Tapno maaksesyo dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti 1-833-821-0849.
Indonesian -	Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi 1-833-821-0849.
Italian -	Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-833-821-0849.
Japanese -	言語サービスを無料でご利用いただくには、1-833-821-0849　までお電話ください。
Karen -	လၢတၢ်ကမၤနှၢ်ကျိဉ်အတၢ်မၤစၢၤအတၢ်ဖံးတၢ်မၤတဖဉ်လၢတအိဉ်ဒီးအပှၤလၢကဘဉ်ဟ့ဉ်အီၤအဂီၢ်ဘဉ်နှဉ် ကိး 1-833-821-0849 တက့ၢ်.
Korean -	무료 언어 서비스를 이용하려면 1-833-821-0849 번으로 전화해 주십시오.
Kru-Bassa -	M̀ dyi wuɖu-dù kà kò ɖò ɓě dyi mɔú ń nì Pídyi ní, nìí, ɖá nɔ̀ɓà nìà kɛ: 1-833-821-0849
Kurdish -	بۆ دەستپێڕاگەیشتن بە خزمەتگوزاری زمان بەبێ تێچوون بۆ تۆ، پەیوەندی بکە بە ژمارەی 1-833-821-0849
Laotian -	ເພືອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕ່ໍກັບທ່ານ, ໃຫ ້ໂທຫາເບີ 1-833-821-0849
Marathi -	कोणत्याह शल्ुकालशवाय भाषा सेवा प्राप्त करण्यासाठ, 1-833-821-0849 वर फोन करा.
Marshallese -	Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlok 1-833-821-0849.
Micronesian-Pohnpeyan -	Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1-833-821-0849.
Mon-Khmer, Cambodian -	េដើម្បីទទួលបាកេនសវកម្មកា ·សា ែដលឥតគិតៃថ្លស្រមា ·ប់ េលាÃកអ្នក សូមេទូរស័ព្ទកា ·ន់ េលខ 1-833-821-0849 ។
Navajo -	T’áá ni nizaad k’ehjí bee níká a’doowoł doo bą́ąh ílínígóó kojį’ hólne’ 1-833-821-0849.
Nepali -	नःशुल्क भाषा सेवा प्राप्त गनर् 1-833-821-0849 मा टेलफोन गनुर्होस् ।
Nilotic-Dinka -	Të kɔɔr yïn wɛëï de thokic ke cïn wëu kɔr keek tënɔŋ yïn. Ke cɔl kɔc ye kɔc kuɔny ne nɔmba 1-833-821-0849.
Norwegian -	For tilgang til kostnadsfri språktjenester, ring 1-833-821-0849.
Pennsylvania Dutch -	Um Schprooch Services zu griege mitaus Koscht, ruff 1-833-821-0849.
Persian -	برای دسترس به خدمات زبان به طور رایگان، با شماره 1-833-821-0849 تماس بگیرید .
Polish -	Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-833-821-0849.
Portuguese -	Para acessar os serviços de idiomas sem custo para você, ligue para 1-833-821-0849.

Punjabi - ਤੁਹਾਡੇ ਲਈ ਿਬਨ◆ਿਕਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵ◆ਦੀ ਵਰਤ◆ਕਰਨ ਲਈ, 1-833-821-0849 ‘ਤੇ ਫ਼ੋਨ ਕਰੋ।

Romanian - Pentru a accesa gratuit serviciile de limbă, apelați 1-833-821-0849.

Russian - Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-833-821-0849.

Samoan - Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, valaʼau le 1-833-821-0849.

Serbo-Croatian - Za besplatne prevodilačke usluge pozovite 1-833-821-0849.

Spanish - Para acceder a los servicios de idiomas sin costo, llame al 1-833-821-0849.

Sudanic-Fulfude - Heeba a nasta jangirde djey wolde wola chede bo apelou lamba 1-833-821-0849.

Swahili - Kupata huduma za lugha bila malipo kwako, piga 1-833-821-0849.

Syriac - ،ܠܗܝܢ ܕܡܬܚܫܒ ܠܟ ܕܬܩܒܠ ܫܘܬܦ ܠܐ ܒܠܫܢܐ ܕܠܟ ܒܠܚܘܕ ܠܐ ܥܠ ܐܢ ܕܬܨܠ ܒ 1-833-821-0849

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Tagalog - Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-833-821-0849.

Telugu - ◆◆◆◆ ◆◆◆◆◆ ◆◆◆◆◆◆ ◆◆◆◆◆◆ ◆