



January 1, 2021

Changes coming to your plan's pharmacy drug lists

There will be changes to the **Aetna Premier Plan** drug list that applies to your plan starting on **January 1, 2021**. It's important that you review the changes in the chart below. Talk to your health care provider about how these changes might impact you.

What if I need a prescription drug that requires a medical exception?

You or your prescriber can request a medical exception to the changes in this letter. If you would like to ask for an exception, talk with your prescriber. Or, you can call us at the toll-free number on your Member ID card.

We'll contact you and your prescriber with our decision. If we approve your exception, you will pay your plan copay or cost-share. But first you must meet any deductible or out-of-pocket requirements of your pharmacy plan.

How to find a preferred medicine that's right for you

You can visit the website that's shown on your member ID card. Then log in to your account. To better understand how your plan's pharmacy benefits work, call us at the number on your member ID card.

UPPER CASE = brand-name medication

lower case = generic medication

If your plan doesn't have formulary exclusions, you will pay the non-preferred copay.

* Changes apply if your plan includes this program. Refer to your plan documents.

Prescription Drug	Change(s)
ABILIFY MAINTENA	Preferred brand drug
ABSORICA	Generic expected; Quantity limits removed
acetaminophen / codeine	You can fill up to 90ml/ day
ADDERALL TAB 10MG	You can fill up to 3/ day
ADDERALL TAB 12.5MG	You can fill up to 3/ day
ADDERALL TAB 15MG	You can fill up to 2/ day
ADDERALL TAB 20MG	You can fill up to 2/ day
ADDERALL TAB 30MG	You can fill up to 1/ day
ADDERALL TAB 5MG	You can fill up to 3/ day
ADDERALL TAB 7.5MG	You can fill up to 3/ day
ADDERALL XR CAP 10MG	Step therapy removed
ADDERALL XR CAP 15MG	Step therapy removed; You can fill up to 1/ day
ADDERALL XR CAP 20MG	Step therapy removed; You can fill up to 1/ day
ADDERALL XR CAP 25MG	Step therapy removed; You can fill up to 1/ day

Prescription Drug	Change(s)
ADDERALL XR CAP 30MG	Step therapy removed; You can fill up to 1/ day
ADDERALL XR CAP 5MG	Step therapy removed
ADHANSIA XR	Preauthorization removed; Step therapy removed
ALECENSA	Preferred specialty drug
ALUNBRIG	Preferred specialty drug
amnestem	Quantity limits removed
amphet / dextr cap 15mg er	You can fill up to 1/ day
amphet / dextr cap 20mg er	You can fill up to 1/ day
amphet / dextr cap 25mg er	You can fill up to 1/ day
amphet / dextr cap 30mg er	You can fill up to 1/ day
amphet / dextr tab 10mg	You can fill up to 3/ day
amphet / dextr tab 12.5mg	You can fill up to 3/ day
amphet / dextr tab 15mg	You can fill up to 2/ day
amphet / dextr tab 20mg	You can fill up to 2/ day
amphet / dextr tab 30mg	You can fill up to 1/ day
amphet / dextr tab 5mg	You can fill up to 3/ day
amphet / dextr tab 7.5mg	You can fill up to 3/ day
amphetamine tab 10mg	You can fill up to 3/ day
amphetamine tab 12.5mg	You can fill up to 3/ day
amphetamine tab 15mg	You can fill up to 2/ day
amphetamine tab 20mg	You can fill up to 2/ day
amphetamine tab 30mg	You can fill up to 1/ day
amphetamine tab 5mg	You can fill up to 3/ day
amphetamine tab 7.5mg	You can fill up to 3/ day
ANNOVERA	Preferred brand drug
APADAZ	You can fill up to 168/ month
APOKYN	Not covered for plans with Formulary Exclusions
ARALAST NP	Not covered for plans with Formulary Exclusions
ARISTADA	Preferred brand drug
atomoxetine	You can fill up to 1/ day
atropine sulfate	Not covered under pharmacy benefit
benzhydrocodone / acetaminophen	You can fill up to 168/ month
BENZIQ	Preferred brand drug
BENZIQ LS	Preferred brand drug
BIJUVA	Quantity limits removed
BREZTRI AEROSPHERE	Preferred brand drug; You can fill up to 1 inhaler/ month*
butalbital / aspirin / caffeine / codeine	You can fill up to 48/ month
CALCIUM-FOLIC ACID PLUS D	Not covered for plans with Formulary Exclusions

Prescription Drug	Change(s)
claravis	Quantity limits removed
CONCERTA TAB 36MG	You can fill up to 2/ day
CONCERTA TAB 54MG	You can fill up to 1/ day
CORVITE 150	Not covered for plans with Formulary Exclusions
CORVITE FE	Not covered for plans with Formulary Exclusions
cyclobenzaprine hcl	Not covered for plans with Formulary Exclusions
DEXEDRINE CAP 15MG CR	You can fill up to 2/ day
dexmethylphenidate hcl	You can fill up to 2/ day
dexmethylphenidate hcl er	Preauthorization removed; Step therapy removed; You can fill up to 1/ day
dextroamphet cap 15mg er	You can fill up to 2/ day
DIALYVITE	Not covered for plans with Formulary Exclusions
DOPTELET	Preferred specialty drug
dorzolamide hcl / timolol maleate	Preferred generic drug
DOVATO	You can fill up to 1/ day*
doxepin hydrochloride cream	You must first try 1 of betamethasone, clobetasol, fluocinolone, hydrocortisone AND 1 of tacrolimus, EUCRISA*
DUPIXENT	Preferred specialty drug
DUPIXENT INJ 200 / 1.14ML	Preferred specialty drug; You can fill up to 2 inj/ 14 days*
DUROLANE	Preferred specialty drug; Step therapy removed
ed-spaz	Preferred generic drug
ENBREL	You can fill up to 8 inj/ month*
ERIVEDGE	Preferred specialty drug
EVZIO	Step therapy removed; You can fill up to 2 cartons(4 auto-injectors)/ 180 days*
FINACEA	Preferred brand drug
FOCALIN	You can fill up to 2/ day
FOCALIN XR	You can fill up to 1/ day
folic acid	Preferred generic drug
GEL-ONE	Not covered for plans with Formulary Exclusions; Step therapy removed
GELSYN-3	Preferred specialty drug; Step therapy removed
GENVISC 850	You must first try 3 of GELSYN-3, SUPARTZ, EUFLEXXA, DUROLANE*
GLASSIA	Not covered for plans with Formulary Exclusions
glydo	You can fill up to 2 ml/ day*
GRASTEK	You must first try 1 oral antihistamine and 1 intranasal corticosteroid*
HOMATROPAIRE	Not covered under pharmacy benefit
homatropine hbr	Not covered under pharmacy benefit
HUMATROPE	Not covered for plans with Formulary Exclusions
HYALGAN	You must first try 3 of GELSYN-3, SUPARTZ, EUFLEXXA, DUROLANE*
hydrocodone / acetaminophen	You can fill up to 6/ day

Prescription Drug	Change(s)
hydrocodone bitartrate / acetaminophen	You can fill up to 90ml/ day
HYMOVIS	You must first try 3 of GELSYN-3, SUPARTZ, EUFLEXXA, DUROLANE*
hyoscyamine sulfate	Preferred generic drug
hyoscyamine sulfate er	Preferred generic drug
hyoscyamine sulfate odt	Preferred generic drug
hyoscyamine sulfate sr	Preferred generic drug
INBRIJA	Preferred specialty drug
isosorbide dinitrate	Not covered for plans with Formulary Exclusions
isotretinoin	Quantity limits removed
JORNAY PM	Step therapy removed
KESIMPTA	Preferred specialty drug
KYLEENA	Preferred brand drug
latanoprost	Preferred generic drug
lidocaine	Not covered for plans with Formulary Exclusions
lidocaine hcl	Preferred generic drug
lidocaine hcl gel 2%	You can fill up to 2 ml/ day*
LILETTA	Not covered for plans with Formulary Exclusions
LYUMJEV	Preferred brand drug; Step therapy removed
LYUMJEV KWIKPEN	Preferred brand drug; Step therapy removed
MAGNEBIND 400	Not covered for plans with Formulary Exclusions
meperidine hcl tab	You can fill up to 18/ month
meperidine sol 50mg / 5ml	You can fill up to 90ml/ month
mesalamine	Preferred generic drug
methadone con 10mg / ml	You can fill up to 1ml/ day
METHADOSE CON 10MG / ML	You can fill up to 1ml/ day
METHADOSE SUGAR-FREE	You can fill up to 1ml/ day
methylphenidate hcl tablet	You can fill up to 3/ day
methylphenidate hydrochloride er 36mg tab	You can fill up to 2/ day
methylphenidate hydrochloride er 54mg tab	You can fill up to 1/ day
MIRENA	Preferred brand drug
MONOVISC	Not covered for plans with Formulary Exclusions
MULPLETA	Preferred specialty drug
myorisan	Quantity limits removed
NEPHPLEX RX	Not covered for plans with Formulary Exclusions
NEULASTA / ONPRO	Not covered for plans with Formulary Exclusions; Quantity limits removed
NEXIUM 24HR	Generic expected
NEXLETOL	Preferred brand drug
NEXLIZET	Preferred brand drug

Prescription Drug	Change(s)
NIFEREX	Not covered for plans with Formulary Exclusions
NINLARO	Preferred specialty drug
NORDITROPIN FLEXPPO	Preferred specialty drug; Step therapy removed
NUCALA	Preferred specialty drug
NUCALA INJ 100MG / ML	Preferred specialty drug
NUFERA	Not covered for plans with Formulary Exclusions
nulev	Preferred generic drug
OCUVEL	Not covered for plans with Formulary Exclusions
ODACTRA	You must first try 1 oral antihistamine and 1 intranasal corticosteroid*
ODOMZO	Preferred specialty drug
omeprazole	Preferred generic drug; You can fill up to 90 caps/365 days*
omeprazole otc	You can fill up to 90 caps/365 days*
OMNIPOD	Preferred brand drug
ORALAIR	You must first try 1 oral antihistamine and 1 intranasal corticosteroid*
ORTHOVISC	Not covered for plans with Formulary Exclusions
oscimin	Preferred generic drug
oscimin sr	Preferred generic drug
OXAYDO	Non-preferred brand drug
PCP 100	Not covered under pharmacy benefit
PENNSAID	You must first try oral NSAID*
phenobarbital / belladonna alkaloids	Not covered under pharmacy benefit
PROLASTIN-C	Preferred specialty drug
PROMACTA TAB 12.5MG	You can fill up to 1/ day*
PROMACTA TAB 25MG	You can fill up to 1/ day*
PROMACTA TAB 50MG	You can fill up to 2/ day*
PROMACTA TAB 75MG	You can fill up to 2/ day*
RAGWITEK	You must first try 1 oral antihistamine and 1 intranasal corticosteroid*
ribavirin inh	Preferred generic drug
RISPERDAL CONSTA	Preferred brand drug
RITALIN	You can fill up to 3/ day
RYDAPT	Preferred specialty drug
SANCUSO	Preferred brand drug
SANDOSTATIN LAR DEPOT	Not covered for plans with Formulary Exclusions
SIGNIFOR LAR	Not covered for plans with Formulary Exclusions; Quantity limits removed
SKYLA	Preferred brand drug
SOMATULINE DEPOT	Preferred specialty drug; You can fill up to 1 inj/ month*
SOMAVERT	Not covered for plans with Formulary Exclusions
STRATTERA	You can fill up to 1/ day
SUPARTZ FX	Preferred specialty drug; Step therapy removed
symax-sl	Preferred generic drug

Prescription Drug	Change(s)
SYNVISC	You must first try 3 of GELSYN-3, SUPARTZ, EUFLEXXA, DUROLANE*
SYNVISC ONE	You must first try 3 of GELSYN-3, SUPARTZ, EUFLEXXA, DUROLANE*
tadalafil	Preferred generic drug; Preauthorization required*; You can fill up to 1/ day*
TECFIDERA	Not covered for plans with Formulary Exclusions; Quantity limits removed
TECFIDERA STARTER PACK	Not covered for plans with Formulary Exclusions; Quantity limits removed
TOUJEO MAX SOLOSTAR	Preferred brand drug; Step therapy removed
TOUJEO SOLOSTAR	Preferred brand drug; Step therapy removed
TRACLEER	Not covered for plans with Formulary Exclusions
tramadol hcl	You can fill up to 1/ day
tramadol hydrochloride / acetaminophen	You can fill up to 40/ month
TRIVISC	You must first try 3 of GELSYN-3, SUPARTZ, EUFLEXXA, DUROLANE*
TRUVADA	Preferred brand drug; If drug is covered by your plan, you will now pay a copay for this drug
UDENYCA	Not covered for plans with Formulary Exclusions; Quantity limits removed
ULTRACET	You can fill up to 40/ month
V-GO	Preferred brand drug
VARUBI	Preferred brand drug
virt-vite forte	Preferred generic drug
VISCO-3	Not covered for plans with Formulary Exclusions; Step therapy removed
VITAL-D RX	Not covered for plans with Formulary Exclusions
VYVANSE CAP 40MG	You can fill up to 1/ day
VYVANSE CAP 50MG	Preauthorization removed; You must first try 3 of generic amphetamine, amphetamine/dextroamphetamine, dexamethylphenidate, dextroamphetamine, methamphetamine, methylphenidate*; You can fill up to 1/ day
VYVANSE CAP 60MG	Preauthorization removed; You must first try 3 of generic amphetamine, amphetamine/dextroamphetamine, dexamethylphenidate, dextroamphetamine, methamphetamine, methylphenidate*; You can fill up to 1/ day
VYVANSE CAP 70MG	Preauthorization removed; You must first try 3 of generic amphetamine, amphetamine/dextroamphetamine, dexamethylphenidate, dextroamphetamine, methamphetamine, methylphenidate*; You can fill up to 1/ day
VYVANSE CHW 40MG	Preauthorization removed; You must first try 3 of generic amphetamine, amphetamine/dextroamphetamine, dexamethylphenidate, dextroamphetamine, methamphetamine, methylphenidate*; You can fill up to 1/ day

Prescription Drug	Change(s)
VYVANSE CHW 50MG	Preauthorization removed; You must first try 3 of generic amphetamine, amphetamine/dextroamphetamine, dexamethylphenidate, dextroamphetamine, methamphetamine, methylphenidate*; You can fill up to 1/ day
VYVANSE CHW 60MG	Preauthorization removed; You must first try 3 of generic amphetamine, amphetamine/dextroamphetamine, dexamethylphenidate, dextroamphetamine, methamphetamine, methylphenidate*; You can fill up to 1/ day
WESTAB MAX	Preferred generic drug
XOSPATA	Preferred specialty drug
XTAMPZA ER	Preferred brand drug; Step therapy removed
ZEMAIRA	Not covered for plans with Formulary Exclusions
zenatane	Quantity limits removed
ZENZEDI TAB 15MG	Step therapy removed; You can fill up to 2/ day
ZENZEDI TAB 20MG	Step therapy removed; You can fill up to 2/ day
ZENZEDI TAB 30MG	Step therapy removed; You can fill up to 1/ day
ZEPOSIA	Preferred specialty drug; Step therapy removed
ZIEXTENZO	Preferred specialty drug; Step therapy removed
ZINBRYTA	You must first try 2 of BETASERON, COPAXONE, MAYZENT, VUMERITY, ZEPOSIA*
ZIOPTAN	Preferred brand drug

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, and their affiliates (Aetna).

Some health benefits and health insurance plans are offered, administered and/or underwritten by Aetna Health Inc., 151 Farmington Avenue, Hartford, CT 06156. Each insurer has sole financial responsibility for its own products.

Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change.

Aetna receives rebates from drug manufacturers that may be taken into account in determining drug lists. Information is subject to change. The drugs on the Pharmacy Drug Guide (formulary), Formulary Exclusions, Precertification, Quantity Limit and Step Therapy Lists are subject to change. In certain states, including Arkansas, Colorado, Connecticut, Delaware, Georgia, Illinois, Louisiana, Maryland, Minnesota, North Dakota, Pennsylvania and Texas, step therapy programs do not apply to fully insured members utilizing prescription drugs for the treatment of stage-four advanced, metastatic cancer.

In accordance with state law, commercial fully insured (including HMO) members in Louisiana and Texas (except Federal Employee Health Benefit Plan members) who are receiving coverage for drugs that are added or removed from the Pharmacy Drug Guide and Specialty Drug List will continue to have those drugs covered at the same benefit level until their plan's renewal date. In Texas, preauthorization approval is known as "preservice utilization review." It is not "verification" as defined by Texas law. Preauthorization means a determination that healthcare services proposed to be provided to a patient are medically necessary and appropriate.

In accordance with state law, certain fully insured commercial California members (except Federal Employee Health Benefit Plan members) who obtained approval from an Aetna plan for coverage of drugs that are later added to the Preauthorization or Step Therapy Lists or removed from the Pharmacy Drug Guide will continue to have those drugs covered, for as long as the treating in-network provider continues prescribing them, provided that the drug is appropriately prescribed and is considered safe and effective for treating the enrollee's medical condition. Aetna reserves the right to periodically request clinical information from your provider to assess your medical condition and the appropriateness of your ongoing treatment. Failure to provide clinical information could result in subsequent denial of coverage for this medication.

In accordance with state law, fully insured commercial Connecticut preferred provider organization (PPO) members (except Federal Employee Health Benefit Plan members) covered under a policy and using a drug for treatment of a chronic illness prior to the drug's removal from the Pharmacy Drug Guide will continue to have the medication covered, provided the prescriber states in writing that the drug is medically necessary and more medically beneficial than other covered drugs. Nothing in this section shall preclude the prescribing provider from prescribing another drug covered by the plan that is medically appropriate for the enrollee, nor shall anything in this section be construed to prohibit generic drug substitutions.

This material is for information only. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. Aetna is part of the CVS Health family of companies.

Policy forms issued in Oklahoma include: AL COC00010, HC COC00010.

Policy forms issued in Missouri include: AL HGrpPol 01R5, HI HGrpAg 05, HO HGrpPol 04, AL SG GrpPOLAmend 2020 01, HI SG GrpAgAmend 2020 01.

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: 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 subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).

TTY: 711

To access language services at no cost to you, call the number on your ID card.

Para acceder a los servicios de idiomas sin costo, llame al número que figura en su tarjeta de identificación. (Spanish)

如欲使用免費語言服務，請致電您 ID 卡上的電話號碼 (Chinese)

Afin d'accéder aux services langagiers sans frais, veuillez composer le numéro inscrit sur votre carte d'identité. (French)

Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tawagan ang numero sa inyong ID card. (Tagalog)

T'áá ni nizaad k'ehjí bee níká a'doowoł doo bááh ílínígóó naaltsoos bee atah níłjigo nanitinígíí bee néého'dółzinígíí béésh bee hane'í bikáá' áají' hólne'. (Navajo)

Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie die Nummer auf Ihrer ID-Karte an. (German)

Për shërbime përkthimi falas për ju, telefononi në numrin që gjendet në kartën tuaj të identitetit. (Albanian)

የድንጋጌ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በመታወቂያዎች ላይ ያለውን ቁጥር ይደውሉ። (Amharic)

للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقتك الشخصية. (Arabic)

Անվճար լեզվական ծառայություններին օգտվելու համար զանգահարեք ձեր ինքնության (ID) քարտի վրա նշված հեռախոսահամարով: (Armenian)

Kugira uronke serivisi z'indimi atakiguzi, Hamagara inumero iri kuri karangamuntu kawe. (Bantu)

আপনাকে বিনামূল্যে ভাষা পরিষেবা পেতে হলে আপনার পরিচয়পত্রে দেওয়া নম্বরে টেলিফোন করুন। (Bengali)

Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa numero sa nimong ID card. (Bisayan-Visayan)

သင့်အနေဖြင့် အခကြေးငွေ မပေးရဲဘဲ ဘာသာစကားဝန်ဆောင်မှုများ ရရှိနိုင်ရန်၊ သင့် ID ကတ်ပေါ်တွင်ရှိသော ဖုန်းနံပါတ်အား ခေါ်ဆိုပါ။ (Burmese)

Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al número indicat a la seva targeta d'identificació. (Catalan)

Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang i numiru gi iyo-mu kard aidentifikasion. (Chamorro)

[illegible]

Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla kv t chi holisso iskitini holhtena takanli ma I paya. (Choctaw)

Tajaajjiiloota afaanii gatii bilisaa ati argaachuuf, lakkoofsa duugda waraaqaa eenyummaa (ID) kee irraa jiruun bilbili. (Cushite-Oromo)

Voor gratis toegang tot taaldiensten, bel het nummer op uw ID-kaart. (Dutch)

Pou jwenn sèvis lang gratis, rele nimewo telefòn ki sou kat idantite ou a. (French Creole-Haitian)

Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό που αναγράφεται στην κάρτα σας προνομίων μέλους. (Greek)

તમારે કોઈ જાતના ખર્ચ વિના ભાષાની સેવાઓની પહોંચ માટે, તમારા આઇડી કાર્ડ ઉપરના નંબરને કોલ કરો. (Gujarati)

No ka wala'au 'ana me ka lawelawe 'ōlelo e kahea aku i ka helu kelepona ma kāu kākēka ID. Kāki 'ole 'ia kēia kōkua nei. (Hawaiian)

आपके लिए बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, अपने आईडी कार्ड पर दिये नम्बर पर कॉल करें। (Hindi)

Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu tus naj npawb ntawm koj daim npav ID.
(Hmong)

Iji nwetaòhèrè na ọrụ gasị asụsụ n'efu, kpọọ nọmba no na kaadị ID gị. (Ibo)

Tapno maaksesyo dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti numero idiay ID cardyo. (Ilocano)

Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi nomor telepon di kartu identitas Anda. (Indonesian)

Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero sulla tessera identificativa.
(Italian)

言語サービスを無料でご利用いただくには、IDカードに記載の番号にお電話ください。
(Japanese)

လၢတၢ်ကမၤန့ၢ်ကျိၣ်အတၢ်မၤစၢၤအတၢ်ဖဲးတၢ်မၤစတၢ်လၢတအိၣ်ဒီးအပ္ပၤလၢနကဘၣ်ဟ့ၣ်အိၣ်ဘၣ်န့ၣ်.ကိးဘၣ်လိတဖီနီၣ်ဂံၢ်လၢအိၣ်လၢနတၢ်ဂီၤဆိ (ID)
အခးလိၣ်တက့ၢ် (Karen)

무료 언어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오. (Korean)

M dyi wudu-dù kà kò dò bě dyi móuń nì pídýi ní, níí, dǎ nòbà nià nì ID káàò kǝ. (Kru-Bassa)

بۆ دەسپێر اگەشتن بە خزمەتگوزاری زمان بەبێ تێچوون بۆ تۆ، پەيوەندی بکە بە ژمارەى سەر ئای دى (ID) کارتی خۆت.
(Kurdish)

ເພື່ອຂໍ້ໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ,
ໃຫ້ໂທຫາເບີໂທທິບອກໄວ້ໃນບັດປະຈຳຕົວຂອງທ່ານ. (Laotian)

कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, तुमच्या ID कार्डावरील क्रमांकावर फोन करा. (Marathi)

Nan etal nan jikin jiban ko ikijen kajin ilo an ejelok onen nan kwe, kirlok nomba eo ilo ID kaat eo am.
(Marshallese)

Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih nempe nan amhw doaropwe en ID.
(Micronesian-Pohnpeian)

ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់
លេខដែលមាននៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក។ (Mon-Khmer, Cambodian)

निःशुल्क भाषा सेवा प्राप्त गर्न आफ्नो परिचयपत्रमा भएको नम्बरमा टेलिफोन गर्नुहोस् । (Nepali)

Tě kɔɔr yīn wěēr de thokic ke cīn wěu kɔr keek tēnɔŋ yīn. Ke cɔl kɔc ye kɔc kuɔny nē nɔmba de abac tō
nē ID kard du kōu. (Nilotic-Dinka)

For tilgang til kostnadsfri språktjenester, ring nummeret på ID-kortet ditt. (Norwegian)

Um Schprooch Services zu griegie mitaus Koscht, ruff die Nummer uff dei ID Kaart. (Pennsylvania Dutch)

برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید. (Persian-Farsi)

Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonić numer telefonu na Twojej
Karcie Identykującej (Polish)

Para acessar os serviços de idiomas sem custo para você, ligue para o número que consta na sua
identidade. (Portuguese)

ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਫ਼ੋਨ
ਕਰੋ। (Punjabi)

Pentru a accesa gratuit serviciile de limbă, apelați numărul de pe cardul dvs. de identificare.
(Romanian)

Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному
на вашей карточке участника плана. (Russian)

