



Good Health HMO 5000/100

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, www.rmhp.org or call 1-800-346-4643. 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 1-800-346-4643 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$5,000 individual /\$10,000 family (In- <u>Network</u>)	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 plan, each family member must meet their own individual deductible until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> is 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?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$5,000 individual /\$10,000 family (In- <u>Network</u>)	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.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billing charges</u> (unless <u>balanced billing</u> is prohibited), and health care this <u>plan</u> doesn't cover.	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 <u>network provider</u> ?	Yes. See www.rmhp.org or call 1-800-346-4643 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</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's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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
		Network Provider (You will pay the least)	Non-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	No charge after <u>deductible</u>	Not covered	None
	<u>Specialist</u> visit	No charge after <u>deductible</u>	Not covered	None
	<u>Preventive care/screening/immunization</u>	No charge; <u>deductible</u> does not apply	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . 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 after <u>deductible</u>	Not covered	May require <u>preauthorization</u> . Please go to www.rmhp.org to find out if a service needs <u>preauthorization</u> . If you don't get <u>preauthorization</u> for out-of-network services, benefits will be denied.
	Imaging (CT/PET scans, MRIs)	No charge after <u>deductible</u>	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
<p>If you need drugs to treat your illness or condition</p> <p>More information about <u>prescription drug coverage</u> is available at www.rmhp.org.</p>	Tier 1 (Lower-cost. Mostly generic drugs, including drugs for cancer treatment. Some brand-name drugs may also be included.)	Preventive: \$10 (R)/\$25 (MO) <u>deductible</u> does not apply; All other Tier 1: No charge after <u>deductible/prescription</u>	Not covered	<p>\$0 copay for contraceptive drugs/devices noted as "H" or "H-PA" on any tier of the <u>formulary</u>. There is also no cost sharing after <u>deductible</u> for oral anti-cancer drugs on any tier of the <u>formulary</u>.</p> <p>Retail (R) and Mail Order (MO) Pharmacy limited up to a 90-day supply. Specialty drugs on any tier and drugs on Tier 4 are limited to a 31-day supply. This limitation doesn't apply to oral contraceptive drugs, patches and rings. You can get up to a 1 year supply after an initial 3 month supply for oral contraceptive drugs and patches.</p> <p>When a drug is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the <u>cost sharing</u> that applies will reflect the number of days dispensed or days the drug will be delivered.</p> <p>Cost sharing will not exceed \$100 per 30 day supply of insulin, regardless of the amount or type of insulin needed to fill your prescription order(s).</p> <p>Retail copay shown 31-day supply, Mail order copay shown 90-day supply.</p> <p>May require <u>preauthorization</u>. Please go to www.rmhp.org to find out if a service needs <u>preauthorization</u>. If you don't get <u>preauthorization</u> for out-of-network services, benefits will be denied.</p>
	Tier 2 (Mid-range cost. A mix of brand-name and generic drugs, including drugs for cancer treatment.)	Preventive: \$10 (R)/ \$25 (MO) <u>deductible</u> does not apply; All other Tier 2: No charge after <u>deductible/prescription</u>	Not covered	
	Tier 3 (Mid-range cost. A mix of brand-name and generic drugs, including drugs for cancer treatment.)	Preventive: \$10 (R)/ \$25 (MO) <u>deductible</u> does not apply; All other Tier 3: No charge after <u>deductible/prescription</u>	Not covered	
	Tier 4 (Highest-cost. Mostly brand-name drugs, as well as some generics, including drugs for cancer treatment.)	Preventive: \$10 (R) and (MO) <u>deductible</u> does not apply; All other Tier 4: No charge after <u>deductible/prescription</u>	Not covered	
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	No charge after <u>deductible</u>	Not covered	
	Physician/surgeon fees	No charge after <u>deductible</u>	Not covered	
<p>If you need immediate medical attention</p>	<u>Emergency room care</u>	No charge after <u>deductible</u>	No charge after <u>deductible</u>	
	<u>Emergency medical transportation</u>	No charge after <u>deductible</u>	No charge after <u>deductible</u>	
	<u>Urgent care</u>	No charge after <u>deductible</u>	No charge after <u>deductible</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after <u>deductible</u>	Not covered	May require <u>preauthorization</u> . Please go to www.rmhp.org to find out if a service needs <u>preauthorization</u> . If you don't get <u>preauthorization</u> for out-of-network services, benefits will be denied.
	Physician/surgeon fees	No charge after <u>deductible</u>	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge after <u>deductible</u>	Not covered	May require <u>preauthorization</u> . Please go to www.rmhp.org to find out if a service needs <u>preauthorization</u> . If you don't get <u>preauthorization</u> for out-of-network services, benefits will be denied.
	Inpatient services	No charge after <u>deductible</u>	Not covered	
If you are pregnant	Office visits	No charge after <u>deductible</u>	Not covered	<u>Cost sharing</u> does not apply for <u>preventive services</u> including routine <u>prenatal care</u> .
	Childbirth/delivery professional services	No charge after <u>deductible</u>	Not covered	
	Childbirth/delivery facility services	No charge after <u>deductible</u>	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge after <u>deductible</u>	Not covered	Coverage is limited to 60 visits/Member/year.
	<u>Rehabilitation services</u>	No charge after <u>deductible</u>	Not covered	Coverage is limited to 20 visits/therapy/Member/year.
	<u>Habilitation services</u>	Not covered	Not covered	None
	<u>Skilled nursing care</u>	No charge after <u>deductible</u>	Not covered	Coverage is limited to 60 days/Member/year.
	<u>Durable medical equipment</u>	No charge after <u>deductible</u>	Not covered	May require <u>preauthorization</u> . Please go to www.rmhp.org to find out if a service needs <u>preauthorization</u> . If you don't get <u>preauthorization</u> for out-of-network services, benefits will be denied.
If your child needs dental or eye care	<u>Hospice services</u>	No charge after <u>deductible</u>	Not covered	None
	Children's eye exam	No charge after <u>deductible</u>	Not covered	Coverage is limited to one/Member/year.
	Children's glasses	No charge after <u>deductible</u>	Not covered	Coverage is provided after covered eye surgery, or with a diagnosis of keratoconus.
	Children's dental check-up	Not covered	Not covered	None

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.)

- | | | |
|---|---|--|
| <ul style="list-style-type: none">• Acupuncture• Bariatric surgery• Children's dental check-up• Cosmetic Surgery | <ul style="list-style-type: none">• Dental care (Adult)• Drugs not included in the <u>formulary</u>• <u>Habilitation services</u>• Infertility treatment | <ul style="list-style-type: none">• Long-term care• Non-emergency care when traveling outside the U.S.• Private-duty nursing• Routine foot care |
|---|---|--|

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

- | | | |
|---|--|--|
| <ul style="list-style-type: none">• Chiropractic care• Hearing Aids (for children) | <ul style="list-style-type: none">• Routine eye care (Adult) | <ul style="list-style-type: none">• Weight loss programs (covered through our Real Appeal Program) |
|---|--|--|

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272, www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.ccilo.cms.gov. 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: you can contact RMHP at 1-800-346-4643.

For group health coverage subject to ERISA, you can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Colorado Department of Insurance at 303-894-7490 or www.dora.state.co.us/insurance.

For non-federal governmental group health plans and church plans that are group health plans, consumer assistance may be offered directly by the plan such as applicable member services, employee services, Human Relations or Fiscal and Personnel Department, or consumer support services. You can also contact the Colorado Department of Insurance at 303-894-7490 or www.dora.state.co.us/insurance.

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 the 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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-346-4643.

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 \$5,000
- Specialist copay \$0
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

This EXAMPLE event includes services like:
Specialist office visits (pre-natal 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>	\$5,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$5,060

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$5,000
- Specialist copay \$0
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

This EXAMPLE event includes services like:
Primary care physician office visits (including disease education)
Diagnostic tests (blood work)
Prescription drugs
Durable medical equipment (glucose meter)

Total Example Cost	\$5,600
In this example, Joe would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,300
<u>Copayments</u>	\$1,300
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$3,620

Mia's Simple Fracture

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

- The plan's overall deductible \$5,000
- Specialist copay \$0
- Hospital (facility) coinsurance 0%
- Other coinsurance 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:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,800
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800



Colorado Supplement to the Summary of Benefits and Coverage Form

INSURANCE COMPANY NAME	Rocky Mountain Health Maintenance Organization, Inc.
NAME OF PLAN	Good Health
1. Type of policy	Large Employer Group Policy
2. Type of plan	Health maintenance organization (HMO)
3. Areas of Colorado where plan is available.	Plan is available throughout Colorado.

SUPPLEMENTAL INFORMATION REGARDING BENEFITS

Important Note: The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. It provides additional information meant to supplement the Summary of Benefits of Coverage you have received for this plan. This plan may exclude coverage for certain treatments, diagnoses, or services not specifically noted. Consult the actual policy to determine the exact terms and conditions of coverage.

	Description
4. Annual Deductible Type	<p>INDIVIDUAL – The amount that each member of the family must meet prior to claims being paid. Claims will not be paid for any other individual until their individual deductible or the family deductible has been met.</p> <p>FAMILY – The maximum amount that the family will pay for the year. The family deductible can be met by [2] or more individuals.</p>
5. Out-of-Pocket Maximum	<p>INDIVIDUAL – The amount that each member of the family must meet prior to claims being paid at 100%. Claims will not be paid at 100% for any other individual until their individual out-of-pocket or the family out-of-pocket has been met.</p> <p>FAMILY – the maximum amount that the family will pay for the year. The family out-of-pocket can be met by [2] or more individuals.</p>

<p>6. What is included in the In-Network Out-of-Pocket Maximum?</p>	<p>All deductibles, copayments, and coinsurance, including those for prescription drugs.</p>
<p>7. Is pediatric dental covered by this plan?</p>	<p>No, the plan does not include pediatric dental.</p>
<p>8. What cancer screenings are covered by this plan?</p>	<p>Subject to the parameters set forth below, cancer screening tests for the following items are covered subject to any applicable plan deductibles, copayments/coinsurance, and maximum benefit levels:</p> <ul style="list-style-type: none"> • Breast – Mammogram • Cervical – PAP test • Colorectal – Colonoscopy, Sigmoidoscopy, Fecal Occult Blood • Ovarian – CA125 • Prostate – PSA <p>Coverage for these cancer screening tests are subject to the following parameters:</p> <p>a) the test must be ordered by your physician, and</p> <p>b) you must comply with plan procedures</p>

USING THE PLAN

	<p>IN-NETWORK</p>	<p>OUT-OF-NETWORK</p>
<p>9. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?</p>	<p>No</p>	<p>Yes</p>
<p>10. Does the plan have a binding arbitration clause?</p>		<p>Yes</p>

Questions: Call 1-800-346-4643 or visit us at www.rmhp.org.

If you are not satisfied with the resolution of your complaint or grievance, contact:

Colorado Division of Insurance
Consumer Services, Life and Health Section
1560 Broadway, Suite 850, Denver, CO 80202
Call: 303-894-7490 (in-state, toll-free: 800-930-3745)
Email: dora_insurance@state.co.us

Notice of Nondiscrimination

Rocky Mountain Health Plans (RMHP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. RMHP does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

RMHP takes reasonable steps to ensure meaningful access and effective communication is provided timely and free of charge:

- Provides free auxiliary aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters (remote interpreting service or on-site appearance)
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language assistance services to people whose primary language is not English, such as:
 - Qualified interpreters (remote or on-site)
 - Information written in other languages

If you need these services, contact the RMHP Member Concerns Coordinator at 800-346-4643, 970-243-7050, or TTY 970-248-5019, 800-704-6370, Relay 711; para asistencia en español llame al 800-346-4643.

If you believe that RMHP has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with: the RMHP EEO Officer. You can file a grievance in person or by phone, mail, fax, or email.

- Phone: 800-346-4643, 970-244-7760, ext. 7883, or TTY 970-248-5019, 800-704-6370, Relay 711; para asistencia en español llame al 800-346-4643
- Mail: ATTN: EEO Officer, Rocky Mountain Health Plans, PO Box 10600, Grand Junction, CO 81502-5600
- Fax: ATTN: EEO Officer, 970-244-7909
- Email: eeoofficer@rmhp.org

If you need help filing a grievance, the RMHP EEO Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Multi-Language Insert

ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en la portada de esta guía.

請注意：如果您說中文(Chinese)，我們免費為您提供語言協助服務。請撥打本手冊封面所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng Việt (Vietnamese), quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Xin vui lòng gọi số điện thoại miễn phí dành cho hội viên trên trang bia của tập sách này.

알림: 한국어(Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 이 책자 앞 페이지에 기재된 무료 회원 전화 번호로 문의하십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog (Tagalog), may makukuha kang mga libreng serbisyo ngtulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nakalista sa harapan ng booklet na ito.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является русским (Russian). Позвоните по бесплатному номеру телефона, указанному на лицевой стороне данной брошюры.

تنبيه: إذا كنت تتحدث العربية ، فهناك خدمات مساعدة لغوية مجانية متاحة. اتصل بالرقم المجاني على غلاف هذا الدليل.

ATANSYON: Si w pale Kreyòl ayisyen (Haitian Creole), ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo telefòn gratis pou manm yo ki sou kouvèti ti liv sa a.

ATTENTION : Si vous parlez français (French), des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone sans frais pour les affiliés figurant au début de ce guide.

UWAGA: Jeżeli mówisz po polsku (Polish), udostępniłmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny członkowski numer telefonu podany na okładce tej broszury.

Multi-Language Insert

ATENÇÃO: Se você fala português (Portuguese), contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número do membro encontrado na frente deste folheto.

ATTENZIONE: in caso la lingua parlata sia l'italiano (Italian), sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero verde per i membri indicato all'inizio di questo libretto.

ACHTUNG: Falls Sie Deutsch (German) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer für Mitglieder auf der Vorderseite dieser Broschüre an.

注意事項：日本語(Japanese)を話される場合、無料の言語支援サービスをご利用いただけます。本冊子の表紙に記載されているメンバー用フリーダイヤルにお電話ください。

توجه: اگر به فارسی صحبت می کنید ، خدمات کمک به زبان رایگان در دسترس است. با شماره تلفن رایگان روی جلد این راهنما تماس بگیرید.

ध्यान दें: यदि आप हिंदी बोलते हैं, तो नि: शुल्क भाषा सहायता सेवाएं उपलब्ध हैं। इस गाइड के कवर पर टोल-फ्री नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus Hmoob (Hmong), muaj kev pab txhais lus pub dawb rau koj. Thov hu tus tswv cuab xov tooj hu dawb teev nyob ntawm sab xub ntiag ntawm phau ntawv no.

ចំណាប់អារម្មណ៍: លើសិនអ្នកនិយាយភាសាខ្មែរ (Khmer) រឺសំរាប់នាយភាសាខ្មែរ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខសមាជិកតែចម្បែង បានកត់ខ្លួនខ្លួនស្រីកៅខ្មែរ។

PAKDAAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Pakitawagan iti miyembro toll-free nga number nga nakasurat iti sango ti libro.

DÍÍ BAA'AKONÍNIZIN: Diné (Navajo) bizaad bee yániití'go, saad bee áka'anída'awo'ígíí, t'áá jíik'eh, bee ná'ahóót'i'. T'áá shq'odí díí naaltsoos bidáanghi t'áá jíik'eh naaltsoos báha díí'éhígíí béésh bee hane'í biká'ígíí bee hodiinih.

OGOW: Haddii aad ku hadasho Soomaali (Somali), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka xubinta ee telefonka bilaashka ah ee ku qoran xagga hore ee buugyaraha.