

YESHIVA UNIVERSITY: Open Choice®

Coverage for: Individual + Family | Plan Type: PPO

Coverage Period: 08/15/2023-08/14/2024



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, <a href="https://www.aetnastudenthealth.com/">https://www.aetnastudenthealth.com/</a> or by calling 866-381-1529. 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 866-381-1529 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For each <u>Plan</u> Year, In- <u>Network</u> : Individual \$600. Out-of-Network: Individual \$2,000.	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. Emergency care, <u>prescription drugs</u> , office visits & <u>preventive care</u> 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
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</u> <u>limit</u> for this <u>plan</u> ?	In- <u>Network:</u> Individual \$9,100 / Family \$18,200. Out-of-Network: Individual NONE / Family NONE.	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 out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover & penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind or call 866-381-1529 for a list of in- <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</u> 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 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  $\underline{\textbf{copayment}}$  and  $\underline{\textbf{coinsurance}}$  costs shown in this chart are after your  $\underline{\textbf{deductible}}$  has been met, if a  $\underline{\textbf{deductible}}$  applies.

	What You Will Pay			
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	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	\$50 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% <u>coinsurance</u> <u>after</u> \$50 <u>copay</u> /visit, <u>deductible</u> doesn't apply	None
	<u>Specialist</u> visit	\$50 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% coinsurance after \$50 copay/visit, deductible doesn't apply	None
	Preventive care /screening /immunization	No charge	30% <u>coinsurance,</u> <u>deductible</u> doesn't apply	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	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	None
n you have a tool	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	None
If you need drugs to treat your illness or condition	Generic drugs	Copay/prescription, deductible doesn't apply: \$25 (retail), \$62.50 (mail order)	Copay/prescription, deductible doesn't apply: \$25 (retail)	Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's
More information about prescription drug coverage is	Preferred brand drugs	Copay/prescription, deductible doesn't apply: \$70 (retail), \$175 (mail order)	Copay/prescription, deductible doesn't apply: \$70 (retail)	
available at <a href="https://www.aetna.c">https://www.aetna.c</a> <a href="https://www.aetna.c">om/individuals-</a> families/pharmacy.h	Non-preferred brand drugs	Copay/prescription, deductible doesn't apply: \$100 (retail), \$250 (mail order)	Copay/prescription, deductible doesn't apply: \$100 (retail)	contraceptives in- <u>network</u> .
<u>tml</u>	Specialty drugs	Not covered	Not covered	Not covered.

What You Will Pay In-Network Out-of-Network				
Common Medical Event	Services You May Need	Provider (You will pay the least)	Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	None
outpatient surgery	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need	Emergency room care	20% coinsurance after \$200 copay/visit, deductible doesn't apply	20% coinsurance after \$200 copay/visit, deductible doesn't apply	No coverage for non-emergency use.
immediate medical	Emergency medical transportation	20% coinsurance	20% coinsurance	None
attention	<u>Urgent care</u>	\$50 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% <u>coinsurance</u> after \$50 <u>copay</u> /visit, <u>deductible</u> doesn't apply	No coverage for non-urgent use.
If you have a	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	<u>Pre-authorization</u> required for out-of-network care.
hospital stay	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$50 copay/visit, deductible doesn't apply; other outpatient services: no charge	Office: 30% coinsurance after \$50 copay/visit, deductible doesn't apply; other outpatient services: no charge	None
	Inpatient services	20% coinsurance	50% coinsurance	<u>Pre-authorization</u> required for out-of-network care.
If you are pregnant	Office visits	No charge	30% coinsurance	Cost sharing does not apply for preventive
	Childbirth/delivery professional services Childbirth/delivery facility services	20% coinsurance 20% coinsurance	50% coinsurance 50% coinsurance	services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Pre-authorization for out-of-network care may apply.
If you need help	Home health care	20% coinsurance	50% coinsurance	None
recovering or have	Rehabilitation services	20% coinsurance	50% coinsurance	Includes Physical, Occupational & Speech

	What You Will Pay			
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
other special	Habilitation services	20% coinsurance	50% coinsurance	Therapy.
health needs	Skilled nursing care	20% coinsurance	50% coinsurance	200 days/plan year. <u>Pre-authorization</u> required for out-of-network care.
	Durable medical equipment	20% coinsurance	50% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	20% coinsurance	50% coinsurance	Pre-authorization required for out-of-network care.
	Children's eye exam	\$20 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% <u>coinsurance,</u> <u>deductible</u> doesn't apply	1 routine eye exam/ <u>plan</u> year up to age 19.
If your child needs dental or eye care	Children's glasses	\$40 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% <u>coinsurance,</u> <u>deductible</u> doesn't apply	1 pair of glasses or lenses/ <u>plan</u> year.
	Children's dental check-up	\$35 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$35 <u>copay</u> /visit, <u>deductible</u> doesn't apply	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.)

- Cosmetic surgery
- Dental care (Adult)

- Long-term care
- Private-duty nursing

- Routine eye care (Adult)
- Routine foot care
- Specialty drugs
- Weight loss programs Except for required preventive services.

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

- Acupuncture
- Bariatric surgery
- Chiropractic care

- Hearing aids 1 hearing aid per ear/36 months.
- Infertility treatment Limited to the diagnosis & treatment of underlying medical condition.
- Non-emergency care when traveling outside the U.S.

## **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: Department of Financial Services, Consumer Assistance Unit, 800-342-3736, http://www.dfs.ny.gov/consumer/fileacomplaint.htm.

- For more information on your rights to continue coverage, contact the plan at 866-381-1529.
- State Consumer Assistance Program, if other than state insurance department contact Community Health Advocates, Community Service Society of New York, 633 Third Avenue, 10th Floor, New York, NY 10017, 1-888-614-5400, <a href="https://www.communityhealthadvocates.org/">https://www.communityhealthadvocates.org/</a>.

### **Your Grievance and Appeals Rights:**

There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 866-381-1529.
- Department of Financial Services, Consumer Assistance Unit, 800-342-3736, http://www.dfs.ny.gov/consumer/fileacomplaint.htm.
- Additionally, a consumer assistance program can help you file your <u>appeal</u>. Contact Community Health Advocates, Community Service Society of New York, 633 Third Avenue, 10th Floor, New York, NY 10017, 1-888-614-5400, http://www.communityhealthadvocates.org/.

### 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 <u>plan</u> 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 <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>	\$600
Specialist copayment	\$50
■ Hospital (facility) coinsurance	20%
Other coinsurance	20%

### This EXAMPLE event includes services like:

Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost	\$12,700
In this example, Peg would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$600
<u>Copayments</u>	\$10
Coinsurance	\$2,200
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,870

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

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

■ The <u>plan's</u> overall <u>deductible</u>	\$600
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	20%
■ Other <u>coinsurance</u>	20%

### This EXAMPLE event includes services like:

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

Diagnostic tests (blood work)

Prescription drugs

<u>Durable medical equipment</u> (glucose meter)

Total Example Cost	\$5,600	
In this example, Joe would pay:		
Cost Sharing		
<u>Deductibles</u>	\$600	
<u>Copayments</u>	\$1,900	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$20	
The total Joe would pay is	\$2,520	

# **Mia's Simple Fracture**

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

■ The <u>plan's</u> overall <u>deductible</u>	\$600
Specialist copayment	\$50
■ Hospital (facility) coinsurance	20%
Other coinsurance	20%

#### This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

Diagnostic test (x-ray)

<u>Durable medical equipment</u> (crutches)

Rehabilitation services (physical therapy)

<b>Total Example Cost</b>	\$2,800	
In this example, Mia would pay:		
Cost Sharing		
<u>Deductibles</u>	\$600	
<u>Copayments</u>	\$100	
<u>Coinsurance</u>	\$300	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$1,000	

The <u>plan</u> 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 866-381-1529.

## **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 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: 1-860-262-7705)

Email: <u>CRCoordinator@aetna.com</u>

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 <a href="https://ocrportal.hhs.gov/ocr/portal/lobby.jsf">https://ocrportal.hhs.gov/ocr/portal/lobby.jsf</a>, 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.

### TTY: 711

### **Language Assistance:**

For language assistance in your language call 866-381-1529 at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 866-381-1529.

Amharic - ለቋንቋ እንዛ በ አማርኛ በ 866-381-1529 በነጻ ይደውሉ

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1529-866 Arabic-

Armenian - Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 866-381-1529 առանց գնով։

Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 866-381-1529 tanpa dikenakan biaya.

Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 866-381-1529 ku busa

Bengali-Bangala - বাংলা্ম ভাষা সহায়তার জন্য বিনামুল্যে ৪66-381-1529-তে কল করুন।

Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 866-381-1529 nga walay bayad.

Burmese - ငွေကုန်ကျစံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 866-381-1529 ကို ခေါ် ဆိုပါ။

Catalan - Per rebre assistència en (català), truqui al número gratuït 866-381-1529.

Chamorro - Para ayuda gi fino' (Chamoru), ågang 866-381-1529 sin gåstu.

Cherokee -  $\theta \circ \partial \mathcal{Y} \theta \circ \mathcal{Y$ 

Chinese - 欲取得繁體中文語言協助,請撥打866-381-1529,無需付費。

Choctaw - (Chahta) anumpa ya apela a chi I paya hinla 866-381-1529.

Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 866-381-1529 irratti bilisaan bilbilaa.

Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 866-381-1529.

French - Pour une assistance linguistique en français appeler le 866-381-1529 sans frais.

French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 866-381-1529 gratis.

German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 866-381-1529 an.

Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 866-381-1529 χωρίς χρέωση.

Gujarati - ગુજરાતીમાં ભાષામાં સહ્રાય માટે કોઈ પણ ખર્ચ વગર 866-381-1529 પર કૉલ કરો.

Hawaiian - No ke kōkua ma ka 'ōlelo Hawai'i, e kahea aku i ka helu kelepona 866-381-1529. Kāki 'ole 'ia kēia kōkua nei.

Hindi- हिन्दी में भाषा सहायता के लिए, 866-381-1529 पर मुफ्त कॉल करें।

Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 866-381-1529.

lbo - Maka enyemaka asusu na Igbo kpoo 866-381-1529 na akwughi ugwo o bula

llocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 866-381-1529 nga awan ti bayadanyo.

Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 866-381-1529.

Japanese - 日本語で援助をご希望の方は、866-381-1529 まで無料でお電話ください。

Karen - လာတာ်မာစားတာ်ကတီးကျိဉ်အင်္ဂါ ကျိုဉ် ကိုး 866-381-1529 လာတအိဉ်ဒီးတာ်လာ၁်ဘူဉ်လာ၁်စူးသည်

Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 866-381-1529 번으로 전화해 주십시오.

Kru-Bassa - Bɛ´m`ké gbo-kpá-kpá dyé pidyi dé Bašsɔɔ́-wuduùn wɛ̃ɛ, dá 866-381-1529

برای راهنمایی به زبان فارسی با شماره 1529-866 به خورایی پهیوهندی بکهن.

Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ866-381-1529 ໂດຍບໍ່ເສຍຄ່າໂທ.

Marathi - कोणत्याही श्ल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-855-821-9720 वर फोन करा.

Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 866-381-1529 ilo ejjelok wōnān.

Micronesian-Pohnpeyan - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 866-381-1529 ni sohte isais.

Mon-Khmer, សម្**រាប់ជំនួយភាសាជា ភាសាខ្**មរ៉ែ សូមទូរស័ព្**ទទ**ៅកាន់លខេ 866-381-1529 ដ**ោយឥតគិតថ្**ល។ៃ Cambodian -

Navajo - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 866-381-1529

Nepali - (नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि ८६६- <sup>381-1529</sup> मा फोन गर्नुहोस् ।

Nilotic-Dinka - Tën kupony ë thok ë Thuonjän col 866-381-1529 kecin ayöc.

Norwegian - For språkassistanse på norsk, ring 866-381-1529 kostnadsfritt.

Panjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 866-381-1529 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।

Pennsylvania Dutch - Fer Helfe in Deitsch, ruf: 866-381-1529 aa. Es Aaruf koschtet nix.

برای راهنمایی به زبان فارسی با شماره 1529-866 بدون هیچ هزینه ای تماس بگیرید. انگلیسی Persian -

Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 866-381-1529.

Portuguese - Para obter assistência linguística em português ligue para o 866-381-1529 gratuitamente.

Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 866-381-1529

Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 866-381-1529.

Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 866-381-1529 e aunoa ma se totogi.

Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 866-381-1529.

Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 866-381-1529.

Sudanic-Fulfude - Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 866-381-1529. Njodi woo fawaaki on.

Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 866-381-1529 bila malipo.

Syriac - K ser K & seric abreste root, or Ly ioser 181,00, 866-381-1529 as

Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 866-381-1529 nang walang bayad.

Telugu - భాషతో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 866-381-1529 కు కాల్ చేయండి. (తెలుగు)

Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 866-381-1529 ฟรีไม่มีค่าใช้จ่าย

Tongan - Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 866-381-1529 'o 'ikai hā ōtōngi.

Trukese - Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 866-381-1529 nge esapw kamé ngonuk.

Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 866-381-1529.

Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 866-381-1529.

بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، ۔ بر بات کریں۔ Urdu - ۔ بر بات کریں۔

Vietnamese - Đê 'được hố trở ngôn ngư bằng (ngôn ngư), hấy gọi miến phi 'đến số '866-381-1529.

Yiddish - פאר שפראך הילף אין אידיש רופט 866-381-1529 פריי פון אפצאל.

Yoruba - Fún ìrànlowo nípa èdè (Yorùbá) pe 866-381-1529 lái san owó kankan rárá.