

DREXEL UNIVERSITY: Open Choice®

Coverage for: Individual + Family | Plan Type: PPO

Coverage Period: 07/01/2022-08/31/2023



The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, <u>https://www.aetnastudenthealth.com/</u> or by calling 1-877-409-7361. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-877-409-7361 to request a copy.

		18/1 T1: 14 ()
Important Questions	Answers	Why This Matters:
What is the overall deductible?	For each <u>Plan</u> Year, In- <u>Network</u> : Individual \$250. Out-of-Network: Individual \$500.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. <u>Prescription drugs</u> ; plus in- <u>network</u> <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 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</u> <u>limit</u> for this <u>plan</u> ?	In- <u>Network:</u> Individual \$5,000 / Family \$10,000. Out-of-Network: Individual \$10,000 / Family \$20,000.	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</u> <u>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 1-877-409-7361 for a list of in-network providers.	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 **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical		What You Will Pay		
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
	Primary care visit to treat an injury or illness	\$20 <u>copay</u> /visit	50% coinsurance	None
If you visit a health care <u>provider</u> 's office	Specialist visit	\$20 <u>copay</u> /visit	50% coinsurance	None
or clinic	Preventive care /screening /immunization	No charge	50% coinsurance	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.
	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	None
If you have a test	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	None
	Generic drugs	Copay/prescription, deductible doesn't apply: \$15 (retail), \$45 (mail order)	Copay/prescription, deductible doesn't apply: \$15 (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 contraceptives in-network.
If you need drugs to treat your illness or condition	Preferred brand drugs	Copay/prescription, deductible doesn't apply: \$40 (retail), \$120 (mail order)	Copay/prescription, deductible doesn't apply: \$40 (retail)	
More information about prescription drug coverage is available at https://www.aetna.com/individuals-families/pharmacy.html	Non-preferred brand drugs	Copay/prescription, deductible doesn't apply: \$75 (retail), \$225 (mail order)	Copay/prescription, deductible doesn't apply: \$75 (retail)	
	Specialty drugs	Copay/prescription, deductible doesn't apply: 20% coinsurance with minimum copay/prescription of \$250 and maximum copay/prescription of \$500	Copay/prescription, deductible doesn't apply: 20% coinsurance with minimum copay/prescription of \$250 and maximum copay/prescription of \$500	None

Common Medical Event	Services You May Need	What Yo In-Network Provider (You will pay the least)	u Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	None
surgery	Physician/surgeon fees	20% coinsurance	50% <u>coinsurance</u>	None
If you need immediate	Emergency room care	20% <u>coinsurance</u> after \$150 <u>copay</u> /visit	20% <u>coinsurance</u> after \$150 <u>copay</u> /visit	No coverage for non-emergency use.
medical attention	Emergency medical transportation	0% <u>coinsurance</u>	0% coinsurance	None
	Urgent care	\$30 <u>copay</u> /visit	50% <u>coinsurance</u> after \$10 <u>copay</u> /visit	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u> after \$250 <u>copay</u> /stay	50% <u>coinsurance</u> after \$250 <u>copay</u> /stay	Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care.
Stay	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral	Outpatient services	Office: \$20 <u>copay</u> /visit; other outpatient services: 20% <u>coinsurance</u>	Office & other outpatient services: 50% coinsurance	None
health, or substance abuse services	Inpatient services	20% <u>coinsurance</u> after \$250 <u>copay</u> /stay	50% <u>coinsurance</u> after \$250 <u>copay</u> /visit	Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	Office visits	No charge	50% coinsurance	Cost sharing does not apply for
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Penalty of \$500 for failure to obtain preauthorization for out-of-network care may apply.
If you are pregnant	Childbirth/delivery facility services	20% <u>coinsurance</u> after \$250 <u>copay</u> /stay	50% <u>coinsurance</u> after \$250 <u>copay</u> /stay	
	Home health care	20% <u>coinsurance</u>	20% coinsurance	60 visits/ <u>plan</u> year.
	Rehabilitation services	20% coinsurance	50% <u>coinsurance</u>	Includes Physical, Occupational &
	Habilitation services	20% coinsurance	50% coinsurance	Speech Therapy.
If you need help recovering or have	Skilled nursing care	20% <u>coinsurance</u> after \$250 <u>copay</u> /stay	50% <u>coinsurance</u> after \$250 <u>copay</u> /stay	Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care.
other special health needs	Durable medical equipment	20% <u>coinsurance</u>	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	20% coinsurance	Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care.

Common Medical Event	Services You May Need	What Yo In-Network Provider (You will pay the least)	u Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Children's eye exam	No charge	20% <u>coinsurance</u> , <u>deductible</u> doesn't apply	1 routine eye exam/ <u>plan</u> year. Covered through the end of the month in which the covered person turns 19.
If your child needs dental or eye care	Children's glasses	No charge	20% <u>coinsurance, deductible</u> doesn't apply	1 pair of glasses or lenses/ <u>plan</u> year. Covered through the end of the month in which the covered person turns 19.
	Children's dental check-up	No charge	20% coinsurance	Covered through the end of the month in which the covered person turns 19.

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.)

Gervices Four <u>Fram</u> Generally Book	is NOT cover (offect your policy of <u>plan</u> document to	i more imormation and a list of any other excluded services.
Acupuncture	Dental care (Adult)	Routine foot care
Bariatric surgery	 Long-term care 	 Weight loss programs - Except for required preventive
Cosmetic surgery	 Private-duty nursing 	services.

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

- Chiropractic care
- Hearing aids 1 hearing aid per ear each policy year.
- Infertility treatment Limited to the diagnosis & treatment of underlying medical condition, artificial insemination & ovulation induction.
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult) 1 routine eye exam/<u>plan</u> year.

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: Pennsylvania Department of Insurance, Bureau of Consumer Services, Phone: 877-881-6388, TTY/TDD: 717-783-3898, http://www.insurance.pa.gov/Consumers. For more information on your rights to continue coverage, contact the plan-at-1-877-409-7361. 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 <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 1-877-409-7361 or Pennsylvania Department of Insurance, Bureau of Consumer Services, Phone: 877-881-6388, TTY/TDD: 717-783-3898, http://www.insurance.pa.gov/Consumers.

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 <u>plan</u> doesn't meet the <u>Minimum Value Standards</u>, you may be eligible for a <u>premium tax credit</u> to help you pay for a <u>plan</u> through the <u>Marketplace</u>.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-409-7361.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-409-7361.

Chinese (中文): 如果需要中文的帮助. 请拨打这个号码 1-877-409-7361.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-409-7361.

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>	\$100
■ Specialist copayment	\$20
■ 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	\$12,800
In this example, Peg would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$100
Copayments	\$80
Coinsurance	\$2,500
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,740

Managing Joe's Type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$100
■ Specialist copayment	\$20
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	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	\$7,400	
In this example, Joe would pay:		
Cost Sharing		
<u>Deductibles</u>	\$100	
<u>Copayments</u>	\$1,500	
Coinsurance	\$10	
What isn't covered		
Limits or exclusions	\$20	
The total Joe would pay is	\$1,630	

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$100
■ Specialist copayment	\$20
■ 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)

Total Example Cost	\$1,900	
In this example, Mia would pay:		
Cost Sharing		
<u>Deductibles</u>	\$100	
<u>Copayments</u>	\$40	
<u>Coinsurance</u>	\$200	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$340	

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 1-877-409-7361.

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 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.

TTY: 711

Language Assistance:

For language assistance in your language call 1-877-409-7361 at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-877-409-7361.

Amharic - ለቋንቋ እንዛ በ አማርኛ በ 1-877-409-7361 በነጻ ይደውሉ

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-877-409-7361 للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني

Armenian - Lեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-877-409-7361 առանց գնով։

Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-877-409-7361 tanpa dikenakan biaya.

Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-877-409-7361 ku busa

Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-877-409-7361-তে কল করুন।

Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-877-409-7361 nga walay bayad.

Burmese - ငွေကုန်ကျစံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-877-409-7361 ကို ခေါ် ဆိုပါ။

Catalan - Per rebre assistència en (català), truqui al número gratuït 1-877-409-7361.

Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-877-409-7361 sin gåstu.

Cherokee - $\theta \omega y \theta s \psi h \omega J J h \omega s \phi y \theta t T (GWY) \phi b W \phi t s 1-877-409-7361 O t A G D J J E G P J h P R O.$

Chinese - 欲取得繁體中文語言協助, 請撥打 1-877-409-7361, 無需付費。

Choctaw - (Chahta) anumpa ya apela a chi I paya hinla 1-877-409-7361.

Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-877-409-7361 irratti bilisaan bilbilaa.

Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-877-409-7361.

French - Pour une assistance linguistique en français appeler le 1-877-409-7361 sans frais.

French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-877-409-7361 gratis.

German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-877-409-7361 an.

Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-877-409-7361 χωρίς χρέωση.

Gujarati - ગુજરાતીમાં ભાષામાં સહ્રાય માટે કોઈ પણ ખર્ચ વગર 1-877-409-7361 પર કૉલ કરો.

Hawaiian -No ke kōkua ma ka 'ōlelo Hawai'i, e kahea aku i ka helu kelepona 1-877-409-7361. Kāki 'ole 'ia kēia kōkua nei.

हिनदी में भाषा सहायता के लिए 1-877-409-7361 पर मुफ़त कॉल करें। Hindi -

Hmong -Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-877-409-7361.

Maka enyemaka asusu na labo koo 1-877-409-7361 na akwughi ugwo o bula lbo -

Ilocano -Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-877-409-7361 nga awan ti bayadanyo.

Italian -Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-877-409-7361.

日本語で援助をご希望の方は、1-877-409-7361 まで無料でお電話ください。 Japanese -

လာတာမြာစားတာကတိုးကျိုာ်အင်္ဂါ ကျိုာ် ကိုး 1-877-409-7361 လာတအိုာ်နီးတာ်လာဘ်ဘွာ်လာဘ်စွာဘည် Karen -

한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-877-409-7361 번으로 전화해 주십시오. Korean -

Kru-Bassa -'Bε'm'ké gbo-kpá-kpá dyé pidyi dé 'Ba'sɔɔɔ̂-wu'duù'n wεε, dá 1-877-409-7361

براي راهنمايي به زبان فارسي باشماره 7361-877-10 به خورايي پهيومندي بكهن. Kurdish -

ຖ້ຳທ່ານຕ້ອງການຄວາມຊ່ວຍເຫືອໃນການແປພາສາລາວ, ກະລນາໂທຫາ-877-409-7361 ໂດຍບໍ່ເສຍຄ່າໂທ. Laotian -

कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-877-409-7361 वर फोन करा. Marathi -

Marshallese -Ñan bōk jipañ ilo Kajin Majol, kallok 1-877-409-7361 ilo ejjelok wōnān.

Micronesian-Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-877-409-7361 ni sohte isais. Pohnpeyan -

Mon-Khmer, សម្ភាប់ជំនួយភាសាជា ភាសាខុមរៃ សូមទូរស័ព្ទទទៅកាន់លខេ 1-877-409-7361 ដោយឥតគិតថ្លាំ។

Cambodian -T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-877-409-7361

877-409-7361 मा फोन गर्नुहोस्। (नेपाली) मा निःश्लक भाषा सहायता पाउनका लागि 1-Nepali -

Nilotic-Dinka -Tën kupony ë thok ë Thuonjan col 1-877-409-7361 kecin ayöc.

Navaio -

For språkassistanse på norsk, ring 1-877-409-7361 kostnadsfritt. Norwegian -

Panjabi -ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-877-409-7361 'ਤੇ ਮਫ਼ਤ ਕਾਲ ਕਰੋ।

Pennsylvania Dutch - Fer Helfe in Deitsch, ruf: 1-877-409-7361 aa. Es Aaruf koschtet nix.

برای راهنمایی به زبان فارسی با شماره 7361-409-1-877 بدون هیچ هزینه ای تماس بگیرید. انگلیسی Persian -

Aby uzyskać pomoc w jezyku polskim, zadzwoń bezpłatnie pod numer 1-877-409-7361. Polish -

Portuguese - Para obter assistência linguística em português ligue para o 1-877-409-7361 gratuitamente.

Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-877-409-7361

Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-877-409-7361.

Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-877-409-7361 e aunoa ma se totogi.

Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-877-409-7361.

Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-877-409-7361.

Sudanic-Fulfude - Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-877-409-7361. Njodi woo fawaaki on.

Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-877-409-7361 bila malipo.

Syriac - K = 32K K & p21 and 21 22 K wain on Ly ippK 181, 20 1-877-409-7361 ap

Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-877-409-7361 nang walang bayad.

Telugu - భాషతో సాయం కొరకు ఎలాంటి ఖర్పు లేకుండా 1-877-409-7361 కు కాల్ చేయండి. (తెలుగు)

Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-877-409-7361 ฟรีไม่มีค่าใช้จ่าย

Tongan - Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-877-409-7361 'o 'ikai hā ōtōngi.

Trukese - Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-877-409-7361 nge esapw kamé ngonuk.

Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-877-409-7361.

Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-877-409-7361.

بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-877-409-7361 یر بات کریں۔

Vietnamese - Đê 'được hố trở ngôn ngư bằng (ngôn ngư), hấy gọi miến phi 'đến số '1-877-409-7361.

Yiddish - פאר שפראך הילף אין אידיש רופט 1-877-409-7361 פריי פון אפצאל.

Yoruba - Fún ìrànlowo nípa èdè (Yorùbá) pe 1-877-409-7361 lái san owó kankan rárá.