

SANTA CLARA UNIVERSITY : Open Choice®

Coverage Period: 08/15/2024-08/14/2025 Coverage for: Individual | Plan Type: PPO



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, https://www.aetnastudenthealth.com or by calling 1-877-480-4161. 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 1-877-480-4161 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 \$500. Out-of-Network: Individual \$1,000.	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.
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 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 \$8,700. Out-of-Network: Individual \$17,400.	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance billing</u> , 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 1-877-480-4161 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.

	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
	Primary care visit to treat an injury or illness	\$20 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$20 <u>copay</u> /visit, <u>deductible</u> doesn't apply	None
If you visit a health care <u>provider</u> 's office or clinic	<u>Specialist</u> visit	\$20 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$20 <u>copay</u> /visit, <u>deductible</u> doesn't apply	None
	Preventive care /screening /immunization	No charge	40% 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.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% coinsurance	None
If you need drugs to treat your illness or condition	Generic drugs	Copay/prescription, deductible doesn't apply: \$15 (retail), \$37.50 (mail order)	Copay/prescription, deductible doesn't apply: \$15 (retail)	
More information about <u>prescription</u> <u>drug coverage</u> is available at www.aetna.com/pha rmacy- insurance/individual s-families	Preferred brand drugs	Copay/prescription, deductible doesn't apply: \$40 (retail), \$100 (mail order)	Copay/prescription, deductible doesn't apply: \$40 (retail)	Covers 30 day supply (retail). Includes contraceptive drugs & devices obtainable from pharmacy. No charge for preferred generic FD approved women's contraceptives in-network.

Common Medical Event	Services You May Need	What You 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
	Non-preferred brand drugs	Copay/prescription, deductible doesn't apply: \$75 (retail), \$187.50 (mail order)	Copay/prescription, deductible doesn't apply: \$75 (retail)	
	Specialty drugs	Copay/prescription, deductible doesn't apply: \$150 (retail)	Copay/prescription, deductible doesn't apply: \$150 (retail)	None
If you have	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
outpatient surgery	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	20% <u>coinsurance</u> after \$150 <u>copay</u> /visit, <u>deductible</u> doesn't apply	20% <u>coinsurance</u> after \$150 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> . No coverage for non-emergency use.
	Emergency medical transportation	20% <u>coinsurance</u> after \$150 <u>copay</u> /trip	20% <u>coinsurance</u> after \$150 <u>copay</u> /trip	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> .
	<u>Urgent care</u>	\$20 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$20 <u>copay</u> /visit, <u>deductible</u> doesn't apply	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	Physician/surgeon fees	20% coinsurance	40% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You 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 need mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$20 copay/visit, deductible doesn't apply; other outpatient services: 20% coinsurance	Office: \$20 <u>copay</u> /visit; other outpatient services: 40% <u>coinsurance</u>	None
	Inpatient services	20% coinsurance	40% <u>coinsurance</u>	Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	Office visits	No charge	40% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and
If you are pregnant	Childbirth/delivery professional services	20% coinsurance	40% <u>coinsurance</u>	services described elsewhere in the SBC (i.e., ultrasound). Penalty of \$500 for failure to obtain
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	pre-authorization for out-of-network care may apply.
	Home health care	20% coinsurance	40% coinsurance	None
If you need help recovering or have other special health needs	Rehabilitation services	\$20 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$20 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Includes Physical, Occupational & Speech
	<u>Habilitation services</u>	\$20 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$20 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Therapy combined.
	Skilled nursing care	20% coinsurance	40% <u>coinsurance</u>	Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	Durable medical equipment	20% coinsurance	40% coinsurance	None
	Hospice services	20% coinsurance	40% coinsurance	Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care.
If your child needs	Children's eye exam	No charge	0% coinsurance	1 routine eye exam/ <u>plan</u> year up to age 19.
dental or eye care	Children's glasses	No charge	0% coinsurance	1 pair of glasses or lenses/ <u>plan</u> year.
delitar of cyc care	Children's dental check-up	No charge	0% coinsurance	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)
- Hearing aids

- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

- Routine foot care
- Weight loss programs Except for required <u>preventive</u> 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
- Infertility treatment Limited to the diagnosis & treatment of underlying medical condition.
- Routine eye care (Adult) 1 routine eye exam. Limited to covered persons age 19 and over

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: California Department of Insurance, Consumer Communications Bureau Health, 300 South Spring Street, South Tower, Los Angeles, CA 90013, 1-800-927-HELP (4357), 1-800-482-4833 (TTY), https://www.insurance.ca.gov.

• For more information on your rights to continue coverage, contact the plan at 1-877-480-4161.

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:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-877-480-4161.
- California Department of Insurance, Consumer Communications Bureau Health, 300 South Spring Street, South Tower, Los Angeles, CA 90013, 1-800-927-HELP (4357), 1-800-482-4833 (TTY), http://www.insurance.ca.gov
- Additionally, a consumer assistance program can help you file your appeal. Contact California Department of Insurance, Consumer Communications Bureau, 300 South Spring Street, South Tower, Los Angeles, CA 90013, 1-800-927-Help (4357), 1-800-482-4833(TTY), www.insurance.ca.gov

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>	\$0
■ 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	\$12,700
In this example, Peg would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$10
Coinsurance	\$2,200
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,770

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>	\$0
■ 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

Durable medical equipment (glucose meter)

Total Example Cost	\$5,600	
In this example, Joe would pay:		
<u>Cost Sharing</u>		
<u>Deductibles</u>	\$100	
<u>Copayments</u>	\$1,200	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$20	
The total Joe would pay is	\$1,320	

Mia's Simple Fracture

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

■ The plan's overall deductible	\$0
■ Specialist copayment	\$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	\$2,800	
In this example, Mia would pay:		
Cost Sharing		
<u>Deductibles</u>	\$500	
<u>Copayments</u>	\$100	
<u>Coinsurance</u>	\$300	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$900	

The plan would be responsible for the other costs of these EXAMPLE covered services.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 866-393-0002.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, disability, gender identity or sexual orientation.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: P.O. Box 24030, Fresno, CA 93779),

1-800-648-7817, TTY: 711,

Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

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

Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies, including Aetna Life Insurance Company and its affiliates (Aetna).

TTY: 711

Language Assistance:

To access language services at no cost to you, call 1-877-480-4161.

Albanian - Për shërbime përkthimi falas për ju, telefononi 1-877-480-4161.

Amharic - የቋንቋ አባልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-877-480-4161 ይደውሉ።

للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء االتصال على الرقم 4161-480-4161 اللغوية دون أي تكلفة، الرجاء التصال على الرقم 4161-480

Armenian - Անվձար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-877-480-4161 հեռախոսահամարով։

Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-877-480-4161 tanpa dikenakan biaya.

Bantu-Kirundi - Kugira uronke serivisi z'indimi atakiguzi, hamagara 1-877-480-4161.

Bengali-Bangala - আপনাকে বিনামৃক্যে ভাষা পবিক্ষাি পপকে হক্ষ এই নম্বকি পেব্যক ান েরুন: 1-877-480-4161

Bisayan-Visayan - Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-877-480-4161.

Burmese - သင့္အေနျဖင့္ အခေၾကးေငြ မေပးရပဲ ဘာသာစကားဝန္ေဆာင္မႈမ်ား ရရွိႏုိင္ရန္ 1-877-480-4161 သို႕ ဖုန္းေခၚဆုိပါ။

Catalan - Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-877-480-4161.

Chamorro - Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-877-480-4161.

Cherokee - GYOJ SOHAOJ OGOLONJ L ALOJ IGEGWIJ PA OPAPARO 1-877-480-4161.

Chinese - 如欲使用免費語言服務, 請致電 1-877-480-4161.

Choctaw - Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-877-480-4161.

Cushite - Tajaajiiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-877-480-4161.

Dutch - Voor gratis toegang tot taaldiensten, bell 1-877-480-4161.

French - Afin d'accéder aux services langagiers sans frais, composez le 1-877-480-4161.

French Creole - Pou jwenn sèvis lang gratis, rele 1-877-480-4161.

German - Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-877-480-4161 an.

Greek - Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό

1-877-480-4161.

Gujarati - તમારેકોઇ જાતના ખર્યવિના ભાષાની સેિાઓની પહોોંર્ માટે, કોલ કરો1-877-480-4161.

Hawaiian - No ka wala'au 'ana me ka lawelawe 'ōlelo e kahea aku i kēia helu kelepona 1-877-480-4161. Kāki 'ole 'ia kēia kōkua nei.

Hindi - आपकेलिए बिना ककसी कीमत केभाषा सेवाओंका उपयोग करनेकेलिए, 1-877-480-4161 पर कॉल करें।

Hmong - Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-877-480-4161.

lgbo - Iji nwetaòhèrè na oru gasi asusu n'efu, kpoo 1-877-480-4161

llocano - Tapno maaksesyo dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti 1-877-480-4161.

Indonesian - Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi 1-877-480-4161.

Italian - Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-877-480-4161.

Japanese - 言語サービスを無料でご利用いただくには、1-877-480-4161 までお電話ください。

Karen - လာတါကမၤနှါ်ကိုဉ်အတါမၢစာၤအတါဖီးတါမာတဗဉ်လာတအိဉ်ဒီးအပူးလာကဘဉ်ဟုဉ်အီးအဂ်ီးဘဉ်နှဉ် ကိုး 1-877-480-4161 တက္၊

Korean - 무료 언어 서비스를 이용하려면 1-877-480-4161 번으로 전화해 주십시오.

Kru-Bassa - M dyi wudu-dù kà kò dò bě dyi moú ń nì Pídyi ní, nìí, dá nòbà nìà kε: 1-877-480-4161

بۆ دەسىپىراگەيشتن بە خزمەتگوزارى زمان بەبئى تېچوون بۆ تۆ، يەيوەندى بكە بە ژمارەي 4161-480-487-1-8-1

Laotian - ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ. ໃຫ້ໂທຫາເບີ1-888-982-3862

Marathi - कोणत्याही शल्कालशवाय भाषा सेवा प्राप्त करण्यासाठी,, 1-877-480-4161 वर फोन करा.

Marshallese - Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlok 1-877-480-4161.

Micronesian-

Pohnpeyan - Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1-877-480-4161.

Mon-Khmer, ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-877- 480-4161។

Cambodian -

Navajo - T'áá ni nizaad k'ehjí bee níká a'doowoł doo bááh ílínígóó kojj' hólne' 1-877-480-4161.

Nepali - निःश्ल्क भाषा सेवा प्राप्त गर्न 1-877-480-4161 मा टेलिफोन गर्नुहोस्।

Nilotic-Dinka - Të koor yin weër de thokic ke cin wëu kor keek tënon yin. Ke col koc ye koc kuony ne nomba 1-877-480-4161.

Norwegian - For tilgang til kostnadsfri språktjenester, ring 1-877-480-4161.

Pennsylvania Dutch - Um Schprooch Services zu griege mitaus Koscht, ruff 1-877-480-4161.

برای دسترسی به خدمات زبان به طور رایگان، با شماره 4161-480-487-1 تماس بگیرید.

Polish - Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-877-480-4161.

Portuguese - Para acessar os serviços de idiomas sem custo para você, ligue para 1-877-480-4161.

Punjabi - ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1-877-480-4161 'ਤੇ ਫ਼ੋਨ ਕਰੋ।

Romanian - Pentru a accesa gratuit serviciile de limbă, apelați 1-877-480-4161.

Russian - Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-877-480-4161.

Samoan - Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala'au le 1-877-480-4161.

Serbo-Croatian - Za besplatne prevodilačke usluge pozovite 1-877-480-4161.

Spanish - Para acceder a los servicios de idiomas sin costo, llame al 1-877-480-4161.

Sudanic-Fulfude - Heeba a nasta jangirde djey wolde wola chede bo apelou lamba 1-877-480-4161.

Swahili - Kupata huduma za lugha bila malipo kwako, piga 1-877-480-4161.

Syriac - : مُعبِعُه ، مُجرِيّع حلَّة المُجلِّة المُجلِّة على المُجلِّة المُجلِّة على المُجلِّة المُحرّد المُحر

Tagalog - Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-877-480-4161.

Telugu - మీరు భాష్ణ సేవలను ఉచితంగా అందుకునందుకు, 1-877-480-4161 కు కాల్ చేయండి.

Thai - หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-877-480-4161.

Tongan - Kapau 'oku ke fiema'u ta'etōtōngi 'a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he 1-877-480-4161.

Trukese - Ren omw kopwe angei aninisin eman chon awewei (ese kamo), kopwe kori 1-877-480-4161.

Turkish - Sizin için ücretsiz dil hizmetlerine erişebilmek için, 1-877-480-4161 numarayı arayın.

Ukrainian - Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-877-480-4161.

بالقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 2862-982-988 پر بات کریں۔

Vietnamese - Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-877-480-4161.

Yiddish - 1-877-480-4161 צו צוטריט שּפרַאך בַאדינונגען אין קיין פרייַז צו איר, רופן

Yoruba - Lati wonú awon ise èdè l'ofe fun o, pe 1-877-480-4161.