

LONE STAR COLLEGE SYSTEM: Open Choice® PPO

Coverage for: Individual + Family | Plan Type: PPO

Coverage Period: 08/10/2021-08/09/2022



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 1-800-783-2573. 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 1-800-783-2573 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 / Family \$1,500. Out-of-Network: Individual \$1,000 / Family \$3,000. | 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. In- <u>network</u> office visits, <u>prescription drugs</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 \$6,850 / Family \$13,700. Out-of-Network: Individual \$13,700 / Family \$27,400. | 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 1-800-783-2573 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 specialist you choose without a referral. |



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.

| 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 |
|--|--|---|--|---|
| | Primary care visit to treat an injury or illness | \$35 <u>copay</u> /visit, <u>deductible</u> doesn't apply | 40% <u>coinsurance</u> | None |
| If you visit a health care <u>provider</u> 's office or clinic | <u>Specialist</u> visit | \$35 <u>copay</u> /visit, <u>deductible</u> doesn't apply | 40% <u>coinsurance</u> | None |
| | Preventive care /screening /immunization | No charge | 40% coinsurance, except no charge for immunizations up to age 6 | 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. |
| | <u>Diagnostic test</u> (x-ray, blood work) | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | None |
| If you have a test | Imaging (CT/PET scans, MRIs) | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | None |

| Common Medical Event | Services You May Need | In-Network Provider | Out-of-Network Provider | Limitations, Exceptions, & Other Important Information |
|---|-----------------------|--|--|---|
| | | (You will pay the least) | (You will pay the most) | |
| | Generic drugs | Copay/prescription, deductible doesn't apply: \$15 (retail), \$45 (mail order) | 50% coinsurance after copay/ prescription, deductible doesn't apply: \$15 (retail), \$45 (mail order) | |
| If you need drugs to treat your | Preferred brand drugs | Copay/prescription, deductible doesn't apply: \$30 (retail), \$90 (mail order) | 50% coinsurance after copay/ prescription, deductible doesn't apply: \$30 (retail), \$90 (mail order) | Covers 30-day supply (retail), 31-90 day supply (retail & mail order). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives in-network. |
| illness or condition More information about prescription drug coverage is | | Copay/prescription, deductible doesn't apply: \$40 (retail), \$120 (mail order) | 50% coinsurance after copay/ prescription, deductible doesn't apply: \$40 (retail), \$120 (mail order) | |
| available at https://www.aetna.c https://www.aetna.c families/pharmacy.h tml | Specialty drugs | Copay/prescription, deductible doesn't apply: \$15 (retail), \$45 (mail order) for Generic drugs, \$30 (retail), \$90 (mail order) for Preferred brand drugs, \$40 (retail), \$120 (mail order) for Nonpreferred brand drugs | 50% coinsurance after copay/prescription, deductible doesn't apply: \$15 (retail), \$45 (mail order) for Generic drugs, \$30 (retail), \$90 (mail order) for Preferred brand drugs, \$40 (retail), \$120 (mail order) for Nonpreferred brand drugs | 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 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 | 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 | No coverage for non-emergency use. |
| immediate medical attention | Emergency medical transportation | 20% coinsurance | 20% coinsurance | None |
| attention | <u>Urgent care</u> | \$35 <u>copay</u> / visit, <u>deductible</u> doesn't apply | 40% coinsurance | No coverage for non-urgent use. |
| If you have a | 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. |
| hospital stay | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | None |
| If you need mental health, behavioral health, or substance abuse | Outpatient services | Office: \$35 <u>copay</u> /visit, <u>deductible</u> doesn't apply; other outpatient services: 20% <u>coinsurance</u> | Office & other outpatient services: 40% coinsurance | None |
| services | Inpatient services | 20% coinsurance | 40% coinsurance | Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care. |
| | Office visits | No charge | 40% coinsurance | |
| If you are pregnant | Childbirth/delivery professional services | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Penalty of \$500 for failure to obtain pre-authorization for out-of-network care may |
| | Childbirth/delivery facility services | 20% coinsurance | 40% coinsurance | apply. |

| 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 |
|---|----------------------------------|---|--|--|
| | Home health care | 20% coinsurance | 40% coinsurance | None. |
| | Rehabilitation services | 20% coinsurance | 40% coinsurance | Includes Physical, Occupational & Speech |
| If you need help | Habilitation services | 20% coinsurance | 40% coinsurance | Therapy. |
| recovering or have other special health needs | Skilled nursing care | 20% coinsurance | 40% coinsurance | Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care. |
| nealth needs | <u>Durable medical equipment</u> | 20% coinsurance | 40% coinsurance | Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse. |
| | Hospice services | 20% coinsurance | 40% coinsurance | Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care. |
| If your shild was do | Children's eye exam | No charge | 40% coinsurance | 1 routine eye exam/ <u>plan</u> year up to age 19. |
| If your child needs dental or eye care | Children's glasses | No charge | 40% coinsurance | 1 pair of glasses or lenses/ <u>plan</u> year. |
| dental of tyte calt | Children's dental check-up | No charge | No charge | Limited to 2 visits every 12 months. |

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.)

| 3 | Services Your <u>Plan</u> Generally Does NOT Cover | Cne | ck your policy or <u>plan</u> document for more into | Orma | ation and a list of any other <u>excluded services</u> .) |
|---|--|-----|--|------|---|
| • | Acupuncture | • | Long-term care | • | Routine foot care |
| • | Cosmetic surgery | • | Private-duty nursing | • | Weight loss programs - Except for required preventive |
| • | Dental care (Adult) | • | Routine eye care (Adult) | | services. |

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

- Bariatric surgery
- Chiropractic care limited to 35 visits/<u>plan</u> year.
- 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: Texas Department of Insurance, 1-800-252-3439, https://www.tdi.texas.gov/consumer/index.html. 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.tdi.texas.gov/consumer/index.html. 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.tdi.texas.gov/consumer/index.html.

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 on how 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 1-800-783-2573.
- Texas Department of Insurance, 1-800-252-3439, https://www.tdi.texas.gov/consumer/index.html.
- Additionally, a consumer assistance program can help you file your <u>appeal</u>. Contact Texas Department of Insurance, Consumer Protection, Mail Code 111-1A, 333 Guadalupe, P.O. Box 149091, Austin, TX 78714-9091, Phone toll-free: 1-800-252-3439, http://www.texashealthoptions.com, Consumer Protection@tdi.texas.gov

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes <u>plans</u>, <u>health insurance</u> available through the <u>Marketplace</u> 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> | \$500 |
|---|-------|
| Specialist copayment | \$35 |
| ■ 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 |
| Copayments | \$100 |
| Coinsurance | \$2,420 |
| What isn't covered | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$3,080 |

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> | \$500 |
|---|-------|
| ■ Specialist copayment | \$35 |
| ■ 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 | \$5,600 |
|---------------------------------|---------|
| In this example, Joe would pay: | |
| <u>Cost Sharing</u> | |
| <u>Deductibles</u> | \$500 |
| <u>Copayments</u> | \$1,700 |
| Coinsurance | \$10 |
| What isn't covered | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$2,230 |

Mia's Simple Fracture

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

| ■ The <u>plan's</u> overall <u>deductible</u> | \$500 |
|---|-------|
| ■ Specialist copayment | \$35 |
| ■ 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 (crutches)</u>

Rehabilitation services (physical therapy)

| Total Example Cost | \$2,800 |
|---------------------------------|---------|
| In this example, Mia would pay: | |
| Cost Sharing | |
| <u>Deductibles</u> | \$500 |
| <u>Copayments</u> | \$70 |
| <u>Coinsurance</u> | \$450 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,020 |

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-800-783-2573.

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 1-800-783-2573 at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-800-783-2573 .

Amharic - ለቋንቋ እንዛ በ አማርኛ በ 1-800-783-2573 በነጻ ይደውሉ

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-800-783-2573

Armenian - Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-800-783-2573 առանց գնով։

Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-783-2573 tanpa dikenakan biaya.

Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-800-783-2573 ku busa

Bengali-Bangala - বাংলা্ম ভাষা সহা্মতার জন্য বিনামুল্যে 1-800-783-2573 -তে কল করুন।

Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-783-2573 nga walay bayad.

Burmese - ငွေကုန်ကျစံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-800-783-2573 ကို ခေါ် ဆိုပါ။

Catalan - Per rebre assistència en (català), truqui al número gratuït 1-800-783-2573.

Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-800-783-2573 sin gåstu.

Cherokee - $\theta \circ D Y \theta S \circ D h \mathcal{A} \circ D J J h \circ D S P \circ D Y \theta t T (GWY) O D W \circ 1S 1-800-783-2573 O \theta T C A F \circ D J D E G P J h P R \theta$.

Chinese - 欲取得繁體中文語言協助, 請撥打1-800-783-2573, 無需付費。

Choctaw - (Chahta) anumpa ya apela a chi I paya hinla 1-800-783-2573.

Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-800-783-2573 irratti bilisaan bilbilaa.

Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-783-2573.

French - Pour une assistance linguistique en français appeler le 1-800-783-2573 sans frais.

French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-800-783-2573 gratis.

German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-783-2573 an.

Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-783-2573 χωρίς χρέωση.

Gujarati - ગુજરાતીમાં ભાષામાં સહ્રાય માટે કોઈ પણ ખર્ચ વગર 1-800-783-2573 પર કૉલ કરો.

Hawaiian - No ke kōkua ma ka 'ōlelo Hawai'i, e kahea aku i ka helu kelepona 1-800-783-2573 . Kāki 'ole 'ia kēia kōkua nei.

Hindi- हिन्दी में भाषा सहायता के लिए, 1-800-783-2573 पर मुफ्त कॉल करें।

Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-800-783-2573.

lbo - Maka enyemaka asusu na Igbo kpoo 1-800-783-2573 na akwughi ugwo o bula

llocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-783-2573 nga awan ti bayadanyo.

Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-800-783-2573.

Japanese - 日本語で援助をご希望の方は、1-800-783-2573 まで無料でお電話ください。

Karen - လာတစ်မာစားတစ်ကတိုးကျိုဉ်အင်္ဂ ကျိုဉ် ကိုး 1-800-783-2573 လာတအိုဉ်ဒီးတစ်လာ၁်ဘူဉ်လာ၁်စာသည်

Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-783-2573 번으로 전화해 주십시오.

Kru-Bassa - Be´m`ké gbo-kpá-kpá dyé pidyi dé Bašsoó-wuduùn wee, dá 1-800-783-2573

برای راهنمایی به زبان فارسی با شماره 2573-783-1800 به خورایی پهیوهندی بکهن.

Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ-800-783-2573 ໂດຍບໍ່ເສຍຄ່າໂທ.

Marathi - कोणत्याही श्ल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-800-783-2573 वर फोन करा.

Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-800-783-2573 ilo ejjelok wōnān.

Micronesian-Pohnpeyan - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-800-783-2573 ni sohte isais.

Mon-Khmer, សម្**រាប់ជំនួយភាសាជា ភាសាខ្**មរែ សូមទូរស័ព្**ទទ**ៅកាន់លខេ 1-800-783-2573 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' 1-800-783-2573

Nepali - (नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1- 800-783-2573 मा फोन गर्नुहोस् ।

Nilotic-Dinka - Tën kuoony ë thok ë Thuonjän col 1-800-783-2573 kecïn ayöc.

Norwegian - For språkassistanse på norsk, ring 1-800-783-2573 kostnadsfritt.

Panjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-800-783-2573 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।

Pennsylvania Dutch - Fer Helfe in Deitsch, ruf: 1-800-783-2573 aa. Es Aaruf koschtet nix.

برای راهنمایی به زبان فارسی با شماره 2573-783-1800 بدون هیچ هزینه ای تماس بگیرید. انگلیسی Persian -

Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-800-783-2573.

Portuguese - Para obter assistência linguística em português ligue para o 1-800-783-2573 gratuitamente.

Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-800-783-2573

Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-800-783-2573 .

Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-800-783-2573 e aunoa ma se totogi.

Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-800-783-2573.

Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-800-783-2573.

Sudanic-Fulfude - Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-800-783-2573 . Njodi woo fawaaki on.

Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-800-783-2573 bila malipo.

Syriac - K = 32 K K & p2-11 abk = 1-800-783-2573 apx .

Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-800-783-2573 nang walang bayad.

Telugu - భాషతో సాయం కొరకు ఎలాంటి ఖర్పు లేకుండా 1-800-783-2573 కు కాల్ చేయండి. (తెలుగు)

Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-800-783-2573 ฟรีไม่มีค่าใช้จ่าย

Tongan - Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-800-783-2573 'o 'ikai hā ōtōngi.

Trukese - Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-800-783-2573 nge esapw kamé ngonuk.

Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-800-783-2573.

Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-800-783-2573.

بلاقیمت زیان سے متعلقہ خدمات حاصل کرنے کے لیے 1-800-783-2573 . پر بات کریں۔

Vietnamese - Đê 'được hố trợ ngôn ngư bằng (ngôn ngư), hấy gọi miến phi 'đên số '1-800-783-2573 .

Yiddish - פאר שפראך הילף אין אידיש רופט 1-800-783-2573 פריי פון אפצאל.

Yoruba - Fún ìrànlowo nípa èdè (Yorùbá) pe 1-800-783-2573 lái san owó kankan rárá.