Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period: 08/15/2022-08/14/2023

aetna™ LAMAR UNIVERSITY:
Open Choice® PPO

Coverage for: Individual + Family | Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, https://www.aetnastudenthealth.com/ or by calling 1-888-407-0445. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-888-407-0445 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For each Plan Year, In-Network: Individual $500 / Family $1,000. Out-of-Network: Individual $1,000 / Family $2,000.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network office visits, prescription drugs & preventive care are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: Individual $7,350 / Family $14,700. Out-of-Network: Individual $15,000 / Family $30,000.	The out–of–pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit 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 1-888-407-0445 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay: In-Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit, deductible doesn't apply	40% coinsurance	None
	Specialist visit	$30 copay/visit, deductible doesn't apply	40% coinsurance	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 provider if the services needed are preventive. Then check what your plan 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% coinsurance	40% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.aetna.com/individuals-families/pharmacy.html	Generic drugs	Copay/prescription, deductible doesn't apply: $20 (retail), $50 (mail order)	40% coinsurance, deductible doesn't apply	Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in-network. Review your formulary for prescriptions requiring precertification or step therapy for coverage.
	Preferred brand drugs	Copay/prescription, deductible doesn't apply: $40 (retail), $100 (mail order)	40% coinsurance, deductible doesn't apply	
	Non-preferred brand drugs	Copay/prescription, deductible doesn't apply: $60 (retail), $150 (mail order)	40% coinsurance, deductible doesn't apply	
	Specialty drugs	Copay/prescription, deductible doesn't apply: $20 (retail), $50 (mail order) for Generic drugs, $40 (retail), $100 (mail order) for Preferred brand drugs, $60 (retail), $150 (mail order) for Non-preferred brand drugs	40% coinsurance, deductible doesn't apply	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay In-Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	Emergency room care	20% coinsurance after $150 copay/ visit, deductible doesn't apply	20% coinsurance after $150 copay/ visit, deductible doesn't apply	No coverage for non-emergency use.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	$50 copay/ visit, deductible doesn't apply	40% coinsurance	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 pre-authorization for out-of-network care.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: $30 copay/visit, deductible doesn't apply; other outpatient services: 20% coinsurance	Office & other outpatient services: 40% coinsurance	None
	Inpatient services	20% coinsurance	40% coinsurance	Penalty of $500 for failure to obtain pre-authorization for out-of-network care.
If you are pregnant	Office visits	No charge	40% coinsurance	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 apply.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	60 visits/plan year.
	Rehabilitation services	20% coinsurance	40% coinsurance	Includes Physical, Occupational & Speech Therapy.
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	25 days/plan year. Penalty of $500 for failure to obtain pre-authorization for out-of-network care.
	Durable medical equipment	20% coinsurance	40% coinsurance	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	20% coinsurance	40% coinsurance	Penalty of $500 for failure to obtain pre-authorization for out-of-network care.

Common Medical Event	Services You May Need	What You Will Pay In-Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If your child needs dental or eye care	Children's eye exam	No charge	40% coinsurance	1 routine eye exam/plan year up to age 19.
	Children's glasses	No charge	40% coinsurance	1 pair of glasses or lenses/plan year.
	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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- 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.)

- Chiropractic care
- Hearing aids – 1 hearing aid per ear/3 years.
- 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.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-888-407-0445 or 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 appeal. 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, ConsumerProtection@tdi.texas.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.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-888-407-0445.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-407-0445.
Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-407-0445.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-407-0445.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$500**
Specialist copayment	**$30**
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:	
Cost Sharing	
Deductibles	$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 plan's overall deductible	**$500**
Specialist copayment	**$30**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$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 plan's overall deductible	**$500**
Specialist copayment	**$30**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

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

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 1-888-407-0445.

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: 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).

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TTY: 711

Language Assistance:

For language assistance in your language call 1-888-407-0445 at no cost.

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-888-407-0445.
Amharic -	ለቋንቋ እገዛ በ አማርኛ በ 1-888-407-0445 በነጻ ይደውሉ
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-888-407-0445
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-888-407-0445 առանց գնով:
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-407-0445 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-888-407-0445 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বিনামুল্যে 1-888-407-0445-তে কল করুন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-888-407-0445 nga walay bayad.
Burmese -	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-888-407-0445 ကို ခေါ်ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-888-407-0445.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-888-407-0445 sin gåstu.
Cherokee -	ᎾᏍᎩᎾ ᏕᏬᏂᎯᏍᏗ ᏗᏂᏍᏕᎵᏍᎩ ᎾᏛᎢ (ᏣᎳᎩ) ᏫᏏᏔᏅᎢᏕ 1-888-407-0445 ᎤᎾᎢ Ꮭ ᎠᎱᏍᏗ ᏧᎬᏩᎶᏗ ᏂᏢᏒᎾ.
Chinese -	欲取得繁體中文語言協助，請撥打 1-888-407-0445，無需付費。
Choctaw -	(Chahta) anumpa ya apela a chi I paya hinla 1-888-407-0445.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-888-407-0445 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-888-407-0445.
French -	Pour une assistance linguistique en français appeler le 1-888-407-0445 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-888-407-0445 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-888-407-0445 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-888-407-0445 χωρίς χρέωση.
Gujarati -	ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-888-407-0445 પર કોલ કરો.

Hawaiian -	No ke kōkua ma ka ʻōlelo Hawaiʻi, e kahea aku i ka helu kelepona 1-888-407-0445. Kāki ʻole ʻia kēia kōkua nei.
Hindi -	हिन्दी में भाषा सहायता के लिए, 1-888-407-0445 पर मुफ्त कॉल करें।
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-888-407-0445.
Ibo -	Maka enyemaka asụsụ na Igbo kpọọ 1-888-407-0445 na akwụghị ụgwọ ọ bụla
Ilocano -	Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-888-407-0445 nga awan ti bayadanyo.
Italian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-888-407-0445.
Japanese -	日本語で援助をご希望の方は、1-888-407-0445 まで無料でお電話ください。
Karen -	လၢတၢ်မၤစၢၤတၢ်ကတိၤကျိာ်အဂီၢ် ကျိာ် ကိး 1-888-407-0445 လၢတအိဉ်ဒီးတၢ်လၢာ်ဘျာ်လၢာ်စုၤဘဉ်
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-407-0445 번으로 전화해 주십시오.
Kru-Bassa -	Ɓɛ´m`ké gbo-kpá-kpá dyé pidyi ɖé Ɓaɓɔɔ̀-wuɖuǔn wɛ̃ɛ, ɖá 1-888-407-0445
Kurdish -	برای راهنمایی به زبان فارسی با شماره 1-888-407-0445 به خۆرایی یەیوەندی بکەن.
Laotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ1-888-407-0445ໂດຍບໍ່ເສຍຄ່າໂທ.
Marathi -	कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-888-407-0445 वर फोन करा.
Marshallese -	Ñan bōk jipañ ilo Kajin Majol, kallok1-888-407-0445 ilo ejjelok wōnān.
Micronesian-Pohnpeyan -	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-888-407-0445 ni sohte isais.
Mon-Khmer, Cambodian -	សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-888-407-0445 ដោយឥតគិតថ្លៃ។
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-888-407-0445
Nepali -	(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1- 888-407-0445 मा फोन गर्नुहोस् ।
Nilotic-Dinka -	Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-888-407-0445 kecïn aɣöc.
Norwegian -	For språkassistanse på norsk, ring 1-888-407-0445 kostnadsfritt.
Panjabi -	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-888-407-0445 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-888-407-0445 aa. Es Aaruf koschtet nix.
Persian -	برای راهنمایی به زبان فارسی با شماره 1-888-407-0445 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Polish -	Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-888-407-0445.

Portuguese -	Para obter assistência linguística em português ligue para o 1-888-407-0445 gratuitamente.
Romanian -	Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-888-407-0445
Russian -	Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-888-407-0445.
Samoan -	Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-888-407-0445 e aunoa ma se totogi.
Serbo-Croatian -	Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-888-407-0445.
Spanish -	Para obtener asistencia lingüística en español, llame sin cargo al 1-888-407-0445.
Sudanic-Fulfude -	Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-888-407-0445. Njodi woo fawaaki on.
Swahili -	Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-888-407-0445 bila malipo.
Syriac -	ܐܢ ܒܥܐ ܐܢܬ ܦܘܪܫܢ ܐܘܕܐ ܒܠܫܢ ܐ ܣܘܪܝܝܐ ܗܘܐ ܠܟ ܩܪܐ ܩܪܝܬܐ 1-888-407-0445 ܡܓܢܐ.
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-888-407-0445 nang walang bayad.
Telugu -	భాషతో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 1-888-407-0445 కు కాల్ చేయండి. (తెలుగు)
Thai -	สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-888-407-0445 ฟรีไม่มีค่าใช้จ่าย
Tongan -	Kapau ‘oku fiema'u hā tokoni ‘i he lea faka-Tonga telefoni 1-888-407-0445 ‘o ‘ikai hā ōtōngi.
Trukese -	Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-888-407-0445 nge esapw kamé ngonuk.
Turkish -	(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-888-407-0445.
Ukrainian -	Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-888-407-0445.
Urdu -	بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-888-407-0445 . پر بات کریں۔
Vietnamese -	Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-888-407-0445.
Yiddish -	פאר שפראך הילף אין אידיש רופט 1-888-407-0445 פריי פון אפצאל.
Yoruba -	Fún ìrànlọwọ nípa èdè (Yorùbá) pe 1-888-407-0445 lái san owó kankan rárá.