♥aetna"

DES MOINES UNIVERSITY: Open Choice®

Coverage for: Individual | 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, <u>https://www.aetnastudenthealth.com/</u> or by calling 1-855-236-2144. 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 1-855-236-2144 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	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 <u>deductible</u> ?	Yes. <u>Prescription drugs</u> & office visits; plus in- <u>network 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 <u>https://www.healthcare.gov/coverage/preventive-care-benefits/</u> .
Are there other <u>deductibles</u> for specific services?	Yes. For <u>prescription drugs</u> - Individual \$100. There are no other specific <u>deductibles</u> .	You don't have to meet deductibles for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	In- <u>Network</u> & Out-of-Network: Individual \$6,600.	The <u>out–of–pocket limit</u> is the most you could pay in a year for covered services.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover & penalties for failure to obtain <u>pre-authorization</u> for services.	Even though you pay these expenses, they don't count toward the <u>out–of–pocket</u> <u>limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.aetna.com/docfind or call 1-855- 236-2144 for a list of in- <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</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 **<u>copayment</u>** and **<u>coinsurance</u>** costs shown in this chart are after your **<u>deductible</u>** has been met, if a **<u>deductible</u>** applies.

Common Medical Event	Services You May Need	What Yo In-Network Provider (You will pay the least)	ou 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	\$30 <u>copay</u> /visit	\$50 <u>copay</u> /visit	None
lf you visit a health care <u>provider</u> 's	<u>Specialist</u> visit	\$30 <u>copay</u> /visit	\$50 <u>copay</u> /visit	None
office or clinic	Preventive care /screening /immunization	No charge	50% <u>coinsurance</u>	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.
lfarm have a feet	Diagnostic test (x-ray, blood work)	20% coinsurance	50% <u>coinsurance</u>	None
If you have a test	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition	Generic drugs	<u>Copay</u> /prescription, <u>deductible</u> after specific <u>deductible</u> : \$15 (retail)	20% <u>coinsurance</u> after <u>copay</u> / specific <u>deductible</u> : \$15 (retail)	Covers 20 day supply (retail) Indudes
More information about prescription	Preferred brand drugs	Copay/prescription, deductible after specific deductible: \$45 (retail)	20% <u>coinsurance</u> after <u>copay</u> / specific <u>deductible</u> : \$45 (retail)	Covers 30-day supply (retail). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA- approved women's contraceptives in-network.
drug coverage is available at https://www.aetna.co	Non-preferred brand drugs	<u>Copay</u> /prescription, <u>deductible</u> after specific <u>deductible</u> : \$75 (retail)	20% <u>coinsurance</u> after <u>copay</u> / specific <u>deductible</u> : \$75 (retail)	approved women's contraceptives in- <u>network</u> .
m/individuals- families/pharmacy.ht ml	Specialty drugs	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
outpatient surgery	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need immediate medical	Emergency room care	20% <u>coinsurance</u> after \$250 <u>copay</u> /visit	20% <u>coinsurance</u> after \$250 <u>copay</u> /visit	No coverage for non-emergency use.
attention	Emergency medical transportation	20% <u>coinsurance</u> after \$100 <u>copay</u> /visit	20% <u>coinsurance</u> after \$100 <u>copay</u> /visit	None

	What You Will Pay		Limitations Fragming 8 Athenthypertent	
Common Medical Event	Services You May Need	In-Network Provider	Out-of-Network Provider	Limitations, Exceptions, & Other Important Information
Lvent		(You will pay the least)	(You will pay the most)	internation
	<u>Urgent care</u>	20% <u>coinsurance</u> after \$50 <u>copay</u> /visit	50% <u>coinsurance</u> after \$75 <u>copay</u> /visit	No coverage for non-urgent use.
If you have a	Facility fee (e.g., hospital room)	20% <u>coinsurance</u> after \$100 <u>copay</u> /stay	50% <u>coinsurance</u> after \$200 <u>copay</u> /stay	Penalty of \$500 for failure to obtain <u>pre-</u> authorization for out-of-network care.
hospital stay	Physician/surgeon fees	20% coinsurance	50% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance	Outpatient services	Office: \$30 <u>copay</u> / visit; other outpatient services: 20% <u>coinsurance</u>	Office: \$50 <u>copay</u> / visit; other outpatient services: 50% <u>coinsurance</u>	None
abuse services	Inpatient services	20% <u>coinsurance</u> after \$100 <u>copay</u> /stay	50% <u>coinsurance</u> after \$200 <u>copay</u> /stay	Penalty of \$500 for failure to obtain <u>pre-</u> <u>authorization</u> for out-of-network care.
	Office visits	No charge	50% coinsurance	Cost sharing does not apply for preventive
lf you are pregnant	Childbirth/delivery professional services	20% <u>coinsurance</u> after \$100 <u>copay</u> /stay	50% <u>coinsurance</u> after \$200 <u>copay</u> /stay	<u>services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Penalty of \$500 for failure to obtain
	Childbirth/delivery facility services	20% coinsurance	50% <u>coinsurance</u>	pre-authorization for out-of-network care may apply.
	Home health care	20% coinsurance	50% coinsurance	Penalty of \$500 for failure to obtain <u>pre-</u> <u>authorization</u> for out-of-network care.
	Rehabilitation services	20% coinsurance	50% <u>coinsurance</u>	Includes Physical, Occupational & Speech
lf	Habilitation services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Therapy, including outpatient hospital services.
If you need help recovering or have other special health needs	Skilled nursing care	20% <u>coinsurance</u> after \$100 <u>copay</u> /stay	50% <u>coinsurance</u> after \$100 <u>copay</u> /stay	Penalty of \$500 for failure to obtain <u>pre-</u> authorization for out-of-network care.
	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	50% <u>coinsurance</u>	Penalty of \$500 for failure to obtain <u>pre-</u> authorization for out-of-network care.
If your child needs dental or eye care	Children's eye exam	No charge	30% <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.
	Children's glasses	No charge	30% <u>coinsurance,</u> <u>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.

Common Medical		What You Will Pay		Limitationa Evantiona 8 Other Important
Event	Services You May Need		Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Children's dental check-up	No charge	30% 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.) Cosmetic surgery Long-term care Routine foot care • ٠ . Dental care (Adult) Routine eye care (Adult) Weight loss programs - Except for required preventive • services. Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) Acupuncture Hearing aids – 1 hearing aid per ear/plan Non-emergency care when traveling outside the U.S. ٠ • ٠ Bariatric surgery year. Private-duty nursing • • Infertility treatment – Limited to the diagnosis Chiropractic care ٠ • & treatment of underlying medical condition.

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: Iowa Insurance Division, Consumer Advocate Bureau, 515-654-6600, or toll free 877-955-1212, <u>http://insuranceca.iowa.gov/</u>. For more information on your rights to continue coverage, contact the <u>plan</u> at 1-855-236-2144. Other coverage options may be available to you, too, including buying individual insurance coverage through the <u>Health</u> Insurance Marketplace. For more information about the <u>Marketplace</u>, visit <u>www.HealthCare.gov</u> 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 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 1-855-236-2144 or lowa Insurance Division, Consumer Advocate Bureau, 515-654-6600, or toll free 877-955-1212, <u>http://insuranceca.iowa.gov/</u>.

Does this plan provide Minimum Essential Coverage? Yes.

<u>Minimum Essential Coverage</u> 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 <u>Minimum Essential Coverage</u>, you may not be eligible for the <u>premium tax credit</u>.

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 1-855-236-2144. Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-236-2144. Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-236-2144. Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-236-2144.

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 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) <u>coinsurance</u>	20%
Other <u>coinsurance</u>	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
<u>Coinsurance</u>	\$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 wellcontrolled condition)

The <u>plan's</u> overall <u>deductible</u>	\$500
Specialist copayment	\$30
Hospital (facility) <u>coinsurance</u>	20%
Other <u>coinsurance</u>	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:	
<u>Cost Sharing</u>	
Deductibles	\$100
<u>Copayments</u>	\$1,400
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,520

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	\$30
Hospital (facility) <u>coinsurance</u>	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
<u>Copayments</u>	\$70
<u>Coinsurance</u>	\$400
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$970

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 1-855-236-2144.

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 <u>https://ocrportal.hhs.gov/ocr/portal/lobby.jsf</u>, 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 1-855-236-2144 at no cost.

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-855-236-2144.
Amharic -	ለቋንቋ እንዛ በ አማርኛ በ 1-855-236-2144 በነጻ ይደውሉ
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 236-236-1-855
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-855-236-2144 առանց գնով։
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-855-236-2144 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-855-236-2144 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বিনামুল্যে 1-855-236-2144-তে কল করুন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-855-236-2144 nga walay bayad.
Burmese -	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-855-236-2144 ကို ခေါ်ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-855-236-2144.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-855-236-2144 sin gåstu.
Cherokee -	ӨоДУӨ <u>\$</u> ©Һ,ЭоД, Льод\$РодУ ӨҍТ (GWУ) Q ЬѠ©і\$ 1-855-236-2144 О'ӨТ Ĺ АГоД, JEGP, I ҺҎ _҄ RѲ.
Chinese -	欲取得繁體中文語言協助,請撥打1-855-236-2144,無需付費。
Choctaw -	(Chahta) anumpa y <u>a</u> apela a chi I p <u>a</u> ya hinla 1-855-236-2144.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-855-236-2144 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-855-236-2144.
French -	Pour une assistance linguistique en français appeler le 1-855-236-2144 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-855-236-2144 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-855-236-2144 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-855-236-2144 χωρίς χρέωση.
Gujarati -	ગુજરાતીમાં ભાષામાં સહ્રાય માટે કોઈ પણ ખર્ચ વગર 1-855-236-2144 પર કૉલ કરો.

Hawaiian -	No ke kōkua ma ka 'ōlelo Hawai'i, e kahea aku i ka helu kelepona 1-855-236-2144. Kāki 'ole 'ia kēia kōkua nei.
Hindi -	हन्दिी में भाषा सहायता के लए, 1-855-236-2144 पर मुफ्त कॉल करें।
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-855-236-2144.
bo -	Maka enyemaka asụsụ na Igbo kpọọ 1-855-236-2144 na akwụghị ụgwọ ọ bụla
locano -	Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-855-236-2144 nga awan ti bayadanyo.
talian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-855-236-2144.
Japanese -	日本語で援助をご希望の方は、1-855-236-2144 まで無料でお電話ください。
Karen -	လ၊ တၢိမၢစၢၤတၢိကတိၢကျိဉ်အဂ်ီ၊ ကျိဉ် ကိႏ 1-855-236-2144 လ၊ တအိုဉ်ဒီးတၢ်လ၊ ၁်ဘူဉ်လ၊ ၁်စူးဘဉ်
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-855-236-2144 번으로 전화해 주십시오.
Kru-Bassa -	Ɓε´m`ké gbo-kpá-kpá dyé pidyi dé Ɓašɔɔ́>̀wùdุuùǐn wɛ̃ɛ, dá 1-855-236-2144
Kurdish -	بر اي ر اهنمايي به زبان فارسي با شمار ه 214-236-255 به خور ايي پهيو مندي بکهن.
∟aotian - Marathi -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ1-855-236-2144 ໂດຍບໍ່ເສຍຄ່າໂທ. कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-855-236-2144 वर फोन करा.
Marshallese -	Ñan bōk jipañ ilo Kajin Majol, kallok 1-855-236-2144 ilo ejjelok wōnān.
Micronesian- Pohnpeyan - Mon-Khmer, Cambodian -	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-855-236-2144 ni sohte isais. សម្ភរាប់ជំនួយភាសាជា ភាសាខុមរៃ សូមទូរស័ព្ ទទ ៅកាន់លខេ 1-855-236-2144 ដ ោយឥតគិតថ្ ល។ៃ
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-855-236-2144
Nepali -	(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1- ⁸⁵⁵⁻²³⁶⁻²¹⁴⁴ मा फोन गर्नुहोस् ।
Nilotic-Dinka -	Tën kuoony ë thok ë Thuonjän col 1-855-236-2144 kecin ayöc.
Norwegian -	For språkassistanse på norsk, ring 1-855-236-2144 kostnadsfritt.
Panjabi -	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-855-236-2144 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-855-236-2144 aa. Es Aaruf koschtet nix.
Persian - Polish -	بر ای ر اهنمایی به زبان فارسی با شماره الهای-236-214 بدون هیچ هزینه ای تماس بگیرید. انگلیسی Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-855-236-2144.

Portuguese -	Para obter assistência linguística em português ligue para o 1-855-236-2144 gratuitamente.
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- Romanian Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-855-236-2144
- Russian Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-855-236-2144.
- Samoan Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-855-236-2144 e aunoa ma se totogi.
- Serbo-Croatian Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-855-236-2144.
- Spanish Para obtener asistencia lingüística en español, llame sin cargo al 1-855-236-2144.
- Sudanic-Fulfude Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-855-236-2144. Njodi woo fawaaki on.
- Swahili Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-855-236-2144 bila malipo.
- Tagalog -Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-855-236-2144 nang walang bayad.
- Telugu భాషతో సాయం కొరకు ఎలాంటి ఖర్పు లేకుండా 1-855-236-2144 కు కాల్ చేయండి. (తెలుగు)
- Thai สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-855-236-2144 ฟรีไม่มีค่าใช้จ่าย
- Tongan Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-855-236-2144 'o 'ikai hā ōtōngi.
- Trukese Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-855-236-2144 nge esapw kamé ngonuk.
- Turkish (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-855-236-2144.
- Ukrainian Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-855-236-2144.
- Urdu -
- بلاقیمت زیان سے متعلقہ خدمات حاصل کرتے کے لیے 2144-256-185 یر بات کریں۔
- Vietnamese Đê'được hố trợ ngôn ngữ băng (ngôn ngữ), hay gọi miến phi đến số 1-855-236-2144.
- Yiddish פאר שפראך הילף אין אידיש רופט 1-855-236-2144 פריי פון אפצאל.
- Yoruba Fún ìrànlowo nípa èdè (Yorùbá) pe 1-855-236-2144 lái san owó kankan rárá.