

CORNELL UNIVERSITY: Aetna Choice® POS II - Weill PPO

Coverage for: All Tiers | Plan Type: POS

Coverage Period: 01/01/2023-12/31/2023



The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, <u>www.HealthReformPlanSBC.com</u> or by calling 1-877-371-2007. 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 1-877-371-2007 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In- <u>Network</u> : Individual \$300 / Family \$600. Out- of-Network: Individual \$750 / Family \$1,500.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. <u>Prescription drugs;</u> plus in- <u>network</u> 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
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 \$2,300 / Family \$4,600. Out-of-Network: Individual \$3,750 / Family \$7,500.	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.	Even though you pay these expenses, they don't count toward the <u>out–of–pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind or call 1-877-371-2007 for a list of in-network providers	You pay the least if you use a <u>provider</u> in Designated In- <u>Network Provider</u> . You pay more if you use a <u>provider</u> in Non-Designated In- <u>Network Provider</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</u> 's 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 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.

			What You Will Pay		
Common Medical Event	Services You May Need	Weill Network Provider (You will pay the least)	Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	\$10 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$20 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% coinsurance	Includes virtual visits by designated virtual network provider or Teladoc.
If you visit a health care <u>provider</u> 's office or clinic	<u>Specialist</u> visit	\$10 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$30 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% coinsurance	Includes virtual visits by designated virtual network provider or Teladoc.
	Preventive care /screening /immunization	No charge	No charge	30% <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.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% coinsurance for laboratory; \$10 copay/visit for x-ray, deductible doesn't apply	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	\$10 <u>copay</u> /visit, <u>deductible</u> doesn't apply	10% coinsurance	30% coinsurance	None
If you need drugs to treat your illness or condition	Generic drugs	Not applicable	Copay/prescription, deductible doesn't apply: \$5 (retail), \$10 (mail order)	Reimbursed 100% of contract rate less copay, deductible doesn't apply	Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices
More information about prescription drug coverage is	Preferred brand drugs	Not applicable	Copay/prescription, deductible doesn't apply: \$30 (retail), \$60 (mail order)	Reimbursed 100% of contract rate less copay, deductible doesn't apply	obtainable from a pharmacy, oral & injectable fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in-network.

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available at OptumRx https://w ww.optumrx.com/pu blic/landing	Non-preferred brand drugs	Not applicable	Copay/prescription, deductible doesn't apply: \$50 (retail), \$90 (mail order)	Reimbursed 100% of contract rate less copay, deductible doesn't apply	Precertification & step therapy required for generic, preferred brand drugs and non-preferred brand drugs.
	Specialty drugs	Not applicable	Applicable cost as noted above for generic or brand drugs	Applicable cost as noted above for generic or brand drugs	None
If you have	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	10% coinsurance	30% coinsurance	None
outpatient surgery	Physician/surgeon fees	10% coinsurance	10% coinsurance	30% coinsurance	None
If you need	Emergency room care	10% coinsurance	10% coinsurance	Paid the same as the Network level of benefits	50% coinsurance for non-emergency use.
immediate medical attention	Emergency medical transportation	10% coinsurance	10% coinsurance	10% coinsurance	Non-emergency transport: not covered, except if pre-authorized.
	<u>Urgent care</u>	10% coinsurance	10% coinsurance	30% coinsurance	50% coinsurance for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	10% coinsurance	30% coinsurance	<u>Pre-authorization</u> required for out-of-network care.
1105pital Stay	Physician/surgeon fees	10% coinsurance	10% <u>coinsurance</u>	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse	Outpatient services	Office: \$10 copay/visit, deductible doesn't apply; other outpatient services: no charge	Office: \$10 copay/visit, deductible doesn't apply; other outpatient services: no charge	Office & other outpatient services: 30% coinsurance	None
services	Inpatient services	10% coinsurance	10% coinsurance	30% coinsurance	<u>Pre-authorization</u> required for out-of-network care.
	Office visits	No charge	No charge	30% coinsurance	Cost sharing does not apply for
If you are pregnant	Childbirth/delivery professional services	10% coinsurance	10% coinsurance	30% coinsurance	preventive services. Maternity care may include tests and services

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	Childbirth/delivery facility services	10% <u>coinsurance</u>	10% <u>coinsurance</u>	30% coinsurance	described elsewhere in the SBC (i.e. ultrasound.) <u>Pre-authorization</u> for out-of-network care may apply.
	Home health care	10% coinsurance	10% coinsurance	30% coinsurance	200 visits/calendar year, including private-duty nursing. Pre-authorization required for out-of-network care.
	Rehabilitation services	10% coinsurance	10% coinsurance	30% coinsurance	60 visits/calendar year for Speech
If you need help recovering or have other special health needs	Habilitation services	10% coinsurance	10% coinsurance	30% coinsurance	Therapy, but unlimited visits for Autism.
	Skilled nursing care	10% coinsurance	10% coinsurance	30% coinsurance	120 days/calendar year. Pre- authorization required for out-of- network care.
	Durable medical equipment	10% coinsurance	10% coinsurance	30% coinsurance	Limited to 1 <u>durable medical</u> <u>equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	0% coinsurance	0% coinsurance	30% coinsurance	<u>Pre-authorization</u> required for out-of-network care.
If your child needs	Children's eye exam	\$10 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$30 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% coinsurance	1 routine eye exam/calendar year.
dental or eye care	Children's glasses	Not covered	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered	Not covered.

# **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 & Child)

- Long-term care
- Glasses (Adult & Child)

- 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 <u>plan</u> document.)

- Acupuncture (When rendered by an MD)
- Bariatric surgery Limited to designated innetwork providers.
- Transgender surgery
- Chiropractic care 36 visits/calendar year.
- Hearing aids \$3,000 maximum/3 years.
- Infertility treatment Limited to the diagnosis & treatment of underlying medical condition.
   Artificial insemination & ovulation induction: 6 combined cycles/lifetime. Advanced reproductive technology: 3 cycles/lifetime & \$20,000 maximum/lifetime combined with comprehensive infertility services.
- Non-emergency care when traveling outside the U.S.

- Private-duty nursing 200 visits/calendar year combined with home health care.
- Routine eye care (Adult & Child) 1 routine eye exam/calendar year.

### **Your Rights to Continue Coverage:**

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- For more information on your rights to continue coverage, contact the <u>plan</u> at 1-800-231-7729.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <a href="http://www.dol/gov/ebsa/healthreform">http://www.dol/gov/ebsa/healthreform</a>
- For non-federal governmental group health <u>plans</u>, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or <u>www.cciio.cms.gov</u>.
- If your coverage is a church <u>plan</u>, church <u>plans</u> are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the <u>Health Insurance Marketplace</u>. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

### **Your Grievance and Appeals Rights:**

There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information 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 1-800-231-7729.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <a href="http://www.dol/gov/ebsa/healthreform">http://www.dol/gov/ebsa/healthreform</a>
- For non-federal governmental group health <u>plans</u>, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or <u>www.cciio.cms.gov</u>.
- Additionally, a consumer assistance program can help you file your appeal. Contact information is at:

http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html.

## 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>	\$300
Specialist copayment	\$10
■ Hospital (facility) coinsurance	10%
Other coinsurance	10%

### This EXAMPLE event includes services like:

Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost	\$12,800	
In this example, Peg would pay:		
Cost Sharing		
<u>Deductibles</u>	\$300	
<u>Copayments</u>	\$50	
Coinsurance	\$1,200	
What isn't covered		
Limits or exclusions	\$60	
The total Peg would pay is	\$1,610	

# 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>	\$300
■ Specialist copayment	\$10
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

### This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits (including disease education64

Diagnostic tests (blood work)

Prescription drugs

<u>Durable medical equipment</u> (glucose meter)

Total Example Cost	\$7,400
In this example, Joe would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$800
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$920

# **Mia's Simple Fracture**

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

■ The <u>plan's</u> overall <u>deductible</u>	\$300
■ Specialist copayment	\$10
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

### This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

Diagnostic test (x-ray)

<u>Durable medical equipment</u> (crutches)

Rehabilitation services (physical therapy)

Total Example Cost	\$1,900	
In this example, Mia would pay:		
Cost Sharing		
<u>Deductibles</u>	\$300	
<u>Copayments</u>	\$20	
<u>Coinsurance</u>	\$100	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$420	

### **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, or disability.

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 <a href="https://ocrportal.hhs.gov/ocr/portal/lobby.jsf">https://ocrportal.hhs.gov/ocr/portal/lobby.jsf</a>, 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 1-800-231-7729 at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-800-231-7729.

Amharic - ለቋንቋ እንዛ በ አማርኛ በ 1-800-231-7729 በንጻ ይደውሉ

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-800-231-7729 للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-800-231-7729

Armenian - Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-800-231-7729 առանց գնով։

Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-231-7729 tanpa dikenakan biaya.

Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-800-231-7729 ku busa

Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য িবনামুলেয় 1-800-231-7729-েত কল করন।

Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-231-7729 nga walay bayad.

Burmese - ငွေကုန်ကျစံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-800-231-7729 ကို ခေါ် ဆိုပါ။

Catalan - Per rebre assistència en (català), truqui al número gratuït 1-800-231-7729.

Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-800-231-7729 sin gåstu.

Cherokee - OOYO SUHAOJ JHOSPOY OLT (CWY) OLWOIS 1-800-231-7729 OOT [ AFOJ JEGPJ HIRO.

Chinese - 欲取得繁體中文語言協助, 請撥打 1-800-231-7729, 無需付費。

Choctaw - (Chahta) anumpa ya apela a chi I paya hinla 1-800-231-7729.

Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-800-231-7729 irratti bilisaan bilbilaa.

Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-231-7729.

French - Pour une assistance linguistique en français appeler le 1-800-231-7729 sans frais.

French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-800-231-7729 gratis.

German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-231-7729 an.

Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-231-7729 χωρίς χρέωση.

Gujarati - ♦જરાતીમાં ભાષામાં સહાય માટ♦ કોઈ પણ ખયર્ વગર 1-800-231-7729 પર કોલ કરો.

Hawaiian - No ke kōkua ma ka 'ōlelo Hawai'i, e kahea aku i ka helu kelepona 1-800-231-7729. Kāki 'ole 'ia kēia kōkua nei.

Hindi - हिन्दी में भाषा सहायता के लिए, 1-800-231-7729 पर मुफ्त कॉल करें।

Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-800-231-7729.

lbo - Maka enyemaka asusu na Igbo kpoo 1-800-231-7729 na akwughi ugwo o bula

llocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-231-7729 nga awan ti bayadanyo.

Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-800-231-7729.

Japanese - 日本語で援助をご希望の方は、1-800-231-7729 まで無料でお電話ください。

Karen - လာတာမောေးတာ်ကတိုးကျိုာ်အင်္ဂါ ကျိုာ် ကို800-231-7729 လာတအိုခ်ိဳးတာ်လာခ်ဘူဉ်လာခ်စူးဘဉ်

Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-231-7729 번으로 전화해 주십시오.

Kru-Bassa - Be´m`ké gbo-kpá-kpá dyé pidyi dé Bašsɔɔ́-wuduùň wẽe, dá 1-800-231-7729

برای راهنمایی به زبان فارسی با شماره 7729-231-800 به خورایی پهیوهندی بکهن.

Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫືອໃນການແປພາສາລາວ, ກະລນາໂທຫუ-800-231-7729 ໂດຍບໍ່ເສຍຄ່າໂທ.

Marathi - कोणत्याह♦ श्रुल्का♦शवाय भाषा सेवा प्राप्त करण्यासाठ♦, 1-800-231-7729) वर फोन करा.

Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-800-231-7729 ilo ejjelok wōnān.

Micronesian-

Pohnpeyan - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-800-231-7729 ni sohte isais.

Mon-Khmer, សម្ភាប់ជំនួយភាសាជា ភាសាខ្មមរែ សូមទូរស័ព្ទទៅកាន់លខេ 1-800-231-7729 ដោយឥតគិតថ្លប់។

Cambodian -

Navajo - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-800-231-7729

Nepali - (नेपाल�) मा �नःशृल्क भाषा सहायता पाउनका ल**ा**�ग 1-800-231-7729 ोस्।

मा फोन गनहह

Nilotic-Dinka - Tën kuoony ë thok ë Thuonjän col 1-800-231-7729 kecïn ayöc.

Norwegian - For språkassistanse på norsk, ring 1-800-231-7729 kostnadsfritt.

Panjabi - ਪੰਜਾਬੀ ਿਵੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-800-231-7729 'ਤੇ ਮਫ਼ਤ ਕਾਲ ਕਰੋ।

Pennsylvania Dutch - Fer Helfe in Deitsch, ruf: 1-800-231-7729 aa. Es Aaruf koschtet nix.

برای راهنمایی به زبان فارسی با شماره 7729-231-1800 بدون هیچ هزینه ای تماس بگیرید. انگلیسی Persian -

Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-800-231-7729.

Portuguese - Para obter assistência linguística em português ligue para o 1-800-231-7729 gratuitamente.

Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-800-231-7729

Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-800-231-7729.

Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-800-231-7729 e aunoa ma se totogi.

Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-800-231-7729.

Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-800-231-7729.

Sudanic-Fulfude - Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-800-231-7729. Njodi woo fawaaki on.

Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-800-231-7729 bila malipo.

Syriac - K = > K = 1-800-231-7729 ap - 1-800-2

Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-800-231-7729 nang walang bayad.

Telugu - ��ష�� �ాయం ��రక� ఎల�ంట� ఖర�్చ ల∤క�ం�� 1-800-231-7729 క� ళాల్ �ేయం��. (�ెల�గ�)

Thai - สำหรับความชวยเหลอ ทางดานภาษาเป็น ภาษาไทย โทร 1-800-231-7729 ฟรีไ ม่เค ่าใชจ้ ่าย

Tongan - Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-800-231-7729 'o 'ikai hā ōtōngi.

Trukese - Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-800-231-7729 nge esapw kamé ngonuk.

Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-800-231-7729.

Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-800-231-7729.

بلاقیمت زیان سے متعلقہ خدمات حاصل کرنے کے لیے ، 7729-231-1-800 . پر بات کریں۔

Vietnamese - Đê 'được hố trở ngôn ngư bằng (ngôn ngư), hấy gọi miến phi 'đến số 1-800-231-7729.

Yiddish - פאר שפראך הילף אין אידיש רופט 1-800-231-7729 פריי פון אפצאל.

Yoruba - Fún ìrànlowo nípa èdè (Yorùbá) pe 1-800-231-7729 lái san owó kankan rárá.