

THE CLEVELAND CLINIC FOUNDATION : Aetna Open Access® Aetna SelectSM - Cleveland Clinic Employee Health Plan - EHP

Coverage for: Individual + Family | Plan Type: EPO

Coverage Period: 01/01/2022-12/31/2022



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>www.HealthReformPlanSBC.com</u> or by calling 1-833-414-2331. 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 1-833-414-2331 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$0.	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your deductible?	Yes. Generic <u>prescription drugs</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?	Yes. For <u>prescription drugs</u> : Individual \$200 / Family \$400.	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	In- <u>Network</u> : Individual \$3,950 / Family \$7,900. RX: Individual \$3,950 / Family \$7,900. Retiree RX: none	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?	<u>Premium</u> s, balance-billing charges, bariatric surgery <u>copay</u> * & health care this <u>plan</u> 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 https://www.aetna.com/dsepublic/#/contentPag e?page=providerSearchLanding&site_id=directl inklogo&planValue=CCDOM EHP or call 1-833-414-2331 for a list of in-network providers.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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

	What You Will Pay				
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
	Primary care visit to treat an injury or illness	No charge	Not covered	None	
If you visit a health	Specialist visit	\$35 <u>copay</u> /visit	Not covered	None	
care <u>provider</u> 's office or clinic	Preventive care /screening /immunization	No charge	Not covered	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.	
	Diagnostic test (x-ray, blood work)	No charge	Not covered	None	
If you have a test	Imaging (CT/PET scans, MRIs)	\$75 <u>copay</u> /visit	Not covered	Refer to the SPD for precertification requirements at www.clevelandclinic.org/healthplan.	
If you need drugs to treat your illness or	Preferred non-specialty generic drugs (tier 1)	Co-insurance after prescription deductible: 20% (CVS), 15% (Cleveland Clinic)	Not covered		
Condition Prescription drug coverage is administered by CVS Caremark	Preferred non-specialty brand drugs (tier 2)	Co-insurance after prescription deductible: 30% (CVS), 25% (Cleveland Clinic)	Not covered	Covers 1-30 day supply (CVS pharmacies), 1-90 day supply (Cleveland Clinic pharmacies). Refer to EHP Prescription Drug Handbook & Formulary for required precertifications, non-covered drugs, and quantity limits available on our website at www.Clevelandclinic.org/healthplan	
More information about prescription drug coverage is	Non-preferred brand & generic drugs (tier 3)	Co-insurance after prescription deductible: 50% (CVS), 45% (Cleveland Clinic)	Not covered	•	
available at www.Clevelandclini c.org/healthplan	Specialty brand & generic drugs (tier 4)	Co-insurance after prescription deductible: 20%	Not covered	Refer to EHP Prescription Drug Handbook & Formulary for required precertification, non-covered drugs, and quantity limits available on our website at www.Clevelandclinic.org/healthplan	

Common Medical Event	Services You May Need	What You In-Network Provider (You will pay the least)	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)	No charge	Not covered	None
outpatient surgery	Physician/surgeon fees	No charge	Not covered	None
If you need immediate medical attention	Emergency room care Emergency medical transportation	\$250 copay/visit No charge	\$250 <u>copay</u> /visit No charge	None Non-emergency transport: not covered, except if precertified.
attention	<u>Urgent care</u>	\$50 <u>copay</u> /visit	\$50 <u>copay</u> /visit	Nne
If you have a hospital stay	Facility fee (e.g., hospital room)	\$350 <u>copay</u> /stay	Not covered	Refer to the SPD for precertification requirements at www.clevelandclinic.org/healthplan.
nospital stay	Physician/surgeon fees	No charge	Not covered	None
If you need mental health, behavioral health, or substance abuse	Outpatient services	Office: \$35 copay/visit; other outpatient services: no charge	Not covered	None
services	Inpatient services	\$350 <u>copay</u> /stay	Not covered	Refer to the SPD for precertification requirements at www.clevelandclinic.org/healthplan
	Office visits	No charge	Not covered	Cost sharing does not apply for preventive
	Childbirth/delivery professional services	No charge	Not covered	services. Maternity care may include tests and
If you are pregnant	Childbirth/delivery facility services	\$350 <u>copay</u> /stay	Not covered	services described elsewhere in the SBC (i.e. ultrasound.) <u>Copay</u> waived on newborn facility <u>claim</u> if baby discharged with mother. Refer to the SPD for precertification requirements at www.clevelandclinic.org/health <u>plan</u> .
	Home health care	No charge	Not covered	60 visits/ calendar year. Precertification required.
If you need help recovering or have other special health needs	Rehabilitation services	\$10 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Not covered	30 visits/calendar year for each physical, occupational, and speech therapy.
	Habilitation services	No charge	Not covered	30 visits/calendar year for each habilitative physical, occupational, and speech therapy for Developmental delay, Cerebral Palsy, Apraxia; No visit limit for Autism/Autism Spectrum Disorder
	Skilled nursing care	\$350 <u>copay</u> /stay	Not covered	60 days/calendar year. Precertification required.

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
	Durable medical equipment	20% coinsurance	Not covered	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	No charge	Not covered	None
If your obild poods	Children's eye exam	No charge	Not covered	2 routine exams/calendar year
If your child needs dental or eye care	Children's glasses	Not covered	Not covered	Not covered.
defital of cyc care	Children's dental check-up	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)
- Glasses (Child)

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

- Routine foot care
- Weight loss programs Except for required <u>preventive</u> services.

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

- Acupuncture 10 visits/calendar year for disease, injury & chronic pain.
- Bariatric surgery
- Chiropractic care 30 visits/calendar year.
- Hearing aids
- Infertility treatment For more information & exceptions, see policy document provided by your employer or call the number on your ID card.
- Long-term care
- Routine eye care (Adult)

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 plan at 1-833-414-2331.
- 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 http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health plans, 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 <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 1-833-414-2331.
- 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 http://www.dol/gov/ebsa/healthreform
- 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 <u>appeal</u>. 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 <u>plan</u> doesn't meet the <u>Minimum Value Standards</u>, you may be eligible for a <u>premium tax credit</u> to help you pay for a <u>plan</u> through the <u>Marketplace</u>.

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

About these Coverage Examples:



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

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ Specialist copayment	\$35
■ Hospital (facility) <u>copayment</u>	\$350
■ Other copayment	\$0

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> *	\$10	
<u>Copayments</u>	\$400	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$60	
The total Peg would pay is	\$470	

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$0
Specialist copayment	\$35
Hospital (facility) copayment	\$350
Other <u>copayment</u>	\$0

This EXAMPLE event includes services like:

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

Diagnostic tests (blood work)

Prescription drugs

Durable medical equipment (glucose meter)

\$5,600
\$200
\$70
\$1,100
\$20
\$1,390

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$0
Specialist copayment	\$35
■ Hospital (facility) copayment	\$350
■ Other copayment	\$0

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

Diagnostic test (x-ray)

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

Rehabilitation services (physical therapy)

Total Example Cost	\$2,800	
In this example, Mia would pay:		
Cost Sharing		
<u>Deductibles</u> *	\$10	
<u>Copayments</u>	\$400	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$410	

^{*}Note: This <u>plan</u> has other <u>deductibles</u> for specific services included in this coverage example. See "Are there other <u>deductibles</u> for specific services?" row above.

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 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 1-833-414-2331 at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-833-414-2331.

Amharic - ለቋንቋ እንዛ በ አማርኛ በ 1-833-414-2331 በነጻ ይደውሉ

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-833-414-2331 الرجاء الاتصال على الرقم المجاني

Armenian - Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-833-414-2331 առանց գնով։

Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-833-414-2331 tanpa dikenakan biaya.

Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-833-414-2331 ku busa

Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-833-414-2331-তে কল করুন।

Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-833-414-2331 nga walay bayad.

Burmese - ငွေကုန်ကျစံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-833-414-2331 ကို ခေါ် ဆိုပါ။

Catalan - Per rebre assistència en (català), truqui al número gratuït 1-833-414-2331.

Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-833-414-2331 sin gåstu.

Chinese - 欲取得繁體中文語言協助,請撥打1-833-414-2331,無需付費。

Choctaw - (Chahta) anumpa ya apela a chi I paya hinla 1-833-414-2331.

Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-833-414-2331 irratti bilisaan bilbilaa.

Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-833-414-2331.

French - Pour une assistance linguistique en français appeler le 1-833-414-2331 sans frais.

French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-833-414-2331 gratis.

German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-833-414-2331 an.

Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-833-414-2331 χωρίς χρέωση.

Gujarati - ગુજરાતીમાં ભાષામાં સહ્ય માટે કોઈ પણ ખર્ચ વગર 1-833-414-2331 પર કૉલ કરો.

Hawaiian - No ke kōkua ma ka 'ōlelo Hawai'i, e kahea aku i ka helu kelepona 1-833-414-2331. Kāki 'ole 'ia kēia kōkua nei.

Hindi - हिन्दी में भाषा सहायता के लिए, 1-833-414-2331 पर मुफ्त कॉल करें।

Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-833-414-2331.

lbo - Maka enyemaka asusu na Igbo kpoo 1-833-414-2331 na akwughi ugwo o bula

llocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-833-414-2331 nga awan ti bayadanyo.

Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-833-414-2331.

Japanese - 日本語で援助をご希望の方は、1-833-414-2331 まで無料でお電話ください。

Karen - လာတာ်မာစားတာ်ကတိုးကျိုဉ်အင်္ဂါ ကျိုဉ် 🗗 833-414-2331 လာတအိုဉ်ဒီးတာ်လာဝ်ဘူဉ်လာဝ်စွာဘဉ်

Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-833-414-2331 번으로 전화해 주십시오.

Kru-Bassa - Be´m`ké gbo-kpá-kpá dyé pidyi dé Bašsoó-wuduùn wee, dá 1-833-414-2331

برای راهنمایی به زبان فارسی با شماره 2331-414-833-1 به خورایی پهیومندی بکن.

Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລນາໂທຫາ-833-414-2331 ໂດຍບໍ່ເສຍຄ່າໂທ.

Marathi - कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-833-414-2331 वर फोन करा.

Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-833-414-2331 ilo ejjelok wōnān.

Micronesian-

Pohnpeyan - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-833-414-2331 ni sohte isais.

Mon-Khmer, សម្រាប់ជំនួយភាសាជា ភាសាខុមរៃ សូមទូសេ័ពទទ**ៅកាន់លខេ 1-833-414-2331 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' 1-833-414-2331

Nepali - (नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-833-414-2331 मा फोन गर्नुहोस् ।

Nilotic-Dinka - Tën kupony ë thok ë Thuonjan col 1-833-414-2331 kecin ayöc.

Norwegian - For språkassistanse på norsk, ring 1-833-414-2331 kostnadsfritt.

Panjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-833-414-2331 'ਤੇ ਮਫ਼ਤ ਕਾਲ ਕਰੋ।

Pennsylvania Dutch - Fer Helfe in Deitsch, ruf: 1-833-414-2331 aa. Es Aaruf koschtet nix.

برای راهنمایی به زبان فارسی با شماره 2331-414-2331 بدون هیچ هزینه ای تماس بگیرید. انگلیسی Persian -

Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-833-414-2331.

Portuguese - Para obter assistência linguística em português ligue para o 1-833-414-2331 gratuitamente.

Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-833-414-2331

Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-833-414-2331.

Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-833-414-2331 e aunoa ma se totogi.

Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-833-414-2331.

Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-833-414-2331.

Sudanic-Fulfude - Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-833-414-2331. Njodi woo fawaaki on.

Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-833-414-2331 bila malipo.

Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-833-414-2331 nang walang bayad.

Telugu - భాషతో సాయం కొరకు ఎలాంటి ఖర్పు లేకుండా 1-833-414-2331 కు కాల్ చేయండి. (తెలుగు)

Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-833-414-2331 ฟรีไม่มีค่าใช้จ่าย

Tongan - Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-833-414-2331 'o 'ikai hā ōtōngi.

Trukese - Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-833-414-2331 nge esapw kamé ngonuk.

Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-833-414-2331.

Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкопітовним номером 1-833-414-2331.

بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 2331-414-833 . پر بات کریں۔

Vietnamese - Đê 'được hố trở ngôn ngư bằng (ngôn ngư), hấy gọi miến phi 'đên số 1-833-414-2331.

Yiddish - פאר שפראך הילף אין אידיש רופט 1-833-414-2331 פריי פון אפצאל.

Yoruba - Fún ìrànlowo nípa èdè (Yorùbá) pe 1-833-414-2331 lái san owó kankan rárá.