♦aetna RICE 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 <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, <u>https://www.aetnastudenthealth.com/</u> or by calling 1-877-375-7908. 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 1-877-480-4161 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	For each <u>Plan</u> Year, <u>In-Network</u> : Individual \$250. <u>Out-of-Network</u> : Individual \$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.
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Prescription drugs;</u> plus <u>in-network</u> <u>preventive care</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <u>https://www.healthcare.gov/coverage/preventive-care-benefits/</u>
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 limit</u> for this <u>plan</u> ?	<u>In-Network</u> : Individual \$6,500/ Family \$13,000. <u>Out-of-Network</u> : Individual \$13,000/ Family \$26,000	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 limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billing 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 1-877- 375-7908 for a list of <u>in-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.

		What You Will Pay		Limitations, Exceptions, & Other	
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information	
	Primary care visit to treat an injury or illness	25% <u>coinsurance</u> after \$25 <u>copay</u> /visit	50% <u>coinsurance</u> after \$25 <u>copay</u> /visit	None	
If you visit a health care provider's office or	<u>Specialist</u> visit	25% <u>coinsurance</u> after \$25 <u>copay</u> /visit	50% <u>coinsurance</u> after \$25 <u>copay</u> /visit	None	
clinic	Preventive care/screening/ immunization	No charge	30% <u>coinsurance</u> , except no charge for immunizations up to age 6	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.	
If you have a test	Diagnostic test (x-ray, blood work)	25% coinsurance	50% coinsurance	Some services are subject to a penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care.	
n you have a lest	Imaging (CT/PET scans, MRIs)	25% coinsurance	50% coinsurance		
If you need drugs to treat your illness or condition	Generic drugs	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$20 (retail)	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$20 (retail)	Covers 30-day supply (retail). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's	
More information about prescription drug coverage is available at	Preferred brand drugs	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$50 (retail)	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$50 (retail)	contraceptives in-network. Certain <u>prescription drugs</u> may require <u>pre-</u> <u>authorization</u> , contact your prescriber or pharmacist if a <u>prescription drug</u> requires	
<u>https://www.aetnastudent</u> <u>health.com/en/school/890</u> 436/members/prescription	Non-preferred brand drugs	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: 50% <u>coinsurance</u> (retail)	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: 50% <u>coinsurance</u> (retail)	pre-authorization.	
<u>s.html</u> .	Specialty drugs	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: 25% <u>coinsurance</u> (retail)	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: 25% <u>coinsurance</u> (retail)	Certain <u>prescription drugs</u> may require <u>pre-authorization</u> , contact your prescriber or pharmacist if a <u>prescription drug</u> requires <u>pre-authorization</u> .	

* For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.aetnastudenthealth.com</u>.

		What Y	ou Will Pay	Limitations Eventions 9 Other
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	 Limitations, Exceptions, & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	50% coinsurance	Some services are subject to a penalty of \$500 for failure to obtain pre-authorization
Surgery	Physician/surgeon fees	25% coinsurance	50% coinsurance	for out-of-network care.
	Emergency room care	25% <u>coinsurance</u> after \$150 <u>copay</u> /visit	25% <u>coinsurance</u> after \$150 <u>copay</u> /visit	No coverage for non-emergency use.
If you need immediate medical attention	Emergency medical transportation	25% coinsurance	25% coinsurance	Penalty of \$500 for failure to obtain <u>pre-</u> <u>authorization</u> for out-of-network care for non-emergency transportation by airplane.
	Urgent care	25% coinsurance	50% coinsurance	No coverage for non-urgent use.
If you have a hospital	Facility fee (e.g., hospital room)	25% coinsurance	50% coinsurance	Penalty of \$500 for failure to obtain <u>pre-</u> <u>authorization</u> for out-of-network care.
stay	Physician/surgeon fees	25% coinsurance	50% coinsurance	None
If you need mental health, behavioral	Outpatient services	Office & other outpatient services: 25% coinsurance	Office & other outpatient services: 50% coinsurance	Some services are subject to a penalty of \$500 for failure to obtain pre-authorization for out-of-network care.
health, or substance abuse services	Inpatient services	25% coinsurance	50% coinsurance	Penalty of \$500 for failure to obtain <u>pre-</u> <u>authorization</u> for out-of-network care.
	Office visits	No charge	30% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests
If you are pregnant	Childbirth/delivery professional services	25% coinsurance	50% coinsurance	and services described elsewhere in the SBC (i.e., ultrasound). Penalty of \$500 for
	Childbirth/delivery facility services	25% coinsurance	50% coinsurance	failure to obtain <u>pre-authorization</u> for out- of-network care may apply.
	Home health care	25% coinsurance	50% coinsurance	Limited to 60 visits/plan year. Penalty of \$500 for failure to obtain pre-authorization for out-of-network care.
	Rehabilitation services	25% coinsurance	50% coinsurance	Includes Physical, Occupational & Speech
If you need help recovering or have other special health needs	Habilitation services	25% coinsurance	50% coinsurance	Therapy.
	Skilled nursing care	25% coinsurance	50% coinsurance	Penalty of \$500 for failure to obtain <u>pre-</u> <u>authorization</u> for out-of-network care.
	Durable medical equipment	25% coinsurance	50% coinsurance	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	25% coinsurance	50% coinsurance	Penalty of \$500 for failure to obtain <u>pre-</u> <u>authorization</u> for out-of-network care.

* For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.aetnastudenthealth.com</u>.

002023-002023-029804 Page 3 of 6

		What You Will Pay		Limitations, Exceptions, & Other
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information
	Children's eye exam	No charge	30% <u>coinsurance,</u> <u>deductible</u> doesn't apply	1 routine eye exam/ <u>plan</u> year. Coverage through end of month turning age 19.
If your child needs dental or eye care	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. Coverage through end of month turning age 19.
	Children's dental check-up	No charge	No charge	Limited to 2 visits every 12 months. Coverage through end of month turning age 19.

Excluded Services & Other Covered Services:

rvices Your <u>Plan</u> Generally Does N	IOT Cover (Check your policy or <u>plan</u> document for more info	mation and a list of any other <u>excluded services</u> .)
Acupuncture Bariatric surgery Cosmetic surgery Dental care (Adult)	 Long-term care Non-emergency care when traveling outside the U.S. Private-duty nursing 	 Routine eye care (Adult) Routine foot care Weight loss programs - Except for required preventive services

Other Covered Services (Limitations may apply t	o these services. This isn't a complete list. Please	see your <u>plan</u> document.)
Chiropractic care	 Hearing aids - 1 hearing aid per ear/36 months. 	 Infertility treatment - Limited to the diagnosis & 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 Texas Department of Insurance, 1-800-252-3439 (Consumer HelpLine), (512) 676-6000 (Local), (800) 578-4677 (Toll-Free), <u>https://www.tdi.texas.gov/consumer/index.html</u>.

- 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 <u>www.dol.gov/ebsa/healthreform</u>.
- For more information on your rights to continue coverage, contact the <u>plan</u> at 1-877-375-7908.
- 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 plan, church plans 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 Health Insurance Marketplace. For more information about the Marketplace, 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 1-877-375-7908 or Texas Department of Insurance, 1-800-252-3439, <u>https://www.tdi.texas.gov/consumer/index.html</u>. Additionally, a consumer assistance program can help you file your <u>appeal</u>. Contact Texas Department of Insurance, Consumer Protection, Mail Code 111-1A, 333 Guadalupe, P.O. Box 149091, Austin, TX 78714-9091, Phone toll-free: 1-800-252-3439, <u>http://www.texashealthoptions.com</u>, <u>ConsumerProtection@tdi.texas.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? Not Applicable.

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 1-877-375-7908. Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-375-7908. Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-375-7908. Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijijgo holne' 1-877-375-7908.

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 <u>plan's</u> overall <u>deductible</u>	\$250
Specialist coinsurance	25%
Hospital (facility) <u>coinsurance</u>	25%
Other coinsurance	25%

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>	\$250
<u>Copayments</u>	\$40
<u>Coinsurance</u>	\$3,100
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$3,450

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>	\$250
Specialist coinsurance	25%
Hospital (facility) coinsurance	25%
Other <u>coinsurance</u>	25%

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		
<u>Deductibles</u>	\$250	
<u>Copayments</u>	\$1,700	
<u>Coinsurance</u>	\$300	
What isn't covered		
Limits or exclusions	\$20	
The total Joe would pay is	\$2,270	

Mia's Simple Fracture (in-network emergency room visit and follow up care)

The <u>plan's</u> overall <u>deductible</u>	\$250
Specialist coinsurance	25%
Hospital (facility) <u>coinsurance</u>	25%
Other coinsurance	25%

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	\$250	
<u>Copayments</u>	\$0	
<u>Coinsurance</u>	\$400	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$650	

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 1-877-375-7908.

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 1-877-375-7908 at no cost.

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-877-375-7908.
Amharic -	ለቋንቋ እንዛ በ አማርኛ በ 1-877-375-7908 በነጻ ይደውሉ
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 7908-1-877-1
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-877-375-7908 առանց գնով։
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-877-375-7908 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-877-375-7908 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বিনামুল্যে 1-877-375-7908 -তে কল করুন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-877-375-7908 nga walay bayad.
Burmese -	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-877-375-7908 ကို ခေါ်ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-877-375-7908 .
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-877-375-7908 sin gåstu.
Cherokee -	ӨℴӘУӨ \$℗ℎℬℴ℈ <i>⅃</i> ⅃ℎℴ℈ℇℙℴ℈℣ ӨҍТ (GWУ) Չ ᲮѠℰѝ҄ 1-877-375-7908 <i>О</i> ӨТ Ĺ АГℴӘ <i>⅃</i> ЈЕ G Ք <i>⅃</i> ℎℙℝѲ.
Chinese -	欲取得繁體中文語言協助,請撥打1-877-375-7908 , 無需付費。
Choctaw -	(Chahta) anumpa y <u>a</u> apela a chi I p <u>a</u> ya hinla 1-877-375-7908 .
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-877-375-7908 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-877-375-7908 .
French -	Pour une assistance linguistique en français appeler le 1-877-375-7908 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-877-375-7908 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-877-375-7908 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-877-375-7908 χωρίς χρέωση.
Gujarati -	ગુજરાતીમાં ભાષામાં સહ્રાય માટે કોઈ પણ ખર્ચ વગર 1-877-375-7908 પર કૉલ કરો.

Hawaiian -	No ke kōkua ma ka 'ōlelo Hawai'i, e kahea aku i ka helu kelepona 1-877-375-7908 . Kāki 'ole 'ia kēia kōkua nei.
Hindi -	हनि्दी में भाषा सहायता के लएि, 1-877-375-7908 पर मुफ्त कॉल करें।
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-877-375-7908 .
bo -	Maka enyemaka asụsụ na Igbo kpọọ 1-877-375-7908 na akwụghị ụgwọ ọ bụla
locano -	Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-877-375-7908 nga awan ti bayadanyo.
talian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-877-375-7908 .
Japanese -	日本語で援助をご希望の方は、1-877-375-7908 まで無料でお電話ください。
Karen -	လ၊ တၢိမၢစၢၤတၢိကတိၢကိုဉ်အဂ်ီ၊ ကိုဉ် ကိႏ 1-877-375-7908 လ၊ တအိဉ်ဒီးတၢိလ၊ ၁်ဘူဉ်လ၊ ၁်စူးဘဉ်
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-877-375-7908 번으로 전화해 주십시오.
Kru-Bassa -	Ɓɛ´m`ké gbo-kpá-kpá dyé pidyi dé Ɓaĭsɔɔ́-̀wùdุùŭn wɛ̃ɛ, dá 1-877-375-7908
Kurdish -	برای راهنمایی به زبان فارسی با شمار ه 7908-375-1771 به خوّر ایی پهیومندی بکهن.
Laotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ1-877-375-7908ໂດຍບໍ່ເສຍຄ່າໂທ.
Marathi -	कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-877-375-7908) वर फोन करा.
Marshallese -	Ñan bōk jipañ ilo Kajin Majol, kallok 1-877-375-7908 ilo ejjelok wōnān.
Micronesian- Pohnpeyan - Mon-Khmer, Cambodian -	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-877-375-7908 ni sohte isais. សម្ភរាប់ជំនួយភាសាជា ភាសាខុមរ៉ែ សូមទូរស័ព្ទទទៅកាន់លខេ 1-877-375-7908 ដោយឥតគិតថ្លល់។
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-877-375-7908
Nepali -	(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि १- 🛛 ८७७-३७५-७०८ मा फोन गर्नुहोस् ।
Nilotic-Dinka -	Tën kuoony ë thok ë Thuonjän col 1-877-375-7908 kecïn ayöc.
Norwegian -	For språkassistanse på norsk, ring 1-877-375-7908 kostnadsfritt.
Panjabi -	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-877-375-7908 <i>'</i> ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-877-375-7908 aa. Es Aaruf koschtet nix.
Persian - Polish -	بر ای ر اهنمایی به زبان فارسی با شمار ه 1-877-375-7908 بدون هیچ هزینه ای تماس بگیرید. انگلیسی Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-877-375-7908.

Portuguese -	Para obter assistência linguística em português ligue para o 1-877-375-7908 gratuitamente.
Romanian -	Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-877-375-7908
Russian -	Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-877-375-7908.
Samoan -	Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-877-375-7908 e aunoa ma se totogi.
Serbo-Croatian -	Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-877-375-7908.
Spanish -	Para obtener asistencia lingüística en español, llame sin cargo al 1-877-375-7908 .
Sudanic-Fulfude -	Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-877-375-7908 . Njodi woo fawaaki on.
Swahili -	Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-877-375-7908 bila malipo.
Syriac -	مر عدم مر ما بعد مار معلد مر مومن به مر مر مر الم ispor 1-877-375-7908 .
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-877-375-7908 nang walang bayad.
Telugu -	భాషతో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 1-877-375-7908 కు కాల్ చేయండి. (తెలుగు)
Thai -	สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-877-375-7908 ฟรีไม่มีค่าใช้จ่าย
Tongan -	Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-877-375-7908 'o 'ikai hā ōtōngi.
Trukese -	Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-877-375-7908 nge esapw kamé ngonuk.
Turkish -	(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-877-375-7908 .
Ukrainian -	Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-877-375-7908 .
Urdu -	یں بات کریں۔ بلاقیمت زیان سے متعلقہ خدمات حاصل کرنے کے لیے *7908-1-877-1
Vietnamese -	Để được hố trợ ngôn ngự băng (ngôn ngự), hấy gọi miến phi đến số 1-877-375-7908 .
Yiddish -	פאר שפראך הילף אין אידיש רופט 1-877-375-7908 פריי פון אפצאל.
Yoruba -	Fún ìrànlowo nípa èdè (Yorùbá) pe 1-877-375-7908 lái san owó kankan rárá.