

UNIVERSITY OF SAN DIEGO OA Managed Choice® POS

Coverage Period: 08/01/2022-07/31/2023

Coverage for: Individual | Plan Type: POS



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, <a href="https://www.aetnastudenthealth.com/">https://www.aetnastudenthealth.com/</a> or by calling 1-866-746-6590. 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 1-866-746-6590 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For each <u>Plan</u> Year, In- <u>Network</u> : Individual \$300. Out-of-Network: Individual \$600.	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 deductible?	Yes. In- <u>network</u> primary care office visits, inpatient hospital services, <u>prescription drugs</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 <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?	Yes. For <u>prescription drugs</u> - Individual \$100. There are no other specific <u>deductibles</u> .	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 \$7,900. Out-of-Network: Individual \$12,700.	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	<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 out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind or call 1-866-746-6590 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 might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider before</u> you get services.</u>
Do you need a <u>referral</u> to see a <u>specialist</u> ?	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if have a <u>referral</u> before you see the <u>specialist</u> .



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

Common Medical Event	Services You May Need	What You 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
	Primary care visit to treat an injury or illness	\$20 <u>copay</u> /visit, <u>deductible</u> doesn't apply	35% coinsurance	None
If you visit a health care <u>provider</u> 's office or clinic	<u>Specialist</u> visit	\$20 <u>copay</u> /visit, <u>deductible</u> doesn't apply	35% <u>coinsurance</u>	None
office of chilic	Preventive care /screening /immunization	No charge	35% <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.
	<u>Diagnostic test</u> (x-ray, blood work)	20% coinsurance	35% <u>coinsurance</u>	None
If you have a test	Imaging (CT/PET scans, MRIs)	20% coinsurance	35% <u>coinsurance</u>	None

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
If you need drugs to treat your	Generic drugs	Copay/prescription, after specific deductible: \$15 (retail), \$37.50 (mail order)	Not covered	
illness or condition  More information about prescription	Preferred brand drugs	Copay/prescription, after specific deductible: \$30 (retail), \$75 (mail order)	Not covered	Covers 30 day supply (retail), 31-90 day supply (mail order). 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.com/individuals-families/pharmacy.h	Non-preferred brand drugs	Copay/prescription, after specific deductible: \$50 (retail), \$125 (mail order)	Not covered	
<u>tml</u>	Specialty drugs	Applicable cost as noted above for generic or brand drugs	Not covered	None
If you have	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	35% coinsurance	None None
outpatient surgery  If you need	Physician/surgeon fees  Emergency room care	20% coinsurance 20% coinsurance after \$150 copay/visit	35% coinsurance 20% coinsurance after \$150 copay/visit	No coverage for non-emergency use.
immediate medical	Emergency medical transportation	20% coinsurance	20% coinsurance	None
attention	<u>Urgent care</u>	\$20 <u>copay</u> /visit, <u>deductible</u> doesn't apply	35% <u>coinsurance</u>	No coverage for non-urgent use.
If you have a	Facility fee (e.g., hospital room)	20% coinsurance	35% coinsurance	Penalty of \$500 for failure to obtain <u>pre-</u> authorization for out-of-network care.
hospital stay	Physician/surgeon fees	20% coinsurance	35% coinsurance	None

	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
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$20 copay/visit, deductible doesn't apply; other outpatient services: 20% coinsurance	Office & other outpatient services: 35% coinsurance	None
Services	Inpatient services	20% coinsurance	35% <u>coinsurance</u>	Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	Office visits	No charge	35% coinsurance	Cost sharing does not apply for preventive
	Childbirth/delivery professional services	20% coinsurance	35% coinsurance	services. Maternity care may include tests and
If you are pregnant	Childbirth/delivery facility services	20% coinsurance	35% coinsurance	services described elsewhere in the SBC (i.e. ultrasound.) Penalty of \$500 for failure to obtain pre-authorization for out-of-network care may apply.
	Home health care	20% coinsurance	35% coinsurance	None
	Rehabilitation services	20% coinsurance	35% coinsurance	Includes Physical, Occupational & Speech
	Habilitation services	20% coinsurance	35% coinsurance	Therapy.
If you need help recovering or have other special health needs	Skilled nursing care	20% coinsurance	35% coinsurance	Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	Durable medical equipment	20% coinsurance	35% coinsurance	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	20% coinsurance	35% <u>coinsurance</u>	Penalty of \$500 for failure to obtain <u>pre-authorization</u> 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 up to age 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.
	Children's dental check-up	No charge	30% coinsurance	None

### **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)
- Hearing aids

- Long-term care
- Private-duty nursing

- Routine foot care
- Weight loss programs Except for required preventive services.

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

- Acupuncture
- Bariatric surgery
- Chiropractic care

- Infertility treatment Limited to the diagnosis & treatment of underlying medical condition.
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult) 1 routine eye exam/<u>plan</u> 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: California Department of Insurance, Consumer Communications Bureau Health, 300 South Spring Street, South Tower, Los Angeles, CA 90013, 1-800-927-HELP (4357), 1-800-482-4833 (TYY), <a href="http://www.insurance.ca.gov">http://www.insurance.ca.gov</a>.

• For more information on your rights to continue coverage, contact the <u>plan</u> at 1-866-746-6590.

## **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:

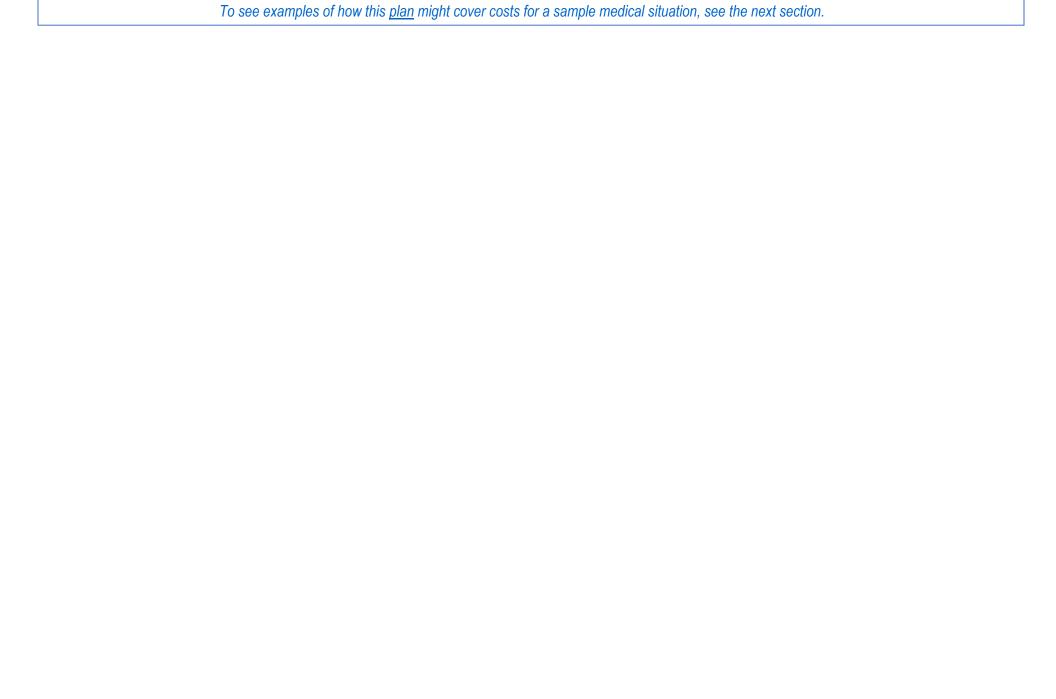
- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-866-746-6590.
- California Department of Insurance, Consumer Communications Bureau Health Unit, 300 South Spring Street, South Tower, Los Angeles, CA 90013, 1-800-927-HELP (4357), 1-800-482-4833 (TYY), http://www.insurance.ca.gov.
- Additionally, a consumer assistance program can help you file your <u>appeal</u>. Contact California Department of Insurance, Consumer Communications Bureau, 300 South Spring Street, South Tower, Los Angeles, CA 90013, 1-800-927-Help (4357), 1-800-482-4833(TTY), <u>www.insurance.ca.gov</u>

# 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.



# **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	\$20
■ Hospital (facility) coinsurance	20%
Other coinsurance	20%

### This EXAMPLE event includes services like:

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

Total Example Cost	\$12,700
In this example, Peg would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$0
Coinsurance	\$2,200
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,570

# Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-

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

■ The <u>plan's</u> overall <u>deductible</u>	\$300
■ Specialist copayment	\$20
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

### This EXAMPLE event includes services like:

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

Diagnostic tests (blood work)

Prescription drugs

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

Total Example Cost	\$5,600	
In this example, Joe would pay:		
Cost Sharing		
<u>Deductibles</u>	\$300	
<u>Copayments</u>	\$1,000	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$20	
The total Joe would pay is	\$1,320	

# **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	\$20
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

#### 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>	\$300		
<u>Copayments</u>	\$50		
<u>Coinsurance</u>	\$400		
What isn't covered			
Limits or exclusions	\$0		
The total Mia would pay is	\$750		

The <u>plan</u> 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 1-866-746-6590.

## **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: <u>CRCoordinator@aetna.com</u>

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 1-866-746-6590 at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-866-746-6590.

Amharic - ለቋንቋ እንዛ በ አማርኛ በ 1-866-746-6590 በነጻ ይደውሉ

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 6590-1-866 العربية)، الرجاء الاتصال على الرقم المجاني

Armenian - Lեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-866-746-6590 առանց գնով։

Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-866-746-6590 tanpa dikenakan biaya.

Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-866-746-6590 ku busa

Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-866-746-6590-তে কল করুন।

Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-866-746-6590 nga walay bayad.

Burmese - ငွေကုန်ကျစံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-866-746-6590 ကို ခေါ် ဆိုပါ။

Catalan - Per rebre assistència en (català), truqui al número gratuït 1-866-746-6590.

Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-866-746-6590 sin gåstu.

Cherokee -  $\theta \circ D Y \theta S \circ D h \circ D J J h \circ D S \circ D Y \theta t T (GWY) O D W \circ 1S 1-866-746-6590 O' \theta T C A G O J d E G P J h \text{PR} \text{R}.$ 

Chinese - 欲取得繁體中文語言協助, 請撥打1-866-746-6590, 無需付費。

Choctaw - (Chahta) anumpa ya apela a chi I paya hinla 1-866-746-6590.

Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-866-746-6590 irratti bilisaan bilbilaa.

Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-866-746-6590.

French - Pour une assistance linguistique en français appeler le 1-866-746-6590 sans frais.

French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-866-746-6590 gratis.

German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-866-746-6590 an.

Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-866-746-6590 χωρίς χρέωση.

Gujarati - ગુજરાતીમાં ભાષામાં સહ્રાય માટે કોઈ પણ ખર્ચ વગર 1-866-746-6590 પર કૉલ કરો.

Hawaiian - No ke kōkua ma ka 'ōlelo Hawai'i, e kahea aku i ka helu kelepona 1-866-746-6590. Kāki 'ole 'ia kēia kōkua nei.

Hindi - हिन्दी में भाषा सहायता के लिए, 1-866-746-6590 पर मुफ्त कॉल करें।

Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-866-746-6590.

lbo - Maka enyemaka asusu na Igbo kpoo 1-866-746-6590 na akwughi ugwo o bula

llocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-866-746-6590 nga awan ti bayadanyo.

Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-866-746-6590.

Japanese - 日本語で援助をご希望の方は、1-866-746-6590 まで無料でお電話ください。

Karen - လာတါမာစားတါကတိုးကျိုာ်အင်္ဂါ ကျိုာ် ကိုး 1-866-746-6590 လာတအိုာ်ဒီးတါလာ၁်ဘူဉ်လာ၁်စ္ခာဘဉ်

Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-866-746-6590 번으로 전화해 주십시오.

Kru-Bassa - Be´m`ké gbo-kpá-kpá dyé pidyi dé Bašsoó-wuduùn wee, dá 1-866-746-6590

برای راهنمایی به زبان فارسی با شماره 6590-746-746-1- به خورایی پهیومندی بکهن.

Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ-866-746-6590 ໂດຍບໍ່ເສຍຄ່າໂທ.

Marathi - कोणत्याही श्ल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-866-746-6590 वर फोन करा.

Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-866-746-6590 ilo ejjelok wōnān.

Micronesian-Pohnpeyan - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-866-746-6590 ni sohte isais.

Mon-Khmer, សម្សាប់ជំនួយភាសាជា ភាសាខ្មមរំ សូមទូរស័ព្ទទទៅកាន់លខេ 1-866-746-6590 ដោយឥតគិតថ្លាំ។ Cambodian -

Navajo - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-866-746-6590

Nepali - (नेपाली) मा निःशूल्क भाषा सहायता पाउनका लागि 1- 866-746-6590 मा फोन गर्नुहोस् ।

Nilotic-Dinka - Tën kupony ë thok ë Thuonjän col 1-866-746-6590 kecïn ayöc.

Norwegian - For språkassistanse på norsk, ring 1-866-746-6590 kostnadsfritt.

Panjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-866-746-6590 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।

Pennsylvania Dutch - Fer Helfe in Deitsch, ruf: 1-866-746-6590 aa. Es Aaruf koschtet nix.

برای راهنمایی به زبان فارسی با شماره 6590-746-866 بدون هیچ هزینه ای تماس بگیرید. انگلیسی Persian -

Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-866-746-6590.

Portuguese - Para obter assistência linguística em português ligue para o 1-866-746-6590 gratuitamente.

Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-866-746-6590

Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-866-746-6590.

Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-866-746-6590 e aunoa ma se totogi.

Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-866-746-6590.

Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-866-746-6590.

Sudanic-Fulfude - Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-866-746-6590. Njodi woo fawaaki on.

Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-866-746-6590 bila malipo.

Syriac - אב שבת הב א שבאו ב מאת שלבב ה שמואה הת לנת וששה בל 1-866-746-6590 בל ב שבת השל ב ל 1-866-746-6590 בל ב

Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-866-746-6590 nang walang bayad.

Telugu - భాషతో సాయం కొరకు ఎలాంటి ఖర్పు లేకుండా 1-866-746-6590 కు కాల్ చేయండి. (తెలుగు)

Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-866-746-6590 ฟรีไม่มีค่าใช้จ่าย

Tongan - Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-866-746-6590 'o 'ikai hā ōtōngi.

Trukese - Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-866-746-6590 nge esapw kamé ngonuk.

Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-866-746-6590.

Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-866-746-6590.

بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-866-746-6590 ۔ پر بات کریں۔

Vietnamese - Để được hố trợ ngôn ngư bằng (ngôn ngư), hấy gọi miến phi đến số 1-866-746-6590.

Yiddish - פאר שפראך הילף אין אידיש רופט 1-866-746-6590 פריי פון אפצאל.

Yoruba - Fún ìrànlowo nípa èdè (Yorùbá) pe 1-866-746-6590 lái san owó kankan rárá.