

THE NEWYORK-PRESBYTERIAN Hospital : Aetna Open Access® Aetna SelectSM- EPO

Coverage for: Individual + Family | Plan Type: EPO

Coverage Period: 01/01/2026-12/31/2026



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 1-888-982-3862. 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 1-888-982-3862 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?	Not Applicable .	You will have to meet the <u>deductible</u> before the <u>plan</u> pays for any services
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 \$3,175 / Family \$6,350.	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 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 1-888-982-3862 for a list of in- <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will not have coverage when using an <u>out-of-network provider</u> with the following exceptions : • Emergencies: See "If you need immediate medical attention" section of this document for specifics. Please note that Out of Network Urgent Care services are not covered in emergency situations • Network Insufficiency When using an <u>out-of-network provider</u> you might receive a bill from the <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 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.

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	\$25 <u>copay</u> /visit; except no charge for office surgery	Not covered	None
If you visit a health care <u>provider</u> 's office or clinic	<u>Specialist</u> visit	\$30 copay/visit for NYP-Affiliated Specialist; except no charge for office surgery \$40 copay/visit for non-NYP specialist; except no charge for office surgery	Not covered	If the place of service the member visits is identified as Facility Setting rather than Office Setting the \$40 copay will apply.
	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.
Other specialist visit	Acupuncture	\$0 copay for the first 25 visits of a calendar year and \$25 thereafter	Not covered	None

Common Medical Event	Services You May Need	In-Network Provider	U Will Pay Out-of-Network Provider	Limitations, Exceptions, & Other Important Information
		(You will pay the least)	(You will pay the most)	
	<u>Diagnostic test</u> : Blood work	No charge for laboratory	Not covered	None
If you have a test	<u>Diagnostic test:</u> X-ray	\$30 copay/visit for X-Ray with NYP- Affiliated Specialist \$40 copay/visit for X-Ray with non- NYP Specialist	Not covered	\$40 copay applies if the service is provided outside of an office visit with an NYP-affiliated specialist. Additionally if the place of service the member visits is identified as Facility Setting rather than Office Setting the \$40 copay will apply.
	Imaging (CT/PET scans, MRIs)	\$30 copay/visit for NYP-Affiliated Specialist; \$40 copay/visit for non-NYP specialist;	Not covered	\$40 copay applies if the service is provided outside of an office visit with an NYP-affiliated specialist. Additionally if the place of service the member visits is identified as Facility Setting rather than Office Setting the \$40 copay will apply.
If you need prescription drugs		Refer to www.	caremark.com	
Telemedicine	Aetna Teladoc	General Medicine and Mental health; \$25 copay/visit Non-NYP Specialist (i.e., dermatologist):	Not applicable	Telemedicine
	NYP Virtual Urgent Care – Adult and Pediatric	\$40 <u>copay</u> /visit \$0 <u>copay</u> /visit	Not applicable	Telemedicine

	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 have	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	None
outpatient surgery	Physician/surgeon fees	No charge	Not covered	None
	Emergency room care	\$150 <u>copay</u> /visit	\$150 copay/visit	No coverage for non-emergency use.
If you need immediate medical	Emergency medical transportation	No charge	No charge	Non-emergency transport: not covered, except if pre-authorized.
attention	<u>Urgent care</u>	\$35 <u>copay</u> /visit	Not covered	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$150 <u>copay</u> /day first 3 days per stay	Not covered	Max <u>copay</u> /per admission: \$450. Pre-authorization required for care.
nospital stay	Physician/surgeon fees	No charge	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <u>copay</u> /Office visit Other outpatient services: No charge Facility: No charge	Not covered	None
00111000	Inpatient services	\$150 <u>copay</u> /day first 3 days per stay	Not covered	Max <u>copay</u> /per admission \$450. Pre-authorization required for care.
If you are pregnant	Office visits	No charge	Not covered	Maternity care may include tests and services
	Childbirth/delivery professional services	No charge	Not covered	described elsewhere in the SBC (i.e. ultrasound.) Max copay/per admission: \$450.
	Childbirth/delivery facility services	\$150 <u>copay</u> /day first 3 days per stay	Not covered	- Μαλ <u>σοραγ</u> τροι ασπιοσιστί. ψ τ σο.

Common Medical		In-Network	ı Will Pay Out-of-Network	Limitations, Exceptions, & Other Important
Event	Services You May Need	Provider (You will pay the least)	Provider (You will pay the most)	Information
	Specialist office visit	\$30 copay/visit for NYP-Affiliated Specialist; except no charge for office surgery \$40 copay/visit for non-NYP specialist; except no charge for office surgery	Not covered	Coverage for gender affirming care follows the clinical guidelines outlined in CPB #0615 (Gender Affirming Surgery).
If you are seeking gender affirming care	Outpatient Services: • Facility fee (e.g., ambulatory surgery center) • Physician/surgeon fees	No charge	Not covered	Your NYP plan also includes enhanced coverage for gender affirming care. This enhanced coverage is inclusive of the following services: Facial Feminization surgery Thyroid chondroplasty
	Inpatient services: Facility fee (e.g. hospital room	\$150 <u>copay</u> /day first 3 days per stay	Not covered	Rhytidectomy Electrolysis Voice Surgery Jaw surgery
	Inpatient services: Physician/surgeon fees	No charge	Not covered	

		What You	ı 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
	Home health care	No charge	Not covered	200 visits/calendar year.
If you need help	Rehabilitation services	\$30 copay/visit for NYP Affiliated Specialist; except no charge for office surgery \$40 copay/visit for non-NYP specialist; except no charge for office surgery	Not covered	60 visits/calendar year for Physical Therapy 30 visits/calendar year for Speech & Occupational Therapy combined, including outpatient hospital services.
other special health needs	Habilitation services	\$25 <u>copay</u> /visit	Not covered	None
	Skilled nursing care	No charge	Not covered	60 days/calendar year. Pre-authorization required for care.
	Durable medical equipment	No charge	Not covered	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse. Includes Electric Breast Pumps limited to 1 per 12 months.
	Hospice services	No charge	Not covered	Pre-authorization required for care.

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
- Glasses

- Long-term care
- Non-emergency care when traveling outside the U.S.
- Prescription drugs

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

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

- Acupuncture
- Bariatric surgery
- NYP Virtual Urgent Care
- Gender Affirming Care

- Chiropractic care
- Hearing aids \$6,000 maximum/3 years.
- Routine Eye Care 1 routine medical eye exam/calendar year. Refer to https://nyp.aetna.com/ under Plan Offerings and select Vision plan for a detailed list of additional vision benefits.
- Infertility treatment Limited to the diagnosis & treatment of underlying medical condition, artificial insemination & ovulation induction. Advanced reproductive technology (subject to coinsurance): \$30,000 maximum/lifetime for iatrogenic infertility only at specific NYP facilities and Aetna® Institutes of Excellence™. Includes: IVF, cryopreservation, storage, thawing (for eggs, sperm and embryo). For Infertility related questions and additional details on infertility benefits please reach out to NIU at 1-800-575-5999 once enrolled

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 1-888-982-3862.
- 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>.
- 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 plan for a denial of a <u>claim</u>. This complaint is called a grievance 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 plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general number at 1-888-982-3862. 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.

<u>Minimum Essential Coverage</u> generally includes <u>plans</u>, <u>health insurance</u> available through the <u>Marketplace</u> or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of <u>Minimum Essential Coverage</u>, you may not be eligible for the <u>premium tax credit</u>.

Does this plan meet Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan 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	\$40
■ Hospital (facility) <u>copayment</u>	\$0
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>	\$0
Copayments	\$40
Coinsurance	\$0
The total Peg would pay is	\$40

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 wellcontrolled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$0
Primary care <u>copayment</u>	\$50
Hospital (facility) copayment	\$150
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

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

Total Example Cost	\$5,600
In this example, Joe would pay:	
Cost Sharing	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$200
Coinsurance	\$0
The total Joe would pay is	\$200

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	\$120
■ Hospital (facility) copayment	\$150
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:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
Copayments	\$270
Coinsurance	\$0
The total Mia would pay is	\$270

The <u>plan</u> would be responsible for the other costs of these EXAMPLE covered services.

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.

Cynthia is Undergoing a Breast Augmentation in an Outpatient Setting

(A year of in-network clinically assisted <u>gender</u> <u>affirming</u> in accordance with the plan generals)

 The <u>plan's</u> overall <u>deductible</u> <u>Specialist copayment</u> Hospital (facility) <u>copayment</u> 	\$0 \$40 \$150		
		■ Other <u>copayment</u>	\$0

This EXAMPLE event includes services like:

Primary care physician office visits (including disease education)

Diagnostic tests (blood work)

Prescription drugs

Durable medical equipment

Total Example Cost	\$17,500
In this example, Cynthia would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
Copayments	\$190
Coinsurance	\$0
The total Cynthia would pay is	\$190

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 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, disability, gender identity or sexual orientation.

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 1-888-982-3862 at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-888-982-3862.

Amharic - ለቋንቋ እንዛ በ አማርኛ በ 1-888-982-3862 በንጻ ይደውሉ

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-888-982-3862 المساعدة في (اللغة العربية)،

Armenian - Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-888-982-3862 առանց գնով։

Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-982-3862 tanpa dikenakan biaya.

Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-888-982-3862 ku busa

Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-888-982-3862-তে কল করুন।

Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-888-982-3862 nga walay bayad.

Burmese - ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-888-982-3862 ကို ခေါ် ဆိုပါ။

Catalan - Per rebre assistència en (català), truqui al número gratuït 1-888-982-3862.

Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-888-982-3862 sin gåstu.

Cherokee - OWYO SOHAWI JHWSPWY OFT (CMX) OPMOIS 1-888-982-3862 OFT CAPWI DEGPJ HIPRO.

Chinese - 欲取得繁體中文語言協助, 請撥打1-888-982-3862, 無需付費。

Choctaw - (Chahta) anumpa ya apela a chi I paya hinla 1-888-982-3862.

Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-888-982-3862 irratti bilisaan bilbilaa.

Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-888-982-3862.

French - Pour une assistance linguistique en français appeler le 1-888-982-3862 sans frais.

French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-888-982-3862 gratis.

German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-888-982-3862 an.

Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-888-982-3862 χωρίς χρέωση.

Gujarati - ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-888-982-3862 પર કૉલ કરો.

Hawaiian - No ke kōkua ma ka 'ōlelo Hawai'i, e kahea aku i ka helu kelepona 1-888-982-3862. Kāki 'ole 'ia kēia kōkua nei.

Hindi - हिन्दी में भाषा सहायता के लिए, 1-888-982-3862 पर मुफ्त कॉल करें।

Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-888-982-3862.

lbo - Maka enyemaka asusu na Igbo kpoo 1-888-982-3862 na akwughi ugwo o bula

llocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-888-982-3862 nga awan ti bayadanyo.

Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-888-982-3862.

Japanese - 日本語で援助をご希望の方は、1-888-982-3862 まで無料でお電話ください。

Karen - လာတာမောက်တတိုးကျိုင်အင်္ဂါ ကျိုင် 🛱 888-982-3862 လာတအို ၁ ဒီးတာ်လာဝ်ဘူဉ်လာဝ်စူးဘဉ်

Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862 번으로 전화해 주십시오.

Kru-Bassa - Be´m`ké qbo-kpá-kpá dyé pidyi dé Bašsoó-wuduun wee, dá 1-888-982-3862

برای راهنمایی به زبان فارسی با شماره 3862-982-982 به خورایی پهیوهندی بکهن.

Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລນາໂທຫາ-888-982-3862 ໂດຍບໍ່ເສຍຄ່າໂທ.

Marathi - कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-888-982-3862) वर फोन करा.

Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-888-982-3862 ilo ejjelok wōnān.

Micronesian-

Pohnpeyan - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-888-982-3862 ni sohte isais.

Mon-Khmer, សម្ភាប់ជំនួយភាសាជា ភាសាខ្មមរៃ សូមទូរស័ព្ទទៅកាន់លខេ 1-888-982-3862 ដោយឥតគិតថ្លប់។

Cambodian -

Navajo - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-888-982-3862

Nepali - (नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-888-982-3862 मा फोन गर्नुहोस् ।

Nilotic-Dinka - Tën kupony ë thok ë Thuonjän col 1-888-982-3862 kecin ayöc.

Norwegian - For språkassistanse på norsk, ring 1-888-982-3862 kostnadsfritt.

Panjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-888-982-3862 'ਤੇ ਮਫ਼ਤ ਕਾਲ ਕਰੋ।

Pennsylvania Dutch - Fer Helfe in Deitsch, ruf: 1-888-982-3862 aa. Es Aaruf koschtet nix.

یر ای راهنمایی به زبان فارسی با شماره 3862-982-1888 بدون هیچ هزینه ای تماس بگیرید انگلیسی Persian -

Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-888-982-3862.

Portuguese - Para obter assistência linguística em português ligue para o 1-888-982-3862 gratuitamente.

Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-888-982-3862

Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-888-982-3862.

Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-888-982-3862 e aunoa ma se totogi.

Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-888-982-3862.

Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-888-982-3862.

Sudanic-Fulfude - Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-888-982-3862. Njodi woo fawaaki on.

Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-888-982-3862 bila malipo.

Syriac - K = 22 K K & D241 abk - 22 K wain or 24 iopk 161,00 1-888-982-3862 apx .

Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-888-982-3862 nang walang bayad.

Telugu - భాషతో సాయం కొరకు ఎలాంటి ఖర్పు లేకుండా 1-888-982-3862 కు కాల్ చేయండి. (తెలుగు)

Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-888-982-3862 ฟรีไม่มีค่าใช้จ่าย

Tongan - Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-888-982-3862 'o 'ikai hā ōtōngi.

Trukese - Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-888-982-3862 nge esapw kamé ngonuk.

Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-888-982-3862.

Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-888-982-3862.

بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 882-982-3862 . پر بات کریں۔

Vietnamese - Đê được hố trợ ngôn ngư bằng (ngôn ngư), hấy gọi miến phi đến số 1-888-982-3862.

Yiddish - פאר שפראך הילף אין אידיש רופט 1-888-982-3862 פריי פון אפצאל.

Yoruba - Fún ìrànlowo nípa èdè (Yorùbá) pe 1-888-982-3862 lái san owó kankan rárá.