Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period: 07/01/2024-06/30/2025

aetna™ SCHOOLS HEALTH INSURANCE FUND : Aetna Choice® POS II - SHIF-NJ EDUCATORS HEALTH PLAN (NJEHP)

Coverage for: Individual + Family | **Plan Type:** POS

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) 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, www.HealthReformPlanSBC.com or by calling 1-800-370-4526. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-800-370-4526 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0. Out-of-Network: Individual $350 / Family $700.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: Individual $500 / Family $1,000. Out-of-Network: Individual $2,000 / Family $5,000. Prescription Drugs separate out-of-pocket limit is $1,600 Individual/ $3,200 Family	The out–of–pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out–of–pocket limits until the overall family out–of–pocket limit 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 out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind or call 1-800-370-4526 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	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 Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay/visit	30% coinsurance	Out-of-network allowances for Chiropractic, Acupuncture and Physical Therapy services are limited to no more than $35.00 per visit for Chiropractic, $60.00 per visit for Acupuncture and $52.00 per visit for Physical Therapy or 75% of the in-network cost per visit, whichever is less. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
	Specialist visit	$15 copay/visit	30% coinsurance	
	Preventive care /screening /immunization	No charge	Not covered	
If you have a test	Diagnostic test (x-ray, blood work)	No charge	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge	30% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drugs	$5 copay - 1-30-day, $10 copay – 31-60-day, $15 – 61–90-day. $10 mail	In-network copay apply. You are responsible for any charges above the allowed amount.	Step Therapy with NO Grandfathering applies. For Brand drugs with a Generic Equivalent available, member pays the difference in cost between generic & brand, plus brand copay. Utilization Management programs may apply.
	Preferred brand drugs	$10 copay - 1-30-day, $20 copay – 31-60-day, $30 – 61–90-day. $20 mail	In-network copay apply. You are responsible for any charges above the allowed amount.	
	Non-preferred brand drugs	$10 copay - 1-30-day, $20 copay – 31-60-day, $30 – 61–90-day. $20 mail	In-network copay apply. You are responsible for any charges above the allowed amount.	

	Specialty drugs	Same as retail	Not covered	Up to 30-day supply – must be filled through Accredo Specialty Pharmacy. Utilization Management programs may appl.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	30% coinsurance	None
	Physician/surgeon fees	No charge	30% coinsurance	30% Coinsurance for out-of-network anesthesia.
Common Medical Event	**Services You May Need**	**What You Will Pay**		**Limitations, Exceptions, & Other Important Information**
		In-Network Provider (You will pay the least)	**Out-of-Network Provider (You will pay the most)**	
If you need immediate medical attention	Emergency room care	$125 copay/visit	$125 copay/visit. Deductible does not apply.	If admitted within 24 hours, the copayment is waived. No coverage for non-emergency use.
	Emergency medical transportation	10% coinsurance	30% coinsurance	Limited to local emergency transport to the nearest facility equipped to treat the emergency condition. Non-emergency transport: not covered
	Urgent care	$15 copay/visit	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	30% coinsurance	Pre-authorization required for out-of-network care.
	Physician/surgeon fees	No charge	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge for Outpatient Hospital. $15 copay/visit, for Mental Health and Behavioral Health. No Charge for Substance Abuse Office Visit.	Office & other outpatient services: 30% coinsurance	Some specialty outpatient services require pre-approval.
	Inpatient services	No charge	30% coinsurance	Requires pre-approval.

If you are pregnant	Office visits	$10.00 copay/visit $15.00 copay/visit for Specialist office.	30% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Pre-authorization may be required for out-of-network care.
	Childbirth/delivery professional services	No charge	30% coinsurance	
	Childbirth/delivery facility services	No charge	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	30% coinsurance	Pre-authorization required for out-of-network care.
	Rehabilitation services	No Charge for Inpatient and Outpatient Facility. $15 copay/visit	30% coinsurance	Requires pre-approval. Out-of-network allowance for Physical Therapy services is limited to $52.00 per visit or 75% of the in-network cost per visit, whichever is less.
Common Medical Event	**Services You May Need**	**What You Will Pay** **In-Network Provider (You will pay the least)**	**Out-of-Network Provider (You will pay the most)**	**Limitations, Exceptions, & Other Important Information**
	Habilitation services	No Charge for Inpatient and Outpatient Facility. $15 copay/visit	30% coinsurance	Requires pre-approval. Out-of-network allowance for Physical Therapy services is limited to $52.00 per visit or 75% of the in-network cost per visit, whichever is less.
	Skilled nursing care	No charge	30% coinsurance	Requires pre-approval. Limited to 120 days for in-network and 60 days out of network facility days for a combined maximum of 120 days per calendar.
	Durable medical equipment	10% coinsurance	30% coinsurance	Requires pre-approval for all rentals and some purchases. Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	No charge	30% coinsurance	Requires pre-approval.

If your child needs dental or eye care	Children's eye exam	$15 copay/visit	Not covered.	1 routine eye exam/calendar year.
	Children's glasses	Not covered	Not covered	Not covered.
	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)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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 - Up to $60 or 75% of in-network payments, whichever is lower for out-of-network.
- Bariatric surgery
- Chiropractic care - 30 visits/calendar year.$35 maximum/visit for out-of-network.
- Hearing aids - 1 hearing aid to $1,000 maximum per ear/24 months up to age 16.
- Infertility treatment - For more information & exceptions, see policy document provided by your employer.
- Private-duty nursing
- Routine eye care (Adult) - 1 routine eye exam/calendar year for in-network only.

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 1-800-370-4526.
- 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 www.cciio.cms.gov.
- 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 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 claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. 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:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-800-370-4526.
- 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 www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your appeal. Contact information is at: http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html.

Does this plan provide Minimum Essential Coverage? **Yes.**

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

Does this plan meet Minimum Value Standards? **No.**

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 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 plan's overall deductible** **$0.00**
- **Specialist copayment** **$15.00**
- **Hospital (facility)coinsurance** **0%**
- **Other coinsurance** **10%**

This EXAMPLE event includes services like:

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0.00
Copayments	$20.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$70.00
The total Peg would pay is	**$90.00**

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

- **The plan's overall deductible** **$0.00**
- **Specialist copayment** **$15.00**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **$10%**

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	
Deductibles	$0.00
Copayments	$100.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$4,300.00
The total Joe would pay is	**$4,400.00**

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

- **The plan's overall deductible** **$0.00**
- **Specialist copayment** **$15.00**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **10%**

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	$0.00
Copayments	$200.00
Coinsurance	$100.00
What isn't covered	
Limits or exclusions	$10.00
The total Mia would pay is	**$310.00**

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 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).

TTY: 711

Language Assistance:

For language assistance in your language call 1-800-370-4526 at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-800-370-4526.

Amharic - ለለለለ ለለለ ለ ለለለለ ለ 1-800-370-4526 ለለለለለለለ

Arabic - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-800-370-4526

Armenian - Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-800-370-4526 առանց գնով:

Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-370-4526 tanpa dikenakan biaya.

Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-800-370-4526 ku busa

Bengali-Bangala - ᏗᏗᏗᏗᏗ ᏗᏗᏗᏗ ᏗᏗᏗᏗᏗᏗᏗᏗ ᏗᏗᏗᏗ ᏗᏗᏗᏗᏗᏗᏗᏗᏗᏗ 1-800-370-4526-ᏗᏗ ᏯBisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-370-4526 nga walay bayad. Burmese - ဌေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-800-370-4526 ကို ခေါ်ဆိုပါ။

Catalan - Per rebre assistència en (català), truqui al número gratuït 1-800-370-4526.

Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-800-370-4526 sin gåstu.

Cherokee - ᎾᏍᎩᎾ ᎦᎪᎻᏰᏍᏗ ᏗᏂᏍᎦᏅᏍᎩ ᎾᏑᎢ (ᏣᎳᎩ) ᎾᏏᎳᎾᏕᎢᎦ 1-800-370-4526 ᎤᎾᎢ Ꮭ ᎪᎱᏍᏗ ᏧᎬᏩᎵᏁ ᏂᏲᎡᎾ.

Chinese - 欲取得繁體中文語言協助，請撥打1-800-370-4526，無需付費。

Choctaw - (Chahta) anumpa ya apela a chi I paya hinla 1-800-370-4526.

Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-800-370-4526 irratti bilisaan bilbilaa.

Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-370-4526.

French - Pour une assistance linguistique en français appeler le 1-800-370-4526 sans frais.

French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-800-370-4526 gratis.

German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-370-4526 an.

Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-370-4526 χωρίς χρέωση.

Gujarati - ᏗᏗᏗᏗᏗᏗᏗᏗ ᏗᏗᏗᏗᏗᏗ ᏗᏗᏗᏗ ᏗᏗᏗᏗ ᏗᏗᏗ ᏗᏗ ᏗᏗᏗᏗ ᏗᏗᏗ 1-800-370-4526 ᏊᏗᏗ. Hawaiian - No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-800-370-4526. Kāki ‘ole ‘ia kēia kōkua nei.

Hindi - हिन्दी में भाषा सहायता के लिए, 1-800-370-4526 पर मुफ्त कॉल करें।

Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-800-370-4526.

Ibo - Maka enyemaka asụsụ na Igbo kpọọ 1-800-370-4526 na akwụghị ụgwọ ọ bụla

Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-370-4526 nga awan ti bayadanyo.

Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-800-370-4526.

Japanese - 日本語で援助をご希望の方は、1-800-370-4526　まで無料でお電話ください。

Karen - လၢတက်မၤစၢၤတက်ကတိၤကျိာ်အကိၢ် ကျိာ် 1-800-370-4526 လၢတအိဉ်ဒီးတက်လၢာ်ဘျာ်လၢာ်စုၤဘဉ်

Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-370-4526 번으로 전화해 주십시오.

Kru-Bassa - Ɓɛ´m`ké gbo-kpá-kpá dyé pidyi ɖé Ɓaɓɔɔ̀-wuɖuùn wɛ̃ɛ, ɖá 1-800-370-4526

Kurdish - بۆ یارمەتی بە زمانی کوردی بە خۆڕایی پەیوەندی بکەن. 1-800-370-4526 برای راهنمایی به زبان فارسی با شماره

Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ1-800-4526 ໂດຍບໍ່ເສຍຄ່າໃຫ.

Marathi - ΛΛΛΛΛΛΛΛΛ ΛΛΛΛΛΛΛΛΛΛΛ ΛΛΛΛ ΛΛΛΛ ΛΛΛΛΛΛΛ ΛΛΛΛΛΛΛΛΛΛ, [redacted] ΛΛ ΛΛΛ ΛΛΛ.

Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-800-370-4526 ilo ejjelokwōnān.

Micronesian-Pohnpeyan - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-800-370-4526 ni sohte isais.

Mon-Khmer, Cambodian - សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-800-370-4526 ដោយឥតគិតថ្លៃ។

Navajo - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-800-370-4526

Nepali - (ΛΛΛΛΛΛ) ΛΛ ΛΛΛΛΛΛΛΛ ΛΛΛΛ ΛΛΛΛΛΛ ΛΛΛΛΛΛ ΛΛΛΛ 1-800-370-4526 ΛΛ ΛΛΛ [redacted]

Nilotic-Dinka - Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-800-370-4526 kecïn aɣöc.

Norwegian - For språkassistanse på norsk, ring 1-800-370-4526 kostnadsfritt.

Panjabi - ΛΛΛΛΛΛ ΛΛΛΛ ΛΛΛΛΛ ΛΛΛΛΛΛ ΛΛ, 1-800-370-4526 'ΛΛ ΛΛΛΛΛΛΛΛΛΛ

Pennsylvania Dutch - Fer Helfe in Deitsch, ruf: 1-800-370-4526 aa. Es Aaruf koschtet nix.

Persian - برای راهنمایی به زبان فارسی با شماره 1-800-370-4526 بدون هیچ هزینه ای تماس بگیرید. انگلیسی

Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-800-370-4526.

Portuguese - Para obter assistência linguística em português ligue para o 1-800-370-4526 gratuitamente.

Romanian - Pentru asistenţă lingvistică în româneşte telefonaţi la numărul gratuit 1-800-370-4526

Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-800-370-4526.

Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-800-370-4526 e aunoa ma se totogi.

Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-800-370-4526.

Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-800-370-4526.

Sudanic-Fulfude - Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-800-370-4526. Njodi woo fawaaki on.

Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-800-370-4526 bila malipo.

Syriac - 1-800-370-4526

Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-800-370-4526 nang walang bayad.

Telugu - ΛΛΛΛΛ ΛΛΛΛ ΛΛΛΛΛ ΛΛΛΛΛΛ ΛΛΛΛΛ ΛΛΛΛΛΛΛ 1-800-370-4526 ΛΛ ΛΛΛΛ ΛΛΛΛΛ(ΛΛΛΛΛ)

Thai - ส ยเหลอทำ งดำ ำ นภำ ษำ เป ำ น ภำ ษำ ไทย โทร 1-800-370- ค ใชจ ย ำก ำ หร ำบคว มชว 4526 ฟรไมม

Tongan - Kapau ‘oku fiema'u hā tokoni ‘i he lea faka-Tonga telefoni 1-800-370-4526 ‘o ‘ikaihā ōtōngi.

Trukese - Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-800-370-4526 nge esapw kamé ngonuk.

Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-800-370-4526.

Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-800-370-4526.

Urdu - بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے، 1-800-370-4526 پر بات کریں۔

Vietnamese - Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-800-370-4526.

Yiddish - פאר שפראך הילף אין אידיש רופט 1-800-370-4526 פריי פון אפצאל.

Yoruba - Fún ìrànlọwọ nípa èdè (Yorùbá) pe 1-800-370-4526 lái san owó kankanrárá.