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

Coverage Period: 04/01/2022-12/31/2022

MTA NEW YORK CITY TRANSIT: Aetna Choice® POS II - Plus Plan

ATU 726 / 1056 / 1179

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.mymta.info or by calling 1-646-376-0123. 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 1-646-376-0123 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $0. Out-of-Network: Individual $1,000 / Family $3,000.	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. Emergency 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?	Yes. $100 for durable medical equipment. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	In-Network: Individual $1,500 / Family $3,000.Out-of-Network: Individual $10,000 / Family $30,000.	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.aetnaNYCT.com or call 1-855-824-5349 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	$5 copay/visit	30% coinsurance	None
	Specialist visit	$5 copay/visit	30% coinsurance	None
	Preventive care /screening /immunization	No charge	30% coinsurance	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.
If you have a test	Diagnostic test (x-ray, blood work)	$5 copay/visit	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge	30% coinsurance	None
If you need drugs to treat your illness or condition **Prescription drug coverage is administered by CVS Caremark** More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs - Lowest cost	Retail/Specialty Medications (Med): 1-30 day: $0 copay; Mail Order (MOD) Med: 31-90 day: $0 copay; MOD Specialty Med: 30 day: $0 copay	You will pay the cost of the med & submit a paper claim for possible reimbursement	Provider means a network pharmacy for purposes of this section. Retail: Up to a 31 day supply Mail-Order: Up to a 90 day supply Mail-Order Specialty: Up to a 30 day supply. See the website listed for information on drugs covered by your plan. Not all drugs are covered.
	Preferred brand drugs - Midrange cost	Retail/Specialty Med: 1-30 day: $20 copay; MOD/Specialty Med: 31-90 day: $40 copay	You will pay the cost of the med & submit a paper claim for possible reimbursement	
	Non-preferred brand drugs- Highest cost	Retail/Specialty Med: 1-30 day: $40 copay; MOD Med: 31-90 day: $80 copay; MOD Specialty Med: 30 day: $0 copay	You will pay the cost of the med & submit a paper claim for possible reimbursement	

<table>
<tr><th rowspan="2">Common Medical Event</th><th rowspan="2">Services You May Need</th><th colspan="2">What You Will Pay</th><th rowspan="2">Limitations, Exceptions, & Other Important Information</th></tr>
<tr><th>In-Network Provider
(You will pay the least)</th><th>Out-of-Network Provider
(You will pay the most)</th></tr>
<tr><td></td><td>Specialty drugs</td><td>Applicable cost as noted above for generic or brand drugs</td><td>You will pay the cost of the med & submit a paper claim for possible reimbursement</td><td></td></tr>
<tr><td rowspan="2">If you have outpatient surgery</td><td>Facility fee (e.g., ambulatory surgery center)</td><td>No charge</td><td>30% coinsurance</td><td>None</td></tr>
<tr><td>Physician/surgeon fees</td><td>No charge</td><td>30% coinsurance</td><td>None</td></tr>
<tr><td rowspan="3">If you need immediate medical attention</td><td>Emergency room care</td><td>$100 copay/visit</td><td>$100 copay/visit</td><td>No coverage for non-emergency use.</td></tr>
<tr><td>Emergency medical transportation</td><td>No charge</td><td>No charge</td><td>Non-emergency transport: not covered, except if pre-authorized.</td></tr>
<tr><td>Urgent care</td><td>$35 copay/visit</td><td>$35 copay/visit</td><td>None</td></tr>
<tr><td rowspan="2">If you have a hospital stay</td><td>Facility fee (e.g., hospital room)</td><td>No charge</td><td>30% coinsurance</td><td>Pre-authorization required for out-of-network care.</td></tr>
<tr><td>Physician/surgeon fees</td><td>No charge</td><td>30% coinsurance</td><td>None</td></tr>
<tr><td rowspan="2">If you need mental health, behavioral health, or substance abuse services</td><td>Outpatient services</td><td>Office & other outpatient services: $5 copay/visit</td><td>Office & other outpatient services: 30% coinsurance</td><td>None</td></tr>
<tr><td>Inpatient services</td><td>No charge</td><td>30% coinsurance</td><td>Pre-authorization required for out-of-network care.</td></tr>
<tr><td rowspan="3">If you are pregnant</td><td>Office visits</td><td>No charge</td><td>30% coinsurance</td><td rowspan="3">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 required for out-of-network care may apply.</td></tr>
<tr><td>Childbirth/delivery professional services</td><td>No charge</td><td>30% coinsurance</td></tr>
<tr><td>Childbirth/delivery facility services</td><td>No charge</td><td>30% coinsurance</td></tr>
<tr><td rowspan="4">If you need help recovering or have other special health needs</td><td>Home health care</td><td>No charge</td><td>25% coinsurance</td><td>200 visits/calendar year. Pre-authorization required for out-of-network care.</td></tr>
<tr><td>Rehabilitation services</td><td>$5 copay/visit</td><td>30% coinsurance</td><td>90 visits/calendar year for Physical, Occupational & Speech Therapy, including outpatient hospital services.</td></tr>
<tr><td>Habilitation services</td><td>$5 copay/visit</td><td>30% coinsurance</td><td>Limited to treatment of Autism.</td></tr>
<tr><td>Skilled nursing care</td><td>No charge</td><td>30% coinsurance</td><td>100 days/calendar year. Pre-authorization required for out-of-network care.</td></tr>
</table>

Common Medical Event	Services You May Need	What You Will Pay In-Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Durable medical equipment	0% coinsurance, after specific ded	50% coinsurance, after specific ded	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	No charge	30% coinsurance	Pre-authorization required for out-of-network care.
If your child needs dental or eye care	Children's eye exam	No charge	30% coinsurance	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.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs

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

- Bariatric surgery
- Chiropractic care
- Infertility treatment.
- Private-duty nursing
- Routine eye care (Adult) - 1 routine eye exam/calendar 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:

- For more information on your rights to continue coverage, contact the plan at 1-646-376-0123.
- 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 1-646-376-0123.
- 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? **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 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**
■ **Specialist copayment**	**$5**
■ **Hospital (facility) copayment**	**$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:	
Cost Sharing	
Deductibles*	$0
Copayments	$50
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$110**

Managing Joe's Type 2 Diabetes

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

■ **The plan's overall deductible**	**$0**
■ **Specialist copayment**	**$5**
■ **Hospital (facility) copayment**	**$0**
■ **Other copayment**	**$0**

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
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$220**

Mia's Simple Fracture

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

■ **The plan's overall deductible**	**$0**
■ **Specialist copayment**	**$5**
■ **Hospital (facility) copayment**	**$0**
■ **Other copayment**	**$0**

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
Copayments	$60
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$60**

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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 1-646-376-0123.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: P.O. Box 24030, Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates.

TTY: 711

Language Assistance:

For language assistance in your language call 1-646-376-0123 at no cost.

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-646-376-0123.
Amharic -	ለቋንቋ እገዛ በ አማርኛ በ 1-646-376-0123 በነጻ ይደውሉ
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-646-376-0123
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-646-376-0123 առանց գնով:
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-646-376-0123 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-646-376-0123 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বিনামুল্যে 1-646-376-0123-তে কল করুন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-646-376-0123 nga walay bayad.
Burmese -	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-646-376-0123 ကို ခေါ်ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-646-376-0123.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-646-376-0123 sin gåstu.
Cherokee -	ᎾᏍᎩᎾ ᏕᏲᏂᎯᏍᏗ ᏗᏂᏍᏕᎵᏍᎩ ᎾᎿᎢ (ᏣᎳᎩ) ᏫᏏᏔᏅᎥᏚ 1-646-376-0123 ᎤᎾᎢ Ꮭ ᎠᎱᏍᏗ ᏧᎬᏩᎶᏗ ᏂᎨᏒᎾ.
Chinese -	欲取得繁體中文語言協助，請撥打 1-646-376-0123，無需付費。
Choctaw -	(Chahta) anumpa ya apela a chi I paya hinla 1-646-376-0123.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-646-376-0123 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-646-376-0123.
French -	Pour une assistance linguistique en français appeler le 1-646-376-0123 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-646-376-0123 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-646-376-0123 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-646-376-0123 χωρίς χρέωση.
Gujarati -	ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-646-376-0123 પર કૉલ કરો.
Hawaiian -	No ke kōkua ma ka ʻōlelo Hawaiʻi, e kahea aku i ka helu kelepona 1-646-376-0123. Kāki ʻole ʻia kēia kōkua nei.

Hindi -	हिन्दी में भाषा सहायता के लिए, 1-646-376-0123 पर मुफ्त कॉल करें।
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-646-376-0123.
Ibo -	Maka enyemaka asụsụ na Igbo kpọọ 1-646-376-0123 na akwụghị ụgwọ ọ bụla
Ilocano -	Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-646-376-0123 nga awan ti bayadanyo.
Italian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-646-376-0123.
Japanese -	日本語で援助をご希望の方は、1-646-376-0123 まで無料でお電話ください。
Karen -	လၢတၢ်မၤစၢၤတၢ်ကတိၤကျိာ်အဂီၢ် ကျိၣ် ဖဲ1-646-376-0123 လၢတအိၣ်ဒီးတၢ်လၢၢ်ဘူၣ်လၢၢ်စ့ၤဘၣ်
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-646-376-0123 번으로 전화해 주십시오.
Kru-Bassa -	Ɓɛ́m`ké gbo-kpá-kpá dyé pídyi ɖé Ɓǎsɔ́ɔ̀-wùɖùǔn wɛ̃ɛ, ɖá 1-646-376-0123
Kurdish -	برای راهنمایی به زبان فارسی با شماره 1-646-376-0123 به خۆرایی پەیوەندی بکەن.
Laotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ1-646-376-0123 ໂດຍບໍ່ເສຍຄ່າໂທ.
Marathi -	कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-646-376-0123 वर फोन करा.
Marshallese -	Ñan bōk jipañ ilo Kajin Majol, kallok 1-646-376-0123 ilo ejjelok wōnān.
Micronesian-Pohnpeyan -	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-646-376-0123 ni sohte isais.
Mon-Khmer, Cambodian -	សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-646-376-0123 ដោយឥតគិតថ្លៃ។
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-646-376-0123
Nepali -	(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-646-376-0123 मा फोन गर्नुहोस् ।
Nilotic-Dinka -	Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-646-376-0123 kecïn aɣöc.
Norwegian -	For språkassistanse på norsk, ring 1-646-376-0123 kostnadsfritt.
Panjabi -	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-646-376-0123 ’ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-646-376-0123 aa. Es Aaruf koschtet nix.
Persian -	برای راهنمایی به زبان فارسی با شماره 1-646-376-0123 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Polish -	Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-646-376-0123.
Portuguese -	Para obter assistência linguística em português ligue para o 1-646-376-0123 gratuitamente.
Romanian -	Pentru asistenţă lingvistică în româneşte telefonaţi la numărul gratuit 1-646-376-0123

Russian -	Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-646-376-0123.
Samoan -	Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-646-376-0123 e aunoa ma se totogi.
Serbo-Croatian -	Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-646-376-0123.
Spanish -	Para obtener asistencia lingüística en español, llame sin cargo al 1-646-376-0123.
Sudanic-Fulfude -	Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-646-376-0123. Njodi woo fawaaki on.
Swahili -	Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-646-376-0123 bila malipo.
Syriac -	ܐܢ ܒܥܐ ܐܢܬ ܠܗ ܡܥܕܪܢܘܬܐ ܒܠܫܢܐ ܐܬܘܪܝܐ ܗܘܐ ܠܟ ܩܪܝ ܥܠ ܡܢܝܢܐ 1-646-376-0123 ܡܓܢܐ.
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-646-376-0123 nang walang bayad.
Telugu -	భాషతో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 1-646-376-0123 కు కాల్ చేయండి. (తెలుగు)
Thai -	สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-646-376-0123 ฟรีไม่มีค่าใช้จ่าย
Tongan -	Kapau ‘oku fiema'u hā tokoni ‘i he lea faka-Tonga telefoni 1-646-376-0123 ‘o ‘ikai hā ōtōngi.
Trukese -	Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-646-376-0123 nge esapw kamé ngonuk.
Turkish -	(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-646-376-0123.
Ukrainian -	Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-646-376-0123.
Urdu -	بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-646-376-0123 . پر بات کریں-
Vietnamese -	Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-646-376-0123.
Yiddish -	פאר שפראך הילף אין אידיש רופט 1-646-376-0123 פריי פון אפצאל.
Yoruba -	Fún ìrànlọwọ nípa èdè (Yorùbá) pe 1-646-376-0123 lái san owó kankan rárá.