

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

Coverage for: Individual + Family | Plan Type: POS

Coverage Period: 05/01/2023-12/31/2023



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.mymta.info</u> or by calling 1-646-376-0123. 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 1-646-376-0123 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In- <u>Network</u> : \$0. Out-of-Network: Individual \$1,000 / Family \$3,000.	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. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. Emergency care is 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 https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other <u>deductibles</u> for specific services?	Yes. \$100 for <u>durable medical equipment</u> . There are no other specific <u>deductible</u> s.	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	In- <u>Network:</u> Individual \$1,500 / Family \$3,000.Out-of-Network: Individual \$10,000 / Family \$30,000.	The <u>out–of–pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out–of–pocket limits</u> until the overall family <u>out–of–pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premium</u> s, balance-billing charges, health care this <u>plan</u> 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.aetnaNYCT.com or call 1-855-824-5349 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</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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

	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	
	Primary care visit to treat an injury or illness	\$5 <u>copay</u> /visit	30% coinsurance	None	
If you visit a health	Specialist visit	\$5 <u>copay</u> /visit	30% coinsurance	None	
care <u>provider</u> 's office or clinic	Preventive care /screening /immunization	No charge	30% <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.	
If you have a test	Diagnostic test (x-ray, blood work)	\$5 <u>copay</u> /visit	30% coinsurance	None	
If you have a test	Imaging (CT/PET scans, MRIs)	No charge	30% coinsurance	None	
If you need drugs to treat your illness or condition	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		
Prescription drug coverage is administered by CVS Caremark More information	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	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.	
about prescription drug coverage is available at www.caremark.com	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		

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
	Specialty drugs	Applicable cost as noted above for generic or brand drugs	You will pay the cost of the med & submit a paper claim for possible reimbursement	
If you have	Facility fee (e.g., ambulatory surgery center)	No charge	30% coinsurance	None
outpatient surgery	Physician/surgeon fees	No charge	30% coinsurance	None
If you need	Emergency room care	\$100 <u>copay</u> /visit	\$100 <u>copay</u> /visit	No coverage for non-emergency use.
immediate medical attention	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	\$35 <u>copay</u> /visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	30% <u>coinsurance</u>	<u>Pre-authorization</u> required for out-of-network care.
nospital stay	Physician/surgeon fees	No charge	30% coinsurance	None
If you need mental health, behavioral health, or	Outpatient services	Office & other outpatient services: \$5 copay/visit	Office & other outpatient services: 30% coinsurance	None
substance abuse services	Inpatient services	No charge	30% coinsurance	<u>Pre-authorization</u> required for out-of-network care.
	Office visits	No charge	30% coinsurance	Cost sharing does not apply for preventive
	Childbirth/delivery professional services	No charge	30% coinsurance	services. Maternity care may include tests and
If you are pregnant	Childbirth/delivery facility services	No charge	30% coinsurance	services described elsewhere in the SBC (i.e. ultrasound.) <u>Pre-authorization</u> required for out-of-network care may apply.
	Home health care	No charge	25% <u>coinsurance</u>	200 visits/calendar year. <u>Pre-authorization</u> required for out-of-network care.
If you need help recovering or have other special	Rehabilitation services	\$5 <u>copay</u> /visit	30% coinsurance	90 visits/calendar year for Physical, Occupational & Speech Therapy, including outpatient hospital services.
health needs	Habilitation services	\$5 <u>copay</u> /visit	30% coinsurance	Limited to treatment of Autism.
	Skilled nursing care	No charge	30% coinsurance	100 days/calendar year. <u>Pre-authorization</u> required for out-of-network care.

Common M Even		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
		<u>Durable medical equipment</u>	0% <u>coinsurance,</u> after specific ded	50% <u>coinsurance,</u> after specific ded	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
		Hospice services	No charge	30% coinsurance	<u>Pre-authorization</u> required for out-of-network care.
lf vour obile	d naada	Children's eye exam	No charge	30% coinsurance	1 routine eye exam/calendar year.
If your child dental or ey		Children's glasses	Not covered	Not covered	Not covered.
defital of ey	ye cale	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	 Glasses (Child) 	 Non-emergency care when traveling outside the U.S. 	
Cosmetic surgery	 Hearing aids 	 Routine foot care 	
 Dental care (Adult & Child) 	 Long-term care 	 Weight loss programs 	

Other Covered Services (Limitatio	ns may apply to these services. This isn't a complete	e list. Please see your <u>plan</u> document.)
Bariatric surgery	 Infertility treatment. 	 Routine eye care (Adult) - 1 routine eye exam/calendar
Chiropractic care	 Private-duty nursing 	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 <u>plan</u> 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 <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 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 <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 <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 1-646-376-0123.
- 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 <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.

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 <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	\$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:	
<u>Cost Sharing</u>	
<u>Deductibles</u> *	\$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
 Specialist copayment
 Hospital (facility) copayment
 Other copayment
 \$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:		
<u>Cost Sharing</u>		
Deductibles*	\$0	
<u>Copayments</u>	\$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 <u>plan's</u> overall <u>deductible</u>	\$0
Specialist copayment	\$5
Hospital (facility) copayment	\$0
Other <u>copayment</u>	\$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:		
Cost Sharing		
<u>Deductibles</u> *	\$0	
<u>Copayments</u>	\$60	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$60	

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

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 እንዛ በ አማርኛ በ 1-646-376-0123 በንጻ ይደውሉ

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-646-376-0123

Armenian - Lեզվի 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 ခေါ် ဆိုပါ။

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 - OOYO SOHAOJ JHOSPOY OLT (CWY) OLWOIS 1-646-376-0123 OOT LAFOJ dEGPJ HIPRO.

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 સહ્યય માટે કોઈ પણ ખર્ચ વગર 1-646-376-0123 પર કૉલ કરો.

Hawaiian - No ke kōkua ma ka 'ōlelo Hawai'i, e kahea aku i ka helu kelepona 1-646-376-0123. Kāki 'ole 'ia 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.

lbo - Maka enyemaka asusu na Igbo kpoo 1-646-376-0123 na akwughi ugwo o bula

llocano - 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 - လာတာမြာစားတာကတိုးကျိုဘ်အင်္ဂါ ကျိုာ် 🗗 646-376-0123 လာတအို ၁ ဒီးတာလာဘ်ဘူဉ်လာဘ်စားဘဉ်

Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-646-376-0123 번으로 전화해 주십시오.

Kru-Bassa - Be´m`ké qbo-kpá-kpá dyé pidyi dé Bašsoó-wuduun wee, dá 1-646-376-0123

برای راهنمایی به زبان فارسی با شماره 0123-376-646 به خورایی پهیوهندی بکهن.

Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລນາໂທຫາ-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, សម្រាប់ជំនួយភាសាជា ភាសាខ្ទមរំ សូមទូរស័ព្ទទេៅកាន់លខេ 1-646-376-0123 ដំោយឥតគិតថ្លប់។

Cambodian -

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 kupony ë thok ë Thuonjan col 1-646-376-0123 kecin ayöc.

Norwegian - For språkassistanse på norsk, ring 1-646-376-0123 kostnadsfritt.

Panjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-646-376-0123 'ਤੇ ਮਫ਼ਤ ਕਾਲ ਕਰੋ।

Pennsylvania Dutch - Fer Helfe in Deitsch, ruf: 1-646-376-0123 aa. Es Aaruf koschtet nix.

برای راهنمایی به زبان فارسی با شماره 0123-376-646 بدون هیچ هزینه ای تماس بگیرید. انگلیسی Persian -

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 asistență lingvistică în românește telefonați 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 - K - 32K K & D241 abk - 21ec K wain on Ly ispor 1646-376-0123 apl

Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-646-376-0123 nang walang bayad.

Telugu - భాషతో సాయం కొరకు ఎలాంటి ఖర్పు 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.

بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 0123-646-376 یر بات کریں۔

Vietnamese - Đê 'được hố trở ngôn ngư bằng (ngôn ngư), hấy gọi miến phi 'đên số 1-646-376-0123.

Yiddish - פאר שפראך הילף אין אידיש רופט 1-646-376-0123 פאר שפראך הילף אין אידיש רופט

Yoruba - Fún ìrànlowo nípa èdè (Yorùbá) pe 1-646-376-0123 lái san owó kankan rárá.