

MTA NEW YORK CITY TRANSIT: Aetna Choice® POS II - High Plan SIR UTU Local 1440/SIR-SSSA/SIRTOA/ADTA/SIRTOA TCU

Coverage for: Individual + Family | Plan Type: POS

Coverage Period: 01/01/2024-12/31/2024



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 \$100 / Family \$0.	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?	No.	You will have to meet the <u>deductible</u> before the <u>plan</u> pays for any services
Are there other <u>deductible</u> s for specific services?	Yes. \$100 for <u>durable medical equipment</u> & \$50 for out-of-network <u>home health care</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> ?	Not applicable	This <u>plan</u> does not have an <u>out–of–pocket limit</u> on your expenses.
What is not included in the out-of-pocket limit?	Not applicable	This <u>plan</u> does not have an <u>out–of–pocket limit</u> on your expenses.
Will you pay less if you use a network provider?	Yes. See www.aetnaNYCT.com or call 1-855-824-5943 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	u 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	\$15 <u>copay</u> /visit, <u>deductible</u> (DED) doesn't apply	Subject to Type D3/EMB Schedule of Allowances.	None
If you visit a health care <u>provider</u> 's office or clinic	Specialist visit	\$15 <u>copay</u> /visit	Subject to Type D3/EMB Schedule of Allowances.	None
Office of Chilic	Preventive care /screening /immunization	No charge	Subject to Type D3/EMB Schedule of Allowances.	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.
Warran barra a danda	<u>Diagnostic test</u> (x-ray, blood work)	\$15 <u>copay</u> /visit	Subject to Type D3/EMB Schedule of Allowances.	None
If you have a test	Imaging (CT/PET scans, MRIs)	\$15 <u>copay</u> /visit	Subject to Type D3/EMB Schedule of Allowances.	None
If you need drugs to treat your illness or condition Prescription drug coverage is	Generic drugs- Your Lowest-Cost Option	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 network pharmacy for purposes of this section. Retail: Up to a 30 day supply. MOD: Up to a 90 day supply. MOD Specialty: up to 30 day supply.

	What You Will Pay			
Common Medical	Services You May Need	In-Network Provider	Out-of-Network Provider	Limitations, Exceptions, & Other Important
Event		(You will pay the least)	(You will pay the most)	Information
administered by CVS Caremark More information about prescription drug coverage is	Preferred brand drugs- Your Mid-Range Cost Option	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	
available at www.caremark.com	Non-preferred brand drugs- Your Highest Cost Option	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	
	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	Subject to Type D3/EMB Schedule of Allowances.	None
outpatient surgery	Physician/surgeon fees	No charge	Subject to Type D3/EMB Schedule of Allowances.	None
	Emergency room care	\$100 copay per visit	\$100 copay per visit	No coverage for non-emergency use.
If you need immedical	Emergency medical transportation	No charge	No charge	Non-emergency transport: not covered, except if pre-authorized.
attention	<u>Urgent care</u>	\$15 <u>copay</u> /visit	\$15 <u>copay</u> /visit, deductible doesn't apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$50 <u>copay</u> /stay	Subject to Type D3/EMB Schedule of Allowances.	Max <u>copay</u> /calendar year: \$240 in- <u>network</u> . Penalty of \$250/day (up to \$500) for failure to obtain <u>pre-authorization</u> for out-of-network care.

Common Medical Event	Services You May Need	In-Network Provider (You will pay the	Out-of-Network Provider (You will pay the	Limitations, Exceptions, & Other Important Information
	Physician/surgeon fees	least) No charge	most) Subject to Type D3/EMB Schedule of Allowances.	None
If you need mental health, behavioral health, or	Outpatient services	Office & other outpatient services: \$15 copay/visit	Office & other outpatient services: Subject to Type D3/EMB Schedule of Allowances.	None
substance abuse services	Inpatient services	\$50 <u>copay</u> /stay	0% <u>coinsurance</u>	Max <u>copay</u> /calendar year: \$240 in- <u>network</u> . Penalty of \$250/day (up to \$500) for failure to obtain <u>pre-authorization</u> for out-of-network care.
If you are pregnant	Office visits	No charge	Office & other outpatient services: Subject to Type D3/EMB Schedule of Allowances.	Cost sharing does not apply for preventive
	Childbirth/delivery professional services	No charge	Office & other outpatient services: Subject to Type D3/EMB Schedule of Allowances.	services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Max copay/calendar year: \$240 innetwork. Penalty of \$250/day (up to \$500) for failure to obtain pre-authorization for out-of-
	Childbirth/delivery facility services	\$50 <u>copay</u> /stay	Office & other outpatient services: Subject to Type D3/EMB Schedule of Allowances.	network care may apply.
If you need help recovering or have other special health needs	Home health care	No charge	25% <u>coinsurance,</u> after specific <u>deductible</u>	200 visits/calendar year in-network & 40 visits/calendar year out-of-network. Max copay/calendar year: \$240 in-network. Penalty of \$250/day (up to \$500) for failure to obtain preauthorization for out-of-network care.

			u 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	
	Rehabilitation services	\$15 <u>copay</u> /visit	Subject to Type D3/EMB Schedule of Allowances.	Physical and occupational therapy each limited to 20 visits/calendar year unless additional visits are medically necessary.	
	Habilitation services	No charge	Subject to Type D3/EMB Schedule of Allowances.	Limited to treatment of Autism.	
	Skilled nursing care	No charge	Subject to Type D3/EMB Schedule of Allowances.	100 days/calendar year. Penalty of \$250/day (up to \$500) for failure to obtain pre-authorization for out-of-network care.	
	<u>Durable medical equipment</u>	0% <u>coinsurance,</u> after specific <u>deductible</u>	50% coinsurance	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.	
	Hospice services	No charge	Subject to Type D3/EMB Schedule of Allowances.	Penalty of \$250/day (up to \$500) for failure to obtain pre-authorization for out-of-network care.	
If your child needs	Children's eye exam	No charge	Subject to Type D3/EMB Schedule of Allowances.	1 routine eye exam/calendar year	
dental or eye care	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)

- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult & Child)
- 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.)

Acupuncture

Chiropractic care

Private-duty nursing

Bariatric surgery

Infertility treatment

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 <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 <u>Marketplace</u>, visit <u>www.HealthCare.gov</u> 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.
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If your <u>plan</u> doesn't meet the <u>Minimum Value Standards</u>, you may be eligible for a <u>premium tax credit</u> to help you pay for a <u>plan</u> through the <u>Marketplace</u>.

To see examples of how this <u>plan</u> 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	\$15
■ Hospital (facility) <u>copayment</u>	\$50
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
<u>Copayments</u>	\$200
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$260

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

■ The <u>plan's</u> overall <u>deductible</u>	\$
■ Specialist copayment	\$1
■ Hospital (facility) <u>copayment</u>	\$5
Other copayment	\$

This EXAMPLE event includes services like:

<u>Primary care physician</u> 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:	
<u>Cost Sharing</u>	
<u>Deductibles</u> *	\$0
<u>Copayments</u>	\$400
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$420

Mia's Simple Fracture

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

■ The plan's overall deductible	\$0
Specialist copayment	\$15
■ Hospital (facility) copayment	\$50
■ 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
<u>Copayments</u>	\$80
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$80

^{*}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 በነጻ ይደውሉ

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 - ငွေကုန်ကျစံစရာမလိုဘဲ (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 - $\theta \circ DY \theta \circ SOh \mathcal{A} \circ J A h \circ DS P \circ DY \theta \circ T (GWY) \circ DSWO^2 is 1-646-376-0123 O \theta T C A F \circ DJ DEGPJ H PRO.$

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 સહ્ય 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 - Bɛ´m`ké gbo-kpá-kpá dyé pidyi dé Bašsɔɔ́-wuduùn wɛ̃ɛ, 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, សមរាប់ជំនួយភាសាជា ភាសាខមរៃ សូមទូសេ័ពទទ**ៅកាន់លខេ 1-646-376-0123** ដ**ោយឥតគិតថ្**លៃ។

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.