

STEVENS INSTITUE OF TECHNOLOGY: Open Choice®

Coverage for: Individual + Family | Plan Type: PPO

Coverage Period: 08/18/2022-08/17/2023



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>https://www.aetnastudenthealth.com/</u> or by calling 1-877-480-4161. 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 1-877-480-4161 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For each <u>Plan</u> Year, \$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.
Are there services covered before you meet your deductible?	Yes. In- <u>network</u> office visits, <u>prescription drugs</u> & <u>preventive care</u> are 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?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	In- <u>Network</u> : Individual \$6,350/ Family \$12,700. Out-of-Network: Individual None/ Family None.	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</u> <u>limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover & penalties for failure to obtain pre-authorization for services.	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 1-877-480-4161 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 before</u> you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the specialist you choose without a referral.



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

		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	15% <u>coinsurance</u>	25% coinsurance	None
If you visit a health	Specialist visit	15% coinsurance	25% coinsurance	None
care <u>provider</u> 's office or clinic	Preventive care /screening /immunization	No charge	No charge	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 tost	<u>Diagnostic test</u> (x-ray, blood work)	5% coinsurance	25% <u>coinsurance</u>	None
If you have a test	Imaging (CT/PET scans, MRIs)	15% coinsurance	25% coinsurance	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://www.aetna.com/individuals-families/pharmacy.html	Generic drugs	Copay/prescription, deductible doesn't apply: \$15 (retail), \$37.50 (mail order)	Copay/prescription, deductible doesn't apply: \$15 (retail), \$37.50 (mail order)	Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral & injectable fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in-network.
	Preferred brand drugs	Copay/prescription, deductible doesn't apply: \$30 (retail), \$75 (mail order)	Copay/prescription, deductible doesn't apply: \$30 (retail), \$75 (mail order)	
	Non-preferred brand drugs	Copay/prescription, deductible doesn't apply: \$60 (retail), \$150 (mail order)	Copay/prescription, deductible doesn't apply: \$60 (retail), \$150 (mail order)	
	Specialty drugs	Applicable cost as noted above for generic or brand drugs	Applicable cost as noted above for generic or brand drugs	None

	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
.,	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	25% coinsurance	None
If you have outpatient surgery	Physician/surgeon fees	15% coinsurance	25% coinsurance	None
If you need	Emergency room care	15% coinsurance	15% coinsurance	No coverage for non-emergency use.
immediate medical	Emergency medical transportation	15% coinsurance	15% coinsurance	None
attention	<u>Urgent care</u>	15% coinsurance	25% coinsurance	No coverage for non-urgent use.
If you have a	Facility fee (e.g., hospital room)	15% <u>coinsurance</u>	25% coinsurance	Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care.
hospital stay	Physician/surgeon fees	15% coinsurance	25% coinsurance	None
If you need mental health, behavioral health, or	Outpatient services	Office & other outpatient services: 15% coinsurance	Office & other outpatient services: 25% coinsurance	None
substance abuse services	Inpatient services	15% <u>coinsurance</u>	25% coinsurance	Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care.
If you are pregnant	Office visits	No charge	No charge	
	Childbirth/delivery professional services	15% <u>coinsurance</u>	25% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e.
	Childbirth/delivery facility services	15% <u>coinsurance</u>	25% <u>coinsurance</u>	ultrasound.) Penalty of \$500 for failure to obtain pre-authorization for out-of-network care may apply.

		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	
	Home health care	15% coinsurance	25% coinsurance	None	
	Rehabilitation services	15% <u>coinsurance</u>	25% <u>coinsurance</u>	Includes Physical, Occupational & Speech Therapy.	
If you need help	<u>Habilitation services</u>	15% coinsurance	25% coinsurance		
recovering or have other special	Skilled nursing care	15% coinsurance	25% coinsurance	Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care.	
health needs	<u>Durable medical equipment</u>	15% coinsurance	25% coinsurance	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.	
	Hospice services	15% <u>coinsurance</u>	25% coinsurance	Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care.	
If your obild no sele	Children's eye exam	No charge	25% coinsurance	1 routine eye exam/plan year up to age 19.	
If your child needs dental or eye care	Children's glasses	No charge	25% coinsurance	1 pair of glasses or lenses/plan year.	
dentar or eye care	Children's dental check-up	No charge	25% coinsurance	None	

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)

- Long-term care
- Routine eye care (Adult)
- 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.)

- Bariatric surgery
- Chiropractic care
- Hearing aids 1 hearing aid/24 months
- Infertility treatment Limited to the diagnosis & treatment of underlying medical condition, artificial insemination& ovulation induction.
 Advanced reproductive technology: 4 cycles/lifetime.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing Limited to in-network providers.

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: Office of Managed Care, Consumer Protection Services, NJ Department of Banking and Insurance, Phone: 1-888-393-1062 or Consumer Hotline: 1-800-446-7467, http://www.state.ni.us/dobi/consumer.htm.

• For more information on your rights to continue coverage, contact the plan at 1-877-480-4161.

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 to submit a <u>claim</u>, 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 1-877-480-4161.
- Office of Managed Care, Consumer Protection Services, NJ Department of Banking and Insurance, Phone: 1-888-393-1062 or Consumer Hotline: 1-800-446-7467, http://www.state.nj.us/dobi/consumer.htm.
- Additionally, a consumer assistance program can help you file your <u>appeal</u>. Contact The Office of the Insurance Ombudsman, NJ Department of Banking and Insurance, 20 West State Street, PO Box 472, Trenton, NJ 08625-0472, 1-800-446-7467, Fax: 609-292-2431, http://www.state.nj.us/dobi/consumer.htm, ombudsman@dobi.state.nj.us

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 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 coinsurance	15%
■ Hospital (facility) <u>coinsurance</u>	15%
■ Other coinsurance	15%

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			
<u>Deductibles</u>	\$0		
Copayments	\$100		
Coinsurance	\$520		
What isn't covered			
Limits or exclusions	\$60		
The total Peg would pay is	\$680		

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 coinsurance	15%
■ Hospital (facility) coinsurance	15%
■ Other coinsurance	15%

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:		
Cost Sharing		
<u>Deductibles</u>	\$0	
<u>Copayments</u>	\$1,800	
Coinsurance	\$760	
What isn't covered		
Limits or exclusions	\$20	
The total Joe would pay is	\$2,580	

Mia's Simple Fracture

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

■ The plan's overall deductible	\$0
■ Specialist coinsurance	15%
■ Hospital (facility) coinsurance	15%
Other coinsurance	15%

This EXAMPLE event includes services like:

<u>Emergency room care</u> (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>	\$100	
<u>Coinsurance</u>	\$540	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$640	

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-877-480-4161.

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 discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides 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: PO Box 24030 Fresno, CA 93779)

1-800-648-7817, TTY: 711, Fax: 859-425-3379 (CA HMO customers: 1-860-262-7705)

Email: 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 1-877-480-4161 at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-877-480-4161.

Amharic - ለቋንቋ እንዛ በ አማርኛ በ 1-877-480-4161 በነጻ ይደውሉ

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-877-480-4161 للمساعدة في (اللغة العربية)،

Armenian - Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-877-480-4161 առանց գնով։

Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-877-480-4161 tanpa dikenakan biaya.

Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-877-480-4161 ku busa

Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বিনামুল্যে 1-877-480-4161-তে কল করুন।

Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-877-480-4161 nga walay bayad.

Burmese - ငွေကုန်ကျစံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-877-480-4161 ကို ခေါ် ဆိုပါ။

Catalan - Per rebre assistència en (català), truqui al número gratuït 1-877-480-4161.

Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-877-480-4161 sin gåstu.

Cherokee- $\theta \circ \partial \mathcal{Y} \theta \circ \mathcal{Y} \theta \circ \mathcal{Y} d \circ \mathcal{Y}$

Chinese - 欲取得繁體中文語言協助, 請撥打1-877-480-4161, 無需付費。

Choctaw - (Chahta) anumpa ya apela a chi I paya hinla 1-877-480-4161.

Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-877-480-4161 irratti bilisaan bilbilaa.

Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-877-480-4161.

French - Pour une assistance linguistique en français appeler le 1-877-480-4161 sans frais.

French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-877-480-4161 gratis.

German- Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-877-480-4161 an.

Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-877-480-4161 χωρίς χρέωση.

Gujarati- ગુજરાતીમાં ભાષામાં સહ્રાય માટે કોઈ પણ ખર્ચ વગર 1-877-480-4161 પર કૉલ કરો.

Hawaiian - No ke kōkua ma ka 'ōlelo Hawai'i, e kahea aku i ka helu kelepona 1-877-480-4161. Kāki 'ole 'ia kēia kōkua nei.

Hindi- हिन्दी में भाषा सहायता के लिए, 1-877-480-4161 पर मुफ्त कॉल करें।

Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-877-480-4161.

lbo - Maka enyemaka asusu na Igbo kpoo 1-877-480-4161 na akwughi ugwo o bula

llocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-877-480-4161 nga awan ti bayadanyo.

Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-877-480-4161.

Japanese - 日本語で援助をご希望の方は、1-877-480-4161 まで無料でお電話ください。

Karen - လာတာ်မာစားတာ်ကတီးကျိဉ်အင်္ဂါ ကျိဉ် ကိုး 1-877-480-4161 လာတအိဉ်ဒီးတာ်လာ၁်ဘူဉ်လာ၁်စ္စာဘဉ်

Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-877-480-4161 번으로 전화해 주십시오.

Kru-Bassa - Be´m`ké gbo-kpá-kpá dyé pidyi dé Bašsoó-wuduùn wee, dá 1-877-480-4161

برای راهنمایی به زبان فارسی با شماره 4161-877-480 به خورایی پهیوهندی بکهن.

Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ1-877-480-4161 ໂດຍບໍ່ເສຍຄ່າໂທ.

Marathi - कोणत्याही श्ल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-877-480-4161 वर फोन करा.

Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-877-480-4161 ilo ejjelok wōnān.

Micronesian-Pohnpeyan - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-877-480-4161 ni sohte isais.

Mon-Khmer, សម្**រាប់ជំនួយភាសាជា ភាសាខ្**មរែ សូមទូរស័ព្**ទទ**ៅកាន់លខេ 1-877-480-4161 ដ**ោយឥតគិតថ្**ល។ៃ Cambodian -

Navajo - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-877-480-4161

Nepali - (नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि १- 877-480-4161 मा फोन गर्नुहोस् ।

Nilotic-Dinka- Tën kuoony ë thok ë Thuonjän col 1-877-480-4161 kecin ayöc.

Norwegian - For språkassistanse på norsk, ring 1-877-480-4161 kostnadsfritt.

Panjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-877-480-4161 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।

Pennsylvania Dutch - Fer Helfe in Deitsch, ruf: 1-877-480-4161 aa. Es Aaruf koschtet nix.

برای راهنمایی به زبان فارسی با شماره 4161-877-480 بدون هیچ هزینه ای تماس بگیرید. انگلیسی Persian -

Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-877-480-4161.

Portuguese - Para obter assistência linguística em português ligue para o 1-877-480-4161 gratuitamente.

Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-877-480-4161

Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-877-480-4161.

Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-877-480-4161 e aunoa ma se totogi.

Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-877-480-4161.

Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-877-480-4161.

Sudanic-Fulfude - Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-877-480-4161. Njodi woo fawaaki on.

Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-877-480-4161 bila malipo.

Syriac - K == K == 1-877-480-4161 abx == Le roai, ror du iopr 181,00,1-877-480-4161 apx .

Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-877-480-4161 nang walang bayad.

Telugu - భాషతో సాయం కొరకు ఎలాంటి ఖర్సు లేకుండా 1-877-480-4161 కు కాల్ చేయండి. (తెలుగు)

Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-877-480-4161 ฟรีไม่มีค่าใช้จ่าย

Tongan- Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-877-480-4161 'o 'ikai hā ōtōngi.

Trukese - Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-877-480-4161 nge esapw kamé ngonuk.

Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-877-480-4161.

Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-877-480-4161.

بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، ۱-877-480-4161 میں۔

Vietnamese - Để được hố trợ ngôn ngư bằng (ngôn ngư), hấy gọi miến phi đến số 1-877-480-4161.

Yiddish- פאר שפראך הילף אין אידיש רופט 1-877-480-4161 פריי פון אפצאל.

Yoruba - Fún ìrànlowo nípa èdè (Yorùbá) pe 1-877-480-4161 lái san owó kankan rárá.