

BARNARD COLLEGE PRIMARY CARE HEALTH SERVICE Open Choice®

Coverage for: Individual | Plan Type: PPO

Coverage Period: 08/22/2023-08/21/2024



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, https://www.aetnastudenthealth.com/ or by calling 1-866-725-4396. 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 1-866-725-4396 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For each <u>Plan</u> Year, In- <u>Network</u> : Individual \$300. Out-of-Network: Individual \$500.	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. Emergency care & <u>prescription drugs</u> ; plus in- <u>network</u> office visits & <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 \$9,100. Out-of-Network: Individual \$10,000.	The out-of-pocket limit is the most you could pay in a year for covered services.
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 <u>out–of–pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind or call 1-866-725-4396 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> ?	Yes, for certain conditions. Refer to policy for details.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan's permission before you see the specialist.



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	\$40 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% coinsurance	None
If you visit a health care <u>provider</u> 's office or clinic	Specialist visit	\$40 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% coinsurance	None
	Preventive care /screening /immunization	No charge	30% coinsurance, except no charge for well child & immunizations up to age 19	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)	20% coinsurance	40% coinsurance	None
ii you nave a test	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	None
If you need drugs to treat your illness or condition	Generic drugs	Copay/prescription, deductible doesn't apply: 20% coinsurance (retail and mail order)	Copay/prescription, deductible doesn't apply: 20% coinsurance (retail)	Covers 30 day supply (retail). 90 day supply (mail order) Includes contraceptive drugs & devices
More information about prescription drug coverage is available at	Preferred brand drugs	Copay/prescription, deductible doesn't apply: 35% coinsurance (retail and mail order)	Copay/prescription, deductible doesn't apply: 35% coinsurance (retail)	obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives in- <u>network</u> .
https://www.aetna.c om/individuals- families/pharmacy.h tml	Non-preferred brand drugs	Copay/prescription, deductible doesn't apply: 50% coinsurance (retail and mail order)	Copay/prescription, deductible doesn't apply: 50% coinsurance (retail)	
If you have	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
outpatient surgery	Physician/surgeon fees	20% coinsurance	40% coinsurance	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
If you need	Emergency room care	\$150 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$150 <u>copay</u> /visit, <u>deductible</u> doesn't apply	No coverage for non-emergency use.
immediate medical	Emergency medical transportation	20% coinsurance	20% coinsurance	None
attention	<u>Urgent care</u>	\$60 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% coinsurance	No coverage for non-urgent use.
If you have a	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Pre-authorization required for out-of-network care.
hospital stay	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$40 copay/visit, deductible doesn't apply; other outpatient services: 0% Coinsurance deductible doesn't app	Office and other outpatient services: 30% coinsurance	None
	Inpatient services	20% coinsurance	40% coinsurance	Pre-authorization required for out-of-network care.
	Office visits	No charge	30% coinsurance	Cost sharing does not apply for preventive
If you are pregnant	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	services. Maternity care may include tests and
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	services described elsewhere in the SBC (i.e. ultrasound.) <u>Pre-authorization</u> for out-of-network care may apply.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information	Common Medical Event
	Home health care	25% coinsurance	25% coinsurance	None
	Rehabilitation services	\$40 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% coinsurance	Includes Physical, Occupational & Speech
If you need help recovering or have	Habilitation services	\$40 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% coinsurance	Therapy.
other special health needs	Skilled nursing care	20% coinsurance	40% coinsurance	Pre-authorization required for out-of-network care.
	Durable medical equipment	20% coinsurance	40% coinsurance	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	20% coinsurance	25% <u>coinsurance</u>	Pre-authorization required for out-of-network care.
	Children's eye exam	No charge	30% <u>coinsurance,</u> <u>deductible</u> doesn't apply	1 routine eye exam/ <u>plan</u> year. Covered through the end of the month in which the covered person turns 19.
If your child needs dental or eye care	Children's glasses	No charge	30% <u>coinsurance,</u> <u>deductible</u> doesn't apply	1 pair of glasses (lenses & frames)/plan year. Covered through the end of the month in which the covered person turns 19.
	Children's dental check-up	No charge	30% coinsurance	1 routine dental exam/6 months. Covered through the end of the month in which the covered person turns 19.

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
- Private-duty nursing
- Routine eye care (Adult)

- Routine foot care
- Specialty drugs
- 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 per ear/24 months.
- Infertility treatment In-vitro fertilization: 3 attempts/live birth.
- Non-emergency care when traveling outside the U.S.

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: Department of Financial Services, Consumer Assistance Unit, 800-342-3736, http://www.dfs.ny.gov/consumer/fileacomplaint.htm.

- For more information on your rights to continue coverage, contact the plan at 1-866-725-4396.
- State Consumer Assistance Program, if other than state insurance department contact Community Health Advocates, Community Service Society of New York, 633 Third Avenue, 10th Floor, New York, NY 10017, 1-888-614-5400, http://www.communityhealthadvocates.org/.

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>, <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 1-866-725-4396.
- Department of Financial Services, Consumer Assistance Unit, 800-342-3736, http://www.dfs.ny.gov/consumer/fileacomplaint.htm.
- Additionally, a consumer assistance program can help you file your <u>appeal</u>. Contact Community Health Advocates, Community Service Society of New York, 633 Third Avenue, 10th Floor, New York, NY 10017, 1-888-614-5400, https://www.communityhealthadvocates.org/.

Does this plan provide Minimum Essential Coverage? Yes.

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

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 <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>	\$300
■ Specialist copayment	\$40
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

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	\$12,800
In this example, Peg would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$100
Coinsurance	\$2,400
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,860

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>	\$300
■ Specialist copayment	\$40
■ Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	\$7,400	
In this example, Joe would pay:		
<u>Cost Sharing</u>		
<u>Deductibles</u>	\$100	
<u>Copayments</u>	\$1,900	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$20	
The total Joe would pay is	\$2,020	

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$300
Specialist copayment	\$40
■ Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	\$1,900
In this example, Mia would pay:	
Cost Sharing	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$400
Coinsurance	\$60
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$760

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-866-725-4396.

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: <u>CRCoordinator@aetna.com</u>

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 1-866-725-4396 at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-866-725-4396.

Amharic - ለቋንቋ እንዛ በ አማርኛ በ 1-866-725-4396 በነጻ ይደውሉ

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-866-725-4396

Armenian - Lեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-866-725-4396 առանց գնով։

Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-866-725-4396 tanpa dikenakan biaya.

Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-866-725-4396 ku busa

Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-866-725-4396-তে কল করুন।

Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-866-725-4396 nga walay bayad.

Burmese - ငွေကုန်ကျစံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-866-725-4396 ကို ခေါ် ဆိုပါ။

Catalan - Per rebre assistència en (català), truqui al número gratuït 1-866-725-4396.

Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-866-725-4396 sin gåstu.

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

Chinese - 欲取得繁體中文語言協助,請撥打1-866-725-4396,無需付費。

Choctaw - (Chahta) anumpa ya apela a chi I paya hinla 1-866-725-4396.

Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-866-725-4396 irratti bilisaan bilbilaa.

Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-866-725-4396.

French - Pour une assistance linguistique en français appeler le 1-866-725-4396 sans frais.

French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-866-725-4396 gratis.

German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-866-725-4396 an.

Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-866-725-4396 χωρίς χρέωση.

Gujarati - ગુજરાતીમાં ભાષામાં સહ્રાય માટે કોઈ પણ ખર્ચ વગર 1-866-725-4396 પર કૉલ કરો.

Hawaiian - No ke kōkua ma ka 'ōlelo Hawai'i, e kahea aku i ka helu kelepona 1-866-725-4396. Kāki 'ole 'ia kēia kōkua nei.

Hindi - हिन्दी में भाषा सहायता के लिए, 1-866-725-4396 पर मुफ्त कॉल करें।

Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-866-725-4396.

lbo - Maka enyemaka asusu na Igbo kpoo 1-866-725-4396 na akwughi ugwo o bula

llocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-866-725-4396 nga awan ti bayadanyo.

Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-866-725-4396.

Japanese - 日本語で援助をご希望の方は、1-866-725-4396 まで無料でお電話ください。

Karen - လာတါ်မာစားတါကတိုးကျိုဉ်အင်္ဂါ ကျိုဉ် ကိုး 1-866-725-4396 လာတအိုဉ်ဒီးတါလာ၁်ဘူဉ်လာ၁်စ္စာဘဉ်

Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-866-725-4396 번으로 전화해 주십시오.

Kru-Bassa - Be´m`ké gbo-kpá-kpá dyé pidyi dé Bašsoó-wuduùn wee, dá 1-866-725-4396

برای راهنمایی به زبان فارسی با شماره 4396-725-866 به خورایی پهیوهندی بکهن.

Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ-866-725-4396 ໂດຍບໍ່ເສຍຄ່າໂທ.

Marathi - कोणत्याही श्ल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-855-821-9720 वर फोन करा.

Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-866-725-4396 ilo ejjelok wōnān.

Micronesian-Pohnpeyan - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-866-725-4396 ni sohte isais.

Mon-Khmer, សម្រាប់ជំនួយភាសាជា ភាសាខ្មមរំ សូមទូរស័ព្ទទ**ៅកាន់លខេ 1-866-725-4396 ដ**ោយឥតគិតថ្លាំ។ Cambodian -

Navajo - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-866-725-4396

Nepali - (नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1- 866-725-4396 मा फोन गर्नुहोस् ।

Nilotic-Dinka - Tën kupony ë thok ë Thuonjän col 1-866-725-4396 kecin ayöc.

Norwegian - For språkassistanse på norsk, ring 1-866-725-4396 kostnadsfritt.

Panjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-866-725-4396 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।

Pennsylvania Dutch - Fer Helfe in Deitsch, ruf: 1-866-725-4396 aa. Es Aaruf koschtet nix.

برای راهنمایی به زبان فارسی با شماره 4396-725-866 بدون هیچ هزینه ای تماس بگیرید. انگلیسی Persian -

Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-866-725-4396.

Portuguese - Para obter assistência linguística em português ligue para o 1-866-725-4396 gratuitamente.

Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-866-725-4396

Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-866-725-4396.

Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-866-725-4396 e aunoa ma se totogi.

Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-866-725-4396.

Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-866-725-4396.

Sudanic-Fulfude - Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-866-725-4396. Njodi woo fawaaki on.

Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-866-725-4396 bila malipo.

Syriac - K sin part abrasic abrasic abrasic or sur in por ibs. 1-866-725-4396 apraca

Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-866-725-4396 nang walang bayad.

Telugu - భాషతో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 1-866-725-4396 కు కాల్ చేయండి. (తెలుగు)

Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-866-725-4396 ฟรีไม่มีค่าใช้จ่าย

Tongan - Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-866-725-4396 'o 'ikai hā ōtōngi.

Trukese - Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-866-725-4396 nge esapw kamé ngonuk.

Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-866-725-4396.

Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-866-725-4396.

بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، بر بات کریں۔ Urdu - 1-877-481-4161

Vietnamese - Đê 'được hố trợ ngôn ngư bằng (ngôn ngư), hấy gọi miến phi 'đên số 1-866-725-4396.

Yiddish - פאר שפראך הילף אין אידיש רופט 1-866-725-4396 פריי פון אפצאל.

Yoruba - Fún ìrànlowo nípa èdè (Yorùbá) pe 1-866-725-4396 lái san owó kankan rárá.