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

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

aetna® THE CLEVELAND CLINIC FOUNDATION : Aetna Open Access® Aetna SelectSM - Cleveland Clinic Employee Health Plan - EHP

Coverage for: Individual + Family | Plan Type: EPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.HealthReformPlanSBC.com or by calling 1-833-414-2331. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-833-414-2331 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0.	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. Generic prescription drugs are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	Yes. For prescription drugs: Individual $200 / Family $400.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	In-Network: Individual $3,950 / Family $7,900. RX: Individual $3,950 / Family $7,900. Retiree RX: none	The out–of–pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out–of–pocket limits until the overall family out–of–pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, bariatric surgery copay.* Autism School & health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See https://www.aetna.com/dsepublic/#/contentPage?page=providerSearchLanding&site_id=directlinklogo&planValue=CCDOM|EHP or call 1-833-414-2331 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	Not covered	None
	Specialist visit	$35 copay/visit	Not covered	None
	Preventive care /screening /immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	$75 copay/visit	Not covered	Refer to the SPD for precertification requirements at www.clevelandclinic.org/healthplan.
If you need drugs to treat your illness or condition **Prescription drug coverage is administered by CVS Caremark** More information about **prescription drug coverage** is available at www.Clevelandclinic.org/healthplan	Preferred non-specialty generic drugs (tier 1)	Co-insurance after prescription deductible: 20% (CVS), 15% (Cleveland Clinic)	Not covered	Covers 1-30 day supply (CVS pharmacies), 1-90 day supply (Cleveland Clinic pharmacies). Refer to EHP Prescription Drug Formulary for required precertifications, non-covered drugs, and quantity limits available on our website at www.Clevelandclinic.org/healthplan
	Preferred non-specialty brand drugs (tier 2)	Co-insurance after prescription deductible: 30% (CVS), 25% (Cleveland Clinic)	Not covered	
	Non-preferred brand & generic drugs (tier 3)	Co-insurance after prescription deductible: 50% (CVS), 45% (Cleveland Clinic)	Not covered	
	Specialty brand & generic drugs (tier 4)	Co-insurance after prescription deductible: 20%	Not covered	Refer to EHP Prescription Drug Formulary for required precertification, non-covered drugs, and quantity limits available on our website at www.Clevelandclinic.org/healthplan
If you have	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
outpatient surgery	Physician/surgeon fees	No charge	Not covered	None
If you need immediate medical attention	Emergency room care	$250 copay/visit	$250 copay/visit	Out-of-network emergency use paid the same as in-network.
	Emergency medical transportation	No charge	No charge	Out-of-network emergency use paid the same as in-network. Non-emergency transport: not covered, except if pre-authorized.
	Urgent care	$50 copay/visit	$50 copay/visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$350 copay/stay	Not covered	Refer to the SPD for precertification requirements at www.clevelandclinic.org/healthplan.
	Physician/surgeon fees	No charge	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: $35 copay/visit; other outpatient services: no charge	Not covered	None
	Inpatient services	$350 copay/stay	Not covered	Refer to the SPD for precertification requirements at www.clevelandclinic.org/healthplan
If you are pregnant	Office visits	No charge	Not covered	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound.) Copay waived on newborn facility claim if baby discharged with mother. Refer to the SPD for precertification requirements at www.clevelandclinic.org/healthplan.
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	$350 copay/stay	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	60 visits/ calendar year. Precertification required.
	Rehabilitation services	$10 copay/visit, deductible doesn't apply	Not covered	30 visits/calendar year for each physical, occupational, and speech therapy, including outpatient hospital services.
	Habilitation services	No charge	Not covered	30 visits/calendar year for each habilitative physical, occupational, and speech therapy for Developmental delay, Cerebral Palsy, Apraxia; No visit limit for Autism/Autism Spectrum Disorder
	Skilled nursing care	$350 copay/stay	Not covered	60 days/calendar year. Precertification required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Durable medical equipment	20% coinsurance	Not covered	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	No charge	Not covered	Precertification required.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	2 routine eye exams/calendar year up to age 18 and 1 routine eye exam/calendar after 18.
	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)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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.)

- Acupuncture - 10 visits/calendar year for disease, injury & chronic pain.
- Bariatric surgery
- Chiropractic care - 30 visits/calendar year.
- Hearing aids
- Infertility treatment - For more information & exceptions, see policy document provided by your employer or call the number on your ID card.
- Long-term care
- Routine eye care (Adult) - 2 routine eye exams/calendar year up to age 18 and 1 routine eye exam/calendar after 18.

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 1-833-414-2331.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance

Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.

- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general number at 1-833-414-2331. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your appeal. Contact information is at: http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html.

Does this plan provide Minimum Essential Coverage? **Yes.**

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

Does this plan meet Minimum Value Standards? **Yes.**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$0**
Specialist copayment	**$35**
Hospital (facility) copayment	**$350**
Other copayment	**$0**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles*	$10
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$470**

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

The plan's overall deductible	**$0**
Specialist copayment	**$35**
Hospital (facility) copayment	**$350**
Other copayment	**$0**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles*	$200
Copayments	$70
Coinsurance	$900
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,190**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$0**
Specialist copayment	**$35**
Hospital (facility) copayment	**$350**
Other copayment	**$0**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles*	$10
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$410**

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

The plan would be responsible for the other costs of these EXAMPLE covered services.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 866-393-0002.

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, disability, gender identity or sexual orientation.

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).

TTY: 711

Language Assistance:

For language assistance in your language call 1-833-414-2331 at no cost.

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-833-414-2331.
Amharic -	□□□□ □□□ □ □□□□ □ 1-833-414-2331 □□□ □□□□
Arabic -	1-833-414-2331 للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-833-414-2331 առանց գնով:
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-833-414-2331 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-833-414-2331 ku busa
Bengali-Bangala -	□□□□□□ □□□□ □□□□□□□□□ □□□□ □□□□□□□□□□□ 1-833-414-2331-□□ কল□□□□ ।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-833-414-2331 nga walay bayad.
Burmese -	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-833-414-2331 ကို ခေါ်ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-833-414-2331.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-833-414-2331 sin gåstu.
Cherokee -	ᎾᏍᎩᎾ ᏕᏬᏂᎯᏍᏗ ᏗᏂᏍᎦᏛᏍᎩ ᎾᎿᎢ (ᏣᎳᎩ) ᏫᏓᎳᏫᏒ 1-833-414-2331 ᏭᎾᎢ Ꮭ ᎪᎱᏍᏗ ᏧᎬᏩᏛᏗ ᏂᎲᏒᎾ.
Chinese -	欲取得繁體中文語言協助，請撥打 1-833-414-2331，無需付費。
Choctaw -	(Chahta) anumpa y<u>a</u> apela a chi I p<u>a</u>ya hinla 1-833-414-2331.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-833-414-2331 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-833-414-2331.
French -	Pour une assistance linguistique en français appeler le 1-833-414-2331 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-833-414-2331 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-833-414-2331 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-833-414-2331 χωρίς χρέωση.
Gujarati -	□□□□□□□□□□ □□□□□□□ □□□□ □□□□ □□□ પણ□□□□ વગર 1-833-414-2331 પર □□□ □□□.
Hawaiian -	No ke kōkua ma ka ʻōlelo Hawaiʻi, e kahea aku i ka helu kelepona 1-833-414-2331. Kāki ʻole ʻia kēia kōkua nei.

Hindi - हनि्दी में भाषा सहायता के लिए, 1-833-414-2331 पर मुफ्त कॉल करें।

Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-833-414-2331.

Ibo - Maka enyemaka asụsụ na Igbo kpọọ 1-833-414-2331 na akwụghị ụgwọ ọ bụla

Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-833-414-2331 nga awan ti bayadanyo.

Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-833-414-2331.

Japanese - 日本語で援助をご希望の方は、1-833-414-2331 まで無料でお電話ください。

Karen - လၢတၢ်မၤစၢၤတၢ်ကတိၤကျိာ်အဂီၢ် ကျိာ် ကိး1-833-414-2331 လၢတအိၣ်ဒီးတၢ်လၢာ်ဘူၣ်လၢာ်စ့ၤဘၣ်

Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-833-414-2331 번으로 전화해 주십시오.

Kru-Bassa - Ɓɛ́m`ké gbo-kpá-kpá dyé pídyi ɖé Ɓǎsɔ́ɔ̀-wùɖùǔn wɛ́ɛ, ɖá 1-833-414-2331

Kurdish - برای راهنمایی به زبان فارسی با شماره 1-833-414-2331 به خۆرایی پەیوەندی بکەن.

Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ1-833-414-2331 ໂດຍບໍ່ເສຍຄ່າໂທ.

Marathi - □□□□□□□□□□ □□□□□□□□□□□□ □□□□ □□□□ □□□□□□□□ □□□□□□□□□□□, 1-833-414-2331 वर □□□ □□□.

Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-833-414-2331 ilo ejjelok wōnān.

Micronesian-Pohnpeyan - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-833-414-2331 ni sohte isais.

Mon-Khmer, Cambodian - សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-833-414-2331 ដោយឥតគិតថ្លៃ។

Navajo - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-833-414-2331

Nepali - (□□□□□□□) □□ □□□□□□□□□ □□□□ □□□□□□□ □□□□□□□ □□□□ 1-833-414-2331 □□ □□□ □□□□□□□□□□ ।

Nilotic-Dinka - Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-833-414-2331 kecïn aɣöc.

Norwegian - For språkassistanse på norsk, ring 1-833-414-2331 kostnadsfritt.

Panjabi - □□□□□□ □□□□ □□□□□ □□□□□□ ਲਈ1-833-414-2331 '□□ □□□□ □□□ □□□।

Pennsylvania Dutch - Fer Helfe in Deitsch, ruf: 1-833-414-2331 aa. Es Aaruf koschtet nix.

Persian - برای راهنمایی به زبان فارسی با شماره 1-833-414-2331 بدون هیچ هزینه ای تماس بگیرید. انگلیسی

Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-833-414-2331.

Portuguese - Para obter assistência linguística em português ligue para o 1-833-414-2331 gratuitamente.

Romanian - Pentru asistenţă lingvistică în româneşte telefonaţi la numărul gratuit 1-833-414-2331

Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-833-414-2331.

Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-833-414-2331 e aunoa ma se totogi.

Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-833-414-2331.

Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-833-414-2331.

Sudanic-Fulfude - Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-833-414-2331. Njodi woo fawaaki on.

Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-833-414-2331 bila malipo.

Syriac - [illegible] 1-833-414-2331 [illegible].

Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-833-414-2331 nang walang bayad.

Telugu - □□□□□ □□□□ □□□□□ □□□□□□ □□□□□ □□□□□□□ 1-833-414-2331 □□ □□□□ □□□□□□. (□□□□□□□)

Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-833-414-2331 ฟรีไม่มีค่าใช้จ่าย

Tongan - Kapau ‘oku fiema'u hā tokoni ‘i he lea faka-Tonga telefoni 1-833-414-2331 ‘o ‘ikai hā ōtōngi.

Trukese - Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-833-414-2331 nge esapw kamé ngonuk.

Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-833-414-2331.

Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-833-414-2331.

Urdu - بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-833-414-2331 . پر بات کریں۔

Vietnamese - Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-833-414-2331.

Yiddish - פאר שפראך הילף אין אידיש רופט 1-833-414-2331 פריי פון אפצאל.

Yoruba - Fún ìrànlọwọ nípa èdè (Yorùbá) pe 1-833-414-2331 lái san owó kankan rárá.