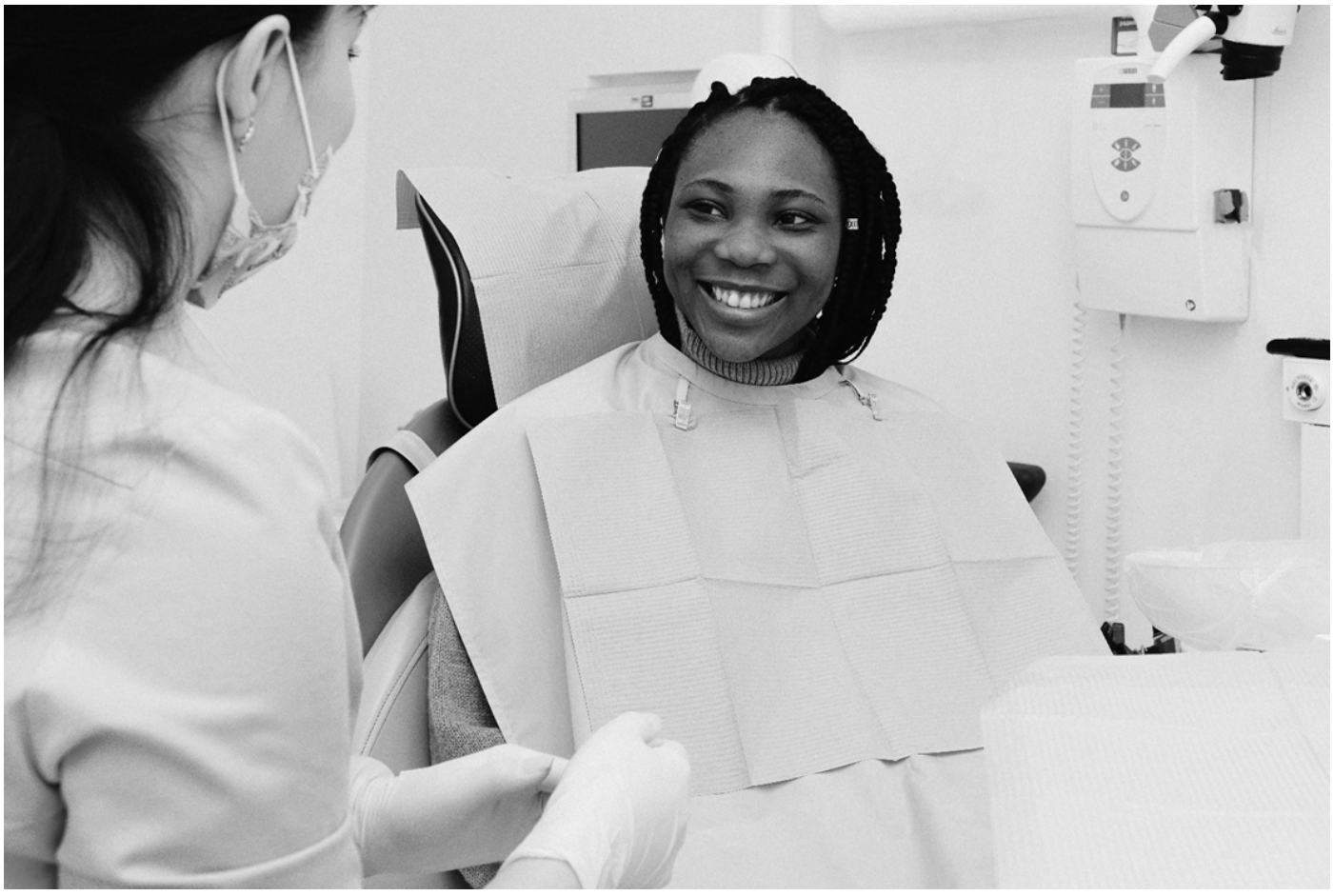
# Aetna Student Health
# Dental Plan Design and Benefits Summary
# Preferred Provider Organization (PPO)

## Boston University

Plan Year: 2025 – 2026
Policy Number: 246832
www.aetnastudenthealth.com/bu
(877) 238-6200



**This Aetna Dental® Preferred Provider Organization (PPO) insurance plan summary is provided by Aetna Life Insurance Company (Aetna)** for some of the more frequently performed dental procedures. Under this plan, you may choose at the time of service either a PPO participating dentist or any nonparticipating dentist. With the PPO plan, savings are possible because the PPO participating dentists have agreed to provide care for covered services at the negotiated fee schedule.

## Who is eligible

All Boston University students are eligible to enroll on a voluntary basis.

## Dependent Coverage

Covered students may also enroll their lawful spouse and/or dependent children (up to the age of 26).

## Coverage Dates and Rates

Coverage for you and your enrolled dependents will take effect on the date we receive a completed enrollment application and you pay any required premium contribution.

Coverage for insured dependents terminates in accordance with the Termination Provisions described in the Certificate of Coverage.

| Coverage Period | Coverage Start Date | Coverage End Date | Enrollment Deadline |
|---|---|---|---|
| **Annual** | 08/15/2025 | 08/14/2026 | 09/20/2025 |
| **Spring/Summer** | 01/01/2026 | 08/14/2026 | 01/31/2026 |

| | Annual | Spring/Summer Semester |
|---|---|---|
| **Student** | $478.00 | $478.00 |
| **Spouse*** | $478.00 | $478.00 |
| **One Child*** | $478.00 | $478.00 |
| **Children*** | $956.00 | $956.00 |

*Dependent Rates are in addition to the student/subscriber's own premium rate.

## Enrollment

If you enrolled on or before the effective date of the student policy and you were eligible for dental benefits at the time, your coverage will take effect as of the effective date of the student policy. Your coverage will take effect on this date if we received your completed enrollment application and you paid the required premium contribution.

To enroll online for voluntary coverage, log on to **www.aetnastudenthealth.com/bu**, then click on Enroll to download the appropriate form.

Please refer to the Coverage Periods section of this document for coverage dates and deadline dates. Enrollment applications will not be accepted after the enrollment deadline.

## Who provides the care

Just as the starting point for coverage under your plan is whether the services and supplies are eligible dental services, the foundation for getting covered care is through our network.

This section tells you about in-network and out-of-network providers.

## In-network providers

We have contracted with dental providers to provide eligible dental services to you. These dental providers make up the network for your plan.

You may select an in-network provider from the directory or by logging on to our website at www.aetnastudenthealth.com. You can search our online directory, for names and locations of dental providers.

You will not have to submit claims for treatment received from in-network providers. Your in-network provider will take care of that for you. And we will directly pay the in-network provider for what the plan owes.

## Out-of-network providers

If you use an out-of-network provider to receive eligible dental services, you are subject to a higher out-of-pocket expense and are responsible for:

- Paying any out-of-network deductibles
- Your out-of-network coinsurance
- Any charges over our recognized charge
- Submitting your own claims

## Description of Benefits

The Plan excludes coverage for certain services (referred to as exceptions and exclusions in the certificate of coverage) and has limitations on the amounts it will pay. While this Plan Design and Benefit Summary document will tell you about some of the important features of the Plan, other features may be important to you and some may further limit what the Plan will pay. To look at the full Plan description, which is contained in the Certificate of Coverage issued to you, go to www.aetnastudenthealth.com. If any discrepancy exists between this Benefit Summary and the Certificate of Coverage, the Certificate will control.

This Plan will pay benefits in accordance with any applicable **Massachusetts I**nsurance Law(s).

## Plan year Deductible

You have to meet your plan year deductible before this plan pays for benefits.

| | In-network coverage | Out-of-network coverage |
|---|---|---|
| Eligible dental services applied to the out-of-network deductibles will be applied to satisfy the in-network deductibles. Eligible dental services applied to the in-network deductibles will be applied to satisfy the out-of-network deductibles. | | |
| **Plan year deductible** | Individual $50<br>Family $150 | |
| The plan year deductible applies to all eligible dental services except Type A treatment expenses. | | |

## Coinsurance listed in the schedule of benefits

The coinsurance listed in the schedule of benefits below reflects the plan coinsurance percentage. This is the coinsurance amount that the plan pays. You are responsible for paying any remaining coinsurance.

## Coinsurance

| Expense | In-network coverage | Out-of-network coverage |
|---|---|---|
| **Type A expenses** | 100% of the negotiated charge | 100% of the recognized charge |
| **Type B expenses** | 80% of the negotiated charge | 60% of the recognized charge |
| **Type C expenses** | 60% of the negotiated charge | 40% of the recognized charge |
| Excludes implants, dentures, temporomandibular joint dysfunction/disorder (TMJ) treatment | | |

### Orthodontic treatment coinsurance

| | In-network coverage | Out-of-network coverage |
|---|---|---|
| **Orthodontic treatment** | 80% of the negotiated charge | 60% of the recognized charge |

### Plan year maximum

This plan year maximum applies to in-network and out-of-network eligible dental services combined.

| | In-network coverage Amounts | Out-of-network coverage Amounts |
|---|---|---|
| **Plan year maximum:** | $1,000 | |
| **Orthodontic lifetime maximum:** | $1,500 | |

## Eligible Dental Services

**Type A expenses: Diagnostic & preventive care**

**Visits and exams**

- Oral evaluations, (2 routine visits and 2 problem focused visits per year)
- Prophylaxis (cleaning) or scaling-moderate/severe inflammation–full mouth or periodontal maintenance, (2 treatments per year)
- Topical application of fluoride if you are under age 16, (1 applications per year)
- Sealants, per tooth (1-application every 3 years for permanent molars only and if you are underage 16)
- Sealant repair - per tooth (for permanent molars only and if you are under age 16)

**Images and pathology**

- Bitewing images (1 set per year)
- Entire dental series, including bitewings or panoramic film (1 set every 3 years)
- Periapical images (1 images per 3 years, combined with other radiographic images)
- Vertical bitewing images (1 set every 3 years)

**Space maintainers** - Only when needed to preserve space resulting from premature loss of deciduous teeth. (Includes all adjustments within 6 months after installation.)

- Fixed or removable (unilateral or bilateral)
- Recementation or removal

**Type B expenses: Basic restorative care**

**Visits and exams**

- Office visit after hours (we will pay either for the office visit charge or for the eligible dental services performed, whichever is more)
- Emergency palliative treatment, per visit

**Images and pathology**

- Intraoral, occlusal view (1image per 3 years, combined with other radiographic images)
- Extra-oral (1 image per 3 years, combined with other radiographic images)
- Accession of tissue

**Restorative** - Excluding inlays, onlays and crowns. Multiple restorations in 1 surface will be considered as a single restoration.

- Amalgam restorations
- Resin-based composite restorations, (other than for molars)
- Protective restoration
- Reattachment of tooth fragment, incisal edge or cusp
- Interim therapeutic restoration – primary dentition
- Pin retention, per tooth, in addition to restoration
- Recementation
- Prefabricated crowns, primary teeth only (excluding temporary crowns)

**Periodontics**

Periodontal maintenance (2 per year)

- Occlusal adjustment, (other than with an appliance or by restoration)
- Root planing and scaling, 1 to 3 teeth per quadrant, (1 per site every 2 years)
- Root planing and scaling, 4 or more teeth per quadrant, (1 separate quadrant every 2 years)
- Surgical revision procedure, per tooth
- Gingivectomy/gingivoplasty, 1 to 3 teeth per quadrant, (1 per site every 3 years)
- Gingivectomy/gingivoplasty, 4 or more teeth per quadrant, (1 per quadrant every 3 years)
- Gingival flap procedure, 1 to 3 teeth per quadrant, (1 per site every 3 years)
- Gingival flap procedure, 4 or more teeth per quadrant, (1 per quadrant every 3 years)
- Apically positioned flap
- Unscheduled dressing change (by someone other than treating dentist or their staff)

**Endodontics**

- Pulp cap
- Pulpal debridement
- Pulpal therapy
- Pulpotomy
- Apexification/recalcification
- Apicoectomy
- Root canal therapy and retreatment once per lifetime

  - Anterior
  - Bicuspid
- Pulpal regeneration
- Periradicular surgery without apicoectomy
- Hemisection
- Retrograde filling
- Root amputation
- Treatment of root canal obstruction
- Incomplete endodontic surgery
- Internal root repair of defect

**Oral surgery**
- Extractions – coronal remnants – deciduous tooth
- Extractions erupted tooth or exposed root
- Surgical removal of impacted tooth
  - Soft tissue
- Surgical removal of erupted tooth
- Surgical removal of residual tooth roots
- Primary closure of a sinus perforation
- Oroantral fistula closure
- Tooth transplantation
- Surgical access of unerupted tooth
- Mobilization of erupted or malpositioned tooth to aid eruption
- Placement of device to facilitate eruption of impacted tooth
- Biopsy of oral tissue
- Exfoliative cytological sample collection
- Alveoloplasty
- Removal of odontogenic cysts or tumors
- Removal of exostosis
- Removal of torus
- Surgical reduction of osseous tuberosity
- Incision and drainage of abscess
- Removal of foreign body
- Sequestrectomy
- Suture of wounds
- Frenectomy/frenuloplasty
- Excision of hyperplastic tissue per arch
- Excision of pericoronal gingiva
- Surgical reduction of fibrous tuberosity
- Sialolithotomy
- Closure of salivary fistula

**Type C expenses: Major restorative care**

**Restorative** – Inlays, onlays, labial veneers and crowns (excludes temporary crowns) are covered only as treatment for decay or acute traumatic injury, and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge. Coverage is limited to 1 per tooth every 8 years. (See the *Replacement rule*.)

- Inlays
- Onlays
- Labial veneers
- Crowns
- Post and core
- Repairs - inlay, onlay, veneer, bridges, crown

**Periodontics -** (Limited to a total of one type of pocket reduction surgery per quadrant or tooth in any 3-year period.)

- Osseous surgery, (including flap and closure), 1 to 3 teeth per quadrant (1 per site every 3 years)
- Osseous surgery, (including flap and closure), 4 or more per teeth per quadrant (1 per quadrant every 3 years)
- Soft tissue graft procedures
- Full mouth debridement (1 per lifetime)

**Endodontics**

- Root canal therapy and retreatment once per lifetime
  - Molar

**Prosthodontics** - The first installation of dentures and bridges is covered only if needed to replace teeth extracted while coverage was in force and which were not abutments to a denture or bridge less than 8 years old. (See the *Tooth missing but not replaced rule*.) Replacement of existing bridges, implants, or dentures is limited to 1 every 8 years. (See the *Replacement rule*.)

- Bridge abutments
- Pontics
- Dentures and partials (fees for dentures and partial dentures include relines, rebases and adjustments within 6 months after installation. Fees for relines and rebases include adjustments within 6 months after installation. Specialized techniques and characterizations are not eligible).
  - Complete upper and lower denture
  - Partial upper and lower (including any conventional clasps, rests and teeth)
  - Removable unilateral partial denture
- Stress breakers
- Interim partial denture (stayplate), anterior only
- Reline (partial or complete)
- Rebase, per denture
- Special tissue conditioning, per denture
- Adjustment to denture more than 6 months after installation
- Repairs, full
- Repairs, partial denture
- Adding teeth and clasps to existing partial denture

- Repairs, bridges
- Occlusal guard for bruxism (1 every 3 years)
- Adjustments, repair or reline of occlusal guard
- Cleaning and inspection of a removable appliance

**Oral surgery**

- Surgical removal of impacted tooth (bony, including wisdom teeth)
- Coronectomy
- Removal of impacted tooth
  - Partially bony
  - Completely bony

**General anesthesia and intravenous sedation**

- General anesthesia and intravenous sedation are covered when provided as part of a covered surgical procedure
- Evaluation by anesthesiologist for deep sedation or general anesthesia

## General exceptions and exclusions

The following are not eligible dental services under your plan except as described in your certificate and schedule of benefits:

- Acupuncture, acupressure and acupuncture therapy
- Asynchronous dental treatment
- Crown, inlays and onlays, and veneers unless for one of the following:
  - It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material
  - The tooth is an abutment to a covered partial denture or fixed bridge
- Dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth and removal of implants
- Dental services and supplies made with high noble metals (gold or titanium) except as covered in the schedule of benefits
- Dentures, crowns, inlays, onlays, bridges, or other prosthetic appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or correcting attrition, abrasion, or erosion
- General anesthesia and intravenous sedation, unless specifically covered and done in connection with another eligible dental service
- Instruction for diet, tobacco counseling and oral hygiene
- Mail order and at-home kits for orthodontic treatment
- Orthodontic treatment except as covered in the schedule of benefits
- Prefabricated porcelain/ceramic crown – permanent tooth
- Services and supplies provided in connection with treatment or care that is not covered under the plan

- Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures
- Replacement of teeth beyond the normal complement of 32
- Services and supplies provided where there is no evidence of pathology, dysfunction or disease, other than covered preventive services
- Space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth
- Surgical removal of impacted wisdom teeth when removed only for orthodontic reasons
- Temporomandibular joint dysfunction/disorder (TMJ)

**The following are not eligible dental services under your plan:**

**Charges for services or supplies**

- Provided by an out-of-network provider in excess of the recognized charge
- Provided for your personal comfort or convenience, or the convenience of any other person, including a dental provider
- Provided in connection with treatment or care that is not covered under the plan
- Cancelled or missed appointment charges or charges to complete claim forms
- Charges for which you have no legal obligation to pay
- Charges that would not be made if you did not have coverage, including:
  - Care in charitable institutions
  - Care for conditions related to current or previous military service
  - Care while in the custody of a governmental authority

**Charges in excess of any benefit limits**

- Any charges in excess of the benefit, dollar, visit, or frequency limits stated in the schedule of benefits.

**Cosmetic services and plastic surgery** (except to the extent coverage is specifically provided in the *Eligible Dental Services* section of the schedule of benefits)

- Cosmetic services and supplies including:
  - Plastic surgery
  - Reconstructive surgery
  - Cosmetic surgery
  - Personalization or characterization of dentures or other services and supplies which improve, alter or enhance appearance
  - Augmentation and vestibuloplasty and other services to protect, clean, whiten, bleach alter the appearance of teeth whether or not for psychological or emotional reasons

  Facings on molar crowns and pontics will always be considered cosmetic

**Court-ordered services and supplies**

- Includes those court-ordered services and supplies, or those required as a condition of parole, probation, release or as a result of any legal proceeding, unless they are an eligible dental service under this plan.

**Dental services and supplies**

- Those covered under any other plan of group benefits provided by the policyholder

**Examinations**

Any dental examinations needed:

- Because a third party requires the exam. Examples include examinations to get or keep a job, or examinations required under a labor agreement or other contract.
- To buy insurance or to get or keep a license.
- To travel.
- To go to a school, camp, or sporting event, or to join in a sport or other recreational activity.

**Experimental or investigational**

- Experimental or investigational drugs, devices, treatments or procedures

**Non-medically necessary services**

- Services, including but not limited to, those treatments, services, prescription drugs and supplies which are not medically necessary (as determined by Aetna) for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your physician or dentist.

**Non-U.S .citizen**

- Services and supplies received by a covered person (who is not a United States citizen) within the covered person's home country but only if the home country has a socialized medicine program

**Other primary payer**

- Payment for a portion of the charge that another party is responsible for as the primary payer

**Outpatient prescription drugs, and preventive care drugs and supplements**

- Prescribed drugs, pre-medication or analgesia

**Personal care, comfort or convenience items**

- Any service or supply primarily for your convenience and personal comfort or that of a third party

**Providers and other health professionals**

- Treatment by other than a dentist. However, the plan will cover some services provided by a licensed dental hygienist under the supervision and guidance of a dentist. These are:
  - Scaling of teeth
  - Cleaning of teeth
  - Topical application of fluoride
- Charges submitted for services by an unlicensed provider or not within the scope of the provider's license

**Services paid under your medical plan**

- Your plan will not pay for amounts that were paid for the same services under a medical plan covering you. When a dental service is covered under both plans, we will figure the amount that would be payable under this plan if you did not have other coverage, then subtract what was paid by your medical plan. If there is any difference, this plan will pay it. If the amount paid by your medical plan is equal to or more than the benefit under this plan, this plan will not pay anything for the service.

**Services provided by a family member**

- Services provided by a spouse, civil union partner, domestic partner, parent, child, step-child, brother, sister, in-law or any household member

**Services received outside of the United States**

- Services, supplies, and prescription drugs received outside of the United States. They are not covered even if they are covered in the United States under this certificate of coverage.

**Teledentistry**

- Services given by dental providers that are not contracted with Aetna as teledentistry providers
- Services given when you are not present at the same time as the dental provider
- Services including:
  - Telephone calls
  - Teledentistry kiosks
  - Electronic vital signs monitoring or exchanges

**Work related illness or injuries**

- Coverage available to you under workers' compensation or under a similar program under local, state or federal law for any illness or injury related to employment or self-employment.
- A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. You may also be covered under a workers' compensation law or similar law.
- If you submit proof that you are not covered for a particular illness or injury under such law, then that illness or injury will be considered "not work related" regardless of cause.

### Dental emergency services

Eligible dental services include dental services provided for a dental emergency. The care provided must be a covered benefit.

If you have a dental emergency, you should consider calling your in-network provider who may be more familiar with your dental needs. However, you can get treatment from any dentist including one that is an out-of-network provider. If you need help in finding a dentist, call us.

If you get treatment from an out-of-network provider for a dental emergency, the plan pays a benefit at the in-network cost-sharing level of coverage.

For follow-up care to treat the dental emergency, you should consider using your in-network dental provider so that you can get the maximum level of benefits. Follow-up care will be paid at the cost-sharing level that applies to the type of eligible dental service and the provider that gives you the care.

## Rules and limits

Several rules apply to the dental benefits. Following these rules will help you use your plan to your advantage by avoiding expenses that are not covered by your plan.

### Alternate treatment rule

Sometimes there are several ways to treat a dental problem, all of which provide acceptable results.

If a charge is made for a non-eligible dental service or supply and an eligible dental service that would provide an acceptable result, then your plan will pay a benefit for the eligible dental service or supply.

If a charge is made for an eligible dental service but another eligible dental service that would provide an acceptable result is less expensive, the benefit will be for the least expensive eligible dental service.

The benefit will be based on the in-network provider's negotiated charge for the eligible dental service or, in the case of an out-of-network provider, on the recognized charge.

You should review the differences in the cost of alternate treatment with your dental provider. Of course, you and your dental provider can still choose the more costly treatment method. You are responsible for any charges in excess of what your plan will cover.

## Reimbursement policies

We reserve the right to apply our reimbursement policies to all services including involuntary services. Those policies may affect the negotiated charge or recognized charge. These policies consider:

- The duration and complexity of a service
- When multiple procedures are billed at the same time, whether additional overhead is required
- Whether an assistant surgeon is necessary for the service
- If follow up care is included
- Whether other characteristics modify or make a particular service unique
- When a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided and
- The educational level, licensure or length of training of the provider

Aetna reimbursement policies are based on our review of:

- Generally accepted standards of dental practice and
- The views of providers and dentists practicing in the relevant clinical areas

## Replacement rule

Some eligible dental services are subject to your plan's replacement rule. The replacement rule applies to replacements of, or additions to existing:

- Crowns
- Inlays
- Onlays
- Implants
- Veneers
- Core build-up
- Complete dentures
- Removable partial dentures
- Fixed partial dentures (bridges)
- Other prosthetic services

These eligible dental services are covered only when you give us proof that:

- While you were covered by the plan:
  - You had a tooth (or teeth) extracted after the existing denture, bridge, or other prosthetic item was installed.
  - As a result, you need to replace or add teeth to your denture, bridge, or other prosthetic item and:
    - The tooth that was removed was not an abutment to a removable or fixed partial denture, bridge, or other prosthetic item installed during the prior 8 years.
    - Your present denture is an immediate temporary one that replaced that tooth (or teeth). A permanent denture is needed and the temporary denture cannot be used as a

permanent denture. Replacement must occur within 12 months from the date that the temporary denture was installed.

- The present item cannot be made serviceable, and is:
  - A crown installed at least 8 years before its replacement.
  - An inlay, onlay, veneer, complete denture, removable partial denture, fixed partial denture (bridge), implant, or other prosthetic item installed at least 8 years before its replacement.

### Tooth missing but not replaced rule

The first installation of complete dentures, removable partial dentures, fixed partial dentures (bridges), and other prosthetic services will be covered if:

- The dentures, bridges or other prosthetic items are needed to replace one or more natural teeth that were removed while you were covered by the plan. (The extraction of a third molar tooth does not qualify.)
- The tooth that was removed was not an abutment to a removable or fixed partial denture installed during the prior 8 years.

Any such appliance or fixed bridge must include the replacement of an extracted tooth or teeth.

**The Boston University Dental® Preferred Provider Organization (PPO) Student Dental Plan is underwritten and administered by Aetna Life Insurance Company (ALIC).** Aetna Student Health℠ is the brand name for products and services provided by these companies and their applicable affiliated companies.

**IMPORTANT NOTICES:**

- **Notice of Non-Discrimination:**
  **Aetna Life Insurance Company** does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan including enrollment and benefit determinations.

- **Sanctioned Countries:**
  If coverage provided under this student policy violates or will violate any economic or trade sanctions, the coverage will be invalid immediately. For example, we cannot pay for eligible health services if it violates a financial sanction regulation. This includes sanctions related to a person or a country under sanction by the United States, unless it is allowed under a written license from the Office of Foreign Asset Control (OFAC). You can find out more by visiting www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

**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 is committed to being an inclusive health care company. Aetna does not discriminate on the basis of ancestry, race, ethnicity, color, religion, sex/gender (including pregnancy), national origin, sexual orientation, gender identity or expression, physical or mental disability, medical condition, age, veteran status, military status, marital status, genetic information, citizenship status, unemployment status, political affiliation, or on any other basis or characteristic prohibited by applicable federal, state or local law.

Aetna provides free aids and services to people with disabilities and free language services to people whose primary language is not English.

These aids and services include:

- Qualified language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Qualified interpreters
- Information written in other languages

If you need these services, contact the number on your ID card. Not an Aetna member? Call us at 1-877-480-4161.

If you have questions about our nondiscrimination policy or have a discrimination-related concern that you would like to discuss, please call us at 1-877-480-4161.

*Please note, Aetna covers health services in compliance with applicable federal and state laws. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations, and conditions of coverage.*

**Language accessibility statement**

***Interpreter services are available for free.***

Attention: If you speak English, language assistance service, free of charge, are available to you. Call **1-877-480-4161** (TTY: **711**).

**Español/Spanish**

Atención: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-480-4161** (TTY: **711**).

አማርኛ**/Amharic**

ልብ ይበሉ: አማርኛ ቋንቋ የሚናገሩ ከሆነ፥ የትርጉም ድጋፍ ሰጪ ድርጅቶች፣ ያለምንም ክፍያ እርስዎን ለማገልገል ተዘጋጅተዋል። የሚከተለው ቁጥር ላይ ይደውሉ **1-877-480-4161** (መስማት ለተሳናቸው: **711**).

العربية**/Arabic**

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-877-480-4161** (رقم الهاتف النصي: **711**).

**Bàsɔ̀ɔ̀ Wùqù/Bassa**

Dè dɛ nìà kɛ dyeʹqeʹ gbo: ɔ juʋ keʹ m̀ dyi Bàsɔ̀ɔ̀-wùqù-po-nyɔ̀ juʋ niʹ, nìiʹ à wuqu kà kò qò po-poɔ̀ ɓɛ́ m̀ gbo kpaʹa. Ɗaʹ **1-877-480-4161** (TTY: **711**).

**中文/Chinese**

注意：如果您说中文，我们可为您提供免费的语言协助服务。请致电 **1-877-480-4161** (TTY: **711**)。

فارسی**/Farsi**

توجه: اگر به زبان فارسی صحبت می کنید، خدمات زبانی رایگان به شما ارایه میگردد، با شماره **1-877-480-4161** (TTY: **711**) تماس بگیرید.

**Français/French**

Attention : Si vous parlez français, vous pouvez disposer d’une assistance gratuite dans votre langue en composant le **1-877-480-4161** (TTY: **711**).

ગુજરાતી**/Gujarati**

ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો ભાષાકીય સહાયતા સેવા તમને નિ:શુલ્ક ઉપલબ્ધ છે.

કૉલ કરો **1-877-480-4161** (TTY: **711**).

**Kreyòl Ayisyen/Haitian Creole**

Atansyon: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-877-480-4161** (TTY: **711**).

**Igbo**

Nrụbama: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-877-480-4161** (TTY: **711**).

**한국어/Korean**

주의: 한국어를 사용하시는 경우, 언어 지원 서비스가 무료로 제공됩니다. **1-877-480-4161**(TTY: **711**)번으로 전화해 주십시오.

**Português/Portuguese**

Atenção: a ajuda está disponível em português por meio do número **1-877-480-4161** (TTY: **711**).
Estes serviços são oferecidos gratuitamente.

**Русский/Russian**

Внимание: если вы говорите на русском языке, вам могут предоставить бесплатные услуги перевода. Звоните по телефону **1-877-480-4161** (TTY: **711**).

**Tagalog**

Paunawa: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-877-480-4161** (TTY: **711**).

**Urdu/**اردو

توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت دستیاب ہیں ۔ (**711** :TTY) **1-877-480-4161** پر کال کریں.

**Tiếng Việt/Vietnamese**

Lưu ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị.
Gọi số **1-877-480-4161** (TTY: **711**).

**Yorùbá/Yoruba**

Àkíyèsí: Bí o bá nsọ èdè Yorùbá, ìrànlọ́wọ́ lórí èdè, lófẹ̀ẹ́, wà fún ọ. Pe **1-877-480-4161** (TTY: **711**).

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