



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, <https://www.aetnastudenthealth.com/en/school/474947/members.html> or by calling 1-877-626-2299. 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 1-877-626-2299 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	For each <u>Plan Year</u> , Select Care or In- <u>Network</u> : Individual \$450. Out-of-Network: Individual \$900.	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 <u>deductible</u> ?	Yes. <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 limit</u> for this <u>plan</u> ?	Select Care or In- <u>Network</u> : Individual \$6,000. Out-of-Network: Individual \$12,000.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover & penalties for failure to obtain <u>pre-authorization</u> for services.	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 <u>network provider</u> ?	Yes. See https://www.aetna.com/dsepublic/#/contentPage?page=providerSearchLanding&site_id=studenthealth or call 1-877-626-2299 for a list of Select Care providers.	You pay the least if you use a <u>provider</u> in Designated In- <u>Network Provider</u> . You pay more if you use a <u>provider</u> in In- <u>Network Provider</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</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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

Common Medical Event	Services You May Need	Select Care Provider (You will pay the least)	What You Will Pay In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$20 <u>copay</u> /visit	50% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$20 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$20 <u>copay</u> /visit	50% <u>coinsurance</u>	None
	<u>Preventive care</u> / <u>screening</u> /immunization	No charge	No charge	50% <u>coinsurance</u>	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	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	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/find-a-medication/2024-aetna-advanced-	Generic drugs	10% coinsurance with minimum & maximum/prescription, deductible doesn't apply: \$15 minimum & \$50 maximum (retail)	10% coinsurance with minimum & maximum/prescription, deductible doesn't apply: \$15 minimum & \$50 maximum (retail)	10% coinsurance with minimum & maximum/prescription, deductible doesn't apply: \$15 minimum & \$50 maximum (retail)	Covers 30 day supply (retail). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives in-network.
	Preferred brand drugs	20% coinsurance with minimum & maximum/prescription, deductible doesn't apply: \$40 minimum & \$150 maximum (retail)	20% coinsurance with minimum & maximum/prescription, deductible doesn't apply: \$40 minimum & \$150 maximum (retail)	20% coinsurance with minimum & maximum/prescription, deductible doesn't apply: \$40 minimum & \$150 maximum (retail)	

Common Medical Event	Services You May Need	Select Care Provider (You will pay the least)	What You Will Pay In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
control-plan-california.html	Non-preferred brand drugs	20% coinsurance with minimum & maximum/prescription, deductible doesn't apply: \$75 minimum & \$150 maximum (retail)	20% coinsurance with minimum & maximum/prescription, deductible doesn't apply: \$75 minimum & \$150 maximum (retail)	20% coinsurance with minimum & maximum/prescription, deductible doesn't apply: \$75 minimum & \$150 maximum (retail)	
	<u>Specialty drugs</u>	Applicable cost as noted above for generic or brand drugs	Applicable cost as noted above for generic or brand drugs	Not covered	First prescription fill at a retail pharmacy or specialty pharmacy. Subsequent fills must be through the Aetna Specialty Pharmacy Network.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Physician/surgeon fees	10% <u>coinsurance</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	10% <u>coinsurance</u> after \$200 <u>copay</u> /visit	10% <u>coinsurance</u> after \$200 <u>copay</u> /visit	10% <u>coinsurance</u> after \$200 <u>copay</u> /visit	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> . No coverage for non-emergency use.
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> .
	<u>Urgent care</u>	\$50 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$50 <u>copay</u> /visit, <u>deductible</u> doesn't apply	50% <u>coinsurance</u>	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u> after \$150 <u>copay</u> /stay	20% <u>coinsurance</u> after \$150 <u>copay</u> /stay	50% <u>coinsurance</u> after \$150 <u>copay</u> /stay	Penalty of \$500 for failure to obtain pre-authorization for out-of-network care.
	Physician/surgeon fees	10% <u>coinsurance</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$10 <u>copay</u> /visit, <u>deductible</u> doesn't apply; other outpatient services: 10% <u>coinsurance</u>	Office: \$10 <u>copay</u> /visit, <u>deductible</u> doesn't apply; other outpatient services: 10% <u>coinsurance</u>	Office & other outpatient services: 50% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	Select Care Provider (You will pay the least)	What You Will Pay In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Inpatient services	10% <u>coinsurance</u>	10% <u>coinsurance</u>	50% <u>coinsurance</u>	Penalty of \$500 for failure to obtain pre-authorization for out-of-network care.
If you are pregnant	Office visits	No charge	No charge	50% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Penalty of \$500 for failure to obtain pre-authorization for out-of-network care may apply.
	Childbirth/delivery professional services	10% <u>coinsurance</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	10% <u>coinsurance</u> after \$150 <u>copay</u> /stay	20% <u>coinsurance</u> after \$150 <u>copay</u> /stay	50% <u>coinsurance</u> after \$150 <u>copay</u> /stay	
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	100 visits/ <u>plan</u> year. Penalty of \$500 for failure to obtain pre-authorization for out-of-network care.
	<u>Rehabilitation services</u>	\$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply	50% <u>coinsurance</u>	Includes Physical, Occupational & Speech Therapy.
	<u>Habilitation services</u>	\$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply	50% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	10% <u>coinsurance</u> after \$150 <u>copay</u> /stay	20% <u>coinsurance</u> after \$150 <u>copay</u> /stay	50% <u>coinsurance</u> after \$150 <u>copay</u> /stay	Penalty of \$500 for failure to obtain pre-authorization for out-of-network care.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	50% <u>coinsurance</u>	Penalty of \$500 for failure to obtain pre-authorization for out-of-network care.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	50% <u>coinsurance</u>	1 routine eye exam/ <u>plan</u> year.
	Children's glasses	No charge	No charge	50% <u>coinsurance</u>	1 pair of glasses or lenses/ <u>plan</u> year.
	Children's dental check-up	No charge	No charge	50% <u>coinsurance</u>	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.)

- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition, including artificial insemination.
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)

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: California Department of Insurance, Consumer Communications Bureau, 300 South Spring Street, South Tower, Los Angeles, CA 90013, 1-800-927-HELP (4357), 1-800-482-4833 (TTY), <http://www.insurance.ca.gov>.

- For more information on your rights to continue coverage, contact the plan at 1-877-626-2299

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:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-877-626-2299.
- California Department of Insurance, Consumer Communications Bureau, 300 South Spring Street, South Tower, Los Angeles, CA 90013, 1-800-927-HELP (4357), 1-800-482-4833 (TTY), <http://www.insurance.ca.gov>
- Additionally, a consumer assistance program can help you file your appeal. Contact California Department of Insurance, Consumer Communications Bureau, 300 South Spring Street, South Tower, Los Angeles, CA 90013, 1-800-927-Help (4357), 1-800-482-4833(TTY), www.insurance.ca.gov.

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 <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist</u> <u>copayment</u>	\$20
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
In this example, Peg would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$450
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$1,100
<u>What isn't covered</u>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,620

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>	\$0
■ <u>Specialist</u> <u>copayment</u>	\$20
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

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:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$1,200
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,320

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist</u> <u>copayment</u>	\$20
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

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:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$450
<u>Copayments</u>	\$90
<u>Coinsurance</u>	\$100
<u>What isn't covered</u>	
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 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).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies, including Aetna Life Insurance Company and its affiliates (Aetna).

Language Assistance:

Albanian -	Për shërbime përkthimi falas për ju, telefononi 1-877-626-2299.
Amharic -	የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-877-626-2299 ይደውሉ።
Arabic -	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-877-626-2299
Armenian -	Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-877-626-2299 հեռախոսահամարով:
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-877-626-2299 tanpa dikenakan biaya.
Bantu-Kirundi -	Kugira uronke serivisi z'indimi atakiguzi, hamagara 1-877-626-2299.
Bengali-Bangala -	আপনাকে বিনামূল্যে ভাষা পবিকষিা পপকে হকয এই নম্বকি পেবযক ান েরুন: 1-877-626-2299
Bisayan-Visayan -	Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-877-626-2299.
Burmese -	သင့်အနေဖြင့် အခမဲ့ကူညီမှု မရပဲ ဘာသာစကားဝန်ဆောင်မှုများ ရရှိလိုပါက 1-877-626-2299 သို့ ဖုန်းခေါ်ဆိုပါ။
Catalan -	Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-877-626-2299.
Chamorro -	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-877-626-2299.
Cherokee -	ᎠᎩᏍᎩ ᎠᎩᏍᎩ ᎠᎩᏍᎩ ᎠᎩᏍᎩ ᎠᎩᏍᎩ ᎠᎩᏍᎩ ᎠᎩᏍᎩ ᎠᎩᏍᎩ 1-877-626-2299.
Chinese -	如欲使用免費語言服務，請致電 1-877-626-2299.
Choctaw -	Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-877-626-2299.
Cushite -	Tajaajiiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-877-626-2299.
Dutch -	Voor gratis toegang tot taaldiensten, bell 1-877-626-2299.
French -	Afin d'accéder aux services langagiers sans frais, composez le 1-877-626-2299.
French Creole -	Pou jwenn sèvis lang gratis, rele 1-877-626-2299.
German -	Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-877-626-2299 an.
Greek -	Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-877-626-2299.
Gujarati -	તમારેકોઇ જાતના ખર્ચવિના ભાષાની સેવાઓની પહોંર માટે, કોલ કરો1-877-626-2299.

Hawaiian -	No ka wala‘au ‘ana me ka lawelawe ‘ōlelo e kahea aku i kēia helu kelepona 1-877-626-2299. Kāki ‘ole ‘ia kēia kōkua nei.
Hindi -	आपकेलिए बिना ककसी कीमत केभाषा सेवाओंका उपयोग करनेकेलिए,1-877-626-2299 पर कॉल करें।
Hmong -	Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-877-626-2299.
Igbo -	Iji nwetaòhèrè na ọrụ gasị asụsụ n'efu, kpọọ 1-877-626-2299
Ilocano -	Tapno maaksesyô dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti 1-877-626-2299.
Indonesian -	Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi 1-877-626-2299.
Italian -	Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-877-626-2299.
Japanese -	言語サービスを無料でご利用いただくには、1-877-626-2299 までお電話ください。
Karen -	လၢတၢ်ကမၤန့ၢ်ကျိၣ်အတၢ်မၤစၢၤအတၢ်ဖဲတၢ်မၤတဖၣ်လၢတအိၣ်ဒီးအပူၤလၢကဘၣ်ဟ့ၣ်အိၣ်အဂီၢ်ဘၣ်န့ၣ် ကိး 1-877-626-2299 တက့ၢ်.
Korean -	무료 언어 서비스를 이용하려면 1-877-626-2299 번으로 전화해 주십시오.
Kru-Bassa -	M̈ dyi wuḍu-dù kà kò ḍò bě dyi m̈oú n̈ ní Pídyi ní, níí, ḍá nòbà n̈à kɛ: 1-877-626-2299
Kurdish -	بۆ دەسپێرانی گەشتن بە خزمەتگوزاری زمان بەی تێچوون بۆ تۆ، پەیوەندی بکە بە ژمارەی 1-877-626-2299
Laotian -	ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາໂປ1-877-626-2299
Marathi -	कोणत्याही शल्ुकालशवाय भाषा सेवा प्राप्त करण्यासाठी,, 1-877-626-2299 वर फोन करा.
Marshallese -	Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlok 1-877-626-2299.
Micronesian- Pohnpeyan -	Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1-877-626-2299.
Mon-Khmer, Cambodian -	ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-877- 480-4161។
Navajo -	T’áá ni nizaad k’ehjí bee níká a’doowoł doo báąh ílínígóó koji’ hólne’ 1-877-626-2299.
Nepali -	निःशुल्क भाषा सेवा प्राप्त गर्न 1-877-626-2299 मा टेलिफोन गर्नुहोस् ।
Nilotic-Dinka -	Të koor yin wɛɛr de thokic ke cīn wëu kɔr keek tənɔŋ yīn. Ke cɔl kɔc ye kɔc kuɔny ne nɔmba 1-877-626-2299.
Norwegian -	For tilgang til kostnadsfri språktjenester, ring 1-877-626-2299.
Pennsylvania Dutch -	Um Schprooch Services zu griege mitaus Koscht, ruff 1-877-626-2299.
Persian -	برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-877-626-2299 تماس بگیرید .
Polish -	Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-877-626-2299.
Portuguese -	Para acessar os serviços de idiomas sem custo para você, ligue para 1-877-626-2299.

Punjabi -	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1-877-626-2299 'ਤੇ ਫ਼ੋਨ ਕਰੋ।
Romanian -	Pentru a accesa gratuit serviciile de limbă, apălați 1-877-626-2299.
Russian -	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-877-626-2299.
Samoan -	Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala'au le 1-877-626-2299.
Serbo-Croatian -	Za besplatne prevodilačke usluge pozovite 1-877-626-2299.
Spanish -	Para acceder a los servicios de idiomas sin costo, llame al 1-877-626-2299.
Sudanese-Fulfulde -	Heeba a nasta jangirde djey wolde wola chede bo apelou lamba 1-877-626-2299.
Swahili -	Kupata huduma za lugha bila malipo kwako, piga 1-877-626-2299.
Syriac -	ܝܠܚܝܩܐ ܠܝܠܚܝܩܐ ܠܚܝܬܐ ܕܝܠܚܝܩܐ, ܡܢ ܒܝܬܐܢܝܐ: 1-877-626-2299
Tagalog -	Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-877-626-2299.
Telugu -	మీరు భాష సేవలను ఉచితంగా అందుకునందుకు, 1-877-626-2299 కు కాల్ చేయండి.
Thai -	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-877-626-2299.
Tongan -	Kapau 'oku ke fiema'u ta'etōtōngi 'a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he 1-877-626-2299.
Trukese -	Ren omw kopwe angei aninisin eman chon awewei (ese kamo), kopwe kori 1-877-626-2299.
Turkish -	Sizin için ücretsiz dil hizmetlerine erişebilmek için, 1-877-626-2299 numarayı arayın.
Ukrainian -	Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-877-626-2299.
Urdu -	بالقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-877-626-2299 پر بات کریں۔
Vietnamese -	Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-877-626-2299.
Yiddish -	צו צוטריט שפראך באדינונגען אין קיין פרייז צו איר, 1-877-626-2299 רופן
Yoruba -	Lati wọnú awọn isẹ èdè l'ọfẹ fun ọ, pe 1-877-626-2299.