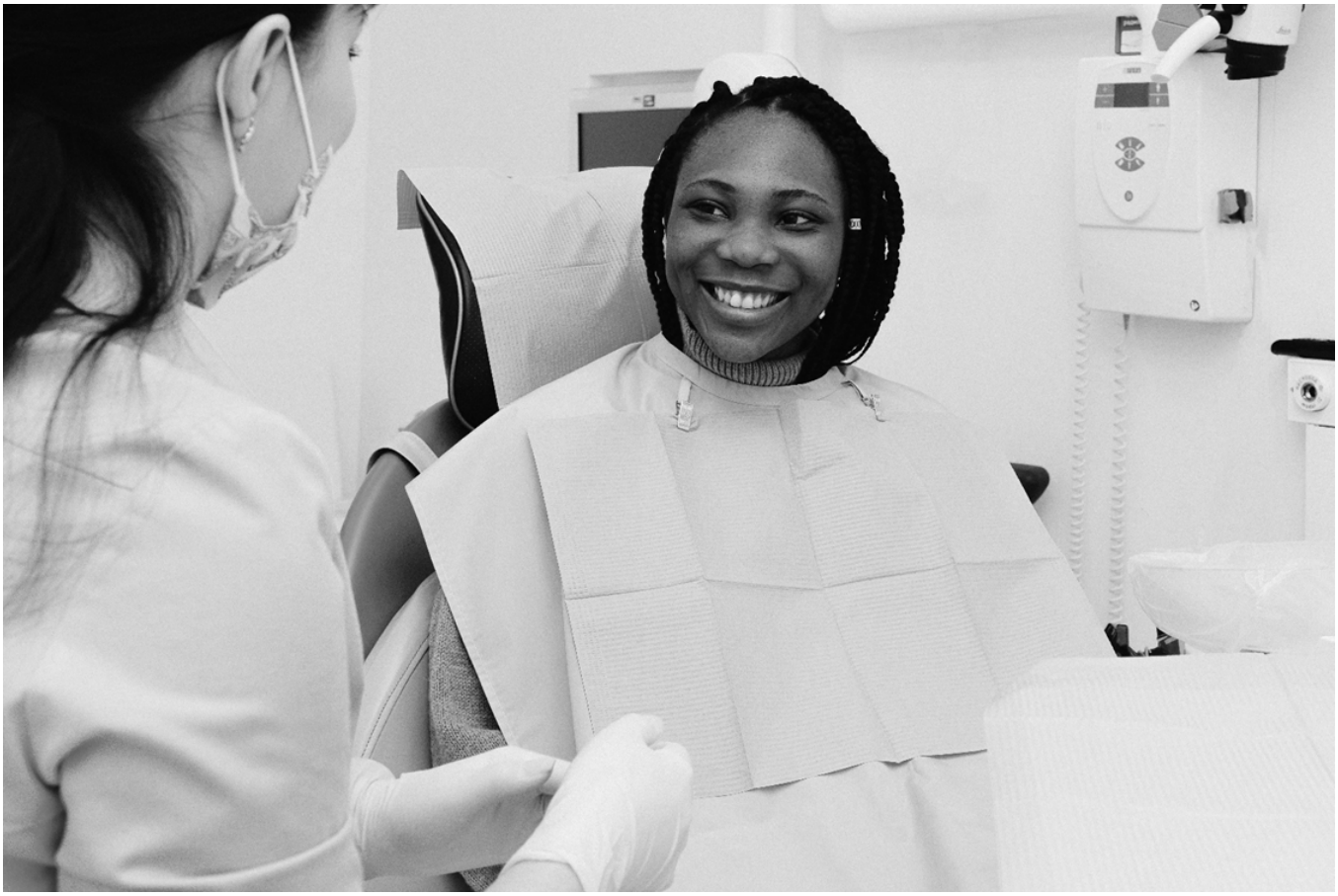
Aetna Student Health
Dental Plan Design and Benefits Summary
Preferred Provider Organization (PPO)

Virginia Tech

Plan Year: 2026 – 2027
Policy Number: 314925
https://www.aetnastudenthealth.com
(866) 376-7450



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.

Coverage Periods

Students:

Coverage for all insured students enrolled for coverage in the Plan for the following Coverage Periods. Coverage will become effective at 12:01 AM on the Coverage Start Date indicated below and will terminate at 11:59 PM on the Coverage End Date indicated.

Dependents:

Coverage will become effective on the same date the insured student's coverage is effective. 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	Open Enrollment Deadline
Annual	08/01/2026	07/31/2027	08/31/2026
New Spring Students	01/01/2027	07/31/2027	01/31/2027

Rates

2026-2027 Dental Plan Rates

	Annual	New Spring Students
Student Only	$476.00	$476.00
Add Spouse/Domestic Partner	$476.00	$476.00
Add 1 Child	$476.00	$476.00
Add 2 or more Children	$952.00	$952.00

Who is eligible?

You are eligible if you are a:

- Student currently enrolled in the medical insurance plan, enrolled as a full-time student at Virginia Tech and actively attending classes for at least the first 31 days after the date when the dental coverage becomes effective.

You must actively attend classes for at least the first 31 days after the date your coverage becomes effective. You cannot meet this eligibility requirement if you take courses through Home study, Correspondence, The internet and Television (TV). Remote online learning due to COVID-19 is eligible. If we find out that you do not meet this eligibility requirement, we are only required to refund any premium contribution minus any claims that we have paid.

Dependent Coverage

If your plan includes dependent coverage, you can enroll the following family members on your plan:

- Your legal spouse that resides with you
- Your domestic partner who meets the rules set by the policyholder and requirements under state law
- Your dependent children – your own or those of your spouse or domestic partner

- The children must be under 26 years of age, and they include:
  - Biological children
  - Stepchildren
  - Legally adopted children
  - A child legally placed with you for adoption (including a foster child)
  - Foster children

Dependents must be currently enrolled in the medical insurance plan in order to be covered under the dental plan.

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 Preferred Care and Non-Preferred Care providers.

How your plan works while you are covered for Preferred Care

Your Preferred Care coverage helps you:

- Pay less cost share when you use a Preferred Care provider.

Aetna's network of dental providers

Aetna's network of dental providers is there to give you the care that you need. You can find Preferred Care providers and see important information about them most easily on our online provider directory. Just log into your Aetna secure website at www.aetnastudenthealth.com.

You can choose any dental provider who is in the dental network.

If you can't find a Preferred Care provider for a service or supply that you need, call the Member Services toll-free number on the back of your ID card. We will help you find a Preferred Care provider.

Your plan often will pay a bigger share for eligible dental services that you get through Preferred Care providers, so choose Preferred Care providers as soon as you can.

How your plan works while you are covered for Non-Preferred Care

The section above told you how your plan works while you are covered for Preferred Care. You also have coverage when:

- You want to get your care from providers who are not part of the Aetna network.

You may pay more cost share when you use a Non- Preferred provider.

Your Non-Preferred Care coverage:

- Means you can get care from dental providers who are not part of the Aetna network.
- Means you will have to pay for services at the time that they are provided. You will be required to pay the full charges and submit a claim for reimbursement to us. You are responsible for completing and submitting claim forms for reimbursement of eligible dental services that you paid directly to a dental provider.
- Means you will pay a higher cost share when you use a Non-Preferred Care provider.

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 Virginia Insurance Law(s).

Policy year deductibles

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

	Preferred Care Coverage	Non-Preferred Care Coverage
Policy year deductibles	Individual $50 Family N/A	Individual $50 Family N/A
The policy year deductibles apply to all eligible dental services except Type A expenses. The dental policy year deductible(s) apply to preferred care and non-preferred care covered expenses separately.		

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

	Preferred Care Coverage	Non-Preferred Care Coverage
Type A expenses	100% of the negotiated charge	100% of the recognized charge
Type B expenses	80% of the negotiated charge	80% of the recognized charge
Type C expenses	60% of the negotiated charge	60% of the recognized charge
Orthodontic treatment expenses	Not Covered	Not Covered

Policy year maximum

	Preferred Care Coverage	Non-Preferred Care Coverage
Policy year maximum:	$1,250	$1,250
The policy year maximums apply to: • Preferred and Non-Preferred eligible dental services combined		

Eligible dental services

Type A expenses: Diagnostic & preventive care

Visits and exams

- Office visit during regular office hours for oral examination (2 routine visits and 2 problem focused visits per year)
- Prophylaxis (cleaning) or scaling-moderate/severe inflammation–full mouth, (2 treatments per policy year)
- Topical application of fluoride if you are under age 16 (1 application per policy year)
- Sealants, per tooth (1 application every 3 policy years for molars only and if you are under age 16)

Images and pathology

- Bitewing images (1 set per policy year)
- Entire dental series, including bitewings or panoramic film (1 set every 3 policy years)

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

- Periapical images
- Intra-oral, occlusal view
- Extra-oral
- Accession of tissue

Restorative

Excluding inlays, on lays and crowns. Multiple restorations in 1 surface will be considered as a single restoration.

- Amalgam restorations
- Resin-based composite restorations, (other than for molars)
- Recementation
- Crowns
- Prefabricated crowns (excluding temporary crowns)
- Pin retention, per tooth, in addition to restoration

Endodontics

- Pulp cap
- Pulpotomy
- Apexification/recalcification
- Apicoectomy
- Root canal therapy and retreatment
  - Anterior
  - Bicuspid

Periodontics

- 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 policy years)
- Root planing and scaling, 4 or more teeth per quadrant, (limited to 1 separate quadrants every 2 policy years)
- Gingivectomy/gingivoplasty, 1 to 3 teeth per quadrant, (1 per site every 5 policy years)
- Gingivectomy/gingivoplasty, 4 or more teeth per quadrant, (limited to 1 per quadrant every 5 policy years)
- Gingival flap procedure, 1 to 3 teeth per quadrant, (limited to 1 per site every 5 policy years)
- Gingival flap procedure, 4 or more teeth per quadrant, (limited to 1 per quadrant every 5 policy years)
- Localized delivery of antimicrobial agents

Oral surgery

- Surgical removal of erupted tooth
- Surgical removal of residual tooth roots
- Removal of impacted tooth
  - Soft tissue
- Oroantral fistula closure
- Tooth transplantation
- Mobilization of erupted or malpositioned tooth to aid eruption
- Alveoloplasty
- Removal of odontogenic cysts or tumors
- Removal of exostosis
- Removal of foreign body
- Sequestrectomy
- Suture of wounds
- Frenectomy/frenuloplasty
- Excision of hyperplastic tissue per arch
- Sialolithotomy
- Closure of salivary fistula

Space maintainers

Only when needed to preserve space resulting from premature loss of deciduous teeth and if you are under age 16. (Includes all adjustments within 6 months after installation.)

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

Type C expenses: Major restorative care

Restorative – Inlays, on lays, 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 policy years. (See the *Replacement rule*.)

- Inlays
- On lays
- Labial veneers
- Post and core
- Repairs - inlay, onlay, veneer, crown

Endodontics

- Root canal therapy and retreatment
  - Molar

Periodontics

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

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 10 policy years old. (See the *Tooth missing but not replaced rule*.) Replacement of existing bridges or dentures is limited to 1 every 8 policy 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 and partial denture
- Adding teeth and clasps to existing partial denture
- Repairs, bridges
- Occlusal guard for bruxism (1 every 5 policy years)

- Adjustments, repair or reline of occlusal guard
- Cleaning and inspection of a removable appliance

Oral surgery

- Removal of impacted tooth
  - Partially bony
  - Completely bony

What rules and limits apply to dental care?

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 Preferred Care provider's negotiated charge for the eligible dental service or, in the case of an Non-Preferred Care 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.

Coverage for Dental Work Begun Before The Covered Person is Covered by the Plan

The plan does not cover dental work that began before the covered person was covered by the plan. This means that the following dental work is not covered:

- An appliance, or modification of an appliance, if an impression for it was made before the covered person was covered by the plan;
- A crown, bridge, or cast or processed restoration, if a tooth was prepared for it before the covered person was covered by the plan; or
- Root canal therapy, if the pulp chamber for it was opened before the covered person was covered by the plan.

Reimbursement policies

We have the right to apply Aetna reimbursement policies. Those policies may reduce the negotiated charge or recognized charge. These policies take into account factors such as:

- 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:

- The Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate
- Generally accepted standards of dental practice and
- The views of providers and dentists practicing in the relevant clinical areas

We use commercial software to administer some of these policies. Some policies are different for professional services than for facility services.

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
- Veneers
- 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 or bridge was installed.
  - As a result, you need to replace or add teeth to your denture or bridge.
- 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), or other prosthetic item installed at least 8 years before its replacement.
- While you were covered by the plan:
  - You had a tooth (or teeth) extracted.
  - Your present denture is an immediate temporary one that replaces 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.

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

Late Entrant Rule

The plan does not cover services and supplies given to a person age 5 or more if that person did not enroll in the plan:
- During the first 31 days the person is eligible for this coverage, or
- During any period of open enrollment agreed to by the Policyholder and Aetna.

This exclusion does not apply to charges incurred:
- After the covered person has been covered by the plan for 12 months or
- As a result of injuries sustained while covered by the plan, or
- For services listed as Visits and X-rays, Visits and Exams, and X-ray and Pathology in the Dental Care Schedule.

Congenital defects treatment rule

For newly born children, dental benefits are provided for medically diagnosed congenital defects and birth abnormalities, including cleft lip, cleft palate or ectodermal dysplasia, to the same extent as other dental conditions.

What your plan doesn't cover – eligible dental service exceptions and exclusions

We already told you about the many dental care services and supplies that are eligible for coverage under your plan in the *What are your eligible dental services* section. In that section we also told you that some dental care services and supplies have exceptions and some are not covered at all which are called "exclusions".

In this section we tell you about the exceptions and exclusions that apply to your plan. And just a reminder, you'll find benefit and coverage limitations in the schedule of benefits.

General exceptions and exclusions

Armed forces

- Services and supplies received from a **provider** as a result of an **injury** sustained, or **illness** contracted, while in the service of the armed forces of any country. When you enter the armed forces of any country, we will refund any unearned pro-rata **premium** to the **policyholder**.

Beyond legal authority

- Services and supplies provided by a **health professional** or other **provider** that is acting beyond the scope of its legal authority

Charges for services or supplies

- Provided by a Preferred Care **provider** in excess of the **negotiated charge**
- Provided by a Non-Preferred **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

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.

Dental services and supplies

- 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 *Eligible Dental Services* section of 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
- First installation of a denture or fixed bridge, and any inlay and crown that serves as an abutment to replace congenitally missing teeth or to replace teeth, all of which were lost while you were not covered
- 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 *Eligible Dental Services* section of the schedule of benefits
- 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

Dental services and supplies that are covered in whole or in part:

- Under any other part of this plan
- 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.
- Because a court order requires it.
- 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

Felony

- Services and supplies that you receive as a result of an **injury** due to your commission of a felony

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

Riot

- Services and supplies that you receive from **providers** as a result of an **injury** from your "participation in a riot". This means when you take part in a riot in any way such as inciting, or conspiring to incite, the riot. It does not include actions that you take in self-defense as long as they are not against people who are trying to restore law and order.

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, domestic partner, parent, child, step-child, brother, sister, in-law or any household member

Telemedicine

- Any services or supplies provided as part of telemedicine. Telemedicine is a telephone or internet-based consult with a **provider**.

Temporomandibular joint dysfunction/disorder

- The following services and supplies:
  - **Orthodontic treatment**
  - Crowns, bridges and dentures
  - Treatment of periodontal disease
  - Implants
  - Root canal therapy

Treatment in a federal, state, or governmental entity

- Any care in a **hospital** or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws

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.

The Virginia Tech 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 http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

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: 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 subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).

TTY: **711**

English	To access language services at no cost to you, call the number on your ID card.
Amharic	የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በመታወቂያዎት ላይ ያለውን ቁጥር ይደውሉ።
Arabic	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة اشتراكك.
Armenian	Ձեր նախընտրած լեզվով ավվճար խորհրդատվություն ստանալու համար զանգահարեք ձեր բժշկական ապահովագրության քարտի վրա նշված հէրախոսահամարով հէրախոսահամարով
Carolinian (Kapasal Falawasch)	Ngir mëna am sarwis lakk yi te doo fay, woo nimero bi am ci sa kàrt.
Chamorro	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang i numiru gi iyo-mu kard aidentifikasion.
Chinese Traditional	如欲使用免費語言服務，請撥打您健康保險卡上所列的電話號碼
Cushitic-Oromo	Tajaajiiloota afaanii gatii bilisaa ati argaachuuf, lakkoofsa fuula waraaqaa eenyummaa (ID) kee irraa jiruun bilbili.
French	Pour accéder gratuitement aux services linguistiques, veuillez composer le numéro indiqué sur votre carte d'assurance santé.
French Creole (Haitian)	Pou ou jwenn sèvis gratis nan lang ou, rele nimewo telefòn ki sou kat idantifikasyon asirans sante ou.
German	Um auf den für Sie kostenlosen Sprachservice auf Deutsch zuzugreifen, rufen Sie die Nummer auf Ihrer ID-Karte an.
Greek	Για πρόσβαση στις υπηρεσίες γλώσσας χωρίς χρέωση, καλέστε τον αριθμό στην κάρτα ασφάλισής σας.
Gujarati	તમારે કોઇ પણ જાતના ખર્ચ વિના ભાષા સેવાઓ મેળવવા માટે, તમારા આઇડી કાર્ડ પર રહેલ નંબર પર કૉલ કરવો.
Hindi	बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, अपने आईडी कार्ड पर दिए नंबर पर कॉल करें।
Hmong	Yuav kom tau kev pab txhais lus tsis muaj nqi them rau koj, hu tus naj npawb ntawm koj daim npav ID.
Italian	Per accedere ai servizi linguistici senza alcun costo per lei, chiami il numero sulla tessera identificativa.
Japanese	無料の言語サービスは、IDカードにある番号にお電話ください。
Karen	လၫ်တၢ်ကမ္ၢၤကျိာတၢ်မၤစၫၤအတၢ်ဖံးတၢ်မၤတဖၣ လၫ်တအိၣ်ဒီးအပှၤလၫ်နကဘၣ်ဟ့ၣ်အီၤအဂီၢ်ကီးဘၣ်လီတဲစိနီၣ်ဂ့ၢ်လၫ်အအိၣ်လၫ်နခိၣ်ဂီၤ ၈ (ၪ) အလိၢ်ၣ်တက့ၢ်၍
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.
Laotian	ເພື່ອເຂົ້າເຖິງບໍລິການພາສາທີ່ບໍ່ເສຍຄ່າ, ໃຫ້ໂທຫາເບີໂທຢູ່ໃນບັດປະຈຳຕົວຂອງທ່ານ.
Mon-Khmer, Cambodian	ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរសព្ទទៅកាន់លេខដែលមាននៅលើបណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក។
Navajo	T’áá ni nizaad k’ehjí bee níká a’doowoł doo bą́ą́h ílínígóó naaltsoos bee atah nílı̨́go nanitinígíí bee néého’dólzinígíí béésh bee hane’í biká’ígíí áajı̨’ hólne’.
Pennsylvanian-Dutch	Um Schprooch Services zu griege mitaus Koscht, ruff die Nummer uff dei ID Kaart.
Persian-Farsi	برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید.
Polish	Aby uzyskać dostęp do bezpłatnych usług językowych, należy zadzwonić pod numer podany na karcie identyfikacyjnej.
Portuguese	Para aceder aos serviços linguísticos gratuitamente, ligue para o número indicado no seu cartão de identificação.
Punjabi	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਪੰਜਾਬੀ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਫ਼ੋਨ ਕਰੋ।
Russian	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей идентификационной карте.
Samoan	Mō le mauaina o 'au'aunaga tau gagana e aunoa ma se totogi, vala'au le numera i luga o lau pepa ID.
Serbo-Croatian	Za besplatne prevodilačke usluge pozovite broj naveden na Vašoj identifikacionoj kartici.
Spanish	Para acceder a los servicios lingüísticos sin costo alguno, llame al número que figura en su tarjeta de identificación.
Syriac-Assyrian	ܠܡܬܚܫܒ ܒܫܘܬܐ ܕܠܫܢܐ ܕܠܝܬ ܠܗ ܥܠܘܬܐ ܒܠܚܘܕ، ܒܥܝ ܠܡܬܚܙܐ ܠܡܝܠܐ ܕܒܬܪ ܡܣܦܪܐ ܕܐܝܬ ܥܠ ܟܪܛܝܣ ܕܐܝܕܝ ܕܝܠܟ.
Tagalog	Upang ma-access ang mga serbisyo sa wika nang walang bayad, tawagan ang numero sa iyong ID card.
Thai	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทรหมายเลขที่แสดงอยู่บนบัตรประจำตัวของท่าน
Ukrainian	Щоб безкоштовнj отримати мовні послуги, задзвоніть за номером, вказаним на вашій ідентифікайній картці.
Vietnamese	Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý vị.