### Summary of Benefits and Coverage:

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, visit [https://www.aetnastudenthealth.com/](https://www.aetnastudenthealth.com/) or call 1-800-239-9697. 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/](https://www.healthcare.gov/sbc-glossary/) or call 1-800-239-9697 to request a copy.

---

### Important Questions

<table>
<thead>
<tr>
<th>What is the overall deductible?</th>
<th>For each Plan Year, In-Network: Individual $100 / Family $200. Out-of-Network: Individual $100 / Family $200</th>
<th>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Prescription drugs; plus in-network preventive care are covered before you meet your deductible.</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>In-Network: Individual $3,500 / Family $7,000. Out-of-Network: Individual $3,500 / Family $7,000.</td>
<td>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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billing charges, health care this plan doesn’t cover &amp; penalties for failure to obtain pre-authorization for services.</td>
<td>Even though you pay these expenses, they don’t count toward the out–of–pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.aetna.com/docfind">www.aetna.com/docfind</a> or call 1-800-239-9697 for a list of in-network providers.</td>
<td>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.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td><img src="#" alt="In-Network Provider" /> <img src="#" alt="Out-of-Network Provider" /></td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td><img src="#" alt="In-Network Provider" /> <img src="#" alt="Out-of-Network Provider" /></td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care / screening / immunization</td>
<td><img src="#" alt="In-Network Provider" /> <img src="#" alt="Out-of-Network Provider" /></td>
<td>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.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td><img src="#" alt="In-Network Provider" /> <img src="#" alt="Out-of-Network Provider" /></td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td><img src="#" alt="In-Network Provider" /> <img src="#" alt="Out-of-Network Provider" /></td>
<td>None</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td><img src="#" alt="In-Network Provider" /> <img src="#" alt="Out-of-Network Provider" /></td>
<td>Covers 30 day supply (retail). Includes contraceptive drugs &amp; devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women’s contraceptives in-network.</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td><img src="#" alt="In-Network Provider" /> <img src="#" alt="Out-of-Network Provider" /></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td><img src="#" alt="In-Network Provider" /> <img src="#" alt="Out-of-Network Provider" /></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td><img src="#" alt="In-Network Provider" /> <img src="#" alt="Out-of-Network Provider" /></td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td><img src="#" alt="In-Network Provider" /> <img src="#" alt="Out-of-Network Provider" /></td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td><img src="#" alt="In-Network Provider" /> <img src="#" alt="Out-of-Network Provider" /></td>
<td>None</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td><img src="#" alt="In-Network Provider" /> <img src="#" alt="Out-of-Network Provider" /></td>
<td>No coverage for non-emergency use.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td><img src="#" alt="In-Network Provider" /> <img src="#" alt="Out-of-Network Provider" /></td>
<td>Non-emergency transport: not covered, except if pre-authorized.</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td><img src="#" alt="In-Network Provider" /> <img src="#" alt="Out-of-Network Provider" /></td>
<td>No coverage for non-urgent use.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td><img src="#" alt="In-Network Provider" /> <img src="#" alt="Out-of-Network Provider" /></td>
<td>Penalty of $500 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
</tbody>
</table>

More information about **prescription drug coverage** is available at [https://www.aetna.com/individuals-families/pharmacy.html](https://www.aetna.com/individuals-families/pharmacy.html)
<table>
<thead>
<tr>
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<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Outpatient services</td>
<td>Office: $20 copay/visit</td>
<td>Office &amp; other outpatient services: 20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>$150 copay/visit</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>0% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>0% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>$150 copay/visit</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>10% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$20 copay/visit</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$20 copay/visit</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>$150 copay/visit</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>10% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>$150 copay/visit</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>No charge</td>
<td>50% coinsurance, deductible doesn't apply</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>No charge</td>
<td>50% coinsurance, deductible doesn't apply</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>No charge</td>
<td>30% coinsurance</td>
</tr>
</tbody>
</table>
Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs - Except for required preventive services.

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

- Bariatric surgery
- Chiropractic care
- Hearing aids - 1 hearing aid per ear/24 months.
- Infertility treatment
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage:
There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Michigan Division of Insurance, (877) 999-6442, http://www.michigan.gov/difs
- For more information on your rights to continue coverage, contact the plan at 1-800-239-9697.
- State Consumer Assistance Program, if other than state insurance department contact Michigan Health Insurance Consumer Assistance Program (HICAP), Michigan Department of Insurance and Financial Services (DIFS), P.O. Box 30220, Lansing, MI 48909-7720, (877) 999-6442, https://www.michigan.gov/difs, difs-HICAP@michigan.gov

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 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 1-800-239-9697.
- Additionally, a consumer assistance program can help you file your appeal. Contact Michigan Health Insurance Consumer Assistance Program (HICAP), Michigan Department of Insurance and Financial Services (DIFS), P.O. Box 30220, Lansing, MI 48909-7720, (877) 999-6442, https://www.michigan.gov/difs, difs-HICAP@michigan.gov

Does this plan provide Minimum Essential Coverage? Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby</th>
<th>Managing Joe’s type 2 Diabetes</th>
<th>Mia’s Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>(9 months of in-network pre-natal care and a hospital delivery)</strong></td>
<td><strong>(a year of routine in-network care of a well-controlled condition)</strong></td>
<td><strong>(in-network emergency room visit and follow up care)</strong></td>
</tr>
<tr>
<td>The plan’s overall deductible</td>
<td>The plan’s overall deductible</td>
<td>The plan’s overall deductible</td>
</tr>
<tr>
<td>$100</td>
<td>$100</td>
<td>$100</td>
</tr>
<tr>
<td>Specialist copayment</td>
<td>Specialist copayment</td>
<td>Specialist copayment</td>
</tr>
<tr>
<td>$20</td>
<td>$20</td>
<td>$20</td>
</tr>
<tr>
<td>Hospital (facility) coinsurance</td>
<td>Hospital (facility) coinsurance</td>
<td>Hospital (facility) coinsurance</td>
</tr>
<tr>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Other coinsurance</td>
<td>Other coinsurance</td>
<td>Other coinsurance</td>
</tr>
<tr>
<td>10%</td>
<td>10%</td>
<td>10%</td>
</tr>
</tbody>
</table>

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

**Total Example Cost** $12,800

In this example, **Peg would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>$100</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copayments</td>
<td>$40</td>
<td></td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
<td></td>
</tr>
</tbody>
</table>

What isn't covered

- Limits or exclusions $60

The total Peg would pay is **$200**

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** $7,400

In this example, **Joe would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>$100</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copayments</td>
<td>$200</td>
<td></td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$600</td>
<td></td>
</tr>
</tbody>
</table>

What isn't covered

- Limits or exclusions $20

The total Joe would pay is **$920**

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

**Total Example Cost** $1,900

In this example, **Mia would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>$100</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copayments</td>
<td>$200</td>
<td></td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
<td></td>
</tr>
</tbody>
</table>

What isn't covered

- Limits or exclusions $0

The total Mia would pay is **$300**

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Note: These numbers assume the patient does not participate in the plan’s wellness program. If you participate in the plan’s wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-239-9697.
Assistive Technology
Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-800-239-9697.

Smartphone or Tablet
To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination
Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779)
1-800-648-7817, TTY: 711, Fax: 859-425-3379 (CA HMO customers: 1-860-262-7705)

Email: CRCordinator@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.
TTY: 711

**Language Assistance:**

For language assistance in your language call 1-800-239-9697 at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-800-239-9697.

Amharic - እንወት እግር እ ከምርት እ 1-800-239-9697 በነጻ ያደውሉ.

Arabic - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-800-239-9697.

Armenian - Ներքին գործազանցություն սպասարձավորի (հայերեն) թաքցի 1-800-239-9697 առանց գնով:

Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-239-9697 tanpa dikenakan biaya.

Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-800-239-9697 ku busa

Bengali-Bangala - বাংলা ভাষা সহায়তার জন্য বিনামূল্যে 1-800-239-9697-তে কল করুন।

Bisayan-Visayan - Alang sa pag-abag sa pinulongang sa (Binisayang Sinugboanon) tawag sa 1-800-239-9697 nga walay bayad.

Burmese - အားပေးမည်နေသူများအတွက် အားလုံးကို 1-800-239-9697 ဖော်ပြပါမည်။

Catalan - Per rebre assistència en (català), truqui al número gratuït 1-800-239-9697.

Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-800-239-9697 sin gåstu.

Cherokee - ᓁᏧᏪᏩ ᎨᏎᏣᏴ.ᎣᏫ.ᏰᎵᏰᏱᎦ ᏯᏣᏯ (GWW) ᏳᎵ᏶Ꮽ 1-800-239-9697 ᎦᏴᏫ.ᎾᏫ.ᎨᎦᏳ.ᎨᎲᏩ.Ᏹ.ᏣᏨ.Ᏻ.Ꭷ.Ꮽ.Ᏻ.ᎨᎵ.Ꭶ.Ꮿ.Ᏻ.Ꮸ.Ᏻ.ᎨᏳ.Ꭹ.Ꭶ.Ꮶ.Ꮿ.Ꮿ.Ꮷ.Ꮻ.Ꮹ.Ꮻ.Ꮹ.Ꮻ.Ꮹ.Ꮻ.Ꮹ.Ꮻ.Ꮹ.Ꮻ.Ꮹ.Ꮻ.Ꮹ.Ꮻ.Ꮹ.Ꮻ.Ꮹ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꮻ.Ꭳ. Wilmington, NC 28403.

Chinese - 欲取得繁體中文語言協助，請撥打1-800-239-9697，無需付費。

Choctaw - (Chahta) anumpa ya apela a chi l paya hinla 1-800-239-9697.

Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakokkofo bilbilaa 1-800-239-9697 irratti bilisaan bilbilaa.

Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-239-9697.

French - Pour une assistance linguistique en français appeler le 1-800-239-9697 sans frais.

French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-800-239-9697 gratis.

German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-239-9697 an.

Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-239-9697 χωρίς χρέωση.

Gujarati - ગુજરાતીમાં સહાય મળે ક્રમે પણ એક વર્ષ વચ્ચે 1-800-239-9697 પર કોલ કરો.
No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-800-239-9697. Kāki ‘ole ‘ia kēia kōkua nei.

Hindi -  
हिन्दी में भाषा सहायता के लिए, 1-800-239-9697 पर मुफ्त कॉल करें।

Hmong -  
Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-800-239-9697.

Ibo -  
Maka enyemaka asụsụ na  Igbo kpoọ 1-800-239-9697 na akwụghị ụgwọ ọ buła

Ilocano -  
Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-239-9697 nga awan ti bayadanyo.

Italian -  
Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-800-239-9697.

Japanese -  
日本語で援助をご希望の方は、1-800-239-9697 まで無料でお電話ください。

Karen -  
ကြိုးနှစ် ရှိသော အချက် အလက်အတွက် အသုံးပြု ပါသည်။

Korean -  
한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-239-9697 변으로 전화해 주십시오.

Kru-Bassa -  
Be’m ké gbo-kpa-kpá dyé pidyi qé Baso-woòñín wët, qa 1-800-239-9697

Kurdish -  
برای راهنمایی به زبان فارسی با شماره 1-800-239-9697 به گوش ای بیوگنده بکن.

Laotian -  
Ohng palien sawas en soum kawewe ni omw lokaia Ponape koahl 1-800-239-9697 ni sohte isais.

Marathi -  
तीलभाषा (मराठी) सहाय्यासाठी 1-800-239-9697 क्रमांकावरकोणत्याहीखार्चिशिवायकॉलकरा.

Marshallese -  
Ñan bök jipaño ilo Kajin Majol, kallok 1-800-239-9697 ilo ejjelok wônân.

Micronesian -  
Ohng palien sawas en soum kawewe ni omw lokaia Ponape koahl 1-800-239-9697 ni sohte isais.

Mon-Khmer, Cambodian -  
(នេះជាសេរីនេះ) សូមសិក្សាសេរីនេះ 1-800-239-9697 សូមសិក្សាសេរីនេះ.

Navajo -  
T'áá shi shizaad k'ehjí bee shiká a'doowol ninízingo Diné k'ehjíkoji' t'áá jíík'e hólne' 1-800-239-9697

Nepali -  
(नेपाली) मा नि: शुल्क भाषा सहायता पाउनका लागि 1- 800-239-9697 मा फोन गर्नुहोस्।

Nilotic-Dinka -  
Tën kuoony ê thok ê Thuonjjaŋ cöl 1-800-239-9697 kecin ayoc.

Norwegian -  
For språkassistanse på norsk, ring 1-800-239-9697 kostnadsfritt.

Panjabi -  
ਪੰਜਾਬੀ ਦੀ ਸਿਕਾ ਭਾਸ਼ਾ ਨਾਲ ਸਹਾਇਤਾ ਤੈਦ ਕਰਓ, 1-800-239-9697 ਉੱਤੇ ਮੁੱਡਾ ਬਰਚ ਵੇਨੇ।

Pennsylvania Dutch -  
Fer Helfe in Deitsch, ruf: 1-800-239-9697 aa. Es Aaruf koschtet nix.

Persian -  
برای راهنمایی به زبان فارسی با شماره 1-800-239-9697 بدون هیچ هزینه ای تماس بگیرید.

Polish -  
Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-800-239-9697.