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/ or by calling 1-800-466-3027. 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 1-800-466-3027 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>For each Plan Year, In-Network: Individual $350 / Family $700. Out-of-Network: Individual $500 / Family $1,000.</td>
<td>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.</td>
</tr>
<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>Yes. For prescription drugs - In-Network &amp; Out-of-Network: Individual $200. There are no other specific deductibles.</td>
<td>You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>In-Network: Individual $5,500 / Family $11,000. Out-of-Network: Individual $11,000 / Family $22,000.</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 1-800-466-3027 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>In-Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</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>10% coinsurance after $25 copay/visit</td>
<td>10% coinsurance after $50 copay/visit</td>
<td>None</td>
</tr>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Specialist visit</td>
<td>10% coinsurance after $25 copay/visit</td>
<td>10% coinsurance after $50 copay/visit</td>
<td>None</td>
</tr>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Preventive care /screening /immunization</td>
<td>No charge</td>
<td>40% coinsurance</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>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>Copay/prescription, after specific deductible: $7 (retail)</td>
<td>Copay/prescription, after specific deductible: $7 (retail)</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>
</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>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>In-Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Preferred brand drugs</td>
<td>20% coinsurance with minimum &amp; maximum/ prescription, after specific deductible: $40 minimum &amp; $80 maximum (retail)</td>
<td>20% coinsurance with minimum &amp; maximum/ prescription, after specific deductible: $40 minimum &amp; $80 maximum (retail)</td>
<td>Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs &amp; devices obtainable from a pharmacy, oral fertility drugs. No charge for preferred generic FDA-approved women’s contraceptives in-network. Review your <a href="#">formulary</a> for prescriptions requiring precertification or step therapy for coverage.</td>
</tr>
<tr>
<td>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.aetnapharmacy.com/valueplus">www.aetnapharmacy.com/valueplus</a></td>
<td>Value Plus Formulary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Non-preferred brand drugs</td>
<td>20% coinsurance with minimum &amp; maximum/ prescription, after specific deductible: $80 minimum &amp; $160 maximum (retail)</td>
<td>20% coinsurance with minimum &amp; maximum/ prescription, after specific deductible: $80 minimum &amp; $160 maximum (retail)</td>
<td>Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs &amp; devices obtainable from a pharmacy, oral fertility drugs. No charge for preferred generic FDA-approved women’s contraceptives in-network. Review your <a href="#">formulary</a> for prescriptions requiring precertification or step therapy for coverage.</td>
</tr>
<tr>
<td>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.aetnapharmacy.com/valueplus">www.aetnapharmacy.com/valueplus</a></td>
<td>Value Plus Formulary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Specialty drugs</td>
<td>20% coinsurance with $80 minimum &amp; $160 maximum/ prescription, after specific deductible</td>
<td>20% coinsurance with $80 minimum &amp; $160 maximum/ prescription, after specific deductible</td>
<td>None</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay In-Network Provider (You will pay the least)</td>
<td>What You Will Pay Out-of-Network Provider (You will pay the most)</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>-----------------------------------------------------------</td>
<td>--------------------------------------------</td>
<td>------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>10% coinsurance after $150 copay/visit</td>
<td>10% coinsurance after $150 copay/visit</td>
<td>No coverage for non-emergency use.</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency medical transportation</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>Non-emergency transport: not covered, except if pre-authorized.</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Urgent care</td>
<td>20% coinsurance</td>
<td>40% coinsurance</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>20% coinsurance after $200 copay/stay</td>
<td>40% coinsurance after $200 copay/stay</td>
<td>Penalty of $500 for failure to obtain pre-authorization for care.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office: 10% coinsurance after $20 copay/visit; other outpatient services: 20% coinsurance</td>
<td>Office: 10% coinsurance after $40 copay/visit; other outpatient services: 40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Inpatient services</td>
<td>20% coinsurance after $200 copay/stay</td>
<td>40% coinsurance after $200 copay/stay</td>
<td>Penalty of $500 for failure to obtain pre-authorization for care.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</td>
<td>40% coinsurance</td>
<td>Cost sharing does not apply for preventive services. 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.</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>---------------------------------------------</td>
<td>--------------------------------------------------</td>
<td>---------------------------------------------------</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Childbirth/delivery professional services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Penalty of $000 for failure to obtain pre-authorization for out-of-network care may apply.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Childbirth/delivery facility services</td>
<td>20% coinsurance after $200 copay/stay</td>
<td>40% coinsurance after $200 copay/stay</td>
<td>Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Penalty of $000 for failure to obtain pre-authorization for out-of-network care may apply.</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>100 visits/plan year. Penalty of $500 for failure to obtain pre-authorization for care.</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Rehabilitation services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>Includes Physical, Occupational &amp; Speech Therapy.</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Habilitation services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>Penalty of $500 for failure to obtain pre-authorization for care.</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Skilled nursing care</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>---------------------------------------------</td>
<td>-------------------------------------------------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Hospice services</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
<td>Penalty of $500 for failure to obtain pre-authorization for care.</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>No charge</td>
<td>40% coinsurance, deductible doesn't apply</td>
<td>1 routine eye exam/plan year. Covered through the end of the month in which the covered person turns 19.</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's glasses</td>
<td>No charge</td>
<td>40% coinsurance, deductible doesn't apply</td>
<td>1 pair of glasses or lenses/plan year. Covered through the end of the month in which the covered person turns 19.</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's dental check-up</td>
<td>No charge</td>
<td>40% coinsurance</td>
<td>Covered through the end of the month in which the covered person turns 19.</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.)**

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

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

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids - 1 hearing aid per ear/plan year.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing - 8- 8 hour shifts/plan year.
- Routine eye care (Adult) - 1 routine eye exam/plan year.
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: Virginia State Corporation Commission, Bureau of Insurance, (800) 552-7945, [http://www.scc.virginia.gov/boi/index.aspx](http://www.scc.virginia.gov/boi/index.aspx).

- For more information on your rights to continue coverage, contact the plan at 1-800-466-3027.
- State Consumer Assistance Program, if other than state insurance department contact Virginia State Corporation Commission, Bureau of Insurance, P.O. Box 1157, Richmond, VA 23218, (804) 371-9741, [http://www.scc.virginia.gov/boi/cons/index.aspx](http://www.scc.virginia.gov/boi/cons/index.aspx), bureauofinsurance@scc.virginia.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 1-800-466-3027.
- Additionally, a consumer assistance program can help you file your appeal. Contact Virginia State Corporation Commission, Bureau of Insurance, P.O. Box 1157, Richmond, VA 23218, (804) 371-9741, [http://www.scc.virginia.gov/boi/cons/index.aspx](http://www.scc.virginia.gov/boi/cons/index.aspx), bureauofinsurance@scc.virginia.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>(9 months of in-network pre-natal care and a hospital delivery)</td>
<td>(a year of routine in-network care of a well-controlled condition)</td>
<td>(in-network emergency room visit and follow up care)</td>
</tr>
<tr>
<td><strong>The plan’s overall deductible</strong></td>
<td>$350</td>
<td><strong>The plan’s overall deductible</strong></td>
</tr>
<tr>
<td><strong>Specialist coinsurance</strong></td>
<td>10%</td>
<td><strong>Specialist coinsurance</strong></td>
</tr>
<tr>
<td><strong>Hospital (facility) coinsurance</strong></td>
<td>20%</td>
<td><strong>Hospital (facility) coinsurance</strong></td>
</tr>
<tr>
<td><strong>Other coinsurance</strong></td>
<td>20%</td>
<td><strong>Other coinsurance</strong></td>
</tr>
</tbody>
</table>

This EXAMPLE event includes services like:
Pregnancy and childbirth care (including disease education)
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:
**Cost Sharing**
Deductibles $400
Copayments $0
Coinsurance $2,400

What isn’t covered
Limits or exclusions $60

**The total Peg would pay is** $2,860

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:
**Cost Sharing**
Deductibles $550
Copayments $1,000
Coinsurance $90

What isn’t covered
Limits or exclusions $20

**The total Joe would pay is** $1,660

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:
**Cost Sharing**
Deductibles $400
Copayments $0
Coinsurance $200

What isn’t covered
Limits or exclusions $0

**The total Mia would pay is** $600

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: 1-800-466-3027.

The plan would be responsible for the other costs of these EXAMPLE covered services.
Assistive Technology
Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-800-466-3027.

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 1-800-466-3027 at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-800-466-3027.
Amharic - እንግታር ከግር ከፋግር ከ 1-800-466-3027 ፈላ ዲ.ሪ.ባ.ት
Arabic - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-800-466-3027
Armenian - Լեզվի գույքը պատկանող հայերեն (հայերեն) քաղցր 1-800-466-3027 առանց գնով:
Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-466-3027 tanpa dikenakan biaya.
Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-800-466-3027 ku busa
Bengali-Bangala - বাংলায় ভাষার সহায়তার জন্য বিনামূল্যে 1-800-466-3027-তে কল করুন।
Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisaya Sinugboanon) tawag sa 1-800-466-3027 nga walay bayad.
Burmese - မီးပါစုံဖော်ပြထိုးခြင်း အုပ်ချုပ်ခြင်း လိုအပ်သူတို့အတွက် 1-800-466-3027 ဖြင့် ဆိုရန်
Catalan - Per rebre assistència en (català), truqui al número gratuït 1-800-466-3027.
Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-800-466-3027 sin gástu.
Cherokee - ᓀᐦᑯᓪᓗ ᓁᓐいらっ ᓁᐦᐣ ᓁᐦᑖᑭᓯ ገ芨 (GWW) ᓃᐦᓯᐴᐨ 1-800-466-3027 ᓁᐦᑖᑭᓯ ᓁᐦᐣ ᓁᐦᐣ ᐃᐦ المال.
Chinese - 欲取得繁體中文語言協助，請拨打 1-800-466-3027，無需付費。
Choctaw - (Chahta) anumpa ya apela a chi l paya hinla 1-800-466-3027.
Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsaa bilbilaa 1-800-466-3027 irratti bilisaa bilbilaa.
Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-466-3027.
French - Pour une assistance linguistique en français appeler le 1-800-466-3027 sans frais.
French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewe 1-800-466-3027 gratis.
German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-466-3027 an.
Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-466-3027 χωρίς χρέωση.
Gujarati - ગુજરાતીમાં સહાય માટે કોઈ પણ અર્થ વગર 1-800-466-3027 પર કોલ કરો.
Hawaiian - No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-800-466-3027. Kāki ‘ole ia kēia kōkua nei.
Hindi - हिन्दी में भाषा सहायता के लिए, 1-800-466-3027 पर मुफ्त कॉल करें।
Hmong - Maka enyemaka ausu na Igbo kpo 1-800-466-3027 na akwughig o bula
Ibo - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-466-3027 nga awan ti bayadanyo.
Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-800-466-3027.
Japanese - 日本語で援助をご希望の方は、1-800-466-3027 まで無料でお電話ください。
Karen - 1-800-466-3027
Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-466-3027 번으로 전화해 주십시오。
Kurdish - 1-800-466-3027
Laotian - 1-800-466-3027
Marathi - तीलभाषा (मराठी) सहाय्यासाठी 1-800-466-3027 क्रमांकावरकोणत्याहीखर्ााशिवायकॉलकरा。
Marshallese - Ñan bök jipañ ilo Kajin Majol, kallok 1-800-466-3027 ilo eijelok wönän.
Micronesian - Ohng palien sawas en sou kawewe ni omw lokaia Ponape koahl 1-800-466-3027 ni sohte isais.
Mon-Khmer - Khmer, Cambodian - 1-800-466-3027 ni sohte isais.
Navajo - T'áá shi shizaad k'ehjí bee shiká a'doowol nibínzino Diné k'ehjí koji' t'áá jílk'e hólné' 1-800-466-3027
Nepali - (नेपाली) भाषा सहायता पाउनका लागि 1-800-466-3027 मा फोन गन्तौरहोस्।
Nilotic-Dinka - Tën kucony ê thok ê Thuurjāŋ col 1-800-466-3027 kecin ayocê.
Norwegian - For språkassistanse på norsk, ring 1-800-466-3027 kostnadsfritt.
Panjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-800-466-3027 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch - Fer Helfe in Deitsch, ruf: 1-800-466-3027 aa. Es Aaruf koschtet nix.
Persian - برای راهنمایی به زبان فارسی با شماره 1-800-466-3027 به شناسایی هر پرسش تاسیس انگلیسی.
Polish - Aby uzyskać pomoc w języku polskim, zadzwon bezpłatnie pod numer 1-800-466-3027.
Para obtener asistencia lingüística en portugués llame para 1-800-466-3027 gratuitamente.

Pentru asistență lingvistică în română telefonați la numărul gratuit 1-800-466-3027.

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-800-466-3027.

Mo fesoasoani tau gagana I le Gagana Samoa vala’au le 1-800-466-3027 e aunoa ma se totopi.

Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-800-466-3027.

Para obtener asistencia lingúística en español, llame sin cargo al 1-800-466-3027.

Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-800-466-3027. Njodi woo fawaaki on.

Ukihitaji usaidiz katika lugha ya Kiswahili piga simu kwa 1-800-466-3027 bila malipo.

Para sa tulong sa wika na Tagalog, tawagan ang 1-800-466-3027 nang walang bayad.

Fún iànlọwọ nípa èdè (Yorùbá) pe 1-800-466-3027 lái san ówó kankan rará.