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/](https://www.aetnastudenthealth.com/) or by calling 1-866-381-1529. 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 1-866-381-1529 to request a copy.

### Important Questions

<table>
<thead>
<tr>
<th>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 $100. Out-of-Network: Individual $100.</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Prescription drugs, 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 $8,700. Out-of-Network: Individual $17,400.</td>
<td>The out–of–pocket limit is the most you could pay in a year for covered services.</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 1-866-381-1529 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>
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<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay In-Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
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<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>15% coinsurance</td>
<td>35% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care /screening /immunization</td>
<td>No charge</td>
<td>0% 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>15% coinsurance</td>
<td>35% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>15% coinsurance</td>
<td>35% 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, deductible doesn't apply: $15 for 30 day supply (retail), $45 for 31-90 day supply (retail &amp; mail order)</td>
<td>Copay/prescription, deductible doesn't apply: $15 for 30 day supply (retail), $45 for 31-90 day supply (retail &amp; mail order)</td>
<td>Covers 30 day supply (retail), 31-90 day supply (retail &amp; participating mail order). 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>Copay/prescription, deductible doesn't apply: $30 for 30 day supply (retail), $90 for 31-90 day supply (retail &amp; mail order)</td>
<td>Copay/prescription, deductible doesn't apply: $30 for 30 day supply (retail), $90 for 31-90 day supply (retail &amp; mail order)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>20% coinsurance, deductible doesn't apply</td>
<td>20% coinsurance, deductible doesn't apply</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>Applicable cost as noted above for generic or brand drugs</td>
<td>Applicable cost as noted above for generic or brand drugs</td>
<td></td>
</tr>
</tbody>
</table>

More information about prescription drug coverage is available at www.aetna.com/pharmacy-insurance/individuals-families

First prescription fill at a retail pharmacy or specialty pharmacy. Subsequent fills must be through the Aetna Specialty Pharmacy Network.
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<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>15% coinsurance</td>
<td>15% coinsurance</td>
<td>Out-of-network emergency use paid the same as in-network. No coverage for non-emergency use.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>15% coinsurance</td>
<td>15% coinsurance</td>
<td>Out-of-network emergency use paid the same as in-network. No coverage for non-emergency use.</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>15% coinsurance</td>
<td>15% 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>15% coinsurance</td>
<td>35% coinsurance</td>
<td>Penalty of $500 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>15% coinsurance</td>
<td>35% 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 &amp; other outpatient services: 15% coinsurance</td>
<td>Office &amp; other outpatient services: 35% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
<td>Penalty of $500 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</td>
<td>30% 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></td>
<td>Childbirth/delivery professional services</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>15% coinsurance</td>
<td>15% coinsurance</td>
<td>40 visits per Plan Year</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>15% coinsurance</td>
<td>15% coinsurance</td>
<td>Includes Physical, Occupational &amp; Speech Therapy.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>15% coinsurance</td>
<td>15% coinsurance</td>
<td>Penalty of $500 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
<td>Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>15% coinsurance</td>
<td>35% coinsurance</td>
<td>Penalty of $500 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
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<td>----------------------</td>
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<td>-------------------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>No charge</td>
<td>20% coinsurance, deductible doesn't apply</td>
<td>1 routine eye exam/plan year up to age 19.</td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>No charge</td>
<td>20% coinsurance, deductible doesn't apply</td>
<td>1 pair of glasses or lenses/plan year.</td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</td>
<td>No charge</td>
<td>0% coinsurance, deductible doesn't apply</td>
<td>None</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
- 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.**)

- Acupuncture – 10 visits/plan year.
- Bariatric surgery
- Chiropractic care
- Hearing aids – 1 hearing aid/3 years.
- Infertility treatment – Limited to the diagnosis & treatment of underlying medical condition.
- 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:
Department of Financial Services, Consumer Assistance Unit, 800-342-3736, https://www.dfs.ny.gov/consumers/health_insurance/home
- For more information on your rights to continue coverage, contact the plan at 1-866-381-1529.

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 1-866-381-1529.
- Department of Financial Services, Consumer Assistance Unit, 800-342-3736, https://www.dfs.ny.gov/consumers/health_insurance/home
- Additionally, a consumer assistance program can help you file your appeal. Contact Community Health Advocates, Community Service Society of New York, 633 Third Avenue 10th Floor, New York, NY 10017, 1-888-614-5400, http://www.communityhealthadvocates.org/.

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 plan’s overall deductible $0
- Specialist coinsurance 15%
- Hospital (facility) coinsurance 15%
- Other coinsurance 15%

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:
Cost Sharing
Deductibles $100
Copayments $10
Coinsurance $1,700
What isn't covered
Limits or exclusions $60
The total Peg would pay is $1,870

Managing Joe’s Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan’s overall deductible $0
- Specialist coinsurance 15%
- Hospital (facility) coinsurance 15%
- Other coinsurance 15%

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:
Cost Sharing
Deductibles $100
Copayments $900
Coinsurance $200
What isn't covered
Limits or exclusions $20
The total Joe would pay is $1,220

Mia’s Simple Fracture
(in-network emergency room visit and follow up care)

- The plan’s overall deductible $0
- Specialist coinsurance 15%
- Hospital (facility) coinsurance 15%
- Other coinsurance 15%

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:
Cost Sharing
Deductibles $100
Copayments $10
Coinsurance $400
What isn't covered
Limits or exclusions $0
The total Mia would pay is $510

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 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).

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TTY: 711

Language Assistance:
To access language services at no cost to you, call 1-866-480-4161.

Albanian - Për shërbime përkthimi falas për ju, telefononi 1-866-480-4161.

Amharic - ረለም ከላይም ምስታትንፋም መልኔን በታትንፋም ከ ከላ ያለ ረለም ከላይም 1-866-480-4161 ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መልኔን ያለ ረለም ከላይም መል mı ከላይም መል mı ከላ Hay 1-866-480-4161.

Arabic - للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء التصالح على الرقم 1-866-480-4161.

Armenian - Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-866-480-4161 հեռախոսահամարով:

Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-866-480-4161 tanpa dikenakan biaya.

Bantu-Kirundi - Kugirauronke serivisi z'indimi atakiguzi, hamagara 1-866-480-4161.


Bisayan-Visayan - Ngadto maakses ang mga serbisyo sa pinulongang alang libre, tawagan sa 1-866-480-4161.

Burmese - ကြည့်စွာတစ်လျောက်ကြည့်စွာတစ်လျောက် အသုံးပြုနိုင်ပါသည်။ 1-866-480-4161 မိုက်ခှန်းသလိုက်ပါက။

Catalan - Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-866-480-4161.

Chamorro - Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-866-480-4161.

Cherokee - ᏩᎩᏍᏗ ᏚᏬᏂᎯᏍᏗ ᎤᏳᎾᏓᏛᏁᏗ ᝥ ᎡᎫᏍdff ᏱᎩ 1-866-480-4161.

Chinese - 如欲使用免費語言服務，請致電 1-866-480-4161.

Choctaw - Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-866-480-4161.

Cushite - Tajaajiloota afaanii garuu bilisaa ati argaachuuf, bilbili 1-866-480-4161.

Dutch - Voor gratis toegang tot taaldiensten, bell 1-866-480-4161.

French - Afin d'accéder aux services langagiers sans frais, composez le 1-866-480-4161.

French Creole - Pou jwenn sèvis lang gratis, rele 1-866-480-4161.

German - Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-866-480-4161 an.

Greek - Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-866-480-4161.

Gujarati - તમારે કોઇ ખચેન ભાષાના સેલ્ફાઇફિંગ પોલીસ માટે, કોલ કરો 1-866-480-4161.
No ka wala‘au ‘ana me ka lawelawe ‘ōlelo e kahea aku i kēia helu kelepona 1-866-480-4161. Kāki ʻole ʻia kēia kōkua nei.
Punjabi - 

Pentru a accesa gratuit serviciile de limbă, apelați 1-866-480-4161 .

Romanian - 

Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-866-480-4161 .

Russian - 

Mo le mauina o auanaga tau gagana e aunoa ma se totogi, vala’au le 1-866-480-4161 .

Samoan - 

Za besplatne prevodilačke usluge pozovite 1-866-480-4161 .

Serbo-Croatian - 

Para acceder a los servicios de idiomas sin costo, llame al 1-866-480-4161 .

Spanish - 

Heeba a nasta jangirde djey wolde wola chede bo apelou lamba 1-866-480-4161 .

Sudanic-Fulfude - 

Kupata huduma za lugha bila malipo kwako, piga 1-866-480-4161 .

Swahili - 

Samoa - 

Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-866-480-4161 .

Tagalog - 

Turkish - 

Ukrainian - 

Vietnamese - 

Yiddish - 

Yoruba - 

1-866-480-4161