The Summary of Benefits and Coverage
For the Endowed Health Plans

The enclosed Summary of Benefits and Coverage (SBC) is a standardized document that is required by the Patient Protection and Affordable Care Act (PPACA). All insurance plans are required to produce SBCs based on a uniform template and distribute to all covered participants.

The purpose of an SBC is to provide a summary of major plan provisions of your health plan coverage and to help you make appropriate coverage decisions. There are also cost sharing examples to assist in your understanding of plan benefits.

Q. What information is included in the SBC?
A. A description of the benefits and coverage under a plan, including cost-sharing requirements and any information regarding exceptions, reductions or limitations.

Q. Should I use the SBC to decide which of the endowed health plans is the best choice for me?
A. No. The SBC is a simple, federally mandated document intended to help consumer understanding at a high level. It does not describe the full scope of coverage under any plan and should not be considered a complete description of a plan’s benefits. For more information, you should refer to the Summary Plan Description that is available for each health plan on our website: https://hr.cornell.edu/

Q. Will my SBC explain how services are covered?
A. Your SBC may provide you with some information that will explain how certain services are covered, such as what your copayment is. However, for more complete information, you should refer to the Summary Plan Description that is available for each health plan on our website: https://hr.cornell.edu/

Q. The Coverage Examples for Having a Baby, Managing Type 2 Diabetes and Simple Fracture indicate a “Total Would Pay” amount. Is this the amount I would actually pay?
A. The Coverage Examples help you to see how deductibles, copayments and coinsurance can add up, and they may help you to see what expenses might be your responsibility if a service or treatment isn’t covered or payment is limited. They are based on a standard set of services that a patient might receive in a similar scenario, and are intended only to help you compare your overall coverage, and not as a cost estimator.

Q. Can I get a paper copy of the Summary of Benefits and Coverage if I need one?
A. Yes, if you need a paper copy, please contact Benefit Services at 607-255-3936 or via email at benefits@cornell.edu

October 2017

Diversity and Inclusion are a part of Cornell University’s heritage. We’re an employer and educator recognized for valuing AA/EEO, Protected Veterans, and Individuals with Disabilities.
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, www.HealthReformPlanSBC.com or by calling 1-888-982-3862. 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 1-888-982-3862 to request a copy.

### Important Questions

| What is the overall deductible? | Network: Individual $100 / Family $200. Out-of-Network: Individual $400 / Family $800. | 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. |
| Are there services covered before you meet your deductible? | Yes. Prescription drugs; plus in-network office visits & preventive care are covered before you meet your deductible. | 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 https://www.healthcare.gov/coverage/preventive-care-benefits/ |
| Are there other deductibles for specific services? | No. | You don’t have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan? | Network: Individual $2,000 / Family $4,000. Out-of-Network: Individual $3,500 / Family $7,000. | 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. |
| What is not included in the out-of-pocket limit? | Premiums, balance-billed charges, health care this plan doesn't cover & penalties for failure to obtain pre-authorization for covered. | Even though you pay these expenses, they don’t count toward the out–of–pocket limit. |
| Will you pay less if you use a network provider? | Yes. See www.aetna.com/docfind or call 1-888-982-3862 for a list of network providers. | 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. |
| Do you need a referral to see a specialist? | No. | You can see the specialist you choose without a referral. |
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>Limitations, Exceptions &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>Network Provider (You will pay the least): $20 copay/visit, deductible doesn't apply</td>
<td>Out-of-Network Provider (You will pay the most): 20% coinsurance</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>Network Provider (You will pay the least): $20 copay/visit, deductible doesn't apply</td>
<td>Out-of-Network Provider (You will pay the most): 20% coinsurance</td>
</tr>
<tr>
<td>Preventive care /screening /immunization</td>
<td>Network Provider (You will pay the least): No charge</td>
<td>Out-of-Network Provider (You will pay the most): 20% coinsurance</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td></td>
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<tr>
<td>Diagnostic test (x-ray, blood work)</td>
<td>Network Provider (You will pay the least): 10% coinsurance</td>
<td>Out-of-Network Provider (You will pay the most): 20% coinsurance</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>Network Provider (You will pay the least): 10% coinsurance</td>
<td>Out-of-Network Provider (You will pay the most): 20% coinsurance</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td></td>
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<tr>
<td>Generic drugs</td>
<td>Network Provider (You will pay the least): Copay/prescription, deductible doesn’t apply: $5 (retail), $10 (mail order)</td>
<td>Out-of-Network Provider (You will pay the most): Reimbursed 100% of contract rate less copay, deductible doesn’t apply</td>
</tr>
<tr>
<td>Preferred brand drugs</td>
<td>Network Provider (You will pay the least): Copay/prescription, deductible doesn’t apply: $30 (retail), $60 (mail order)</td>
<td>Out-of-Network Provider (You will pay the most): Reimbursed 100% of contract rate less copay, deductible doesn’t apply</td>
</tr>
<tr>
<td>Non-preferred brand drugs</td>
<td>Network Provider (You will pay the least): Copay/prescription, deductible doesn’t apply: $50 (retail), $90 (mail order)</td>
<td>Out-of-Network Provider (You will pay the most): Reimbursed 100% of contract rate less copay, deductible doesn’t apply</td>
</tr>
<tr>
<td>Specialty drugs</td>
<td>Network Provider (You will pay the least): Applicable cost as noted above for generic or brand drugs</td>
<td>Out-of-Network Provider (You will pay the most): Applicable cost as noted above for generic or brand drugs</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>Network Provider (You will pay the least): 10% coinsurance</td>
<td>Out-of-Network Provider (You will pay the most): 20% coinsurance</td>
</tr>
<tr>
<td>Physician/surgeon fees</td>
<td>Network Provider (You will pay the least): 10% coinsurance</td>
<td>Out-of-Network Provider (You will pay the most): 20% coinsurance</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
</tr>
<tr>
<td>-----------------------------------------------------------</td>
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</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>10% coinsurance</td>
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<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>10% coinsurance</td>
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<td></td>
<td>Urgent care</td>
<td>10% coinsurance</td>
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<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>10% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office: $20 copay/visit, deductible doesn't apply; other outpatient services: no charge</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>10% coinsurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal care</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>10% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>10% 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>
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<tr>
<td></td>
<td>Rehabilitation services</td>
<td>10% coinsurance</td>
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<tr>
<td></td>
<td>Habilitation services</td>
<td>10% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>10% coinsurance</td>
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<tr>
<td></td>
<td>Durable medical equipment</td>
<td>10% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>0% coinsurance</td>
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</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.)**

|-------------|------------------|-----------------------------|----------------|----------------|------------------|---------------------------------------------------------------|

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

<table>
<thead>
<tr>
<th>Bariatric surgery</th>
<th>Chiropractic care</th>
<th>Hearing aids - 1 hearing aid to $1,500 maximum per ear, every 2 years for children age 12 and under &amp; per 4 years thereafter.</th>
<th>Infertility treatment - Limited to the diagnosis &amp; treatment of underlying medical condition. Artificial insemination, ovulation induction &amp; advanced reproductive technology: $20,000 maximum/lifetime.</th>
<th>Non-emergency care when traveling outside the U.S.</th>
<th>Private-duty nursing - 70-8 hour shifts/calendar year.</th>
<th>Routine eye care (Adult) - 1 routine eye exam/calendar year.</th>
</tr>
</thead>
</table>

### 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:

- For more information on your rights to continue coverage, contact the plan at 1-888-982-3862.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
• If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

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 1-888-982-3862.
• If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
• For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
• Additionally, a consumer assistance program can help you file your appeal. Contact information is at: http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html.

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 Standard? 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.

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#### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible:** $100
- **Specialist copayment:** $20
- **Hospital (facility) coinsurance:** 10%
- **Other coinsurance:** 10%

This EXAMPLE event includes services like:
- 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>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$100</td>
<td>$60</td>
<td>$1,200</td>
</tr>
</tbody>
</table>

**What isn't covered**

- Limits or exclusions (i.e. OTC medications): $60

**The total Peg would pay is:** $1,420

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

- **The plan's overall deductible:** $100
- **Specialist copayment:** $20
- **Hospital (facility) coinsurance:** 10%
- **Other coinsurance:** 10%

This EXAMPLE event includes services like:
- Primary care physician office visits (including disease education)
- Diagnostic tests (blood work)
- Prescription drugs
- Durable medical equipment (glucose meter)

**Total Example Cost:** $7,400

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$100</td>
<td>$900</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn't covered**

- Limits or exclusions (i.e. OTC medications): $20

**The total Joe would pay is:** $1,020

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

- **The plan's overall deductible:** $100
- **Specialist copayment:** $20
- **Hospital (facility) coinsurance:** 10%
- **Other coinsurance:** 10%

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

**Total Example Cost:** $1,900

In this example, Mia would pay:

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

**What isn't covered**

- Limits or exclusions (i.e. OTC medications): $0

**The total Mia would pay is:** $240

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Note: If your plan has a wellness program and you choose to participate, you may be able to reduce your costs.

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 1-888-982-3862.

**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: 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](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

**Language Assistance:**

For language assistance in your language call 1-888-982-3862 at no cost.

- **Albanian** - Për asistencë në gjëhën shqipe telefononi falas në 1-888-982-3862.
- **Amharic** - እንወ ከም ዓ ከምር ከ 1-888-982-3862 ከለ የደረሰው.
- **Arabic** - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-888-982-3862.
- **Armenian** - Տեղեկատվություն կանգնելու համար կիսանորսական համար 1-888-982-3862 համար զրկեք.
- **Bahasa Indonesia** - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-982-3862 tanpa dikenakan biaya.
- **Bantu-Kirundi** - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-888-982-3862 ku busa.
- **Bengali-Bangala** - বাংলাদেশের ভাষায় সহায়তার জন্য বিনামূল্যে 1-888-982-3862-তে কল করুন।
- **Bisayan-Visayan** - Alang sa pag-abag sa pinulongan sa (Binisayaay Sinugboanon) tawag sa 1-888-982-3862 nga walay bayad.
- **Burmese** - များစွာ သိမ်းဆည်းမည်ဖြစ်သည်။ 1-888-982-3862 ဖြင့် ဆက်စပ်ပါ။
- **Catalan** - Per rebre assistència en (català), truqui al número gratuit 1-888-982-3862.
- **Chamorro** - Para ayuda gi fino' (Chamoru), āgang 1-888-982-3862 sin āgustu.
- **Cherokee** - ᎠᎦᏬᏂᎨ ᎠᏭᎫᏯ I.T (GWW) ᎡᎣᏫᏫ 1-888-982-3862 OR ᎣᏫ ᎠᏭᎫᏯ JEGP.I hPRO.
- **Chinese** - 欲取得繁體中文語言協助，請撥打 1-888-982-3862，無需付費。
- **Choctaw** - (Chahta) anumpa ya apela a chi l paya hinla 1-888-982-3862.
- **Cushite** - Gargaarsa afaan Oromiffa hiikuu argachuuff lakkokkofsa bilbilaa 1-888-982-3862 irratti bilisaa bilbilaa.
- **Dutch** - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-888-982-3862.
- **French** - Pour une assistance linguistique en français appeler le 1-888-982-3862 sans frais.
- **French Creole** - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-888-982-3862 gratis.
- **German** - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-888-982-3862 an.
- **Greek** - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-888-982-3862 χωρίς χρέωση.
- **Gujarati** - ગુજરાતીમાં લાગણી સહાય માટે કોઈ પણ વર્ષ વગર 1-888-982-3862 પર કોલ કરો.

Hindi - हिन्दी में भाषा सहायता के लिए, 1-888-982-3862 पर मुफ्त कॉल करें।

Hmong - Maka enyemaka aṣusṣu na Igbo kpọọ 1-888-982-3862 na akwughị ọgwọ ọbụla

Ibo - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-888-982-3862 nga awan ti bayadanyo.

Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-888-982-3862 nga awan ti bayadanyo.

Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-888-982-3862.

Japanese - 日本語で援助をご希望の方は、1-888-982-3862まで無料でお電話ください。

Karen - 1-888-982-3862

Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862번으로 전화해 주십시오.

Kru-Bassa - Bɛ́m ké gbo-kpá-kpá dyé pídyi dë Basso-wuďuń wëe, qa 1-888-982-3862

Kurdish - برای راهنمایی به زبان فارسی با شماره 1-888-982-3862 بدون هیچ هزینه ای تماس بگیرید. انگلیسی

Laotian - Ñan bôk jipañ ilo Kajin Majol, kallok 1-888-982-3862 ilo ejjelok wönän.

Marathi - तीलभाषा (मराठी) सहाय्यासाठी 1-888-982-3862 क्रमांकावरकोणत्याहीखर्दीशिवायकॉलकरा.

Marshallese - Ñan bôk jipañ ilo Kajin Majol, kallok 1-888-982-3862 ilo ejjelok wönän.

Micronesian-Pohnpeyan - Ohng palien sawas en soukawewe ni omw lokaia Ponape koahl 1-888-982-3862 ni sohte isais.

Mon-Khmer, Cambodian - 1-888-982-3862 ni sohte isais.

Navajo - T’áá shi shaa’d k’ehjí bee shiká a’doowol nínízingo Diné k’ehjí kojí’ t’áá jií’k’e hólne’ 1-888-982-3862

Nepali - (लेपाली) मा नि:शुल्क भाषा सहायता पाउनका लागि 1-888-982-3862 मा फोन गर्नुहोस्।

Nilotic-Dinka - Tën kuowny ê thok ê Thuŋjāŋ col 1-888-982-3862 kecin ayôc.

Norwegian - For språkassistanse på norsk, ring 1-888-982-3862 kostnadsfritt.

Panjabi - ਪੰਜਾਬੀ ਵਿਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-888-982-3862 'ਉ ਬੁੱਡੂਰ ਵਰਚ ਵਲੇ।


Persian - برای راهنمایی به زبان فارسی با شماره 1-888-982-3862 بدون هیچ هزینه ای تماس بگیرید. انگلیسی

Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-888-982-3862.