## Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

**ST. JOHN'S UNIVERSITY: Aetna Choice® POS II - CORE Plan**

**Coverage Period:** 01/01/2024-12/31/2024

**Coverage for:** Individual + Family | **Plan Type:** POS

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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.

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### Important Questions | Answers | Why This Matters:
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What is the overall deductible? | In-Network: Individual $500 / Family $1,000. Out-of-Network: Individual $1,000 / Family $2,000. | 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. Emergency care; 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? | In-Network: Individual $1,500 / Family $3,000. Out-of-Network: Individual $3,000 / Family $6,000. | 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-billing charges, health care this plan doesn’t cover & penalties for failure to obtain pre-authorization for services. | 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 in-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>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td><strong>In-Network Provider</strong> (You will pay the least)</td>
<td><strong>Out-of-Network Provider</strong> (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$30 <em>copay</em> /visit, deductible doesn't apply</td>
<td>30% <em>coinsurance</em></td>
</tr>
<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>$40 <em>copay</em> /visit, deductible doesn't apply</td>
<td>30% <em>coinsurance</em></td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>No charge</td>
<td>30% <em>coinsurance</em></td>
</tr>
<tr>
<td></td>
<td>Preventive care /screening /immunization</td>
<td>No charge</td>
<td>30% <em>coinsurance</em></td>
</tr>
<tr>
<td>If you have a test</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge</td>
<td>30% <em>coinsurance</em></td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>No charge</td>
<td>30% <em>coinsurance</em></td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>Retail: $10 <em>copay</em></td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>Retail: $25 <em>copay</em></td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>Retail: $50 <em>copay</em></td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>$10/$25/$50</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>10% <em>coinsurance</em></td>
<td>30% <em>coinsurance</em></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% <em>coinsurance</em></td>
<td>30% <em>coinsurance</em></td>
</tr>
<tr>
<td>Common Medical Event</td>
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<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
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<tr>
<td>----------------------</td>
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</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency room care</td>
<td></td>
<td>$100 copay/visit, deductible doesn't apply</td>
<td>Out-of-network emergency use paid the same as in-network. No coverage for non-emergency use.</td>
</tr>
<tr>
<td>Emergency medical transportation</td>
<td>No charge</td>
<td>No charge</td>
<td>Out-of-network emergency use paid the same as in-network. Non-emergency transport: not covered, except if pre-authorized.</td>
</tr>
<tr>
<td>Urgent care</td>
<td>$50 copay/visit, deductible doesn't apply</td>
<td>30% coinsurance</td>
<td>No coverage for non-urgent use.</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room) 10% coinsurance 30% coinsurance</td>
<td>Penalty of $500 for failure to obtain pre-authorization for out-of-network care. None</td>
<td></td>
</tr>
<tr>
<td>Physician/surgeon fees</td>
<td>10% coinsurance 30% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td>Outpatient services</td>
<td>Office: $40 copay/visit, deductible doesn't apply; other outpatient services: no charge</td>
<td>None</td>
</tr>
<tr>
<td>Inpatient services</td>
<td>10% coinsurance 30% coinsurance</td>
<td>Penalty of $500 for failure to obtain pre-authorization for out-of-network care.</td>
<td></td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Office visits</td>
<td>No charge 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>Childbirth/delivery professional services</td>
<td>10% coinsurance 30% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childbirth/delivery facility services</td>
<td>10% coinsurance 30% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td>Home health care</td>
<td>$40 copay/visit, deductible doesn't apply 30% coinsurance</td>
<td>60 visits/calendar year. Penalty of $500 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>$40 copay/visit, deductible doesn't apply 30% coinsurance</td>
<td>90 visits/calendar year for Physical, Occupational &amp; Speech Therapy combined.</td>
<td></td>
</tr>
<tr>
<td>Habilitation services</td>
<td>No charge 30% coinsurance</td>
<td>None</td>
<td></td>
</tr>
<tr>
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<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>Skilled nursing care</td>
<td></td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td></td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>Hospice services</td>
<td></td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
</tbody>
</table>

If your child needs dental or eye care

<table>
<thead>
<tr>
<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>Children's eye exam</td>
<td>No charge</td>
<td>1 routine eye exam/12 months. Covered under the Aetna Vision Plan that's bundled with medical.</td>
</tr>
<tr>
<td>Children's glasses</td>
<td>Not covered</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Children's dental check-up</td>
<td>Not covered</td>
<td>Not covered.</td>
</tr>
</tbody>
</table>

Excluded Services & Other Covered Services:

### Services Your Plan Generally Does NOT Cover

- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)¹
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Prescription Drugs
- Private-duty nursing
- Routine foot care
- Weight loss programs - Except for required preventive services.

### Other Covered Services

- Acupuncture - 40 visits/calendar year for disease, injury & chronic pain.
- Bariatric surgery
- Chiropractic care
- Hearing aids - 2 hearing aids per ear/3 years.
- Infertility treatment - For more information & exceptions, see policy document provided by your employer or call the number on your ID card.
- Routine eye care (Adult) - 1 routine eye exam/12 months.

¹ Eye Classes are covered under the Aetna Vision plan that's bundled with the St. John’s University medical plan.
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 http://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 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:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general number at 1-888-982-3862. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://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.

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.

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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: $500
- Specialist copayment: $40
- Hospital (facility) coinsurance: 10%
- Other coinsurance: 10%

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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,000</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $70

**The total Peg would pay is**: $1,570

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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: $500
- Specialist copayment: $40
- 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
- Diabetic supplies (glucose meter)

**Total Example Cost**: $5,600

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

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$300</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $4,300

**The total Joe would pay is**: $4,600

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

- The plan’s overall deductible: $500
- Specialist copayment: $40
- 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**: $2,800

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

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$300</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $10

**The total Mia would pay is**: $310

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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: 1-888-982-3862.

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 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).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies, including Aetna Life Insurance Company and its affiliates (Aetna).
TTY: 711

Language Assistance:
To access language services at no cost to you, call 1-888-982-3862.

Albanian - Për shërbime përkthimi falas për ju, telefononi 1-888-982-3862.

Amharic - የእኔግ ከፋኔጋ ስ냅ነጋም ምለፍጥ መስጡና Herrera ታ ከ 1-888-982-3862 ፋቷ ታ ከ

Arabic - للحصول على الخدمات اللغوية دون أي تكلفة، الراجع التصال على الرقم 1-888-982-3862.

Armenian - Մաշկից ենթարկվող ծառայությունները զանգահարեք համար 1-888-982-3862. հեռախոսահամարով:

Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-982-3862 tanpa dikenakan biaya.

Bantu-Kirundi - Kugira uronke serivisi z’indimi atakiguzi, hamagara 1-888-982-3862.

Bengali-Bangala - আপনাকে বিনা মূল্যে তালিকা পাপকে হকহ এই নম্বরি সেবাকে তার জন্য: 1-888-982-3861

Bisayan-Visayan - Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-888-982-3862.

Burmese - သင့်အဖြင့် အေချိအေမပးရပါသည်။ မိမိနေသည် ကိုယ်စားလှယ်အား ကြားလာခြင်းဖြစ် 1-888-982-3862 သို့ ဖော်ပြချင်ပါ။

Catalan - Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-888-982-3862.

Chamorro - Para un hago' i setbision lengguåhi ni dibåtde para hågu, ágang 1-888-982-3862.

Cherokee - ᏩᎩᏍᏗ ᏚᏬᏂᎯᏍᏗ ᎤᏳᎾᏓᏛᏗenthal 1-888-982-3862, ᏫᏩᎳᏗenthal 1-888-982-3862.

Chinese - 如欲使用免費語言服務，請致電 1-888-982-3862.

Choctaw - Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-888-982-3862.

Cushite - Tajaajilloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-888-982-3862.

Dutch - Voor gratis toegang tot taaldiensten, bell 1-888-982-3862.

French - Afin d'accéder aux services langagiers sans frais, composez le 1-888-982-3862.

French Creole - Pou jwenn sèvis lang gratis, rele 1-888-982-3862.

German - Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-888-982-3862 an.

Greek - Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-888-982-3862.

Gujarati - તમારે વધુ જાણો આપ્યું વિભાગી સેવાઓની પહોંચ, કોટા 1-888-982-3862.

Hindi - आपके लिए बिना ककसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, 1-888-982-3862 पर कॉल करें।

Hmong - Xav tau kev pab txhais lus tsi muaj nqi them rau koj, hu 1-888-982-3862.

Igbo - Iji nwetaòhèrè na ọrụ gasị asụsụ n'efu, kpọọ 1-888-982-3862

Ilocano - Tapno maaksesyo dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti 1-888-982-3862.

Indonesian - Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi 1-888-982-3862.

Italian - Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-888-982-3862.

Japanese - 言語サービスを無料でご利用いただくには、1-888-982-3862 までお電話ください。

Karen - မိုးရှင်းအကြောင်းများသောကြိယာအဖွဲ့ ဦးပေးခြင်း 1-888-982-3862 အတွက် လိုအပ်သည်။

Korean - 무료 언어 서비스를 이용하려면 1-888-982-3862 번으로 전화해 주십시오.

Kru-Bassa - M̀dyi wuɖu-dù kà kò ɖò ɓě dyi mɔ̀u nì Pidyi nì, nìi, qà nɔ̀ɓà ni kɛ: 1-888-982-3862

Kurdish - یۆ دەسپێڕاگەیشتن بە خزمەتگوزاری زمان بەبە چیتوون بەتو، پەڕەوە بەکە بە زەمارەیە 1-888-982-3862

Laotian - ທ່ອງເຫັດເຫັດວິທະນະພາບທີ່ເປັນຂໍ້ມູນຕໍ່ມື້ວ່າ, ໂທຣາທະຍານ 1-888-982-3862

Marathi - कोणत्याही शल्काशवाय भाषा सेवा प्राप्त करण्यासाठी, 1-888-982-3862 वर फोन करा.

Marshallese - Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlok 1-888-982-3862.

Micronesian - Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1-888-982-3862.

Mon-Khmer, Cambodian - អប់រំប៉ុន្មានសេចក្តីប្រការជាអ្នកអត្ថបទ 1-888-982-3862។

Navajo - T’áá ni nizaad k’ehji bee niká a’dowowł doo bağıh ilínígökoj’ hólne’ 1-888-982-3862.

Nepali - निश्चित भाषा सेवा प्राप्त गरन् 1-888-982-3862 मा टेलिफोन गर्नुहोस्।

Nilotic-Dinka - Tè koor yín weéř de thökic ke cân wěu kor keek tēnçø yín. Ke cöl koc ye koc kuony ne nomba 1-888-982-3862.

Norwegian - For tilgang til kostnadsfri språktjenester, ring 1-888-982-3862.

Pennsylvania Dutch - Um Schprooch Services zu griege mitaus Koscht, ruff 1-888-982-3862.

Persian - برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-888-982-3862 تماس بگیرید.

Polish - Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonić 1-888-982-3862.

Portuguese - Para acessar os serviços de idiomas sem custo para você, ligue para 1-888-982-3862.