



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, go to www.wellfleetstudent.com or call toll free 1-877-657-5030. 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 www.healthcare.gov/sbc-glossary or call 1-800-318-2596 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In- Network Provider : \$250/individual Out-of- Network Provider : \$500/individual	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes. In- Network Preventive care , In- Network and Zero Cost Generic Prescription Drugs , In- Network Laboratory Procedures, Student Health Center/Infirmary Expense, Home Health Care, Medical Evacuation, Repatriation, and Barrow Marrow Testing expenses 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?	Combined In- Network Provider and Out-of- Network Provider : \$6,350/individual; \$12,700/family	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, and health care this plan doesn't cover.	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 Cigna Open Access Plus (OAP) www.cigna.com or call 1-877-657-5030 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.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$40 copayment /visit	50% coinsurance	Limit one visit per day.
	Specialist visit	\$40 copayment /visit Chiropractic Care: \$40 copayment /visit	50% coinsurance Chiropractic Care: 50% coinsurance	When requested and approved by the attending Physician. Limited to 1 visit per day. Chiropractic Care: Pre-Certification required after 5 th In-Network visit, and Pre-Certification required after the 12 th Out-of-Network visit.
	Preventive care/screening/immunization	No Charge	50% coinsurance	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.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance Deductible does not apply to Outpatient Lab Procedures	50% coinsurance	Pre-Certification required but not for Laboratory Procedures. When prescribed by an attending physician.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Pre-Certification required. When prescribed by an attending physician.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.wellfleetstudent.com	Tier 1 (Generic drugs)	30 day supply: \$5 copay /prescription, % coinsurance Deductible does not apply More than a 30 day supply but less than a 61 day supply: \$10 copay /prescription, % coinsurance Deductible does not apply More than a 60 day supply: \$15 copay /prescription, % coinsurance Deductible does not apply	30 day supply: 50% coinsurance More than a 30 day supply but less than a 61 day supply: 50% coinsurance More than a 60 day supply: 50% coinsurance	Out-of-Network Provider benefits are provided on a reimbursement basis. Claim forms must be received within 90 days. No cost sharing applies to ACA Preventive Care medications filled at a participating network pharmacy and Zero Cost Generics.

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.wellfleetstudent.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Tier 2 (Preferred brand drugs)	30 day supply: \$40 copay /prescription, % coinsurance <u>Deductible</u> does not apply More than a 30 day supply but less than a 61 day supply: \$80 copay /prescription, % coinsurance <u>Deductible</u> does not apply More than a 60 day supply: \$120 copay /prescription, % coinsurance <u>Deductible</u> does not apply	30 day supply: 50% coinsurance More than a 30 day supply but less than a 61 day supply: 50% coinsurance More than a 60 day supply: 50% coinsurance	<u>Out-of-Network Provider</u> benefits are provided on a reimbursement basis. Claim forms must be received within 90 days. No <u>cost sharing</u> applies to ACA <u>Preventive Care</u> medications filled at a participating <u>network</u> pharmacy and Zero Cost Generics.
	Tier 3 (Non-preferred brand drugs)	30 day supply: \$40 copay /prescription, % coinsurance <u>Deductible</u> does not apply More than a 30 day supply but less than a 61 day supply: \$80 copay /prescription, % coinsurance <u>Deductible</u> does not apply More than a 60 day supply: \$120 copay /prescription, % coinsurance <u>Deductible</u> does not apply	30 day supply: 50% coinsurance More than a 30 day supply but less than a 61 day supply: 50% coinsurance More than a 60 day supply: 50% coinsurance	

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.wellfleetstudent.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Specialty drugs	30 day supply: \$40 copay /prescription, % coinsurance <u>Deductible</u> does not apply More than a 30 day supply but less than a 61 day supply: \$80 copay /prescription, % coinsurance <u>Deductible</u> does not apply More than a 60 day supply: \$120 copay /prescription, % coinsurance <u>Deductible</u> does not apply	30 day supply: 50% coinsurance More than a 30 day supply but less than a 61 day supply: 50% coinsurance More than a 60 day supply: 50% coinsurance	<u>Out-of-Network Provider</u> benefits are provided on a reimbursement basis. Claim forms must be received within 90 days. No <u>cost sharing</u> applies to ACA <u>Preventive Care</u> medications filled at a participating <u>network</u> pharmacy and Zero Cost Generics.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	—————none—————
	Physician/surgeon fees	20% coinsurance	50% coinsurance	Physicians: limited to one visit per day. <u>Pre-Certification</u> Required.
If you need immediate medical attention	Emergency room care	\$175 copay /visit 0% coinsurance	\$175 copay /visit 0% coinsurance	Emergency treatment received at a hospital's emergency room or at an <u>Urgent Care</u> Facility. <u>Copay</u> waived if admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Including ground and/or air, water transportation.
	Urgent care	20% coinsurance	50% coinsurance	Treatment for non-life-threatening conditions.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Subject to Semi-Private room rate unless intensive care unit is required. <u>Pre-Certification</u> required.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	<u>Pre-Certification</u> required. Physicians: limited to one visit per day.

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.wellfleetstudent.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Outpatient Services, other than office visits: 20% <u>coinsurance</u> <u>Deductible</u> does not apply Office visits: \$40 <u>copay/</u>	Outpatient Services, other than office visits: 20% <u>coinsurance</u> Office visits: 20% <u>coinsurance</u>	Outpatient Services, other than office visits, include but are not limited to the following: Intensive Outpatient Programs; Partial Hospitalization, Electronic Convulsive Therapy, Repetitive Transcranial Magnetic Stimulation (rTMS); Psychiatric and Neuro Psychiatric testing; and Gender Dysphoria surgery. Office Visits include but are not limited to: physician visits, individual and group therapy, hormone therapy, medication management. <u>Pre-Certification</u> required except for office visits.
	Inpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Pre-certification</u> required.
If you are pregnant	Office visits	\$40 <u>copayment</u> /visit	50% <u>coinsurance</u>	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Up to 48 hours for normal vaginal delivery and 96 hours (not including the day of surgery) for a caesarean section delivery unless the caesarean section delivery is the result of <u>Complications of Pregnancy</u> . <u>Pre-Certification</u> required for all inpatient maternity care after the initial 48/96 hours.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u> <u>Deductible</u> does not apply	50% <u>coinsurance</u> <u>Deductible</u> does not apply	<u>Pre-Certification</u> required.
	<u>Rehabilitation services</u>	Inpatient: 20% <u>coinsurance</u> Outpatient: \$30 <u>copay</u> /visit	Inpatient: 50% <u>coinsurance</u> Outpatient: 50% <u>coinsurance</u>	Includes Inpatient Rehabilitation Facility: <u>Pre-Certification</u> is required. 90 maximum facility days/ Policy Year. Outpatient Includes Physical, Occupational, and Speech therapies. Limit of one visit per day. <u>Pre-Certification</u> required for Speech Therapy. <u>Pre-Certification</u> required after the 5 th <u>In-Network</u> visit for Physical Therapy and/or Occupational Therapy. <u>Pre-Certification</u> required after the 12 th <u>Out-of-Network</u> visit for Physical Therapy and after the 12 th <u>Out-of-Network</u> visit for Occupational Therapy.
		20% <u>coinsurance</u>	50% <u>coinsurance</u>	Other Outpatient: Cardiac and Pulmonary Rehabilitation. Limited to one visit/day.

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.wellfleetstudent.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Habilitation services	\$30 <u>copay</u> /visit	50% <u>coinsurance</u>	Includes Physical, Occupational and Speech Therapies. When prescribed by the attending Physician, limited to one visit per day. Covered to the extent that they are <u>Medically Necessary</u> . Pre-Certification required for Speech Therapy. Pre-Certification required after the 5 th In-Network visit for Physical Therapy and/or Occupational Therapy. Pre-Certification required after the 12 th <u>Out-of-Network</u> visit for Physical Therapy and after the 12 th <u>Out-of-Network</u> visit for Occupational Therapy.
	Skilled nursing care	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Pre-Certification required. Covered to the extent of Medical Necessity. Limited to 90 days per Policy Year
	Durable medical equipment	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Pre-Certification is required for over \$500.
	Hospice services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	60 maximum Hospice Care days/Policy Year. 6 maximum Social Services visits/lifetime. 2 maximum Bereavement visits/lifetime.
If your child needs dental or eye care	Children's eye exam	0% <u>coinsurance</u>	0% <u>coinsurance</u>	To the end of the month when the Insured Person turns age 19. Limited to 1 visit per Policy Year.
	Children's glasses	0% <u>coinsurance</u>	0% <u>coinsurance</u>	To the end of the month when the Insured Person turns age 19. Limited to 1 pair of prescribed lenses and frames or contact lenses (in lieu of eyeglasses) per Policy Year.
	Children's dental check-up	0% <u>coinsurance</u>	0% <u>coinsurance</u>	Limited to 2 exams every 12 months to the end of the month in which the Insured Person turns age 19. For Preventive.

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.wellfleetstudent.com.

Excluded Services & Other Covered Services:

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

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Long-term care
- Routine foot care
- Weight loss programs

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

- Chiropractic care ([Pre-Certification](#) is required after 5th [In-Network](#) visit, and [Pre-Certification](#) required after the 12th [Out-of-Network](#) visit.)
- Dental care (Adult) (Accidental Injury, treatment for Insured Person's over age 18. Dental Sickness.)
- Hearing aids (for Insured Persons, limited to 1 pair of hearing aids every 24 months)
- Infertility treatment ([Pre-Certification](#) is required)
- Non-emergency care when traveling outside the U.S. (\$10,000 maximum per Policy Year)
- Private-duty nursing (While confined)
- Routine eye care (Adult) (age 19 and older for Routine Eye Exam once every 12 months)

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: <http://www.ct.gov/cid/site/default.asp>. 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: <http://www.ct.gov/cid/site/default.asp>.

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 the 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.

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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	\$250
■ Specialist copayment	\$40
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	0%

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$10
Coinsurance	\$2,500
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,820

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$250
■ Specialist copayment	\$40
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	0%

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$1,000
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,370

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$250
■ Specialist copayment	\$40
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	0%

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$300
Coinsurance	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$950

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

NOTICE OF NON-DISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

The Company complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Company does not exclude people or treat them worse because of their race, color, national origin, age, disability, or sex.

The Company provides free aids and services to people with disabilities to communicate effectively with us, such as:

1. Qualified sign language interpreters
2. Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose first language is not English when needed to communicate effectively with us, such as:

1. Interpreters
2. information translated into other languages

If you need these services, contact Betsy M. Stevens and John Kelley Civil Rights Coordinators.

If you believe that Wellfleet Insurance Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Betsy M. Stevens and John Kelley Civil Rights Coordinators,
PO Box 15369, Springfield, MA 01115-5369
(413)-733-4540; (413)-733-4612
Bstevens@wellfleetinsurance.com, or Jkelley@wellfleetinsurance.com.

You can file a grievance in person, by mail, fax, or email. If you need help filing a grievance Betsy M. Stevens and John Kelley of Civil Rights Coordinators are available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building
Washington, DC 20201
800-8681019; 800-537-7697 (TDD)
Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

The Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

LANGUAGE ASSISTANCE PROGRAM

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call (877) 657-5030.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al (877) 657-5030.

請注意：如果您說中文 (**Chinese**)，我們免費為您提供語言協助服務。請致電：(877) 657-5030。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi (877) 657-5030.

알림: 한국어(**Korean**)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다.
(877) 657-5030번으로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Mangyaring tumawag sa (877) 657-5030.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по номеру (877) 657-5030.

تعبيرنا تحدثت تنك اذا: ميبنت (**Arabic**)، بل اصتلاً عاجرلا. اكله تحاتم تينا جملا تيوغلا تدعاسملا تامدخ نإف (877) 657-5030.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nan (877) 657-5030.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le (877) 657-5030.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer (877) 657-5030.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para (877) 657-5030.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero (877) 657-5030.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie (877) 657-5030 an.

注意事項：日本語(**Japanese**)を話される場合、無料の言語支援サービスをご利用いただけます。(877) 657-5030にお電話ください。

ی سراف امشد نابز رگا: هجوتہ (Farsi) دشاد ی مامشدر ایتخا رد ناگیار روط مہ ی نابز دادما ت امدخ، ت سا.
تمس با بیگرید. (877) 657-5030

कृपा ध्या दा: याद आप हंदा (Hindi) भाषी ह तो आपके लए भाषा सहायता सेवाएं: शुल् उपलब् ह। कृपा पर काल कर। (877) 657-5030

CEEBOOM: Yog koj hais Lus Hmoob (Hmong), muaj kev pab txhais lus pub dawb rau koj. Thov hu rau (877) 657-5030.

ប្រយ័ត្ន: ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ (Khmer) សេវាកម្មភាសាជំនួយឥតគិតថ្លៃមានសម្រាប់អ្នក។ សូមទូរស័ព្ទមកលេខ (877) 657-5030 ។

PAKDAAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti (877) 657-5030.

DÍI BAA'ÁKONÍNÍZIN: Diné (Navajo) bizaad bee yánilti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shoodí kohjí' (877) 657-5030 hodíilnih.

OGOW: Haddii aad ku hadasho Soomaali (Somali), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac (877) 657-5030

ગુજરાતી (Gujarati) યુ ના: જો તમે જરાતી બોલતા હો, તો િન:લુ ભાષા સહાય સેવાઓ તમારા માટ ઉપલબ્ધ છે. ફોન કરો (877) 657-5030

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