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Aetna Student Health

Dental Plan Design and Benefits Summary

Preferred Provider Organization (PPO)

Emory University

Policy Year: 2018 - 2019

Policy Number: 686178

www.aetnastudenthealth.com

877-238-6200



This Aetna Dental® Preferred Provider Organization (PPO) insurance plan summary is provided by Aetna Life Insurance Company (Aetna) for some of the more frequently performed dental procedures. Under this plan, you may choose at the time of service either a PPO participating dentist or any nonparticipating dentist. With the PPO plan, savings are possible because the PPO participating dentists have agreed to provide care for covered services at the negotiated fee schedule.

Coverage Periods

Students:

Dental coverage is included in the medical insurance premium for students and their dependents. The dental plan becomes effective at or after 12:01 a.m. on the coverage dates indicated on the Medical Summary of Benefits, and will terminate at or before 11:59 p.m. on the coverage dates on the Medical Summary of Benefits.

Dependent coverage

Coverage will become effective on the same date the insured student's coverage is effective. Coverage for insured dependents terminates in accordance with the Termination Provisions described in the certificate of coverage.

Rates

The cost for the Aetna Dental PPO Insurance Plan is included in the Emory University Student Health Insurance Plan premium.

Who is eligible?

You are eligible if you are a:

- Enrolled in the Emory University Student Health Insurance Plan.

You must actively attend classes for at least the first 31 days after the date your coverage becomes effective. You cannot meet this eligibility requirement if you take courses through:

- Home study
- Correspondence
- The internet
- Television (TV).

If we find out that you do not meet this eligibility requirement, we are only required to refund any premium contribution minus any claims that we have paid.

Who provides the care?

Just as the starting point for coverage under your plan is whether the services and supplies are eligible dental services, the foundation for getting covered care is through our network.

This section tells you about in-network and out-of-network providers.

In-network providers

We have contracted with dental providers to provide eligible dental services to you. These dental providers make up the network for your plan.

You may select an in-network provider from the directory or by logging on to our website at www.aetnastudenthealth.com. You can search our online directory, DocFind®, for names and locations of dental providers.

You will not have to submit claims for treatment received from in-network providers. Your in-network provider will take care of that for you. And we will directly pay the in-network provider for what the plan owes.

Out-of-network providers

You also have access to out-of-network providers. This means you can receive eligible dental services from an out-of-network provider.

If you use an out-of-network provider to receive eligible dental services, you are responsible for submitting your own claims.

Description of Benefits

The Plan excludes coverage for certain services (referred to as exceptions and exclusions in the certificate of coverage) and has limitations on the amounts it will pay. While this Plan Design and Benefit Summary document will tell you about some of the important features of the Plan, other features may be important to you and some may further limit what the Plan will pay. To look at the full Plan description, which is contained in the Certificate of Coverage issued to you, go to www.aetnastudenthealth.com. If any discrepancy exists between this Benefit Summary and the Certificate of Coverage, the Certificate will control.

This Plan will pay benefits in accordance with any applicable **GA** Insurance Law(s).

Policy year maximum

	In-network coverage	Out-of-network coverage
Policy year maximum:		\$1,000
The policy year maximum applies to:		
<ul style="list-style-type: none">in-network and out-of-network eligible dental services combined		

Policy year Deductibles

You have to meet your policy year deductible before this plan pays for benefits.

	In-network coverage	Out-of-network coverage
Policy year deductible	Individual: \$50 Family: \$150	Individual: \$50 Family: \$150
The policy year deductible applies to all eligible dental services except Type A expenses.		

The coinsurance listed in the schedule of benefits below reflects the plan coinsurance percentage. This is the coinsurance amount that the plan pays. You are responsible for paying any remaining coinsurance.

About in-network and out-of-network providers:

Your benefits, cost-sharing, and maximums are the same for in-network and out-of-network providers. However, you might pay more when you use an out-of-network provider. Out-of-network providers do not have to accept the negotiated charge that the in-network providers have agreed to be paid. We pay out-of-network providers based on the recognized charge, and they may balance bill you for charges over our recognized charge.

Type A Expenses: Diagnostic and Preventative Services	In-network coverage	Out-of-network coverage
<p>Diagnostic & preventive care</p> <p>Visits and exams</p> <ul style="list-style-type: none"> • Office visit during regular office hours for oral examination, 2 visits per policy year) • Prophylaxis (cleaning) or scaling-moderate/severe inflammation–full mouth, (2 treatments per policy year) • Topical application of fluoride if you are under age 14 (1 applications per policy year) • Sealants, per tooth (1 application every 5 policy years for permanent bicuspid and molars only and if you are under age 14) <p>Images and pathology</p> <ul style="list-style-type: none"> • Bitewing images (1 set per policy year) • Entire dental series, including bitewings or panoramic film (1 set every 5 policy years) 	100% of the negotiated charge	100% of the recognized charge
Type B Expenses: Basic Restorative Care	In-network coverage	Out-of-network coverage
<p>Visits and exams</p> <ul style="list-style-type: none"> • Office visit after hours (we will pay either for the office visit charge or for the eligible dental services performed, whichever is more) • Emergency palliative treatment, per visit <p>Images and pathology</p> <ul style="list-style-type: none"> • Periapical images • Intra-oral, occlusal view • Extra-oral • Accession of tissue 	80% of the negotiated charge	80% of the recognized charge

Type B Expenses: Basic Restorative Care (continued)	In-network coverage	Out-of-network coverage
<p>Oral surgery</p> <ul style="list-style-type: none"> • Extractions – coronal remnants – deciduous tooth • Extractions erupted tooth or exposed root • Surgical removal of erupted tooth • Removal of impacted tooth – Soft tissue • Surgical removal of residual tooth roots • Coronectomy • Primary closure of a sinus perforation • Oroantral fistula closure • Tooth transplantation • Surgical access of unerupted tooth • Mobilization of erupted or malpositioned tooth to aid eruption • Placement of device to facilitate eruption of impacted tooth • Biopsy of oral tissue • Exfoliative cytological sample collection • Alveoloplasty • Removal of odontogenic cysts or tumors • Removal of exostosis • Removal of torus • Surgical reduction of osseous tuberosity • Incision and drainage of abscess • Removal of foreign body • Sequestrectomy • Suture of wounds • Frenectomy/frenuloplasty • Excision of hyperplastic tissue per arch • Excision of pericoronal gingiva • Surgical reduction of fibrous tuberosity • Sialolithotomy • Closure of salivary fistula • Treatment of complications (post-surgical) <p>Periodontics</p> <ul style="list-style-type: none"> • Occlusal adjustment, (other than with an appliance or by restoration) • Root planing and scaling, 1 to 3 teeth per quadrant, (1 per site every 2 policy years) • Root planing and scaling, 4 or more teeth per quadrant, (4 separate quadrants every 2 policy years) • Surgical revision procedure, per tooth 	80% of the negotiated charge	80% of the recognized charge

Type B Expenses: Basic Restorative Care (continued)	In-network coverage	Out-of-network coverage
<ul style="list-style-type: none"> • Gingivectomy/gingivoplasty, 1 to 3 teeth per quadrant, (1 per site every 2 policy years) • Gingivectomy/gingivoplasty, 4 or more teeth per quadrant, (1 per quadrant every 3 policy years) • Gingival flap procedure, 1 to 3 teeth per quadrant, (1 per site every 3 policy years) • Gingival flap procedure, 4 or more teeth per quadrant, (1 per quadrant every 3 policy years) • Apically positioned flap • Unscheduled dressing change (by someone other than treating dentist or their staff) <p>Endodontics</p> <ul style="list-style-type: none"> • Pulp cap • Pulpotomy • Apexification/recalcification • Apicoectomy • Root canal therapy and retreatment <ul style="list-style-type: none"> - Anterior - Bicuspid <p>Restorative Excluding inlays, onlays and crowns. Multiple restorations in 1 surface will be considered as a single restoration.</p> <ul style="list-style-type: none"> • Amalgam restorations • Resin-based composite restorations, (other than for molars) • Crowns • Recementation • Repairs - inlay, onlay, veneer, crown • Prefabricated crowns (excluding temporary crowns) • Pin retention, per tooth, in addition to restoration 	80% of the negotiated charge	80% of the recognized charge

Type C Expenses: Major Restorative Care	In-network coverage	Out-of-network coverage
<p>Restorative – Inlays, onlays, labial veneers and crowns (excludes temporary crowns) are covered only as treatment for decay or acute traumatic injury, and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge. Coverage is limited to 1 per tooth every 10 policy years. (See the <i>Replacement rule</i>.)</p> <ul style="list-style-type: none"> • Inlays • Onlays • Labial veneers • Post and core • Core build-up <p>Endodontics</p> <ul style="list-style-type: none"> • Root canal therapy and retreatment <ul style="list-style-type: none"> – Molar <p>Periodontics</p> <ul style="list-style-type: none"> • Osseous surgery, (including flap and closure), 1 to 3 teeth per quadrant (1 per site every 5 policy years) • Osseous surgery, (including flap and closure), 4 or more per teeth per quadrant (1 per quadrant every 5 policy years) • Soft tissue graft procedures <p>Prosthodontics</p> <p>The first installation of dentures and bridges is covered only if needed to replace teeth extracted while coverage was in force and which were not abutments to a denture or bridge less than 10 years old. (See the <i>Tooth missing but not replaced rule</i>.) Replacement of existing bridges or dentures is limited to 1 every 10 policy years. (See the <i>Replacement rule</i>.)</p> <ul style="list-style-type: none"> • Bridge abutments • Pontics • Implants 	50% of the negotiated charge	50% of the recognized charge

Type C Expenses: Major Restorative Care (continued)	In-network coverage	Out-of-network coverage
<ul style="list-style-type: none"> • Dentures and partials (fees for dentures and partial dentures include relines, rebases and adjustments within 6 months after installation. Fees for relines and rebases include adjustments within 6 months after installation. <ul style="list-style-type: none"> – Complete upper and lower denture – Partial upper and lower (including any conventional clasps, rests and teeth) – Removable unilateral partial denture • Stress breakers • Interim partial denture (stayplate), anterior only • Reline (partial or complete) • Rebase, per denture • Special tissue conditioning, per denture • Adjustment to denture more than 6 months after installation • Repairs, full and partial denture • Adding teeth and clasps to existing partial denture • Repairs, bridges • Occlusal guard for bruxism (1 every 5 policy years) • Adjustments, repair or reline of occlusal guard • Cleaning and inspection of a removable appliance <p>Oral surgery</p> <ul style="list-style-type: none"> • Removal of impacted tooth <ul style="list-style-type: none"> – Partially bony – Completely bony <p>General anesthesia and intravenous sedation</p> <ul style="list-style-type: none"> • General anesthesia and intravenous sedation are covered when provided as part of a covered surgical procedure • Evaluation by anesthesiologist for deep sedation or general anesthesia <p>Space maintainers Only when needed to preserve space resulting from premature loss of deciduous teeth (Includes all adjustments within 6 months after installation.)</p> <ul style="list-style-type: none"> • Fixed or removable (unilateral or bilateral) • Recementation or removal • Appliance therapy to control harmful habits 	50% of the negotiated charge	50% of the recognized charge

What your plan doesn't cover – eligible dental service exceptions and exclusions

We already told you about the many dental care services and supplies that are eligible for coverage under your plan in the *What are your eligible dental services* section. In that section we also told you that some dental care services and supplies have exceptions and some are not covered at all which are called “exclusions”.

In this section we tell you about the exceptions and exclusions that apply to your plan. And just a reminder, you'll find benefit and coverage limitations in the schedule of benefits.

General exceptions and exclusions

The following are not eligible dental services under your plan except as described in:

- The *Eligible dental services under your plan* section of this certificate of coverage or
- A rider or amendment issued to you for use with this certificate of coverage

Beyond legal authority

- Services and supplies provided by a health professional or other provider that is acting beyond the scope of its legal authority

Charges in excess of any benefit limits

- Any charges in excess of the benefit, dollar, visit, or frequency limits stated in the schedule of benefits

Cosmetic services and plastic surgery (except to the extent coverage is specifically provided in the *Eligible Dental Services* section of the schedule of benefits)

- Cosmetic services and supplies including:
 - Plastic surgery
 - Reconstructive surgery, unless medically necessary surgical or non-surgical treatment for the correction of temporomandibular joint dysfunction by a physician or dentist professionally qualified by training and experience, or for the correction of functional deformities of the maxilla and mandible
 - Cosmetic surgery
 - Personalization or characterization of dentures or other services and supplies which improve, alter or enhance appearance
 - Augmentation and vestibuloplasty and other services to protect, clean, whiten, bleach alter the appearance of teeth whether or not for psychological or emotional reasons

Court-ordered services and supplies

- Includes those court-ordered services and supplies, or those required as a condition of parole, probation, release or as a result of any legal proceeding.

Dental services and supplies

- Acupuncture, acupressure and acupuncture therapy
- Asynchronous dental treatment
- Crown, inlays and onlays, and veneers unless for one of the following:
 - It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material
 - The tooth is an abutment to a covered partial denture or fixed bridge
- Dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth and removal of implants
- Dental services and supplies made with high noble metals (gold or titanium) except as covered in the *Eligible Dental Services* section of the schedule of benefits
- Dentures, crowns, inlays, onlays, bridges, or other prosthetic appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or correcting attrition, abrasion, or erosion
- First installation of a denture or fixed bridge, and any inlay and crown that serves as an abutment to replace congenitally missing teeth or to replace teeth, all of which were lost while you were not covered
- General anesthesia and intravenous sedation, unless specifically covered and done in connection with another eligible dental service
- Instruction for diet, tobacco counseling and oral hygiene
- Mail order and at-home kits for orthodontic treatment
- Orthodontic treatment except as covered in the *Eligible Dental Services* section of the schedule of benefits
- Services and supplies provided in connection with treatment or care that is not covered under the plan
- Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures
- Replacement of teeth beyond the normal complement of 32
- Services and supplies provided where there is no evidence of pathology, dysfunction or disease, other than covered preventive services
- Space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth
- Surgical removal of impacted wisdom teeth when removed only for orthodontic reasons
- Temporomandibular joint dysfunction/disorder

Dental services and supplies that are covered in whole or in part:

- Under any other part of this plan
- Under any other plan of group benefits provided by the policyholder

Examinations

Any dental examinations needed:

- Because a third party requires the exam. Examples include examinations to get or keep a job, or examinations required under a labor agreement or other contract.
- Because a court order requires it.
- To buy insurance or to get or keep a license.
- To travel.
- To go to a school, camp, or sporting event, or to join in a sport or other recreational activity.

Experimental or investigational

- Experimental or investigational drugs, devices, treatments or procedures

Felony

- Services and supplies that you receive as a result of an injury due to your commission of a felony

Judgment or settlement

- Services and supplies for the treatment of an injury or illness to the extent that payment is made as a judgment or settlement by any person deemed responsible for the injury or illness (or their insurers)

Mandatory no-fault laws

- Treatment for an injury to the extent benefits are payable under any state no-fault automobile coverage or first party medical benefits payable under any other mandatory no-fault law

Motor vehicle accidents

- Services and supplies given by a provider for injuries sustained from a motor vehicle accident but only when benefits are payable under other valid and collectible insurance. This applies whether or not a claim is made for such benefits.

Non-medically necessary services

- Services, including but not limited to, those treatments, services, prescription drugs and supplies which are not medically necessary (as determined by Aetna) for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your physician or dentist.

Non-U.S .citizen

- Services and supplies received by a covered person (who is not a United States citizen) within the covered person's home country but only if the home country has a socialized medicine program

Other primary payer

- Payment for a portion of the charge that another party is responsible for as the primary payer

Outpatient prescription drugs, and preventive care drugs and supplements

- Prescribed drugs, pre-medication or analgesia

Personal care, comfort or convenience items

- Any service or supply primarily for your convenience and personal comfort or that of a third party

Providers and other health professionals

- Treatment by other than a dentist. However, the plan will cover some services provided by a licensed dental hygienist under the supervision and guidance of a dentist. These are:
 - Scaling of teeth
 - Cleaning of teeth
 - Topical application of fluoride
- Charges submitted for services by an unlicensed provider or not within the scope of the provider's license

School health services

- Services and supplies normally provided by the policyholder's:
 - School health services
 - Infirmary
 - Hospital
 - Pharmacy or

by health professionals who

- Are employed by
- Are Affiliated with
- Have an agreement or arrangement with, or
- Are otherwise designated by the policyholder.

Services paid under your medical plan

- Your plan will not pay for amounts that were paid for the same services under a medical plan covering you. When a dental service is covered under both plans, we will figure the amount that would be payable under this plan if you did not have other coverage, then subtract what was paid by your medical plan. If there is any difference, this plan will pay it. If the amount paid by your medical plan is equal to or more than the benefit under this plan, this plan will not pay anything for the service.

Services provided by a family member

- Services provided by a spouse, civil union partner, domestic partner, parent, child, step-child, brother, sister, in-law or any household member

Services, supplies and prescription drugs received outside of the United States

- Services, supplies, and prescription drugs received outside of the United States. They are not covered even if they are covered in the United States under this certificate of coverage.

Sports

- Any services or supplies given by providers as a result from play or practice of collegiate or intercollegiate sports, not including intercollegiate club sports and intramurals.

Temporomandibular joint dysfunction/disorder

- The following services and supplies:
 - Orthodontic treatment
 - Crowns, bridges and dentures
 - Treatment of periodontal disease
 - Implants
 - Root canal therapy

Treatment in a federal, state, or governmental entity

- Any care in a hospital or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws

Use of drugs, alcohol or intoxicants

- Services and supplies to treat an injury resulting from the use of:
 - Drugs (except as prescribed by a physician)
 - Alcohol
 - Intoxicants

Valid and collectable insurance

- Services and supplies covered by any other valid and collectible medical, dental, health, or accident insurance but only to the extent that benefits are payable under other valid and collectible insurance. This applies whether or not a claim is made for such benefits.

Work related illness or injuries

- Coverage available to you under workers' compensation or under a similar program under local, state or federal law for any illness or injury related to employment or self-employment.
- A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. You may also be covered under a workers' compensation law or similar law. If you submit proof that you are not covered for a particular illness or injury under such law, then that illness or injury will be considered "not work related" regardless of cause.

What rules and limits apply to dental care?

Several rules apply to the dental benefits. Following these rules will help you use your plan to your advantage by avoiding expenses that are not covered by your plan.

Alternate treatment rule

Sometimes there are several ways to treat a dental problem, all of which provide acceptable results.

If a charge is made for a non-eligible dental service or supply and an eligible dental service that would provide an acceptable result, then your plan will pay a benefit for the eligible dental service or supply.

If a charge is made for an eligible dental service but another eligible dental service that would provide an acceptable

result is less expensive, the benefit will be for the least expensive eligible dental service.

The benefit will be based on the in-network provider's negotiated charge for the eligible dental service or, in the case of an out-of-network provider, on the recognized charge.

You should review the differences in the cost of alternate treatment with your dental provider. Of course, you and your dental provider can still choose the more costly treatment method. You are responsible for any charges in excess of what your plan will cover.

Coverage for dental work begun before you are covered by the plan

Your plan does not cover dental work that began before you were covered by the plan. This means that the following dental work is not covered:

- An appliance, or modification of an appliance, if an impression for it was made before you were covered by the plan
- A crown, bridge, or cast or processed restoration, if a tooth was prepared for it before you were covered by the plan
- Root canal therapy, if the pulp chamber for it was opened before you were covered by the plan

Replacement rule

Some eligible dental services are subject to your plan's replacement rule. The replacement rule applies to replacements of, or additions to existing:

- Crowns
- Inlays
- Onlays
- Veneers
- Complete dentures
- Removable partial dentures
- Fixed partial dentures (bridges)
- Other prosthetic services

These eligible dental services are covered only when you give us proof that:

- While you were covered by the plan:
 - You had a tooth (or teeth) extracted after the existing denture or bridge was installed.
 - As a result, you need to replace or add teeth to your denture or bridge.
- The present item cannot be made serviceable, and is:
 - A crown installed at least 10 years before its replacement.
 - An inlay, onlay, veneer, complete denture, removable partial denture, fixed partial denture (bridge), or other prosthetic item installed at least 10 years before its replacement.
- While you were covered by the plan:
 - You had a tooth (or teeth) extracted.
 - Your present denture is an immediate temporary one that replaces that tooth (or teeth).
 - A permanent denture is needed, and the temporary denture cannot be used as a permanent denture.

Replacement must occur within 12 months from the date that the temporary denture was installed.

Tooth missing but not replaced rule

The first installation of complete dentures, removable partial dentures, fixed partial dentures (bridges), and other prosthetic services will be covered if:

- The dentures, bridges or other prosthetic items are needed to replace one or more natural teeth that were removed while you were covered by the plan. (The extraction of a third molar tooth does not qualify.)
- The tooth that was removed was not an abutment to a removable or fixed partial denture installed during the prior 10 years. Any such appliance or fixed bridge must include the replacement of an extracted tooth or teeth.

The Emory University Dental® Preferred Provider Organization (PPO) Student Dental Plan is underwritten and administered by Aetna Life Insurance Company (ALIC). Aetna Student HealthSM is the brand name for products and services provided by these companies and their applicable affiliated companies.

IMPORTANT NOTICES:

- **Notice of Non-Discrimination:**
Aetna Life Insurance Company does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan including enrollment and benefit determinations.
- **Sanctioned Countries:**
If coverage provided under this student policy violates or will violate any economic or trade sanctions, the coverage will be invalid immediately. For example, we cannot pay for eligible health services if it violates a financial sanction regulation. This includes sanctions related to a person or a country under sanction by the United States, unless it is allowed under a written license from the Office of Foreign Asset Control (OFAC). You can find out more by visiting <http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx>.

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: 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 subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).

TTY: 711

To access language services at no cost to you, call 877-238-6200.

Para acceder a los servicios de idiomas sin costo, llame al 877-238-6200. (Spanish)

如欲使用免費語言服務，請致電 877-238-6200。 (Chinese)

Afin d'accéder aux services langagiers sans frais, composez le 877-238-6200. (French)

Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 877-238-6200. (Tagalog)

Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 877-238-6200 an. (German)

للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 877-238-6200. (Arabic)

Pou jwenn sèvis lang gratis, rele 877-238-6200. (French Creole-Haitian)

Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 877-238-6200. (Italian)

言語サービスを無料でご利用いただくには、877-238-6200 までお電話ください。 (Japanese)

무료 언어 서비스를 이용하려면 877-238-6200 번으로 전화해 주십시오. (Korean)

برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-800-###-#### تماس بگیرید. (Persian-Farsi)

Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonić 877-238-6200. (Polish)

Para acessar os serviços de idiomas sem custo para você, ligue para 877-238-6200. (Portuguese)

Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 877-238-6200. (Russian)

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 877-238-6200. (Vietnamese)