



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, <https://www.aetna.com/sbcsearch/getcbpolicydocs?P=0772247&Y=24>, or by calling 1-844-365-7373. 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 1-844-365-7373 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	In- <u>Network</u> : Individual \$795 / Family \$1,590.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. Certain office visits, <u>preventive care</u> , <u>urgent care</u> and <u>prescription drugs</u> in- <u>network</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	In- <u>Network</u> : Individual \$9,195 / Family \$18,390.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<u>Premiums</u> and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="https://aetna.com/providersearch_aetna">https://aetna.com/providersearch_aetna</a> or call 1-844-365-7373 for a list of in- <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .



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)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$15 <u>copay</u> /visit, <u>deductible</u> does not apply	Not covered	None
	<u>Specialist</u> visit	\$35 <u>copay</u> /visit, <u>deductible</u> does not apply	Not covered	None
	<u>Preventive care</u> / <u>screening</u> /immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	Lab: \$20 <u>copay</u> /visit, <u>deductible</u> does not apply; X-ray: \$35 <u>copay</u> /visit, <u>deductible</u> does not apply	Not covered	None
	Imaging (CT/PET scans, MRIs)	40% <u>coinsurance</u>	Not covered	None
<b>If you need drugs to treat your illness or condition</b> More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://aet.na/ilivl24">http://aet.na/ilivl24</a>	Preferred generic drugs	Tier 1A: \$5 <u>copay</u> /prescription for up to a 30 day supply, \$12.50 <u>copay</u> /prescription for up to a 90 day supply; Tier 1: \$10 <u>copay</u> /prescription for up to a 30 day supply, \$25 <u>copay</u> /prescription for up to a 90 day supply, <u>deductible</u> does not apply	Not covered	Covers up to a 30 day supply (retail prescription), 31-90 day supply (retail & mail order prescription). Applicable cost share plus difference (brand minus generic cost) applies for brand when generic available. No charge for preferred generic FDA-approved women's contraceptives in- <u>network</u> .
	Preferred brand drugs	\$40 <u>copay</u> /prescription for up to a 30 day supply, \$100 <u>copay</u> /prescription for up to a 90 day supply, <u>deductible</u> does not apply	Not covered	
	Non-preferred generic/brand drugs	\$70 <u>copay</u> /prescription for up to a 30 day supply, \$175 <u>copay</u> /prescription for up to a 90 day supply,	Not covered	

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)	
		<u>deductible</u> does not apply		
	Preferred/non-preferred <u>specialty drugs</u>	\$250 <u>copay</u> / prescription for up to a 30 day supply, <u>deductible</u> does not apply	Not covered	All specialty <u>prescription drug</u> fills on initial fill must be filled at a <u>network</u> specialty pharmacy except for urgent situations. Your <u>plan</u> may include access to CVS retail pharmacies for certain <u>specialty drugs</u> .
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% <u>coinsurance</u> for hospital facility; 25% <u>coinsurance</u> for free standing facility	Not covered	None
	Physician/surgeon fees	40% <u>coinsurance</u> for hospital facility; 25% <u>coinsurance</u> for free standing facility	Not covered	None
If you need immediate medical attention	<u>Emergency room care</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	Out-of-network <u>emergency room care</u> cost-share same as in- <u>network</u> . No coverage for non-emergency care.
	<u>Emergency medical transportation</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	Out-of-network cost-share same as in- <u>network</u> .
	<u>Urgent care</u>	\$25 <u>copay</u> /visit, <u>deductible</u> does not apply	Not covered	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	50% <u>coinsurance</u>	Not covered	None
	Physician/surgeon fees	50% <u>coinsurance</u>	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Outpatient office visits: \$15 <u>copay</u> /visit, <u>deductible</u> does not apply; All other outpatient services: 40% <u>coinsurance</u>	Not covered	None
	Inpatient services	50% <u>coinsurance</u>	Not covered	None

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 are pregnant	Office visits	No charge	Not covered	Cost sharing does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	50% <u>coinsurance</u>	Not covered	
	Childbirth/delivery facility services	50% <u>coinsurance</u>	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	\$35 <u>copay/visit</u> , <u>deductible</u> does not apply	Not covered	None
	<u>Rehabilitation services</u>	\$35 <u>copay/visit</u> , <u>deductible</u> does not apply	Not covered	None
	<u>Habilitation services</u>	40% <u>coinsurance</u>	Not covered	None
	<u>Skilled nursing care</u>	50% <u>coinsurance</u>	Not covered	None
	<u>Durable medical equipment</u>	40% <u>coinsurance</u>	Not covered	Coverage is limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	50% <u>coinsurance</u>	Not covered	None
If your child needs dental or eye care	Children's eye exam	\$10 <u>copay/visit</u> , <u>deductible</u> does not apply	Not covered	Coverage is limited to 1 exam every 12 months up to age 19.
	Children's glasses	\$10 <u>copay/visit</u> , <u>deductible</u> does not apply	Not covered	Coverage is limited to 1 set of frames and 1 set of contact lenses or eyeglass lenses per calendar year up to age 19.
	Children's dental check-up	Not covered	Not covered	Not covered.

#### 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                 | • Long-term care                                     | • Routine eye care (Adult) |
| • Cosmetic surgery            | • Non-emergency care when traveling outside the U.S. | • Routine foot care        |
| • Dental care (Adult & Child) |  | • Weight loss programs     |

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

- |  |  |                        |
|--|--|------------------------|
| • Abortion   | • Hearing aids - Hearing aids limited to 1 hearing aid per ear every 24 months. Bone anchored hearing aids and cochlear <u>implants</u> are covered. | • Private-duty nursing |
| • Bariatric surgery  | • Infertility treatment - Benefit limitations may apply.   |                        |
| • Chiropractic care - Coverage is limited to 25 visits per manipulation. |  |                        |

**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: Illinois Department of Insurance, Office of Consumer Health Insurance, 1-877-527-9431 toll free, 1-866-323-5321 (TDD), <https://idoihelpcenter.illinois.gov/s/>.

- For more information on your rights to continue coverage, contact the plan at 1-844-365-7373.
- State Consumer Assistance Program, if other than state insurance department contact Illinois Department of Insurance, Office of Consumer Health Insurance, Consumer Services Section, 122 S. Michigan Ave, 19th floor, Chicago, IL 60603, 1-312-814-2420, Or 320 W. Washington Street, Springfield, IL 62767, 1-877-527-9431 toll free, 1-217-782-4515, 1-866-323-5321 (TDD) , <https://idoihelpcenter.illinois.gov/s/>

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](http://www.HealthCare.gov) or call 1-800-318-2596 or state health insurance marketplace or SHOP.

**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:

- Illinois Department of Insurance, Office of Consumer Health Insurance, 1-877-527-9431 toll free, 1-866-323-5321 (TDD), <https://idoihelpcenter.illinois.gov/s/>.
- Additionally, a consumer assistance program can help you file your appeal. Contact Illinois Department of Insurance, Office of Consumer Health Insurance, Consumer Services Section, 122 S. Michigan Ave, 19th floor, Chicago, IL 60603, 1-312-814-2420, Or 320 W. Washington Street, Springfield, IL 62767, 1-877-527-9431 toll free, 1-217-782-4515, 1-866-323-5321 (TDD), <https://idoihelpcenter.illinois.gov/s/>

**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? Not Applicable.**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$795
■ <u>Specialist</u> copayment	\$35
■ Hospital (facility) <u>coinsurance</u>	50%
■ Other <u>coinsurance</u>	50%

#### 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
<b>In this example, Peg would pay:</b>	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$795
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$4,600
<u>What isn't covered</u>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$5,655</b>

### Managing Joe's Type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$795
■ <u>Specialist</u> copayment	\$35
■ Hospital (facility) <u>coinsurance</u>	50%
■ Other <u>coinsurance</u>	50%

#### This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)  
Diagnostic tests (*blood work*)  
Prescription drugs  
Diabetic supplies (*glucose meter*)

<b>Total Example Cost</b>	<b>\$5,600</b>
<b>In this example, Joe would pay:</b>	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$1,000
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,020</b>

### Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$795
■ <u>Specialist</u> copayment	\$35
■ Hospital (facility) <u>coinsurance</u>	50%
■ Other <u>coinsurance</u>	50%

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
<b>In this example, Mia would pay:</b>	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$795
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$600
<u>What isn't covered</u>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,595</b>

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: 1-844-365-7373.

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 1-844-365-7373.

### 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).

**Health plans are offered or underwritten or administered by Aetna Health Inc. (Pennsylvania) (Aetna). Aetna is part of the CVS Health family of companies.**



**Language Assistance:**

Albanian -	Për shërbime përkthimi falas për ju, telefononi 1-844-365-7373.
Amharic -	የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-844-365-7373 ይደውሉ።
Arabic -	مقررنا على لاصتالاء اجرنا، فكلكتي أنودا عوغلل تادمخا على ع لوصحلل 1-844-365-7373
Armenian -	Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-844-365-7373 հեռախոսահամարով:
Bahasa-Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-844-365-7373 tanpa dikenakan biaya.
Bantu-Kirundi -	Kugira uronke serivisi z'indimi atakiguzi, hamagara 1-844-365-7373.
Bengali-Bangala -	আপনাকে বিনামূল্যে ভাষা পৰিক্ৰিা পপকে হকয় এই নম্বকি পবেযক ন ব্রুন: 1-844-365-7373।
Bisayan-Visayan -	Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-844-365-7373.
Burmese -	သင့်အနေဖြင့် အခကြေးငွေ မပေးရပဲ ဘာသာစကားဝန်ဆောင်မှုများ ရရှိနိုင်ရန် 1-844-365-7373 သို့ ဖုန်းခေါ်ဆိုပါ။
Catalan -	Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-844-365-7373.
Chamorro -	Para un hago' i setbision lengguahi ni dibatde para hagu, agang 1-844-365-7373.
Cherokee -	Ⴀႃႉႃ Ⴑႃႉႃႃႃ Ⴑႃႉႃႃႃ Ⴑ Ⴑႃႉႃ Ⴑႃႉႃႃႃႃ Ⴑႃႉႃ, Ⴑႃႉႃႃႃႃႃ 1-844-365-7373.
Chinese -	如欲使用免費語言服務，請致電 1-844-365-7373。
Choctaw -	Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-844-365-7373.
Cushite -	Tajaajiiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-844-365-7373.
Dutch -	Voor gratis toegang tot taaldiensten, bell 1-844-365-7373.
French -	Afin d'accéder aux services langagiers sans frais, composez le 1-844-365-7373.
French Creole -	Pou jwenn sèvis lang gratis, rele 1-844-365-7373.
German -	Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-844-365-7373 an.
Greek -	Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-844-365-7373.



Gujarati -	તમારે કોઇ જાતના ખર્ચ વાનિ ભાષાની સેવિઓની પહોર માટે, કોલ કરો 1-844-365-7373.
Hawaiian -	No ka wala'au 'ana me ka lawelawe 'ōlelo e kahea aku i kēia helu kelepona 1-844-365-7373 Kāki 'ole 'ia kēia kōkua nei.
Hindi -	आपके लिए बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, 1-844-365-7373 पर कॉल करें।
Hmong -	Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-844-365-7373.
Igbo -	Iji nwetaòhèrè na ọrụ gasị asụsụ n'efu, kpọọ 1-844-365-7373.
Ilocano -	Tapno maaksesyô dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti 1-844-365-7373.
Indonesian -	Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi 1-844-365-7373.
Italian -	Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-844-365-7373.
Japanese -	言語サービスを無料でご利用いただくには、1-844-365-7373 までお電話ください
Karen -	လၢတၢ်ကမၤန့ၢ်ကိၣ်အတၢ်မၤစၢၤအတၢ်ဖံးတၢ်မၤတဖၣ်လၢတအိၣ်ဒီးအပူၤလၢကဘၣ်ဟ့ၣ်အိၣ်အဂီၢ်ဘၣ်န့ၣ် ကိး 1-844-365-7373 တက့ၢ်.
Korean -	무료 언어 서비스를 이용하려면 1-844-365-7373 번으로 전화해 주십시오.
Kru-Bassa -	M dyi wuḍu-dù kà kò dò bě dyi móuń ñì Pídyi ní, níí, dá nòbà nà ke: 1-844-365-7373.
Kurdish -	1-844-365-7373 یەرامژ مە مەکەب یەدەنەوی مە پ، وێت وێ مە نووچێت ئێبە مە نامز یراز و گەتەمەز مە نەتشی هەگاری ئێسە دە وێ
Laotian -	ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕົກກັບທ່ານ, ໃຫ້ໂທຫາເບີ 1-844-365-7373.
Marathi -	कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी 1-844-365-7373 वर फोन करा.
Marshallese -	Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirluk 1-844-365-7373.
Micronesian Pohnpeyan -	Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1-844-365-7373.
Mon-Khmer Cambodian -	ដើម្បីប្រើប្រាស់សេវាភាសាដោយឥតគិតថ្លៃសម្រាប់អ្នកខ្មែរ មុនពេលទូរស័ព្ទសេវាភាសាសូម 1-844-365-7373។
Navajo -	T'áá ni nizaad k'ehjí bee níká a'doowol doo b'ááh ílínígóó kojí' hólne' 1-844-365-7373.
Nepali -	निःशुल्क भाषा सेवा प्राप्त गनन 1-844-365-7373 मा टेलिफोन गनुनहोस् ।
Nilotic-Dinka -	Të koor yin wëër de thokic ke cîn wëu kor keek tënɔŋ yîn. Ke cɔl koc ye koc kuony ne nɔmba 1-844-365-7373.
Norwegian -	For tilgang til kostnadsfri språktjenester, ring 1-844-365-7373.

[illegible]