



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, visit www.ih-aetna.com/fcps or call 1-888-236-6249. 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 1-888-236-6249 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In- <u>Network</u> : Individual \$250 / Family \$500. Out-of- <u>Network</u> : Individual \$500 / Family \$1,000.	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> .
Are there services covered before you meet your deductible?	Yes. In- <u>network</u> <u>preventive care</u> is covered before you meet your <u>deductible</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 https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	In- <u>Network</u> : Individual \$2,000 / Family \$4,000. Out-of- <u>Network</u> : Individual \$4,000 / Family \$8,000. Pharmacy: Individual \$1,500 / Family \$3,000	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.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , balance-billing charges, health care this <u>plan</u> doesn't cover, and penalties for failure to obtain pre-authorization for services. Coinsurance and copayments for covered prescriptions apply to a separate pharmacy out-of-pocket maximum.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See www.ih-aetna.com/fcps or call 1-888-236-6249 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.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 <u>copay</u> /visit	40% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$20 <u>copay</u> /visit	40% <u>coinsurance</u>	None
	<u>Preventive care</u> / <u>screening</u> /immunization	No charge. Deductible does not apply.	40% <u>coinsurance</u>	Age & frequency limits may apply. 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.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	40% <u>coinsurance</u>	Refer to http://www.ih-aetna.com/fcps for participating laboratories/radiology facilities. Copay applies to complex radiology services.
	Imaging (CT/PET scans, MRIs)	\$75 <u>copay</u> /visit	40% <u>coinsurance</u>	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://info.caremark.com/fcps	Generic drugs	Retail: \$7/\$14/\$21 (30/60/90-day supply) Mail Order: \$14 (up to 90-day supply)	Pay in full, then file claim for reimbursement. Reimbursement limited to amount plan would have paid if network pharmacy was used.	Maximum \$50 copay per 30-day supply of insulin. Participants using a CVS retail pharmacy for maintenance medications may receive a 90-day supply for two retail copays. For plan details, see http://info.caremark.com/fcps (employees and non-Medicare retirees).
	Preferred brand drugs	20% of cost of drug; maximum copay: Retail: \$75/\$150/\$225 (30/60/90-day supply) Mail Order: \$150 (up to 90-day supply)		
	Non-preferred brand drugs	Not covered	Not covered	Your plan uses a network of participating pharmacies and a formulary (a list of preferred covered medications). Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered.
	<u>Specialty</u> drugs	20% of cost of drug, \$75 max (up to 30-day supply)	Must use CVS Specialty Pharmacy after first fill	Deductible does not apply to prescription coverage. Certain preventive medications covered for \$0 copay.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization may be required depending on type of service rendered.
	Physician/surgeon fees	10% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	10% <u>coinsurance</u> plus \$250 <u>copay/visit</u>	10% <u>coinsurance</u> plus \$250 <u>copay/visit</u>	\$250 copay waived if admitted. No coverage for non-emergency use; prudent layperson rules & definitions apply.
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Must be medically necessary. Non-emergency transport: not covered, except if pre-authorized
	<u>Urgent care</u>	10% <u>coinsurance</u> , <u>deductible</u> doesn't apply	10% <u>coinsurance</u> , <u>deductible</u> doesn't apply	If using a non-participating provider, may be required to pay in full & file for reimbursement.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u> plus \$150 <u>copay/stay</u>	40% <u>coinsurance</u> plus \$150 <u>copay/stay</u>	Pre-authorization required for all inpatient hospital stays.
	Physician/surgeon fees	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization may be required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <u>copay/office visit</u> ; 10% <u>coinsurance</u> <u>outpatient facility</u>	40% <u>coinsurance</u>	Pre-authorization is not required for Outpatient Therapy. Pre-authorization required for Psychological Testing, Neuropsychological Testing, Outpatient ECT, Biofeedback, Outpatient Detoxification & Home Health Care .
	Inpatient services	10% <u>coinsurance</u> plus \$150 <u>copay/stay</u>	40% <u>coinsurance</u> plus \$150 <u>copay/stay</u>	Pre-authorization required for all inpatient hospital & treatment facility stays, in addition to care received in Intensive Outpatient, Partial Hospitalization & Residential Treatment settings.
If you are pregnant	Office visits	No charge	40% <u>coinsurance</u>	<u>Cost sharing</u> doesn't apply to certain <u>preventive services</u> . Depending on the type of service, a copayment, coinsurance or deductible may apply. Maternity care may include tests & services described elsewhere in the SBC (i.e. ultrasound). Pre-authorization required for maternity & newborn confinements that exceed the standard length of stay for normal vaginal delivery or C-Section. Pre-authorization may be required for out-of-network care.
	Childbirth/delivery professional services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	10% <u>coinsurance</u> plus \$150 <u>copay/stay</u>	40% <u>coinsurance</u> plus \$150 <u>copay/stay</u>	

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 help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	90 visits/calendar year. Pre-authorization required for certain services.
	<u>Rehabilitation services</u>	\$20 <u>copay</u> /visit	40% <u>coinsurance</u>	90 visits/therapy/calendar year. Subject to review for medical necessity.
	<u>Habilitation services</u>	\$20 <u>copay</u> /visit	40% <u>coinsurance</u>	No visit limit for treatment of Autism. Other habilitative services covered as part of Early Intervention Program (birth to age 3). For diagnosis other than Autism, 90 visits/calendar year each for Habilitation Physical, Occupational & Speech Therapy.
	<u>Skilled nursing care</u>	10% <u>coinsurance</u> plus \$150 <u>copay</u> /stay	40% <u>coinsurance</u> plus \$150 <u>copay</u> /stay	120 days max/confinement. Days renewed when out of facility for 60 consecutive days. Pre-authorization required. \$150 copay waived if directly transferred from inpatient facility
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required for certain <u>durable medical equipment</u> (i.e. motorized wheelchairs, customized braces). Limited to 1 for same/similar purpose. Frequency limits apply. Excludes repairs for misuse/abuse
	<u>Hospice services</u>	10% <u>coinsurance</u> plus \$150 <u>copay</u> /stay for inpatient; 10% <u>coinsurance</u> for outpatient	40% <u>coinsurance</u> plus \$150 <u>copay</u> /stay for inpatient; 40% <u>coinsurance</u> for outpatient	<u>Pre-authorization</u> required. Per admission <u>copay</u> waived if transferred directly from inpatient or skilled nursing facility.
If your child needs dental or eye care	Children's eye exam	\$20 <u>copay</u> /visit, not subject to <u>deductible</u> .	Reimbursement up to \$40/visit.	Once every 12 months. Routine vision services not subject to deductible.
	Children's glasses	Standard glasses covered in full up to \$130 allowance	Reimbursement \$40-\$80	Lenses once per 12 months; frames once per 24 months; max \$130 allowance.
	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.)

- Cosmetic surgery
- Dental care (Adult & Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine Foot Care
- Weight loss programs - Except for required preventive services.

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

- Accupuncture – only if used by physician in lieu of anesthesia
- Bariatric surgery – subject to Utilization Management approval
- Chiropractic care – subject to Utilization Management
- Hearing aids - subject to maximum of \$1,500 per ear every 36 months
- Infertility treatment – Subject to Utilization Management approval.
- Private-duty nursing – limited to 120 days per plan year
- Routine eye care (Adult and Child)

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 www.fcps.edu or 571-423-3200, Option 3.
- 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.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Aetna directly by calling 1-888-236-6249.
- 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>.

For grievances and appeals regarding your drug coverage, contact:

- CVS Caremark at 1-888-217-4161 or visit <http://info.caremark.com/fcps> (active employees/non-Medicare retirees)

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.

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 \$20
- 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:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$900
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,410

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 \$20
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

This EXAMPLE event includes services like:

- Primary care physician office visits (*including disease education*)
- Diagnostic tests (*blood work*)
- Prescription drugs
- Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
In this example, Joe would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$450
<u>Coinsurance</u>	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$1,760

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

- The plan's overall deductible \$250
- Specialist copayment \$20
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

This EXAMPLE event includes services like:

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

Total Example Cost	\$1,900
In this example, Mia would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$750

The plan would be responsible for the other costs of these EXAMPLE covered services.

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

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-888-236-6249. TTY: 711.

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/Innovation Health 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, or disability.

Aetna/Innovation Health 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, please call 1-888-236-6249.

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).

Innovation Health is the brand name used for products and services provided by Innovation Health Insurance Company and/or Innovation Health Plan, Inc. Innovation Health is an affiliate of Inova and Aetna Life Insurance Company and its affiliates. Aetna and its affiliates provide certain management services to Innovation Health.

- Hindi - हन्दिी में भाषा सहायता के लिए, 1-800-370-4526 पर मुफ्त कॉल करें।
- Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-800-370-4526.
- Ibo - Maka enyemaka asụsụ na Igbo kpọọ 1-800-370-4526 na akwughị ugwo ọ bụla
- Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-370-4526 nga awan ti bayadanyo.
- Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-800-370-4526.
- Japanese - 日本語で援助をご希望の方は、1-800-370-4526 まで無料でお電話ください。
- Karen - လာဝာ်မစာလာ်ကလာ်ကျိ်အဂီ် ကျိ် 1-800-370-4526 လာဝအိ်ဒီးလာ်လာ်ကျိ်လာ်စုလာ်
- Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-370-4526 번으로 전화해 주십시오.
- Kru-Bassa - Be'm'ké gbo-kpá-kpá dyé pídyi dé Baśwó`wuđuùñ wěë, dá 1-800-370-4526
- Kurdish - برای راهنمایی به زبان فارسی با شماره 1-800-370-4526 به خورایی یه یهوندی بکن.
- Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-800-370-4526 ໂດຍບໍ່ເສຍຄ່າໂທ.
- Marathi - कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-800-370-4526 वर फोन करा.
- Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-800-370-4526 ilo ejjelok wōnān.
- Micronesian - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-800-370-4526 ni sohte isais.
- Pohnpeyan - ສຸຍກຳບໍ່ເຊີຍກາສາລາ ກາສາຊຸຍ ສຸຍຊຸສັດຊອຣາ ກາສັດລາ 1-800-370-4526 ສາຍສັດສັດຊຸຍໄ້
- Mon-Khmer, Cambodian - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-800-370-4526
- Navajo - (नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-800-370-4526 मा फोन गर्नुहोस् ।
- Nepali - (नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-800-370-4526 मा फोन गर्नुहोस् ।
- Nilotic-Dinka - Tën kuwoony è thok è Thuonjäŋ cöl 1-800-370-4526 kec'in ayöc.
- Norwegian - For språkassistanse på norsk, ring 1-800-370-4526 kostnadsfritt.
- Panjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਮਦਦ ਲਈ, 1-800-370-4526 'ਤੇ ਮੁਫਤ ਕਾਲ ਕਰੋ।
- Pennsylvania Dutch - Fer Hilfe in Deutsch, ruf: 1-800-370-4526 aa. Es Aaruf koschtet nix.
- Persian - برای راهنمایی به زبان فارسی با شماره 1-800-370-4526 بدون هیچ هزینه ای تماس بگیرد. انگلیسی
- Polsish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-800-370-4526.
- Portuguese - Para obter assistência linguística em português ligue para o 1-800-370-4526 gratuitamente.
- Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-800-370-4526

- Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-800-370-4526.
- Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-800-370-4526 e aunoa ma se totogi.
- Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-800-370-4526.
- Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-800-370-4526.
- Sudanic-Fulfude - Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-800-370-4526. Njodi woo fawaaki on.
- Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-800-370-4526 bila malipo.
- Syriac - ܟܠܟܘܢܐ ܟܠܟܘܢܐ ܟܠܟܘܢܐ ܟܠܟܘܢܐ ܟܠܟܘܢܐ ܟܠܟܘܢܐ ܟܠܟܘܢܐ ܟܠܟܘܢܐ ܟܠܟܘܢܐ ܟܠܟܘܢܐ ܟܠܟܘܢܐ 1-800-370-4526 ܟܠܟܘܢܐ.
- Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-800-370-4526 nang walang bayad.
- Telugu - భాషలో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 1-800-370-4526 కు కాల్ చేయండి. (తెలుగు)
- Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-800-370-4526 ฟรีไม่มีค่าใช้จ่าย
- Tongan - Kapau ‘oku fiema'u hā tokoni ‘i he lea faka-Tonga telefoni 1-800-370-4526 ‘o ‘ikai hā ʻōtōngi.
- Trukese - Ren ánninnisin chiakú ren (Kapasen Chuuk) kopwe kékkéeri 1-800-370-4526 nge esapw kamé ngonuk.
- Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemedен 1-800-370-4526.
- Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-800-370-4526.
- Urdu - بلا قیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-800-370-4526 پر بات کریں۔
- Vietnamese - Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-800-370-4526.
- Yiddish - פאר שפראך הילף אין אידיש רופט 1-800-370-4526 פון אפצאל.
- Yoruba - Fún ìrànṣọwọ nípa èdè (Yorùbá) pe 1-800-370-4526 láí san owó kankan rárá.