



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 <u>deductible</u>?	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 <u>deductible</u>?	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 <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	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 <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance-billing</u> charges & health care this <u>plan</u> doesn't cover, 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 <u>network provider</u>?	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 <u>referral</u> to see a <u>specialist</u>?	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.	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). 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. Deductible does not apply to prescription coverage.
	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)	Reimbursement limited to amount plan would have paid if network pharmacy was used.	
	Non-preferred brand drugs	Not covered	Not covered	
	<u>Specialty drugs</u>	20% of cost of drug, \$75 max (up to 30-day supply)	Must use CVS Specialty Pharmacy after first fill	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Pre-authorization</u> may be required depending on type of service rendered.
	Physician/surgeon fees	10% <u>coinsurance</u>	40% <u>coinsurance</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 need immediate medical attention	<u>Emergency room care</u>	10% <u>coinsurance</u> plus \$150 <u>copay/visit</u>	10% <u>coinsurance</u> plus \$150 <u>copay/visit</u>	\$150 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.
	<u>Urgent care</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	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>	<u>Pre-authorization</u> required for all inpatient hospital stays.
	Physician/surgeon fees	10% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Pre-authorization</u> 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> outpatient facility	40% <u>coinsurance</u>	<u>Pre-authorization</u> is not required for Outpatient Therapy. <u>Pre-authorization</u> 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>	<u>Pre-authorization</u> 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>	Cost sharing 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). <u>Pre-authorization</u> required for maternity & newborn confinements that exceed the standard length of stay for normal vaginal delivery or C-Section. <u>Pre-authorization</u> 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>	



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 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. <u>Pre-authorization</u> 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>	For treatment of Autism. Other habilitative services covered as part of Early Intervention Program (birth to age 3).
	<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; <u>Pre-authorization</u> required. \$150 copay waived if directly transferred from inpatient facility.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Pre-authorization</u> required for certain <u>durable medical equipment</u> (i.e. motorized wheelchairs, customized braces).
	<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.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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	\$12,640
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$430
Coinsurance	\$870
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,610

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	\$7,460
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$420
Coinsurance	\$1,060
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$1,790

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	\$2,010
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$290
Coinsurance	\$140
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$680

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 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: PO Box 24030 Fresno, CA 93779),

1-800-648-7817. TTY: 711.: 711, Fax: 859-425-3379 (CA HMO customers: 1-860-262-7705),

Email: 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 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.

- Hawaiian - No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-888-236-6249. Kāki ‘ole ‘ia kēia kōkua nei.
- Hindi - **हन्दि में भाषा सहायता के लएि, 1-888-236-6249 पर मुफ्त कॉल करें।**
- Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-888-236-6249.
- Ibo - **Maka enyemaka asụsụ na Igbo kpọọ 1-888-236-6249 na akwụghị ugwọ ọ bụla**
- Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-888-236-6249 nga awan ti bayadanyo.
- Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-888-236-6249.
- Japanese - **日本語で援助をご希望の方は、1-888-236-6249 まで無料でお電話ください。**
- Karen - လာဝတ်မစာတတ်ကတိကုန်အင်္ဂါ ကျိန် ကိး 1-888-236-6249 လာတအိန်ဒီးတတ်လာဝ်ဘူဝ်လာဝ်စုဘူဝ်
- Korean - **한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-236-6249 번으로 전화해 주십시오.**
- Kru-Bassa - **Ḃe m'ké gbo-kpá-kpá dyé pídyi dé Ḃaśwó-wuḂuñ wěě, dǎ 1-888-236-6249**
- Kurdish - **برای راهنمایی به زبان فارسی با شماره 1-888-236-6249 به خۆرای یه یومندی بکهن.**
- Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ1-888-236-6249 ໂດຍບໍ່ເສຍຄ່າໂທ.
- Marathi - **तीलभाषा (मराठी) सहाय्यासाठी 1-888-236-6249 क्रमांकावरकोणत्याहीखर्चाशिवायकॉलकरा.**
- Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-888-236-6249 ilo ejjelok wōnān.
- Micronesian-Pohnpeyan - **Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-888-236-6249 ni sohte isais.**
- Mon-Khmer, Cambodian - **សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទទេៅកាន់លេខ 1-888-236-6249 ដោយឥតគិតថ្លៃ។**
- Navajo - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-888-236-6249
- Nepali - **(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-888-236-6249 मा फोन गर्नुहोस् ।**
- Nilotic-Dinka - **Tèn kuwoony ë thok ë Thuwojjäŋ col 1-888-236-6249 kec'in ayöc.**
- Norwegian - **For språkassistanse på norsk, ring 1-888-236-6249 kostnadsfritt.**
- Panjabi - **ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-888-236-6249 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।**
- Pennsylvania Dutch - **Fer Hefle in Deitsch, ruf: 1-888-236-6249 aa. Es Aaruf koschtet nix.**
- Persian - **برای راهنمایی به زبان فارسی با شماره 1-888-236-6249 بدون هیچ هزینه ای تماس بگیرید. انگلیسی**
- Polish - **Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-888-236-6249.**

- Portuguese - Para obter assistência linguística em português ligue para o 1-888-236-6249 gratuitamente.
- Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-888-236-6249
- Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-888-236-6249.
- Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-888-236-6249 e aunoa ma se totagi.
- Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-888-236-6249.
- Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-888-236-6249.
- Sudanic-Fulfude - Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-888-236-6249. Njodi woo fawaaki on.
- Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-888-236-6249 bila malipo.
- Syriac - ܠܟܘܢ ܠܗܘܠܐܢܘܢ ܕܡܘܨܪܝܐ 1-888-236-6249 ܕܡܘܨܪܝܐ.
- Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-888-236-6249 nang walang bayad.
- Telugu - భాషతో సాయం కోరకు ఎలాంటి ఖర్చు లేకుండా 1-888-236-6249 కు కాల్ చేయండి. (తెలుగు)
- Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-888-236-6249 ฟรีไม่มีค่าใช้จ่าย
- Tongan - Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-888-236-6249 'o 'ikai hā ʻōtōngi.
- Trukese - Ren ʻāninnisin chiakú ren (Kapasen Chuuk) kopwe kékkéeri 1-888-236-6249 nge esapw kamé ngonuk.
- Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemedен 1-888-236-6249.
- Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-888-236-6249.
- Urdu - اگر کسی کو اردو کی زبان کی مدد کی ضرورت ہے تو براہ کرم 1-888-236-6249 پر کال کریں۔
- Vietnamese - Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-888-236-6249.
- Yiddish - פאר שפראך הילף אין אידיש רופט 1-888-236-6249 פון אפצאל.
- Yoruba - Fún ìrànṣọwọ nípa èdè (Yorùbá) pe 1-888-236-6249 láí san owó kankan rárá.