This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.ih-aetna.com/fcps or call 888-236-6249.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For participating providers: **$250** person/**$500** family For non-participating providers: **$500** person/**$1,000** family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	The deductible applies to all medical plan expenses except preventive care. The deductible does not apply to prescription drugs.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. For participating providers: **$1,000** person/**$2,000** family For non-participating providers: **$2,000** person/**$4,000** family. Applies to copays, coinsurance, and deductibles.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, penalties for failure to obtain pre-authorization for services, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. A separate out of pocket limit applies to outpatient prescription drugs.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of participating providers, see www.ih-aetna.com/fcps or call 1-888-236-6249.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without obtaining a referral. Some procedures require prior authorization.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

Questions: Call Aetna/Innovation Health at 1-888-236-6249 or visit at www.ih-aetna.com/fcps for questions on your medical coverage. **For questions about your prescription drug coverage, c**all CVS Caremark at 1-888-217-4161 or visit http://info.caremark.com/fcps (active employees/non-Medicare retirees), or call SilverScript at 1-877-321-2597 or visit http://fairfaxps.silverscript.com (Medicare retirees). If you aren't clear about any of the bolded terms used in this form, see the Glossary at **www.healthcare.gov/glossary**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit, subject to deductible	40% coinsurance, subject to deductible	No visit limits
	Specialist visit	$20 copay/visit, subject to deductible	40% coinsurance, subject to deductible	Therapeutic services limited to 90 visit max, per therapy, per calendar year
	Other practitioner office visit	$20 copay/visit, subject to deductible	40% coinsurance, subject to deductible	Includes chiropractic services.
	Preventive care/screening/ immunization	$0 copay/visit	40% coinsurance, subject to deductible	Age and frequency limits may apply.
If you have a test	Diagnostic test (x-ray, blood work)	No charge for preventive services. Other services subject to deductible.	40% coinsurance, subject to deductible	Refer to www.ih-aetna.com/fcps for participating laboratories/radiology facilities.
	Imaging (CT/PET scans, MRIs)	No charge, subject to deductible.	40% coinsurance, subject to deductible	Prior authorization required for complex imaging such as MRI, CT scans, PET scans, and cardiac nuclear stress testing.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition	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.	Participants using a CVS retail pharmacy for maintenance medications may receive a 90 day supply for two copays. For plan details, see http://info.caremark.com/fcps (Employees/Non-Medicare retirees); http://fairfaxps.silverscript.ps.com (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
	Brand drugs	20% of cost of drug, subject to following maximums: Retail: $50/$100/$150 (30/60/90-day supply) Mail Order: $100 (up to 90-day supply)		
	Specialty drugs	20% of cost of drug, $50 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% coinsurance, subject to deductible	40% coinsurance, subject to deductible	Prior authorization may be required depending on type of service rendered.
	Physician/surgeon fees	10% coinsurance, subject to deductible	40% coinsurance, subject to deductible	
If you need immediate medical attention	Emergency room services	$150 emergency room copay, then 10% coinsurance on all services. Deductible applies.	$150 emergency room copay, then 10% coinsurance on all services. Deductible applies.	$150 copay waived if admitted. Non-emergency use of emergency room not covered; prudent layperson rules and definitions apply.
	Emergency medical transportation	10% coinsurance, subject to deductible	40% coinsurance, subject to deductible	*Must be medically necessary.
	Urgent care	10% coinsurance, subject to deductible	10% coinsurance, subject to deductible	If using a non-participating provider, may be required to pay in full and file for reimbursement.

Questions: Call Aetna/Innovation Health at 1-888-236-6249 or visit at www.ih-aetna.com/fcps for questions on your medical coverage. **For questions about your prescription drug coverage, c**all CVS Caremark at 1-888-217-4161 or visit http://info.caremark.com/fcps (active employees/non-Medicare retirees), or call SilverScript at 1-877-321-2597 or visit http://fairfaxps.silverscript.com (Medicare retirees). If you aren't clear about any of the bolded terms used in this form, see the Glossary at **www.healthcare.gov/glossary**.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have a hospital stay	Facility fee (e.g., hospital room)	$150 per admission copay, then 10% coinsurance. Deductible applies	$150 per admission copay, then 40% coinsurance. Deductible applies	Prior authorization required
	Physician/surgeon fee	10% coinsurance, subject to deductible	40% coinsurance, subject to deductible	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% coinsurance, subject to deductible (outpatient hospital); $20 copay/office visit, subject to deductible	40% coinsurance, subject to deductible	Prior authorization is not required for Outpatient Therapy Visits. Prior authorization required for Psychological Testing, Neuropsychological Testing, Outpatient ECT; Biofeedback; Outpatient Detoxification; and Home Health Care. Prior authorization required for all inpatient hospital and treatment facility stays, in addition to care received in Intensive Outpatient, Partial Hospitalization and Residential Treatment settings.
	Mental/Behavioral health inpatient services	$150 per admission copay, then 10% coinsurance. Deductible applies.	$150 per admission copay, then 40% coinsurance. Deductible applies.	
	Substance use disorder outpatient services	10% coinsurance, subject to deductible (outpatient hospital); $20 copay/office visit, subject to deductible	40% coinsurance, subject to deductible	
	Substance use disorder inpatient services	$150 copay/ admission and 10% coinsurance, subject to deductible	$150 copay/ admission and 40% coinsurance, subject to deductible	
If you are pregnant	Prenatal and postnatal care	Covered in full for office visits. Some lab and radiology services, subject to coinsurance and deductible.	40% coinsurance, subject to deductible	For routine pre/post natal office visits only. For non-routine obstetrical care or complications of pregnancy, cost sharnig may apply.
	Delivery and all inpatient services	$150 per admission copay, then 10% coinsurance. Deductible applies.	$150 per admission copay, then 40% coinsurance. Deductible applies.	Prior authorization required for maternity and newborn confinements that exceed the standard length of stay for normal vaginal delivery or C-Section.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you need help recovering or have other special health needs	Home health care	10% coinsurance, subject to deductible	40% coinsurance, subject to deductible	90 visits/calendar year; prior authorization required for certain services
	Rehabilitation services	10% coinsurance, subject to deductible (inpatient or outpatient hospital); $20 copay/office visit, subject to deductible	40% coinsurance, subject to deductible	90 visits/therapy/calendar year; prior authorization and Utilization Management review required.
	Habilitation services	10% coinsurance, subject to deductible (inpatient or outpatient hospital); $20 copay/office visit, subject to deductible	40% coinsurance, subject to deductible	Prior authorization required. Coverage for Autism and Pervasive Development Disorder limited to ages 2-10. Other habilitative services covered as part of Early Intervention Program (birth to age 3).
	Skilled nursing care	$150 per admission copay, then 10% coinsurance. Deductible applies.	$150 per admission copay, then 40% coinsurance. Deductible applies.	120 day max/confinement; days renewed when out of facility for 60 consecutive days; prior authorization required. $150 copay waived if directly transferred from inpatient facility.
	Durable medical equipment	10% coinsurance, subject to deductible	40% coinsurance, subject to deductible	Prior authorization required for certain durable medical equipment (i.e. motorized wheelchairs, customized braces)
	Hospice service	$150 per admission copay (facility), then 10% coinsurance. 10% coinsurance for all other services. Deductible applies.	$150 per admission copay (facility), then 40% coinsurance. 40% coinsurance for all other services. Deductible applies.	Prior authorization required. Per admission copay waived if transferred directly from inpatient or skilled nursing facility.
If your child needs dental or eye care	Eye exam	$20 copay, not subject to deductible.	Reimbursement up to $40.	Once every 12 months. Routine vision services not subject to deductible.
	Glasses	Standard glasses covered in full up to the $130 allowance	Reimbursement $40-$80	Lenses once per 12 months; Frames once per 24 months; max $130 allowance

Questions: Call Aetna/Innovation Health at 1-888-236-6249 or visit at www.ih-aetna.com/fcps for questions on your medical coverage. **For questions about your prescription drug coverage, c**all CVS Caremark at 1-888-217-4161 or visit http://info.caremark.com/fcps (active employees/non-Medicare retirees), or call SilverScript at 1-877-321-2597 or visit http://fairfaxps.silverscript.com (Medicare retirees). If you aren't clear about any of the bolded terms used in this form, see the Glossary at **www.healthcare.gov/glossary**.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
	Dental check-up	Not covered under medical plan	Not covered under medical plan	

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

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

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture-only if used by physician in lieu of anesthesia
- Bariatric Surgery-subject to Utilization Management approval
- Chiropractic care
- Hearing aids-only if result of accidental injury
- Infertility treatment-subject to Utilitization Management approval
- Emergency care when traveling outside the U.S.
- Private duty nursing-outpatient only- limited to 120 days per plan year
- Routine eye care

Questions: Call Aetna/Innovation Health at 1-888-236-6249 or visit at www.ih-aetna.com/fcps for questions on your medical coverage. **For questions about your prescription drug coverage, c**all CVS Caremark at 1-888-217-4161 or visit http://info.caremark.com/fcps (active employees/non-Medicare retirees), or call SilverScript at 1-877-321-2597 or visit http://fairfaxps.silverscript.com (Medicare retirees). If you aren't clear about any of the bolded terms used in this form, see the Glossary at **www.healthcare.gov/glossary**.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at www.fcps.edu or 571-423-3200, Option 3. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Aetna/Innovation Health by calling the toll free number on your Medical ID Card. Additionally, a consumer assistance program can help you file an **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) or

SilverScript at 1-877-321-2597 or visit http://fairfaxps.silverscript.com (Medicare retirees) .

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

See the attached information for language assistance information.

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

Questions: Call Aetna/Innovation Health at 1-888-236-6249 or visit at www.ih-aetna.com/fcps for questions on your medical coverage. **For questions about your prescription drug coverage, c**all CVS Caremark at 1-888-217-4161 or visit http://info.caremark.com/fcps (active employees/non-Medicare retirees), or call SilverScript at 1-877-321-2597 or visit http://fairfaxps.silverscript.com (Medicare retirees). If you aren't clear about any of the bolded terms used in this form, see the Glossary at **www.healthcare.gov/glossary**.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These coverage examples calculations are based on Individual Coverage Tier numbers for this plan.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,466
- **Plan pays:** $6,420
- **Patient pays:** $1,046

Sample care costs:

Hospital charges (includes mother, baby and anesthesia)	$4,471
Routine obstetric care	$2,084
Laboratory tests	$527
Prescriptions	$173
Radiology	$176
Vaccines, other preventive	$35
Total	**$7,466**

Patient pays:

Deductibles	$250
Copays	$165
Coinsurance	$481
Limits or exclusions	$150
Total	**$1,046**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,489
- **Plan pays:** $4,446
- **Patient pays:** $1,043

Sample care costs:

Prescriptions	$4,131
Medical Equipment and Supplies	$66
Office Visits and Procedures	$851
Education	$161
Laboratory tests	$137
Vaccines, other preventive	$140
Total	**$5,489**

Patient pays:

Deductibles	$250
Copays	$460
Coinsurance	$254
Limits or exclusions	$79
Total	**$1,043**

Questions: Call Aetna/Innovation Health at 1-888-236-6249 or visit at www.ih-aetna.com/fcps for questions on your medical coverage. **For questions about your prescription drug coverage, c**all CVS Caremark at 1-888-217-4161 or visit http://info.caremark.com/fcps (active employees/non-Medicare retirees), or call SilverScript at 1-877-321-2597 or visit http://fairfaxps.silverscript.com (Medicare retirees). If you aren't clear about any of the bolded terms used in this form, see the Glossary at **www.healthcare.gov/glossary**.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call Aetna/Innovation Health at 1-888-236-6249 or visit at www.ih-aetna.com/fcps for questions on your medical coverage; call CVS Caremark at 1-888-217-4161 or visit http://info.caremark.com/fcps for active member prescription questions, call CVS Caremark at 1-877-321-2597 or visit http://fairfaxps.silverscript.com for EGWP prescription questions. If you aren't clear about any of the bolded terms used in this form, see the Glossary at **www.healthcare.gov/glossary**.

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Aetna:

• Provides free aids and services to people with disabilities to communicate effectively with us, such as:
○ Qualified sign language interpreters
○ Written information in other formats (large print, audio, accessible electronic formats, other formats)
• Provides free language services to people whose primary language is not English, such as:
○ Qualified interpreters
○ Information written in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 14462, Lexington, KY 40512, 1-800-648-7817, TTY 711, Fax 859-425-3379, CRCoordinator@aetna.com. California HMO/HNO Members: Civil Rights Coordinator, PO Box 24030 Fresno CA, 93779, 1-800-648-7817, TTY 711, Fax 860-262-7705, CRCoordinator@aetna.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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.

Language Assistance

TTY: 711

For language assistance in English call 1-888-982-3862 at no cost. (English)

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 14462, Lexington, KY 40512, 1-800-648-7817, TTY 711, Fax 859-425-3379, CRCoordinator@aetna.com. California HMO/HNO Members: Civil Rights Coordinator, PO Box 24030 Fresno CA, 93779, 1-800-648-7817, TTY 711, Fax 860-262-7705, CRCoordinator@aetna.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
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Language Assistance
TTY: 711
For language assistance in English call 1-888-982-3862 at no cost. (English)

Para obtener asistencia lingüística en español, llame sin cargo al 1-888-982-3862 . (Spanish)

欲取得繁體中文語言協助，請撥打1-888-982-3862 ， 無需付費。 (Chinese)

Pour une assistance linguistique en français appeler le 1-888-982-3862 sans frais. (French)

Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-888-982-3862 nang walang bayad. (Tagalog)

T'áá shí shizaad k'ehjí bee shíká a'doowoł nínízingo Diné k'ehjí koji' t'áá jíik'e hólne' 1-888-982-3862 (Navajo)

Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-888-982-3862 an. (German)

Për asistencë në gjuhën shqipe telefononi falas në 1-888-982-3862 . (Albanian)

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للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-888-982-3862. (Arabic)

Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-888-982-3862 առանց գնով: (Armenian)

Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-888-982-3862 ku busa. (Bantu-Kirundi)

Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-888-982-3862 nga walay bayad. (Bisayan-Visayan)

বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-888-982-3862 -তে কল করুন। (Bengali- Bangala)

ဒွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-888-982-3862 ကို ခေါ်ဆိုပါ။ (Burmese)

Per rebre assistència en (català), truqui al número gratuït 1-888-982-3862 . (Catalan)

Para ayuda gi fino' (Chamoru), ågang 1-888-982-3862 sin gåstu. (Chamorro)

ᏱᎩᎾᎦᏅᏗᏓᏍᏆᏂᎪᏙᎾᎩ ᎾᏍᎩᏯ (ᏣᎳᎩ) ᏫᏂᏣᏏᏅ 1-888-982-3862 ᎤᏪᏥ ᏧᎪᏩᏛᎯᏓᏍᏕᎸᎯᏳᏒ. (Cherokee)

(Chahta) anumpa ya apela a chi l paya hinla **1**-888-982-3862 . (Choctaw)

Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-888-982-3862 irratti bilisaan bilbilaa. (Cushite)

Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-888-982-3862 . (Dutch)

Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-888-982-3862 gratis. (French Creole)

Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-888-982-3862 χωρίς χρέωση. (Greek)

(Gujarati) ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-888-982-3862 પર કૉલ કરો.

No ke kōkua ma ka ʻōlelo Hawaiʻi, e kahea aku i ka helu kelepona 1-888-982-3862 . Kāki ʻole ʻia kēia kōkua nei. (Hawaiian)

(Hindi) हिन्दी में भाषा सहायता के लिए, 1-888-982-3862 पर मुफ्त कॉल करें।

Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-888-982-3862 . (Hmong)

Maka enyemaka asụsụ na Igbo kpọọ 1-888-982-3862 na akwụghị ụgwọ ọ bụla (Ibo)

Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-888-982-3862 nga awan ti bayadanyo. (Ilocano)

Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-982-3862 tanpa dikenakan biaya. (Bahasa Indonesia)

Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-888-982-3862 . (Italian)

日本語で援助をご希望の方は、1-888-982-3862 まで無料でお電話ください。(Japanese)

လာတ်မၤစၢၤတ်ကတိၤကျိဉ်အဂီၢ် ကျိဉ် ကိး 1-888-982-3862 လၢတအိဉ်ဒီးတ်လၢာ်ဘျဉ်လၢာ်စုဟဉ် (Karen)

한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862 번으로 전화해 주십시오. (Korean)

Bé m̀ ké gbo-kpá-kpá dyé pídyi ɖé Bǎsɔ́ɔ̀-wùɖùǔn wɛ̃ɛ, ɖá 1-888-982-3862 (Kru-Bassa)

(Kurdish) .بۆ وەرگرتنی ڕێنوێنی پێوەندیدار بە زمان بە زمان بە ژمارەی 1-888-982-3862 بە خۆڕایی پەیوەندی بکەن

ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-888-982-3862 ໂດຍບໍ່ເສຍຄ່າໂທ. (Laotian)

तील भाषा (मराठी) सहाय्यासाठी 1-888-982-3862 क्रमांकावर कोणत्याही खर्चाशिवाय कॉल करा. (Marathi)

Ñan bōk jipañ ilo Kajin Majol, kallok 1-888-982-3862 ilo ejjelok wōnān. (Marshallese)

Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-888-982-3862 ni sohte isais. (Micronesian-Pohnpeian).

សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-888-982-3862 ដោយឥតគិតថ្លៃ។ (Mon-Khmer, Cambodian)

(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-888-982-3862 मा फोन गर्नुहोस् । (Nepali)

Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-888-982-3862 kecïn aɣöc. (Nilotic-Dinka)

For språkassistanse på norsk, ring 1-888-982-3862 kostnadsfritt. (Norwegian)

Fer Helfe in Deitsch, ruf: 1-888-982-3862 aa. Es Aaruf koschtet nix. (Pennsylvanian Dutch)

برای راهنمایی به زبان فارسی با شماره 1-888-982-3862 بدون هیچ هزینه ای تماس بگیرید. انگلیسی (Persian)

Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-888-982-3862 . (Polish)

Para obter assistência linguística em português ligue para o 1-888-982-3862 gratuitamente. (Portuguese)

(Punjabi) ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-888-982-3862 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।

Pentru asistenţă lingvistică în româneşte telefonaţi la numărul gratuit 1-888-982-3862 (Romanian)

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-888-982-3862 . (Russian)

Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-888-982-3862 e aunoa ma se totogi. (Samoan)

Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-888-982-3862 . (Serbo-Croatian)

Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-888-982-3862 . Njodi woo fawaaki on. (Sudanic-Fulfulde)

Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-888-982-3862 bila malipo. (Swahili)

ܐܢ ܐܢܬ ܐܝܬܠܟ ܡܬܘܪܓܡܢܘܬܐ ܒܠܫܢܐ ܣܘܪܝܝܐ

ܩܪܝ ܥܠ ܡܢܝܢܐ 1-888-982-3862 ܡܓܢܐܝܬ. (Assyrian-Syriac)

భాషతో సాయం కోరకు ఎలాంటి ఖర్చు లేకుండా 1-888-982-3862 కాల్ చేయండి. (తెలుగు) (Telugu)

สำหรับความช่วยเหลือทางด้านภาษาเป็นภาษาไทย โทร 1-888-982-3862 ฟรีไม่มีค่าใช้จ่าย (Thai)

Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-888-982-3862 'o 'ikai hā tōtōngi. (Tongan)

Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-888-982-3862 nge esapw kamé ngonuk. (Turkese-Chuukese)

(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-888-982-3862 . (Turkish)

Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-888-982-3862. (Ukrainian)

اُردو میں لسانی معاونت کے لیے 1-888-982-3862 پر مفت کال کریں۔ (Urdu)

Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-888-982-3862. (Vietnamese)

פאר שפראך הילף אין אידיש רופט 1-888-982-3862 פריי פון אפצאל. (Yiddish)

Fún ìrànlọwọ nípa èdè (Yorùbá) pe 1-888-982-3862 lái san owó kankan rárá. (Yoruba)