



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, www.HealthReformPlanSBC.com or by calling 1-888-982-3862. 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 1-888-982-3862 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In- <u>Network</u> (All Tiers): Individual \$500 / Family \$1,000. Out-of- <u>Network</u> : Individual \$1,000 / Family \$2,000.	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> office visits, <u>prescription drugs</u> & <u>preventive care</u> are 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> (All Tiers): Individual \$3,500 / Family \$7,000. Out-of- <u>Network</u> : Individual \$6,000 / Family \$13,000.	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> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover & penalties for failure to obtain <u>pre-authorization</u> for services.	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.aetna.com/dse/custom/inova or call 1-888-982-3862 for a list of in- <u>network providers</u> .	You pay the least if you use a <u>provider</u> in Maximum Savings In- <u>Network</u> . You pay more if you use a <u>provider</u> in Standard Savings Plus In- <u>Network</u> or Standard Savings In- <u>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			Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
		Maximum Savings In-Network Provider (You will pay the least)	Standard Savings Plus In-Network Provider (You will pay more)	Standard Savings In-Network Provider (You will pay more)		
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	\$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$25 <u>copay</u> /visit, <u>deductible</u> doesn't apply	50% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$20 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$20 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$50 <u>copay</u> /visit, <u>deductible</u> doesn't apply	50% <u>coinsurance</u>	None
	<u>Preventive care</u> / <u>screening</u> /immunization	No charge	No charge	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.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge for Inova Diagnostic Laboratory; 20% <u>coinsurance</u> for laboratory; \$25 <u>copay</u> /visit for x-ray, <u>deductible</u> doesn't apply	20% <u>coinsurance</u> for laboratory; \$25 <u>copay</u> /visit for x-ray, <u>deductible</u> doesn't apply	20% <u>coinsurance</u> for laboratory; \$100 <u>copay</u> /visit for x-ray, <u>deductible</u> doesn't apply	50% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	\$100 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$100 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$400 <u>copay</u> /visit, <u>deductible</u> doesn't apply	50% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay			Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
		Maximum Savings In-Network Provider (You will pay the least)	Standard Savings Plus In-Network Provider (You will pay more)	Standard Savings In-Network Provider (You will pay more)		
<p>If you need drugs to treat your illness or condition</p> <p><u>Prescription drug coverage is administered by Capital Rx</u></p> <p>More information about <u>prescription drug coverage</u> is available at www.cap-rx.com</p>	Generic drugs	<u>Copay</u> /prescription, deductible doesn't apply: \$5 (30 day retail), \$15 (31-90 day retail & mail order); Only applies to prescriptions filled at the in house pharmacy	Not applicable	<u>Copay</u> /prescription, deductible doesn't apply: \$10 (30 day retail), \$30 (31-90 day retail & mail order)	Not covered	<p>Covers 30 day supply (retail), 31-90 day supply (Inova Plus Pharmacy, select retail 90 locations & Optum Home Delivery).</p> <p>Includes contraceptive drugs & devices obtainable from a pharmacy, oral & injectable fertility drugs limited to \$20,000 maximum/lifetime. No charge for preferred generic FDA-approved women's contraceptives in-<u>network</u>.</p> <p>Review your <u>formulary</u> for prescriptions requiring precertification or step therapy for coverage.</p>
	Preferred brand drugs	20% <u>Coinsurance</u> with minimum & maximum/ prescription, deductible doesn't apply: \$20/\$50 (30 day retail), \$50/\$125 (31-90 day retail & mail order); Only applies to prescriptions filled at the in house pharmacy	Not applicable	20% <u>Coinsurance</u> with minimum & maximum/ prescription, deductible doesn't apply: \$25/\$80 (30 day retail), \$65/\$200 (31-90 day retail & mail order)	Not covered	

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Maximum Savings In-Network Provider (You will pay the least)	Standard Savings Plus In-Network Provider (You will pay more)	Standard Savings In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	Non-preferred brand drugs	30% <u>coinsurance</u> with minimum & maximum/prescription, deductible doesn't apply: \$55/\$100 (30 day retail), \$150/\$250 (31-90 day retail & mail order); Only applies to prescriptions filled at the in house pharmacy	Not applicable	35% <u>coinsurance</u> with minimum & maximum/prescription, deductible doesn't apply: \$75/\$120 (30 day retail), \$190/\$300 (31-90 day retail & mail order)	Not covered	Your cost will be higher for choosing Brand over Generics. Maintenance drugs- after two retail fills, members are required to fill a 90-day supply at Inova Pharmacy Plus, Optum Home Delivery mail service, or select retail pharmacy location, otherwise, higher costs may apply. Certain medications will need to be filled at Inova Pharmacy Plus including but not limited to specialty medications.
	<u>Specialty drugs</u>	30% <u>coinsurance</u> up to maximum prescription, deductible doesn't apply: \$100 (generic and preferred), \$200 (non-preferred)	Not applicable	30% <u>coinsurance</u> up to maximum prescription, deductible doesn't apply: \$100 (generic and preferred), \$200 (non-preferred); Only certain Specialty Drugs apply	Not covered	Must use Inova Pharmacy Plus for most <u>specialty drugs</u> .
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Physician/surgeon fees	10% <u>coinsurance</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Maximum Savings In-Network Provider (You will pay the least)	Standard Savings Plus In-Network Provider (You will pay more)	Standard Savings In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u> after \$200 <u>copay/visit</u>	20% <u>coinsurance</u> after \$200 <u>copay/visit</u>	20% <u>coinsurance</u> after \$200 <u>copay/visit</u>	20% <u>coinsurance</u> after \$200 <u>copay/visit</u>	Out-of-network emergency use paid the same as in-network. No coverage for non-emergency use.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Out-of-network emergency use paid the same as in-network. Non-emergency transport: not covered, except 50% <u>coinsurance</u> if pre-authorized.
	<u>Urgent care</u>	\$5 <u>copay/visit</u> , <u>deductible</u> doesn't apply for Go Health; otherwise \$35 <u>copay/visit</u> , <u>deductible</u> doesn't apply.	\$35 <u>copay/visit</u> , <u>deductible</u> doesn't apply	\$50 <u>copay/visit</u> , <u>deductible</u> doesn't apply	50% <u>coinsurance</u>	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u> after \$100 <u>copay/stay</u>	20% <u>coinsurance</u> after \$100 <u>copay/stay</u>	50% <u>coinsurance</u> after \$500 <u>copay/stay</u>	50% <u>coinsurance</u> after \$1,000 <u>copay/stay</u>	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$20 <u>copay/visit</u> , <u>deductible</u> doesn't apply; other outpatient services: no charge	Office: \$20 <u>copay/visit</u> , <u>deductible</u> doesn't apply; other outpatient services: no charge	Office: \$50 <u>copay/visit</u> , <u>deductible</u> doesn't apply; other outpatient services: no charge	Office & other outpatient services: 40% <u>coinsurance</u>	None
	Inpatient services	20% <u>coinsurance</u> after \$100 <u>copay/stay</u>	20% <u>coinsurance</u> after \$100 <u>copay/stay</u>	50% <u>coinsurance</u> after \$500 <u>copay/stay</u>	40% <u>coinsurance</u> after \$1,000 <u>copay/stay</u>	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
If you are pregnant	Office visits	No charge	No charge	No charge	50% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Maximum Savings In-Network Provider (You will pay the least)	Standard Savings Plus In-Network Provider (You will pay more)	Standard Savings In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	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). Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care may apply.
	Childbirth/delivery facility services	20% <u>coinsurance</u> after \$100 <u>copay/stay</u>	20% <u>coinsurance</u> after \$100 <u>copay/stay</u>	50% <u>coinsurance</u> after \$500 <u>copay/stay</u>	50% <u>coinsurance</u> after \$1,000 <u>copay/stay</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	120 visits/calendar year. Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u> , except 50% <u>coinsurance</u> for Physical Therapy	50% <u>coinsurance</u>	90 visits/calendar year for Physical, Occupational & Speech Therapy combined.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Skilled nursing care</u>	20% <u>coinsurance</u> after \$100 <u>copay/stay</u>	20% <u>coinsurance</u> after \$100 <u>copay/stay</u>	20% <u>coinsurance</u> after \$500 <u>copay/stay</u>	50% <u>coinsurance</u> after \$1,000 <u>copay/stay</u>	120 days/calendar year. Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Maximum Savings In-Network Provider (You will pay the least)	Standard Savings Plus In-Network Provider (You will pay more)	Standard Savings In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	Hospice services	20% <u>coinsurance</u> after \$100 <u>copay</u> /stay for inpatient; 20% <u>coinsurance</u> for outpatient	20% <u>coinsurance</u> after \$100 <u>copay</u> /stay for inpatient; 20% <u>coinsurance</u> for outpatient	20% <u>coinsurance</u> after \$500 <u>copay</u> /stay for inpatient; 20% <u>coinsurance</u> for outpatient	50% <u>coinsurance</u> after \$1,000 <u>copay</u> /stay for inpatient; 50% <u>coinsurance</u> for outpatient	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	Not covered	Not covered.
	Children's glasses	Not covered	Not covered	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	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)
- Glasses (Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult & Child)
- 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.)

- Acupuncture - 20 visits/calendar year for pain therapy.
- Bariatric surgery
- Chiropractic care - 30 visits/calendar year.
- Gender Affirmation Benefits
- Hearing aids - 1 hearing aid per ear/calendar year.
- Infertility treatment - For more information & exceptions, see policy document provided by your employer or call the number on your ID card.
- Private-duty nursing - 70- 8 hour shifts/calendar year.

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 1-888-982-3862.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <http://www.dol.gov/ebsa/healthreform>
- 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.

- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

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 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:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general number at 1-888-982-3862. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <http://www.dol.gov/ebsa/healthreform>
- 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>.

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 \$500
- Specialist copayment \$20
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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:	
<i>Cost Sharing</i>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$1,900
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,470

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$500
- Specialist copayment \$20
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

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

Total Example Cost	\$5,600
In this example, Joe would pay:	
<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$520

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

- The plan's overall deductible \$500
- Specialist copayment \$20
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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	\$2,800
In this example, Mia would pay:	
<i>Cost Sharing</i>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$50
<u>Coinsurance</u>	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$950

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: 1-888-982-3862.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-888-877-0943.

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

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, 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,
1-800-648-7817, TTY: 711,
Fax: 859-425-3379, 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).

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TTY: 711

Language Assistance:

To access language services at no cost to you, call 1-888-982-3862.

- Albanian - Për shërbime përkthimi falas për ju, telefononi 1-888-982-3862.
- Amharic - የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-888-982-3862 ይደውሉ።
- Arabic - للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-888-982-3862
- Armenian - Անվճար լեզվակլան ծառայություններից օգտվելու համար զանգահարեք 1-888-982-3862 հեռախոսահամարով:
- Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-982-3862 tanpa dikenakan biaya.
- Bantu-Kirundi - Kugira uronke serivisi z'indimi atakiguzi, hamagara 1-888-982-3862.
- Bengali-Bangala - আপনাকে বিনামূল্যে ভাষা পবিকষিা পপকে হকয এই নষ্বকি পেবযক ান েরুন: 1-888-982-3862
- Bisayan-Visayan - Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-888-982-3862.
- Burmese - သင့်အေချဖင့် အေေဟကးေငြ မေပးရဲဲ ဘာသာစကားဝန်ေဆာင့်မ်း ရရှိုံးိုင့်န 1-888-982-3862 သို့ ဖုန်းေခေင့်ဆိုပါ။
- Catalan - Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-888-982-3862.
- Chamorro - Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-888-982-3862.
- Cherokee - Ⴀႃ႗ႃ Ⴀႃ႗ႃ႗ႃ Ⴀႃ႗ႃ႗ႃ Ⴀႃ႗ႃ Ⴀႃ႗ႃ႗ႃ Ⴀႃ႗ႃ Ⴀႃ႗ႃ႗ႃ 1-888-982-3862.
- Chinese - 如欲使用免費語言服務，請致電 1-888-982-3862.
- Choctaw - Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-888-982-3862.
- Cushite - Tajaajiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-888-982-3862.
- Dutch - Voor gratis toegang tot taaldiensten, bell 1-888-982-3862.
- French - Afin d'accéder aux services langagiers sans frais, composez le 1-888-982-3862.
- French Creole - Pou jwenn sèvis lang gratis, rele 1-888-982-3862.
- German - Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-888-982-3862 an.
- Greek - Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-888-982-3862.
- Gujarati - તમારેકોઇ જાતના ખર્ચવિના ભાષાની સેિાઓની પહોોર માટે, કોલ કરો 1-888-982-3862.

- Hawaiian - No ka wala'au 'ana me ka lawelawe 'ōlelo e kahea aku i kēia helu kelepona 1-888-982-3862. Kāki 'ole 'ia kēia kōkua nei.
- Hindi - आपकेलिए बिना ककसी कीमत केभाषा सेवाओंका उपयोग करनेकेलिए, 1-888-982-3862 पर कॉल करें।
- Hmong - Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-888-982-3862.
- Igbo - Iji nwetaòhèrè na ọrụ gasị asụsụ n'efu, kpọọ 1-888-982-3862
- Ilocano - Tapno maaksesyo dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti 1-888-982-3862.
- Indonesian - Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi 1-888-982-3862.
- Italian - Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-888-982-3862.
- Japanese - 言語サービスを無料でご利用いただくには、1-888-982-3862 までお電話ください。
- Karen - လာတာကမနာကိပ်အတာမစာအတာဖံးတာမတဖုလာတအိပ်ဒီးအပူလာကဘုဟုအိအဂီဘုနု ကိး 1-888-982-3862 တကု.
- Korean - 무료 언어 서비스를 이용하려면 1-888-982-3862 번으로 전화해 주십시오.
- Kru-Bassa - M̈ d̈yi wuɖu-dù kà kò d̈ò b̈ě d̈yi m̈óú n̈ ní Pídyi ní, níí, d̈á n̈òb̈à n̈ià ke: 1-888-982-3862
- Kurdish - 1-888-982-3862 بۆ دەسپێرێ کەشتن بە خزمەتگوزاری زمان بەی تێچوون بۆ تۆ، پەیمەندی بکە بە ژمارە 1-888-982-3862
- Laotian - ຕຳແໜ່ງໃຊ້ການບໍລິການພາສາໃດໜຶ່ງເພື່ອບໍ່ຈ່າຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໃບທາດປີ1-888-982-3862
- Marathi - कोणत्याही शब्दकालशाखा भाषा सेवा प्राप्त करण्यासाठी,, 1-888-982-3862 वर फोन करा.
- Marshallese - Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlok 1-888-982-3862.
- Micronesian-Pohnpeyan - Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1-888-982-3862.
- Mon-Khmer, Cambodian - ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-888-982-3862។
- Navajo - T'áá ni nizaad k'ehjí bee níká a'doowoł doo bááh ílínígóó kojí' hólne' 1-888-982-3862.
- Nepali - निःशुल्क भाषा सेवा प्राप्त गर्न 1-888-982-3862 मा टेलिफोन गर्नुहोस् ।
- Nilotic-Dinka - Të koor yin wëër de thokic ke cïn wëu kør keek tënɔŋ yin. Ke cɔl kɔc ye kɔc kuɔny ne nɔmba 1-888-982-3862.
- Norwegian - For tilgang til kostnadsfri språktjenester, ring 1-888-982-3862.
- Pennsylvania Dutch - Um Schprooch Services zu griege mitaus Koscht, ruff 1-888-982-3862.
- Persian - برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-888-982-3862 تماس بگیرید .
- Polish - Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-888-982-3862.
- Portuguese - Para acessar os serviços de idiomas sem custo para você, ligue para 1-888-982-3862.
- Punjabi - ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1-888-982-3862 'ਤੇ ਫ਼ੋਨ ਕਰੋ।

