



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, <https://www.aetna.com/sbcsearch/getcbpolicydocs?P=0774622&Y=25>, or by calling 1-844-365-7375. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-844-365-7375 to request a copy.

| Important Questions  | Answers  | Why This Matters:   |
|--|--|---|
| <b>What is the overall deductible?</b>                             | In- <u>Network</u> : Individual \$5,000 / Family \$10,000.   | 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> .   |
| <b>Are there services covered before you meet your deductible?</b> | Yes. Certain office visits, <u>preventive care</u> and <u>urgent care in-network</u> .   | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .  |
| <b>Are there other deductibles for specific services?</b>          | No.  | You don't have to meet <u>deductibles</u> for specific services.  |
| <b>What is the out-of-pocket limit for this plan?</b>              | In- <u>Network</u> : Individual \$8,000 / Family \$16,000.   | 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.   |
| <b>What is not included in the out-of-pocket limit?</b>            | <u>Premiums</u> and health care this <u>plan</u> doesn't cover.  | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .  |
| <b>Will you pay less if you use a network provider?</b>            | Yes. See <a href="https://aetna.com/providersearch_innovationhealth">https://aetna.com/providersearch_innovationhealth</a> or call 1-844-365-7375 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 charge</u> and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| <b>Do you need a referral to see a specialist?</b>                 | Yes.   | This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .  |



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event   | Services You May Need                                   | What You Will Pay   |   | Limitations, Exceptions, & Other Important Information   |
|--|---|---|---|--|
|  |   | In-Network Provider (You will pay the least)  | Out-of-Network Provider (You will pay the most) |  |
| <b>If you visit a health care provider's office or clinic</b>  | Primary care visit to treat an injury or illness        | \$40 <u>copay</u> /visit, <u>deductible</u> does not apply; including virtual services  | Not covered                                     | None   |
|  | <u>Specialist</u> visit                                 | \$80 <u>copay</u> /visit, <u>deductible</u> does not apply  | Not covered                                     | None   |
|  | <u>Preventive care</u> / <u>screening</u> /immunization | No charge   | Not covered                                     | You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.  |
| <b>If you have a test</b>  | <u>Diagnostic test</u> (x-ray, blood work)              | 40% <u>coinsurance</u>  | Not covered                                     | None   |
|  | Imaging (CT/PET scans, MRIs)                            | 40% <u>coinsurance</u>  | Not covered                                     | None   |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://aet.na/vaiv125">http://aet.na/vaiv125</a> | Preferred/non-preferred generic drugs                   | <u>Copay</u> / prescription, <u>deductible</u> does not apply: Tier 1: \$20 for up to a 30 day supply, \$50 for up to a 90 day supply | Not covered                                     | Covers up to a 30 day supply (retail prescription), 31-90 day supply (retail & mail order prescription). Applicable cost share plus difference (brand minus generic cost) applies for brand when generic available. No charge for preferred generic FDA-approved women's contraceptives in- <u>network</u> . Review your <u>formulary</u> for prescriptions requiring precertification or step therapy for coverage. |
|  | Preferred brand drugs                                   | <u>Copay</u> / prescription, <u>deductible</u> does not apply: \$40 for up to a 30 day supply, \$100 for up to a 90 day supply        | Not covered                                     |  |
|  | Non-preferred brand drugs                               | <u>Copay</u> / prescription: \$80 for up to a 30 day supply, \$200 for up to a 90 day supply  | Not covered                                     |  |
|  | Preferred/non-preferred <u>specialty drugs</u>          | \$350 <u>copay</u> / prescription for up to a 30 day supply   | Not covered                                     | All specialty <u>prescription drug</u> fills on initial fill must be filled at a <u>network</u> specialty pharmacy except for urgent situations. Your <u>plan</u> may include access to selected participating retail pharmacies for certain <u>specialty drugs</u> .  |
| <b>If you have outpatient surgery</b>  | Facility fee (e.g., ambulatory surgery center)          | 40% <u>coinsurance</u>  | Not covered                                     | None   |
|  | Physician/surgeon fees                                  | 40% <u>coinsurance</u>  | Not covered                                     | None   |

| Common Medical Event  | Services You May Need                     | What You Will Pay   |   | Limitations, Exceptions, & Other Important Information   |
|---|---|---|---|--|
|   |   | In-Network Provider (You will pay the least)  | Out-of-Network Provider (You will pay the most) |  |
| If you need immediate medical attention                                   | <u>Emergency room care</u>                | 40% <u>coinsurance</u>  | 40% <u>coinsurance</u>                          | Out-of-network <u>emergency room care</u> cost-share same as in-network. No coverage for non-emergency care.   |
|   | <u>Emergency medical transportation</u>   | 40% <u>coinsurance</u>  | 40% <u>coinsurance</u>                          | Out-of-network cost-share same as in-network.  |
|   | <u>Urgent care</u>                        | \$60 <u>copay/visit</u> , <u>deductible</u> does not apply  | Not covered                                     | No coverage for non-urgent use.  |
| If you have a hospital stay   | Facility fee (e.g., hospital room)        | 40% <u>coinsurance</u>  | Not covered                                     | None   |
|   | Physician/surgeon fees                    | 40% <u>coinsurance</u>  | Not covered                                     | None   |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | Outpatient office visits: \$40 <u>copay/visit</u> , <u>deductible</u> does not apply; All other outpatient services: 40% <u>coinsurance</u> | Not covered                                     | All other outpatient services includes Applied Behavioral Analysis (ABA) services.   |
|   | Inpatient services                        | 40% <u>coinsurance</u>  | Not covered                                     | None   |
| If you are pregnant   | Office visits                             | No charge   | Not covered                                     | <u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |
|   | Childbirth/delivery professional services | 40% <u>coinsurance</u>  | Not covered                                     |  |
|   | Childbirth/delivery facility services     | 40% <u>coinsurance</u>  | Not covered                                     |  |
| If you need help recovering or have other special health needs            | <u>Home health care</u>                   | \$40 <u>copay/visit</u> , <u>deductible</u> does not apply  | Not covered                                     | Coverage is limited to 100 visits.   |
|   | <u>Rehabilitation services</u>            | \$40 <u>copay/visit</u> , <u>deductible</u> does not apply  | Not covered                                     | Coverage is limited to 30 visits for Physical Therapy and Occupational Therapy combined, 30 visits for Speech Therapy.   |
|   | <u>Habilitation services</u>              | 40% <u>coinsurance</u>  | Not covered                                     | None   |
|   | <u>Skilled nursing care</u>               | 40% <u>coinsurance</u>  | Not covered                                     | Coverage is limited to 100 days per admission.   |
|   | <u>Durable medical equipment</u>          | 50% <u>coinsurance</u>  | Not covered                                     | Coverage is limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.   |
|   | <u>Hospice services</u>                   | 40% <u>coinsurance</u>  | Not covered                                     | None   |

| Common Medical Event                          | Services You May Need      | What You Will Pay  |   | Limitations, Exceptions, & Other Important Information  |
|---|----------------------------|--|---|---|
|   |                            | In-Network Provider (You will pay the least)               | Out-of-Network Provider (You will pay the most) |   |
| <b>If your child needs dental or eye care</b> | Children's eye exam        | \$10 <u>copay</u> /visit, <u>deductible</u> does not apply | Not covered                                     | Coverage is limited to 1 exam every 12 months up to age 19.   |
|   | Children's glasses         | \$10 <u>copay</u> /visit, <u>deductible</u> does not apply | Not covered                                     | Coverage is limited to 1 set of frames and 1 set of contact lenses or eyeglass lenses every 12 months up to age 19. |
|   | Children's dental check-up | Not covered  | Not covered                                     | Not covered.  |

**Excluded Services & Other Covered Services:**

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

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

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

- Chiropractic care - Coverage is limited to 30 visits.
- Dental care (Adult) - Coverage is limited to ages 19 and up. Routine Cleaning (2 per calendar year). \$1,000 calendar year maximum for all dental services (Routine check-up, Basic & Major).
- Hearing aids - Coverage is limited to one hearing aid per ear every 24 months up to \$1,500 per hearing aid for ages 0-18.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition, including artificial insemination.
- Private-duty nursing - Coverage is limited to 16 hours.
- Routine eye care (Adult) - Coverage is limited to ages 19 and up. 1 routine eye exam, including dilation. Coverage does not include the office visit for the fitting of prescription contact lenses.

**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: State Corporation Commission, Virginia Bureau of Insurance, 1-877-310-6560, <https://scc.virginia.gov/pages/Insurance>.

- For more information on your rights to continue coverage, contact the plan at 1-844-365-7375.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596 or state health insurance marketplace or SHOP.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete

information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- State Corporation Commission, Virginia Bureau of Insurance, 1-877-310-6560, <https://scc.virginia.gov/pages/Insurance>.

**Does this plan provide Minimum Essential Coverage? Yes.**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**Does this plan meet Minimum Value Standards? Not Applicable.**

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

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

## About these Coverage Examples:



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

### Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$5,000
- Specialist copayment \$80
- Hospital (facility) coinsurance 40%
- Other coinsurance 40%

#### This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
Diagnostic tests (*ultrasounds and blood work*)  
Specialist visit (*anesthesia*)

|  |                 |
|--|-----------------|
| <b>Total Example Cost</b>              | <b>\$12,700</b> |
| <b>In this example, Peg would pay:</b> |                 |
| <i>Cost Sharing</i>                    |                 |
| <u>Deductibles</u>                     | \$5,000         |
| <u>Copayments</u>                      | \$10            |
| <u>Coinsurance</u>                     | \$2,600         |
| <i>What isn't covered</i>              |                 |
| Limits or exclusions                   | \$60            |
| <b>The total Peg would pay is</b>      | <b>\$7,670</b>  |

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

- The plan's overall deductible \$5,000
- Specialist copayment \$80
- Hospital (facility) coinsurance 40%
- Other coinsurance 40%

#### This EXAMPLE event includes services like:

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

|  |                |
|--|----------------|
| <b>Total Example Cost</b>              | <b>\$5,600</b> |
| <b>In this example, Joe would pay:</b> |                |
| <i>Cost Sharing</i>                    |                |
| <u>Deductibles</u>                     | \$100          |
| <u>Copayments</u>                      | \$1,600        |
| <u>Coinsurance</u>                     | \$0            |
| <i>What isn't covered</i>              |                |
| Limits or exclusions                   | \$20           |
| <b>The total Joe would pay is</b>      | <b>\$1,720</b> |

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

- The plan's overall deductible \$5,000
- Specialist copayment \$80
- Hospital (facility) coinsurance 40%
- Other coinsurance 40%

#### This EXAMPLE event includes services like:

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

|  |                |
|--|----------------|
| <b>Total Example Cost</b>              | <b>\$2,800</b> |
| <b>In this example, Mia would pay:</b> |                |
| <i>Cost Sharing</i>                    |                |
| <u>Deductibles</u>                     | \$1,900        |
| <u>Copayments</u>                      | \$300          |
| <u>Coinsurance</u>                     | \$0            |
| <i>What isn't covered</i>              |                |
| Limits or exclusions                   | \$0            |
| <b>The total Mia would pay is</b>      | <b>\$2,200</b> |

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-844-365-7375.

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

### Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-844-365-7375.

### 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](mailto: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:**

For language assistance in your language call 1-844-365-7375 at no cost.

- Albanian - Për shërbime përkthimi falas për ju, telefononi 1-844-365-7375.
- Amharic - የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-844-365-7375 ይደውሉ።
- Arabic - مقررا لى ع ل اص ت ال اء اجر ل ا ؁ ةفل ك ت ي أ ن و د ة و ع ل ل ل ا ت ا م د خ ل ا ل ع ل و ص ح ل ل 1-844-365-7375
- Armenian - Անվճար լեզվակախ ծառայություններից օգտվելու համար զանգահարեք 1-844-365-7375 հեռախոսահամարով:
- Bahasa-Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-844-365-7375 tanpa dikenakan biaya.
- Bantu-Kirundi - Kugira uronke serivisi z'indimi atakiguzi, hamagara 1-844-365-7375.
- Bengali-Bangala - আপনাকে বিনামূল্যে ভাষা পবকিষাি পপকে হকয এই নম্বকি পবেযক ান ব্লেন: 1-844-365-7375।
- Bisayan-Visayan - Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-844-365-7375.
- Burmese - သင့်အနေဖြင့် အခကြေးငွေ မပေးရပဲ ဘာသာစကားဝန်ဆောင်မှုများ ရရှိနိုင်ရန် 1-844-365-7375 သို့ ဖုန်းခေါ်ဆိုပါ။
- Catalan - Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-844-365-7375.
- Chamorro - Para un hago' i setbision lengguâhi ni dibâtde para hâgu, âgang 1-844-365-7375.
- Cherokee - ႠႃႆႠ ႠႃႆႠ ႠႃႆႠ ႠႃႆႠ ႠႃႆႠ ႠႃႆႠ ႠႃႆႠ ႠႃႆႠ ႠႃႆႠ ႠႃႆႠ 1-844-365-7375.
- Chinese - 如欲使用免費語言服務，請致電 1-844-365-7375。
- Choctaw - Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-844-365-7375.
- Cushite - Tajaajiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-844-365-7375.
- Dutch - Voor gratis toegang tot taaldiensten, bell 1-844-365-7375.
- French - Afin d'accéder aux services langagiers sans frais, composez le 1-844-365-7375.
- French Creole - Pou jwenn sèvis lang gratis, rele 1-844-365-7375.
- German - Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-844-365-7375 an.
- Greek - Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-844-365-7375.



- Gujarati - તમારે કોઇ જાતના ખર્ચ વગિ ભાષાની સેવિઓની પહોર માટે, કોલ કરો 1-844-365-7375.
- Hawaiian - No ka wala'au 'ana me ka lawelawe 'olelo e kahea aku i kēia helu kelepona 1-844-365-7375 Kāki 'ole 'ia kēia kōkua nei.
- Hindi - आपके लिए बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लए, 1-844-365-7375 पर कॉल करें।
- Hmong - Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-844-365-7375.
- Igbo - Iji nwetaòhèrè na orụ gasị asụsụ n'efu, kpọọ 1-844-365-7375.
- Ilocano - Tapno maaksesyo dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti 1-844-365-7375.
- Indonesian - Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi 1-844-365-7375.
- Italian - Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-844-365-7375.
- Japanese - 言語サービスを無料でご利用いただくには、1-844-365-7375 までお電話ください
- Karen - လာတၢ်ကမၤန့ၢ်ကိၣ်အတၢ်မၤစၢၤအတၢ်ဖံးတၢ်မၤတဖၣ်လၢတအိၣ်ဒီးအပူၤလၢကဘၣ်ဟ့ၣ်အိၣ်အဂီၢ်ဘၣ်န့ၣ် ကိး 1-844-365-7375 တက့ၢ်.
- Korean - 무료 언어 서비스를 이용하려면 1-844-365-7375 번으로 전화해 주십시오.
- Kru-Bassa - M dyi wudu-dù kà kò dò bě dyi móun nì Pídyi ní, níí, dá nòbà nà ke: 1-844-365-7375.
- Kurdish - 1-844-365-7375 یەرامژ مە مەكەب یەدن هەوی هەپ، و تۆ بۆ نوو چۆ ئۆت ئۆبەب نامز یراز و گەتەمەز مەب نەت شە یەگەر ئۆبەس دە و ب
- Laotian - ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ 1-844-365-7375.
- Marathi - कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी 1-844-365-7375 वर फोन करा.
- Marshallese - Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlök 1-844-365-7375.
- Micronesian Pohnpeyan - Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1-844-365-7375.
- Mon-Khmer Cambodian - ដើម្បីប្រើប្រាស់សេវាភាសាដោយឥតគិតថ្លៃសម្រាប់អ្នកមុន ឬ មុន ទៅកាន់ដល់ 1-844-365-7375។.
- Navajo - T'áá ni nizaad k'ehjí bee níká a'doowol doo b'áá h' ílínígóó kojí' hólne' 1-844-365-7375.
- Nepali - निःशुल्क भाषा सेवा प्राप्त गनन 1-844-365-7375 मा टेलिफोन गनुनहोस् ।
- Nilotic-Dinka - Të koor yin wëër de thokic ke cìn wëu kor keek tënɔŋ yin. Ke cɔl koc ye koc kuony ne nɔmba 1-844-365-7375.
- Norwegian - For tilgang til kostnadsfri språktjenester, ring 1-844-365-7375.

- Pennsylvania Dutch - Um Schprooch Services zu griege mitaus Koscht, ruff 1-844-365-7375.
- Persian - ديري گب سامت 1-844-365-7375 مر امش اب ،ن اگي ار روط هب نابز تا مدخ هب ی سررتسد ی ارب
- Polish - Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-844-365-7375.
- Portuguese - Para acessar os serviços de idiomas sem custo para você, ligue para 1-844-365-7375.
- Punjabi - ਤੁਹਾਡੇ ਲਈ ਬਨਿਾਂ ਬਸਿੇ ਮਿਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਰਿਨ ਲਈ, 1-844-365-7375 'ਤੇ ਫੋਨ ਰਿ।
- Romanian - Pentru a accesa gratuit serviciile de limbă, apălați 1-844-365-7375.
- Russian - Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-844-365-7375.
- Samoan - Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala'au le 1-844-365-7375.
- Serbo-Croatian - Za besplatne prevodilačke usluge pozovite 1-844-365-7375.
- Spanish - Para acceder a los servicios de idiomas sin costo, llame al 1-844-365-7375.
- Sudanic-Fulfulde - Heeba a nasta jangirde djey wolde wola chede bo apelou lamba 1-844-365-7375.
- Swahili - Kupata huduma za lugha bila malipo kwako, piga 1-844-365-7375.
- Syriac - 1-844-365-7375 .
- Tagalog - Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-844-365-7375.
- Telugu - మరొక భాష నవలను ఉచితంగా అందుకునందుకు, 1-844-365-7375 కు కల్ చీయండి.
- Thai - หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-844-365-7375.
- Tongan - Kapau 'oku ke fiema'u ta'etötōngi 'a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he 1-844-365-7375.
- Trukese - Ren omw kopwe angei aninisin eman chon awewei (ese kamo), kopwe kori 1-844-365-7375.
- Turkish - Sizin için ücretsiz dil hizmetlerine erişebilmek için, 1-844-365-7375 numarayı arayın.
- Ukrainian - Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-844-365-7375.
- Urdu - سیرک تاب رپ 1-844-365-7375 سے نرک لصاح تا مدخ مقل عتم سے نابز تم قلاب۔
- Vietnamese - Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-844-365-7375.
- Yiddish - צו צוטריט קארפּש באַדינונגען אין קיין פּרייז צו איר, רופן 1-844-365-7375
- Yoruba - Lati wonú awon isẹ èdè l'ofẹ fun o, pe 1-844-365-7375.