innovation HEALTH' Aetra linova : VA IH Bronze 8700 100% HMO



The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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=0751718&Y=22, or by calling 1-844-365-7375. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> 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.

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Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	In- <u>network</u> : Individual \$8,700 / Family \$17,400.	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. <u>Preventive care</u> in- <u>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 <u>https://www.healthcare.gov/coverage/preventive-care-benefits</u> /.
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet deductibles for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	In- <u>network</u> : Individual \$8,700 / Family \$17,400.	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</u> <u>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> ?	Premiums and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a <u>network provider</u> ?	Yes. See https://aet.na/providersearch_innovationhealth or call 1-844-365-7375 for a list of in- <u>network providers</u> .	This <u>plan</u> uses a <u>provider</u> <u>network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's</u> <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 <u>referral</u> to see a <u>specialist</u> ?	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 **<u>copayment</u>** and **<u>coinsurance</u>** costs shown in this chart are after your **<u>deductible</u>** has been met, if a <u>**deductible**</u> applies.

		What You Will Pay		
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out–of–Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	0% coinsurance	Not covered	None
If you visit a health care	<u>Specialist</u> visit	0% coinsurance	Not covered	None
<u>provider's</u> office or clinic	<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.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	Not covered	Applies to services received in office or in outpatient setting.
n you nave a test	Imaging (CT/PET scans, MRIs)	0% coinsurance	Not covered	Applies to services received in office or in outpatient setting.
	Preferred generic drugs	0% <u>coinsurance</u> for up to a 90 day supply	Not covered	Covers up to a 30 day supply (retail prescription), 31-90 day supply (retail & mail
If you need drugs to treat your illness or condition	Preferred brand drugs	0% <u>coinsurance</u> for up to a 90 day supply	Not covered	order prescription). Applicable cost share plus difference (brand minus generic cost) applies
More information about prescription drug <u>coverage</u> is available at http://aet.na/vaihivl	Non-preferred generic/brand drugs	0% <u>coinsurance</u> for up to a 90 day supply	Not covered	for brand when generic available. No charge for preferred generic FDA-approved women's contraceptives in- <u>network</u> .
	Preferred <u>Specialty drugs,</u> Non-preferred <u>Specialty drugs</u>	0% <u>coinsurance</u> 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 CVS retail pharmacies for certain <u>specialty drugs</u> .
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	Not covered	None
	Physician/surgeon fees	0% <u>coinsurance</u>	Not covered	None
If you need immediate	Emergency room care	0% coinsurance	0% coinsurance	Out-of-network <u>emergency room care</u> cost-share same as in- <u>network</u> .
medical attention	Emergency medical transportation	0% coinsurance	0% coinsurance	Out-of-network cost-share same as in-network.
	Urgent care	0% coinsurance	Not covered	No coverage for non-urgent use.

		What You Will Pay		
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out–of–Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have a	Facility fee (e.g., hospital room)	0% coinsurance	Not covered	None
hospital stay	Physician/surgeon fees	0% coinsurance	Not covered	None
If you need mental health, behavioral health, or	Outpatient services	Office visits and all other outpatient services: 0% coinsurance	Not covered	None
substance abuse services	Inpatient services	0% <u>coinsurance</u>	Not covered	None
	Office visits	No charge	Not covered	Cost sharing does not apply for preventive
If you are pregnant	Childbirth/delivery professional services	0% coinsurance	Not covered	services. Maternity care may include tests and services described elsewhere in the SBC
	Childbirth/delivery facility services	0% coinsurance	Not covered	(i.e. ultrasound).
	Home health care	0% coinsurance	Not covered	Coverage is limited to 100 visits.
	Rehabilitation services	0% coinsurance	Not covered	Coverage is limited to 30 visits for Physical Therapy and Occupational Therapy combined, 30 visits for Speech Therapy.
If you need help recovering or have other	Habilitation services	0% coinsurance	Not covered	None
special health needs	Skilled nursing care	0% coinsurance	Not covered	Coverage is limited to 100 days per admission.
	Durable medical equipment	0% coinsurance	Not covered	Coverage is limited to 1 <u>durable medical</u> <u>equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	0% coinsurance	Not covered	None
If your child needs dental or eye care	Children's eye exam	0% coinsurance	Not covered	Coverage is limited to 1 exam every 12 months up to age 19.
	Children's glasses	0% coinsurance	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 <u>Plan</u> Generally Does NOT Co	ver (Check your policy or <u>plan</u> document for mor	e information and a list of any other <u>excluded services</u> .)
Abortion	 Infertility treatment 	Routine foot care
Bariatric surgery	Long-term care	 Weight loss programs
Cosmetic surgery	 Non-emergency care when traveling of 	putside the
Dental care (Adult & Child)	U.S.	
Hearing aids	 Routine eye care (Adult) 	

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

- Private-duty nursing Coverage is limited to 16 Acupuncture - Coverage is limited to 10 visits. hours.
- Chiropractic care Coverage is limited to 30 visits.

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: Virginia State Corporation Commission, Bureau of Insurance - SCC, 800-552-7945 (Virginia only), 804-371-9741, 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 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:

Virginia State Corporation Commission, Bureau of Insurance – SCC, 800-552-7945 (Virginia only), 804-371-9741, 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 <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost-sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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 <u>plan's</u> overall <u>deductible</u>	\$8,700
Specialist coinsurance	0%
Hospital (facility) <u>coinsurance</u>	0%
Other <u>coinsurance</u>	0%
This EXAMPLE event includes services	s like:
Specialist office visits (prenatal care)	
Childbirth/Delivery Professional Services	
Childbirth/Delivery Facility Services	
Diagnostic tests (ultrasounds and blood w	vork)
Specialist visit (anesthesia)	

Total Example Cost	\$12,700
In this example, Peg would pay:	
<u>Cost Sharing</u>	
Deductibles	\$8,700
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$8,760

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

 The <u>plan's</u> overall <u>deductible</u> <u>Specialist coinsurance</u> Hospital (facility) <u>coinsurance</u> Other <u>coinsurance</u> 	\$8,700 0% 0% 0%
This EXAMPLE event includes service	
Primary care physician office visits (inclue disease education)	ding
Diagnostic tests (blood work)	
<u>Prescription drugs</u> <u>Durable medical equipment</u> (glucose me	ter)

Total Example Cost	\$5,600
In this example, Joe would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$5,400
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$5,420

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

The <u>plan's</u> overall <u>deductible</u>	\$8,700
Specialist coinsurance	0%
Hospital (facility) <u>coinsurance</u>	0%
Other <u>coinsurance</u>	0%
This EXAMPLE event includes service	ces like:
Emergency room care (including medic	al supplies)
Diagnostic test (x-ray)	
Durable medical equipment (crutches)	
Rehabilitation services (physical therap	y)

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

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

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.

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).

Health plans are offered and/or insured by Innovation Health Plan, Inc. ("Innovation Health"). Innovation Health is the brand name used for products and services provided by Innovation Health Plan, Inc. Innovation Health Plan, Inc. Innovation Health Plan, Inc. is an affiliate of Inova and Aetna Life Insurance Company and its affiliates (Aetna). Aetna provides certain management services to Innovation Health. Aetna is part of the CVS Health family of companies.

TTY: 711

Language Assistance:

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

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-844-365-7375.
Amharic -	ለቋንቋ እንዛ በ አማርኛ በ 1-844-365-7375 በነጻ ይደውሉ
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 7375-365-444-1
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-844-365-7375 առանց գնով։
Bahasa-Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-844-365-7375 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-844-365-7375 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বনিামুল্য(1–844–365–7375–ত েকল করুন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-844-365-7375 nga walay bayad.
Burmese -	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် ¹⁻⁸⁴⁴⁻³⁶⁵⁻⁷³⁷⁵ ကို ခေါ် ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-844-365-7375.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-844-365-7375 sin gåstu.
Cherokee -	ӨӘУӨ Տ ೮հАӘЈ ЈһӘՏРӘУ Ө५Т (СѠУ) ՉЬѠᲝℹ Տ 1-844-365-7375 ውӨТ Ը АГӘЈ ЈЕСРЈ һՒℝӨ.
Chinese -	欲取得繁體中文語言協助,請撥打 1-844-365-7375,無需付費。
Choctaw -	(Chahta) anumpa ya apela a chi I paya hinla 1-844-365-7375.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-844-365-7375 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-844-365-7375.
French -	Pour une assistance linguistique en français appeler le 1-844-365-7375 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-844-365-7375 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-844-365-7375 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-844-365-7375 χωρίς χρέωση.
Gujarati -	ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-844-365-7375 પર કૉલ કરો.

Hawaiian -	No ke kōkua ma ka 'ōlelo Hawai'i, e kahea aku i ka helu kelepona 1-844-365-7375. Kāki 'ole 'ia kēia kōkua nei.
Hindi -	हन्दिी में भाषा सहायता के लएि, 1-844-365-7375 पर मुफ्त कॉल करें।
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-844-365-7375.
lbo -	Maka enyemaka asụsụ na Igbo kpọọ 1-844-365-7375 na akwụghị ụgwọ ọ bụla
llocano -	Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-844-365-7375 nga awan ti bayadanyo.
Italian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-844-365-7375.
Japanese -	日本語で援助をご希望の方は、1-844-365-7375 まで無料でお電話ください。
Karen -	လ၊တာ်မဖားတာ်ကတိၤကျိဉ်အဂီၢ် ကျိဉ် ကိး 1-844-365-7375 လ၊တအိဉ်ဒီးတာ်လ၊၁်ဘူဉ်လ၊၁်စုးဘာ
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-844-365-7375 번으로 전화해 주십시오.
Kru-Bassa -	Ɓε´m`ké gbo-kpá-kpá dyé pidyi dé Ɓašɔɔ́-̀wù̀dùùň wε̃ε, dá 1-844-365-7375
Kurdish -	برای راهنمایی به زبان فارسی با شمار ه 7375-365-444 آ به خۆړایی پهیومندی بکهن.
Laotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-844-365-7375 ໂດຍບໍ່ເສຍຄ່າໂທ.
Marathi -	कोणत्याही शुल्काशविाय भाषा सेवा प्राप्त करण्यासाठी, 1-844-365-7375 वर फोन करा.
Marshallese -	Ñan bōk jipañ ilo Kajin Majol, kallok 1-844-365-7375 ilo ejjelok wōnān.
Micronesian - Pohnpeyan	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-844-365-7375 ni sohte isais.
Mon-Khmer, Cambodian -	សម្ភរាប់ជំនួយភាសាជា ភាសាខ្ ម រែ សូមទូរស័ព្ ទទ ៅកាន់លខេ 1-844-365-7375ដ ោយឥតគិតថ្ ល។ៃ
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-844-365-7375
Nepali -	(नेपाली) मा नन्शिुल्क भाषा सहायता पाउनका लाग ि1-844-365-7375 मा फोन गर् नुहोस् ।
Nilotic-Dinka -	Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-844-365-7375 kecïn aɣöc.
Norwegian -	For språkassistanse på norsk, ring 1-844-365-7375 kostnadsfritt.
Panjabi -	ਪੰਜਾਬੀ ਵੱਚਿ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-844-365-7375 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-844-365-7375 aa. Es Aaruf koschtet nix.

Persian -	برای راهنمایی به زبان فارسی با شماره ۲375-365-844 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Polish -	Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-844-365-7375.
Portuguese -	Para obter assistência linguística em português ligue para o 1-844-365-7375 gratuitamente.
Romanian -	Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-844-365-7375
Russian -	Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-844-365-7375.
Samoan -	Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-844-365-7375 e aunoa ma se totogi.
Serbo-Croatian -	Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-844-365-7375.
Spanish -	Para obtener asistencia lingüística en español, llame sin cargo al 1-844-365-7375.
Sudanic-Fulfude -	Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-844-365-7375 Njodi woo fawaaki on.
Swahili -	Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-844-365-7375 bila malipo.
Syriac -	к - эшк к b 2211, abr эле - к caim m In in pr sh J, sa 1-844-365-7375 apr .
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-844-365-7375 nang walang bayad.
Telugu -	భషతో సయం కొరకు ఎలెంటి ఖర్చు లేకుండా 1-844-365-7375 కు కల్ చేయండి. (తిలుగు)
Thai -	สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-844-365-7375 ฟรีไม่มีค่าใช้จ่าย
Tongan -	Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-844-365-7375 'o 'ikai hā tōtōngi.
Trukese -	Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-844-365-7375 nge esapw kamé ngonuk.
Turkish -	(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-844-365-7375.
Ukrainian -	Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-844-365-7375.
Urdu -	بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 7375-365-844-1 . پر بات کریں
Vietnamese -	Đê được hố trợ ngôn ngự băng (ngôn ngự), hãy gọi miến phi đên số 1-844-365-7375.
Yiddish -	פאר שפראך הילף אין אידיש רופט 1-844-365-7375 פריי פון אפצאל.
Yoruba -	Fún ìrànlowo nípa èdè (Yorùbá) pe 1-844-365-7375 lái san owó kankan rárá.