**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay for Covered Services

**THE UNIVERSITY OF VIRGINIA HEALTH PLAN:** Value Health

**Coverage Period:** 01/01/2024-12/31/2024

**Coverage for:** Individual + Family  |  **Plan Type:** PPO

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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.

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<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>UVA In-Network: Individual $800 / Family $1,600. Aetna In-Network: Individual $800 / Family $1,600. Out-of-Network: Individual $2,400 / Family $4,800.</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes. In-network generic prescription drugs; plus in-network office visits &amp; preventive care are covered before you meet your deductible.</td>
<td>This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a></td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>UVA In-Network: Individual $5,500 / Family $11,000. Aetna In-Network: Individual $5,500 / Family $11,000. Out-of-Network: Individual $11,000 / Family $22,000.</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Premiums, balance-billing charges &amp; health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td><strong>Will you pay less if you use a network provider?</strong></td>
<td>Yes. See <a href="http://www.aetna.com/docfind">www.aetna.com/docfind</a> or call 1-800-370-4526 for a list of UVA In-Network providers.</td>
<td>You pay the least if you use a provider in UVA In-Network. You pay more if you use a provider in Aetna In-Network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td><strong>Do you need a referral to see a specialist?</strong></td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>UVA In-Network (You will pay the least)</th>
<th>Aetna In-Network (You will pay more)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$25 copay/office visit only, deductible doesn't apply; 20% coinsurance for all other services</td>
<td>$40 copay/office visit only, deductible doesn't apply; 20% coinsurance for all other services</td>
<td>40% coinsurance</td>
<td>Includes Internist, General Physician, Family Practitioner, Pediatrician &amp; Gynecologist/Obstetrician.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$50 copay/office visit only, deductible doesn't apply; 20% coinsurance for all other services</td>
<td>$80 copay/office visit only, deductible doesn't apply; 20% coinsurance for all other services</td>
<td>40% coinsurance</td>
<td>Coverage is limited to 26 visits for Chiropractic care and 20 visits for acupuncture per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Preventive care /screening /immunization</td>
<td>No charge</td>
<td>No charge</td>
<td>Not covered</td>
<td>You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Age and frequency schedules may apply.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>Deductible doesn't apply: $6 copay/30 days (retail), $14 copay/90 days</td>
<td>Deductible doesn't apply: $6 copay/30 days (retail), $14 copay/90 days</td>
<td>Deductible doesn't apply: $6 copay plus billed amount minus contracted rate/30 days (retail)</td>
<td>Covers 30 day supply (retail), 31-90 day supply (mail order, UVA Network, CVS pharmacies). Includes contraceptive drugs &amp; devices obtainable from a pharmacy, oral &amp; injectable fertility drugs. No charge for</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>UVA In-Network (You will pay the least)</td>
<td>Aetna In-Network (You will pay more)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
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</tr>
<tr>
<td>More information about prescription drug coverage is available at <a href="http://www.aetnapharmacy.com/standard">www.aetnapharmacy.com/standard</a></td>
<td>Preferred brand drugs</td>
<td>After deductible, 20% coinsurance with $200 max 30 days (retail); 20% coinsurance with $425 max 90 days</td>
<td>After deductible, 20% coinsurance with $34 min &amp; $200 max/30 days (retail); 20% coinsurance with $75 min &amp; $425 max/90 days</td>
<td>After deductible, 20% coinsurance with $34 min &amp; $200 max plus billed amount minus contracted rate/30 days (retail)</td>
<td>preferred generic FDA-approved women's contraceptives in-network. Review your formulary for prescriptions requiring precertification or step therapy for coverage. Your cost will be higher for choosing Brand over Generics; cost difference penalty doesn't apply to deductible or out-of-pocket limit. Maintenance drugs- after two retail fills, members are required to fill a 90-day supply at UVA Pharmacies, CVS Caremark® Mail Service Pharmacy or CVS Pharmacies. Deductible doesn't apply to certain preventive &amp; chronic medications.</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>After deductible, 20% coinsurance with $275 max/30 days (retail); 20% coinsurance with $525 max/90 days</td>
<td>After deductible, 20% coinsurance with $68 min &amp; $275 max/30 days (retail); 20% coinsurance with $150 min &amp; $525 max/90 days</td>
<td>After deductible, 20% coinsurance with $68 min &amp; $275 max plus billed amount minus contracted rate/30 days (retail)</td>
<td></td>
</tr>
<tr>
<td>Specialty drugs: Generic (G), Preferred brand (P), Non-preferred brand (N)</td>
<td>Specialty drugs: Generic (G), Preferred brand (P), Non-preferred brand (N)</td>
<td>After deductible, G: 20% coinsurance with $150 max; P: 20% coinsurance with $200 max; N: 20% coinsurance with $350 max</td>
<td>After deductible, G: 20% coinsurance with $150 max; P: 20% coinsurance with $200 max; N: 20% coinsurance with $350 max</td>
<td>Not covered</td>
<td>Covers up to 30-day supply. Specialty drugs must be filled through UVA Specialty Pharmacy. Limited distribution specialty drugs may be filled through CVS Specialty Pharmacy. Mandatory generics required.</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>25% coinsurance</td>
<td>25% coinsurance</td>
<td>25% coinsurance</td>
<td>Out-of-network emergency use paid the same as in-network. No coverage for non-emergency use.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>Out-of-network emergency use paid the same as in-network. Non-emergency transport: not covered, except if pre-authorized.</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>UVA In-Network (You will pay the least)</td>
<td>Aetna In-Network (You will pay more)</td>
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<td>Limitations, Exceptions, &amp; Other Important Information</td>
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<td>--------------------------------------------------</td>
</tr>
<tr>
<td>Urgent care</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td></td>
<td>No coverage for non-urgent use.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>Pre-authorization required for out-of-network care.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office: $25 copay/visit, deductible doesn’t apply; other outpatient services 20% coinsurance</td>
<td>Office: $40 copay/visit, deductible doesn’t apply; other outpatient services 20% coinsurance</td>
<td>Office &amp; other outpatient services: 40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>Pre-authorization required for out-of-network care.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge for routine services</td>
<td>No charge for routine services</td>
<td>40% coinsurance</td>
<td>Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Pre-authorization required for out-of-network care.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>90 visits/calendar year. Pre-authorization required for out-of-network care.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$40 copay/visit, deductible doesn’t apply</td>
<td>$40 copay/visit, deductible doesn’t apply</td>
<td>40% coinsurance</td>
<td>40 visits/calendar year for Physical &amp; Occupational Therapy combined, 40 visits/calendar year for Speech Therapy, including outpatient hospital services.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$40 copay/visit, deductible doesn’t apply</td>
<td>$40 copay/visit, deductible doesn’t apply</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>180 days/calendar year. Pre-authorization required for out-of-network care.</td>
</tr>
<tr>
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</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse. Pre-authorization required for out-of-network care.</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered.</td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered.</td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered.</td>
</tr>
</tbody>
</table>

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.
- Private-duty nursing
- 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 disease, injury & chronic pain.
- Bariatric surgery - Limited to Institutes of Quality contracted facility only.
- Chiropractic care - 26 visits/calendar year.
- Hearing aids - $1,200 maximum/48 months.
- Infertility treatment - For more information & exceptions, see policy document provided by your employer or call the number on your ID card.

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: $800
- Specialist copayment: $50
- 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:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$800</td>
</tr>
<tr>
<td>Copayments</td>
<td>$10</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$2,100</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $60

**The total Peg would pay is**: $2,970

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

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

- The plan’s overall deductible: $800
- Specialist copayment: $50
- 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:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$800</td>
</tr>
<tr>
<td>Copayments</td>
<td>$900</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $20

**The total Joe would pay is**: $1,720

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

- The plan’s overall deductible: $800
- Specialist copayment: $50
- 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:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$800</td>
</tr>
<tr>
<td>Copayments</td>
<td>$200</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$300</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $0

**The total Mia would pay is**: $1,300

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 866-393-0002.

Smartphone or Tablet
To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination
Aetna 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 (CA HMO customers: P.O. Box 24030, Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), 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).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies, including Aetna Life Insurance Company and its affiliates (Aetna).
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.

**Arabic** - للحصول على الخدمات اللغوية دون أي تكلفة، الراجاء التصالح على الرقم 1-888-982-3862.

**Armenian** - Անվճար լեզվական ծառայություններից օգնության համար զանգահարեք 1-888-982-3862 հեռախոսահամարով:

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

**Bengali** - আপনার বিনামূল্যে ভাষা পরিকল্পনা প্রস্তাব করতে হলে এই নম্বর পেরিয়ে আসুন: 1-888-982-3862।

**Bisayan** - Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-888-982-3862.

**Burmese** - သင္ၷ္ေအႀက္ၷ္အေမပးရပဲ ဘာသာစကား၀န္ေဆာင�ႈမ်ားရရွိႏ�ိင�န္ 1-888-982-3862 သို႕ဖုန္ႀကိၸဆုႈပါ။

**Catalan** - Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-888-982-3862.

**Chinese** - 如欲使用免费语言服务，请致电 1-888-982-3862.

**Choctaw** - Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-888-982-3862.

**Cushite** - Tajaajiiloota afaanii garuu bilisaa atiargaachuuf,bibili 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** - તમારી જરૂરાની ભાષાની સેવાઓની પહોંચ માટે, કોલ કરો 1-888-982-3862.
Hawaiian - No ka walaʻau ʻana me ka lawelawe ʻōlelo e kahea aku i kēia helu kelepona 1-888-982-3862. Kāki ʻole ia kēia kōkua nei.

Hindi - आपके लिए बिना कोई कमत्री, क्रिम्म भाषा सेवाओं का उपयोग करनेके लिए, 1-888-982-3862 पर कॉल करें।

Hmong - Xav tau kev pab txais lus tsis muaj nqi them rau koj, hu 1-888-982-3862.

Igbo - Iji nweta hôrè na orú gasi 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 - 1-888-982-3862

Korean - 무료 언어 서비스를 이용하려면 1-888-982-3862 번으로 전화해 주십시오.

Kru-Bassa - Mɗi wuɖu dà kò bë die moû ní Pidy ní, ní, dà nòbà ni ke: 1-888-982-3862

Kurdish - بو دیسپیراگەشان بە خزمەتگزاری زمان بەبیابەنگە تەجوون بو تو، پەیەوەندی بەکەی بە زەمارەی 1-888-982-3862

Laotian - ທ່ານເດີ່ນອາກາດໍາແລ້ວພາສາໂດຍບໍລິໂດຍ, ຈະທີ່ທີ່1-888-982-3862

Marathi - कोणत्याही शल्कालशवाय 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 - េដើម្បីទទួលនេសកម្ពុជ៍សូមទូរស័ព្ទលេខ 1-888-982-3862।

Navajo - T’áá ni nizaad k’ehjí bee níká a’doowol doo bágh ilínígó kojí’ hólne’ 1-888-982-3862.

Nepali - नि:शुल्क भाषा सेवा प्राप्त गर्न 1-888-982-3862 मा टेलिफोन गन्तौहोस्।


Norwegian - For tilgang til kostnadsfri språktjenester, ring 1-888-982-3862.

Pennsylvania Dutch - Um Schprooch Services zu griegen 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 zadzwonić 1-888-982-3862.

Portuguese - Para acessar os serviços de idiomas sem custo para você, ligue para 1-888-982-3862.
For language services without cost, call 1-888-982-3862.