**♥aetnaCVS**Health.: 2023 GA Aetna CVS Silver 2: Atlanta HMO OFF

Coverage for: Individual + Family | Plan Type: 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=0759990&Y=23, or by calling 1-844-365-7373. 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 1-844-365-7373 to request a copy.

| Important Questions  | Answers   | Why This Matters:  |
|--|---|--|
| What is the overall deductible?                                      | 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> .  |
| Are there services covered before you meet your <u>deductible</u> ?  | Yes. Certain office visits, <u>preventive care</u> and <u>urgent 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .   |
| Are there other deductibles for specific services?                   | No.   | You don't have to meet <u>deductibles</u> for specific services.   |
| What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ? | In- <u>Network</u> : Individual \$8,000 / 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.  |
| 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 <u>out-of-pocket limit</u> .   |
| Will you pay less if you use a <u>network provider</u> ?             | Yes. See https://aet.na/providersearch_aetna or call 1-844-365-7373 for a list of in-network providers. | 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</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 provider</u> before you get services. |
| Do you need a <u>referral</u> to see a <u>specialist</u> ?           | No.   | You can see the specialist you choose without a referral.  |



|   |  | What You Will Pay   |   |   |  |
|---|--|---|---|---|--|
| Common<br>Medical Event   | Services You May Need                            | In-Network Provider (You will pay the least)  | Out-of-Network<br>Provider (You will pay<br>the most) | Limitations, Exceptions, & Other Important Information  |  |
|   | Primary care visit to treat an injury or illness | \$25 <u>copay</u> /visit, <u>deductible</u> does not apply  | Not covered   | None  |  |
| If you visit a health care  | Specialist visit                                 | \$50 copay/visit, deductible does not apply   | Not covered   | None  |  |
| provider's office or clinic                                       | Preventive care /screening /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. |  |
|   | Diagnostic test (x-ray, blood work)              | 40% coinsurance   | Not covered   | Applies to services received in office or in outpatient setting.  |  |
| If you have a test  | Imaging (CT/PET scans, MRIs)                     | 40% coinsurance   | Not covered   | Applies to services received in office or in outpatient setting. Cost share applies to all places of service.   |  |
| If you need drugs to treat your illness or condition              | Preferred generic drugs                          | \$15 <u>copay/</u> prescription (retail), \$37.50 <u>copay/</u> prescription (mail order), <u>deductible</u> does not apply | Not covered   | Covers up to a 30 day supply (retail prescription), 31-90 day supply (mail order prescription). Applicable cost share plus  |  |
| More information about prescription drug coverage is available at | Preferred brand drugs                            | \$50 <u>copay</u> / prescription<br>(retail), \$125 <u>copay</u> /<br>prescription (mail order)                             | Not covered   | difference (brand minus generic cost) applies<br>for brand when generic available. No charge for<br>preferred generic FDA-approved women's                              |  |
| http://aet.na/gaivl23   | Non-preferred generic/brand drugs                | 40% <u>coinsurance</u> (retail & mail order)  | Not covered   | contraceptives in- <u>network</u> .   |  |
|   | Preferred/non-preferred specialty drugs          | 50% coinsurance for up to a 30 day supply   | Not covered   | None  |  |
| If you have outpatient  | Facility fee (e.g., ambulatory surgery center)   | 40% coinsurance for hospital facility; 20% coinsurance for free standing facility   | Not covered   | None  |  |
| surgery   | Physician/surgeon fees                           | 40% coinsurance for hospital facility; 20% coinsurance for free standing facility   | Not covered   | None  |  |

|   |   | What You Will Pay   |   |   |
|---|---|---|---|---|
| Common<br>Medical Event   | Services You May Need                     | In-Network Provider (You will pay the least)  | Out-of-Network<br>Provider (You will pay<br>the most) | Limitations, Exceptions, & Other Important<br>Information   |
| If you need immediate   | Emergency room care                       | 40% coinsurance   | 40% coinsurance                                       | Out-of-network <u>emergency room care</u> cost-share same as in- <u>network</u> . No coverage for non-emergency care.         |
| medical attention   | Emergency medical transportation          | 40% coinsurance   | 40% coinsurance                                       | Out-of-network cost-share same as in- <u>network</u> .  |
|   | Urgent care                               | \$50 copay/visit, deductible does not apply   | Not covered   | No coverage for non-urgent use.   |
| If you have a   | Facility fee (e.g., hospital room)        | 40% coinsurance   | Not covered   | None  |
| hospital stay   | Physician/surgeon fees                    | 40% coinsurance   | Not covered   | None  |
| If you need mental health,<br>behavioral health, or<br>substance abuse services | Outpatient services                       | Outpatient office visits: \$25<br>copay/visit, deductible does<br>not apply; All other<br>outpatient services: 40%<br>coinsurance | Not covered   | None  |
| Substance abase services  | Inpatient services                        | 40% coinsurance   | Not covered   | None  |
|   | Office visits                             | No charge   | Not covered   | Cost sharing does not apply for preventive  |
| If you are pregnant   | Childbirth/delivery professional services | 40% coinsurance   | Not covered   | services. Maternity care may include tests and services described elsewhere in the SBC  |
|   | Childbirth/delivery facility services     | 40% coinsurance   | Not covered   | (i.e. ultrasound).  |
|   | Home health care                          | 40% coinsurance   | Not covered   | Coverage is limited to 120 visits.  |
|   | Rehabilitation services                   | 40% coinsurance   | Not covered   | Coverage is limited to 40 visits for Physical Therapy and Occupational Therapy combined, 40 visits for Speech Therapy.        |
| If you need help recovering or have other                                       | Habilitation services                     | 40% coinsurance   | Not covered   | None  |
| special health needs  | Skilled nursing care                      | 40% coinsurance   | Not covered   | Coverage is limited to 60 days.   |
|   | Durable medical equipment                 | 50% 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                          | 40% coinsurance   | Not covered   | None  |

|                                |  |  | What You Will Pay                                     |             | Limitations, Exceptions, & Other Important<br>Information  |
|--------------------------------|--|--|---|-------------|--|
|                                | Common dical Event Services You May Need | In-Network Provider (You will pay the least) | Out-of-Network<br>Provider (You will pay<br>the most) |             |  |
|                                |  | Children's eye exam                          | 50% coinsurance                                       | Not covered | Coverage is limited to 1 exam every 12 months, through the end of the month after the person attains age 19.   |
| If your child need or eye care | eds dental                               | Children's glasses                           | 50% coinsurance                                       | Not covered | Coverage is limited to 1 set of frames and 1 set of contact lenses or eyeglass lenses every 12 months, through the end of the month after the person attains 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 Bariatric surgery
- Cosmetic surgery
- Dental care (Adult & Child)

- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- 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.)

- Acupuncture Coverage is limited to 10 visits.
- Chiropractic care Coverage is limited to 20 visits.
- Hearing aids Coverage is limited to \$3,000 maximum per 48 months per ear for hearing aid. Paid as billed.

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: Georgia Office of the Commissioner of Insurance and Safety Fire, Consumer Services Division, Local: (404) 656-2070, Toll-free: 800-656-2298, https://oci.georgia.gov/insurance-resources.

• For more information on your rights to continue coverage, contact the <u>plan</u> at 1-844-365-7373.

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 <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact:

Georgia Office of the Commissioner of Insurance and Safety Fire, Consumer Services Division, Local: (404) 656-2070, Toll-free: 800-656-2298,

https://oci.georgia.gov/insurance-resources.

## 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 <u>plan</u> 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>       | \$5,000 |
|---|---------|
| Specialist copayment                              | \$50    |
| <ul><li>Hospital (facility) coinsurance</li></ul> | 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>       | \$12,700 |  |
|---------------------------------|----------|--|
| In this example, Peg would pay: |          |  |
| Cost Sharing                    |          |  |
| <u>Deductibles</u>              | \$5,000  |  |
| <u>Copayments</u>               | \$10     |  |
| <u>Coinsurance</u>              | \$2,600  |  |
| What isn't covered              |          |  |
| Limits or exclusions            | \$60     |  |
| The total Peg would pay is      | \$7,670  |  |

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

well-controlled condition)

The plan's overall deductible
 Specialist copayment
 Hospital (facility) coinsurance
 \$5,000
 \$50
 40%

#### This EXAMPLE event includes services like:

40%

<u>Primary care physician</u> office visits (including disease education)

Diagnostic tests (blood work)

Prescription drugs

Other coinsurance

<u>Durable medical equipment</u> (glucose meter)

| Total Example Cost              | \$5,600 |  |  |
|---------------------------------|---------|--|--|
| In this example, Joe would pay: |         |  |  |
| Cost Sharing                    |         |  |  |
| <u>Deductibles</u>              | \$3,200 |  |  |
| <u>Copayments</u>               | \$800   |  |  |
| <u>Coinsurance</u>              | \$0     |  |  |
| What isn't covered              |         |  |  |
| Limits or exclusions \$2        |         |  |  |
| The total Joe would pay is      | \$4,020 |  |  |

## **Mia's Simple Fracture**

(in-network emergency room visit and follow up care)

| ■ The <u>plan's</u> overall <u>deductible</u>     | \$5,000 |
|---|---------|
| <ul><li>Specialist copayment</li></ul>            | \$50    |
| <ul><li>Hospital (facility) coinsurance</li></ul> | 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)

| Total Example Cost              | \$2,800 |  |
|---------------------------------|---------|--|
| In this example, Mia would pay: |         |  |
| Cost Sharing                    |         |  |
| <u>Deductibles</u>              | \$2,300 |  |
| <u>Copayments</u>               | \$100   |  |
| <u>Coinsurance</u>              | \$0     |  |
| What isn't covered              |         |  |
| Limits or exclusions            | \$0     |  |
| The total Mia would pay is      | \$2,400 |  |

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: 1-844-365-7373.

## **Assistive Technology**

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-844-365-7373.

## **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 <a href="https://ocrportal.hhs.gov/ocr/portal/lobby.jsf">https://ocrportal.hhs.gov/ocr/portal/lobby.jsf</a>, 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 or underwritten or administered by Aetna Health Inc. (Georgia) (Aetna). Aetna is part of the CVS Health family of companies.

#### TTY: 711

#### **Language Assistance:**

For language assistance in your language call 1-844-365-7373 at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-844-365-7373.

Amharic - ለቋንቋ እንዛ በ አማርኛ በ 1-844-365-7373 በነጻ ይደውሉ

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 7373-365-4-1-844

Armenian - Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-844-365-7373 առանց գնով։

Bahasa-Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-844-365-7373 tanpa dikenakan biaya.

Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-844-365-7373 ku busa

Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বিনামূল্য( 1-844-365-7373-ত( কল করুন।

Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-844-365-7373 nga walay bayad.

Burmese - ငွေကုန်ကျစံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-844-365-7373 ကို ခေါ် ဆိုပါ။

Catalan - Per rebre assistència en (català), truqui al número gratuït 1-844-365-7373.

Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-844-365-7373 sin gåstu.

Chinese - 欲取得繁體中文語言協助,請撥打 1-844-365-7373,無需付費。

Choctaw - (Chahta) anumpa ya apela a chi I paya hinla 1-844-365-7373.

Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-844-365-7373 irratti bilisaan bilbilaa.

Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-844-365-7373.

French - Pour une assistance linguistique en français appeler le 1-844-365-7373 sans frais.

French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-844-365-7373 gratis.

German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-844-365-7373 an.

Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-844-365-7373 χωρίς χρέωση.

Gujarati - ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ય વગર 1-844-365-7373 પર કૉલ કરો.

Hawaiian - No ke kōkua ma ka 'ōlelo Hawai'i, e kahea aku i ka helu kelepona 1-844-365-7373. Kāki 'ole 'ia kēia kōkua nei.

Hindi - हिन्दी में भाषा सहायता के लिए, 1-844-365-7373 पर मुफ्त कॉल करें।

Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-844-365-7373.

lbo - Maka enyemaka asusu na Igbo kpoo 1-844-365-7373 na akwughi ugwo o bula

llocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-844-365-7373 nga awan ti bayadanyo.

Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-844-365-7373.

Japanese - 日本語で援助をご希望の方は、1-844-365-7373 まで無料でお電話ください。

Karen - လာတာ်မာစားတာ်ကတိာကျိန်အင်္ဂ ကျိန် ကိုး 1-844-365-7373 လာတအိန်ာင်္ဂီးတာ်လာခ်စူးသာ

Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-844-365-7373 번으로 전화해 주십시오.

Kru-Bassa - Be´m`ké gbo-kpá-kpá dyé pidyi dé Bašsoó-wuduun wee, dá 1-844-365-7373

برای راهنمایی به زبان فارسی با شماره 7373-365-441-1 به خورایی پهیومندی بکهن.

Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-844-365-7373 ໂດຍບໍ່ເສຍຄ່າໂທ.

Marathi - कोणत्याही शूल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-844-365-7373 वर फोन करा.

Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-844-365-7373 ilo ejjelok wōnān.

Micronesian - Pohnpeyan Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-844-365-7373 ni sohte isais.

Mon-Khmer, Cambodian - សម្ភាប់ជំនួយភាសាជា ភាសាខ្មមរៃ សូមទូរស័ព្**ទទ**ៅកាន់លខេ 1-844-365-7373 ដ**ោយឥតគិតថ្**ល។ៃ

Navajo - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-844-365-7373

Nepali - (नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-844-365-7373 मा फोन गर्नुहोस् ।

Nilotic-Dinka - Tën kuoony ë thok ë Thuonjän col 1-844-365-7373 kecin ayöc.

Norwegian - For språkassistanse på norsk, ring 1-844-365-7373 kostnadsfritt.

Panjabi - ਪੰਜਾਬੀ ਵੀੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-844-365-7373 'ਤੇ ਮਫ਼ਤ ਕਾਲ ਕਰੋ।

Pennsylvania Dutch - Fer Helfe in Deitsch, ruf: 1-844-365-7373 aa. Es Aaruf koschtet nix.

برای راهنمایی به زبان فارسی با شماره 7373-365-844 بدون هیچ هزینه ای تماس بگیرید. انگلیسی Persian -

Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-844-365-7373.

Portuguese - Para obter assistência linguística em português ligue para o 1-844-365-7373 gratuitamente.

Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-844-365-7373

Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-844-365-7373.

Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-844-365-7373 e aunoa ma se totogi.

Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-844-365-7373.

Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-844-365-7373.

Sudanic-Fulfude - Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-844-365-7373 Njodi woo fawaaki on.

Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-844-365-7373 bila malipo.

Syriac - R - 22 K K & D2.31 abr 21.2 K oai, or Ly iapr 361, 20, 1-844-365-7373 apr. .

Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-844-365-7373 nang walang bayad.

Telugu - భషతో నయంకొరకు ఎలంటి ఖర్చు లేకుండా 1-844-365-7373 కు కల్ చేయండి. (తెలుగు)

Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-844-365-7373 ฟรีไม่มีค่าใช้จ่าย

Tongan - Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-844-365-7373 'o 'ikai hā tōtōngi.

Trukese - Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-844-365-7373 nge esapw kamé ngonuk.

Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-844-365-7373.

Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-844-365-7373.

بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 7373-365-1-844. پر بات کریں

Vietnamese - Đê 'được hố' trợ ngôn ngư băng (ngôn ngư), hay gọi miến phi 'đên số '1-844-365-7373.

Yiddish - פאר שפראך הילף אין אידיש רופט 1-844-365-7373 פריי פון אפצאל

Yoruba - Fún ìrànlowo nípa èdè (Yorùbá) pe 1-844-365-7373 lái san owó kankan rárá.