◆aetnaCVSHealth.: 2023 VA Aetna CVS Silver: Richmond HMO OFF PD Standard

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=0764091&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 Why This Matters: Answers 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 What is the overall In-Network: Individual \$5,800 / Family \$11,600. family member must meet their own individual deductible until the total amount of deductible? deductible expenses paid by all family members meets the overall family deductible. 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 Are there services Yes. Certain office visits, preventive care and urgent certain preventive services without cost sharing and before you meet your deductible. covered before you meet care in-network. your deductible? See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. Are there other deductibles for specific No. You don't have to meet deductibles for specific services. services? The out-of-pocket limit is the most you could pay in a year for covered services. If you What is the out-of-pocket In-Network: Individual \$8,900 / Family \$17,800. have other family members in this plan, they have to meet their own out-of-pocket limit for this plan? limits until the overall family out-of-pocket limit has been met. What is not included in 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. the out-of-pocket limit? This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might Yes. See https://aet.na/providersearch_aetna or call receive a bill from a provider for the difference between the provider's charge and what Will you pay less if you use a network provider? 1-844-365-7373 for a list of in-network providers. 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. This plan will pay some or all of the costs to see a specialist for covered services but Do you need a referral to Yes. see a specialist? only if you have a referral before you see the specialist.



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

		What You V	Vill 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	\$40 <u>copay</u> /visit, <u>deductible</u> does not apply	Not covered	None
If you visit a health care	<u>Specialist</u> visit	\$80 <u>copay</u> /visit, <u>deductible</u> does not apply	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)	40% coinsurance	Not covered	Applies to services received in office or in outpatient setting.
n you have a test	Imaging (CT/PET scans, MRIs)	40% coinsurance	Not covered	Applies to services received in office or in outpatient setting.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://aet.na/vaivl23	Preferred/non-preferred generic drugs	\$20 <u>copay</u> / prescription for up to a 30 day supply, \$50 <u>copay</u> / prescription for up to a 90 day supply, <u>deductible</u> does not apply	Not covered	Covers up to a 30 day supply (retail
	Preferred brand drugs	\$40 <u>copay</u> / prescription for up to a 30 day supply, \$100 <u>copay</u> / prescription for up to a 90 day supply, <u>deductible</u> does not apply	Not covered	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-network.
	Non-preferred brand drugs	\$80 <u>copay</u> / prescription for up to a 30 day supply, \$200 <u>copay</u> / prescription for up to a 90 day supply	Not covered	contraceptives in- <u>network</u> .
	Preferred/non-preferred <u>specialty</u> <u>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 CVS retail pharmacies for certain <u>specialty drugs</u> .

		What You V	Vill 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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance	Not covered	None
Surgery	Physician/surgeon fees	40% coinsurance	Not covered	None
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> .
If you need immediate medical attention	Emergency medical transportation	40% coinsurance	40% coinsurance	Out-of-network cost-share same as in-network.
	<u>Urgent care</u>	\$60 <u>copay</u> /visit, <u>deductible</u> 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, behavioral health, or substance abuse services	Outpatient services	Outpatient office visits: \$40 <u>copay</u> /visit, <u>deductible</u> does not apply; All other outpatient services: 40% <u>coinsurance</u>	Not covered	None
	Inpatient services	40% coinsurance	Not covered	None
	Office visits	No charge	Not covered	Cost sharing does not apply for preventive
lf 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 100 visits.
If you need help recovering or have other special health needs	Rehabilitation services	\$40 <u>copay</u> /visit, <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.
	Habilitation services	40% coinsurance	Not covered	None
	Skilled nursing care	40% coinsurance	Not covered	Coverage is limited to 100 days per admission.
	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			
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 your child needs dental or eye care	Children's eye exam	50% coinsurance	Not covered	Coverage is limited to 1 exam every 12 months up to age 19.	
		Children's glasses	50% coinsurance		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	0% coinsurance	Not covered	Coverage is limited 2 visits every 12 months up to age 19.		

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NO	T Cover (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)	U.S.	
Hearing aids	 Routine eye care (Adult) 	
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Other Covered Services (Limitations may apply to the	se services. This isn't a complete list. Please see your <u>plan</u> document.)
 Acupuncture - Coverage is limited to 10 visits. Chiropractic care - Coverage is limited to 30 visits. 	 Private-duty nursing - Coverage is limited to 16 hours.

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, <u>https://scc.virginia.gov/pages/Insurance</u>.

• 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 <u>Marketplace</u>. For more information about the <u>Marketplace</u>, visit <u>www.HealthCare.gov</u> or call 1-800-318-2596 or state health insurance <u>marketplace</u> or SHOP.

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

• 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 <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>	\$5,800
Specialist copayment	\$80
Hospital (facility) <u>coinsurance</u>	40%
Other <u>coinsurance</u>	40%
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	/ork)
Specialist visit (anesthesia)	

Total Example Cost	\$12,700
In this example, Peg would pay:	
<u>Cost Sharing</u>	
Deductibles	\$5,800
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$2,300
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$8,170

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 copayment</u> 	\$5,800 \$80
 Hospital (facility) coinsurance 	40%
 Other <u>coinsurance</u> 	40%
This EXAMPLE event includes service	es like:
Primary care physician office visits (inclu	ıding
disease education)	
Diagnostic tests (blood work)	
Prescription drugs	
Durable medical equipment (glucose me	eter)

Total Example Cost	\$5,600
In this example, Joe would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$1,600
<u>Coinsurance</u>	\$0
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	\$5,800
Specialist copayment	\$80
Hospital (facility) <u>coinsurance</u>	40%
Other <u>coinsurance</u>	40%
This EXAMPLE event includes servi	ces like:
Emergency room care (including medi	cal supplies)
Diagnostic test (x-ray)	
Durable medical equipment (crutches)	
Rehabilitation services (physical therap	by)

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

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 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 or underwritten or administered by Aetna Health Inc. (Pennsylvania) (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
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 7373-365-444-1
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 বনিামুল্য 1–844–365–7373–ত কেল করুন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-844-365-7373 nga walay bayad.
Burmese -	ငွေကုန်ကျခံစရာမလိုဘဲ (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.
Cherokee -	ӨӘУӨ Տ ೮հАӘЈ ЛһӘՏРӘУ Ө५Т (СѠУ) Չ ЬѠᲝℹ Տ 1-844-365-7373 ОӨТ Ը АГӘЈ ЈЕСРЈ һՒ℞Ѳ.
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 ખર્ચ 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 -	हन्दिी में भाषा सहायता के लएि, 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 asụsụ na Igbo kpọọ 1-844-365-7373 na akwụghị ụgwọ ọ bụla
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 -	လ၊တၢ်မာစားတၢ်ကတိၤကျိဉ်အဂီၢ် ကျိဉ် ကိး 1-844-365-7373 လ၊တအိဉ်ဒီးတၢ်လ၊၁်ဘူဉ်လ၊၁်စ္၊ဘာ
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-844-365-7373 번으로 전화해 주십시오.
Kru-Bassa -	Ɓɛ´m`ké gbo-kpá-kpá dyé pidyi dé Ɓašɔɔ́-̀wù̀dùùň wɛ̃ɛ, dá 1-844-365-7373
Kurdish -	برای راهنمایی به زبان فارسی با شمار ه 7373-844-1 ا به خۆرایی پهیومندی بکهن.
Laotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-844-365-7373 ໂດຍບໍ່ເສຍຄ່າໂທ.
Marathi -	कोणत्याही शुल्काशविाय 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 -	សម្ភរាប់ជំនួយភាសាជា ភាសាខ្ ម រែ សូមទូរស័ព្ ទទ ៅកាន់លខេ1-844-365-7373ដ ោ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 नन्शिुल्क भाषा सहायता पाउनका लाग ि1-844-365-7373 मा फोन गर् नुहोस् ।
Nilotic-Dinka -	Tën kuoony ë thok ë Thuonjän col 1-844-365-7373 kecin avöc.
Norwegian -	For språkassistanse på norsk, ring 1-844-365-7373 kostnadsfritt.
Panjabi -	ਪੰਜਾਬੀ ਵੱਚਿ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-844-365-7373 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-844-365-7373 aa. Es Aaruf koschtet nix.

Persian -	برای راهنمایی به زبان فارسی با شماره ۲373-844-1 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
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 -	ка эшк ка di alik alik alik mк Ju iopk idd, aa 1-844-365-7373 apa
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-844-365-7373 nang walang bayad.
Telugu -	భషతో సయం కొరకు ఎలింటి ఖర్చు లేకుండా 1-844-365-7373 కు శల్ చేయండి. (తిలుగు)
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.
Urdu -	بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 7373-365-844-1 . پر بات کریں
Vietnamese -	Đê được hố trở ngôn ngữ băng (ngôn ngữ), hấy 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.