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

**♦ aetna CVS**Health.: 2024 IN Bronze 2: HMO AI/AN CSR LTD

**AI AN Limited Cost Sharing** 

Coverage for: Individual + Family | Plan Type: HMO



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, https://www.aetna.com/sbcsearch/getcbpolicydocs?P=0771824&Y=24, or by calling 1-844-365-7373. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-844-365-7373 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$0 at Indian Health Care Provider (IHCP) or with IHCP referral at non-IHCP. Non-IHCP In-Network: Individual \$6,200 / Family \$12,400.	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 <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> Non-IHCP: Individual \$7,500 / Family \$15,000.	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</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 <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 Non-IHCP In-Network_providers.	You pay the least if you use a <u>provider</u> in <u>Indian Health Care (IHCP)</u> or <u>IHCP Referred</u> . You pay more if you use a <u>provider</u> in <u>Non-IHCP In-Network</u> . You will pay the most if you use an <u>Non-IHCP Out-of-Network</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>Non-IHCP Out-of-Network</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> ?	No.	You can see the specialist you choose without a referral.



		What You Will Pay			
Common Medical Event	Services You May Need	Indian Health Care (IHCP) or IHCP Referred Provider (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health	Primary care visit to treat an injury or illness	No charge	50% coinsurance	Not covered	0% <u>coinsurance</u> after <u>deductible</u> for in- <u>network</u> virtual primary care telemedicine <u>provider</u> visits for certain services.
care <u>provider's</u>	Specialist visit	No charge	50% coinsurance	Not covered	None
office or clinic	Preventive care /screening /immunization	No charge	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	<u>Diagnostic test</u> (x-ray, blood work)	No charge	50% coinsurance	Not covered	None
ii you iiave a test	Imaging (CT/PET scans, MRIs)	No charge	50% coinsurance	Not covered	None
If you need drugs to treat your illness or condition  More information about prescription drug coverage is available at http://aet.na/inivl24	Preferred generic drugs	No charge	Tier 1A: \$5 copay/ prescription (retail), \$12.50 copay/ prescription (mail order); Tier 1: \$25 copay/ prescription (retail), \$62.50 copay/ prescription (mail order)	Not covered	Covers up to a 30 day supply (retail prescription), 31-90 day supply (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.
	Preferred brand drugs	No charge	35% <u>coinsurance</u> (retail & mail order)	Not covered	
	Non-preferred generic/brand drugs	No charge	45% <u>coinsurance</u> (retail & mail order)	Not covered	
	Preferred/non-preferred specialty drugs	No charge for up to a 30 day supply	50% <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

	What You Will Pay				
Common Medical Event	Services You May Need	Indian Health Care (IHCP) or IHCP Referred Provider (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
					certain specialty drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	50% coinsurance	Not covered	None
outputient surgery	Physician/surgeon fees	No charge	50% coinsurance	Not covered	None
If you need immediate medical	Emergency room care	No charge	50% coinsurance	50% coinsurance	Out-of-network <u>emergency room care</u> cost-share same as Non-IHCP in- <u>network</u> . No coverage for non-emergency care.
attention	Emergency medical transportation	No charge	50% coinsurance	50% coinsurance	Out-of-network cost-share same as Non-IHCP in-network.
	<u>Urgent care</u>	No charge	50% coinsurance	Not covered	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	50% coinsurance	Not covered	None
noophui stay	Physician/surgeon fees	No charge	50% coinsurance	Not covered	None
If you need mental health, behavioral	Outpatient services	Office visits and all other outpatient services: No charge	Office visits and all other outpatient services: 50% coinsurance	Not covered	None
health, or substance abuse services	Inpatient services	No charge	50% coinsurance	Not covered	None
	Office visits	No charge	No charge	Not covered	Cost sharing does not apply for
If you are pregnant	Childbirth/delivery professional services	No charge	50% coinsurance	Not covered	preventive services. Maternity care may include tests and services
	Childbirth/delivery facility services	No charge	50% coinsurance	Not covered	described elsewhere in the SBC (i.e., ultrasound).

		What You Will Pay			
Common Medical Event	Services You May Need	Indian Health Care (IHCP) or IHCP Referred Provider (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Home health care	No charge	50% coinsurance	Not covered	Coverage is limited to 100 visits.
	Rehabilitation services	No charge	50% coinsurance	Not covered	Coverage is limited to 20 visits each for Physical Therapy & Occupational Therapy, 20 visits for Speech Therapy.
If you need help	Habilitation services	No charge	50% coinsurance	Not covered	None
recovering or have other special health	Skilled nursing care	No charge	50% coinsurance	Not covered	Coverage is limited to 90 days.
needs	Durable medical equipment	No charge	50% coinsurance	Not covered	Coverage is limited to 1 <u>durable</u> <u>medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	No charge	50% coinsurance	Not covered	None
If your child needs dental or eye care	Children's eye exam	No charge	\$10 <u>copay</u> /visit, <u>deductible</u> does not apply	Not covered	Coverage is limited to 1 exam every 12 months up to age 19.
	Children's glasses	No charge	\$10 <u>copay</u> /visit, <u>deductible</u> does not apply	Not covered	Coverage is limited to 1 set of frames and 1 set of contact lenses or eyeglass lenses per calendar year up to age 19.
	Children's dental check-up	Not covered	Not covered	Not covered	Not covered.

#### **Excluded Services & Other Covered Services:**

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

- Abortion
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult & Child)

- · Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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 <u>plan</u> document.)

- Chiropractic care Coverage is limited to 12 visits.
- Private-duty nursing Coverage is limited to 82 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:

Indiana Department of Insurance, Consumer Services Department, (800) 622-4461, 317-232-2395, https://www.in.gov/idoi/consumer-services/.

• 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 <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:

• Indiana Department of Insurance, Consumer Services Department, (800) 622-4461, 317-232-2395, https://www.in.gov/idoi/consumer-services/.

#### 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 plan's overall deductible	\$(
Specialist copayment	\$(
Hospital (facility) copayment	\$(
Other copayment	\$(

# 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>deduct</u>	ible \$6
<ul> <li>Specialist copayment</li> </ul>	<u> </u>
<ul><li>Hospital (facility) copaym</li></ul>	<u>ent</u> \$(
<ul><li>Other copayment</li></ul>	 \$(

# Mia's Simple Fracture etwork emergency room visit and

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

The <u>plan's</u> overall <u>deductible</u>	\$0
Specialist copayment	\$0
Hospital (facility) copayment	\$0
Other copayment	\$0

#### 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:		
Cost Sharing		
<u>Deductibles</u>	\$0	
<u>Copayments</u>	\$0	
<u>Coinsurance</u>	\$0	
What isn't covered		
Limits or exclusions	\$60	
The total Peg would pay is	\$60	

#### This EXAMPLE event includes services like:

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

<u>Diagnostic tests</u> (blood work)

Prescription drugs

Diabetic supplies (glucose meter)

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

#### This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

<u>Diagnostic test</u> (x-ray)

<u>Durable medical equipment</u> (crutches)

Rehabilitation services (physical therapy)

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

Note: These numbers assume the patient received care from an IHCP <u>provider</u> or with IHCP <u>referral</u> at a non-IHCP. If you receive care from a non-IHCP <u>provider</u> without a <u>referral</u> from an IHCP your costs may be higher.

#### **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. (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 shërbime përkthimi falas për ju, telefononi 1-844-365-7373.

Amharic - የቋንቋ አንልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-844-365-7373 ይደውሉ፡፡

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Armenian - Անվձար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-844-365-7373 հեռախոսահամարով։

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

Bantu-Kirundi - Kugira uronke serivisi z'indimi atakiguzi, hamagara 1-844-365-7373.

Bengali-Bangala - আপনাক বেনিামুক্য ভোষা প্রকিষা প্রপক হক্য এই নম্বক প্রেযক ান রেন: 1-844-365-7373।

Bisayan-Visayan - Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-844-365-7373.

Burmese - သင့်အနေဖြင့် အခကြေးငွေ မပေးရပဲ ဘာသာစကားပန်ဆောင်မှုများ ရရှိနိုင်ရန် 1-844-365-7373 သို့ ဖုန်းခေါ် ဆိုပါ။

Catalan - Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-844-365-7373.

Chamorro - Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-844-365-7373.

Cherokee - GYOJ SULAOJ OGOLOJJ L ALOJ JCEGWJJ VY, OLABWOL 1-844-365-7373.

Chinese - 如欲使用免費語言服務,請致電 1-844-365-7373。

Choctaw - Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-844-365-7373.

Cushite - Tajaajiiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-844-365-7373.

Dutch - Voor gratis toegang tot taaldiensten, bell 1-844-365-7373.

French - Afin d'accéder aux services langagiers sans frais, composez le 1-844-365-7373.

French Creole - Pou jwenn sèvis lang gratis, rele 1-844-365-7373.

German - Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-844-365-7373 an.

Greek - Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-844-365-7373.

Gujarati - તમારે કોઇ જાતના ખર્ય વિના ભાષાની સેમિઓની પહોોર માટે, કોલ કરો 1-844-365-7373.

Hawaiian - No ka wala'au 'ana me ka lawelawe 'ōlelo e kahea aku i kēia helu kelepona 1-844-365-7373 Kāki 'ole 'ia kēia kōkua nei.

Hindi - आपके लिए बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, 1-844-365-7373 पर कॉल करें।

Hmong - Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-844-365-7373.

lgbo - Iji nwetaòhèrè na oru gasi asusu n'efu, kpoo 1-844-365-7373.

llocano - Tapno maaksesyo dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti 1-844-365-7373.

Indonesian - Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi 1-844-365-7373.

Italian - Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-844-365-7373.

Japanese - 言語サービスを無料でご利用いただくには、1-844-365-7373 までお電話ください

Karen - လာတာ်ကမာန္နာ်ကိုြာအတာ်မာစားအတာ်ဖံးတာ်မာတဖဉ်လာတအို် ဒီးအပူးလာကဘဉ်ဟုဉ်အီးအဂ်ီးဘဉ်နှဉ် ကိုး 1-844-365-7373 တက္၏.

Korean - 무료 언어 서비스를 이용하려면 1-844-365-7373 번으로 전화해 주십시오.

Kru-Bassa - Μ dyi wudu-dù kà kò dò bě dyi móuń nì Pídyi ní, nìí, dá nòbà nìà kε: 1-844-365-7373.

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Laotian - ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບື່ເສຍຄື່າຕື້ກັບທີ່ານ, ໃຫ້ໂທຫາເບີ 1-844-365-7373.

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

Marshallese - Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlok 1-844-365-7373.

Micronesian Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1-844-365-7373. Pohnpeyan -

Mon-Khmer ដ ទើម្បីទទួលបានដវោកម្មភាសាដ លឥតគិតថ្លាម្រែរាប់ដទោកអុនក រូ មុដទៅទូរពែុទដ**ៅ**កាន់ដលខ 1-844-365-7373។. Cambodian -

Navajo - T'áá ni nizaad k'ehjí bee níká a'doowol doo bą́ąh ílínígóó kojį' hólne' 1-844-365-7373.

Nepali - निःशुल्क भाषा सेवा प्राप्त गनन 1-844-365-7373 मा टेलिफोन गन्नहोस् ।

Nilotic-Dinka - Të koor yin wëër de thokic ke cin wëu kor keek tënon yin. Ke col koc ye koc kuony ne nomba 1-844-365-7373.

Norwegian - For tilgang til kostnadsfri språktjenester, ring 1-844-365-7373.

Pennsylvania Dutch - Um Schprooch Services zu griege mitaus Koscht, ruff 1-844-365-7373.

ديرىگب سامت 7373-465-1 هر امش اب ،ناگىار روط مب نابن تامدخ مب ىسر تسد ىار ب

Polish - Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-844-365-7373.

Portuguese - Para acessar os serviços de idiomas sem custo para você, ligue para 1-844-365-7373.

Punjabi - ਤੁਹਾਡੇ ਲਈ ਬਨਿਾਂ ਬਸਿੇ ਮਿਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਰਿਨ ਲਈ, 1-844-365-7373 'ਤੇ ਫ਼ੋਨ ਰਿੈ।

Romanian - Pentru a accesa gratuit serviciile de limbă, apelați 1-844-365-7373.

Russian - Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-844-365-7373.

Samoan - Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala'au le 1-844-365-7373.

Serbo-Croatian - Za besplatne prevodilačke usluge pozovite 1-844-365-7373.

Spanish - Para acceder a los servicios de idiomas sin costo, llame al 1-844-365-7373.

Sudanic-Fulfulde - Heeba a nasta jangirde djey wolde wola chede bo apelou lamba 1-844-365-7373.

Swahili - Kupata huduma za lugha bila malipo kwako, piga 1-844-365-7373.

Tagalog - Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-844-365-7373.

Telugu - మీరు భష నేవలను ఉచితంగ అందుకున ందుకు, 1-844-365-7373 కు శల్ చేయండి.

Thai - หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-844-365-7373.

Tongan - Kapau 'oku ke fiema'u ta'etōtōngi 'a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he 1-844-365-7373.

Trukese - Ren omw kopwe angei aninisin eman chon awewei (ese kamo), kopwe kori 1-844-365-7373.

Turkish - Sizin için ücretsiz dil hizmetlerine erişebilmek için, 1-844-365-7373 numarayı arayın.

Ukrainian - Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-844-365-7373.

ںیرک تاب رپ 7373-365-444-1 ہے کے ہنرک لصاح تامدخ مقلعتم ہس نابز تمیقالاب۔

Vietnamese - Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-844-365-7373.

Yiddish - 1-844-365-7373 צו צוטריט רארפשַ באדַינונגען אין קיין פרייַז צו איר, רופן

Yoruba - Lati wonú awon ise èdè l'ofe fun o, pe 1-844-365-7373.