♦ aetna CVSHealth.: 2024 IL Gold S: Southern HMO + Ped Dental

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=0772290&Y=24, 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 \$1,500 / Family \$3,000.	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> , <u>urgent care</u> and <u>prescription drugs</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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
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 \$8,700 / Family \$17,400.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket 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 before</u> you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .



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

		What You Will Pay		
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	\$30 <u>copay</u> /visit, <u>deductible</u> does not apply	Not covered	None
If you visit a health care	Specialist visit	\$60 <u>copay</u> /visit, <u>deductible</u> 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.
If you have a test	Diagnostic test (x-ray, blood work)	25% coinsurance	Not covered	None
ii you liuvo u toot	Imaging (CT/PET scans, MRIs)	25% coinsurance	Not covered	None
	Preferred/non-preferred generic drugs	\$15 copay/ prescription for up to a 30 day supply, \$37.50 copay/ prescription for up to a 90 day supply, deductible does not apply	Not covered	Covers up to a 30 day supply (retail
If you need drugs to treat your illness or condition More information about prescription drug	Preferred brand drugs	\$30 copay/ prescription for up to a 30 day supply, \$75 copay/ prescription for up to a 90 day supply, deductible 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
coverage is available at http://aet.na/ilivl24	Non-preferred brand drugs	\$60 copay/ prescription for up to a 30 day supply, \$150 copay/ prescription for up to a 90 day supply, deductible does not apply	Not covered	contraceptives in- <u>network</u> .
	Preferred/non-preferred specialty drugs	\$250 copay/ prescription for up to a 30 day supply, deductible does not apply	Not covered	All specialty <u>prescription drug</u> fills on initial fill must be filled at a <u>network</u> specialty pharmacy except for urgent situations. Your <u>plan</u> may include access to CVS retail pharmacies for certain <u>specialty drugs</u> .
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% 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	
	Physician/surgeon fees	25% coinsurance	Not covered	None	
If you need immediate	Emergency room care	25% <u>coinsurance</u>	25% 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	25% coinsurance	25% coinsurance	Out-of-network cost-share same as in-network.	
	Urgent care	\$45 <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)	25% coinsurance	Not covered	None	
hospital stay	Physician/surgeon fees	25% coinsurance	Not covered	None	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Outpatient office visits: \$30 copay/visit, deductible does not apply; All other outpatient services: 25% coinsurance	Not covered	None	
	Inpatient services	25% 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	25% coinsurance	Not covered	services. Maternity care may include tests and services described elsewhere in the SBC	
	Childbirth/delivery facility services	25% coinsurance	Not covered	(i.e., ultrasound).	
	Home health care	\$30 <u>copay</u> /visit, <u>deductible</u> does not apply	Not covered	None	
	Rehabilitation services	\$30 <u>copay</u> /visit, <u>deductible</u> does not apply	Not covered	None	
If you need help recovering or have other	Habilitation services	25% coinsurance	Not covered	None	
special health needs	Skilled nursing care	25% coinsurance	Not covered	None	
	Durable medical equipment	25% 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	25% 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	
	Children's eye exam	\$10 copay/visit, deductible does not apply	Not covered	Coverage is limited to 1 exam every 12 months up to age 19.	
	If your child needs dental or eye care	Children's glasses	\$10 copay/visit, deductible 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	0% coinsurance	Not covered	Coverage is limited to 2 exams every 12 months up to age 19.	

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.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)

- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Private-duty nursing

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

- Abortion
- Bariatric surgery
- Chiropractic care Coverage is limited to 25 visits per manipulation.
- Hearing aids Hearing aids limited to 1 hearing aid per ear every 24 months. Bone anchored hearing aids and cochlear implants are covered.
- Infertility treatment Benefit limitations may apply.

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: Illinois Department of Insurance, Office of Consumer Health Insurance, 1-877-527-9431 toll free, 1-866-323-5321 (TDD), https://idoihelpcenter.illinois.gov/s/.

- For more information on your rights to continue coverage, contact the plan at 1-844-365-7373.
- State Consumer Assistance Program, if other than state insurance department contact Illinois Department of Insurance, Office of Consumer Health Insurance, Consumer Services Section, 122 S. Michigan Ave, 19th floor, Chicago, IL 60603, 1-312-814-2420, Or 320 W. Washington Street, Springfield, IL 62767, 1-877-527-9431 toll free, 1-217-782-4515, 1-866-323-5321 (TDD), https://idoihelpcenter.illinois.gov/s/

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:

- Illinois Department of Insurance, Office of Consumer Health Insurance, 1-877-527-9431 toll free, 1-866-323-5321 (TDD), https://idoihelpcenter.illinois.gov/s/.
- Additionally, a consumer assistance program can help you file your <u>appeal</u>. Contact Illinois Department of Insurance, Office of Consumer Health Insurance, Consumer Services Section, 122 S. Michigan Ave, 19th floor, Chicago, IL 60603, 1-312-814-2420, Or 320 W. Washington Street, Springfield, IL 62767, 1-877-527-9431 toll free, 1-217-782-4515, 1-866-323-5321 (TDD), https://idoihelpcenter.illinois.gov/s/

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes <u>plans</u>, <u>health insurance</u> available through the <u>Marketplace</u> or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of <u>Minimum Essential Coverage</u>, you may not be eligible for the <u>premium tax credit</u>.

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	\$1,500
Specialist copayment	\$60
Hospital (facility) coinsurance	25%
Other coinsurance	25%

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

The plan's overall deductible	\$1,500
Specialist copayment	\$60
Hospital (facility) coinsurance	25%
Other coinsurance	25%

Mia's Simple Fracture

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

The <u>plan's</u> overall <u>deductible</u>	\$1,500
Specialist copayment	\$60
Hospital (facility) coinsurance	25%
Other coinsurance	25%

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>	\$1,500	
<u>Copayments</u>	\$10	
<u>Coinsurance</u>	\$2,500	
What isn't covered		
Limits or exclusions	\$60	
The total Peg would pay is	\$4,070	

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>	\$100	
<u>Copayments</u>	\$1,200	
<u>Coinsurance</u>	\$0	
What isn't covered		
Limits or exclusions	\$20	
The total Joe would pay is	\$1,320	

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>	\$1,500	
<u>Copayments</u>	\$200	
<u>Coinsurance</u>	\$100	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$1,800	

Note: These numbers assume the patient does not participate in the <u>plan's</u> wellness program. If you participate in the <u>plan's</u> wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-844-365-7373.

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 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.