



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=0778869&Y=25>, 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:   |
|--|---|---|
| <b>What is the overall deductible?</b>                             | \$0.  | See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.  |
| <b>Are there services covered before you meet your deductible?</b> | No.   | You will have to meet the <u>deductible</u> before the <u>plan</u> pays for any services.   |
| <b>Are there other deductibles for specific services?</b>          | Yes. For <u>prescription drugs</u> - <u>In-network</u> : Individual \$250 / Family \$500. Does not apply to <u>in-network</u> for preferred generic and preferred brand drugs. There are no other specific <u>deductibles</u> . | You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.  |
| <b>What is the out-of-pocket limit for this plan?</b>              | <u>In-Network</u> : Individual \$6,595 / Family \$13,190.   | 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.   |
| <b>What is not included in the out-of-pocket limit?</b>            | <u>Premiums</u> and health care this <u>plan</u> doesn't cover.   | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .  |
| <b>Will you pay less if you use a network provider?</b>            | Yes. See <a href="https://aetna.com/providersearch">https://aetna.com/providersearch</a> or call 1-844-365-7373 for a list of <u>in-network providers</u> .   | 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</u> before you get services. |
| <b>Do you need a referral to see a specialist?</b>                 | No.   | You can see the <u>specialist</u> you choose without a <u>referral</u> .  |



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

| Common Medical Event   | Services You May Need                                   | What You Will Pay   |   | Limitations, Exceptions, & Other Important Information  |
|--|---|---|---|---|
|  |   | In-Network Provider (You will pay the least)  | Out-of-Network Provider (You will pay the most) |   |
| <b>If you visit a health care provider's office or clinic</b>  | Primary care visit to treat an injury or illness        | Designated: No charge;<br>Non-Designated: \$20 <u>copay</u> /visit; including virtual services  | Not covered                                     | None  |
|  | <u>Specialist</u> visit                                 | \$25 <u>copay</u> /visit  | Not covered                                     | None  |
|  | <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.   |
| <b>If you have a test</b>  | <u>Diagnostic test</u> (x-ray, blood work)              | Lab: \$20 <u>copay</u> /visit; X-ray: \$35 <u>copay</u> /visit  | Not covered                                     | None  |
|  | Imaging (CT/PET scans, MRIs)                            | \$500 <u>copay</u> /visit   | Not covered                                     | None  |
| <b>If you need drugs to treat your illness or condition</b><br><br>More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://aet.na/gaiv125">http://aet.na/gaiv125</a> | Preferred generic drugs                                 | <u>Copay</u> /prescription, <u>deductible</u> does not apply: Tier 1A: \$3 (retail), \$7.50 (mail order); Tier 1: \$15 (retail), \$37.50 (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- <u>network</u> . Review your <u>formulary</u> for prescriptions requiring precertification or step therapy for coverage. |
|  | Preferred brand drugs                                   | <u>Copay</u> /prescription, <u>deductible</u> does not apply: \$35 (retail), \$87.50 (mail order)   | Not covered                                     |   |
|  | Non-preferred generic/brand drugs                       | 35% <u>coinsurance</u> (retail & mail order), after specific <u>deductible</u>  | Not covered                                     |   |
|  | Preferred/non-preferred <u>specialty drugs</u>          | 45% <u>coinsurance</u> for up to a 30 day supply, after specific <u>deductible</u>  | Not covered                                     | None  |
| <b>If you have outpatient surgery</b>  | Facility fee (e.g., ambulatory surgery center)          | \$600 <u>copay</u> /visit for hospital facility; \$400 <u>copay</u> /visit for free standing facility   | Not covered                                     | None  |
|  | Physician/surgeon fees                                  | \$250 <u>copay</u> /visit   | Not covered                                     | None  |

| Common Medical Event  | Services You May Need                     | What You Will Pay  |   | Limitations, Exceptions, & Other Important Information  |
|---|---|--|---|---|
|   |   | In-Network Provider (You will pay the least)   | Out-of-Network Provider (You will pay the most) |   |
| If you need immediate medical attention                                   | <u>Emergency room care</u>                | \$750 <u>copay</u> /visit  | \$750 <u>copay</u> /visit                       | <u>Copay</u> waived if admitted. Out-of-network <u>emergency room care</u> cost-share same as in-network. No coverage for non-emergency care.                 |
|   | <u>Emergency medical transportation</u>   | \$750 <u>copay</u> /trip   | \$750 <u>copay</u> /trip                        | Out-of-network cost-share same as in-network.   |
|   | <u>Urgent care</u>                        | \$25 <u>copay</u> /visit   | Not covered                                     | No coverage for non-urgent use.   |
| If you have a hospital stay   | Facility fee (e.g., hospital room)        | \$1,000 <u>copay</u> /day, days 1-5  | Not covered                                     | None  |
|   | Physician/surgeon fees                    | No charge  | Not covered                                     | None  |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | Outpatient office visits:<br>Designated: No charge;<br>Non-Designated: \$20 <u>copay</u> /visit; All other outpatient services: \$25 <u>copay</u> /visit | Not covered                                     | All other outpatient services includes Applied Behavioral Analysis (ABA) services.  |
|   | Inpatient services                        | \$1,000 <u>copay</u> /day, days 1-5  | Not covered                                     | None  |
| If you are pregnant   | Office visits                             | No charge  | Not covered                                     | Cost sharing does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |
|   | Childbirth/delivery professional services | No charge  | Not covered                                     |   |
|   | Childbirth/delivery facility services     | \$1,000 <u>copay</u> /day, days 1-5  | Not covered                                     |   |

| Common Medical Event  | Services You May Need            | What You Will Pay   |   | Limitations, Exceptions, & Other Important Information   |
|---|----------------------------------|---|---|--|
|   |                                  | In-Network Provider (You will pay the least)  | Out-of-Network Provider (You will pay the most) |  |
| <b>If you need help recovering or have other special health needs</b> | <u>Home health care</u>          | \$25 <u>copay</u> /visit  | Not covered                                     | Coverage is limited to 120 visits.   |
|   | <u>Rehabilitation services</u>   | \$25 <u>copay</u> /visit  | Not covered                                     | Coverage is limited to 40 visits for Physical Therapy and Occupational Therapy combined, 40 visits for Speech Therapy.   |
|   | <u>Habilitation services</u>     | \$25 <u>copay</u> /visit  | Not covered                                     | None   |
|   | <u>Skilled nursing care</u>      | \$1,000 <u>copay</u> /day, days 1-5   | Not covered                                     | Coverage is limited to 60 days.  |
|   | <u>Durable medical equipment</u> | 50% <u>coinsurance</u>  | Not covered                                     | Coverage is limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.   |
|   | <u>Hospice services</u>          | Inpatient: \$1,000 <u>copay</u> /day, days 1-5;<br>Outpatient: \$25 <u>copay</u> /visit | Not covered                                     | None   |
| <b>If your child needs dental or eye care</b>                         | Children's eye exam              | \$10 <u>copay</u> /visit  | Not covered                                     | Coverage is limited to 1 exam every 12 months, through the end of the month after the person attains age 19.   |
|   | Children's glasses               | \$10 <u>copay</u> /visit  | 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 <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .) |   |   |
|--|---|---|
| <ul style="list-style-type: none"> <li>• Abortion</li> <li>• Acupuncture</li> <li>• Bariatric surgery</li> <li>• Cosmetic surgery</li> </ul>                           | <ul style="list-style-type: none"> <li>• Dental care (Adult &amp; Child)</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Routine eye care (Adult)</li> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul> |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.) |  |  |
|---|--|--|
| <ul style="list-style-type: none"> <li>• Chiropractic care - Coverage is limited to 20 visits.</li> </ul>                           | <ul style="list-style-type: none"> <li>• Hearing aids - Coverage is limited to \$3,000 maximum per 48 months per ear for hearing aid. Paid as billed.</li> </ul> | <ul style="list-style-type: none"> <li>• Infertility treatment - Limited to the diagnosis &amp; treatment of underlying medical condition, including artificial insemination.</li> </ul> |

**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 plan 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](http://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 claim, appeal, or a grievance for any reason to your plan. 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 plan might cover costs for a sample medical situation, see the next section.*

About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

**Peg is Having a Baby**  
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$0
- Specialist copayment \$25
- Hospital (facility) copayment \$1,000
- 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: |          |
| <u>Cost Sharing</u>             |          |
| Deductibles                     | \$0      |
| Copayments                      | \$2,200  |
| Coinsurance                     | \$0      |
| <u>What isn't covered</u>       |          |
| Limits or exclusions            | \$60     |
| The total Peg would pay is      | \$2,260  |

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

- The plan's overall deductible \$0
- Specialist copayment \$25
- Hospital (facility) copayment \$1,000
- Other copayment \$0

**This EXAMPLE event includes services like:**  
Primary care physician office visits (*including disease education*)  
Diagnostic tests (*blood work*)  
Prescription drugs  
Diabetic supplies (*glucose meter*)

|                                 |         |
|---------------------------------|---------|
| Total Example Cost              | \$5,600 |
| In this example, Joe would pay: |         |
| <u>Cost Sharing</u>             |         |
| Deductibles                     | \$0     |
| Copayments                      | \$900   |
| Coinsurance                     | \$0     |
| <u>What isn't covered</u>       |         |
| Limits or exclusions            | \$20    |
| The total Joe would pay is      | \$920   |

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

- The plan's overall deductible \$0
- Specialist copayment \$25
- Hospital (facility) copayment \$1,000
- Other copayment \$0

**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: |         |
| <u>Cost Sharing</u>             |         |
| Deductibles                     | \$0     |
| Copayments                      | \$1,500 |
| Coinsurance                     | \$0     |
| <u>What isn't covered</u>       |         |
| Limits or exclusions            | \$0     |
| The total Mia would pay is      | \$1,500 |

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

\*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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

### Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 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](mailto: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. (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 shërbime përkthimi falas për ju, telefononi 1-844-365-7373.   |
| Amharic -          | የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-844-365-7373 ይደውሉ።   |
| Arabic -           | مقررا إلى ع لاصتالاء اجرال، قفلكت ي أنود قيوغللال تامدخال إلى ع لوصحلل 1-844-365-7373                                       |
| Armenian -         | Անվճար 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 -  | আপনাকে বিনামূল্যে ভাষা পবকিসাি পপকে হকয এই নম্বকি পবেযক ান ব্রুন: 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 ဘာသာစကားဝန်ဆောင်မှုများ ရရှိနိုင်ရန် 1-844-365-7373 သို့ ဖုန်းခေါ်ဆိုပါ။                     |
| 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 -         | ႤႬႃႆႠ ႱႃႆႠႃႆႠ ႱႃႆႠႃႆႠ ႱႃႆႠႃႆႠ ႱႃႆႠႃႆႠ ႱႃႆႠႃႆႠ ႱႃႆႠႃႆႠ 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 -          | Tajaajiloota 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 ખર્ચ વાનિ ભાષાની સેલિઓની પહોર 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.  |
| Igbo -                  | Iji nwetaòhèrè na ọrụ gasị asụsụ n'efu, kpọọ 1-844-365-7373.   |
| Ilocano -               | 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 -                 | လၢတၢ်ကမၤန့ၢ်ကိၣ်အတၢ်မၤစၢၤအတၢ်ဖံးတၢ်မၤတဖၣ်လၢတအိၣ်ဒီးအပူၤလၢကဘၣ်ဟ့ၣ်အိၣ်အဂီၢ်ဘၣ်န့ၣ် ကိး 1-844-365-7373 တက့ၢ်.                  |
| Korean -                | 무료 언어 서비스를 이용하려면 1-844-365-7373 번으로 전화해 주십시오.  |
| Kru-Bassa -             | M dyi wuḍu-dù kà kò dò bë dyi móuñ nì Pídyi ní, nîí, dá nòbà nìà ke: 1-844-365-7373.   |
| Kurdish -               | 1-844-365-7373 یەرامژ مە مەکەب یەدەنەوی مە پ، وێت وێ مە نووچێت ئێبە مە نامز یراز و گەتەمەز مە مە نەتشی مە گەرا ئێبە مە دە وێ |
| Laotian -               | ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕົວຈິງທ່ານ, 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, kirluk 1-844-365-7373.                                     |
| Micronesian Pohnpeyan - | Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1-844-365-7373.  |
| Mon-Khmer Cambodian -   | ដើម្បីប្រើប្រាស់សេវាភាសាដោយឥតគិតថ្លៃសម្រាប់អ្នកកម្ពុជា មុនពេលទូរស័ព្ទសេវាភាសាសូម 1-844-365-7373។                             |
| Navajo -                | T'áá ni nizaad k'ehjí bee níká a'doowol doo bááq'á h'ílinígóó kojí' hólne' 1-844-365-7373.                                   |
| Nepali -                | निःशुल्क भाषा सेवा प्राप्त गनन 1-844-365-7373 मा टेलिफोन गनुनहोस् ।  |
| Nilotic-Dinka -         | Të koor yin wëër de thokic ke cîn wëu kor keek tënɔŋ yîn. Ke cɔl kɔc ye kɔc kuɔny ne nɔmba 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.   |
| Persian -            | ديري گب سامت 1-844-365-7373 مراش اب ،ناگي ار روط ماب نابز تامدخ مبي سرتسد يارب                                    |
| 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 ਬਨਿੰ ਬਸਿੰ ਮਿਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਰਿਨ ਲਈ, 1-844-365-7373 'ਤੇ ਫੋਨ ਰਿ।                          |
| Romanian -           | Pentru a accesa gratuit serviciile de limbă, apălați 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.  |
| Syriac -             | ܠܝܬܝܢܝܢ ܠܝܬܝܢܝܢ ܠܝܬܝܢܝܢ ܠܝܬܝܢܝܢ ܠܝܬܝܢܝܢ ܠܝܬܝܢܝܢ ܠܝܬܝܢܝܢ ܠܝܬܝܢܝܢ 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 నీవలను ఉచితంగా అందుకున ందుకు, 1-844-365-7373 కు కల్ చీయండి.   |
| 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.                          |
| Urdu -               | سیرک تاب رپ 1-844-365-7373 سے لے کے ے نرک لصاح تامدخ مقل عتم سے نابز تم قلاب۔                                     |
| 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 באַדינונגען אין קיין פּרייז צו איר, רופן   |
| Yoruba -             | Lati wọnú awọn isẹ èdè l’ọfẹ fun ọ, pe 1-844-365-7373.  |