◆aetnaCVSHealth.: 2025 IN Gold 10 Advanced: HMO Al/AN CSR LTD + Adult Dental + Vision

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=0774701&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:
What is the overall deductible?	\$0 at Indian Health Care Provider (IHCP) or with IHCP referral at non-IHCP. Non-IHCP In-network: Individual \$0 / Family \$0.	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your deductible?	No.	You will have to meet the <u>deductible</u> before the <u>plan</u> pays for any services.
Are there other deductibles for specific services?	Yes. For <u>prescription drug</u> expenses - In- <u>network</u> : Individual \$250 / Family \$500. Does not apply to in- <u>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.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	In- <u>Network</u> Non-IHCP: 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.
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
	Primary care visit to treat an injury or illness	No charge; including virtual services	No charge; including virtual services	Not covered	None
If you visit a health	Specialist visit	No charge	\$25 <u>copay</u> /visit	Not covered	None
care <u>provider's</u> 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	Lab: \$20 <u>copay</u> /visit; X-ray: \$35 <u>copay</u> /visit	Not covered	None
ii you nave a test	Imaging (CT/PET scans, MRIs)	No charge	\$500 copay/visit	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/inivl25	Preferred generic drugs	No charge	Copay/prescription, deductible 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-network. Review your formulary for prescriptions requiring precertification or step therapy for coverage.
	Preferred brand drugs	No charge	Copay/prescription, deductible does not apply: \$35 (retail), \$87.50 (mail order)	Not covered	
	Non-preferred generic/brand drugs	No charge	35% coinsurance (retail & mail order), after specific deductible	Not covered	
	Preferred/non-preferred specialty drugs	No charge for up to a 30 day supply	45% coinsurance for up to a 30 day supply, after specific deductible	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 selected participating retail

	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
					pharmacies for certain specialty drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	\$600 <u>copay</u> /visit for hospital facility; \$400 <u>copay</u> /visit for free standing facility	Not covered	None
	Physician/surgeon fees	No charge	\$250 copay/visit	Not covered	None
If you need immediate medical attention	Emergency room care	No charge	\$750 <u>copay</u> /visit	\$750 <u>copay</u> /visit	Copay waived if admitted. Out-of-Network emergency room care cost-share same as Non-IHCP In-Network. No coverage for non-emergency care.
attention	Emergency medical transportation	No charge	\$750 <u>copay</u> /trip	\$750 <u>copay</u> /trip	Out-of-network cost-share same as Non-IHCP In-Network.
	<u>Urgent care</u>	No charge	\$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)	No charge	\$1,000 <u>copay</u> /day, days 1-5	Not covered	None
noophal olay	Physician/surgeon fees	No charge	No charge	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits and all other outpatient services: No charge	Outpatient office visits: No charge; All other outpatient services: \$25 <u>copay</u> /visit	Not covered	All other outpatient services includes Applied Behavioral Analysis (ABA) services.
	Inpatient services	No charge	\$1,000 <u>copay</u> /day, days 1-5	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	No charge	Not covered	preventive services. Maternity care may include tests and services
	Childbirth/delivery facility services	No charge	\$1,000 <u>copay</u> /day, days 1-5	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	\$25 <u>copay</u> /visit	Not covered	Coverage is limited to 100 visits.
	Rehabilitation services	No charge	\$25 <u>copay</u> /visit	Not covered	Coverage is limited to 20 visits each for Physical Therapy and Occupational Therapy, 20 visits for Speech Therapy.
	Habilitation services	No charge	\$25 copay/visit	Not covered	None
If you need help recovering or have	Skilled nursing care	No charge	\$1,000 <u>copay</u> /day, days 1-5	Not covered	Coverage is limited to 90 days.
If your child needs dental or eye care	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	Outpatient: \$25 <u>copay</u> /visit; Inpatient: \$1,000 <u>copay</u> /day, days 1-5	Not covered	None
	Children's eye exam	No charge	\$10 <u>copay</u> /visit	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	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 (Child)
- Hearing aids
- Long-term care

- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs

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

- Chiropractic care Coverage is limited to 12 visits.
- Dental care (Adult) Coverage is limited to ages 19 and up. Routine Cleaning (2 per calendar year).
 \$1,000 maximum for all dental services (Routine check-up, Basic & Major).
- Infertility treatment Limited to the diagnosis & treatment of underlying medical condition, including artificial insemination.
- Private-duty nursing Coverage is limited to 82 visits.
- Routine eye care (Adult) Coverage is limited to ages 19 and up. 1 routine eye exam, including dilation. Coverage does not include the office visit for the fitting of prescription contact lenses.

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

Mia's Simple Fracture

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

The plan's overall deductible	\$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	
Coinsurance	\$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	
Copayments	\$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 referral 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 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 SULJOJ O'GOLONJI L'AFOJ JCEGWAJ AY, OLJEWOL 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 ဦးအပူးလာကဘဉ်ဟုဉ်အီးအင်္ဂါဘဉ်နှဉ် 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 - निःशूल्क 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 7373-465-1-844 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 7373-844-1 ہے کہ ہے نرک لصاح تامدخ مقل عتم ہے س نابز تمیق اب۔.

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.