# ◆aetnaCVSHealth.: 2025 GA Gold 3 Advanced: HMO

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, <u>https://www.aetna.com/sbcsearch/getcbpolicydocs?P=0774790&Y=25</u>, or by calling 1-844-365-7373. For general definitions of common terms, such as <u>allowed amount, balance billing, coinsurance, copayment, deductible, 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<br><u>deductible</u> ?                                | In- <u>Network</u> : Individual \$895 / Family \$1,790.   | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount<br>before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each<br>family member must meet their own individual <u>deductible</u> until the total amount of<br><u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .  |
| Are there services<br>covered before you meet<br>your <u>deductible</u> ? | Yes. Certain office visits, <u>preventive care</u> and <u>urgent</u><br><u>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><br>amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers<br>certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> .<br>See a list of covered <u>preventive services</u> at<br><u>https://www.healthcare.gov/coverage/preventive-care-benefits</u> /.   |
| Are there other<br><u>deductibles</u> for specific<br>services?           | No.   | You don't have to meet deductibles for specific services.   |
| What is the <u>out-of-pocket</u><br>limit for this <u>plan</u> ?          | In- <u>Network</u> : Individual \$9,195 / Family \$18,390.  | 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 out-of-pocket limit.  |
| Will you pay less if you<br>use a <u>network provider</u> ?               | Yes. See <u>https://aet.na/providersearch_aetna</u> or call 1-844-365-7373 for a list of in- <u>network providers</u> . | This <u>plan</u> uses a <u>provider</u> <u>network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's</u> <u>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. |
| Do you need a <u>referral</u> to see a <u>specialist</u> ?                | 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.

|  | Services You May Need                                      | What You Will Pay  |   |  |
|--|--|--|---|--|
| Common<br>Medical Event  |  | In-Network Provider (You will pay the least)   | Out–of–Network<br>Provider (You will pay<br>the most) | Limitations, Exceptions, & Other Important<br>Information  |
|  | Primary care visit to treat an injury or illness           | \$15 <u>copay</u> /visit, <u>deductible</u><br>does not apply; including<br>virtual services   | Not covered   | None   |
| If you visit a health care<br>provider's office or clinic  | <u>Specialist</u> visit                                    | \$35 <u>copay</u> /visit, <u>deductible</u><br>does not apply  | Not covered   | None   |
| provider's office of clinic  | <u>Preventive care</u> / <u>screening</u><br>/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   | <u>Diagnostic test</u> (x-ray, blood work)                 | Lab: \$25 <u>copay</u> /visit,<br><u>deductible</u> does not apply;<br>X-ray: \$50 <u>copay</u> /visit,<br><u>deductible</u> does not apply                        | Not covered   | None   |
|  | Imaging (CT/PET scans, MRIs)                               | 35% coinsurance  | Not covered   | None   |
| If you need drugs to treat<br>your illness or condition<br>More information about<br>prescription drug<br><u>coverage</u> is available at<br>http://aet.na/gaivl25 | Preferred generic drugs                                    | <u>Copay</u> / prescription,<br><u>deductible</u> does not apply:<br>Tier 1A: \$3 (retail), \$7.50<br>(mail order); Tier 1: \$15<br>(retail), \$37.50 (mail order) | Not covered   | Covers up to a 30 day supply (retail<br>prescription), 31-90 day supply (mail order<br>prescription). Applicable cost share plus<br>difference (brand minus generic cost) applies            |
|  | Preferred brand drugs                                      | <u>Copay</u> / prescription,<br><u>deductible</u> does not apply:<br>\$40 (retail), \$100 (mail<br>order)  | Not covered   | for brand when generic available. No charge for<br>preferred generic FDA-approved women's<br>contraceptives in- <u>network</u> . Review your<br><u>formulary</u> for prescriptions requiring |
|  | Non-preferred generic/brand drugs                          | 40% <u>coinsurance</u> (retail & mail order)   | Not covered   | precertification or step therapy for coverage.   |
|  | Preferred/non-preferred <u>specialty</u><br>drugs          | 50% <u>coinsurance</u> for up to a 30 day supply   | Not covered   | None   |
| lf you have outpatient<br>surgery  | Facility fee (e.g., ambulatory surgery center)             | 40% <u>coinsurance</u> for<br>hospital facility; 30%<br><u>coinsurance</u> for free<br>standing facility   | Not covered   | None   |

|   |   | What You Will Pay   |   |   |
|---|---|---|---|---|
| Common<br>Medical Event   | Services You May Need                     | In-Network Provider (You<br>will pay the least)   | Out–of–Network<br>Provider (You will pay<br>the most) | Limitations, Exceptions, & Other Important<br>Information   |
|   | Physician/surgeon fees                    | 40% <u>coinsurance</u> for<br>hospital facility; 30%<br><u>coinsurance</u> for free<br>standing facility  | Not covered   | None  |
| If you need immediate   | Emergency room care                       | 45% coinsurance   | 45% coinsurance                                       | Out-of-network <u>emergency room care</u><br>cost-share same as in- <u>network</u> . No coverage<br>for non-emergency care. |
| medical attention   | Emergency medical transportation          | 45% coinsurance   | 45% coinsurance                                       | Out-of-network cost-share same as in-network.   |
|   | <u>Urgent care</u>                        | \$25 <u>copay</u> /visit, <u>deductible</u><br>does not apply   | Not covered   | No coverage for non-urgent use.   |
| If you have a   | Facility fee (e.g., hospital room)        | 45% coinsurance   | Not covered   | None  |
| hospital stay   | Physician/surgeon fees                    | 45% coinsurance   | Not covered   | None  |
| If you need mental health,<br>behavioral health, or<br>substance abuse services | Outpatient services                       | Outpatient office visits: \$15<br><u>copay</u> /visit, <u>deductible</u> does<br>not apply; All other<br>outpatient services: 35%<br><u>coinsurance</u> | Not covered   | All other outpatient services includes Applied<br>Behavioral Analysis (ABA) services.                                       |
|   | Inpatient services                        | 45% coinsurance   | Not covered   | None  |
| lf you are pregnant   | Office visits                             | No charge   | Not covered   | Cost sharing does not apply for preventive  |
|   | Childbirth/delivery professional services | 45% coinsurance   | Not covered   | services. Maternity care may include tests<br>and services described elsewhere in the SBC                                   |
|   | Childbirth/delivery facility services     | 45% coinsurance   | Not covered   | (i.e., ultrasound).   |

|   |                            | What You Will Pay   |   |   |
|---|----------------------------|---|---|---|
| Common<br>Medical Event                   | Services You May Need      | In-Network Provider (You<br>will pay the least)                             | Out–of–Network<br>Provider (You will pay<br>the most) | Limitations, Exceptions, & Other Important<br>Information   |
|   | Home health care           | \$35 <u>copay</u> /visit, <u>deductible</u><br>does not apply               | Not covered   | Coverage is limited to 120 visits.  |
|   | Rehabilitation services    | \$35 <u>copay</u> /visit, <u>deductible</u><br>does not apply               | Not covered   | Coverage is limited to 40 visits for Physical<br>Therapy and Occupational Therapy combined,<br>40 visits for Speech Therapy.  |
| If you need help                          | Habilitation services      | 35% coinsurance   | Not covered   | None  |
| recovering or have other                  | Skilled nursing care       | 45% coinsurance   | Not covered   | Coverage is limited to 60 days.   |
| special health needs                      | Durable medical equipment  | 45% coinsurance   | Not covered   | Coverage is limited to 1 <u>durable medical</u><br><u>equipment</u> for same/similar purpose. Excludes<br>repairs for misuse/abuse.   |
|   | Hospice services           | Inpatient: 45%<br><u>coinsurance;</u> Outpatient:<br>40% <u>coinsurance</u> | Not covered   | None  |
| If your child needs dental<br>or eye care | Children's eye exam        | \$10 <u>copay</u> /visit, <u>deductible</u><br>does not apply               | Not covered   | Coverage is limited to 1 exam every 12 months,<br>through the end of the month after the person<br>attains age 19.  |
|   | Children's glasses         | \$10 <u>copay</u> /visit, <u>deductible</u><br>does not apply               | Not covered   | Coverage is limited to 1 set of frames and 1 set<br>of contact lenses or eyeglass lenses every 12<br>months, through the end of the month after the<br>person attains age 19. |
|   | Children's dental check-up | Not covered   | Not covered   | Not covered.  |

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

| Services Your Plan Generally Does NOT Cover (Chec  | k your policy or plan document for more information   | and a list of any other <u>excluded services</u> .)   |
|--|---|---|
| <ul> <li>Abortion</li> <li>Acupuncture</li> <li>Bariatric surgery</li> <li>Cosmetic surgery</li> </ul> | <ul> <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> <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 the   |   | · · · · · · · · · · · · · · · · · · ·   |
| <ul> <li>Chiropractic care - Coverage is limited to 20 visits.</li> </ul>                              | <ul> <li>Hearing aids - Coverage is limited to \$3,000</li> </ul>   | <ul> <li>Infertility treatment - Limited to the diagnosis &amp;</li> </ul>  |

Coverage is limited to 20 visits.
 Hearing aids - Coverage is limited to \$3,000

 Infertility treatment - Limited to the diagnosis &
 treatment of underlying medical condition, including
 artificial insemination.

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 <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:

• 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 <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 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 deliverv)

45%

| The <u>plan's</u> overall <u>deductible</u> | \$895 |
|---|-------|
| Specialist copayment                        | \$35  |
| Hospital (facility) coinsurance             | 45%   |

- Hospital (facility) coinsurance
- Other coinsurance

# 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>              | \$895    |
| Copayments                      | \$200    |
| Coinsurance                     | \$4,100  |
| What isn't covered              |          |
| Limits or exclusions            | \$60     |
| The total Peg would pay is      | \$5,255  |

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

| The plan's overall of the plan's overall         | leductible \$895 |
|--|------------------|
| Specialist copayme                               | <u>ent</u> \$35  |
| <ul> <li>Hospital (facility) <u>c</u></li> </ul> | oinsurance 45%   |
| Other <u>coinsurance</u>                         | 45%              |

# 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: |         |
| Cost Sharing                    |         |
| Deductibles                     | \$0     |
| <u>Copayments</u>               | \$900   |
| <u>Coinsurance</u>              | \$0     |
| What isn't covered              |         |
| 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 <u>plan's</u> overall <u>deductible</u>                | \$895 |
|--|-------|
| Specialist copayment                                       | \$35  |
| <ul> <li>Hospital (facility) <u>coinsurance</u></li> </ul> | 45%   |
| Other coinsurance  | 45%   |

#### 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: |         |
| Cost Sharing                    |         |
| Deductibles                     | \$895   |
| <u>Copayments</u>               | \$200   |
| Coinsurance                     | \$500   |
| What isn't covered              |         |
| Limits or exclusions            | \$0     |
| The total Mia would pay is      | \$1,595 |

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.

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.

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. (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 አ <i>ገ</i> ል <i>ግሎቶችን ያ</i> ለክፍያ ለ <i>ጣግኘት</i> ፣ በ 1-844-365-7373 ይደውሉ፡፡   |
| Arabic -           | مقرل ا عال عال مقرل ا عاجرل ا ، ةف لكت يأ نود ةي و غلل ا تامدخل ا على لوص حل ا 365-7373 - 1-844                             |
| 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 বেনিামূকম ভোষা পবকিষাি পপক হেকম এই নম্বক পিবেযক ান রেুন: 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 ရရှိနိင်ရန် 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 -         | ԱՋՅ⅃ Տ೮ՒԹՅ⅃ ԾՇՅԵՐՂ⅃ Ը АՐՅ⅃ ⅃ℂℇGWՂ⅃ ՃՋ, ՕՒℬᲮWᲝᲮ 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 ખર્ચ વનાિ ભાષાની સેાિઓની પહોોર્ 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 लएि, 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 ọrụ gasị asụsụ n'efu, kpọọ 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 -                    | လ၊တၢ်ကမၤန္နာ်ကိုဉ်အတာ်မၤစၢၤအတၢ်ဖံးတာ်မၤတဖဉ်လၢတအိဉ်ဒီးအၒၟၤလၢကဘဉ်ဟ့ဉ်အီၤအဂ်ီ၊ဘဉ်နှဉ် ကိး 1-844-365-7373 တက္ၢ်            |
| Korean -                   | 무료 언어 서비스를 이용하려면 1-844-365-7373 번으로 전화해 주십시오.  |
| Kru-Bassa -                | Μ dyi wuqu-dù kà kò qò ɓĕ dyi mɔ́uń nì Pídyi ní, nìí, qá nɔ̀ɓà nìà kɛ: 1-844-365-7373.                                 |
| Kurdish -                  | ىەرامژ ھب ھكب ىدنھويھپ ،ۆت ۆب نووچىٽ ئىبھب نامز ىرازوگىتىمزخ ھب نتشىيھگارىخپسەد ۆب 7373-365-1844                       |
| Laotian -                  | ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບື້ເສຍຄື່າຕື້ກັບທີ່ານ, 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<br>Pohnpeyan - | Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1-844-365-7373.  |
| Mon-Khmer<br>Cambodian -   | ដ ើមបីទទួលបានដវោកមមភាសាដ លឥតគិតថលម្រៃរាប់ដលាកអ៊នក ូ មុដ <b>ៅទូរពែទដ</b> ៅកាន់ដលខ 1-844-365-7373 <sup>4</sup> .         |
| Navajo -                   | T'áá ni nizaad k'ehjí bee níká a'doowol doo bą́ą́h ílínígóó kojį′ hólne' 1-844-365-7373.                               |
| Nepali -                   | निःशुल्क भाषा सेवा प्राप्त गनन 1-844-365-7373 मा टेलिफोन गनुनहोस् ।  |
| Nilotic-Dinka -            | Të kɔɔr yïn wɛ̈ɛr de thokic ke cïn wëu kɔr keek tënɔŋ yïn. 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 -<br>Polish -                 | د <i>ير یگ</i> ب سامت <b>1-844-365-7373</b> مرامش اب ،ناگيار روط مب نابز تامدخ مب یسرتسد یارب<br>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 ਮਿਿਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਰਿਨ ਲਈ, 1-844-365-7373 'ਤੇ ਫ਼ੋਨ ਰਿ।   |
| 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.  |
| Syriac -<br>Tagalog -                 | د المربح ب مربح ب م<br>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 కల్ చేయండి.  |
| Thai -<br>Tongan -                    | หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-844-365-7373.<br>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 -<br>Urdu -<br>Vietnamese - | Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-844-365-7373.<br>ںیرک تاب رپ 1-844-365-7373 ےیل ےک ےنرک لصاح تامدخ مقل عتم ےس نابن تمی قلاب۔.<br>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 ךארפשַ באדַינונגען אין קיין פרייַז צו איר, רופן  |
| Yoruba -                              | Lati wọnú awọn isẹ èdè l'ọfẹ fun ọ, pe 1-844-365-7373.  |