### Important Questions | Answers | Why This Matters:

#### What is the overall deductible?
- **In-Network:** Individual $7,500 / Family $15,000.

- Generally, you must pay all of the costs from providers up to the **deductible** amount before this **plan** begins to pay. If you have other family members on the **plan**, each family member must meet their own individual **deductible** until the total amount of **deductible** expenses paid by all family members meets the overall family **deductible**.

#### Are there services covered before you meet your deductible?
- Yes. Certain office visits, **preventive care** and **urgent care** in-network.

- This **plan** covers some items and services even if you haven’t yet met the **deductible** amount. But a **copayment** or **coinsurance** may apply. For example, this **plan** covers certain **preventive services** without **cost sharing** and before you meet your **deductible**. See a list of covered **preventive services** at [https://www.healthcare.gov/coverage/preventive-care-benefits/](https://www.healthcare.gov/coverage/preventive-care-benefits/).

#### Are there other deductibles for specific services?
- No.

- You don’t have to meet **deductibles** for specific services.

#### What is the out-of-pocket limit for this plan?
- **In-Network:** Individual $9,000 / Family $18,000.

- The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this **plan**, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.

#### What is not included in the out-of-pocket limit?
- **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 use a network provider?
- Yes. See [https://aet.na/providersearch_aetna or call 1-844-365-7373 for a list of in-network providers](https://aet.na/providersearch_aetna) for a list of in-network providers. Select 2023 TX Aetna CVS Bronze: HMO OFF PD Standard.

- This **plan** uses a **provider network**. You will pay less if you use a **provider** in the **plan’s network**. You will pay the most if you use an out-of-network **provider**, and you might receive a bill from a **provider** for the difference between the **provider**’s charge and what your **plan** pays (balance billing). Be aware, your **network provider** might use an out-of-network **provider** for some services (such as lab work). Check with your **provider** before you get services.

#### Do you need a referral to see a specialist?
- Yes.

- This **plan** will pay some or all of the costs to see a **specialist** for covered services but only if you have a referral before you see the specialist.
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider's office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td><strong>In-Network Provider (You will pay the least)</strong>: $50 copay/visit, deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td><strong>In-Network Provider (You will pay the least)</strong>: $100 copay/visit, deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Preventive care /screening /immunization</td>
<td><strong>In-Network Provider (You will pay the least)</strong>: No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td><strong>In-Network Provider (You will pay the least)</strong>: 50% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td><strong>In-Network Provider (You will pay the least)</strong>: 50% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Preferred/non-preferred generic drugs</td>
<td><strong>In-Network Provider (You will pay the least)</strong>: $25 copay/ prescription for up to a 30 day supply, $62.50 copay/ prescription for up to a 90 day supply, deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td><strong>In-Network Provider (You will pay the least)</strong>: $50 copay/ prescription for up to a 30 day supply, $125 copay/ prescription for up to a 90 day supply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td><strong>In-Network Provider (You will pay the least)</strong>: $100 copay/ prescription for up to a 30 day supply, $250 copay/ prescription for up to a 90 day supply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Preferred/non-preferred specialty drugs</td>
<td><strong>In-Network Provider (You will pay the least)</strong>: $500 copay/ prescription for up to a 30 day supply</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td><strong>In-Network Provider (You will pay the least)</strong>: 50% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>---------------------------------------------</td>
<td>------------------------------------------------</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Physician/surgeon fees</td>
<td>50% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>Emergency room care</td>
<td>50% coinsurance</td>
<td>50% coinsurance</td>
<td>Out-of-network emergency room care cost-share same as in-network. No coverage for non-emergency care.</td>
</tr>
<tr>
<td>Emergency medical transportation</td>
<td>50% coinsurance</td>
<td>50% coinsurance</td>
<td>Out-of-network cost-share same as in-network.</td>
</tr>
<tr>
<td>Urgent care</td>
<td>$75 copay/visit, deductible does not apply</td>
<td>Not covered</td>
<td>No coverage for non-urgent use.</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>50% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>Physician/surgeon fees</td>
<td>50% coinsurance</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td>Outpatient services</td>
<td>Outpatient office visits: $50 copay/visit, deductible does not apply; All other outpatient services: 50% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>Inpatient services</td>
<td>50% coinsurance</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Office visits</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>Childbirth/delivery professional services</td>
<td>50% coinsurance</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td>Childbirth/delivery facility services</td>
<td>50% coinsurance</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td>Home health care</td>
<td>50% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>$50 copay/visit, deductible does not apply</td>
<td>Not covered</td>
<td>Coverage is limited to 35 visits for Physical Therapy, Occupational Therapy, Speech Therapy and Chiropractic care combined.</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>50% coinsurance</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>50% coinsurance</td>
<td>Not covered</td>
<td>Coverage is limited to 25 days.</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>50% coinsurance</td>
<td>Not covered</td>
<td>Coverage is limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.</td>
</tr>
<tr>
<td>Hospice services</td>
<td>50% coinsurance</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td></td>
<td>What You Will Pay</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>-----------------------------</td>
<td></td>
<td>In-Network Provider (You will pay the least)</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>50% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>50% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</td>
<td>0% coinsurance</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

### 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 - except when the life of the mother is endangered, or complications arise.
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Acupuncture - Coverage is limited to 10 visits.
- Chiropractic care - Coverage is limited to 35 visits for Physical Therapy, Occupational Therapy, Speech Therapy and Chiropractic care combined.
- Hearing aids
- Private-duty nursing - Coverage is limited to inpatient when medically necessary.

### 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:

- 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 Texas Department of Insurance, Consumer Protection, Mail Code 111-1A, 333 Guadalupe, P.O. Box 149091, Austin, TX 78714-9091, Phone toll-free: 1-800-252-3439, [http://www.texashealthoptions.com](http://www.texashealthoptions.com), ConsumerProtection@tdi.texas.gov

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:

- Texas Department of Insurance, 1-800-252-3439 (Consumer HelpLine), (512) 676-6000 (Local), (800) 578-4677 (Toll-Free), [https://www.tdi.texas.gov/consumer/index.html](https://www.tdi.texas.gov/consumer/index.html)
Additionally, a consumer assistance program can help you file your appeal. Contact Texas Department of Insurance, Consumer Protection, Mail Code 111-1A, 333 Guadalupe, P.O. Box 149091, Austin, TX 78714-9091, Phone toll-free: 1-800-252-3439, http://www.texashealthoptions.com, ConsumerProtection@tdi.texas.gov

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.

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

- **The plan’s overall deductible:** $7,500
- **Specialist copayment:** $100
- **Hospital (facility) coinsurance:** 50%
- **Other coinsurance:** 50%

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)*

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$12,700</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In this example, Peg would pay:</strong></td>
<td></td>
</tr>
<tr>
<td>Cost Sharing</td>
<td></td>
</tr>
<tr>
<td>Deductibles</td>
<td>$7,500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,500</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$60</td>
</tr>
<tr>
<td><strong>The total Peg would pay is</strong></td>
<td>$9,060</td>
</tr>
</tbody>
</table>

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

- **The plan’s overall deductible:** $7,500
- **Specialist copayment:** $100
- **Hospital (facility) coinsurance:** 50%
- **Other coinsurance:** 50%

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

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$5,600</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In this example, Joe would pay:</strong></td>
<td></td>
</tr>
<tr>
<td>Cost Sharing</td>
<td></td>
</tr>
<tr>
<td>Deductibles</td>
<td>$3,200</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,200</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$20</td>
</tr>
<tr>
<td><strong>The total Joe would pay is</strong></td>
<td>$4,420</td>
</tr>
</tbody>
</table>

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

- **The plan’s overall deductible:** $7,500
- **Specialist copayment:** $100
- **Hospital (facility) coinsurance:** 50%
- **Other coinsurance:** 50%

This EXAMPLE event includes services like:
- Emergency room care *(including medical supplies)*
- Diagnostic test *(x-ray)*
- Durable medical equipment *(crutches)*
- Rehabilitation services *(physical therapy)*

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$2,800</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In this example, Mia would pay:</strong></td>
<td></td>
</tr>
<tr>
<td>Cost Sharing</td>
<td></td>
</tr>
<tr>
<td>Deductibles</td>
<td>$1,900</td>
</tr>
<tr>
<td>Copayments</td>
<td>$400</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$0</td>
</tr>
<tr>
<td><strong>The total Mia would pay is</strong></td>
<td>$2,300</td>
</tr>
</tbody>
</table>

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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 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. (Texas) (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 asistencë në gjuhën shqipe telefononi falas në 1-844-365-7373.
Amharic - እስከ.jwtentityManager ያለወጠሩ ከ እ.የ.ቀ. ከ 1-844-365-7373 የተፈጠረ የፋዳራለ.
Arabic - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-844-365-7373.
Armenian - Անգերասպ գույքի առաջադրություն (հայերեն) ցանցիվ 1-844-365-7373 քանդավ գնի՞լ:
Bahasa-Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-844-365-7373 tanpa dikenakan biaya.
Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-844-365-7373 ku busa
Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-844-365-7373-এ কল করুন।
Bisayan-Visayan - Alang sa pag-abag sa pinulongang sa (Binisayang Sinugboanon) tawag sa 1-844-365-7373 nga walay bayad.
Burmese - 1-844-365-7373
Catalan - Per rebre assistència en (català), truqui al número gratuït 1-844-365-7373.
Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-844-365-7373 sin gástu.
Cherokee - Ꭳ hypertension ᎝ୁୱେୟେସୁୱେୟେ ଜ୍ୟେସୂସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁସୁperl.asia Elemental Preview! 1-844-365-7373 9 8 7 6 5 4 3 2 1
Chinese - 欲取得繁體中文語言協助，請撥打 1-844-365-7373，無需付費。
Choctaw - (Chahta) anumpa ya apela a chi l paya hinla 1-844-365-7373.
Cushite - Gargaarsa afan Oromiffa hiikuu argachuuf lakko kikosha bilbilaa 1-844-365-7373 irratti bilisaan bilbilaa.
Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-844-365-7373.
French - Pour une assistance linguistique en français appelez le 1-844-365-7373 sans frais.
French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-844-365-7373 gratis.
Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-844-365-7373 χωρίς χρέωση.
Gujarati - ગુજરાતીમાં ભાષા માટે કોઈ પણ પરસ્પર વચ્ચે 1-844-365-7373 પર ડલ્ટ કરો.
No ke kōkua ma ka ʻōlelo Hawaiʻi, e kahea aku i ka helu kelepona 1-844-365-7373. Kāki ʻole ia kēia kōkua nei.

हिंदी में भाषा सहायता के लिए, 1-844-365-7373 पर मुफ्त कॉल करें।

Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-844-365-7373.

Maka enyemaka asusu na Igbo kpọọ 1-844-365-7373 na akwu ghị ọ bụla

Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-844-365-7373 nga awan ti bayadanyo.

Per ricevere assistenza linguistica in italiano, puo' chiamare gratuitamente 1-844-365-7373.

日本語で援助をご希望の方は、1-844-365-7373 まで無料でお電話ください。

韩国어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-844-365-7373 번으로 전화해 주십시오.

Braye Rahemtai be Ziban Farsiyi Ba Shmarhe 1-844-365-7373 Be Khvrai Piwphendi Pekan.

Фрійше спілкування залежно від мови, зв'язку 1-844-365-7373 дозволено.

हॅल्दी में भाषा सहायता के लिए, 1-844-365-7373 पर मुफ्त कॉल करें।

 vascular karama na yin madda, da 1-844-365-7373

 ब्राय राहेंमती बी जिबन फारसी पार शमरे 1-844-365-7373 बी हॉसी पनपेंडी पबकान।

nëtëkëmëo amalëtumë amëndësë ñësëmëmëo ñësëmëmëo, mëngëkëmë mëndëgë 1-844-365-7373 këwëñëéëjëkëntë.

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ień bok jipañ ilo Kajin Majol, kallok 1-844-365-7373 ilo ejjelok wônân.

Ohng palien sawas en soum kawewe ne omw lokaia Ponape koahl 1-844-365-7373 no sohte isais.

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For språkassistanse på norsk, ring 1-844-365-7373 kostnadsfritt.

Navajo - T'áá shi shizaad k'ehji bee shiká a'doowol ninizando Diné k'ehji koji' t'áá jíik'e hólne' 1-844-365-7373

Nepali - (नेपाली) मा नभिश्वक्र भाषा सहायता पाउनका लागि 1-844-365-7373 मा फोन गरि सुहोसू।

Nilotic-Dinka - Tën kuccion ë thok ë Thuonjâñ col 1-844-365-7373 kecën ayoc.

Panjabi - Panjabi diwanci barmangi mantiginda latti, 1-844-365-7373 'nde bhuda waxe bante.

1-844-365-7373