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, visit https://www.aetna.com/sbcsearch/getcbpolicydocs?P=0764656&Y=23, 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 and Answers

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>In-Network: Individual $800 / Family $1,600.</td>
<td>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.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Certain office visits, preventive care and urgent care in-network.</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>In-Network: Individual $3,000 / Family $6,000.</td>
<td>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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="https://aetna/providersearch_aetna">https://aetna/providersearch_aetna</a> or call 1-844-365-7373 for a list of in-network providers. Select 2023 TX Aetna CVS Silver: HMO CSR 87 ON Standard.</td>
<td>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.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>Yes.</td>
<td>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.</td>
</tr>
</tbody>
</table>
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></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>In-Network Provider (You will pay the least)</strong></td>
<td><strong>Out-of-Network Provider (You will pay the most)</strong></td>
</tr>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>$20 copay/visit, deductible does not apply</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>$40 copay/visit, deductible does not apply</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>Not covered</td>
<td>You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic test (x-ray, blood work)</td>
<td>30% coinsurance</td>
<td>Not covered</td>
<td>Applies to services received in office or in outpatient setting.</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>30% coinsurance</td>
<td>Not covered</td>
<td>Applies to services received in office or in outpatient setting.</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>In-Network Provider (You will pay the least)</strong></td>
<td><strong>Out-of-Network Provider (You will pay the most)</strong></td>
</tr>
<tr>
<td>Preferred/non-preferred generic drugs</td>
<td>$10 copay/ prescription for up to a 30 day supply, $25 copay/ prescription for up to a 90 day supply, deductible does not apply</td>
<td>Not covered</td>
<td>Covers up to a 30 day supply (retail prescription), 31-90 day supply (retail &amp; 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.</td>
</tr>
<tr>
<td>Preferred brand drugs</td>
<td>$20 copay/ prescription for up to a 30 day supply, $50 copay/ prescription for up to a 90 day supply, deductible does not apply</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Non-preferred brand drugs</td>
<td>$60 copay/ prescription for up to a 30 day supply, $150 copay/ prescription for up to a 90 day supply</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Preferred/non-preferred specialty drugs</td>
<td>$250 copay/ prescription for up to a 30 day supply</td>
<td>Not covered</td>
<td>All specialty prescription drug fills on initial fill must be filled at a network specialty pharmacy except for urgent situations. Your plan may include access to CVS retail pharmacies for certain specialty drugs.</td>
</tr>
</tbody>
</table>

More information about **prescription drug coverage** is available at [http://aetna.com/txivl23](http://aetna.com/txivl23)

Texas TX Shoppers: To find TX plan consumer drug cost estimates go to [https://www.aetna.com/individuals-families/aca-texas-plans.html](https://www.aetna.com/individuals-families/aca-texas-plans.html) or call us toll-free at 1-844-393-7139.
<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>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>30% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>30% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>30% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>30% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$30 copay/visit, deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>30% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>30% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Outpatient office visits: $20 copay/visit, deductible does not apply; All other outpatient services: 30% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>30% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>30% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>30% coinsurance</td>
<td>Not covered</td>
</tr>
</tbody>
</table>
### Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>In-Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Home health care</strong></td>
<td>30% coinsurance</td>
<td>Not covered</td>
<td>Coverage is limited to 60 visits.</td>
</tr>
<tr>
<td><strong>Rehabilitation services</strong></td>
<td>$20 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><strong>Habilitation services</strong></td>
<td>30% coinsurance</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td><strong>Skilled nursing care</strong></td>
<td>30% coinsurance</td>
<td>Not covered</td>
<td>Coverage is limited to 25 days.</td>
</tr>
<tr>
<td><strong>Durable medical equipment</strong></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><strong>Hospice services</strong></td>
<td>30% coinsurance</td>
<td>Not covered</td>
<td>None</td>
</tr>
</tbody>
</table>

#### If your child needs dental or eye care

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>In-Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Children's eye exam</strong></td>
<td>50% coinsurance</td>
<td>Not covered</td>
<td>Coverage is limited to 1 exam every 12 months up to age 19.</td>
</tr>
<tr>
<td><strong>Children's glasses</strong></td>
<td>50% coinsurance</td>
<td>Not covered</td>
<td>Coverage is limited to 1 set of frames and 1 set of contact lenses or eyeglass lenses per calendar year up to age 19.</td>
</tr>
<tr>
<td><strong>Children's dental check-up</strong></td>
<td>Not covered</td>
<td>Not covered</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 & Child)
- 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: 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).

- For more information on your rights to continue coverage, contact the plan at 1-844-365-7373.
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.
- 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.

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

- The plan’s overall deductible: $800
- Specialist copayment: $40
- Hospital (facility) coinsurance: 30%
- Other coinsurance: 30%

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:
- Deductibles: $800
- Copayments: $0
- Coinsurance: $2,200
- What isn’t covered: $60
- The total Peg would pay is: $3,060

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

- The plan’s overall deductible: $800
- Specialist copayment: $40
- Hospital (facility) coinsurance: 30%
- Other coinsurance: 30%

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)

Total Example Cost: $5,600

In this example, Joe would pay:
- Deductibles: $100
- Copayments: $900
- Coinsurance: $0
- What isn’t covered: $20
- The total Joe would pay is: $1,020

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

- The plan’s overall deductible: $800
- Specialist copayment: $40
- Hospital (facility) coinsurance: 30%
- Other coinsurance: 30%

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:
- Deductibles: $800
- Copayments: $900
- Coinsurance: $300
- What isn’t covered: $0
- The total Mia would pay is: $1,200

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.

080700-090020-252232 Page 6 of 6
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 gjihuën shqipe telefononi falas në 1-844-365-7373.

**Amharic** - ኢትዮጵያ ኢትዮጵያ ከ ኢትዮጵያ ከ 1-844-365-7373 የከ ከፋል.

**Arabic** - للمساعدة في (اللغة العربية)، الوجه الاتصال على الرقم المجاني 1-844-365-7373.

**Armenian** - Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-844-365-7373 առանց գնով:

**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 বিনামূল্য 1-844-365-7373-তে কল করুন।

**Bisayan-Visayan** - Alang sa pag-abag sa pinulongan 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), âgang 1-844-365-7373 sin gástu.

**Cherokee** - (Chahta) anumpa ya apela a chi l paya hinla 1-844-365-7373.

**Cushite** - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa 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 grats.

**German** - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-844-365-7373 an.

**Greek** - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-844-365-7373 χωρίς χρέωση.

**Gujarati** - ગુજરાતીમાં લાઇનમાં સહાય માટે કોઈ પણ પરસ્પર વચ્ચે 1-844-365-7373 પર કોલ કરો.
Hawaiian - No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-844-365-7373. Kāki ‘ole ia kēia kōkua nei.
Hindi - हिन्दी में भाषा सहायता के लिए, 1-844-365-7373 पर मुफ्त कॉल करें।
Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-844-365-7373.
Ibo - Maka enyemaka asụṣụ na Igbo kpọọ 1-844-365-7373 na akwụghị ụgwọ ọ bụla
Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-844-365-7373 nga awan ti bayadanyo.
Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-844-365-7373.
Japanese - 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。
Karen - [file]
Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호 1-844-365-7373 번으로 전화해 주십시오.
Kurdish - 1-844-365-7373
Laotian -ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ,
Marshallese - Ñan bōk jipaŋ ilo Kajin Majol, kallok 1-844-365-7373 ilo ejjelok wōnān.
Micronesian - Ohng palien sawas en sou na kawewe ni omw lokaia Ponape koahl 1-844-365-7373 ni sohte isais.
Mon-Khmer, Cambodian - ប្រែសូត្រក្នុងភាសានេះ ដាក់ឲ្យសូមចូលទៅកាន់ 1-844-365-7373 គ្នាឍំឝុតបេសាក
Navajo - T'āá shi shizaad k'ehji bee shiká a'doowol nínizingo Diné k'ehji kòij t'āá jiik'e hólne' 1-844-365-7373
Nepali - (लेखाली) मा निष्ठुल्क भाषा सहायता पाउनका लागि 1-844-365-7373 मा फोन गर्नुहोस्।
Nilotic-Dinka - Tèn kuɔɔny ɛ thòk ɛ Thuɔnjàŋ col 1-844-365-7373 kecín ayòc.
Norwegian - For språkassistanse på norsk, ring 1-844-365-7373 kostnadsfritt.
Panjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਲਈ, 1-844-365-7373 ਉੱਤੇ ਮੁਫਤ ਵਾਸਤੇ।
Persian - برای راهنمایی به زبان فارسی با شماره ۷۳۷-۳۶۵-۳۶۴-۱۸۴۴. 

Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-844-365-7373. 

Portuguese - Para obter assistência lingüística em português ligue para o 1-844-365-7373 gratuitamente. 

Romanian - Pentru asistență lingvistică în românescete telefonați la numărul gratuit 1-844-365-7373. 

Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-844-365-7373. 

Samoan - Mo fesoasoani tau gagana i le Gagana Samoa vala’au le 1-844-365-7373 e aunoa ma se totogi. 

Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-844-365-7373. 

Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-844-365-7373. 

Sudanic-Fulfude - Fii yo on hebu balal e ko yowittie e haala Pular noddee e oo numero doo 1-844-365-7373 Njodi woo fawaaki on. 

Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-844-365-7373 bila malipo. 

Syriac - ܢܶܐ ܐܶܥܳܒ ܢܰܐ ܬܽܘܢܳܪܕܰܥܡ ܐܳܢܫܶܠܒ ܐܳܿܝܳܝܪܽܘܣ ܐܳܗ ܟܳܠ ܐܳܡܩܰܪ ܢܘफܝܠܬܕ 1-844-365-7373 ܰܢܓܰܡܘ. 

Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-844-365-7373 nang walang bayad. 

Telugu - భాషతో సాయం కొరకు ఎలాంటి ఖర్చులేకుండా 1-844-365-7373 కు కాల్ చేయండి. (తెలుగు) 

Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็นภาษาไทยโทร 1-844-365-7373 ฟรีไม่มีค่าใช้จ่าย 

Tongan - Kapau `oku fiemau hā tokoni `i he lea faka-Tonga telefoni 1-844-365-7373 `o `ikai hā tōtōngi. 

Trukese - Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékékért 1-844-365-7373 nge esapw kamé ngonuk. 

Turkish - (Dil) çağırsı dil yarım için. Hiçbir ücret ödemeden 1-844-365-7373. 

Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-844-365-7373. 

Urdu - بلائمت زبان سے متعلق خدمات حاصل کرنے کے لئے ، ۷۳۷-۶۴۴-۱۸۴۴. 

Vietnamese - Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí để số 1-844-365-7373. 

Yiddish - פאר שפראר הילף און אידיש רופס 1-844-365-7373. 

Yoruba - Fún irànìlòwò nípa èdè (Yorùbá) pe 1-844-365-7373 lái san owò kankan rárà.