Banner[•] | ***aetna**^{••} : AZ Banner Silver \$25 Copay 6000 Tucson 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, https://www.aetna.com/sbcsearch/getcbpolicydocs?P=0755994&Y=22, or by calling 1-844-365-7374. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other <u>underlined</u> terms, see the Glossary. You can view the Glossary at

https://www.healthcare.gov/sbc-glossary/ or call 1-844-365-7374 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	In- <u>network</u> : Individual \$6,000 / Family \$12,000.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. Certain office visits, <u>preventive care</u> and <u>urgent</u> <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> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <u>https://www.healthcare.gov/coverage/preventive-care-benefits</u> /.
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet deductibles for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	In- <u>network</u> : Individual \$8,700 / Family \$17,400.	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 use a <u>network provider</u> ?	Yes. See https://aet.na/providersearch_banneraetna or call 1-844-365-7374 for a list of in- <u>network</u> providers.	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.

		What You V	Will Pay	
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out–of–Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	\$25 <u>copay</u> /visit, <u>deductible</u> does not apply	Not covered	None
If you visit a health care	<u>Specialist</u> visit	\$75 <u>copay</u> /visit, <u>deductible</u> does not apply	Not covered	None
<u>provider's</u> office or clinic	<u>Preventive care</u> / <u>screening</u> /immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	40% coinsurance	Not covered	Applies to services received in office or in outpatient setting.
n you have a test	Imaging (CT/PET scans, MRIs)	40% coinsurance	Not covered	Applies to services received in office or in outpatient setting.
If you need drugs to treat	Preferred generic drugs	\$10 <u>copay</u> / prescription (retail), \$25 <u>copay</u> / prescription (mail order), <u>deductible</u> does not apply	Not covered	Covers up to a 30 day supply (retail prescription), 31-90 day supply (mail order prescription). Applicable cost share plus
More information about	Preferred brand drugs	\$50 <u>copay</u> / prescription (retail), \$125 <u>copay</u> / prescription (mail order)	Not covered	difference (brand minus generic cost) applies for brand when generic available. No charge for preferred generic FDA-approved women's
coverage is available at http://aet.na/azbhaivl	Non-preferred generic/brand drugs	45% <u>coinsurance</u> (retail & mail order)	Not covered	contraceptives in- <u>network</u> .
	Preferred <u>Specialty drugs,</u> Non-preferred <u>Specialty drugs</u>	50% <u>coinsurance</u> for up to a 30 day supply	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 CVS retail pharmacies for certain <u>specialty drugs</u> .
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance	Not covered	None
	Physician/surgeon fees	40% coinsurance	Not covered	None

		What You V	Will Pay				
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out–of–Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information			
If you need immediate	Emergency room care	40% coinsurance	40% <u>coinsurance</u>	Out-of-network <u>emergency room care</u> cost-share same as in- <u>network</u> . No coverage for non-emergency care.			
medical attention	Emergency medical transportation	40% coinsurance	40% coinsurance	Out-of-network cost-share same as in-network.			
	<u>Urgent care</u>	\$75 <u>copay</u> /visit, <u>deductible</u> does not apply	Not covered	No coverage for non-urgent use.			
If you have a	Facility fee (e.g., hospital room)	40% coinsurance	Not covered	None			
hospital stay	Physician/surgeon fees	40% coinsurance	Not covered	None			
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Outpatient office visits: \$25 copay/visit, deductible does not apply; All other outpatient services: 40% coinsurance	Not covered	None			
	Inpatient services	40% coinsurance	Not covered	None			
	Office visits	No charge	Not covered	Cost sharing does not apply for preventive			
If you are pregnant	Childbirth/delivery professional services	40% coinsurance	Not covered	services. Maternity care may include tests and services described elsewhere in the SBC			
	Childbirth/delivery facility services	40% coinsurance	Not covered	(i.e. ultrasound).			
	Home health care	40% coinsurance	Not covered	Coverage is limited to 42 visits.			
	Rehabilitation services	40% coinsurance	Not covered	Coverage is limited to 60 visits for Physical Therapy, Occupational Therapy & Speech Therapy combined.			
If you need help recovering or have other	Habilitation services	40% coinsurance	Not covered	None			
special health needs	Skilled nursing care	40% coinsurance	Not covered	Coverage is limited to 90 days.			
	Durable medical equipment	50% coinsurance	Not covered	Coverage is limited to 1 <u>durable medical</u> <u>equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.			
	Hospice services	40% coinsurance	Not covered	None			

		What You \	Nill Pay	Limitations, Exceptions, & Other Important Information			
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out–of–Network Provider (You will pay the most)				
	Children's eye exam	50% coinsurance	Not covered	Coverage is limited to 1 exam every 12 months up to age 19.			
your child needs dental eye care	Children's glasses	50% coinsurance	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.			

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Co	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 Cosmetic surgery Dental care (Adult & Child) Infertility treatment 	 Long-term care Non-emergency care when traveling outside the U.S. Private-duty nursing 	 Routine eye care (Adult) Routine foot care Weight loss programs 								

Other Co	overed	Servic	es (Lir	nitat	tions	may	apply t	to these se	rvices.	This i	isn't a co	mplete	lis	t. Ple	ease	see ye	our <u>plan</u>	docur	nent.)				
		•									•												

- Chiropractic care Coverage is limited to 20 visits. Acupuncture - Coverage is limited to 10 visits.
- Bariatric surgery

• Hearing aids - Coverage is limited to 1 per ear.

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: Arizona Department of Insurance and Financial Institutions, 800-325-2548, 602-364-2499 (Phoenix), 602-364-2977 (Spanish), https://insurance.az.gov/consumers.

• For more information on your rights to continue coverage, contact the plan at 1-844-365-7374.

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 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:

• Arizona Department of Insurance and Financial Institutions, 800-325-2548, 602-364-2499 (Phoenix), 602-364-2977 (Spanish), https://insurance.az.gov/consumers.

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 <u>plan's</u> overall <u>deductible</u>	\$6,000
Specialist copayment	\$75
Hospital (facility) <u>coinsurance</u>	40%
Other <u>coinsurance</u>	40%
This EXAMPLE event includes services	s like:
Specialist office visits (prenatal care)	
Childbirth/Delivery Professional Services	
Childbirth/Delivery Facility Services	
Diagnostic tests (ultrasounds and blood w	/ork)
Specialist visit (anesthesia)	

Total Example Cost	\$12,700						
In this example, Peg would pay:							
Cost Sharing							
Deductibles	\$6,000						
<u>Copayments</u>	\$10						
<u>Coinsurance</u>	\$2,200						
What isn't covered							
Limits or exclusions	\$60						
The total Peg would pay is	\$8,270						

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

The <u>plan's</u> overall <u>deductible</u>	\$6,000
Specialist copayment	\$75
Hospital (facility) <u>coinsurance</u>	40%
Other <u>coinsurance</u>	40%
This EXAMPLE event includes service	es like:
Primary care physician office visits (inclu	ıding
disease education)	
Diagnostic tests (blood work)	
Prescription drugs	
Durable medical equipment (glucose me	eter)

Total Example Cost	\$5,600						
In this example, Joe would pay:							
Cost Sharing							
<u>Deductibles</u>	\$3,200						
<u>Copayments</u>	\$700						
<u>Coinsurance</u>	\$0						
What isn't covered							
Limits or exclusions	\$20						
The total Joe would pay is	\$3,920						

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

The <u>plan's</u> overall <u>deductible</u>	\$6,000					
Specialist copayment	\$75					
Hospital (facility) <u>coinsurance</u>	40%					
Other <u>coinsurance</u>	40%					
This EXAMPLE event includes services like:						
Emergency room care (including medical supplies,						
Diagnostic test (x-ray)						
Durable medical equipment (crutches)						
Rehabilitation services (physical therap	<i>y)</i>					

Total Example Cost	\$2,800						
In this example, Mia would pay:							
Cost Sharing							
<u>Deductibles</u>	\$2,300						
<u>Copayments</u>	\$200						
Coinsurance	\$0						
What isn't covered							
Limits or exclusions	\$0						
The total Mia would pay is	\$2,500						

Note: These numbers assume the patient does not participate in the <u>plan's</u> wellness program. If you participate in the <u>plan's</u> wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-844-365-7374.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-844-365-7374.

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

Banner Health | 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, 1-800-648-7817, TTY: 711, Fax: 859-425-3379, 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 by Banner Health and Aetna Health Plan Inc. (Banner|Aetna). Aetna Life Insurance Company and its affiliates, including Banner|Aetna, are part of the CVS Health family of companies. Banner|Aetna has sole financial responsibility for its own products.

TTY: 711

Language Assistance:

For language assistance in your language call 1-844-365-7374 at no cost.

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-844-365-7374.
Amharic -	ለቋንቋ <i>እገ</i> ዛ በ አማርኛ በ 1-844-365-7374 በነጻ ይደውሉ
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 7374-365-1844
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-844-365-7374 առանց գնով։
Bahasa-Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-844-365-7374 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-844-365-7374 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বনিামুল্য(1–844–365–7374–ত(কল করুন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-844-365-7374 nga walay bayad.
Burmese -	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် ¹⁻⁸⁴⁴⁻³⁶⁵⁻⁷³⁷⁴ ကို ခေါ် ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-844-365-7374.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-844-365-7374 sin gåstu.
Cherokee -	ӨӘУӨ S ೮ҺѦӘЛ ЛһӘЅРӘУ ӨҍТ (СѠУ) ᲢЬѠѴ҄і Ѕ 1-844-365-7374 ОӨТ L АГӘЛ ЈЕСРЛ һҎ _҄ RѲ.
Chinese -	欲取得繁體中文語言協助,請撥打 1-844-365-7374,無需付費。
Choctaw -	(Chahta) anumpa ya apela a chi I paya hinla 1-844-365-7374.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-844-365-7374 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-844-365-7374.
French -	Pour une assistance linguistique en français appeler le 1-844-365-7374 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-844-365-7374 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-844-365-7374 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-844-365-7374 χωρίς χρέωση.
Gujarati -	ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-844-365-7374 પર કૉલ કરો.

Hawaiian -	No ke kōkua ma ka 'ōlelo Hawai'i, e kahea aku i ka helu kelepona 1-844-365-7374. Kāki 'ole 'ia kēia kōkua nei.
Hindi -	हनि्दी में भाषा सहायता के लएि, 1-844-365-7374 पर मुफ्त कॉल करें।
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-844-365-7374.
lbo -	Maka enyemaka asụsụ na Igbo kpọọ 1-844-365-7374 na akwụghị ụgwọ ọ bụla
llocano -	Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-844-365-7374 nga awan ti bayadanyo.
Italian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-844-365-7374.
Japanese -	日本語で援助をご希望の方は、1-844-365-7374 まで無料でお電話ください。
Karen -	လ၊တၢ်မာ့စားတၢ်ကတိုးကျိဉ်အဂီ၊ ကျိဉ် ကိုး 1-844-365-7374 လ၊တအိုဉ်ဒီးတ၊်လ၊ာ်ဘူဉ်လ၊ာ်စုံးဘာ
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-844-365-7374 번으로 전화해 주십시오.
Kru-Bassa -	Ɓε´m`ké gbo-kpá-kpá dyé pidyi dé Ɓašɔɔ́-̀wù̀dùùň wε̃ε, dá 1-844-365-7374
Kurdish -	بر ای راهنمایی به زبان فارسی با شمار ه 7374-365-444 به خۆرایی پهیوهندی بکهن.
Laotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-844-365-7374 ໂດຍບໍ່ເສຍຄ່າໂທ.
Marathi -	कोणत्याही शुल्काशविाय भाषा सेवा प्राप्त करण्यासाठी, 1-844-365-7374 वर फोन करा.
Marshallese -	Ñan bōk jipañ ilo Kajin Majol, kallok 1-844-365-7374 ilo ejjelok wōnān.
Micronesian - Pohnpeyan	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-844-365-7374 ni sohte isais.
Mon-Khmer, Cambodian -	សម្ភរាប់ជំនួយភាសាជា ភាសាខ្ ម រែ សូមទូរស័ព្ ទទ ៅកាន់លខេ 1-844-365-7374 ដ ោយឥតគិតថ្ ល។ៃ
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-844-365-7374
Nepali -	(नेपाली) मा नन्शिुल्क भाषा सहायता पाउनका लाग ि1-844-365-7374 मा फोन गर् नुहोस् ।
Nilotic-Dinka -	Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-844-365-7374 kecïn aɣöc.
Norwegian -	For språkassistanse på norsk, ring 1-844-365-7374 kostnadsfritt.
Panjabi -	ਪੰਜਾਬੀ ਵੱਚਿ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-844-365-7374 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-844-365-7374 aa. Es Aaruf koschtet nix.

Persian -	بر ای ر اهنمایی به زبان فارسی با شماره ۲374-365-844 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Polish -	Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-844-365-7374.
Portuguese -	Para obter assistência linguística em português ligue para o 1-844-365-7374 gratuitamente.
Romanian -	Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-844-365-7374
Russian -	Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-844-365-7374.
Samoan -	Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-844-365-7374 e aunoa ma se totogi.
Serbo-Croatian -	Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-844-365-7374.
Spanish -	Para obtener asistencia lingüística en español, llame sin cargo al 1-844-365-7374.
Sudanic-Fulfude -	Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-844-365-7374 Njodi woo fawaaki on.
Swahili -	Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-844-365-7374 bila malipo.
Syriac -	к - эшк к » рили, abir эли, к vaime me In ioper sol, sa, 1-844-365-7374 apix .
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-844-365-7374 nang walang bayad.
Telugu -	భషతో సయం కొరకు ఎలెంటి ఖర్చు లేకుండా 1-844-365-7374 కు శల్ చేయండి. (తిలుగు)
Thai -	สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-844-365-7374 ฟรีไม่มีค่าใช้จ่าย
Tongan -	Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-844-365-7374 'o 'ikai hā tōtōngi.
Trukese -	Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-844-365-7374 nge esapw kamé ngonuk.
Turkish -	(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-844-365-7374.
Ukrainian -	Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-844-365-7374.
Urdu -	بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 7374-365-444۔1 . پر بات کریں
Vietnamese -	Đê được hố trợ ngôn ngữ băng (ngôn ngữ), hấy gọi miến phi đên số 1-844-365-7374.
Yiddish -	פאר שפראך הילף אין אידיש רופט 1-844-365-7374 פריי פון אפצאל.
Yoruba -	Fún ìrànlowo nípa èdè (Yorùbá) pe 1-844-365-7374 lái san owó kankan rárá.