## Banner<sup>®</sup> | **\*aetna**<sup>®</sup> : AZ Banner Gold \$15 Copay 1450 Phoenix 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, https://www.aetna.com/sbcsearch/getcbpolicydocs?P=0756277&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 underlined 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<br><u>deductible</u> ?                                | In- <u>network</u> : Individual \$1,450 / Family \$2,900.   | 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<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> 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<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><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<br>use a <u>network provider</u> ?               | Yes. See https://aet.na/providersearch_banneraetna<br>or call 1-844-365-7374 for a list of in- <u>network</u><br><u>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.

|   |  | What You V   | 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  |
|   | Primary care visit to treat an injury or illness   | \$15 <u>copay</u> /visit, <u>deductible</u><br>does not apply  | Not covered   | None   |
| If you visit a health care                      | <u>Specialist</u> visit  | \$35 <u>copay</u> /visit, <u>deductible</u><br>does not apply  | Not covered   | None   |
| <u>provider's</u> office or clinic              | Preventive care /screening<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                              | Diagnostic test (x-ray, blood work)         20% coinsurance         Not covered                                    |  | Not covered   | Applies to services received in office or in outpatient setting.   |
| n you have a lest                               | Imaging (CT/PET scans, MRIs)   | 20% coinsurance  | Not covered   | Applies to services received in office or in outpatient setting.   |
| If you need drugs to treat                      | Preferred generic drugs  | \$15 <u>copay</u> / prescription<br>(retail), \$37.50 <u>copay</u> /<br>prescription (mail order),<br><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  | \$40 <u>copay</u> / prescription<br>(retail), \$100 <u>copay</u> /<br>prescription (mail order)  | Not covered   | difference (brand minus generic cost) applies<br>for brand when generic available. No charge for<br>preferred generic FDA-approved women's   |
| coverage is available at http://aet.na/azbhaivl | Non-preferred generic/brand drugs  | 40% <u>coinsurance</u> (retail & mail order)   | Not covered   | contraceptives in- <u>network</u> .  |
|   | Preferred Specialty drugs,<br>Non-preferred Specialty drugs50% coinsurance for up to<br>a 30 day supplyNot covered |  | Not covered   | All specialty <u>prescription drug</u> fills on initial fill<br>must be filled at a <u>network</u> specialty pharmacy<br>except for urgent situations. Your <u>plan</u> may<br>include access to CVS retail pharmacies for<br>certain <u>specialty drugs</u> . |
| If you have outpatient surgery                  | Facility fee (e.g., ambulatory surgery center)   | 20% coinsurance  | Not covered   | None   |
|   | Physician/surgeon fees   | 20% coinsurance  | Not covered   | None   |

|   |   | What You V  | Nill 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   |  |  |
| If you need immediate   | Emergency room care                       | 20% coinsurance   | 20% 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          | 20% coinsurance   | 20% coinsurance | Out-of-network cost-share same as in-network.   |  |  |
|   | Urgent care                               | \$35 <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)        | 20% coinsurance   | Not covered     | None  |  |  |
| hospital stay   | Physician/surgeon fees                    | 20% coinsurance   | Not covered     | None  |  |  |
| If you need mental health,<br>behavioral health, or<br>substance abuse services | Outpatient services                       | Outpatient office visits: \$15<br>copay/visit, deductible does<br>not apply; All other<br>outpatient services: 20%<br>coinsurance | Not covered     | None  |  |  |
|   | Inpatient services                        | 20% 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 | 20% coinsurance   | Not covered     | services. Maternity care may include tests and services described elsewhere in the SBC  |  |  |
|   | Childbirth/delivery facility services     | 20% coinsurance   | Not covered     | (i.e. ultrasound).  |  |  |
|   | Home health care                          | 20% coinsurance   | Not covered     | Coverage is limited to 42 visits.   |  |  |
|   | Rehabilitation services                   | 20% coinsurance   | Not covered     | Coverage is limited to 60 visits for Physical<br>Therapy, Occupational Therapy & Speech<br>Therapy combined.                        |  |  |
| If you need help<br>recovering or have other                                    | Habilitation services                     | 20% coinsurance   | Not covered     | None  |  |  |
| special health needs  | Skilled nursing care                      | 20% 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><br><u>equipment</u> for same/similar purpose. Excludes<br>repairs for misuse/abuse. |  |  |
|   | Hospice services                          | 20% coinsurance   | Not covered     | None  |  |  |

|                         |                                     |                            | What You \                                      | Nill 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  |  |
|                         |                                     | 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<br>eye care | Children's glasses         | 50% coinsurance                                 | Not covered   | Coverage is limited to 1 set of frames and 1 set<br>of contact lenses or eyeglass lenses per<br>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 Cover (Check your policy or plan document for more information and a list of any other excluded services.) |  |   |  |  |  |  |  |  |
|--|--|---|--|--|--|--|--|--|
| <ul> <li>Abortion</li> <li>Cosmetic surgery</li> <li>Dental care (Adult &amp; Child)</li> <li>Infertility treatment</li> </ul>                   | <ul> <li>Long-term care</li> <li>Non-emergency care when traveling outside the U.S.</li> <li>Private-duty nursing</li> </ul> | <ul> <li>Routine eye care (Adult)</li> <li>Routine foot care</li> <li>Weight loss programs</li> </ul> |  |  |  |  |  |  |

| Other C | overed | l Servic | ces (Li | mitat | ions | may | apply to th | hese services. | . This i | isn't a cor | nplete list. | Please | see your <u>plar</u> | document. | ) |  |  |
|---------|--------|----------|---------|-------|------|-----|-------------|----------------|----------|-------------|--------------|--------|----------------------|-----------|---|--|--|
|         |        | -        |         |       |      |     |             | <b></b>        |          | -           |              |        |                      |           |   |  |  |

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

Chiropractic care - Coverage is limited to 20 visits
 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), <u>https://insurance.az.gov/consumers</u>.

• For more information on your rights to continue coverage, contact the <u>plan</u> 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 <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 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> | \$1,450 |
|---|---------|
| Specialist copayment                        | \$35    |
| Hospital (facility) <u>coinsurance</u>      | 20%     |
| Other <u>coinsurance</u>                    | 20%     |
| 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)   |
| <u>Specialist</u> visit <i>(anesthesia)</i> |         |

| Total Example Cost              | \$12,700 |  |  |  |
|---------------------------------|----------|--|--|--|
| In this example, Peg would pay: |          |  |  |  |
| <u>Cost Sharing</u>             |          |  |  |  |
| <u>Deductibles</u>              | \$1,450  |  |  |  |
| Copayments                      | \$10     |  |  |  |
| <u>Coinsurance</u>              | \$2,000  |  |  |  |
| What isn't covered              |          |  |  |  |
| Limits or exclusions            | \$60     |  |  |  |
| The total Peg would pay is      | \$3,520  |  |  |  |

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

| The plan's overall deductible               | \$1,450  |
|---|----------|
| Specialist copayment                        | \$35     |
| Hospital (facility) <u>coinsurance</u>      | 20%      |
| Other <u>coinsurance</u>                    | 20%      |
| 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: |         |
| <u>Cost Sharing</u>             |         |
| <u>Deductibles</u>              | \$1,450 |
| <u>Copayments</u>               | \$1,000 |
| <u>Coinsurance</u>              | \$0     |
| What isn't covered              |         |
| Limits or exclusions            | \$20    |
| The total Joe would pay is      | \$2,470 |

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

| The plan's overall deductible            | \$1,450       |
|--|---------------|
| Specialist copayment                     | \$35          |
| Hospital (facility) <u>coinsurance</u>   | 20%           |
| Other <u>coinsurance</u>                 | 20%           |
| This EXAMPLE event includes servi        | ces like:     |
| Emergency room care (including medic     | cal 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: |         |  |
| <u>Cost Sharing</u>             |         |  |
| <u>Deductibles</u>              | \$1,450 |  |
| <u>Copayments</u>               | \$80    |  |
| <u>Coinsurance</u>              | \$200   |  |
| What isn't covered              |         |  |
| Limits or exclusions            | \$0     |  |
| The total Mia would pay is      | \$1,730 |  |

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 <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 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 <sup>1-844-365-7374</sup> 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 <del>S</del> ೮ҺѦӘЛ ЛһӘЅРӘУ ӨҍТ (СѠУ) ᲢЬѠѴ҄і <del>Ѕ</del> 1-844-365-7374 ОӨТ L АГӘЛ ЈЕСРЛ һҎ <sub>҄</sub> 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 -<br>Pohnpeyan | Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-844-365-7374 ni sohte isais.                     |
| Mon-Khmer,<br>Cambodian -  | សម្ភរាប់ជំនួយភាសាជា ភាសាខ្ <b>ម</b> រែ សូមទូរស័ព្ <b>ទទ</b> ៅកាន់លខេ 1-844-365-7374 ដ <b>ោយឥតគិតថ្</b> 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 <b>ि1-844-365-7374 मा फोन गर्</b> 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.                                   |