Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services Banner VUMA ELEMENTARY SCHOOL DISTRICT ONE : Open Access POS II -750 Plan

Coverage for: Individual + Family | Plan Type: POS



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, www.HealthReformPlanSBC.com or by calling 1-844-267-2253 (Licensed Entity). 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 1-844-267-2253 (Licensed Entity) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	For each <u>Plan</u> Year, Banner Health In- <u>Network</u> : Individual \$750 / Family \$1,500. Out-of- Network: Individual \$1,500 / Family \$3,000.	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. <u>Prescription drugs;</u> plus in- <u>network</u> office visits & <u>preventive care</u> are covered before you meet your <u>deductible</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>deductible</u> s 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> ?	Banner Health In- <u>Network</u> : Individual \$5,750 / Family \$11,500. Out-of-Network: Individual \$9,000 / Family \$18,000.	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> ?	<u>Premium</u> s, <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover & penalties for failure to obtain <u>pre-authorization</u> for services.	Even though you pay these expenses, they don't count toward the <u>out–of–pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.myplanportal.com/dse/custom/banneraetn a1 or call 1-844-267-2253 (Licensed Entity) for a list of Banner Health in- <u>network providers</u> .	This <u>plan</u> uses a <u>provider</u> <u>network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's</u> <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All **<u>copayment</u>** and **<u>coinsurance</u>** costs shown in this chart are after your **<u>deductible</u>** has been met, if a **<u>deductible</u>** applies.

What You Will Pay				
Common Medical Event	Services You May Need	Banner Health 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> doesn't apply	50% <u>coinsurance</u>	None
If you visit a health care <u>provider</u> 's office or clinic	<u>Specialist</u> visit	\$25 <u>copay</u> /visit, <u>deductible</u> doesn't apply	50% <u>coinsurance</u>	None
	Preventive care /screening /immunization	No charge	50% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$25 <u>copay</u> /visit, <u>deductible</u> doesn't apply	50% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	None
If you need drugs to treat your illness or condition More information about <u>prescription</u>	Generic drugs	<u>Copav</u> /prescription, <u>deductible</u> doesn't apply: \$10 (retail), \$20 (mail order)	Deductible doesn't apply: 20% <u>coinsurance</u> after <u>copay</u> /prescription: \$10 (retail); \$20 <u>copay</u> / prescription (mail order)	Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives in- <u>network</u> . Your cost will be higher for choosing Brand over Generics unless prescribed Dispense as Written; cost difference

Common Medical Event	What You Will PayBanner Health In-Out-of-NetworkServices You May NeedNetwork Provider(You will pay the(You will pay the		Limitations, Exceptions, & Other Important Information	
		least)	most)	
drug coverage is available at www.aetnapharmac y.com/standard	Preferred brand drugs	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: 30% with \$10 minimum & \$150 maximum/prescripti on (retail), \$40 (mail order)	<u>Deductible</u> doesn't apply: 20% <u>coinsurance</u> after <u>copay</u> /prescription: 30% with \$10 minimum & \$150 maximum/ prescription (retail); \$40 <u>copay</u> / prescription (mail order)	penalty doesn't apply to <u>out-of-pocket limit</u> . Maintenance drugs- after two retail fills, members are required to fill a 90-day supply at CVS Caremark® Mail Service Pharmacy or CVS Pharmacy.
	Non-preferred brand drugs	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: 40% with \$10 minimum & \$150 maximum/prescripti on (retail), \$60 (mail order)	<u>Deductible</u> doesn't apply: 20% <u>coinsurance</u> after <u>copay</u> /prescription: 40% with \$10 minimum & \$150 maximum/ prescription (retail); \$60 <u>copay</u> / prescription (mail order)	
	<u>Specialty drugs</u>	Copay/prescription, deductible apply: 25%	Not covered	All prescriptions must be filled through the Banner Aetna Specialty Pharmacy <u>Network</u> . Precertification required for coverage.
If you have	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	None
outpatient surgery	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need immediate medical	Emergency room care	20% <u>coinsurance</u> after \$150 <u>copay</u> /visit	20% <u>coinsurance</u> after \$150 <u>copay</u> /visit	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> . No coverage for non-emergency use.
attention	Emergency medical transportation	20% coinsurance	20% coinsurance	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> . Non-emergency transport: not covered, except if pre-authorized.

	What You Will Pay			
Common Medical Event	Services You May Need	Banner Health In- Network Provider (You will pay the	Out-of-Network Provider (You will pay the	Limitations, Exceptions, & Other Important Information
		least)	most)	
	<u>Urgent care</u>	\$50 <u>copay</u> /visit, <u>deductible</u> doesn't apply	50% <u>coinsurance</u> after \$50 <u>copay</u> /visit, <u>deductible</u> doesn't apply	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Penalty of \$400 for failure to obtain <u>pre-</u> <u>authorization</u> for out-of-network care.
nospilai slay	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse	Outpatient services	Office: \$25 <u>copay</u> /visit, <u>deductible</u> doesn't apply; other outpatient services: no charge	Office & other outpatient services: 50% <u>coinsurance</u>	None
services	Inpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Penalty of \$400 for failure to obtain <u>pre-</u> authorization for out-of-network care.
	Office visits	No charge	50% coinsurance	Cost sharing does not apply for preventive
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	services. Maternity care may include tests and
lf you are pregnant	Childbirth/delivery facility services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	services described elsewhere in the SBC (i.e., ultrasound). Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care may apply.
	Home health care	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Penalty of \$400 for failure to obtain <u>pre-</u> <u>authorization</u> for out-of-network care.
lf you need help	Rehabilitation services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	50 visits/ <u>plan</u> year for Physical, Occupational & Speech Therapy combined.
recovering or have	Habilitation services	No charge	50% coinsurance	None
other special health needs	Skilled nursing care	20% <u>coinsurance</u>	50% <u>coinsurance</u>	60 days/ <u>plan</u> year. Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	Durable medical equipment	20% coinsurance	50% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.

Common Medical Event	Services You May Need	What You Banner Health In- Network Provider (You will pay the least)	u Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Hospice services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Penalty of \$400 for failure to obtain <u>pre-</u> authorization for out-of-network care.
If your child needs	Children's eye exam Children's glasses	Not covered Not covered	Not covered Not covered	Not covered. Not covered.
dental or eye care	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u>.)

 Cosmetic surgery Dental care (Adult & Child) Glasses (Child) Hearing aids Long-term care Non-emergency care when traveling outside the U.S. Private-duty nursing 	 Routine eye care (Adult & Child) Routine foot care Weight loss programs - Except for required <u>preventive</u> <u>services</u>.
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

Acupuncture - 10 visits/ <u>plan</u> year for disease, Chiropractic care	 Infertility treatment - Limited to the diagnosis & treatment of
injury & chronic pain.	underlying medical condition.
Bariatric surgery	

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 <u>plan</u> at 1-844-267-2253 (Licensed Entity).
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or <u>www.cciio.cms.gov</u>.
- If your coverage is a church <u>plan</u>, church <u>plans</u> are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about

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 plan documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general number at 1-844-267-2253 (Licensed Entity). You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <u>http://www.dol/gov/ebsa/healthreform</u>
- For non-federal governmental group health <u>plans</u>, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or <u>www.cciio.cms.gov</u>.
- Additionally, a consumer assistance program can help you file your <u>appeal</u>. Contact information is at: <u>http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html</u>.

Does this plan provide Minimum Essential Coverage? Yes.

<u>Minimum Essential Coverage</u> generally includes <u>plans</u>, <u>health insurance</u> available through the <u>Marketplace</u> or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of <u>Minimum Essential Coverage</u>, you may not be eligible for the <u>premium tax credit</u>.

Does this plan meet Minimum Value Standards? Yes.

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)		

\$750

\$25 20%

20%

The <u>plan's</u> overall <u>deductible</u>
Specialist copayment
Hospital (facility) <u>coinsurance</u>
Other <u>coinsurance</u>

This EXAMPLE event includes services like: <u>Specialist</u> office visits (*prenatal care*) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests</u> (*ultrasounds and blood work*) <u>Specialist</u> visit (*anesthesia*)

Total Example Cost	\$12,700
In this example, Peg would pay:	
<u>Cost Sharing</u>	
Deductibles	\$750
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$1,900
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,910

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

The <u>plan's</u> overall <u>deductible</u>	\$750
Specialist copayment	\$25
Hospital (facility) <u>coinsurance</u>	20%
Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like: <u>Primary care physician</u> office visits (including disease education) <u>Diagnostic tests</u> (blood work) <u>Prescription drugs</u> <u>Diabetic supplies</u> (glucose meter)

Total Example Cost	\$5,600	
In this example, Joe would pay:		
<u>Cost Sharing</u>		
<u>Deductibles</u>	\$0	
<u>Copayments</u>	\$800	
<u>Coinsurance</u>	\$0	
What isn't covered		
Limits or exclusions	\$20	
The total Joe would pay is	\$820	

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

The <u>plan's</u> overall <u>deductible</u>	\$750
Specialist copayment	\$25
Hospital (facility) <u>coinsurance</u>	20%
Other coinsurance	20%

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:		
<u>Cost Sharing</u>		
Deductibles	\$750	
<u>Copayments</u>	\$60	
<u>Coinsurance</u>	\$300	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$1,110	

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-844-267-2253 (Licensed Entity).

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|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, <u>CRCoordinator@aetna.com</u>.

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).

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TTY: 711

Language Assistance:

To access language services at no cost to you, call 1-844-267-2253 (Licensed Entity).

Albanian -	Për shërbime përkthimi falas për ju, telefononi 1-844-267-2253 (Licensed Entity).
Amharic -	የቋንቋ አንልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-844-267-2253 (Licensed Entity) ይደውሉ።
Arabic -	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء االتصال على الرقم (Licensed Entity) 1-844-267
Armenian - հեռախոսահամարով։	ԱնվՃար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-844-267-2253 (Licensed Entity)
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-844-267-2253 (Licensed Entity) tanpa dikenakan biaya.
Bantu-Kirundi -	Kugira uronke serivisi z'indimi atakiguzi, hamagara 1-844-267-2253 (Licensed Entity).
Bengali-Bangala -	আপনাকে বিনামূকযে ভাষা পৰিকষিা পপকে হকয এই নম্বকি পেবযক ান েরুন: 1-888-982-3861
Bisayan-Visayan -	Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-844-267-2253 (Licensed Entity).
Burmese -	သင့္အေနျဖင့္ အခေၾကးေငြ မေပးရပဲ ဘာသာစကားဝန္ေဆာင္မႈမ်ား ရရွိႏုိင္ရန္ 1-844-267-2253 (Licensed Entity) သို႕ ဖုန္းေခၚဆုိပါ။
Catalan -	Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-844-267-2253 (Licensed Entity).
Chamorro -	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-844-267-2253 (Licensed Entity).
Cherokee -	GУодЈ Sூh.ЭодЈ OGፀ66ግЛ L АГодЈ JGEGWЛЈ љУ, ወϷℬᲮ₩6°Ь 1-844-267-2253 (Licensed Entity).
Chinese -	如欲使用免費語言服務,請致電 1-844-267-2253 (Licensed Entity).
Choctaw -	Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-844-267-2253 (Licensed Entity).
Cushite -	Tajaajiiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-844-267-2253 (Licensed Entity).
Dutch -	Voor gratis toegang tot taaldiensten, bell 1-844-267-2253 (Licensed Entity).
French -	Afin d'accéder aux services langagiers sans frais, composez le 1-844-267-2253 (Licensed Entity).
French Creole -	Pou jwenn sèvis lang gratis, rele 1-844-267-2253 (Licensed Entity).
German -	Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-844-267-2253 (Licensed Entity) an.
Greek -	Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-844-267-2253 (Licensed Entity).

Gujarati -	તમારેકોઇ જાતના ખર્ચવિના ભાષાની સેિાઓની પહોોંર્ માટે, કોલ કરો1-844-267-2253 (Licensed Entity).
Hawaiian -	No ka wala'au 'ana me ka lawelawe 'ōlelo e kahea aku i kēia helu kelepona 1-844-267-2253 (Licensed Entity). Kāki 'ole 'ia kēia kōkua nei.
Hindi -	आपकेलिए बिना ककसी कीमत केभाषा सेवाओंका उपयोग करनेकेलिए,1-844-267-2253 (Licensed Entity) पर कॉल करें।
Hmong -	Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-844-267-2253 (Licensed Entity).
lgbo -	lji nwetaòhèrè na ọrụ gasi asụsụ n'efu, kpọọ 1-844-267-2253 (Licensed Entity)
llocano - Entity).	Tapno maaksesyo dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti 1-844-267-2253 (Licensed
Indonesian -	Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi 1-844-267-2253 (Licensed Entity).
Italian -	Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-844-267-2253 (Licensed Entity).
Japanese -	言語サービスを無料でご利用いただくには、1-844-267-2253 (Licensed Entity) までお電話ください。
Karen -	လ၊တါကမာနာ်ကိုဉ်အတါမာစားအတါဖံးတါမာတဖဉ်လ၊တအိဉ်ဒီးအမှုးလ၊ကဘဉ်ဟုဉ်အီးအဂ်ီ၊ဘဉ်နဉ် ကိး 1-844-267-2253 (bigénsed Entity)
Korean -	무료 언어 서비스를 이용하려면 1-844-267-2253 (Licensed Entity) 번으로 전화해 주십시오.
Kru-Bassa -	Μੇ dyi wuqu-dù kà kò qò ɓĕ dyi mɔú ń nì Pídyi ní, nìí, qá nɔ̀ɓà nìà kɛ: 1-844-267-2253 (Licensed Entity)
Kurdish -	بۆ دەسپێراگەيشتن بە خزمەتگوزارى زمان بەبى نٽيچوون بۆ تۆ، پەيوەندى بكە بە ژمارەى (Licensed Entity) 1-844-267
Laotian -	ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ1-888-982-3862
Marathi -	कोणत्याही शल्ुकालशवाय भाषा सेवा प्राप्त करण्यासाठी,, 1-844-267-2253 (Licensed Entity) वर फोन करा.
Marshallese - Micronesian-	Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlok 1-844-267-2253 (Licensed Entity).
Pohnpeyan -	Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1-844-267-2253 (Licensed Entity).
Mon-Khmer, Cambodian -	ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-888- 982-3862។
Navajo -	T'áá ni nizaad k'ehjí bee níká a'doowoł doo bą́ą́h ílínígóó kojį' hólne' 1-844-267-2253 (Licensed Entity).
Nepali -	निःशुल्क भाषा सेवा प्राप्त गर्न 1-844-267-2253 (Licensed Entity) मा टेलिफोन गर्नुहोस् ।
Nilotic-Dinka - (Licensed Entity).	Të kɔɔr yïn wɛɛ̈r de thokic ke cïn wëu kɔr keek tënɔŋ yïn. Ke cɔl kɔc ye kɔc kuɔny ne nɔmba 1-844-267-2253
Norwegian -	For tilgang til kostnadsfri språktjenester, ring 1-844-267-2253 (Licensed Entity).
Pennsylvania Dutch -	Um Schprooch Services zu griege mitaus Koscht, ruff 1-844-267-2253 (Licensed Entity).

Persian - Polish - Portuguese -	برای دسترسی به خدمات زبان به طور رایگان، با شماره (Licensed Entity) برای د. Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-844-267-2253 (Licensed Entity). Para acessar os serviços de idiomas sem custo para você, ligue para 1-844-267-2253 (Licensed Entity).
Punjabi -	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1-844-267-2253 (Licensed Entity) 'ਤੇ ਫ਼ੋਨ ਕਰੋ।
Romanian -	Pentru a accesa gratuit serviciile de limbă, apelați 1-844-267-2253 (Licensed Entity).
Russian -	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-844-267-2253 (Licensed Entity).
Samoan -	Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala'au le 1-844-267-2253 (Licensed Entity).
Serbo-Croatian -	Za besplatne prevodilačke usluge pozovite 1-844-267-2253 (Licensed Entity).
Spanish -	Para acceder a los servicios de idiomas sin costo, llame al 1-844-267-2253 (Licensed Entity).
Sudanic-Fulfude -	Heeba a nasta jangirde djey wolde wola chede bo apelou lamba 1-844-267-2253 (Licensed Entity).
Swahili -	Kupata huduma za lugha bila malipo kwako, piga 1-844-267-2253 (Licensed Entity).
Syriac -	: مەبقە، 1-844-267-2253 (Licensed Entity) جل يىلخىۋى، تەبتاھى دىغىتى خىرىكى، مەبىھە، مەبىھە، مەبىھە:
Tagalog -	Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-844-267-2253 (Licensed Entity).
Telugu -	మీరు భాష సేవలను ఉచితంగా అందుకునందుకు, 1-844-267-2253 (Licensed Entity) కు కాల్ చేయండి.
Thai -	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-844-267-2253 (Licensed Entity).
Tongan -	Kapau 'oku ke fiema'u ta'etōtōngi 'a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he 1-844-267-2253
(Licensed Entity).	
Trukese -	Ren omw kopwe angei aninisin eman chon awewei (ese kamo), kopwe kori 1-844-267-2253 (Licensed Entity).
Turkish -	Sizin için ücretsiz dil hizmetlerine erişebilmek için, 1-844-267-2253 (Licensed Entity) numarayı arayın.
Ukrainian -	Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-844-267-2253 (Licensed Entity).
Urdu -	بالقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 3862-982-1888 پر بات کریں۔
Vietnamese -	Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-844-267-2253 (Licensed Entity)
Yiddish -	רופן (Licensed Entity) צו צוטריט שפרַאך בַאדינונגען אין קיין פרייַז צו איר, רופן
Yoruba -	Lati wonú awon ise èdè l'ofe fun o, pe 1-844-267-2253 (Licensed Entity).