



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 1-866-830-5701 (24X7). 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 1-866-830-5701 (24X7) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Banner Health In-Network: Individual \$3,000 / Family \$7,500. Out-of-Network: Individual \$5,000 / Family \$15,000.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Emergency care; plus in-network office visits & preventive care are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Banner Health In-Network: Individual \$6,000 / Family \$12,000. Out-of-Network: Individual \$25,000 / Family \$50,000.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover & penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.myplanportal.com/dse/custom/banneraetna1 or call 1-866-830-5701 (24X7) for a list of Banner Health in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.



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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Banner Health In-Network (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$30 <u>copay</u> /visit, <u>deductible</u> doesn't apply	50% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$50 <u>copay</u> /visit, <u>deductible</u> doesn't apply	50% <u>coinsurance</u>	None
	<u>Preventive care</u> / <u>screening</u> /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)	\$20 <u>copay</u> /visit, <u>deductible</u> doesn't apply	50% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition	Generic drugs	Not covered	Not covered	Not covered.
	Preferred brand drugs	Not covered	Not covered	
More information about <u>prescription drug coverage</u> is available at www.aetna.com/pharmacy-insurance/individuals-families	Non-preferred brand drugs	Not covered	Not covered	Not covered.
	<u>Specialty drugs</u>	Not covered	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Physician/surgeon fees	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Banner Health In-Network (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	\$200 <u>copay/visit</u> , <u>deductible</u> doesn't apply	\$200 <u>copay/visit</u> , <u>deductible</u> doesn't apply	No coverage for non-emergency use.
	<u>Emergency medical transportation</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	Non-emergency transport: not covered, except if pre-authorized.
	<u>Urgent care</u>	\$75 <u>copay/visit</u> , <u>deductible</u> doesn't apply	50% <u>coinsurance</u>	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	Physician/surgeon fees	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$50 <u>copay/visit</u> , <u>deductible</u> doesn't apply; other outpatient services: no charge	Office & other outpatient services: 50% <u>coinsurance</u>	None
	Inpatient services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
If you are pregnant	Office visits	No charge	50% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and 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.
	Childbirth/delivery professional services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	<u>Rehabilitation services</u>	\$50 <u>copay/visit</u> , <u>deductible</u> doesn't apply	50% <u>coinsurance</u>	25 visits/calendar year for Physical & Occupational Therapy combined, 20 visits/calendar year for Speech Therapy.
	<u>Habilitation services</u>	\$50 <u>copay/visit</u> , <u>deductible</u> doesn't apply	50% <u>coinsurance</u>	Limited to treatment of Autism.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Banner Health In-Network (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<u>Skilled nursing care</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	60 days/calendar year. Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	<u>Durable medical equipment</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered.
	Children's glasses	Not covered	Not covered	Not covered.
	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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Prescription drugs
- Private-duty nursing
- Routine eye care (Adult & Child)
- Routine foot care
- Weight loss programs - Except for required preventive services.

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

- Chiropractic care
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- For more information on your rights to continue coverage, contact the plan at 1-866-830-5701 (24X7).

- 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 www.cciio.cms.gov.
 - If your coverage is a church plan, church plans 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 the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

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:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-866-830-5701 (24X7).
- 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 www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your appeal. Contact information is at: <http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html>.

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? 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 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 \$3,000
- Specialist copayment \$50
- 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
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$3,000
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$2,100
<i>What isn't covered</i>	
Limits or exclusions	\$70
The total Peg would pay is	\$5,270

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

- The plan's overall deductible \$3,000
- Specialist copayment \$50
- 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
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$4,300
The total Joe would pay is	\$4,700

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

- The plan's overall deductible \$3,000
- Specialist copayment \$50
- 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
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$900
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$10
The total Mia would pay is	\$1,410

[Assistive Technology](#)

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-866-830-5701 (24X7).

[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, or disability.

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).

Banner Health | Aetna is the brand name used for products and services provided by Banner Health and Aetna Health Insurance Company and Banner Health and Aetna Health Plan Inc. Health benefits and health insurance plans are offered and/or underwritten by Banner Health and Aetna Health Insurance Company and/or Banner Health and Aetna Health Plan Inc. (Banner Health | Aetna). Each insurer has sole financial responsibility for its own products. Banner Health and Aetna Health Insurance Company and Banner Health and Aetna Health Plan Inc. are affiliates of Banner Health and, of Aetna and its affiliates (Aetna). Aetna provides certain management services to Banner Health | Aetna.

TTY: 711

Language Assistance:

For language assistance in your language call 1-866-830-5701 (24X7) at no cost.

- Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-866-830-5701 (24X7).
- Amharic - ለቋንቋ እገዛ በ አማርኛ በ 1-866-830-5701 (24X7) በነጻ ይደውሉ
- Arabic - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-866-830-5701 (24X7)
- Armenian - Լեզվի ցուցաբերած աջակցության (հայերեն) գանգի 1-866-830-5701 (24X7) առանց գնով:
- Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-866-830-5701 (24X7) tanpa dikenakan biaya.
- Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-866-830-5701 (24X7) ku busa
- Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-866-830-5701 (24X7)-তে কল করুন।
- Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-866-830-5701 (24X7) nga walay bayad.
- Burmese - ငွေတန်ကျခံရမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-866-830-5701 (24X7) ခေါ်ဆိုပါ။
- Catalan - Per rebre assistència en (català), truqui al número gratuït 1-866-830-5701 (24X7).
- Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-866-830-5701 (24X7) sin gåstu.
- Cherokee - ፀጠፃ ፂፗፏፗ ፈፃፃፗ ፂፗፏፗ ፂፗፏፗ ፀፂፕ (GWY) ፂፃፃፂፂፂፂ 1-866-830-5701 (24X7) ፂፂፂ ፂ ፂፂፂፂ ፂፂፂፂፂፂ ፂፂፂፂፂፂ.
- Chinese - 欲取得繁體中文語言協助，請撥打1-866-830-5701 (24X7)，無需付費。
- Choctaw - (Chahta) anumpa ya apela a chi I paya hinla 1-866-830-5701 (24X7).
- Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-866-830-5701 (24X7) irratti bilisaan bilbilaa.
- Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-866-830-5701 (24X7).
- French - Pour une assistance linguistique en français appeler le 1-866-830-5701 (24X7) sans frais.
- French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-866-830-5701 (24X7) gratis.
- German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-866-830-5701 (24X7) an.
- Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-866-830-5701 (24X7) χωρίς χρέωση.
- Gujarati - ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-866-830-5701 (24X7) પર કોલ કરો.

- Hawaiian - No ke kōkua ma ka 'ōlelo Hawai'i, e kahea aku i ka helu kelepona 1-866-830-5701 (24X7). Kāki 'ole 'ia kēia kōkua nei.
- Hindi - **हन्दि में भाषा सहायता के लिए, 1-866-830-5701 (24X7) पर मुफ्त कॉल करें।**
- Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-866-830-5701 (24X7).
- Ibo - **Maka enyemaka asụsụ na Igbo kpọọ 1-866-830-5701 (24X7) na akwughị ugwo ọ bụla**
- Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-866-830-5701 (24X7) nga awan ti bayadanyo.
- Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-866-830-5701 (24X7).
- Japanese - **日本語で援助をご希望の方は、1-866-830-5701 (24X7) まで無料でお電話ください。**
- Karen - လာဘာမစားဘဲကူညီပေးနိုင်ဖို့အတွက် ကျင့် ဝန် 1-866-830-5701 (24X7) ဝန်ဆောင်ခီးတာလားဘုရားလားစားဘုရား
- Korean - **한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-866-830-5701 (24X7) 번으로 전화해 주십시오.**
- Kru-Bassa - **Bɛ́ m`ké gbo-kpá-kpá dyé pídyi dé Bǎsɔ́w-wuɖuũn wɛ́ɛ, ɖá** 1-866-830-5701 (24X7)
- Kurdish - **برای راهنمایی به زبان فارسی با شماره 1-866-830-5701 (24X7) به خورایی یه یومندی بکمن.**
- Laotian - **ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-866-830-5701 (24X7) ຍ່ໍ່ເສຍຄ່າໂທ.**
- Marathi - **कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-866-830-5701 (24X7) वर फोन करा.**
- Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-866-830-5701 (24X7) ilo ejjelok wōnān.
- Micronesian-
Pohnpeyan - **Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-866-830-5701 (24X7) ni sohte isais.**
- Mon-Khmer,
Cambodian - **សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ រឺ សូមទូរស័ព្ទទៅកាន់លេខ 1-866-830-5701 (24X7) ឥតគិតថ្លៃ។**
- Navajo - **T'áá shi shizaad k'ehjí bee shiká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne'** 1-866-830-5701 (24X7)
- Nepali - **(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-866-830-5701 (24X7) मा फोन गर्नुहोस् ।**
- Nilotic-Dinka - **Tën kuwoɲy ë thok ë Thuoɲjäɲ ɔɔl** 1-866-830-5701 (24X7) **keciɲ ayöc.**
- Norwegian - **For språkassistanse på norsk, ring 1-866-830-5701 (24X7) kostnadsfritt.**
- Panjabi - **ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-866-830-5701 (24X7) 'ਤੇ ਮੁਫਤ ਕਾਲ ਕਰੋ।**
- Pennsylvania Dutch - **Fer Hilfe in Deutsch, ruf: 1-866-830-5701 (24X7) aa. Es Aaruf koschtet nix.**
- Persian - **برای راهنمایی به زبان فارسی با شماره 1-866-830-5701 (24X7) بدون هیچ هزینه ای تماس بگیرید. انگلیسی**
- Polish - **Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-866-830-5701 (24X7).**
- Portuguese - **Para obter assistência linguística em português ligue para o 1-866-830-5701 (24X7) gratuitamente.**

- Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-866-830-5701 (24X7)
- Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-866-830-5701 (24X7).
- Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-866-830-5701 (24X7) e aunoa ma se totogi.
- Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-866-830-5701 (24X7).
- Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-866-830-5701 (24X7).
- Sudanic-Fulfude - Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-866-830-5701 (24X7). Njodi woo fawaaki on.
- Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-866-830-5701 (24X7) bila malipo.
- Syriac -  1-866-830-5701 (24X7)
- Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-866-830-5701 (24X7) nang walang bayad.
- Telugu - భాషతో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 1-866-830-5701 (24X7) కు కాల్ చేయండి. (తెలుగు)
- Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-866-830-5701 (24X7) ฟรีไม่มีค่าใช้จ่าย
- Tongan - Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-866-830-5701 (24X7) 'o 'ikai hā ʻōtōngi.
- Trukese - Ren ánninnisin chiakú ren (Kapasen Chuuk) kopwe kékékéeri 1-866-830-5701 (24X7) nge esapw kamé ngonuk.
- Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemedden 1-866-830-5701 (24X7).
- Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-866-830-5701 (24X7).
- Urdu -  1-866-830-5701 (24X7) پر بات کریں۔
- Vietnamese - Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-866-830-5701 (24X7).
- Yiddish -  1-866-830-5701 (24X7) פאר שפראך הילף אין אידיש
- Yoruba - Fún irànlọwọ nípa èdè (Yorùbá) pe 1-866-830-5701 (24X7) láí san owó kankan rárá.