Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period: 07/01/2021-06/30/2022

SUN HEALTH EMPLOYEE SERVICES LLC : Open Access POS II - 2800
Qualified High Deductible Health Plan

Coverage for: EE Only; EE+ 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 1-866-830-5701 (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: EE Only $2,800 / EE+ Family $5,600. Out-of-Network: EE Only $4,000 / EE+ Family $8,000.	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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. In-network preventive care is 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: EE Only $3,500 / EE+ Family $6,000. Out-of-Network: EE Only $6,000 / EE+ Family $12,000.	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, the overall family out–of–pocket limit must be 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 Provider (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	20% coinsurance	50% coinsurance	None
	Specialist visit	20% coinsurance	50% coinsurance	None
	Preventive care /screening /immunization	No charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetna.com/pharmacy-insurance/individuals-families	Generic drugs	See Express Scripts Summary for Details	See Express Scripts Summary for Details	Prescription drug coverage is through Express Scripts www.express-scripts.com
	Preferred brand drugs	See Express Scripts Summary for Details	See Express Scripts Summary for Details	
	Non-preferred brand drugs	See Express Scripts Summary for Details	See Express Scripts Summary for Details	
	Specialty drugs	See Express Scripts Summary for Details	See Express Scripts Summary for Details	Prescription drug coverage is through Express Scripts www.express-scripts.com
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	None
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	No coverage for non-emergency use.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Non-emergency transport: not covered, except if pre-authorized.
	Urgent care	20% coinsurance	50% coinsurance	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Penalty of $400 for failure to obtain pre-authorization for out-of-network care.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Banner Health In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: 20% coinsurance	Office & other outpatient services: 50% coinsurance	None
	Inpatient services	20% coinsurance	50% coinsurance	Penalty of $400 for failure to obtain pre-authorization for out-of-network care.
If you are pregnant	Office visits	No charge	50% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Penalty of $400 for failure to obtain pre-authorization for out-of-network care may apply.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	3 visits/day. Penalty of $400 for failure to obtain pre-authorization for out-of-network care.
	Rehabilitation services	20% coinsurance	50% coinsurance	25 visits/calendar year for Physical & Occupational Therapy combined, 20 visits/calendar year for Speech Therapy.
	Habilitation services	20% coinsurance	50% coinsurance	Limited to treatment of Autism.
	Skilled nursing care	20% coinsurance	50% coinsurance	60 days/calendar year. Penalty of $400 for failure to obtain pre-authorization for out-of-network care.
	Durable medical equipment	20% coinsurance	50% coinsurance	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	20% coinsurance	50% coinsurance	Penalty of $400 for failure to obtain pre-authorization 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 : https://www.dol.gov/agencies/ebsa
- 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 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 https://www.dol.gov/agencies/ebsa
- 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.**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? **No.**
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	**$2,800**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$700
What isn't covered	
Limits or exclusions	$100
The total Peg would pay is	**$3,600**

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

The plan's overall deductible	**$2,800**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	**$7,400**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$1,200
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$6,000
The total Joe would pay is	**$7,200**

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

The plan's overall deductible	**$2,800**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**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	**$1,900**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

The plan would be responsible for the other costs of these EXAMPLE covered services.

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 | Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Banner | Aetna provides 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

Email: 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 benefits and health insurance plans are offered and/or underwritten by Banner Health and Aetna Health Plan Inc. and Banner Health and Aetna Health Insurance Company (Banner | Aetna). Banner | Aetna are affiliates of Banner Health and of Aetna Life Insurance Company and its affiliates (Aetna). Aetna provides certain management services to Banner |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) զանգի 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 nomero 1-866-830-5701 (24X7) ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বিনামুল্যে 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 -	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-866-830-5701 (24X7) ထံ ဆိုပါ။
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 -	ᎾᏍᎩᎾ ᎦᏬᏂᎯᏍᏗ ᏗᏂᏍᏕᎵᏍᎩ ᎾᎿᎢ (ᏣᎳᎩ) ᏪᏴᏔᏅᎢᎦ 1-866-830-5701 (24X7) ᏱᎾᎢ ᏝᎪᎱᏍᏗ ᏧᎬᏩᎶᏗ ᏂᎦᏛᎾ.
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 -	हिन्दी 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 akwụghị ụgwọ 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 -	လာတ်မၤစၢၤတ်ကတိၤကျိာ်အဂီၢ် ကျိာ် ကိး 1-866-830-5701 (24X7)အိဉ်ဒီးတ်လၢာ်ဘျဉ်လၢာ်စုၤဘဉ်
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-866-830-5701 (24X7) 번으로 전화해 주십시오.
Kru-Bassa -	Ɓɛ́m`ké gbo-kpá-kpá dyé pídyi ɖé Ɓaɓɔɔ̀-wuɖuǔn wɛ̃ɛ, ɖá 1-866-830-5701 (24X7)
Kurdish -	برای راهنمایی به زبان فارسی با شخ به خۆرایی یەیوەندی بکەن. 1-866-830-5701 (24X7)
Laotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ1-866-830-5701 (24X7)ໂດຍບໍ່ເສຍຄ່າໃຫ.
Marathi -	तीलभाषा (मराठी) सहाय्यासाठी 1-866-830-5701 (24X7) क्रमांकावरकोणत्याहीखर्चाशिवायकॉलकरा.
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 សូមទូរស័ព្ទទៅកាន់លេខ 1-866-830-5701 (24X7)ដោយឥតគិតថ្លៃ។
Navajo -	T'áá shi shizaad k'ehjí bee shíká 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 kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-866-830-5701 (24X7) kecïn aɣöc.
Norwegian -	For språkassistanse på norsk, ring 1-866-830-5701 (24X7) kostnadsfritt.
Panjabi -	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-866-830-5701 (24X7) ‘ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-866-830-5701 (24X7) aa. Es Aaruf koschtet nix.
Persian -	برای راهنمایی به زبان فارسی با شخ بدون هیچ هزینه ای تماس بگیرید. انگلیسی 1-866-830-5701 (24X7)
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 asistenţă lingvistică în româneşte telefonaţi 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 - fawaaki on.	Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-866-830-5701 (24X7). Njodi woo
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 ōtōngi.
Trukese -	Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-866-830-5701 (24X7) nge esapw kamé ngonuk.
Turkish -	(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-866-830-5701 (24X7).
Ukrainian - (24X7).	Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-866-830-5701
Urdu -	1-866-830-5701 (24X7)
Vietnamese -	Đê ̉ đươ ̣c hô ̃ trơ ̣ ngôn ngư ̃ bă ̀ng (ngôn ngư ̃), hă ̃y goi miễn phi ́đê ́n sô ́1-866-830-5701 (24X7).
Yiddish -	1-866-830-5701 (24X7)
Yoruba -	Fún ìrànlọwọ nípa èdè (Yorùbá) pe 1-866-830-5701 (24X7) lái san owó kankan rárá.

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period: 07/01/2021-06/30/2022

Banner | aetna

SUN HEALTH EMPLOYEE SERVICES LLC : Open Access POS II - 3000
Open Access POS II - Connecticut

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 1-866-830-5701 (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 Provider (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 copay/visit, deductible doesn't apply	50% coinsurance	None
	Specialist visit	$50 copay/visit, deductible doesn't apply	50% coinsurance	None
	Preventive care /screening /immunization	No charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$20 copay/visit, deductible doesn't apply	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetna.com/pharmacy-insurance/individuals-families	Generic drugs	See Express Scripts Summary for Details	See Express Scripts Summary for Details	Prescription drug coverage is through Express Scripts www.express-scripts.com
	Preferred brand drugs	See Express Scripts Summary for Details	See Express Scripts Summary for Details	
	Non-preferred brand drugs	See Express Scripts Summary for Details	See Express Scripts Summary for Details	
	Specialty drugs	See Express Scripts Summary for Details	See Express Scripts Summary for Details	Prescription drug coverage is through Express Scripts www.express-scripts.com
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	None
	Physician/surgeon fees	30% coinsurance	50% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Banner Health In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$200 copay/visit, deductible doesn't apply	$200 copay/visit, deductible doesn't apply	No coverage for non-emergency use.
	Emergency medical transportation	30% coinsurance	30% coinsurance	Non-emergency transport: not covered, except if pre-authorized.
	Urgent care	$75 copay/visit, deductible doesn't apply	50% coinsurance	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Penalty of $400 for failure to obtain pre-authorization for out-of-network care.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: $50 copay/visit, deductible doesn't apply; other outpatient services: no charge	Office & other outpatient services: 50% coinsurance	None
	Inpatient services	30% coinsurance	50% coinsurance	Penalty of $400 for failure to obtain pre-authorization for out-of-network care.
If you are pregnant	Office visits	No charge	50% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Penalty of $400 for failure to obtain pre-authorization for out-of-network care may apply.
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	3 visits/day. Penalty of $400 for failure to obtain pre-authorization for out-of-network care.
	Rehabilitation services	$50 copay/visit, deductible doesn't apply	50% coinsurance	25 visits/calendar year for Physical & Occupational Therapy combined, 20 visits/calendar year for Speech Therapy.
	Habilitation services	$50 copay/visit, deductible doesn't apply	50% coinsurance	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 Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Skilled nursing care	30% coinsurance	50% coinsurance	60 days/calendar year. Penalty of $400 for failure to obtain pre-authorization for out-of-network care.
	Durable medical equipment	30% coinsurance	50% coinsurance	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	30% coinsurance	50% coinsurance	Penalty of $400 for failure to obtain pre-authorization 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 : https://www.dol.gov/agencies/ebsa
- 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 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 https://www.dol.gov/agencies/ebsa
- 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.**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? **No.**

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	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$3,000
Copayments	$200
Coinsurance	$2,500
What isn't covered	
Limits or exclusions	$100
The total Peg would pay is	**$5,800**

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	**$7,400**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$6,000
The total Joe would pay is	**$6,400**

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	**$1,900**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$600
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,000**

The plan would be responsible for the other costs of these EXAMPLE covered services.

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 | Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Banner | Aetna provides 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

Email: 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 benefits and health insurance plans are offered and/or underwritten by Banner Health and Aetna Health Plan Inc. and Banner Health and Aetna Health Insurance Company (Banner | Aetna). Banner | Aetna are affiliates of Banner Health and of Aetna Life Insurance Company and its affiliates (Aetna). Aetna provides certain management services to Banner |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) զանգի 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 nomero 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 -	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-866-830-5701 (24X7) ကိုခေါ် ဆိုပါ။
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 -	ᎾᏍᎩᎾ ᏕᏬᏂᎯᏍᏗ ᏗᏂᏍᏕᎵᏍᎩ ᎾᏕᎢ (ᏣᎳᎩ) ᏫᏴᎳᏅᎯᏌ 1-866-830-5701 (24X7) ᎤᎾᎢ Ꮭ ᎪᎱᏍᏗ ᏧᎬᏩᎶᏗ ᏂᎨᏒᎾ.
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 -	हिन्दी 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 akwụghị ụgwọ 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 -	လၢတၢ်မၤစၢၤတၢ်ကတိၤကျိာ်အဂီၢ် ကျိာ် ကိး 1-866-830-5701 (24X7)အိဉ်ဒီးတၢ်လၢာ်ဘျာ်လၢာ်စုၤဟဉ်
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-866-830-5701 (24X7) 번으로 전화해 주십시오.
Kru-Bassa -	Ɓɛ́m`ké gbo-kpá-kpá dyé pídyi ɖé Ɓaǎsɔɔ́-wuɖuǔn wɛ̃ɛ, ɖá 1-866-830-5701 (24X7)
Kurdish -	بۆ یارمەتی بە زمانی کوردی بە خۆرایی پەیوەندی بکەن بە 1-866-830-5701 (24X7)
Laotian -	ສໍາລັບການຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-866-830-5701 (24X7) ໂດຍບໍ່ເສຍຄ່າໂທ.
Marathi -	तीलभाषा (मराठी) सहाय्यासाठी 1-866-830-5701 (24X7) क्रमांकावरकोणत्याहीखर्चाशिवायकॉलकरा.
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 សូមទូរស័ព្ទទៅកាន់លេខ 1-866-830-5701 (24X7) ដោយឥតគិតថ្លៃ។
Navajo -	T'áá shi shizaad k'ehjí bee shíká 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 kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-866-830-5701 (24X7) kecïn aɣöc.
Norwegian -	For språkassistanse på norsk, ring 1-866-830-5701 (24X7) kostnadsfritt.
Panjabi -	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-866-830-5701 (24X7) 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Helfe in Deitsch, 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 asistenţă 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 - fawaaki on.	Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-866-830-5701 (24X7). Njodi woo
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 ōtōngi.
Trukese -	Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-866-830-5701 (24X7) nge esapw kamé ngonuk.
Turkish -	(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-866-830-5701 (24X7).
Ukrainian - (24X7).	Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-866-830-5701
Urdu -	1-866-830-5701 (24X7)
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)
Yoruba -	Fún ìrànlọwọ nípa èdè (Yorùbá) pe 1-866-830-5701 (24X7) lái san owó kankan rárá.

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Banner | aetna SUN HEALTH EMPLOYEE SERVICES : Open Access POS II - 2500 Open Access POS II - Connecticut

Coverage Period: 07/01/2021-06/30/2022

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 1-866-830-5701 (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 $2,500 / Family $5,000. Out-of-Network: Individual $3,000 / Family $6,000.	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 $4,000 / Family $12,000. Out-of-Network: Individual $10,000 / Family $30,000.	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 Provider (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	$25 copay/visit, deductible doesn't apply	50% coinsurance	None
	Specialist visit	$40 copay/visit, deductible doesn't apply	50% coinsurance	None
	Preventive care /screening /immunization	No charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$20 copay/visit, deductible doesn't apply	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetna.com/pharmacy-insurance/individuals-families	Generic drugs	See Express Scripts Summary for Details	See Express Scripts Summary for Details	Prescription drug coverage is through Express Scripts www.express-scripts.com
	Preferred brand drugs	See Express Scripts Summary for Details	See Express Scripts Summary for Details	
	Non-preferred brand drugs	See Express Scripts Summary for Details	See Express Scripts Summary for Details	
	Specialty drugs	See Express Scripts Summary for Details	See Express Scripts Summary for Details	Prescription drug coverage is through Express Scripts www.express-scripts.com
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	None
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Banner Health In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$150 copay/visit, deductible doesn't apply	$150 copay/visit, deductible doesn't apply	No coverage for non-emergency use.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Non-emergency transport: not covered, except if pre-authorized.
	Urgent care	$75 copay/visit deductible doesn't apply	50% coinsurance	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Penalty of $400 for failure to obtain pre-authorization for out-of-network care.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: $40 copay/visit, deductible doesn't apply; other outpatient services: no charge	Office & other outpatient services: 50% coinsurance	None
	Inpatient services	20% coinsurance	50% coinsurance	Penalty of $400 for failure to obtain pre-authorization for out-of-network care.
If you are pregnant	Office visits	No charge	50% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Penalty of $400 for failure to obtain pre-authorization for out-of-network care may apply.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Penalty of $400 for failure to obtain pre-authorization for out-of-network care.
	Rehabilitation services	$40 copay/visit, deductible doesn't apply	50% coinsurance	25 visits/calendar year for Physical & Occupational Therapy combined, 20 visits/calendar year for Speech Therapy.
	Habilitation services	$40 copay/visit, deductible doesn't apply	50% coinsurance	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 Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Skilled nursing care	20% coinsurance	50% coinsurance	60 days/calendar year. Penalty of $400 for failure to obtain pre-authorization for out-of-network care.
	Durable medical equipment	20% coinsurance	50% coinsurance	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	20% coinsurance	50% coinsurance	Penalty of $400 for failure to obtain pre-authorization 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 : https://www.dol.gov/agencies/ebsa
- 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 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 https://www.dol.gov/agencies/ebsa
- 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.**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? **No.**

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	**$2,500**
Specialist copayment	**$40**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$2,500
Copayments	$100
Coinsurance	$1,400
What isn't covered	
Limits or exclusions	$100
The total Peg would pay is	**$4,100**

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

The plan's overall deductible	**$2,500**
Specialist copayment	**$40**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	**$7,400**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$6,000
The total Joe would pay is	**$6,300**

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

The plan's overall deductible	**$2,500**
Specialist copayment	**$40**
Hospital (facility) coinsurance	**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	**$1,900**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$600
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,000**

The plan would be responsible for the other costs of these EXAMPLE covered services.

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 | Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Banner | Aetna provides 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

Email: 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 benefits and health insurance plans are offered and/or underwritten by Banner Health and Aetna Health Plan Inc. and Banner Health and Aetna Health Insurance Company (Banner | Aetna). Banner | Aetna are affiliates of Banner Health and of Aetna Life Insurance Company and its affiliates (Aetna). Aetna provides certain management services to Banner |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) զանգի 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 nomero 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 -	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-866-830-5701 (24X7) ကိုခေါ်ဆိုပါ။
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 -	ᎾᏍᎩᎾ ᏚᏬᏂᎯᏍᏗ ᏗᏂᏍᏕᎵᏍᎩ ᎾᏏᎢ (ᏣᎳᎩ) ᏫᏴᎳᏬᎥᏚ 1-866-830-5701 (24X7) ᎤᎾᎢ Ꮭ ᎪᎱᏍᏗ ᏧᎬᏩᎶᏗ ᏂᎨᏒᎾ.
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 -	हिन्दी 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 akwụghị ụgwọ 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 -	လာတ်မၤစၢၤတ်ကတိၤကျိာ်အဂီၢ် ကျိာ် ကိး 1-866-830-5701 (24X7)အိာ်ဒီးတ်လၢာ်ဘျာ်လၢာ်စုၤဘၣ်
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-866-830-5701 (24X7) 번으로 전화해 주십시오.
Kru-Bassa -	Ɓɛ́m`ké gbo-kpá-kpá dyé pídyi ɖé Ɓaɓɔɔ̀-wuɖuǔn wɛ̃ɛ, ɖá 1-866-830-5701 (24X7)
Kurdish -	برای راهنمایی به زبان فارسی با شماره به خوراییه‌یوەندی بکەن. 1-866-830-5701 (24X7)
Laotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ1-866-830-5701 (24X7)ໂດຍບໍ່ເສຍຄ່າໃຫ.
Marathi -	तीलभाषा (मराठी) सहाय्यासाठी 1-866-830-5701 (24X7) क्रमांकावरकोणत्याहीखर्चाशिवायकॉलकरा.
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 សូមទូរស័ព្ទទៅកាន់លេខ 1-866-830-5701 (24X7)ដោយឥតគិតថ្លៃ។
Navajo -	T'áá shi shizaad k'ehjí bee shíká 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 kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-866-830-5701 (24X7) kecïn aɣöc.
Norwegian -	For språkassistanse på norsk, ring 1-866-830-5701 (24X7) kostnadsfritt.
Panjabi -	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-866-830-5701 (24X7) ‘ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-866-830-5701 (24X7) aa. Es Aaruf koschtet nix.
Persian -	برای راهنمایی به زبان فارسی با شماره بدون هیچ هزینه ای تماس بگیرید. انگلیسی 1-866-830-5701 (24X7)
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 asistenţă lingvistică în româneşte telefonaţi 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 - fawaaki on.	Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-866-830-5701 (24X7). Njodi woo
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 ōtōngi.
Trukese -	Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-866-830-5701 (24X7) nge esapw kamé ngonuk.
Turkish -	(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-866-830-5701 (24X7).
Ukrainian - (24X7).	Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-866-830-5701
Urdu -	1-866-830-5701 (24X7)
Vietnamese -	Đê ̉ đươ ̣c hô ̃ trơ ̣ ngôn ngư ̃ bă ̀ng (ngôn ngư ̃), hă ̃y goi miễn phi ́đê ́n sô ́1-866-830-5701 (24X7).
Yiddish -	פאר שפראך הילף אין אידיש רופט 1-866-830-5701 (24X7) פרייַ פון אפצאל.
Yoruba -	Fún ìrànlọwọ nípa èdè (Yorùbá) pe 1-866-830-5701 (24X7) lái san owó kankan rárá.