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

Coverage Period: 07/01/2022-06/30/2023

Banner | aetna

PINAL COUNTY, A POLITICAL SUBDIVISION OF THE STATE OF ARIZONA : Open Access EPO Plus - EPO Basic, EPO Plus

Coverage for: Individual + Family | Plan Type: EPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.HealthReformPlanSBC.com or by calling 1-844-267-2253 (Licensed Entity). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-844-267-2253 (Licensed Entity) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For each Plan Year, Banner Health In-Network: EE Only $300; EE+ Family: Individual $300/ Family $600.	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. 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: EE Only $2,750; EE+ Family: Individual $2,750/ Family $5,500.	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.	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 1-844-267-2253 (Licensed Entity) for a list of 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 copay/visit, deductible doesn't apply	Not covered	None
	Specialist visit	$40 copay/visit, deductible doesn't apply	Not covered	None
	Preventive care /screening /immunization	No charge	Not covered	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)	No charge for laboratory; 10% coinsurance for x-ray	Not covered	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	Not covered	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	Not covered	Not covered	Benefits may be available under a separate plan.
	Preferred brand drugs	Not covered	Not covered	Benefits may be available under a separate plan.
	Non-preferred brand drugs	Not covered	Not covered	Benefits may be available under a separate plan.
	Specialty drugs	Not covered	Not covered	Benefits may be available under a separate plan.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not covered	None
	Physician/surgeon fees	10% coinsurance	Not covered	None
If you need immediate medical attention	Emergency room care	10% coinsurance after $300 copay/visit	10% coinsurance after $300 copay/visit	Out-of-network emergency use paid the same as in-network. No coverage for non-emergency use.
	Emergency medical transportation	10% coinsurance	10% coinsurance	Out-of-network emergency use paid the same as in-network. Non-emergency transport: not covered, except if pre-authorized.
	Urgent care	$50 copay/visit, deductible doesn't apply	Not covered	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	Not covered	None
	Physician/surgeon fees	10% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: $20 copay/visit, deductible doesn't apply	Not covered	None
	Inpatient services	10% coinsurance	Not covered	None
If you are pregnant	Office visits	No charge	Not covered	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	10% coinsurance	Not covered	
	Childbirth/delivery facility services	10% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	Not covered	60 visits/plan year.
	Rehabilitation services	10% coinsurance	Not covered	None
	Habilitation services	10% coinsurance	Not covered	None
	Skilled nursing care	10% coinsurance	Not covered	60 days/plan year.
	Durable medical equipment	10% coinsurance	Not covered	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	10% coinsurance	Not covered	None
	Children's eye exam	Not covered	Not covered	Not covered.

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 your child needs dental or eye care	Children's glasses	No charge	No charge	$500 maximum/12 months.
	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
- Cosmetic surgery
- Dental care (Adult & Child)
- 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.)

- Bariatric surgery - $25,000 maximum/lifetime for in-network only.
- Chiropractic care - 30 visits/plan year.
- Hearing aids - $1,000 maximum/lifetime.
- 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 1-844-267-2253 (Licensed Entity).
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or 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:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general number at 1-844-267-2253 (Licensed Entity). You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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? **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	**$300**
Specialist copayment	**$40**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$1,370**

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

The plan's overall deductible	**$300**
Specialist copayment	**$40**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	**$4,500**

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

The plan's overall deductible	**$300**
Specialist copayment	**$40**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$300
Copayments	$80
Coinsurance	$200
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$590**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-844-267-2253 (Licensed Entity).

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 1-844-267-2253 (Licensed Entity).

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

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

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512,
1-800-648-7817, TTY: 711,
Fax: 859-425-3379, CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

TTY: 711

Language Assistance:

For language assistance in your language call 1-844-267-2253 (Licensed Entity) at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-844-267-2253 (Licensed Entity).

Amharic - □□□□ □□□ □ □□□□ □ 1-844-267-2253 (Licensed Entity) □□□ □□□□

Arabic - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-844-267-2253 (Licensed Entity)

Armenian - Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-844-267-2253 (Licensed Entity) առանց գնով:

Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-844-267-2253 (Licensed Entity) tanpa dikenakan biaya.

Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-844-267-2253 (Licensed Entity) ku busa

Bengali-Bangala - □□□□□□ □□□□ □□□□□□□□□ □□□□ □□□□□□□□□□ 1-844-267-2253 (Licensed Entity)-□□ □□ □□□□□

Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-844-267-2253 (Licensed Entity) nga walay bayad.

Burmese - ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-844-267-2253 (Licensed Entity) ကိုခေါ်ဆိုပါ။

Catalan - Per rebre assistència en (català), truqui al número gratuït 1-844-267-2253 (Licensed Entity).

Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-844-267-2253 (Licensed Entity) sin gåstu.

Cherokee - ᎾᏍᎩᎾ ᏕᏅᏂᎯᏍᏗ ᏗᏂᏍᏕᎵᏍᎩ ᎾᏥᎢ (ᏣᎳᎩ) ᏬᏏᏔᏅᎢᏍ 1-844-267-2253 (Licensed Entity) ᎤᎾᎢ Ꮭ ᎠᎱᏍᏗ ᏧᎬᏬᎵᏗ ᏂᎯᏒᎾ.

Chinese - 欲取得繁體中文語言協助，請撥打 1-844-267-2253 (Licensed Entity)，無需付費。

Choctaw - (Chahta) anumpa ya apela a chi I paya hinla 1-844-267-2253 (Licensed Entity).

Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-844-267-2253 (Licensed Entity) irratti bilisaan bilbilaa.

Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-844-267-2253 (Licensed Entity).

French - Pour une assistance linguistique en français appeler le 1-844-267-2253 (Licensed Entity) sans frais.

French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-844-267-2253 (Licensed Entity) gratis.

German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-844-267-2253 (Licensed Entity) an.

Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-844-267-2253 (Licensed Entity) χωρίς χρέωση.

Gujarati - □□□□□□□□□□ □□□□□□□ □□□□ □□□□ □□□ □□ □□□□ □□□ 1-844-267-2253 (Licensed Entity) □□ □□□

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Hawaiian - No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-844-267-2253 (Licensed Entity). Kāki ‘ole ‘ia kēia kōkua nei.

Hindi - हिन्दी में भाषा सहायता के लिए, 1-844-267-2253 (Licensed Entity) पर मुफ़्त कॉल करें।

Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-844-267-2253 (Licensed Entity).

Ibo - Maka enyemaka asụsụ na Igbo kpọọ 1-844-267-2253 (Licensed Entity) na akwụghị ụgwọ ọ bụla

Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-844-267-2253 (Licensed Entity) nga awan ti bayadanyo.

Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-844-267-2253 (Licensed Entity).

Japanese - 日本語で援助をご希望の方は、1-844-267-2253 (Licensed Entity) まで無料でお電話ください。

Karen - လၢတၢ်မၤစၢၤတၢ်ကတိၤကျိာ်အဂီၤ် ကျိာ် ဒိ-844-267-2253 (Licensed Entity)တၢ်လၢာ်ဘူဉ်လၢာ်စုၤဟဉ်

Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-844-267-2253 (Licensed Entity) 번으로 전화해 주십시오.

Kru-Bassa - Ɓɛ́m`ké gbo-kpá-kpá dyé pídyi ɖé Ɓaɓɔɔ̀-wuɖuǔn wɛ̃ɛ, ɖá 1-844-267-2253 (Licensed Entity)

Kurdish - برای راهنمایی به زبان فارسی با ما تماس بگیرید. به خۆرایی یەیوەندی بکەن 1-844-267-2253 (Licensed Entity)

Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-844-267-2253 (Licensed Entity) ໂດຍບໍ່ເສຍຄ່າໃຫ.

Marathi - □□□□□□□□□□ □□□□□□□□□□□□ □□□□ □□□□ □□□□□□□ □□□□□□□□□□□, 1-844-267-2253 (Licensed Entity) □□ □□□ □□□.

Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-844-267-2253 (Licensed Entity) ilo ejjelok wōnān.

Micronesian-Pohnpeyan - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-844-267-2253 (Licensed Entity) ni sohte isais.

Mon-Khmer, Cambodian - សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-844-267-2253 (Licensed Entity) ដោយមិនគិតថ្លៃ។

Navajo - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-844-267-2253 (Licensed Entity)

Nepali - (□□□□□□□) □□ □□□□□□□□ □□□□ □□□□□□ □□□□□□ □□□□ 1-844-267-2253 (Licensed Entity) □□ □□□ □□□□□□□□□□ □

Nilotic-Dinka - Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-844-267-2253 (Licensed Entity) kecïn aɣöc.

Norwegian - For språkassistanse på norsk, ring 1-844-267-2253 (Licensed Entity) kostnadsfritt.

Panjabi - □□□□□□ □□□□ □□□□□ □□□□□□ □□, 1-844-267-2253 (Licensed Entity) ‘□□ □□□□ □□□ □□□□

Pennsylvania Dutch - Fer Helfe in Deitsch, ruf: 1-844-267-2253 (Licensed Entity) aa. Es Aaruf koschtet nix.

Persian - برای راهنمایی به زبان فارسی بدون هیچ هزینه ای تماس بگیرید. انگلیسی 1-844-267-2253 (Licensed Entity)

Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-844-267-2253 (Licensed Entity).

Portuguese - Para obter assistência linguística em português ligue para o 1-844-267-2253 (Licensed Entity) gratuitamente.

Romanian - Pentru asistenţă lingvistică în româneşte telefonaţi la numărul gratuit 1-844-267-2253 (Licensed Entity)

Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-844-267-2253 (Licensed Entity).

Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-844-267-2253 (Licensed Entity) e aunoa ma se totogi.

Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-844-267-2253 (Licensed Entity).

Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-844-267-2253 (Licensed Entity).

Sudanic-Fulfude - Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-844-267-2253 (Licensed Entity). Njodi woo fawaaki on.

Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-844-267-2253 (Licensed Entity) bila malipo.

Syriac - 1-844-267-2253 (Licensed Entity)

Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-844-267-2253 (Licensed Entity) nang walang bayad.

Telugu - (□□□□□□) □□□□□ □□□□□ □□□□□□ □□□□□□□ □□□□□ □□□□□□□□ 1-844-267-2253 (Licensed Entity) □□ □□□□ □□□□□□.

Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-844-267-2253 (Licensed Entity) ฟรีไม่มีค่าใช้จ่าย

Tongan - Kapau ‘oku fiema'u hā tokoni ‘i he lea faka-Tonga telefoni 1-844-267-2253 (Licensed Entity) ‘o ‘ikai hā ōtōngi.

Trukese - Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-844-267-2253 (Licensed Entity) nge esapw kamé ngonuk.

Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-844-267-2253 (Licensed Entity).

Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-844-267-2253 (Licensed Entity).

Urdu - بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-844-267-2253 (Licensed Entity) پر بات کریں۔

Vietnamese - Đê ̉ đươ ̣c hô ̃ trơ ̣ ngôn ngư ̃ bă ̀ng (ngôn ngư ̃), hă ̃y goi miễn phi ́đê ́n sô ́1-844-267-2253 (Licensed Entity).

Yiddish - 1-844-267-2253 (Licensed Entity) פּאר שפּראך הילף אין אידיש פֿרײַ פֿון אפּצאָל.

Yoruba - Fún ìrànlọwọ́ nípa èdè (Yorùbá) pe 1-844-267-2253 (Licensed Entity) lái san owó kankan rárá.