Coverage for: Individual + Family | Plan Type: PPO



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 1-800-370-4526. 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 1-800-370-4526 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	In- <u>Network</u> : Individual \$125 / Family \$250. Out- of-Network: Individual \$500 / Family \$1,000.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. Emergency care; plus in- <u>network</u> office visits & <u>preventive care</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <u>https://www.healthcare.gov/coverage/preventive-care-benefits/</u>
Are there other <u>deductible</u> s for specific services?	No.	You don't have to meet deductibles for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	In- <u>Network</u> : Individual \$500 / Family \$1,000.Out-of-Network: Individual \$1,500 / Family \$3,000.	The <u>out–of–pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out–of–pocket</u> <u>limits</u> until the overall family <u>out–of–pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premium</u> s, balance-billing charges, health care this <u>plan</u> doesn't cover & penalties for failure to obtain <u>pre-authorization</u> for services.	Even though you pay these expenses, they don't count toward the <u>out–of–pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.aetna.com/docfind or call 1-800- 370-4526 for a list of in- <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's</u> <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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

	What You Will Pay			
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	\$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% <u>coinsurance</u> after deductible	None
If you visit a health care <u>provider</u> 's	<u>Specialist</u> visit	\$35 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% <u>coinsurance</u> after deductible	None
office or clinic	Preventive care /screening /immunization	No charge	30% <u>coinsurance</u> after deductible	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	5% <u>coinsurance</u> <u>after deductible</u> for hospital; no charge for independent lab & free-standing facility	5% <u>coinsurance</u> after deductible	None
	Imaging (CT/PET scans, MRIs)	5% <u>coinsurance</u> after deductible	5% <u>coinsurance</u> after deductible	None
If you need drugs	Generic drugs	Not covered	Not covered	Not covered
to treat your	Preferred brand drugs	Not covered	Not covered	Not covered
illness or	Non-preferred brand drugs	Not covered	Not covered	Not covered
condition More information about <u>prescription</u> <u>drug coverage</u> is available at www.caremark.com	Specialty drugs	Not covered	Not covered	Not covered

Common Medical Event	Services You May Need	What Yo In-Network Provider (You will pay the least)	u Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
lf you have	Facility fee (e.g., ambulatory surgery center)	5% coinsurance after deductible	30% <u>coinsurance</u> after deductible	None
outpatient surgery	Physician/surgeon fees	5% coinsurance after deductible	30% <u>coinsurance</u> after deductible	None
If you need	Emergency room care	\$75 <u>copay</u> /visit, <u>deductible</u> doesn't apply. Copay waived if admitted.	\$75 <u>copay</u> /visit <u>deductible</u> doesn't apply. Copay waived if admitted.	No coverage for non-emergency use.
immediate medical attention	Emergency medical transportation	No charge	No charge	None
attention	<u>Urgent care</u>	\$35 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$35 <u>copay</u> /visit, <u>deductible</u> doesn't apply	No coverage for non-urgent use.
lf you have a	Facility fee (e.g., hospital room)	5% <u>coinsurance</u> after deductible	30% <u>coinsurance</u> after deductible	Pre-authorization required for out-of-network care.
hospital stay	Physician/surgeon fees	5% <u>coinsurance</u> after deductible	30% <u>coinsurance</u> after deductible	None
If you need mental health, behavioral health, or substance abuse	Outpatient services	Office: \$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply; other outpatient services: no charge	Office & other outpatient services: 30% <u>coinsurance</u> <u>after deductible</u>	None
services	Inpatient services	5% coinsurance after deductible	30% <u>coinsurance</u> <u>after deductible</u>	Pre-authorization required for out-of-network care.
	Office visits	No charge	30% <u>coinsurance</u> after deductible	Cost sharing does not apply for preventive
lf you are pregnant	Childbirth/delivery professional services	5% <u>coinsurance</u> after deductible	30% <u>coinsurance</u> after deductible	services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Pre-authorization required for out-of-
	Childbirth/delivery facility services	5% coinsurance after deductible	30% <u>coinsurance</u> after deductible	network care may apply.
If you need help recovering or have	Home health care	No charge	No charge	Pre-authorization required for out-of-network care.

	What You Will Pay			
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
other special health needs	Rehabilitation services	\$35 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% <u>coinsurance</u> after deductible	300 visits/calendar year for Physical, Occupational & Speech Therapy combined.
	Habilitation services	No charge	30% <u>coinsurance</u> after deductible	None
	Skilled nursing care	5% <u>coinsurance</u> after deductible	30% <u>coinsurance</u> after deductible	120 days/calendar year out-of-network. <u>Pre-</u> authorization required for out-of-network care.
	Durable medical equipment	5% <u>coinsurance</u> after deductible	5% <u>coinsurance</u> after deductible	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	No charge	No charge	Pre-authorization required for out-of-network care.
lf your shild needs	Children's eye exam	Not covered	Not covered	Not covered.
If your child needs dental or eye care	Children's glasses	Not covered	Not covered	Not covered.
dental of eye cale	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.)

- Cosmetic surgery •
- Dental care (Adult & Child) •
- Glasses (Child) •

Long-term care •

•

- Non-emergency care when traveling outside • the U.S. Prescription Drugs
- 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.)

- Acupuncture
- Bariatric surgery

- Chiropractic care
- Hearing aids 2 hearing aid to \$1,400 maximum per ear/36 months.
- Infertility treatment For more information & exceptions, see policy document provided by your employer or call the number on your ID card.
- Private-duty nursing

Your Rights to Continue Coverage:

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

- For more information on your rights to continue coverage, contact the <u>plan</u> at 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or <u>www.cciio.cms.gov</u>.
- If your coverage is a church <u>plan</u>, church <u>plans</u> are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the <u>Health Insurance Marketplace</u>. For more information about the <u>Marketplace</u>, visit <u>www.HealthCare.gov</u> or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or <u>www.cciio.cms.gov</u>.
- Additionally, a consumer assistance program can help you file your <u>appeal</u>. Contact information is at: <u>http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html</u>.

Does this plan provide Minimum Essential Coverage? Yes.

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.

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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 Havin	ig a Bab)y		
9 months of i	n-network	pre-natal	care	and	а

hospital delivery)

The <u>plan's</u> overall <u>deductible</u>	\$125
Specialist copayment	\$35
Hospital (facility) <u>coinsurance</u>	5%
Other <u>coinsurance</u>	5%

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:	
<u>Cost Sharing</u>	
Deductibles	\$100
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$400
What isn't covered	
Limits or exclusions	\$70
The total Peg would pay is	\$570

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

The plan's overall deductible	\$125
Specialist copayment	\$35
Hospital (facility) <u>coinsurance</u>	5%
Other <u>coinsurance</u>	5%

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:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$200
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$4,300
The total Joe would pay is	\$4,600

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

The <u>plan's</u> overall <u>deductible</u>	\$125
Specialist copayment	\$35
Hospital (facility) <u>coinsurance</u>	5%
Other <u>coinsurance</u>	5%

This EXAMPLE event includes services like:

Emergency room care (including medical supplies) Diagnostic test (x-ray) Durable medical equipment (crutches) Rehabilitation services (physical therapy)

Total Example Cost	\$2,800
In this example, Mia would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$300
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$10
The total Mia would pay is	\$310

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 866-393-0002.

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

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

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

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

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting: Civil Rights Coordinator, P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: P.O. Box 24030, Fresno, CA 93779), 1-800-648-7817, TTY: 711, Fax: 859-425-3379 (CA HMO customers: 860-262-7705), 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).

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TTY: 711

Language Assistance:

For language assistance in your language call 1-800-370-4526 at no cost.

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-800-370-4526.
Amharic -	ለቋንቋ <i>እነ</i> ዛ በ አማርኛ በ 1-800-370-4526 በነጻ ይደውሉ
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 626-370-4526
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-800-370-4526 առանց գնով։
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-370-4526 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-800-370-4526 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বিনামুল্যে 1-800-370-4526-তে কল করুন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-370-4526 nga walay bayad.
Burmese -	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-800-370-4526 ကို ခေါ် ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-800-370-4526.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-800-370-4526 sin gåstu.
Cherokee -	0 0 0 0 0 0 0 0
Chinese -	欲取得繁體中文語言協助,請撥打1-800-370-4526,無需付費。
Choctaw -	(Chahta) anumpa y <u>a</u> apela a chi I p <u>a</u> ya hinla 1-800-370-4526.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-800-370-4526 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-370-4526.
French -	Pour une assistance linguistique en français appeler le 1-800-370-4526 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-800-370-4526 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-370-4526 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-370-4526 χωρίς χρέωση.
Gujarati -	ગુજરાતીમાં ભાષામાં સહ્રાય માટે કોઈ પણ ખર્ચ વગર 1-800-370-4526 પર કૉલ કરો.
Hawaiian -	No ke kōkua ma ka 'ōlelo Hawai'i, e kahea aku i ka helu kelepona 1-800-370-4526. Kāki 'ole 'ia kēia kōkua nei.

Hindi -	हनि्दी में भाषा सहायता के लएि, ₁₋₈₀₀₋₃₇₀₋₄₅₂₆ पर मुफ्त कॉल करें।
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-800-370-4526.
lbo -	Maka enyemaka asụsụ na Igbo kpọọ 1-800-370-4526 na akwụghị ụgwọ ọ bụla
llocano -	Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-370-4526 nga awan ti bayadanyo.
Italian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-800-370-4526.
Japanese -	日本語で援助をご希望の方は、1-800-370-4526 まで無料でお電話ください。
Karen -	လ၊ တၢိမာစားတၢိဳကတိုးကျိုခ်အင်္ဂါ ကျိုခ် အီ800-370-4526 လ၊ တအိုခ်ိဒီးတၢိဳလ၊ ခ်ဘူခ်လ၊ ခ်စူးဘခ်
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-370-4526 번으로 전화해 주십시오.
Kru-Bassa -	Ɓε´m`ké gbo-kpá-kpá dyé pidyi dé Ɓašɔɔ́-̀wùdุùùn wɛ̃ɛ, dá 1-800-370-4526
Kurdish -	بر اي ر اهنمايي به زبان فارسي با شمار ه 4526-370-800 به خوّر ايي پهيو مندي بکهن.
Laotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ-800-370-4526 ໂດຍບໍ່ເສຍຄ່າໂທ.
Marathi -	कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-800-370-4526 वर फोन करा.
Marshallese -	Ñan bōk jipañ ilo Kajin Majol, kallok 1-800-370-4526 ilo ejjelok wōnān.
Micronesian- Pohnpeyan -	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-800-370-4526 ni sohte isais.
Mon-Khmer, Cambodian -	សម្ភរាប់ជំនួយភាសាជា ភាសាខុមរៃ សូមទូរស័ព្ ទទ ៅកាន់លខេ 1-800-370-4526 ដោយឥតគិតថ្ ល ។ៃ
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-800-370-4526
Nepali -	(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-800-370-4526 मा फोन गर्नुहोस् ।
Nilotic-Dinka -	Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-800-370-4526 kecïn aɣöc.
Norwegian -	For språkassistanse på norsk, ring 1-800-370-4526 kostnadsfritt.
Panjabi -	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-800-370-4526 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-800-370-4526 aa. Es Aaruf koschtet nix.
Persian -	برای راهنمایی به زبان فارسی با شماره ۵۲۵-۵۶۰-۱۰۵۰ بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Polish -	Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-800-370-4526.
Portuguese -	Para obter assistência linguística em português ligue para o 1-800-370-4526 gratuitamente.
Romanian -	Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-800-370-4526

Russian -	Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-800-370-4526.
Samoan -	Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-800-370-4526 e aunoa ma se totogi.
Serbo-Croatian -	Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-800-370-4526.
Spanish -	Para obtener asistencia lingüística en español, llame sin cargo al 1-800-370-4526.
Sudanic-Fulfude -	Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-800-370-4526. Njodi woo fawaaki on.
Swahili -	Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-800-370-4526 bila malipo.
Syriac -	ר שבר רג א שביוו מאר שלב ד ממואיר הר לית isper זאל, שם 1-800-370-4526 משי ג.
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-800-370-4526 nang walang bayad.
Telugu -	భాషతో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 1-800-370-4526 కు కాల్ చేయండి. (తెలుగు)
Thai -	สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-800-370-4526 ฟรีไม่มีค่าใช้จ่าย
Tongan -	Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-800-370-4526 'o 'ikai hā ōtōngi.
Tongan - Trukese -	Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-800-370-4526 'o 'ikai hā ōtōngi. Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-800-370-4526 nge esapw kamé ngonuk.
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Trukese -	Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-800-370-4526 nge esapw kamé ngonuk. (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-800-370-4526. Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-800-370-4526.
Trukese - Turkish -	Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-800-370-4526 nge esapw kamé ngonuk. (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-800-370-4526.
Trukese - Turkish - Ukrainian -	Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-800-370-4526 nge esapw kamé ngonuk. (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-800-370-4526. Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-800-370-4526.
Trukese - Turkish - Ukrainian - Urdu -	Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-800-370-4526 nge esapw kamé ngonuk. (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-800-370-4526. Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-800-370-4526. بالقرمت زیان سے متعلقہ خدمات حاصل کرتے کے لیے ، 1-800-370-4526 یر بات کریں۔