Coverage for: Individual + Family | Plan Type: PPO



aetna: :

The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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, go to http://www.mcclatchylivewell.com/ or by calling 1-888-982-3862. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-888-982-3862 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	<u>Network</u> : EE Only \$2,000; EE+Spouse/Child(ren) \$4,000; EE+Family \$6,000. Out–of–Network: EE Only \$3,300; EE+Spouse/Child(ren) \$4,950; EE+Family \$6,600.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> is 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>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	<u>Network</u> : EE Only \$5,000; EE+Spouse/Child(ren) \$7,500; EE+ Family \$10,000. Out-of-Network: Individual \$6,350; EE+Spouse/Child(ren) \$9,525; EE+Family \$12,700.	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 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?	Premiums, <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover & penalties for failure to obtain <u>pre-authorization</u> for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.aetna.com/docfind or call 1-888-982-3862 for a list of <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	Network Provider (You will pay the least)	Out–of–Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
lf you visit a health	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	40% coinsurance	Includes internal medicine, general practice, family practice and pediatrics.
care <u>provider's</u> office	<u>Specialist</u> visit	20% coinsurance	40% coinsurance	None
or clinic	Preventive care / screening / immunization	No charge	No charge	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are preventive, then check what your <u>plan</u> will pay for. Age and frequency limits may apply.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
If you have a test	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	None
If you need drugs to treat your illness or	Generic drugs	After <u>deductible</u> : 20% coinsurance	Not covered	Covers 30 day supply (retail), 31-90 day supply (retail or mail order). Review your formulary for
condition Prescription drug coverage is administered by CVS/Caremark	Preferred brand drugs	After <u>deductible</u> : 20% coinsurance	Not covered	prescriptions requiring precertification or step therapy.
	Non-preferred brand drugs	After <u>deductible</u> : 20% coinsurance	Not covered	
	Specialty drugs	After <u>deductible</u> : 20% coinsurance	Not covered	First prescription must be filled at a participating retail pharmacy or CVS Specialty
More information about <u>prescription drug</u> <u>coverage</u> is available at www.caremark.com				Pharmacy. Subsequent fills must be through CVS Specialty Pharmacy.
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
surgery	Physician/surgeon fees	20% coinsurance	40% <u>coinsurance</u>	None
If you need immediate	Emergency room care	20% coinsurance	20% <u>coinsurance</u>	No coverage for non-emergency use.
medical attention	Emergency medical transportation	20% coinsurance	20% <u>coinsurance</u>	None
	<u>Urgent care</u>	20% coinsurance	40% coinsurance	None

lf you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Penalty of \$250 for failure to obtain <u>pre-</u> authorization for out-of-network care.
Slay	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental	Outpatient services	20% coinsurance	40% coinsurance	None
health, behavioral health, or substance abuse services	Inpatient services	20% <u>coinsurance</u>	40% coinsurance	Penalty of \$250 for failure to obtain <u>pre-</u> <u>authorization</u> for out-of-network care.
	Office visits	No charge	40% coinsurance	Cost sharing doesn't apply to certain preventive
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	services. Maternity care may include tests &
lf you are pregnant	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	services described elsewhere in the SBC (i.e. ultrasound). Includes outpatient postnatal care. Penalty of \$250 for failure to obtain <u>pre-</u> <u>authorization</u> for out-of-network care may apply.
	Home health care	20% <u>coinsurance</u>	40% coinsurance	Coverage is limited to 120 visits/calendar year. Penalty of \$250 for failure to obtain <u>pre-</u> <u>authorization</u> for out-of-network care.
	Rehabilitation services	20% coinsurance	40% coinsurance	None
lf you need help	Habilitation services	20% coinsurance	40% coinsurance	Limited to children up to age 6 for neurodevelopmental therapy.
recovering or have other special health needs	Skilled nursing care	20% <u>coinsurance</u>	40% coinsurance	Coverage is limited 100 days/calendar year. Penalty of \$250 for failure to obtain <u>pre-</u> <u>authorization</u> for out-of-network care.
	Durable medical equipment	20% coinsurance	40% coinsurance	None
	Hospice services	20% coinsurance	40% coinsurance	Penalty of \$250 for failure to obtain <u>pre-</u> authorization for out-of-network care.
If your child poods	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.
uental of eye cale	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

 Cosmetic surgery Dental care (Adult & Child) Glasses (Child) Long-term care 	 Non-emergency care when traveling outside the U.S. Routine eye care (Adult & Child) Routine foot care 	 Weight loss programs - Except for required preventive services.
Other Covered Services (Limitations may apply t	o these services. This isn't a complete list. Please see yo	pur <u>plan</u> document.)
 Acupuncture - 12 visits/calendar year. Bariatric surgery - \$5,000 maximum/lifetime for 	 Hearing aids - 1 hearing aid to \$1,000 maximum /24 months for children up to age 19 & 1 hearing aid to \$1,000 maximum/36 months thereafter. 	 Private-duty nursing - 70- 8-hour shifts/calendar year.

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 1-888-982-3862.
- 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 <u>www.dol.gov/ebsa/healthreform</u>.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance <u>Marketplace</u>. 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 <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 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 1-888-982-3862.
- 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 <u>www.dol.gov/ebsa/healthreform</u>.
- Additionally, a consumer assistance program can help you file your <u>appeal</u>. 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 Standard? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

-----To see examples of how this plan might cover costs for a sample medical situation, see the next section.-----



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage.

Peg is Having a baby (9 months of in-network pre-natal can hospital delivery)	re and a	Managing Joe's type 2 Diabetes (a year of routine i network care of a well-controll	n-
 The <u>plan's</u> overall <u>deductible</u> <u>Specialist coinsurance</u> Hospital (facility) <u>coinsurance</u> Other <u>coinsurance</u> 	\$2,000 20% 20% 20%	 The <u>plan's</u> overall <u>deductible</u> <u>Specialist coinsurance</u> Hospital (facility) <u>coinsurance</u> Other <u>coinsurance</u> 	\$2,(2 2 2
This EXAMPLE event includes service	eslike:	This EXAMPLE event includes service	es like:
Specialist office visits (prenatal care)		Primary care physician office visits (inclu	ıding
Childbirth/Delivery Professional Services	3	disease education)	-
Childbirth/Delivery Facility Services		Diagnostic tests (blood work)	
Diagnostic tests (ultrasounds and blood	work)	Prescription drugs	
Specialist visit (anesthesia)		Durable medical equipment (glucose me	eter)

Total Example Cost	\$12,800
In this example, Peg would pay:	
Cost Sharing	
Deductibles	\$2,000

The total Peg would pay is	\$3,660
Limits or exclusions	\$60
What isn't covered	
Coinsurance	\$1,600
Copayments	\$0
Deductibles	\$2,000

 The <u>plan's</u> overall <u>deductible</u> <u>Specialist coinsurance</u> Hospital (facility) <u>coinsurance</u> Other <u>coinsurance</u> 	\$2,000 20% 20% 20%
This EXAMPLE event includes services like: Primary care physician office visits (<i>including</i> <i>disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)	
Total Example Cost \$7,4	
In this example, Joe would pay:	
Cost Sharing	
Deductibles	\$2,000
Copayments	\$0
Coinsurance \$1,0	
What isn't covered	
Limits or exclusions	\$60
The total Joe would pay is	\$3,060

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

The plan's overall deductible	\$2,000
Specialist coinsurance	20%
Hospital (facility) <u>coinsurance</u>	20%
Other coinsurance	20%

This EXAMPLE event includes services like:

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

Total Example Cost	\$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

Note: If your **<u>plan</u>** has a wellness program and you choose to participate, you may be able to reduce your costs.

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 1-888-982-3862.

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 discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

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 (CA HMO customers: PO Box 24030, Fresno, CA 93779)

1-800-648-7817, TTY: 711, Fax: 859-425-3379 (CA HMO customers: 1-860-262-7705)

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).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).

TTY: 711

Language Assistance:

For language assistance in your language call 1-888-982-3862 at no cost.

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-888-982-3862.
Amharic -	ለቋንቋ እንዛ በ አማርኛ በ 1-888-982-3862 በነጻ ይደውሉ
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 3862-982-1888-1
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-888-982-3862 առանց գնով։
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-982-3862 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-888-982-3862 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বিনামুল্যে 1–888–982–3862–তে কল করুন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-888-982-3862 nga walay bayad.
Burmese -	ေငြကုန္က်ခံစရာမလိုဘဲ (ျမန္မာဘာသာစကား)ျဖင့္ ဘာသာစကားအကူအညီရယူရန္ 1-888-982-3862 ကို ေခၚဆိုပါ။ Catalan – Per rebre assistència en (català),
truqui al número gra	tuït 1-888-982-3862.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-888-982-3862 sin gåstu.
Cherokee -	ፀፙሃፀ ያሚክንፙቭ Jhፙያዮፙሃ ፀቲፐ (GWY) ወይ₩6°ì\$ 1-888-982-3862 ውፀፐ ር AГፙቭ JEGPJ ከቅጽፀ.
Chinese -	欲取得繁體中文語言協助,請撥打1-888-982-3862,無需付費。
Choctaw -	(Chahta) anumpa y <u>a</u> apela a chi <u>I pa</u> ya hinla 1-888-982-3862.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-888-982-3862 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-888-982-3862.
French -	Pour une assistance linguistique en français appeler le 1-888-982-3862 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-888-982-3862 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-888-982-3862 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-888-982-3862 χωρίς χρέωση.
Gujarati -	ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-888-982-3862 પર કૉલ કરો.

Hawaiian -	No ke kōkua ma ka 'ōlelo Hawai'i, e kahea aku i ka helu kelepona 1-888-982-3862. Kāki 'ole 'ia kēia kōkuanei.
Hindi -	हिन्दी में भाषा सहायता के लिए, 1-888-982-3862 पर मुफ्त कॉल करें।
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-888-982-3862.
lbo -	Maka enyemaka asụsụ na Igbo kpọọ 1-888-982-3862 na akwụghị ụgwọ ọ bụla
llocano -	Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-888-982-3862 nga awan ti bayadanyo.
Italian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-888-982-3862.
Japanese -	日本語で援助をご希望の方は、1-888-982-3862 まで無料でお電話ください。
Karen -	v>w>frRp>Rw>fuwdRusd.ft*D>f usd.f ud; 1-888-982-3862 v>wtd.f'D;w>fv>mfbl.fv>mfphRb.f
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862번으로 전화해 주십시오.
Kru-Bassa -	Ɓć ṁ ké gbo-kpá-kpá dyé pídyi dé Ɓǎsɔ́ɔ̀-wùdùǔn wɛ̃ɛ, dá 1-888-982-3862
Kurdish -	بر ای راهنمایی به زبان فارسی با شمار ه 386-982-1888 به خوّر ایی پهیومندی بکهن.
Laotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-888-982-3862 ໂດຍບໍ່ເສຍຄ່າໂທ.
Marathi -	तीलभाषा (मराठी) सहाय्यासाठी 1-888-982-3862 क्रमांकावरकोणत्याहीखर्चाशिवायकॉलकरा.
Marshallese -	Ñan bōk jipañ ilo Kajin Majol, kallok 1-888-982-3862 ilo ejjelok wōnān.
Micronesian- Pohnpeyan -	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-888-982-3862 ni sohte isais.
Mon-Khmer, Cambodian -	សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-888-982-3862 ដោយឥតគិតថ្លៃ។
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-888-982-3862
Nepali -	(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-888-982-3862 मा फोन गर्नुहोस् ।
Nilotic-Dinka -	Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl1-888-982-3862 kecïn aɣöc.
Norwegian -	For språkassistanse på norsk, ring 1-888-982-3862 kostnadsfritt.
Panjabi -	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-888-982-3862 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ
ਕਰੋ। Pennsylvania D	utch - Fer Helfe in Deitsch, ruf: 1-888-982-3862 aa. Es Aaruf koschtetnix.
Persian -	بر ای را هنمایی به زبان فارسی با شمار ه ₃₈₆₂₋₃₈₉₋₁ بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Polish -	Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-888-982-3862.

Portuguese -	Para obter assistência linguística em português ligue para o 1-888-982-3862 gratuitamente.
Romanian -	Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-888-982-3862
Russian -	Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-888-982-3862.
Samoan -	Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-888-982-3862 e aunoa ma se totogi.
Serbo-Croatian -	Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-888-982-3862.
Spanish -	Para obtener asistencia lingüística en español, llame sin cargo al 1-888-982-3862.
Sudanic-Fulfude -	Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-888-982-3862. Njodi woo fawaaki on.
Swahili -	Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-888-982-3862 bila malipo.
- Syriac	نَكِحه 1-888-1 1se نَصْحَة حُل مُعْنَة حُل مُعْنَة من مُنْعَلْد ممَّلُمنَة عمر المَيَّم مُحْد ثم.
Tagalog - Telugu -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-888-982-3862 nang walang bayad. భాషతో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 1-888-982-3862 కు కాల్ చేయండి. (తెలుగు)
Thai -	สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-888-982-3862 ฟรีไม่มีค่าใช้จ่าย
Tongan -	Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-888-982-3862 'o 'ikai hā tōtōngi.
Trukese -	Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-888-982-3862 nge esapwkamé ngonuk.
Turkish -	(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-888-982-3862.
Ukrainian -	Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-888-982-3862.
Urdu -	ا رورک لکتف م رب ₁₋₈₈₈₋₉₈₂₋₃₈₆₂ س <u>حال ک</u> ستن و اع محن مل لی رو در
Vietnamese -	Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-888-982-3862.
Yiddish -	.פאר שפראך הילף אין אידיש רופט 1-888-982-3862 פריי פון אפצאל