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



The NEWYORK-PRESBYTERIAN HOSPITAL : Aetna Choice® POS II

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, <u>www.HealthReformPlanSBC.com</u> 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> ?	\$0. Out-of-Network: Individual \$750 / Family \$1,875.	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 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 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 \$3,175 / Family \$6,350. Out-of-Network: Individual \$4,500 / Family \$11,250.	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 <u>out-of-pocket limit</u> ?	<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 1-888- 982-3862 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	\$25 <u>copay</u> /visit except no charge for office surgery	<u>Deductible</u> + 30% <u>coinsurance</u>	None
If you visit a health care <u>provider</u> 's office or clinic	<u>Specialist</u> visit	\$35 <u>copay</u> /visit, except no charge for office surgery	<u>Deductible</u> +30% <u>coinsurance</u>	None
	Preventive care /screening /immunization	No charge	<u>Deductible</u> +30% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
Other Specialist Visit	Acupuncture	\$0 <u>copav</u> for the first 25 visits of a calendar year and \$25 thereafter	<u>Deductible</u> +30% <u>coinsurance</u>	None
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge for laboratory; \$35 <u>copay</u> /visit for x-ray	<u>Deductible</u> +30% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	\$35 <u>copay</u> /visit	Deductible +30% coinsurance	None
If you need prescription drugs	Refer to <u>www.caremark.com</u>			
Telemedicine	Aetna Teladoc	Aetna Teladoc: \$25, for general medicine and mental health; \$35 <u>copav</u> /visit for dermatology	Not Applicable	Telemedicine
	NYP Virtual Urgent Care – Adult and Pediatric	\$0 <u>copay</u> /visit		

	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	
lf you have	Facility fee (e.g., ambulatory surgery center)	No charge	Deductible +30% coinsurance	None	
outpatient surgery	Physician/surgeon fees	No charge	Deductible +30% coinsurance	None	
lf you need	Emergency room care	\$150 <u>copay</u> /visit	\$150 <u>copay</u> /visit <u>deductible</u> doesn't apply	No coverage for non-emergency use.	
immediate medical attention	Emergency medical transportation	No charge	No charge	Non-emergency transport: not covered, except 30% <u>coinsurance</u> if pre-authorized.	
	<u>Urgent care</u>	\$35 <u>copay</u> /visit	Deductible +30% coinsurance	No coverage for non-urgent use.	
If you have a	Facility fee (e.g., hospital room)	\$100 <u>copav</u> /day, first 3 days per stay	Deductible +30% coinsurance	Max <u>copay</u> /calendar year: \$300 in- <u>network</u> . Penalty of \$400 for failure to obtain <u>pre-</u> <u>authorization</u> for out-of-network care.	
hospital stay	Physician/surgeon fees	No charge	Deductible +30% coinsurance	None	
If you need mental health, behavioral health, or	Outpatient services	\$25 <u>copay</u> /visit, <u>deductible</u> outpatient services: no charge Facility: No charge.	Office & other outpatient services: <u>Deductible</u> +30% <u>coinsurance</u>	None	
substance abuse services	Inpatient services	\$100 <u>copav</u> /day, first 3 days per stay	Deductible +30% coinsurance	Max <u>copay</u> /calendar year: \$300 in- <u>network</u> . Penalty of \$400 for failure to obtain <u>pre-</u> <u>authorization</u> for out-of-network care.	
	Office visits	No charge	Deductible +30% coinsurance	<u>Cost sharing</u> does not apply for <u>preventive</u> <u>services</u> . Maternity care may include tests and	
lf you are pregnant	Childbirth/delivery professional services	No charge	Deductible +30% coinsurance	services described elsewhere in the SBC (i.e. ultrasound.) Max copay/calendar year: \$300 in-	
	Childbirth/delivery facility services	\$100 <u>copay</u> /day	Deductible +30% coinsurance	network. Penalty of \$400 for failure to obtain pre- authorization for out-of-network care may apply.	
lf you need help recovering or have	Home health care	No charge	Deductible +30% coinsurance	200 visits/calendar year. Penalty of \$400 for failure to obtain <u>pre-authorization</u> 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	<u>Rehabilitation services</u>	\$35 <u>copay</u> /visit	Physical Therapy Only: <u>Deductible</u> +30% <u>coinsurance</u> ;	 60 visits/calendar year for In-Network and Out-of-Network Physical Therapy combined. 30 visits/calendar year for Speech & Occupational Therapy In-Network only combined, including outpatient hospital services. Speech and Occupational Therapy are not covered for Out-of-Network Services
	Habilitation services	\$25 <u>copay</u> /visit	Physical Therapy Only: <u>Deductible</u> + 30% <u>coinsurance</u>	Speech and Occupational Therapy are not covered for Out-of-Network Services
	Skilled nursing care	No charge	Deductible +30% coinsurance	60 days/calendar year. Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	<u>Durable medical equipment</u>	No charge	<u>Deductible</u> +30% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse. Includes Electric Breast Pumps limited 1 per 12 months.
	Hospice services	No charge	<u>Deductible</u> +30% <u>coinsurance</u>	Penalty of \$400 for failure to obtain <u>pre-</u> authorization for out-of-network care

Excluded Services & Other Covered Services:

Cosmetic surgery Dental care Glasses	 Long-term care Non-emergency care when traveling outside the U.S. Prescription drugs 	 Private-duty nursing Routine foot care Weight loss programs - Except for required <u>preventive</u> <u>services</u>.
Other Covered Services (Limitations may apply t Acupuncture Bariatric surgery - Limited to Institutes of Quality contracted facility for in-network only.	 to these services. This isn't a complete list. Pleas Chiropractic care Hearing aids - \$6,000 maximum/3 years. Routine Eye Care 1 routine medical eye exam/calendar year. Refer to 	 Infertility treatment - Limited to the diagnosis & treatment underlying medical condition, artificial insemination & ovulation induction. Advanced Reproductive Technology (subject to <u>coinsurance</u>) \$30,000 maximum/lifetime at

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 1-888-982-3862.
- 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 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 <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 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 1-888-982-3862. 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 <u>plans</u>, 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.

<u>Minimum Essential Coverage</u> generally includes <u>plans</u>, <u>health insurance</u> available through the <u>Marketplace</u> or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of <u>Minimum Essential Coverage</u>, you may not be eligible for the <u>premium tax credit</u>.

Does this plan meet Minimum Value Standards? Yes.

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

To see examples of how this <u>plan</u> 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 <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 care and a
hospital delivery)

\$0

\$35

\$0

\$100

The plan's overall deductible
Specialist copayment
Hospital (facility) <u>copayment</u>
Other <u>copayment</u>

This EXAMPLE event includes services like: <u>Specialist</u> office visits (*prenatal care*) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests</u> (*ultrasounds and blood work*) <u>Specialist</u> visit (*anesthesia*)

Total Example Cost	\$12,700
In this example, Peg would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$1,600
The total Peg would pay is	\$1,900

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

The <u>plan's</u> overall <u>deductible</u>	\$0
Specialist copayment	\$35
Hospital (facility) <u>copayment</u>	\$100
Other <u>copayment</u>	\$0

This EXAMPLE event includes services like:Primary care physicianoffice visits (includingdisease education)Diagnostic tests (blood work)Prescription drugsDurable medical equipment (glucose meter)

Total Example Cost	\$5,600	
In this example, Joe would pay:		
<u>Cost Sharing</u>		
<u>Deductibles</u>	\$0	
<u>Copayments</u>	\$300	
<u>Coinsurance</u>	\$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>	\$0
Specialist copayment	\$35
Hospital (facility) <u>copayment</u>	\$100
Other copayment	\$0

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	\$0	
<u>Copayments</u>	\$300	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$900	
The total Mia would pay is	\$1,200	

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, 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 (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 1-888-982-3862 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 3862-382
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 -	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-888-982-3862 ကို ခေါ် ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-888-982-3862.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-888-982-3862 sin gåstu.
Cherokee -	Յ ԾУӨ Տ ℗ℎ ℬԾ <i>⅄ ⅄</i> ℎⅆℨℙⅆ℣ Მ℄ℸ (GWУ) Չ Ხ₩ℰℹՑ 1-888-982-3862 ℺Მℸ Ը АГⅆՆ <i>⅄</i> Ⅎℇ Ⴚ Ք <i>⅄</i> ℎℙℝ℈.
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 I p <u>a</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 kōkua nei.

हनि्दी में भाषा सहायता के लएि, ₁₋₈₈₈₋₉₈₂₋₃₈₆₂ पर मुफ्त कॉल करें।
Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-888-982-3862.
Maka enyemaka asụsụ na Igbo kpọọ 1-888-982-3862 na akwụghị ụgwọ ọ bụla
Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-888-982-3862 nga awan ti bayadanyo.
Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-888-982-3862.
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。
လ၊ တၢိမၢစားတၢိဳကတိုးကျိဉ်အဂ်ီ၊ ကျိဉ် ြာန888-982-3862 လ၊ တအိုဉ်ဒီးတၢိဳလ၊ ၁်ဘူဉ်လ၊ ၁်စူးဘဉ်
한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862 번으로 전화해 주십시오.
Ɓɛ´m`ké gbo-kpá-kpá dyé pidyi dé Ɓašɔɔ́-̀wùdุùùn wɛ̃ɛ, dá 1-888-982-3862
بر ای ر اهنمایی به زبان فارسی با شمار ه 3862-982-1888 به خوّر ایی پهیومندی بکهن.
ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ-888-982-3862 ໂດຍບໍ່ເສຍຄ່າໂທ.
कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-888-982-3862 वर फोन करा.
Ñan bōk jipañ ilo Kajin Majol, kallok 1-888-982-3862 ilo ejjelok wōnān.
Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-888-982-3862 ni sohte isais.
សម្ភរាប់ជំនួយភាសាជា ភាសាខុមរែ សូមទូរស័ព្ ទទ ៅកាន់លខេ 1-888-982-3862 ដ ោយឥតគិតថ្ ល។ៃ
T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-888-982-3862
(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-888-982-3862 मा फोन गर्नुहोस् ।
Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-888-982-3862 kecïn aɣöc.
For språkassistanse på norsk, ring 1-888-982-3862 kostnadsfritt.
ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-888-982-3862 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Fer Helfe in Deitsch, ruf: 1-888-982-3862 aa. Es Aaruf koschtet nix.
برای راهنمایی به زبان فارسی با شماره 1-888-982-3862 بدون هیچ هزینه ای تماس بگیرید. انگلیسی Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-888-982-3862.
Para obter assistência linguística em português ligue para o 1-888-982-3862 gratuitamente.
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.
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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 -	ר שבר רג א שביוו מאר שלב ד ממואיר הר לי ובשר זאל, שמ 1-888-982-3862 משי י
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-888-982-3862 nang walang bayad.
Telugu -	భాషతో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 1-888-982-3862 కు కాల్ చేయండి. (తెలుగు)
Thai -	สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-888-982-3862 ฟรีไม่มีค่าใช้จ่าย
Thai - Tongan -	สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-888-982-3862 ฟรีไม่มีค่าใช้จ่าย Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-888-982-3862 'o 'ikai hā ōtōngi.
Tongan -	Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-888-982-3862 'o 'ikai hā ōtōngi.
Tongan - Trukese -	Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-888-982-3862 'o 'ikai hā ōtōngi. Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-888-982-3862 nge esapw kamé ngonuk.
Tongan - Trukese - Turkish -	Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-888-982-3862 'o 'ikai hā ōtōngi. Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-888-982-3862 nge esapw kamé ngonuk. (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-888-982-3862.
Tongan - Trukese - Turkish - Ukrainian -	 Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-888-982-3862 'o 'ikai hā ōtōngi. Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-888-982-3862 nge esapw kamé ngonuk. (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-888-982-3862. Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-888-982-3862.
Tongan - Trukese - Turkish - Ukrainian - Urdu -	Караи 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-888-982-3862 'o 'ikai hā ōtōngi. Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-888-982-3862 nge esapw kamé ngonuk. (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-888-982-3862. Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-888-982-3862. устал слада стала стала стала стала стала сала сал