aetna® : TRS-ACTIVECARE : Aetna Open Access® Aetna Select℠ - ActiveCare Select

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.trsactivecareaetna.com or by calling 1-800-222-9205. 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 1-800-222-9205 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For each Plan Year, Network: Individual $1,200 / Family $3,600.	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. Prescription drugs; plus in-network office visits, urgent care 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?	Yes. $200 for prescription drug expenses. Doesn't apply to generic drugs. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Network: Individual $7,150 / Family $14,300.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover & penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.trsactivecareaetna.com or call 1-800-222-9205 for a list of 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
		Network Provider (You will pay the least)	Out–of–Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit, deductible doesn't apply; except 20% coinsurance for office surgery	Not covered	Includes Internist, General Physician, Family Practitioner, Pediatrician or Gynecologist.
	Specialist visit	$60 copay/visit, deductible doesn't apply; except 20% coinsurance for office surgery	Not covered	None
	Preventive care / screening / immunization	No charge, except $60 copay/visit for hearing exam	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)	20% coinsurance, except no charge for Quest facility	Not covered	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance after $100 copay/visit	Not covered	Pre-authorization may be required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out–of–Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition Prescription drug coverage is administered by CVS Caremark More information about prescription drug coverage is available at www.cvscaremark.com	Generic drugs	Copay/prescription, deductible doesn't apply: $20 (Retail first fill), $35 (Retail refill), $45 (Mail Order or Retail-*Plus*)	Copay/prescription, deductible doesn't apply: $20 (Retail first fill), $35 (Retail refill), $45 (Mail Order or Retail-*Plus*)	Covers 31 day supply (Retail), 60-90 day supply (Mail Order or Retail-*Plus*). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives in-network. Precertification & step therapy required. Your cost will be higher for choosing Brand over Generics unless prescribed Dispense as Written. Out-of-Network: reimbursement is the allowed amount for what would have been charged by a network pharmacy less the copay after the drug deductible is met.
	Preferred brand drugs	Copay/prescription, after specific deductible: $40 (Retail first fill), $60 (Retail refill), $105 (Mail Order or Retail-*Plus*)	Copay/prescription, after specific deductible: $40 (Retail first fill), $60 (Retail refill), $105 (Mail Order or Retail-*Plus*)	
	Non-preferred brand drugs	50% coinsurance, after specific deductible (Retail & Mail Order or Retail-*Plus*)	50% coinsurance, after specific deductible (Retail & Mail Order or Retail-*Plus*)	
	Specialty drugs	20% coinsurance, after specific deductible	Not covered	All Specialty drugs must be filled at Specialty Pharmacy. Retail not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after $150 copay/visit	Not covered	None
	Physician/surgeon fees	20% coinsurance	Not covered	None
If you need immediate medical attention	Emergency room care	20% coinsurance after $200 copay/visit	20% coinsurance after $200 copay/visit	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	$50 copay/visit, deductible doesn't apply	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after $150 copay/day first 5 days	Not covered	Maximum/plan year per individual: $2,250.
	Physician/surgeon fees	20% coinsurance	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out–of–Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Outpatient: 20% coinsurance Office: $60 copay/visit	Not covered	Pre-authorization may be required for care.
	Inpatient services	20% coinsurance after $150 copay/day first 5 days	Not covered	Maximum/plan year per individual: $2,250.
If you are pregnant	Office visits	No charge	Not covered	Cost sharing doesn't apply to certain preventive services. Maternity care may include tests & services described elsewhere in the SBC (i.e. ultrasound). Maximum/plan year per individual: $2,250.
	Childbirth/delivery professional services	20% coinsurance	Not covered	
	Childbirth/delivery facility services	20% coinsurance after $150 copay/day first 5 days	Not covered	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	60 visits/plan year.
	Rehabilitation services	$60 copay/visit, deductible doesn't apply	Not covered	None
	Habilitation services	$60 copay/visit, deductible doesn't apply	Not covered	Limited to treatment of Autism.
	Skilled nursing care	20% coinsurance	Not covered	25 days/plan year.
	Durable medical equipment	20% coinsurance	Not covered	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	20% coinsurance	Not covered	None
If your child needs dental or eye care	Children's eye exam	$60 copay/visit, deductible doesn't apply	Not covered	1 routine eye exam/plan year. Performed by an ophthalmologist or optometrist using calibrated instruments.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs - Except for required preventive services.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care - 35 visits/plan year.
- Hearing aids - $1,000 maximum/36 months.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.
- Routine eye care (Adult) - 1 routine eye exam/plan 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 1-800-222-9205.
- 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 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 to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-800-222-9205.
- 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 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.

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.----------

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	$1,200
Specialist copay	$60
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost $12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles*	$1,200
Copayments	$100
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,360**

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

The plan's overall deductible	$1,200
Specialist copay	$60
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost $7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$200
Copayments	$1,900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,120**

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

The plan's overall deductible	$1,200
Specialist copay	$60
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost $1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$1,200
Copayments	$300
Coinsurance	$30
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,530**

Note: If your plan has a wellness program and you choose to participate, you may be able to reduce your costs.
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above

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 1-800-222-9205.

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 on the basis of race, color, national origin, age, disability, or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Aetna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 14462, Lexington, KY 40512, 1-800-648-7817, TTY 711, Fax 859-425-3379, CRCoordinator@aetna.com.

California HMO/HNO Members: Civil Rights Coordinator, PO Box 24030 Fresno CA, 93779, 1-800-648-7817, TTY 711, Fax 860-262-7705, CRCoordinator@aetna.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

TTY: 711

Language Assistance:

For language assistance in your language call 1-800-222-9205 at no cost.

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-800-222-9205.
Amharic -	ለቋንቋ እገዛ በ አማርኛ በ 1-800-222-9205 በነጻ ይደውሉ
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-800-222-9205
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-800-222-9205 առանց գնով:
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-222-9205 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-800-222-9205 ku busa
Bengali-Bangala -	□□□□□□ □□□□ □□□□□□□□ □□□□ □□□□□□□□□□ 1-800-222-9205-□□ কল□□□□।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-222-9205 nga walay bayad.
Burmese -	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-800-222-9205 ကို ခေါ်ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-800-222-9205.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-800-222-9205 sin gåstu.
Cherokee -	□□□□ □□□□□□ □□□□□□□ □□□ (□□□) □□□□□□ 1-800-222-9205 □□□ □ □□□□ □□□□□ □□□□.
Chinese -	欲取得繁體中文語言協助，請撥打 1-800-222-9205，無需付費。
Choctaw -	(Chahta) anumpa ya apela a chi ɬ paya hinla 1-800-222-9205.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-800-222-9205 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-222-9205.
French -	Pour une assistance linguistique en français appeler le 1-800-222-9205 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-800-222-9205 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-222-9205 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-222-9205 χωρίς χρέωση.
Gujarati -	□□□□□□□□□□ □□□□□□□ □□□□ □□□□ □□□ ૧૮૭૧□□□ ૯૩૫-800-222-9205 ૫૨□□□ □□□.

Hawaiian - No ke kōkua ma ka ʻōlelo Hawaiʻi, e kahea aku i ka helu kelepona 1-800-222-9205. Kāki ʻole ʻia kēia kōkua nei.

Hindi - □□□□□□□ □□□ □□□□ □□□□□□□ □□ □□□, 1-800-222-9205 पर□□□□□□ □□□ □□□□□□

Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-800-222-9205.

Ibo - Maka enyemaka asụsụ na Igbo kpọọ 1-800-222-9205 na akwụghị ụgwọ ọ bụla

Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-222-9205 nga awan ti bayadanyo.

Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-800-222-9205.

Japanese - 日本語で援助をご希望の方は、1-800-222-9205 まで無料でお電話ください。

Karen - လၢတၢ်မၤစၢၤတၢ်ကတိၤကျိာ်အဂီၢ် ကျိာ် ကိး 1-800-222-9205 လၢတအိာ်ဒီးတၢ်လၢာ်ဘူးလၢာ်စ့ၤဘၣ်

Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-222-9205번으로 전화해 주십시오.

Kru-Bassa - Ɓɛ́ m̀ ké gbo-kpá-kpá dyé pídyi ɖé Ɓǎsɔ́ɔ̀-wùɖùǔn wɛ̃ɛ, ɖá 1-800-222-9205

Kurdish - برای راهنمایی به زبان فارسی با شماره 1-800-222-9205 به خۆڕایی پەیوەندی بکەن.

Laotian - □□, □□□□□□□□□□□□1-800-222-9205 □□□□□□□□□□□□□□□□□.

Marathi - □□□□□□□□(□□□□□□)□□□□□□□□□□□□1-800-222-9205 □□.

Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-800-222-9205 ilo ejjelok wōnān.

Micronesian-Pohnpeyan - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-800-222-9205 ni sohte isais.

Mon-Khmer, Cambodian - □□□□□□□□□□□□□□□□□□□□□□ □□□□□□□□□□ □□□□□□□□□□□□□□□□□□□□□□□□1-800-222-9205 □□□□□□□□□□□□□□□

Navajo - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-800-222-9205

Nepali - (□□□□□□□) □□ □□□□□□□□□ □□□□ 1-800-222-9205 □□ □□□ □□□□□□□□□□ । □□□□□□□ □□□□□□□ □□□□

Nilotic-Dinka - Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-800-222-9205 kecïn aɣöc.

Norwegian - For språkassistanse på norsk, ring 1-800-222-9205 kostnadsfritt.

Panjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-800-222-9205 ‘ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।

Pennsylvania Dutch - Fer Helfe in Deitsch, ruf: 1-800-222-9205 aa. Es Aaruf koschtet nix.

Persian - برای راهنمایی به زبان فارسی با شماره 1-800-222-9205 بدون هیچ هزینه ای تماس بگیرید. انگلیسی

Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-800-222-9205.

Portuguese -	Para obter assistência linguística em português ligue para o 1-800-222-9205 gratuitamente.
Romanian -	Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-800-222-9205
Russian -	Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-800-222-9205.
Samoan -	Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-800-222-9205 e aunoa ma se totogi.
Serbo-Croatian -	Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-800-222-9205.
Spanish -	Para obtener asistencia lingüística en español, llame sin cargo al 1-800-222-9205.
Sudanic-Fulfude -	Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-800-222-9205. Njodi woo fawaaki on.
Swahili -	Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-800-222-9205 bila malipo.
- Syriac	ܐܢ ܐܢܬ ܗܘܝܬ ܐܬܘܪܝܐ ܡܨܐܝܬ ܐܫܬܥܠ ܐܘܢܐ ܗܘ ܟܠ ܐܝܡܐ ܕܬܠܒܘܬ ܠ1-800-222-9205 ܡܓܢܐ.
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-800-222-9205 nang walang bayad.
Telugu - (□□□□□□□)	□□□□□ □□□□ □□□□□ □□□□□□ □□□□□ □□□□□□□ 1-800-222-9205 □□ □□□□ □□□□□□.
Thai - □□□□□□□□□□□□□□□□□□□□	□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□ ภาษาไทย 1-800-222-9205
Tongan -	Kapau ‘oku fiema'u hā tokoni ‘i he lea faka-Tonga telefoni 1-800-222-9205 ‘o ‘ikai hā tōtōngi.
Trukese -	Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-800-222-9205 nge esapw kamé ngonuk.
Turkish -	(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-800-222-9205.
Ukrainian -	Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-800-222-9205.
Urdu -	اریرک ل کفتم رپ 1-800-222-9205 ےعلکتنو اعمیننلل ریم و در
Vietnamese -	Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-800-222-9205.
Yiddish -	פאר שפראך הילף אין אידיש רופט 1-800-222-9205 פריי פון אפצאל.
Yoruba -	Fún ìrànlọ́wọ́ nípa èdè (Yorùbá) pe 1-800-222-9205 lái san owó kankan rárá.