Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services ILLINOIS INSTITUTE OF TECHNOLOGY: ♥aetna[™]

Open Choice®

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, https://www.aetnastudenthealth.com/ or by calling 1-877-480-4161. 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 1-877-480-4161 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	For each <u>Plan</u> Year, In- <u>Network</u> : Individual \$300. Out-of-Network: Individual \$400.	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.
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Prescription drugs;</u> plus in-network <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>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 \$6,850 / Family \$13,700.	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</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>Premiums</u> , <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 1-877- 480-4161 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	ı 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	20% coinsurance	40% coinsurance	None	
lf you visit a health	<u>Specialist</u> visit	20% coinsurance	40% coinsurance	None	
care <u>provider</u> 's office or clinic	Preventive care /screening /immunization	No charge	20% <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.	
16	Diagnostic test (x-ray, blood work)	20% coinsurance	40% <u>coinsurance</u>	None	
If you have a test	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	None	
If you need drugs to treat your	Generic drugs	Copay/prescription, deductible doesn't apply: \$12 (retail)	Not covered	Covers 30 day supply (retail). Includes	
illness or condition	Preferred brand drugs	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$40 (retail)	Not covered	contraceptive drugs & devices obtainable from a pharmacy, oral & injectable fertility drugs. No charge for preferred generic FDA-approved	
More information about <u>prescription</u> <u>drug coverage</u> is available at	Non-preferred brand drugs	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$55 (retail)	Not covered	women's contraceptives in- <u>network</u> .	
https://www.aetna.c om/individuals- families/pharmacy.h tml	Specialty drugs	20% coinsurance up to maximum/ prescription, <u>deductible</u> doesn't apply: \$150 (retail)	Not covered	None	
	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None	
lf you have outpatient surgery	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None	

	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 need	Emergency room care	20% <u>coinsurance</u>	20% coinsurance	No coverage for non-emergency use.	
immediate medical	Emergency medical transportation	20% coinsurance	20% coinsurance	None	
attention	<u>Urgent care</u>	20% coinsurance	40% coinsurance	No coverage for non-urgent use.	
If you have a	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% coinsurance	Pre-authorization required for out-of-network care.	
hospital stay	Physician/surgeon fees	20% <u>coinsurance</u>	40% coinsurance	None	
lf you need mental health, behavioral health, or	Outpatient services	Office & other outpatient services: 20% <u>coinsurance</u>	Office & other outpatient services: 40% <u>coinsurance</u>	None	
substance abuse services	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required for out-of-network care.	
	Office visits	No charge	20% <u>coinsurance,</u> <u>deductible</u> doesn't apply	Cost sharing does not apply for preventive	
lf you are pregnant	Childbirth/delivery professional services	20% <u>coinsurance,</u> <u>deductible</u> doesn't apply	40% <u>coinsurance,</u> <u>deductible</u> doesn't apply	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	20% <u>coinsurance,</u> <u>deductible</u> doesn't apply	40% <u>coinsurance,</u> <u>deductible</u> doesn't apply	network care may apply.	
	Home health care	20% coinsurance	40% coinsurance	None	
	Rehabilitation services	20% coinsurance	40% coinsurance	Includes Physical, Occupational & Speech	
lf you need help	Habilitation services	20% coinsurance	40% <u>coinsurance</u>	Therapy.	
If you need help recovering or have other special health needs	Skilled nursing care	20% <u>coinsurance</u>	40% coinsurance	Pre-authorization required for out-of-network care.	
	Durable medical equipment	0% <u>coinsurance</u>	20% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.	
	Hospice services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required for out-of-network care.	

Common Medical Event	Services You May Need		ı Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
	Children's eye exam	No charge	20% <u>coinsurance,</u> <u>deductible</u> doesn't apply	None	
lf your child needs dental or eye care	Children's glasses	No charge	20% <u>coinsurance,</u> <u>deductible</u> doesn't apply	1 pair of glasses or lenses/ <u>plan</u> year.	
	Children's dental check-up	No charge	30% <u>coinsurance</u>	None	

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)

- Long-term care
- Private-duty nursing
- Routine eye care (Adult)

- 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.)

•	Abortion	٠	Infertility treatment - Limited to the diagnosis	٠	Non-emergency care when traveling outside the U.S.
•	Acupuncture		& treatment of underlying medical condition,		
•	Bariatric surgery		artificial insemination & ovulation induction.		
•	Chiropractic care		Advanced reproductive technology: 4 oocyte		
•	Hearing aids - 1 hearing aid per ear/24		retrievals, if life birth 2 additional retrievals.		
	months.				

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: Illinois Department of Insurance, Office of Consumer Health Insurance, 1-877-527-9431 toll free, 1-866-323-5321 (TDD), <u>http://insurance.illinois.gov/</u>.

• For more information on your rights to continue coverage, contact the plan at 1-877-480-4161.

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 1-877-480-4161.
- Illinois Department of Insurance, Office of Consumer Health Insurance, 1-877-527-9431 toll free, 1-866-323-5321 (TDD), http://insurance.illinois.gov/.
- Additionally, a consumer assistance program can help you file your <u>appeal</u>. Contact Office of Consumer Health Insurance, Consumer Services Section, 122 South Michigan Avenue, 19th floor, Chicago, IL 60603, Or 320 W. Washington Street, Springfield, IL 62767-0001, 877-527-9431, 1-866-323-5321 (TDD), http://insurance.illinois.gov/

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? 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 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	\$200
Specialist coinsurance	20%
Hospital (facility) <u>coinsurance</u>	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	\$12,700	
In this example, Peg would pay:		
Cost Sharing		
<u>Deductibles</u>	\$300	
<u>Copayments</u>	\$40	
<u>Coinsurance</u>	\$2,500	
What isn't covered		
Limits or exclusions	\$60	
The total Peg would pay is	\$2,900	

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

The <u>plan's</u> overall <u>deductible</u>	\$200
Specialist coinsurance	20%
Hospital (facility) <u>coinsurance</u>	20%
Other <u>coinsurance</u>	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	\$5,600
In this example, Joe would pay:	
Cost Sharing	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$1,300
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,820

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

The plan's overall deductible	\$200
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	\$2,800
In this example, Mia would pay:	
<u>Cost Sharing</u>	
Deductibles	\$300
Copayments	\$0
Coinsurance	\$300
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$600

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 1-877-480-4161.

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 <u>https://ocrportal.hhs.gov/ocr/portal/lobby.jsf</u>, 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.

TTY: 711

Language Assistance:

For language assistance in your language call 1-877-480-4161 at no cost.

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-877-480-4161.		
Amharic -	ለቋንቋ እንዛ በ አማርኛ በ 1-877-480-4161 በነጻ ይደውሉ		
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-877-480-4161		
Armenian -	Հեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-877-480-4161 առանցգնով։		
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-877-480-4161 tanpa dikenakan biaya.		
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-877-480-4161 ku busa		
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বিনামুল্যে1-877-480-4161-তে কল করুন।		
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-877-480-4161 nga walay bayad.		
Burmese -	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-877-480-4161 ကို ခေါ် ဆိုပါ။		
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-877-480-4161.		
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-877-480-4161 sin gåstu.		
Cherokee -	Յℴ ⅌℣℈ ℁℗ℎℬℴ⅌ℳℎℴ⅁℁ℙℴ⅌℣ ℈℄ℸ(GWУ) ℗ℎℍℰ℩℁1-877-480-4161 ℺℮ℸℒÅℾℴ⅌ℳⅆℇ℞ℙℳℎℙℝ℈		
Chinese -	欲取得繁體中文語言協助,請撥打1-877-480-4161,無需付費。		
Choctaw -	(Chahta) anumpa y <u>a</u> apela a chi I p <u>a</u> ya hinla 1-877-480-4161.		
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-877-480-4161 irratti bilisaan bilbilaa.		
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-877-480-4161.		
French-	Pour une assistance linguistique en français appeler le 1-877-480-4161 sans frais.		
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-877-480-4161 gratis.		
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-877-480-4161 an.		
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-877-480-4161 χωρίς χρέωση.		
Gujarati -	ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-877-480-4161 પર કૉલ કરો.		

-lawaiian -	No ke kōkua ma ka 'ōlelo Hawai'i, e kahea aku i ka helu kelepona 1-877-480-4161. Kāki 'ole 'ia kēia kōkua nei.			
-lindi -	हनिदी में भाषा सहायता के लएि, 1-877-480-4161 पर मुफ्त कॉल करें।			
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-877-480-4161.			
bo -	Maka enyemaka asụsụ na Igbo kpọọ 1-877-480-4161 na akwụghị ụgwọ ọ bụla			
locano -	Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-877-480-4161 nga awan ti bayadanyo.			
talian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-877-480-4161.			
Japanese -	日本語で援助をご希望の方は、1-877-480-4161 まで無料でお電話ください。			
Karen -	လ၊ တၢိမၢစၢၤတၢိကတိၢကိုုဉ်အင်္ဂါ ကိုုဉ် ကိႏ 1-877-480-4161 လ၊ တအိုဉ်ဒီးတၢ်လ၊ ၁်ဘူဉ်လ၊ ၁်စူးဘဉ်			
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-877-480-4161 번으로 전화해 주십시오.			
Kru-Bassa -	Ɓε´m`ké gbo-kpá-kpá dyé pidyi dé Ɓašɔɔ́-̀wùdุuùǐn wɛ̃ɛ, dá 1-877-480-4161			
Kurdish -	بر اي ر اهنمايي به زبان فارسي با شمار ه 4161-480-877 به خوّر ايي پهيو مندي بکهن.			
Laotian - Marathi -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-877-480-4161 ໂດຍບໍ່ເສຍຄ່າໂທ. कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-877-480-4161 वर फोन करा.			
Marshallese -	Ñan bōk jipañ ilo Kajin Majol, kallok 1-877-480-4161 ilo ejjelok wōnān.			
Micronesian- Pohnpeyan - Mon-Khmer, Cambodian -	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-877-480-4161 ni sohte isais. សម្ភាប់ជំនួយភាសាជា ភាសាខុមរែ សូមទូរស័ព្ទទទៅកាន់លខេ 1-877-480-4161 ដោយឥតគិតថុល។ៃ			
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-877-480-4161			
Nepali -	(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि १- 🛛 ८७७-४१६१मा फोन गर्नुहोस् ।			
Nilotic-Dinka -	Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl1-877-480-4161 kecïn aγöc.			
Norwegian -	For språkassistanse på norsk, ring 1-877-480-4161 kostnadsfritt.			
Panjabi -	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-877-480-4161 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।			
Pennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-877-480-4161 aa. Es Aaruf koschtet nix.			
Persian - Polish -	بر ای راهنمایی به زبان فارسی با شماره ۲۵۵-4۱۵۱ ۱-۵۶۶-۱۰ بدون هیچ هزینه ای تماس بگیرید. انگلیسی Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-877-480-4161.			

Portuguese -	Para obter assistência linguística em j	português ligue para o 1-87	7-480-4161 gratuitamente.
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- Romanian Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-877-480-4161
- Russian Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-877-480-4161.
- Samoan Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-877-480-4161 e aunoa ma se totogi.
- Serbo-Croatian Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-877-480-4161.
- Spanish Para obtener asistencia lingüística en español, llame sin cargo al 1-877-480-4161.
- Sudanic-Fulfude Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-877-480-4161. Njodi woo fawaaki on.
- Swahili Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-877-480-4161 bila malipo.
- Tagalog -Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-877-480-4161 nang walang bayad.
- Telugu భాషతో సాయం కొరకు ఎలాంటి ఖర్పు లేకుండా 1-877-480-4161 కు కాల్ చేయండి. (తెలుగు)
- Thai- สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-877-480-4161 ฟรีไม่มีค่าใช้จ่าย
- Tongan- Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-877-480-4161 'o 'ikai hā ōtōngi.
- Trukese Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-877-480-4161 nge esapw kamé ngonuk.
- Turkish (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-877-480-4161.
- Ukrainian Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-877-480-4161.
- Urdu -

بلاقیمت زیان سے متعلقہ خدمات حاصل کرنے کے لیے [،] '₁₋₁₋₁877-480 ۔ پر بات کریں۔

- Vietnamese Đê'được hố trơ ngôn ngữ bằng (ngôn ngữ), hấy gọi miến phi đên số 1-877-480-4161.
- Yiddish- פאר שפראך הילף אין אידיש רופט 1-877-480-4161 פריי פון אפצאל.
- Yoruba Fún ìrànlowo nípa èdè (Yorùbá) pe 1-877-480-4161 lái san owó kankan rárá.