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, visit http://home.commonspirit.org/employeecentral/mybenefits or call 1-844-450-9450, option 1. 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 www.healthcare.gov/sbc-glossary or call 1-844-450-9450, option 1, to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Enhanced Network Provider (CIN): **$2,800** individual /**$5,600** family per calendar year In-Network (IN) Provider: **$2,800** individual /**$5,600** family per calendar year Out of Network: No coverage	Generally, you must pay all 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. Well-child care, preventive drug list medications and 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 www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Enhanced Network Provider (CIN): **$4,000** individual /**$8,000** family per calendar year In-Network (IN) Provider: **$6,450** individual /**$12,900** family per calendar year Out of Network: No coverage	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, pre-service review penalties, balance-billed charges, and health care this plan doesn't cover.	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. You have two levels for network providers. Enhanced Network Level: CHI Texas Health Network In-Network Level: Aetna Open Access, Aetna Select℠ Network, see www.aetna-commonspirit.com or call 1-866-925-1543 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. 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
		Enhanced Network Provider/CIN (You will pay the least)	In-Network Provider (You will pay more)	Out-of- Network Provider (Not covered)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	15% coinsurance	20% coinsurance	Not covered	Primary Care Physicians (PCP) are defined as General and Family Practice, Internal Medicine, OB/GYN, Pediatricians, Nurse Practitioners and PAs. Enhanced level/Level 1 services are facility services received at and provided by physicians recognized by CHI Texas Health Network. Level 2 services are in-network providers. Level 3 services are out-of-network and are not covered.
	Specialist visit	20% coinsurance	25% coinsurance	Not covered	Applies to Non-PCP provider types
	Preventive care/screening/ immunization	No charge Deductible does not apply	No charge Deductible does not apply	Not covered	See www.healthcare.gov for preventive care guidelines. There may be additional benefits available. See your Employer Summary Plan Description for details. 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)	15% coinsurance	25% coinsurance	Not covered	For a test in a provider's office or clinic, your cost is included in the cost-share listed above.
	Imaging (CT/PET scans, MRIs)	15% coinsurance	25% coinsurance	Not covered	None

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
		Enhanced Network Provider/CIN (You will pay the least)	In-Network Provider (You will pay more)	Out-of- Network Provider (Not covered)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com For specialty prescriptions, go to www.dignityhealth.org/arizona/locations/stjosephs/services/pharmacy	Generic drugs	Retail: $5 copay Home delivery: $12.50 copay	Retail: $10 copay Home delivery: $25 copay	60% coinsurance	Covers up to a 30-day supply from an in-network retail pharmacy or a 90-day supply from a home delivery pharmacy. If you fill a brand-name prescription when a generic equivalent is available, you will pay the brand-name coinsurance plus the difference between the generic and brand-name. Maintenance medications must be filled for a 90-day supply using the CommonSpirit Health home delivery pharmacy, OptumRx Home Delivery, or a Walgreens retail network pharmacy. Any combination of diabetic supplies and insulin purchased at a network retail pharmacy on the same day are subject to one copayment or the applicable coinsurance amount. Additional copayment / coinsurance amounts will apply to any combination of supplies purchased separately from an insulin purchase. Specialty prescriptions must be processed through the CommonSpirit Health Specialty Pharmacy. If the CommonSpirit Health Specialty Pharmacy can't fill your medication, your prescription will be routed to the OptumRx Specialty Pharmacy.
	Preferred brand drugs	15% coinsurance Retail: $20 min/$55 max Home delivery: $50 min/$87.50 max	30% coinsurance Retail: $40 min/$110 max Home delivery: $100 min/$175 max	60% coinsurance	
	Non-preferred brand drugs	25% coinsurance Retail: $32.50 min/$80 max Home delivery: $80 min/$162.50 max	50% coinsurance Retail: $65 min/$160 max Home delivery: $160 min/$325 max	60% coinsurance	
	Specialty drugs	Refer to above costs	Refer to above costs	Refer to above costs	

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
		Enhanced Network Provider/CIN (You will pay the least)	In-Network Provider (You will pay more)	Out-of- Network Provider (Not covered)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	25% coinsurance	Not covered	Waive coinsurance on first colonoscopy of the benefit period.
	Physician/ surgeon fees	15% coinsurance	25% coinsurance	Not covered	None
If you need immediate medical attention	Emergency room care	$200 copay per facility per date of service for facility and physician(s) services combined	$200 copay per facility per date of service for facility and physician(s) services combined	$200 copay per facility per date of service for facility and physician(s) services combined Deductible does not apply	50% coinsurance applies to non-emergency medical services. For emergency medical conditions treated out-of-network, you may be balance billed. Dental treatment for accidental injury is limited to care completed within 12 months of the injury.
	Emergency medical transportation	No charge after deductible	No charge after deductible	No charge after deductible	Ambulance services received from an out-of-network provider may balance bill the difference in the billed amount and the allowed amount.
	Urgent care	$50 copay per provider per date of service	$75 copay per provider per date of service	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	25% coinsurance	Not covered	Reduction for failure to pre-certify services is $500 per admission.
	Physician/ surgeon fees	15% coinsurance	25% coinsurance	Not covered	None

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
		Enhanced Network Provider/CIN (You will pay the least)	In-Network Provider (You will pay more)	Out-of- Network Provider (Not covered)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office PCP and Facility: 15% coinsurance	Office PCP: 20% coinsurance Facility: 25% coinsurance	Not covered	None
	Inpatient services	15% coinsurance	25% coinsurance	Not covered	Residential treatment is covered with no 24-hour nursing supervision requirement. Reduction for failure to pre-certify services is $500 per admission.
If you are pregnant	Office visits	Office PCP and Facility: 15% coinsurance	Office PCP: 20% coinsurance Facility: 25% coinsurance	Not covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply to certain preventive services. Any in-network services that fall outside of preventive care/routine obstetric care, will pay at the most appropriate benefit in the plan document.
	Childbirth/ delivery professional services	15% coinsurance	25% coinsurance	Not covered	Benefits shown reflect OB/GYN practitioner services which may be globally billed at time of delivery for pre-natal, post-natal and delivery services. Not all services are billed globally.
	Childbirth/ delivery facility services	15% coinsurance	25% coinsurance	Not covered	None

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
		Enhanced Network Provider/CIN (You will pay the least)	In-Network Provider (You will pay more)	Out-of- Network Provider (Not covered)	
If you need help recovering or have other special health needs	Home health care	15% coinsurance	25% coinsurance	Not covered	None
	Rehabilitation services	Office PCP and Facility: 15% coinsurance Office Non-PCP: 20% coinsurance	Office PCP: 20% coinsurance Office Non-PCP and Facility: 25% coinsurance	Not covered	In-Network outpatient/office physical, speech and occupational therapies are limited to 30 combined visits per calendar year. CommonSpirit Health Provider/Facility aka Enhanced Network is not subject to 30-visit maximum.
	Habilitation services	Office PCP and Facility: 15% coinsurance Office Non-PCP: 20% coinsurance	Office PCP: 20% coinsurance Office Non-PCP and Facility: 25% coinsurance	Not covered	
	Skilled nursing care	15% coinsurance	25% coinsurance	Not covered	Reduction for failure to pre-certify services is $500 per admission.
	Durable medical equipment	15% coinsurance	25% coinsurance	Not covered	One wig per calendar year is covered when related to medical condition. 2 pair of foot orthotics covered per calendar year.
	Hospice services	15% coinsurance	25% coinsurance	Not covered	Hospice respite care is limited to 15 inpatient and 15 outpatient days per lifetime.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	Not covered	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
- Custodial care – in home or facility
- Dental care
- Eye exam
- Glasses
- Hearing aids
- Long-term care
- Massage therapy
- Routine eye care – Adult
- Routine foot care
- Weight loss programs

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

- Acupuncture (10 visits per calendar year)
- Bariatric surgery (covered only at CommonSpirit Health facility locations)
- Chiropractic care (20 visits per calendar year)
- Infertility treatment ($15,000 LTM, $5,000 LTM for infertility medications, excludes some services)
- Private-duty nursing – short-term intermittent home skilled nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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: CommonSpirit Health Benefits Contact Center at 1-844-450-9450, option 1; Aetna Customer Service at 1-866-925-1543; or Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 the 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 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 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	**$2,800**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**25%**
Other coinsurance	**25%**

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	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$**2,800**
Copayments	$0
Coinsurance	$2,495
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,355**

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

The plan's overall deductible	**$2,800**
Primary care coinsurance	**20%**
Hospital (facility) coinsurance	**25%**
Other coinsurance	**25%**

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	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$**2,800**
Copayments	$310
Coinsurance	$1,072
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$4,242**

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

The plan's overall deductible	**$2,800**
Hospital (facility) coinsurance	**25%**
Other coinsurance	**25%**

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	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,010
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,010**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

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 እገዛ በ አማርኛ በ 1-888-982-3862 በነጻ ይደውሉ
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-888-982-3862
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 ခေါ်ဆိုပါ။
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 -	ᎾᏍᎩᎾ ᏕᏬᏂᎯᏍᏗ ᏗᏂᏍᏕᎵᏍᎩ ᎾᏛᎢ (ᏣᎳᎩ) ᏫᏓᎳᏅᎯᏍ 1-888-982-3862 ᎤᎾᎢ ᏝᎪᎱᏍᏗ ᏧᎬᏩᎶᏗ ᏂᎨᏒᎾ.
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 ya apela a chi I paya 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 કોલ કરો.
Hawaiian -	No ke kōkua ma ka ʻōlelo Hawaiʻi, e kahea aku i ka helu kelepona 1-888-982-3862. Kāki ʻole ʻia kēia kōkua nei.

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.
Ibo -	Maka enyemaka asụsụ na Igbo kpọọ 1-888-982-3862 na akwụghị ụgwọ ọ bụla
Ilocano -	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 -	လၢတၢ်မၤစၢးတၢ်ကတိၤကျိာ်အဂီၢ် ကျိာ် ကိး 1-888-982-3862 လၢတအိဉ်ဒီးတၢ်လၢာ်ဘျုာ်လၢာ်စုးဘဉ်
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862 번으로 전화해 주십시오.
Kru-Bassa -	Bɛ́m̀ké gbo-kpá-kpá dyé pídyi dé Bǎsɔ́ɔ̀-wùdùǔn wɛ̃ɛ, dá 1-888-982-3862
Kurdish -	برای راهنمایی به زبان فارسی با شماره 1-888-982-3862 به خۆرایی پەیوەندی بکەن.
Laotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ1-888-982-3862 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 cɔl 1-888-982-3862 kecïn ayöc.
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 Dutch -	Fer Helfe in Deitsch, ruf: 1-888-982-3862 aa. Es Aaruf koschtet nix.
Persian -	برای راهنمایی به زبان فارسی با شماره 1-888-982-3862 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 asistenţă lingvistică în româneşte telefonaţi 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 - [illegible] 1-888-982-3862 [illegible]

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

Tongan - Kapau ‘oku fiema'u hā tokoni ‘i he lea faka-Tonga telefoni 1-888-982-3862 ‘o ‘ikai hā ōtōngi.

Trukese - Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-888-982-3862 nge esapw kamé 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 - اردو میں لسانی معاونت کے لیے 1-888-982-3862 پر مفت کال کریں۔

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.

Yoruba - Fún ìrànlọwọ nípa èdè (Yorùbá) pe 1-888-982-3862 lái san owó kankan rárá.