

ANGELO STATE: 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 Year</u> , In- <u>Network</u> : Individual \$500 / Family \$1,000. Out-of- <u>Network</u> : Individual \$1,500 / Family \$3,000.                     | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .   |
| Are there services covered before you meet your <u>deductible</u> ? | Yes. <u>Prescription drugs</u> ; plus in- <u>network</u> office visits & <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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>  |
| Are there other <u>deductibles</u> for specific services?           | No.   | You don't have to meet <u>deductibles</u> for specific services.  |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?       | In- <u>Network</u> : Individual \$7,900 / Family \$15,800. Out-of- <u>Network</u> : Individual \$15,800 / Family \$31,600.  | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.   |
| What is not included in the <u>out-of-pocket limit</u> ?            | <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 <a href="http://www.aetna.com/docfind">www.aetna.com/docfind</a> 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 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 charge</u> 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 **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  |
|---|---|--|---|---|
|   |   | In-Network Provider<br>(You will pay the least)                            | Out-of-Network Provider<br>(You will pay the most)  |   |
| <b>If you visit a health care provider's office or clinic</b>   | Primary care visit to treat an injury or illness        | \$50 <u>copay</u> /visit, <u>deductible</u> doesn't apply                  | 50% <u>coinsurance</u>  | None  |
|   | <u>Specialist</u> visit                                 | \$50 <u>copay</u> /visit, <u>deductible</u> doesn't apply                  | 50% <u>coinsurance</u>  | None  |
|   | <u>Preventive care</u> / <u>screening</u> /immunization | No charge  | 50% <u>coinsurance</u> , except no charge for immunizations up to age 6                                 | 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.                   |
| <b>If you have a test</b>   | <u>Diagnostic test</u> (x-ray, blood work)              | 25% <u>coinsurance</u>   | 50% <u>coinsurance</u>  | None  |
|   | Imaging (CT/PET scans, MRIs)                            | 25% <u>coinsurance</u>   | 50% <u>coinsurance</u>  | None  |
| <b>If you need drugs to treat your illness or condition</b><br><br>More information about <b>prescription drug coverage</b> is available at <a href="https://www.aetna.com/individuals-families/pharmacy.html">https://www.aetna.com/individuals-families/pharmacy.html</a> | Generic drugs   | <u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$15 (retail) | 40% <u>coinsurance</u> after <u>copay</u> /prescription, <u>deductible</u> doesn't apply: \$15 (retail) | Covers 30 day supply (retail). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives <u>in-network</u> . |
|   | Preferred brand drugs                                   | <u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$50 (retail) | 40% <u>coinsurance</u> after <u>copay</u> /prescription, <u>deductible</u> doesn't apply: \$50 (retail) |   |
|   | Non-preferred brand drugs                               | <u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$65 (retail) | 40% <u>coinsurance</u> after <u>copay</u> /prescription, <u>deductible</u> doesn't apply: \$65 (retail) |   |

| Common Medical Event   | Services You May Need                          | What You Will Pay   |   | Limitations, Exceptions, & Other Important Information   |
|--|--|---|---|--|
|  |  | In-Network Provider<br>(You will pay the least)   | Out-of-Network Provider<br>(You will pay the most)                                      |  |
|  | <u>Specialty drugs</u>                         | <u>Copay/prescription, deductible doesn't apply: \$150</u>  | 40% <u>coinsurance</u> after <u>copay/prescription, deductible doesn't apply: \$150</u> | None   |
| <b>If you have outpatient surgery</b>  | Facility fee (e.g., ambulatory surgery center) | 25% <u>coinsurance</u>  | 50% <u>coinsurance</u>  | None   |
|  | Physician/surgeon fees                         | 25% <u>coinsurance</u>  | 50% <u>coinsurance</u>  | None   |
| <b>If you need immediate medical attention</b>                                   | <u>Emergency room care</u>                     | 25% <u>coinsurance</u> after \$200 <u>copay/visit</u>   | 25% <u>coinsurance</u> after \$200 <u>copay/visit</u>                                   | No coverage for non-emergency use.   |
|  | <u>Emergency medical transportation</u>        | 25% <u>coinsurance</u>  | 25% <u>coinsurance</u>  | None   |
|  | <u>Urgent care</u>                             | \$50 <u>copay/visit</u> , deductible doesn't apply  | 50% <u>coinsurance</u>  | No coverage for non-urgent use.  |
| <b>If you have a hospital stay</b>   | Facility fee (e.g., hospital room)             | 25% <u>coinsurance</u>  | 50% <u>coinsurance</u>  | Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care.   |
|  | Physician/surgeon fees                         | 25% <u>coinsurance</u>  | 50% <u>coinsurance</u>  | None   |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                            | Office: 100% <u>coinsurance</u> after \$50 <u>copay/visit</u> , deductible doesn't apply; other outpatient services: 25% <u>coinsurance</u> | Office & other outpatient services: 50% <u>coinsurance</u>                              | None   |
|  | Inpatient services                             | 25% <u>coinsurance</u>  | 50% <u>coinsurance</u>  | Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care.   |
| <b>If you are pregnant</b>   | Office visits                                  | No charge   | 50% <u>coinsurance</u>  | <u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care may apply. |
|  | Childbirth/delivery professional services      | 25% <u>coinsurance</u> , deductible doesn't apply   | 50% <u>coinsurance</u>  |  |
|  | Childbirth/delivery facility services          | 25% <u>coinsurance</u> , deductible doesn't apply   | 50% <u>coinsurance</u>  |  |

| Common Medical Event   | Services You May Need            | What You Will Pay                               |  | Limitations, Exceptions, & Other Important Information  |
|--|----------------------------------|---|--|---|
|  |                                  | In-Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |   |
| If you need help recovering or have other special health needs | <u>Home health care</u>          | 25% <u>coinsurance</u>                          | 50% <u>coinsurance</u>                             | 60 Visits per policy year<br>Includes Physical, Occupational & Speech Therapy.<br>Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care. 25 days per policy year.<br>Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.<br>Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care. |
|  | <u>Rehabilitation services</u>   | 25% <u>coinsurance</u>                          | 50% <u>coinsurance</u>                             |   |
|  | <u>Habilitation services</u>     | 25% <u>coinsurance</u>                          | 50% <u>coinsurance</u>                             |   |
|  | <u>Skilled nursing care</u>      | 25% <u>coinsurance</u>                          | 50% <u>coinsurance</u>                             |   |
|  | <u>Durable medical equipment</u> | 25% <u>coinsurance</u>                          | 50% <u>coinsurance</u>                             |   |
|  | <u>Hospice services</u>          | 25% <u>coinsurance</u>                          | 50% <u>coinsurance</u>                             |   |
| If your child needs dental or eye care                         | Children's eye exam              | No charge                                       | 50% <u>coinsurance</u>                             | 1 routine eye exam/ <u>plan</u> year up to age 19.  |
|  | Children's glasses               | No charge                                       | 50% <u>coinsurance</u>                             | 1 pair of glasses or lenses/ <u>plan</u> year.  |
|  | Children's dental check-up       | No charge                                       | No charge  | 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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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.)

- Chiropractic care
- Hearing aids - 1 hearing aid per ear/36 months.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.

### **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: Texas Department of Insurance, 1-800-252-3439, <https://www.tdi.texas.gov/consumer/index.html>.

- 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 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 1-877-480-4161.
- Texas Department of Insurance, 1-800-252-3439, <https://www.tdi.texas.gov/consumer/index.html>.
- Additionally, a consumer assistance program can help you file your appeal. Contact Texas Department of Insurance, Consumer Protection, Mail Code 111-1A, 333 Guadalupe, P.O. Box 149091, Austin, TX 78714-9091, Phone toll-free: 1-800-252-3439, <http://www.texashealthoptions.com>, [ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov)

### **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 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.*-----

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 \$500
- Specialist copayment \$50
- 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,800</b> |
|---------------------------|-----------------|

**In this example, Peg would pay:**

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$500          |
| Copayments                        | \$100          |
| Coinsurance                       | \$3,000        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$3,660</b> |

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

- The plan's overall deductible \$500
- Specialist copayment \$50
- 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$7,400</b> |
|---------------------------|----------------|

**In this example, Joe would pay:**

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$100          |
| Copayments                        | \$1,900        |
| Coinsurance                       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$2,020</b> |

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

- The plan's overall deductible \$500
- Specialist copayment \$50
- 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$1,900</b> |
|---------------------------|----------------|

**In this example, Mia would pay:**

| <i>Cost Sharing</i>               |              |
|-----------------------------------|--------------|
| Deductibles                       | \$500        |
| Copayments                        | \$100        |
| Coinsurance                       | \$300        |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$900</b> |

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](mailto:CRCoordinator@aetna.com)

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

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







- Hawaiian - 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.
- Hindi - हनिदी में भाषा सहायता के लिए, 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.
- Ibo - Maka enyemaka asụsụ na Igbo kpọọ 1-877-480-4161 na akwụghị ugwọ ọ bụla
- Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-877-480-4161 nga awan ti bayadanyo.
- Italian - 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 - လာဘာမရဘဲလဲကတိတ်ကျိပ်အင်္ဂါ ကျိပ် ကိး 1-877-480-4161 လာဘာအိတ်ဒီးဘာလာဘာကျိပ်လာဘာကျိပ်
- Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-877-480-4161 번으로 전화해 주십시오.
- Kru-Bassa - Ɓe m'ké gbo-kpá-kpá dyé pídyi dé Ɓáwó-wuḍuŋ wɛɛ, dǎ 1-877-480-4161
- Kurdish - برآی راهنمایی به زبان فارسی با شماره 1-877-480-4161 به خورایی یه یومندی بکن.
- Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ1-877-480-4161 ໂດຍບໍ່ເສຍຄ່າໂທ.
- Marathi - तीलभाषा (मराठी) सहाय्यासाठी 1-877-480-4161 क्रमांकावरकोणत्याहीखर्चाशिवायकॉलकरा.
- Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-877-480-4161 ilo ejjelok wōnān.
- Micronesian-Pohnpeyan - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-877-480-4161 ni sohte isais.
- Mon-Khmer, Cambodian - សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទទេកាន់លេខ 1-877-480-4161 ដោយឥតគិតថ្លៃ។
- 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 1- 877-480-4161 मा फोन गर्नुहोस् ।
- Nilotic-Dinka - Tën kuwoony ë thok ë Thuonjäng col 1-877-480-4161 kec'in ayöc.
- Norwegian - For språkassistanse på norsk, ring 1-877-480-4161 kostnadsfritt.
- Panjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-877-480-4161 'ਤੇ ਮੁਫਤ ਕਾਲ ਕਰੋ।
- Pennsylvania Dutch - Fer Hefte in Deitsch, ruf: 1-877-480-4161 aa. Es Aaruf koschtet nix.
- Persian - برآی راهنمایی به زبان فارسی با شماره 1-877-480-4161 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
- Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-877-480-4161.

- Portuguese - Para obter assistência linguística em português ligue para o 1-877-480-4161 gratuitamente.
- 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 totagi.
- 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 hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-877-480-4161. Njodi woo fawaaki on.
- Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-877-480-4161 bila malipo.
- Syriac - ܟܠ ܥܡܟܢ ܟܠ ܕܗ ܡܫܚܝܢ ܕܗܟܠ ܥܠܟܠ ܟܠ ܗܘܢܝܟܠ ܡܟܠ ܕܗܝ ܝܗܘܟܠ ܕܗܠܗܝܟܠ ܕܗܠܗܝܟܠ 1-877-480-4161 ܕܗܠܗܝܟܠ.
- Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-877-480-4161 nang walang bayad.
- Telugu - భాషతో సాయం కోరకు ఎలాంటి ఖర్చు 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 ʻōtōngi.
- Trukese - Ren ánninnisin chiakú ren (Kapasen Chuuk) kopwe kékkéeri 1-877-480-4161 nge esapw kamé ngonuk.
- Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemedен 1-877-480-4161.
- Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-877-480-4161.
- Urdu - اری رکال گفتفام رپ 1-877-480-4161 حول کیستن و اع م عن ملزل ریم و در
- Vietnamese - Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-877-480-4161.
- Yiddish - פאר שפראך הילף אין אידיש רופט 1-877-480-4161 פא"ן אפצאל.
- Yoruba - Fún ìrànṣọwọ nípa èdè (Yorùbá) pe 1-877-480-4161 láí san owó kankan rárá.