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

Coverage Period: 01/01/2025-12/31/2025

Coverage for: Individual + Family | Plan Type: PPO

LAUNDRY AND DRY CLEANING WORKERS H&W TRUST FUND : Aetna
Aetna Choice POS II Open Access® - 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, www.HealthReformPlanSBC.com or by calling 1-800-524-8687. 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 1-800-524-8687 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes.	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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$4,000 Individual / $8,000 Family	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 (unless balance billing is prohibited or inclusion under the limit is required by law), health care this plan doesn't cover & penalties for failure to obtain pre-authorization for services. Certain specialty pharmacy drugs are considered non-essential health benefits and fall outside of the out-of-pocket limits.	Even though you pay these expenses, they don't count toward the out-of-pocket limit. The cost of certain specialty pharmacy drugs (though reimbursed by the manufacturer at no cost to you) will not be applied towards satisfying your out-of-pocket maximums.
Will you pay less if you use a network provider?	Yes. For a list of network providers see www.aetna.com or call 1-800-524-8687.	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: In-Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay/visit	$10 copay/visit	None
	Specialist visit	$10 copay/visit	$10 copay/visit	None
	Preventive care /screening /immunization	No charge	No charge	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 of the Plan's allowed amount	40% coinsurance of the UCR allowed amount	
	Imaging (CT/PET scans, MRIs)	20% coinsurance of the Plan's allowed amount	40% coinsurance of the UCR allowed amount	None
If you need drugs to treat your illness or condition Prescription drug coverage is administered by Express Scripts More information about prescription drug coverage is	Generic drugs	No charge	Not covered	
	Preferred brand drugs	10% coinsurance of costs per prescription (retail & mail-order)	Not covered	$15 maximum copayment for a 30-day supply of retail drugs; $30 maximum copayment for a 90-day supply of mail-order drugs
	Non-preferred brand drugs	20% coinsurance of costs per prescription (retail and mail-order)	Not covered	$25 maximum copayment for a 30-day supply of retail drugs; $50 maximum copayment for a 90-day supply of mail-order drugs

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
available at www.Express-Scripts.com	Specialty drugs	No charge for injectable drugs; $10 copay/prescription (generic oral drugs); $30 copay/prescription (brand oral drugs)	Not covered	Please see "Important Questions" regarding the plan's out-of-pocket limit.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance of the Plan's allowed amount	40% coinsurance of the UCR allowed amount	Some non-emergency surgeries must be pre-authorized through Aetna's medical management. Penalty of $200 for failure to obtain pre-authorization for out-of-network care.
	Physician/surgeon fees	20% coinsurance of the Plan's allowed amount	40% coinsurance of the UCR allowed amount	None
If you need immediate medical attention	Emergency room care	$200 copay/visit, plus 20% coinsurance of the Plan's allowed amount	$200 copay/visit, plus 20% coinsurance of the Plan's allowed amount	$200 copayment is waived if admitted.
	Emergency medical transportation	20% coinsurance of the Plan's allowed amount	20% coinsurance of the Plan's allowed amount	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Urgent care	$10 copay/visit	$10 copay/visit	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance of the Plan's allowed amount	40% coinsurance of the UCR allowed amount	Non-emergency inpatient admission must be pre-authorized through Aetna's medical management. Penalty of $200 for failure to obtain pre-authorization for out-of-network care.
	Physician/surgeon fees	20% coinsurance of the Plan's allowed amount	40% coinsurance of the UCR allowed amount	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 copay/office visit and for other outpatient services	$10 copay/office visit and for other outpatient services	No preauthorization required for outpatient mental health services.
	Inpatient services	20% coinsurance of the Plan's allowed amount	40% coinsurance of the UCR allowed amount	Non-emergency inpatient admission must be pre-authorized through Aetna's medical management. Penalty of $200 for failure to obtain pre-authorization for out-of-network care.
If you are pregnant	Office visits	Pre-natal care is included with the delivery charge. $10 copay/visit for post-natal care.	40% coinsurance of the UCR allowed amount	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Pre-natal care is included with the delivery charge, and is paid at the same level as the physician/surgeon charge for in-patient hospitalization. Penalty of $200 for failure to obtain pre-authorization for out-of-network care. Covered in-network abortion and abortion-related services are covered without any
	Childbirth/delivery professional services	20% coinsurance of the Plan's allowed amount	40% coinsurance of the UCR allowed amount	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	20% coinsurance of the Plan's allowed amount	40% coinsurance of the UCR allowed amount	coinsurance, copayment or any other cost-sharing requirements.
If you need help recovering or have other special health needs	Home health care	20% coinsurance of the Plan's allowed amount	40% coinsurance of the UCR allowed amount	45 day visit limit per person, per calendar year. No coverage for care that is not medically necessary. Coverage must be pre-authorized through Aetna's medical management. Penalty of $200 for failure to obtain pre-authorization for out-of-network care.
	Rehabilitation services	20% coinsurance of the Plan's allowed amount	40% coinsurance of the UCR allowed amount	None
	Habilitation services	20% coinsurance of the Plan's allowed amount	40% coinsurance of the UCR allowed amount	None
	Skilled nursing care	20% coinsurance of the Plan's allowed amount	40% coinsurance of the UCR allowed amount	30 day visit limit per person, per calendar year. No coverage for care that is not medically necessary . Penalty of $200 for failure to obtain pre-authorization for out-of-network care.
	Durable medical equipment	20% coinsurance of the Plan's allowed amount	Not Covered.	
	Hospice services	20% coinsurance of the Plan's allowed amount	40% coinsurance of the UCR allowed amount	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered.
	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 • Glasses (Child)	• Hearing aids • Infertility treatment • 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	• Dental care (Adult & Child) - Covered under a separate dental plan.	• Routine eye care (Adult & Child) - Covered under a separate vision plan.

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 1-800-524-8687.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church 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 on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-800-524-8687.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272)or http://www.dol/gov/ebsa/healthreform

- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- 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.

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 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	$0
Specialist copayment	$10
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	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,060

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

The plan's overall deductible	$0
Specialist copayment	$10
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	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$100
Coinsurance	$800
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$920

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

The plan's overall deductible	$0
Specialist copayment	$10
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	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$230
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$730

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 866-393-0002.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: P.O. Box 24030, Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

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

TTY: 711

Language Assistance:

For language assistance in your language call 1-800-524-8687 at no cost.

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-800-524-8687.
Amharic -	ለቋንቋ እገዛ በ አማርኛ በ 1-800-524-8687 በነጻ ይደውሉ
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-800-524-8687
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-800-524-8687 առանց գնով:
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-524-8687 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-800-524-8687 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জনয্ িওবনামুেওলয্ 1-800-524-8687- ওত কল করন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-524-8687 nga walay bayad.
Burmese -	ဌေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-800-524-8687 ကို ခေါ်ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-800-524-8687.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-800-524-8687 sin gåstu.
Cherokee -	ᎾᏍᎩᎾ ᎦᏬᏂᎯᏍᏗ ᏗᏂᏍᎦᏅᏍᎩ ᎾᏆᎢ (ᏣᎳᎩ) ᎾᏏᎳᎢᎥᎦ 1-800-524-8687 ᎤᎾᎢ Ꮷ ᎪᎵᏍᏗ ᏧᎬᏩᏁᏗ ᏂᏲᎡᎾ.
Chinese -	欲取得繁體中文語言協助，請撥打1-800-524-8687，無需付費。
Choctaw -	(Chahta) anumpa ya apela a chi I paya hinla 1-800-524-8687.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-800-524-8687 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-524-8687.
French -	Pour une assistance linguistique en français appeler le 1-800-524-8687 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-800-524-8687 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-524-8687 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-524-8687 χωρίς χρέωση.
Gujarati -	◆જરોતીમોાં ભાષામોાં સહાય મોટ◆ કોઈ પણ ખચર્ વગર 1-800-524-8687 પર કોલ કરો.
Hawaiian -	No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-800-524-8687. Kāki ‘ole ‘ia kēia kōkua nei.

Hindi - हिन्दी में भाषा सहायता के लिए, 1-800-524-8687 पर मुफ्त कॉल करें।

Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-800-524-8687.

Ibo - Maka enyemaka asụsụ na Igbo kpọọ 1-800-524-8687 na akwụghị ụgwọ ọ bụla

Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-524-8687 nga awan ti bayadanyo.

Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-800-524-8687.

Japanese - 日本語で援助をご希望の方は、1-800-524-8687 まで無料でお電話ください。

Karen - လၢတၢ်မၤစၢၤတၢ်ကတိၤကျိာ်အဂီၢ် ကျိာ် 1-800-524-8687 လၢတအိဉ်ဒီးတၢ်လၢာ်ဘျဉ်လၢာ်စုၤဟဉ်

Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-524-8687 번으로 전화해 주십시오.

Kru-Bassa - Ɓɛ´m`ké gbo-kpá-kpá dyé pídyi ɖé Ɓaɓɔɔ̀-wuɖuǔn wɛ̃ɛ, ɖá 1-800-524-8687

Kurdish - برای راهنمایی به زبان فارسی با شماره 1-800-524-8687 به خۆرایی یەیوەندی بکەن.

Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ1-800-524-8687 ໂດຍບໍ່ເສຍຄ່າໂທ.

Marathi - कोणत्या◌ाह◌ी श◌ु ल्क◌ा◌शवाय भ◌ाषा स◌े व◌ा ◌ाप्त करण्य◌ास◌ाठ◌ी, 1-800-524-8687 वर फोन कर◌ा.

Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-800-524-8687 ilo ejjelok wōnān.

Micronesian-Pohnpeyan - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-800-524-8687 ni sohte isais.

Mon-Khmer, Cambodian - សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-800-524-8687 ដោយឥតគិតថ្លៃ។

Navajo - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-800-524-8687

Nepali - (ने◌ पाल◌ी) मा ◌नः श◌ु ल्क भ◌ाषा सह◌ायता प◌ाउनक◌ा ला◌ी◌ग 1-800-524-8687 ◌ोस◌्।

Nilotic-Dinka - Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-800-524-8687 kecïn

Norwegian - For språkassistanse på norsk, ring 1-800-524-8687 kostnadsfritt.

Panjabi - ਪੰਜਾਬੀ ਿ◌ੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-800-524-8687 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।

Pennsylvania Dutch - Fer Helfe in Deitsch, ruf: 1-800-524-8687 aa. Es Aaruf koschtet nix.

Persian - برای راهنمایی به زبان فارسی با شماره 1-800-524-8687 بدون هیچ هزینه ای تماس بگیرید. انگلیسی

Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-800-524-8687.

Portuguese - Para obter assistência linguística em português ligue para o 1-800-524-8687 gratuitamente.

Romanian - Pentru asistenţă lingvistică în româneşte telefonaţi la numărul gratuit 1-800-524-8687

Russian -	Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-800-524-8687.
Samoan -	Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-800-524-8687 e aunoa ma se totogi.
Serbo-Croatian -	Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-800-524-8687.
Spanish -	Para obtener asistencia lingüística en español, llame sin cargo al 1-800-524-8687.
Sudanic-Fulfude -	Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-800-524-8687. Njodi woo fawaaki on.
Swahili -	Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-800-524-8687 bila malipo.
Syriac -	ܠܥ ܕܫܡ ܠܥ ܒܐ ܟܫܝܐ ܘܒܡ ܕܠܫ ܠܥ ܘܩܝ̈ܡ ܡܡ ܠܐ ܝܫܟܡ ܝܫܠ̈ܟ 1-800-524-8687 ܒܫܠ̈ܐ.
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-800-524-8687 nang walang bayad.
Telugu -	ఉచిత సహాయం కోసం మీరు తెలుగులో 1-800-524-8687 కి కాల్ చేయండి. (టోల్ ఫ్రీ)
Thai - ฟรี	สำหรับความชวยเหลอทางดานภาษาเป็น ภาษาไทย โทร 1-800-524-8687 มค่ าใชจ่าย มค
Tongan -	Kapau ‘oku fiema'u hā tokoni ‘i he lea faka-Tonga telefoni 1-800-524-8687 ‘o ‘ikai hā ōtōngi.
Trukese -	Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-800-524-8687 nge esapw kamé ngonuk.
Turkish -	(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-800-524-8687.
Ukrainian -	Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-800-524-8687.
Urdu -	بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے 1-800-524-8687 پر بات کریں۔
Vietnamese -	Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-800-524-8687.
Yiddish -	פאר שפראך הילף אין אידיש רופט 1-800-524-8687 פריי פון אפצאל.
Yoruba -	Fún ìrànlọwọ nípa èdè (Yorùbá) pe 1-800-524-8687 lái san owó kankan rárá.