Coverage for: Individual + Family | Plan Type: HMO



The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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, <u>www.HealthReformPlanSBC.com</u>, <u>www.uchp.uchicago.edu</u> or by calling 1-888-982-3862. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-888-982-3862 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	UCHP Home Host UCHP <u>Network</u> : \$0.	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your <u>deductible</u> ?	No deductible applies.	You will have no <u>deductible</u> to meet before the <u>plan</u> pays for any services
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> ?	University of Chicago Health Plan In- <u>Network</u> : Individual \$1,500 / Family \$3,000.	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 <u>out-of-pocket limit</u> ?	Premiums, balance-billing charges & health care this plan doesn't cover.	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 http://www.aetna.com/dse/custom/uchp for a list of Primary Care Providers (PCP) or call 1-855-824-3632 for UCHP Network providers. Your PCP will handle all referrals to a network specialist	This <u>plan</u> uses a <u>provider network</u> limited to the University of Chicago Medical Center and Ingalls Hospital providers under the UCHP health plan. There is no coverage outside of the UCHP network.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .



All **<u>copayment</u>** and <u>**coinsurance**</u> costs shown in this chart apply unless otherwise noted.

		What You	u 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 <u>Specialist</u> visit	\$25 <u>copay</u> /visit \$45 <u>copay</u> /visit	Not covered Not covered	None None
If you visit a health care <u>provider</u> 's office or clinic	Preventive care /screening /immunization	No charge	Not covered	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.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	None
If you have a test	Imaging (CT/PET scans, MRIs)	No charge	Not covered	None
If you need drugs to treat your illness or condition More information about <u>prescription</u>	Generic drugs	Filled at DCAM: \$5 copay/30 day prescription \$10 copay/90 day prescription Filled at Retail Pharmacy:	Not covered	Members filling order at a retail pharmacy (i.e. CVS) will receive two prescription fills at the copayment amount. For the third and subsequent fills, the member's cost will be 50% of the medication cost.
drug coverage available at www.aetna.com/pha rmacy- insurance/individual s-families		\$10 copay/30 day prescription Filled by CVS Caremark Mail Order: \$20 copay/90 day prescription		

	What You Will Pay			
Common Medical		In-Network	Out-of-Network	Limitations, Exceptions, & Other Important
Event	Services You May Need	Provider	Provider	Information
Lvent		(You will pay the	(You will pay the	
		least)	most)	
	Preferred brand drugs	Filled at DCAM: \$15 copay/30 day prescription \$30 copay/90 day prescription Filled at Retail Pharmacy: \$30 copay/30 day prescription Filled by CVS Caremark Mail Order: \$60 copay/90 day prescription	Not covered	Members filling order at a retail pharmacy (i.e. CVS) will receive two prescription fills at the copayment amount. For the third and subsequent fills, the member's cost will be 50% of the medication cost.
	Non-preferred brand drugs	Filled at DCAM: \$30 copay/30 day prescription \$60 copay/90 day prescription Filled at Retail Pharmacy: \$50 copay/30 day prescription Filled by CVS Caremark Mail Order: \$100 copay/90 day prescription	Not covered	

Common Medical Event	Services You May Need	What You In-Network Provider (You will pay the least)	u Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	<u>Specialty drugs</u>	\$75 copay/prescription for 30 day order	Not covered	Drugs used for treatment of infertility, impotence and smoking deterrents have plan limitations (i.e. drugs used for the treatment of infertility are covered at 75% of cost).
If you have	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	None
outpatient surgery	Physician/surgeon fees	No charge	Not covered	None
	Emergency room care	\$125 <u>copay</u> /visit	\$125 <u>copay</u> /visit	No coverage for non-emergency use.
lf you need	Emergency medical transportation	No charge	No charge	Non-emergency transport: not covered, except if pre-authorized.
immediate medical attention	<u>Urgent care</u>	\$45 <u>copay</u> /visit	Not covered	In network providers include University of Chicago Hospitals, Ingalls Quick Care (Crestwood), CVS Minute Clinics and other select urgent care locations.
lf you have a	Facility fee (e.g., hospital room)	\$350 <u>copay</u> /stay	Not covered	None
hospital stay	Physician/surgeon fees	No charge	Not covered	None
If you need mental health, behavioral health, or substance abuse	Outpatient services	Office: \$25 <u>copav</u> /visit; other outpatient services: no charge	Not covered	None
services	Inpatient services	\$350 <u>copay</u> /stay	Not covered	None
	Office visits	No charge	Not covered	Cost sharing does not apply for preventive
	Childbirth/delivery professional services	No charge	Not covered	services. Maternity care may include tests and
lf you are pregnant	Childbirth/delivery facility services	\$350 <u>copay</u> /stay	Not covered	services described elsewhere in the SBC (i.e. ultrasound.) Specialist office visit copay of \$45 applies for initial visit only.
If you need help	Home health care	No charge	Not covered	None
recovering or have other special	Rehabilitation services	No charge	Not covered	60 visits/calendar year for Physical, Occupational & Speech Therapy combined.
health needs	Habilitation services	No charge	Not covered	Limited to treatment of Autism.

Common Medical Event	Services You May Need	What You In-Network Provider (You will pay the Ieast)	ı Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Skilled nursing care	No charge	Not covered	None
	Durable medical equipment	No charge	Not covered	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	No charge	Not covered	None
If your child needs dental or eye care	Children's eye exam	\$45/visit for one visit/lifetime; otherwise Not covered	Not covered	1 routine eye exam/lifetime under the age of 18.
	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:

Acupuncture	Glasses (Child)	٠	Prescription drugs
Chiropractic care	Hearing aids	٠	Private-duty nursing
Cosmetic surgery	Long-term care	٠	Routine foot care
Dental care (Adult & Child)	 Non-emergency care when traveling outside the U.S. 	•	Weight loss programs - Except for required preventive services.
Other Covered Services (Limitations n	nay apply to these services. This isn't a complete list. Plea	se se	e your <u>plan</u> document.)
Other Covered Services (Limitations n Bariatric surgery 	 Infertility treatment - For more information & exceptions, see policy document provided by your employer or call the number on your 	se se	e your <u>plan</u> document.)

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 <u>plan</u> at 1-888-982-3862.
- 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 <u>www.cciio.cms.gov</u>.
- If your coverage is a church <u>plan</u>, church <u>plans</u> 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 <u>Health Insurance Marketplace</u>. For more information about the <u>Marketplace</u>, visit <u>www.HealthCare.gov</u> or call 1-800-318-2596.

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 1-888-982-3862.
- 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 <u>appeal</u>. Contact information is at: <u>http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html</u>.

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)			

\$0

\$45

\$350

\$0

The <u>plan's</u> overall <u>deductible</u>	
Specialist copayment	
Hospital (facility) <u>copayment</u>	
Other copayment	

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:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$395
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$0
The total Peg would pay is	\$395

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

The <u>plan's</u> overall <u>deductible</u>	\$0
Primary care physician <u>copayment</u>	\$25
Hospital (facility) <u>copayment</u>	\$350
Other <u>copayment</u> RX	\$10

This EXAMPLE event includes services like: Primary care physician 3 office visits (including disease education) Diagnostic tests (blood work) Prescription drugs (3 fills) Durable medical equipment (glucose meter)

Total Example Cost	\$5,600		
In this example, Joe would pay:			
<u>Cost Sharing</u>			
<u>Deductibles</u>	\$0		
<u>Copayments</u>	\$105		
Coinsurance	\$0		
What isn't covered			
Limits or exclusions	\$0		
The total Joe would pay is	\$105		

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

The <u>plan's</u> overall <u>deductible</u>	\$0
Specialist copayment	\$45
ER (facility) <u>copayment</u>	\$125
Other <u>copayment</u>	\$0

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
<u>Copayments</u>	\$170
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$170

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).

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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 እንዛ በ አማርኛ በ 1-888-982-3862 በነጻ ይደውሉ
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 3862-382
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 ခေါ် ဆိုပါ။
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 -	Յ ԾУӨ Տ ℗ℎ ℬԾ <i>⅄ ⅄</i> ℎⅆℨℙⅆ℣ Მ℄ℸ (GWУ) Չ Ხ₩ℰℹՑ 1-888-982-3862 ℺Მℸ Ը АГⅆՆ <i>⅄</i> Ⅎℇ Ⴚ Ք <i>⅄</i> ℎℙℝ℈.
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 y <u>a</u> apela a chi I p <u>a</u> ya 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 કૉલ કરો.
Hawaiian -	No ke kōkua ma ka 'ōlelo Hawai'i, e kahea aku i ka helu kelepona 1-888-982-3862. Kāki 'ole 'ia kēia kōkua nei.

हनि्दी में भाषा सहायता के लएि, ₁₋₈₈₈₋₉₈₂₋₃₈₆₂ पर मुफ्त कॉल करें।
Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-888-982-3862.
Maka enyemaka asụsụ na Igbo kpọọ 1-888-982-3862 na akwụghị ụgwọ ọ bụla
Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-888-982-3862 nga awan ti bayadanyo.
Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-888-982-3862.
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。
လ၊ တၢိမၢဖားတၢိဳကတိုးကျိဉ်အဂ်ီ၊ ကျိဉ် ြာန888-982-3862 လ၊ တအိုဉ်ဒီးတၢိဳလ၊ ၁်ဘူဉ်လ၊ ၁်စူးဘဉ်
한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862 번으로 전화해 주십시오.
Ɓɛ´m`ké gbo-kpá-kpá dyé pidyi dé Ɓašɔɔ́-̀wùdุùùn wɛ̃ɛ, dá 1-888-982-3862
بر ای ر اهنمایی به زبان فارسی با شمار ه 3862-982-1888 به خوّر ایی پهیومندی بکهن.
ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ-888-982-3862 ໂດຍບໍ່ເສຍຄ່າໂທ.
कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-888-982-3862 वर फोन करा.
Ñan bōk jipañ ilo Kajin Majol, kallok 1-888-982-3862 ilo ejjelok wōnān.
Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-888-982-3862 ni sohte isais.
សម្ភរាប់ជំនួយភាសាជា ភាសាខុមរែ សូមទូរស័ព្ ទទ ៅកាន់លខេ 1-888-982-3862 ដ ោយឥតគិតថ្ ល។ៃ
T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-888-982-3862
(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-888-982-3862 मा फोन गर्नुहोस् ।
Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-888-982-3862 kecïn aɣöc.
For språkassistanse på norsk, ring 1-888-982-3862 kostnadsfritt.
ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-888-982-3862 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Fer Helfe in Deitsch, ruf: 1-888-982-3862 aa. Es Aaruf koschtet nix.
برای راهنمایی به زبان فارسی با شماره 1-888-982-3862 بدون هیچ هزینه ای تماس بگیرید. انگلیسی Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-888-982-3862.
Para obter assistência linguística em português ligue para o 1-888-982-3862 gratuitamente.
Pentru asistență lingvistică în românește telefonați 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 -	ר שבר רג א שביוו מאר שלב ד ממואיר הר לי ובשר זאל, שמ 1-888-982-3862 משי י
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
Thai - Tongan -	สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-888-982-3862 ฟรีไม่มีค่าใช้จ่าย Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-888-982-3862 'o 'ikai hā ōtōngi.
Tongan -	Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-888-982-3862 'o 'ikai hā ōtōngi.
Tongan - Trukese -	Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-888-982-3862 'o 'ikai hā ōtōngi. Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-888-982-3862 nge esapw kamé ngonuk.
Tongan - Trukese - Turkish -	Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-888-982-3862 'o 'ikai hā ōtōngi. Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-888-982-3862 nge esapw kamé ngonuk. (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-888-982-3862.
Tongan - Trukese - Turkish - Ukrainian -	 Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-888-982-3862 'o 'ikai hā ōtōngi. Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-888-982-3862 nge esapw kamé ngonuk. (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-888-982-3862. Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-888-982-3862.
Tongan - Trukese - Turkish - Ukrainian - Urdu -	Караи 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-888-982-3862 'o 'ikai hā ōtōngi. Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-888-982-3862 nge esapw kamé ngonuk. (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-888-982-3862. Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-888-982-3862. устал слада стала стала стала стала стала сала сал