AMERICAN AIR LIQUIDE HOLDINGS INC. : Aetna Choice® POS II - Aetna Choice Value Plan

Coverage for: Individual + Family | Plan Type: POS



aetna

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> or by calling 1-866-449-6495. 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 <u>https://www.healthcare.gov/sbc-glossary</u>/ or call 1-866-449-6495 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	<u>Network</u> : EE Only \$3,000; EE+ Family \$6,000. Out-of-Network: EE Only \$9,000; EE+ Family \$18,000.	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 policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your <u>deductible</u> ?	Yes. In- <u>network preventive care</u> is covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <u>https://www.healthcare.gov/coverage/preventive-care-benefits/</u>
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet deductibles for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	<u>Network</u> : EE Only \$6,000; EE+ Family \$12,000. Out-of-Network: EE Only \$18,000; EE+ Family \$36,000.	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> ?	<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 <u>www.aetna.com/docfind</u> or call 1-866- 449-6495 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider</u> <u>network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's</u> <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All **<u>copayment</u>** and **<u>coinsurance</u>** costs shown in this chart are after your **<u>deductible</u>** has been met, if a **<u>deductible</u>** applies.

		What You	u Will Pay	
Common Medical Event	Services You May Need	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	30% coinsurance	50% coinsurance	None
	<u>Specialist</u> visit	30% coinsurance	50% coinsurance	None
If you visit a health care <u>provider</u> 's office or clinic	Preventive care /screening /immunization	No charge	30% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	50% <u>coinsurance</u>	None
If you have a test	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	None
If you need drugs	Generic drugs	30% coinsurance.	30% coinsurance.	Mail Order: 30% coinsurance.
to treat your	Preferred brand drugs	30% coinsurance.	30% coinsurance.	Mail Order: 30% coinsurance.
illness or	Non-preferred brand drugs	30% coinsurance	30% coinsurance.	Mail Order: 30% coinsurance.
condition More information about <u>prescription</u> <u>drug coverage</u> is available at www.caremark.com	<u>Specialty drugs</u>	Covered at Preferred or Non- Preferred brand drug coinsurance as applicable	Not covered	None
lf you have	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% <u>coinsurance</u>	None
outpatient surgery	Physician/surgeon fees	30% coinsurance	50% coinsurance	None
lf you need	Emergency room care	30% coinsurance	30% <u>coinsurance</u>	No coverage for non-emergency use.
immediate medical	Emergency medical transportation	30% coinsurance	30% coinsurance	None
attention	<u>Urgent care</u>	30% coinsurance	50% <u>coinsurance</u>	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Penalty of 50% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care.
noopital Stay	Physician/surgeon fees	30% coinsurance	50% coinsurance	None

		What Yo	u Will Pay	
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or	Outpatient services	Office & other outpatient services: 30% <u>coinsurance</u>	Office & other outpatient services: 50% <u>coinsurance</u>	None
substance abuse services	Inpatient services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Penalty of 50% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care.
	Office visits	No charge	50% coinsurance	Cost sharing does not apply for preventive
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	services. Maternity care may include tests and
lf you are pregnant	Childbirth/delivery facility services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	services described elsewhere in the SBC (i.e. ultrasound.) Penalty of 50% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of- network care may apply.
	Home health care	0% <u>coinsurance</u>	0% <u>coinsurance</u>	40 visits/calendar year combined with private- duty nursing. Penalty of 50% of <u>allowed amount</u> or failure to obtain <u>pre-authorization</u> for out-of- network care.
	Rehabilitation services	30% coinsurance	50% coinsurance	None
If you need help	Habilitation services	Not covered	Not covered	Not covered.
recovering or have other special health needs	Skilled nursing care	30% <u>coinsurance</u>	50% <u>coinsurance</u>	60 days/calendar year. Penalty of 50% of <u>allowed</u> <u>amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care.
	Durable medical equipment	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Penalty of 50% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care.
If your child needs	Children's eye exam	Not covered	Not covered	Not covered.
dental or eye care	Children's glasses	Not covered	Not covered	Not covered.
dontal of Cyc dale	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Cosmetic surgery Dental care (Adult & Child)	Habilitation servicesLong-term care	Routine eye care (Adult & Child)Routine foot care
Glasses (Child)	 Non-emergency care when traveling outside the U.S. 	Weight loss programs
	the U.S.	
Other Covered Services (Limitations may ap	oly to these services. This isn't a complete list. Pleas	se see vour plan document.)
	bly to these services. This isn't a complete list. Pleas	
Other Covered Services (Limitations may app Acupuncture Bariatric surgery - Limited to in-network	 bly to these services. This isn't a complete list. Pleas Chiropractic care - 35 visits/calendar year. Hearing aids 	 se see your <u>plan</u> document.) Infertility treatment Private-duty nursing - 40 visits/calendar year combin

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 1-866-449-6495.
- 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 <u>www.dol.gov/ebsa/healthreform</u>.
- 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 <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 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 <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 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 1-866-449-6495.
- 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 <u>www.dol.gov/ebsa/healthreform</u>.
- For non-federal governmental group health <u>plans</u>, 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>.
- Additionally, a consumer assistance program can help you file your <u>appeal</u>. 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.

If you don't have <u>Minimum Essential Coverage</u> 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 Standard? 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 <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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 <u>plan's</u> overall <u>deductible</u>	\$3,000
Specialist coinsurance	30%
Hospital (facility) <u>coinsurance</u>	30%
Other <u>coinsurance</u>	30%

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	\$3,000
Copayments	\$0
Coinsurance	\$2,900
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$5,960

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>	\$3,000
Specialist coinsurance	30%
Hospital (facility) <u>coinsurance</u>	30%
Other <u>coinsurance</u>	30%

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	\$7,400
In this example, Joe would pay:	
Cost Sharing	
Deductibles	\$3,000
Copayments	\$0
Coinsurance	\$1,300
What isn't covered	
Limits or exclusions	\$60
The total Joe would pay is	\$4,360

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

The plan's overall deductible	\$3,000
Specialist coinsurance	30%
Hospital (facility) <u>coinsurance</u>	30%
Other coinsurance	30%

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	\$1,900
In this example, Mia would pay:	
Cost Sharing	
Deductibles	\$1,900
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,900

Note: If your **plan** has a wellness program and you choose to participate, you may be able to reduce your costs.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-866-449-6495.

Smartphone or Tablet

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

Non-Discrimination

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

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

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

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),

1-800-648-7817, TTY: 711, Fax: 859-425-3379 (CA HMO customers: 1-860-262-7705),

Email: CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at 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 (Aetna).

TTY: 711

Language Assistance:

For language assistance in your language call 1-866-449-6495 at no cost.

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-866-449-6495.
Amharic -	ለቋንቋ እንዛ በ አማርኛ በ 1-866-449-6495 በነጻ ይደውሉ
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 6495-1-866-149
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-866-449-6495 առանց գնով։
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-866-449-6495 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-866-449-6495 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বিনামুল্যে 1-866-449-6495-তে কল করুন।
Bisayan-Visayan-	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-866-449-6495 nga walay bayad.
Burmese -	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-866-449-6495 <mark>ကို ခေါ် ဆိုပါ။</mark>
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-866-449-6495.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-866-449-6495 sin gåstu.
Cherokee -	Օ ⅆ℣℈ <i>Ֆ</i> ℗ℎℬⅆℷℳℎⅆℇℙⅆ℣℈℔ℾ(GWУ)ⅆℎℍℰℹՖ1-866-449-6495 ℺℈ℾℒÅℾⅆℷℳℲℇ℞ℙℷℎℙℝ℈.
Chinese -	欲取得繁體中文語言協助,請撥打1-866-449-6495,無需付費。
Choctaw -	(Chahta) anumpa y <u>a</u> apela a chi I p <u>a</u> ya hinla 1-866-449-6495.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-866-449-6495 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-866-449-6495.
French -	Pour une assistance linguistique en français appeler le 1-866-449-6495 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-866-449-6495 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-866-449-6495 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-866-449-6495 χωوἰς χϱἑωση.
Gujarati -	ગુજરાતીમાં ભાષામાં સહ્રાય માટે કોઈ પણ ખર્ચ વગર 1-866-449-6495 પર કૉલ કરો.

Hawaiian -	No ke kōkua ma ka 'ōlelo Hawai'i, e kahea aku i ka helu kelepona 1-866-449-6495. Kāki 'ole 'ia kēia kōkua nei.
Hindi -	हन्दिी में भाषा सहायता के लएि,1-866-449-6495 पर मुफ्त कॉल करें।
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-866-449-6495.
bo -	Maka enyemaka asụsụ na Igbo kpọọ 1-866-449-6495 na akwụghị ụgwọ ọ bụla
locano -	Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-866-449-6495 nga awan ti bayadanyo.
talian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-866-449-6495.
Japanese -	日本語で援助をご希望の方は、1-866-449-6495 まで無料でお電話ください。
Karen -	လ၊ တၢိမၢစၢၤတၢိကတိၤကိျဉ်အဂ်ီ၊ ကိျဉ် ကိႏ 1-866-449-6495 လ၊ တအိဉ်ဒီးတၢဴလ၊ ၁်ဘူဉ်လ၊ ၁်စ္၊ဘဉ်
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-866-449-6495번으로 전화해 주십시오.
Kru-Bassa -	Ɓɛ´m`ké gbo-kpá-kpá dyé pidyi dé Ɓašɔɔ́-̀wùdุùùň wɛ̃ɛ, dá 1-866-449-6495
Kurdish - Laotian - Marathi -	برای راهنمایی به زبان فارسی با شماره 1-866-449-6495 به خوّر ایی یعیومندی بکهن. ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-866-449-6495 ໂດຍບໍ່ເສຍຄ່າໂທ. तीलभाषा (मराठी) सहाय्यासाठी 1-866-449-6495 क्रमांकावरकोणत्याहीखर्चाशिवायकॉलकरा.
Marshallese -	Ñan bōk jipañ ilo Kajin Majol, kallok 1-866-449-6495 ilo ejjelok wōnān.
Micronesian- Pohnpeyan - Mon-Khmer, Cambodian -	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-866-449-6495 ni sohte isais. សម្ភរាប់ជំនួយភាសាជា ភាសាខុមរែ សូមទូរស័ព្ ទទ ៅកាន់លខេ 1-866-449-6495 ដ ោយឥតគិតថ្ ល។ៃ
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-866-449-6495
Nepali -	(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि १- 🔋 ⁸⁶⁶⁻⁴⁴⁹⁻⁶⁴⁹⁵ मा फोन गर्नुहोस् ।
Nilotic-Dinka -	Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-866-449-6495 kecïn aɣöc.
Norwegian -	For språkassistanse på norsk, ring 1-866-449-6495 kostnadsfritt.
Panjabi -	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-866-449-6495 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-866-449-6495 aa. Es Aaruf koschtet nix.
Persian - Polish -	بر ای راهنمایی به زبان فارسی با شماره اله ۲-۵66-449-6495 بدون هیچ هزینه ای تماس بگیرید. انگلیسی Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-866-449-6495.

Portuguese -	Para obter assistência linguística em português ligue para o 1-866-449-6495 gratuitamente.
Romanian -	Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-866-449-6495
Russian -	Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-866-449-6495.
Samoan -	Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-866-449-6495 e aunoa ma se totogi.
Serbo-Croatian -	Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-866-449-6495.
Spanish -	Para obtener asistencia lingüística en español, llame sin cargo al 1-866-449-6495.
Sudanic-Fulfude -	Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-866-449-6495. Njodi woo fawaaki on.
Swahili -	Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-866-449-6495 bila malipo.
Syriac -	< שביר הנ א הבאו מאה שלב ה ממזאה הה לי ובהה אלל, שם 1-866-449-6495 מהי .
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-866-449-6495 nang walang bayad.
Telugu -	భాషతో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 1-866-449-6495 కు కాల్ చేయండి. (తెలుగు)
Thai -	สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-866-449-6495 ฟรีไม่มีค่าใช้จ่าย
Tongan -	Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-866-449-6495 'o 'ikai hā ōtōngi.
Trukese -	Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-866-449-6495 nge esapw kamé ngonuk.
Turkish -	(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-866-449-6495.
Ukrainian -	Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-866-449-6495.
Urdu -	ا ربی رک ل کمیت م رب 1-866-449-6495 سی اعمین از اعمین اس ل ربی م و در
Vietnamese -	Đê được hố trợ ngôn ngữ băng (ngôn ngữ), hãy gọi miến phi đến số 1-866-449-6495.
Yiddish -	פאר שפראך הילף אין אידיש רופט 1-866-449-6495 פריי פון אפצאל.
Yoruba -	Fún ìrànlowo nípa èdè (Yorùbá) pe 1-866-449-6495 lái san owó kankan rárá.