

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

Coverage for: Individual + Family Plan Type: POS

Coverage Period: 01/01/2022-12/31/2022



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

| Important Questions | Answers | Why This Matters: |
|--|--|--|
| What is the overall deductible? | In- <u>Network</u> : EE Only \$1,500; EE+ Family \$3,000. Out-of-Network: EE Only \$4,500; EE+ Family \$9,000. | 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 deductible? | 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 https://www.healthcare.gov/coverage/preventive-care-benefits/ |
| 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</u> <u>limit</u> for this <u>plan</u> ? | In- <u>Network</u> : EE Only \$3,650; EE+ Family \$7,300. Out-of-Network: EE Only \$10,200; EE+ Family \$20,400. | 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> , the overall family <u>out–of–pocket limit</u> must be met. |
| What is not included in the out-of-pocket limit? | Premiums, balance-billing charges, health care this plan doesn't cover & penalties for failure to obtain pre-authorization 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 network provider? | Yes. See www.aetna.com/docfind or call 1-866-449-6495 for a list of in-network providers. | 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</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 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 $\underline{\textbf{copayment}}$ and $\underline{\textbf{coinsurance}}$ costs shown in this chart are after your $\underline{\textbf{deductible}}$ has been met, if a $\underline{\textbf{deductible}}$ applies.

| What You 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 | 20% coinsurance | 40% coinsurance | None |
| If you visit a boalth | Specialist visit | 20% coinsurance | 40% coinsurance | None |
| If you visit a health care <u>provider</u> 's office or clinic | Preventive care /screening /immunization | No charge | 20% coinsurance | 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 h 44 | Diagnostic test (x-ray, blood work) | 20% coinsurance | 40% coinsurance | None |
| If you have a test | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 40% coinsurance | None |
| | Generic drugs | \$10 copay | \$10 copay | Mail Order: \$25 copay |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com | Preferred brand drugs | 30% coinsurance (\$30 min. \$75 max copay) | 30% coinsurance (\$30 min. \$75 max copay) | Mail Order: 30% coinsurance (\$70 min. \$175 max copay) |
| | Non-preferred brand drugs | 40% coinsurance (\$60 min. \$125 max copay) | 40% coinsurance (\$60 min. \$125 max copay) | Mail Order: 40% coinsurance (\$140 min. \$295 max. copay) |
| | Specialty drugs | Covered at Preferred or Non- Preferred brand drug coinsurance/copays as applicable | Not covered | None |
| If you have | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 40% coinsurance | None |
| outpatient surgery | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | None |
| If you need | Emergency room care | 20% coinsurance | 20% coinsurance | No coverage for non-emergency use. |
| immediate medical attention | Emergency medical transportation | 20% coinsurance | 20% coinsurance | Non-emergency transport: not covered. |
| | Urgent care | 20% coinsurance | 40% coinsurance | No coverage for non-urgent use. |
| If you have a | Facility fee (e.g., hospital room) | 20% coinsurance | 40% coinsurance | Penalty of 50% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care. |
| hospital stay | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | None |

| | | What You 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 | |
| If you need mental health, behavioral health, or | Outpatient services | Office & other outpatient services: 20% coinsurance | Office & other outpatient services: 40% coinsurance | None | |
| substance abuse services | Inpatient services | 20% coinsurance | 40% coinsurance | Penalty of 50% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care. | |
| | Office visits Childbirth/delivery professional services | No charge 20% coinsurance | 40% coinsurance 40% coinsurance | Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. | |
| If you are pregnant | Childbirth/delivery facility services | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | 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> for failure to obtain <u>pre-authorization</u> for out-of- network care. | |
| | Rehabilitation services | 20% coinsurance | 40% coinsurance | None | |
| If you need help | Habilitation services | 20% coinsurance | 40% coinsurance | None | |
| recovering or have other special health needs | Skilled nursing care | 20% <u>coinsurance</u> | 40% <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 | 20% coinsurance | 40% coinsurance | Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse. | |
| | Hospice services | 20% coinsurance | 40% coinsurance | 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. | |
| dental of eye care | 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.)

- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)

- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult & Child)
- 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.)

- Acupuncture
- Bariatric surgery Limited to Institutes of Quality contracted facility only, in-network only.
- Chiropractic care 35 visits/calendar year.
- Hearing aids

- Infertility treatment
- Private-duty nursing 40 visits/calendar year combined with home health care.

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 1-866-449-6495.
- 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: https://www.dol.gov/agencies/ebsa
- 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>.
- 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 https://www.dol.gov/agencies/ebsa
- 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 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 495050-799381-301006

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 <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 <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> | \$1,500 |
|---|---------|
| ■ Specialist coinsurance | 20% |
| ■ 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 | \$1,500 |
| Copayments | \$0 |
| Coinsurance | \$2,200 |
| What isn't covered | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$3,760 |
| | |

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

| ■ The plan's overall deductible | \$1,500 |
|-----------------------------------|---------|
| ■ Specialist coinsurance | 20% |
| ■ 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 | \$1,500 | |
| Copayments | \$100 | |
| Coinsurance | \$1,000 | |
| What isn't covered | | |
| Limits or exclusions | \$20 | |
| The total Joe would pay is | \$2,620 | |

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

| ■ The <u>plan's</u> overall <u>deductible</u> | \$1,500 |
|---|---------|
| ■ Specialist coinsurance | 20% |
| ■ 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 | \$1,500 | |
| Copayments | \$10 | |
| Coinsurance | \$300 | |
| What isn't covered | | |
| Limits or exclusions | \$0 | |
| The total Mia would pay is | \$1,810 | |

Note: These numbers assume the patient does not participate in the <u>plan's</u> wellness program. If you participate in the <u>plan's</u> wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-866-449-6495.

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: <u>CRCoordinator@aetna.com</u>.

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

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 649-649-1-866 المجاني 1-866-449

Armenian - Lեզվի 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 - বাংলা্ম ভাষা সহা্মতার জন্য বিনাম্ল্যে 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 - ငွေကုန်ကျစံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-866-449-6495 ကို ခေါ် ဆိုပါ။

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 - $\theta \circ \partial \mathcal{Y} \theta \circ \mathcal{Y$

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 ya apela a chi I paya 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 χωρίς χρέωση.

Gujarati - ગુજરાતીમાં ભાષામાં સહ્યય 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- हिन्दी में भाषा सहायता के लिए, 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.

lbo - Maka enyemaka asusu na Igbo kpoo 1-866-449-6495 na akwughi ugwo o bula

llocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-866-449-6495 nga awan ti bayadanyo.

Italian - 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 - လာတါမာစားတါကတိုးကျိုာ်အင်္ဂါ ကျိုာ် ကိုး 1-866-449-6495 လာတအိုာ်ဒီးတါလာ၁်ဘူဉ်လာ၁်စ္ခာဘဉ်

Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-866-449-6495 번으로 전화해 주십시오.

Kru-Bassa - Be´m`ké gbo-kpá-kpá dyé pidyi dé Bašsoó-wuduùn wee, dá 1-866-449-6495

برای راهنمایی به زبان فارسی با شماره 6495-449-1-866 به خورایی پهیومندی بکهن.

Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ-866-449-6495 ໂດຍບໍ່ເສຍຄ່າໂທ.

Marathi - 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 - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-866-449-6495 ni sohte isais.

Mon-Khmer, សម្សាប់ជំនួយភាសាជា ភាសាខ្មមរំ សូមទូរស័ព្ទទទៅកាន់លខេ 1-866-449-6495 ដោយឥតគិតថ្លាំ។ Cambodian -

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 निःश्ल्क भाषा सहायता पाउनका लागि 1-866-449-6495 मा फोन गर्नुहोस्।

Nilotic-Dinka - Tën kuoony ë thok ë Thuonjän col 1-866-449-6495 kecin ayöc.

Norwegian - For språkassistanse på norsk, ring 1-866-449-6495 kostnadsfritt.

Panjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-866-449-6495 'ਤੇ ਮਫ਼ਤ ਕਾਲ ਕਰੋ।

Pennsylvania Dutch - Fer Helfe in Deitsch, ruf: 1-866-449-6495 aa. Es Aaruf koschtet nix.

برای راهنمایی به زبان فارسی با شماره 6495-449-1-866 بدون هیچ هزینه ای تماس بگیرید. انگلیسی Persian -

Polish - 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 - K sin pai abr size ob pai abr size ob size of los 1-866-449-6495 apr .

Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-866-449-6495 nang walang bayad.

Telugu - భాషతో సాయం కొరకు ఎలాంటి ఖర్పు 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.

ا رورک ل کتف م رب 495-449-1-866 <u>عال کتن و اعمین اس ل رق م</u> و در

Vietnamese - Đê 'được hố 'trợ ngôn ngư bằng (ngôn ngư), hấy gọi miến phi 'đên 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.