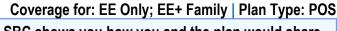
**♥**aetna°

LEIDOS, INC. : Aetna Choice® POS II - Healthy Focus Advantage Plan





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 1-800-843-9126. 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 1-800-843-9126 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: EE Only \$1,500; EE+ Family \$3,000. Out-of-Network: EE Only \$3,000; EE+ Family \$6,000.	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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	In- <u>Network</u> : EE Only \$3,200; EE+ Family \$6,400. Out-of-Network: EE Only \$6,400; EE+ Family \$12,800.	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 out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind or call 1-800-843-9126 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 **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **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	50% coinsurance	None
If you visit a health care <u>provider</u> 's office or clinic	Specialist visit  Preventive care /screening /immunization	20% <u>coinsurance</u> No charge	50% <u>coinsurance</u> 50% <u>coinsurance</u>	None 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)	20% coinsurance	50% coinsurance	None
ii you nave a test	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	None
If you need drugs to treat your	Generic drugs	Copay/prescription: \$5	Not covered	
illness or	Preferred brand drugs	30% coinsurance	Not covered	
condition	Non-preferred brand drugs	50% coinsurance	Not covered	
Prescription drug coverage is administered by ESI  More information about prescription drug coverage is available at www.express- scripts.com.	Specialty drugs	Applicable costs as noted above for generic and brand drugs	Not covered	All benefits are after <u>deductible</u> . Administered by ESI. Questions on Rx: call 1-877-223-4721 or visit www.express-scripts.com. Certain preventive drugs not subject to <u>deductible</u> .
If you have	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% <u>coinsurance</u>	None
outpatient surgery	Physician/surgeon fees	20% coinsurance	50% coinsurance	None

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 immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> . 50% <u>coinsurance</u> for non-emergency use.
	Emergency medical transportation	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> . Non-emergency transport: not covered, except 50% <u>coinsurance</u> if preauthorized.
	<u>Urgent care</u>	20% coinsurance	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Penalty of 20% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care.
nospital stay	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or	Outpatient services	Office & other outpatient services: 20% coinsurance	Office & other outpatient services: 50% coinsurance	None
substance abuse services	Inpatient services	20% coinsurance	50% coinsurance	Penalty of 20% 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	50% <u>coinsurance</u> 50% <u>coinsurance</u>	Cost sharing does not apply for preventive services. Maternity care may include tests and
If you are pregnant	Childbirth/delivery facility services	20% <u>coinsurance</u>	50% coinsurance	services described elsewhere in the SBC (i.e. ultrasound.). Penalty of 20% of allowed amount for failure to obtain pre-authorization for out-of-network care may apply.
If you need help recovering or have other special health needs	Home health care	20% <u>coinsurance</u>	50% coinsurance	100 visits/calendar year combined with private- duty nursing. Penalty of 20% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of- network care.
	Rehabilitation services	20% coinsurance	50% coinsurance	60 visits/calendar year for Physical, Occupational
	Habilitation services	20% coinsurance	50% coinsurance	& Speech Therapy combined, including outpatient hospital services. Includes treatment of Autism with no limit.
	Skilled nursing care	20% coinsurance	50% coinsurance	60 days/calendar year. Penalty of 20% of <u>allowed</u> <u>amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care.

	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
	Durable medical equipment	20% coinsurance	50% coinsurance	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	20% coinsurance	50% coinsurance	Penalty of 20% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care.
If your shild woods	Children's eye exam	Not covered	Not covered	Not covered.
If your child needs dental or eye care	Children's glasses	Not covered	Not covered	Not covered.
dental of eye cale	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 <u>preventive</u> <u>services</u>.

# Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric surgery

- Chiropractic care
- Hearing aids \$2,500 maximum/3 years.
- Infertility treatment For more information & exceptions, see policy document provided by your employer or call the number on your ID card.
- Private-duty nursing Included as part of <u>home health care</u>.

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 1-800-843-9126.
- 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 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:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general number at 1-800-843-9126. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <a href="http://www.dol/gov/ebsa/healthreform">http://www.dol/gov/ebsa/healthreform</a>
- 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: <a href="http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html">http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html</a>.

## 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 <u>plan</u> doesn't meet the <u>Minimum Value Standards</u>, you may be eligible for a <u>premium tax credit</u> to help you pay for a <u>plan</u> through the <u>Marketplace</u>.

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)

\$12,700
\$1,500
\$0
\$1,700
\$60
\$3,260

# Managing Joe's Type 2 Diabetes

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

■ 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:

<u>Primary care physician</u> office visits (including disease education)

Diagnostic tests (blood work)

Prescription drugs

<u>Durable medical equipment</u> (glucose meter)

Total Example Cost	\$5,600	
In this example, Joe would pay:		
Cost Sharing		
<u>Deductibles</u>	\$1,500	
<u>Copayments</u>	\$200	
Coinsurance	\$900	
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)

<u>Durable medical equipment</u> (crutches)

Rehabilitation services (physical therapy)

Total Example Cost	\$2,800		
In this example, Mia would pay:			
Cost Sharing			
<u>Deductibles</u>	\$1,500		
<u>Copayments</u>	\$10		
<u>Coinsurance</u>	\$300		
What isn't covered			
Limits or exclusions	\$0		
The total Mia would pay is	\$1,810		

### **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, disability, gender identity or sexual orientation.

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 <a href="https://ocrportal.hhs.gov/ocr/portal/lobby.jsf">https://ocrportal.hhs.gov/ocr/portal/lobby.jsf</a>, 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 companies, including Aetna Life Insurance Company and its affiliates (Aetna).

#### TTY: 711

## **Language Assistance:**

For language assistance in your language call 1-800-843-9126 at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-800-843-9126.

Amharic - ለቋንቋ እንዛ በ አማርኛ በ 1-800-843-9126 በንጻ ይደውሉ

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-800-843-9126

Armenian - Lեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-800-843-9126 առանց գնով։

Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-843-9126 tanpa dikenakan biaya.

Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-800-843-9126 ku busa

Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বিনামুল্যে 1-800-843-9126-তে কল করুন।

Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-843-9126 nga walay bayad.

Burmese - ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-800-843-9126 ကို ခေါ် ဆိုပါ။

Catalan - Per rebre assistència en (català), truqui al número gratuït 1-800-843-9126.

Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-800-843-9126 sin gåstu.

Cherokee - OWYO SOHAWI JHWSPWY OFT (CMA) OPMOIS 1-800-843-9126 OPM CALWIN ALWAY OF TO ALWAY OF THE CONTRACT OF

Chinese - 欲取得繁體中文語言協助, 請撥打 1-800-843-9126, 無需付費。

Choctaw - (Chahta) anumpa ya apela a chi I paya hinla 1-800-843-9126.

Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-800-843-9126 irratti bilisaan bilbilaa.

Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-843-9126.

French - Pour une assistance linguistique en français appeler le 1-800-843-9126 sans frais.

French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-800-843-9126 gratis.

German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-843-9126 an.

Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-843-9126 χωρίς χρέωση.

Gujarati - ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-800-843-9126 પર કૉલ કરો.

Hawaiian - No ke kōkua ma ka 'ōlelo Hawai'i, e kahea aku i ka helu kelepona 1-800-843-9126. Kāki 'ole 'ia kēia kōkua nei.

Hindi - हिन्दी में भाषा सहायता के लिए, 1-800-843-9126 पर मुफ्त कॉल करें।

Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-800-843-9126.

lbo - Maka enyemaka asusu na Igbo kpoo 1-800-843-9126 na akwughi ugwo o bula

llocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-843-9126 nga awan ti bayadanyo.

Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-800-843-9126.

Japanese - 日本語で援助をご希望の方は、1-800-843-9126 まで無料でお電話ください。

Karen - လာတာမ်ာစားတာကတိုးကျိုဘ်အင်္ဂါ ကျိုာ် 🛱 800-843-9126 လာတအို ၁ ဒီးတာလာဘ်ဘူဉ်လာဘ်စားဘဉ်

Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-843-9126 번으로 전화해 주십시오.

Kru-Bassa - Be´m`ké qbo-kpá-kpá dyé pidyi dé Bašsoó-wuduun wee, dá 1-800-843-9126

برای راهنمایی به زبان فارسی با شماره 9126-843-912 به خورایی پهیوهندی بکهن.

Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລນາໂທຫາ-800-843-9126 ໂດຍບໍ່ເສຍຄ່າໂທ.

Marathi - कोणत्याही शल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी. 1-800-843-9126 वर फोन करा.

Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-800-843-9126 ilo ejjelok wōnān.

Micronesian-

Pohnpeyan - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-800-843-9126 ni sohte isais.

Mon-Khmer, សម្ភាប់ជំនួយភាសាជា ភាសាខ្មមរំ សូមទូរស័ព្ទទៅកាន់លខេ 1-800-843-9126 ដោយឥតគិតថ្លាំ។

Cambodian -

Navajo - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-800-843-9126

Nepali - (नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-800-843-9126 मा फोन गर्नुहोस् ।

Nilotic-Dinka - Tën kupony ë thok ë Thuonjän col 1-800-843-9126 kecin ayöc.

Norwegian - For språkassistanse på norsk, ring 1-800-843-9126 kostnadsfritt.

Panjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-800-843-9126 'ਤੇ ਮਫ਼ਤ ਕਾਲ ਕਰੋ।

Pennsylvania Dutch - Fer Helfe in Deitsch, ruf: 1-800-843-9126 aa. Es Aaruf koschtet nix.

برای راهنمایی به زبان فارسی با شماره 9126-843-900 بدون هیچ هزینه ای تماس بگیرید. انگلیسی Persian -

Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-800-843-9126.

Portuguese - Para obter assistência linguística em português ligue para o 1-800-843-9126 gratuitamente.

Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-800-843-9126

Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-800-843-9126.

Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-800-843-9126 e aunoa ma se totogi.

Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-800-843-9126.

Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-800-843-9126.

Sudanic-Fulfude - Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-800-843-9126. Njodi woo fawaaki on.

Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-800-843-9126 bila malipo.

Syriac - אבת א שבאו מאר שלב דר שמאואר הר לע ושבר זאל,שם ב-1-800-843-9126 משל .

Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-800-843-9126 nang walang bayad.

Telugu - భాషతో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 1-800-843-9126 కు కాల్ చేయండి. (తెలుగు)

Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-800-843-9126 ฟรีไม่มีค่าใช้จ่าย

Tongan - Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-800-843-9126 'o 'ikai hā ōtōngi.

Trukese - Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-800-843-9126 nge esapw kamé ngonuk.

Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-800-843-9126.

Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-800-843-9126.

بلاقیمت زیان سے متعلقہ خدمات حاصل کرنے کے لیے ، 9126-843-912 . پر بات کریں۔

Vietnamese - Đê 'được hố 'trở ngôn ngư bằng (ngôn ngư), hấy gọi miến phi 'đên số 1-800-843-9126.

Yiddish - פאר שפראך הילף אין אידיש רופט 1-800-843-9126 פריי פון אפצאל.

Yoruba - Fún ìrànlowo nípa èdè (Yorùbá) pe 1-800-843-9126 lái san owó kankan rárá.