Coverage Period: 01/01/2019 - 12/31/2019

Coverage for: Individual + Family | Plan Type: HMO

aetna® : NIAGARA BOTTLING LLC HMO Deductible



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,

https://www.aetna.com/sbcsearch/getpolicydocs?u=081100-100020-021805 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 reguest a copy.

| Important Questions | Answers | Why This Matters: |
|--|--|---|
| What is the overall deductible? | Participating: Individual \$1,500 / Family \$3,000. | 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 <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> . |
| Are there services covered before you meet your <u>deductible</u> ? | Yes. In- <u>network</u> office visits, <u>prescription drugs</u> & <u>preventive care</u> are 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 deductibles 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> ? | Participating: Individual \$3,500 / Family \$7,000. | 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 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, balance-billing</u> charges & health care this <u>plan</u> 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/docfind or call 1-888-982-3862 for a list of participating 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 before</u> you get services. |
| 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> . |

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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 | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
| | Primary care visit to treat an injury or illness | \$25 <u>copay</u> /visit, <u>deductible</u> doesn't apply | Not covered | None |
| If you visit a health care | Specialist visit | \$40 <u>copay</u> /visit, <u>deductible</u> doesn't apply | Not covered | None |
| provider'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. |
| | Diagnostic test (x-ray, blood work) | No charge | Not covered | None |
| If you have a test | Imaging (CT/PET scans, MRIs) | \$100 copay/visit, deductible doesn't apply | Not covered | None |
| | Preferred generic drugs | Copay/prescription, deductible doesn't apply: \$15 (retail & mail order) | Not covered | Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & |
| If you need drugs to treat your illness or condition More information about | Preferred brand drugs | Copay/prescription, deductible doesn't apply: \$30 (retail), \$60 (mail order) | Not covered | devices obtainable from a pharmacy, oral fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in-network. Review your formulary for |
| prescription drug coverage is available at www.aetnapharmacy.com/v alueplus | Non-preferred generic/brand drugs | Copay/prescription, deductible doesn't apply: \$50 (retail), \$100 (mail order) | Not covered | prescriptions requiring precertification or step therapy for coverage. Your cost will be higher for choosing Brand over Generics. |
| Value Plus <u>Formulary</u> | Specialty drugs | 30% copay, <u>deductible</u> doesn't apply | Not covered | First prescription fill at a retail pharmacy or specialty pharmacy. Subsequent fills must be through the Aetna Specialty Pharmacy Network. \$150 maximum copay for each 30 day supply. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance | Not covered | None |
| - Cargory | Physician/surgeon fees | 10% coinsurance | Not covered | None |

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| | | | Will Pay | | |
|---|---|---|---|---|--|
| Common Medical Event | Services You May Need | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information | |
| | Emergency room care | \$150 copay/visit | \$150 <u>copay</u> /visit | No coverage for non-emergency use. | |
| If you need immediate medical attention | Emergency medical transportation | \$100 copay/trip, deductible doesn't apply | \$100 <u>copay</u> /trip, <u>deductible</u> doesn't apply | Non-emergency transport: not covered, except if pre-authorized. | |
| | Urgent care | \$25 <u>copay</u> /visit, <u>deductible</u> doesn't apply | Not covered | No coverage for non-urgent use. | |
| If you have a | Facility fee (e.g., hospital room) | 10% coinsurance | Not covered | None | |
| hospital stay | Physician/surgeon fees | 10% coinsurance | Not covered | None | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Office: \$40 copay/visit, deductible doesn't apply; other outpatient services: no charge | Not covered | Other outpatient services: partial hospitalization, intensive programs, behavioral health treatment for pervasive developmental disorder/autism, home health care, electroconvulsive therapy, day treatment, medical treatment for withdrawal symptoms & outpatient monitoring of injectable therapy. | |
| | Inpatient services | 10% coinsurance | Not covered | None | |
| If you are pregnant | Office visits | No charge | Not covered | Cost sharing does not apply for preventive | |
| | Childbirth/delivery professional services | \$25 <u>copay</u> /pregnancy, <u>deductible</u> doesn't apply | Not covered | services. Maternity care may include tests and services described elsewhere in the SBC | |
| | Childbirth/delivery facility services | 10% coinsurance | Not covered | (i.e. ultrasound.) | |

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| | | What You Will Pay | | |
|--|----------------------------|--|--|--|
| Common Medical Event | Services You May Need | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
| | Home health care | 0% coinsurance | Not covered | 120 visits/calendar year. |
| | Rehabilitation services | \$40 <u>copay</u> /visit, <u>deductible</u> doesn't apply | Not covered | None |
| If you need help | Habilitation services | \$40 <u>copay</u> /visit, <u>deductible</u> doesn't apply | Not covered | None |
| If you need help recovering or have other special health needs | Skilled nursing care | 10% coinsurance | Not covered | 100 days/calendar year. |
| | Durable medical equipment | 50% coinsurance | Not covered | Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse. |
| | Hospice services | 10% <u>coinsurance</u> for inpatient; 0% <u>coinsurance</u> for outpatient | Not covered | None |
| 16 191 1 1 6 1 | Children's eye exam | No charge | Not covered | 1 routine eye exam/24 months. |
| If your child needs dental or eye care | 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:

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|---|--|----------------------------|
| - Services Your Plan Generally Lines NULL Cover IC neck | VALIF DALICY OF DISH ACCUMENT FOR MARE INTORMATION AND A LIST OF SHV | ATHAL BACILINAN SALVICAS I |
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- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Long-term care

- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care

 Weight loss programs - Except for required preventive services.

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

- Acupuncture
- Bariatric surgery
- Chiropractic care 20 visits/calendar year.

- · Hearing aids
- Infertility treatment Limited to the diagnosis & treatment of underlying medical condition.
- Routine eye care (Adult) 1 routine eye exam/24 months.

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: California Department of Managed Health Care, (888) 466-2219, 1-877-688-9891 (TTY), http://www.dmhc.ca.gov.

• 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 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 1-888-982-3862.
- California Department of Managed Health Care, (888) 466-2219, 1-877-688-9891 (TTY), http://www.dmhc.ca.gov.
- 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 California Consumer Assistance Program, Operated by the California Department of Managed Health Care and Department of Insurance, 980 9th Street, Suite #500, Sacramento, CA 95814, (888) 466-2219, http://www.healthhelp.ca.gov

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 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 plan might cover costs for a sample medical situation, see the next section.-----

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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 copayment | \$40 |
| Hospital (facility) coinsurance | 10% |
| Other coinsurance | 10% |

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 | \$12,800 |
|---------------------------------|----------|
| In this example, Peg would pay: | |
| Cost Sharing | |
| Deductibles | \$1,500 |
| Copayments | \$100 |
| Coinsurance | \$700 |
| What isn't covered | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$2,360 |

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 copayment | \$40 |
| ■ Hospital (facility) coinsurance | 10% |
| Other coinsurance | 10% |
| · · · · · · · · · · · · · · · · · · · | |

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 | \$0 | |
| Copayments | \$1,500 | |
| Coinsurance | \$0 | |
| What isn't covered | | |
| Limits or exclusions | \$20 | |
| The total Joe would pay is | \$1,520 | |

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 copayment | \$40 |
| Hospital (facility) coinsurance | 10% |
| Other coinsurance | 10% |

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 | \$500 |
| Copayments | \$300 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$800 |

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: 1-888-982-3862.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-888-982-3862.

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 24030, Fresno, CA 93779

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

Fax: 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.

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

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 3862-982-982-1-888.

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 বিনামূল্য(1-888-982-3862-ত(কল করুন।

Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-888-982-3862 nga walay bayad.

Burmese - ငွေကုန်ကျစံစရာမလိုဘဲ (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.

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 ya apela a chi I paya 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 ખરય 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.

Hindi - हिन्दी में भाषा सहायता के लिए, 1-888-982-3862 पर मुफ्त कॉल करें।

Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-888-982-3862.

lbo - Maka enyemaka asusu na Igbo kpoo 1-888-982-3862 na akwughi ugwo o bula

llocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-888-982-3862 nga awan ti bayadanyo.

Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-888-982-3862.

Japanese - 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。

Karen - လာတာ်မာစားတာ်ကတိာကျိန်အင်္ဂ ကျိန် ကိုး 1-888-982-3862 လာတအိန်ဒီးတာ်လာ၁ိဘူန်လာ၁ိစ္စာဘာ

Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862 번으로 전화해 주십시오.

Kru-Bassa - Be´m`ké gbo-kpá-kpá dyé pidyi dé Bašsoó-wuduun wee, dá 1-888-982-3862

برای راهنمایی به زبان فارسی با شماره 3862-982-188-1 به خورایی پهیومندی بکهن. - Kurdish

Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-888-982-3862 ໂດຍບໍ່ເສຍຄ່າໂທ.

Marathi - तीलभाषा(मराठी)सहाययासाठी 1-888-982-3862 क्रमांकावरकोणत्याहीखर्चाशविायकॉलकरा.

Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-888-982-3862 ilo ejjelok wōnān.

Micronesian - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-888-982-3862 ni sohte isais.

Mon-Khmer, Cambodian - សម្ភាប់ជំនួយភាសាជា ភាសាខ្**មរែ សូមទូរស័ព្**ទទ**ៅកាន់លខេ 1-888-982-3862 ដ**ោយឥតគិតថ្លាំ។

Navajo - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-888-982-3862

Nepali - (नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-888-982-3862 मा फोन गर्नुहोस् ।

Nilotic-Dinka - Tën kupony ë thok ë Thuonjän col 1-888-982-3862 kecin ayöc.

Norwegian - For språkassistanse på norsk, ring 1-888-982-3862 kostnadsfritt.

Panjabi - ਪੰਜਾਬੀ ਵੱਚਿ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-888-982-3862 'ਤੇ ਮੂਫ਼ਤ ਕਾਲ ਕਰੋ।

Pennsylvania Dutch - Fer Helfe in Deitsch, ruf: 1-888-982-3862 aa. Es Aaruf koschtet nix.

برای راهنمایی به زبان فارسی با شماره 3862-982-18-1 بدون هیچ هزینه ای تماس بگیرید. انگلیسی Persian -

Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-888-982-3862.

Portuguese - Para obter assistência linguística em português ligue para o 1-888-982-3862 gratuitamente.

Romanian - 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 - K sur of bound and sur of bound and sur of the sur shall, so 1-888-982-3862 as .

Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-888-982-3862 nang walang bayad.

Telugu - భషతో నయంకొరకు ఎలంటి ఖర్చు లేకుండా 1-888-982-3862 కు శల్ చేయండి. (తెలుగు)

Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-888-982-3862 ฟรีไม่มีค่าใช้จ่าย

Tongan - Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-888-982-3862 'o 'ikai hā tōtōngi.

Trukese - Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-888-982-3862 nge esapw kamé ngonuk.

Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-888-982-3862.

Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-888-982-3862.

ا رورک ل گنتف م رپ 3862-982 <u>1-888 مىل ك</u>نتنو اعمى ن الى ل روم و در

Vietnamese - Để được hố trợ ngôn ngư băng (ngôn ngư), hấy gọi miến phi đến số 1-888-982-3862.

Yiddish - פאר שפראך הילף אין אידיש רופט 1-888-982-3862 פריי פון אפצאל

Yoruba - Fún ìrànlowo nípa èdè (Yorùbá) pe 1-888-982-3862 lái san owó kankan rárá.