Coverage Period: 07/01/2019 - 08/09/2020

Coverage for: Student/Family | Plan Type: PPO



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, visit www.uhcsr.com or call 1-800-767-0700. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance (coins)</u>, <u>copayment (copay)</u>, <u>deductible (ded)</u>, <u>provider</u>, or other <u>underlined</u> terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-767-0700 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Preferred Providers \$1,000 (Person) Out of Network \$2,000 (Person)	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.
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> , Pediatric Dental, Pediatric Vision, Physician's Visits and Prescription Drugs 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 <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?	Yes. Pediatric Dental \$500, *Prescription Drugs \$100 Ded (Per Policy Year). There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	Preferred Providers \$5,000 (Person) Preferred Providers \$10,000 (Family) Out of Network \$12,700 (Person)	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 out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.uhcsr.com or call 1-800-767-0700 for a list of <u>network providers</u> .	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 might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider before you get services</u>.</u>
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the specialist you choose without a referral.

	Services You May Need	What You Will Pay			
Common Medical Event		Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$30 <u>Copay</u> per visit; <u>ded</u> does not apply	25% <u>Coins</u> \$30 <u>Copay</u> per visit; <u>ded</u> does not apply	May not apply when related to surgery or	
	<u>Specialist</u> visit	\$30 <u>Copay</u> per visit; <u>ded</u> does not apply	25% <u>Coins</u> \$30 <u>Copay</u> per visit; <u>ded</u> does not apply	Physiotherapy.	
	Preventive care/screening/immunization	No Charge	25% <u>Coins</u>	Includes <u>preventive services</u> specified in the health care reform law or benefits provided as mandated by state law. 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	<u>Diagnostic test</u> (x-ray, blood work)	\$50 <u>Copay</u> per visit; <u>ded</u> does not apply	\$50 <u>Copay</u> per visit; <u>ded</u> does not apply 25% <u>Coins</u>	none	
	Imaging (CT/PET scans, MRIs)	\$50 <u>Copay</u> per visit; <u>ded</u> does not apply	\$50 <u>Copay</u> per visit; <u>ded</u> does not apply 25% <u>Coins</u>	none	
If you need drugs to treat your illness or condition	Tier 1 - Your Lowest-Cost Option	\$15 <u>Copay</u> per prescription Tier 1; <u>ded</u> does not apply	50% Coins	Preferred Providers: up to a 31 day supply per prescription Preferred Providers: Mail order	
	Tier 2 - Your Midrange-Cost Option	\$30 <u>Copay</u> per prescription Tier 2; <u>ded</u> does not apply	50% Coins	Prescription Drugs through UHCP at 2.5 times the retail Copay up to a 90 day supply	
	Tier 3 - Your Highest-Cost Option	\$60 <u>Copay</u> per prescription Tier 3; <u>ded</u> does not apply	50% Coins	Out of Network: up to a 31 day supply per prescription You may need to obtain certain specialty	

		What Y	ou Will Pay	Limitations, Exceptions, & Other Important Information	
Common Medical Event	Services You May Need	Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)		
	Tier 4 - Additional High-Cost Option	Not Covered	Not Covered	drugs from a pharmacy designated by us.	
	Facility fee (e.g., ambulatory surgery center)	30% <u>Coins</u>	50% <u>Coins</u>	none	
If you have outpatient surgery	Physician/surgeon fees	Anesthetist Services: 75% of Surgery Allowance Assistant Surgeon Fees: 75% of Surgery Allowance Surgery: 30% Coins	Anesthetist Services: 75% of Surgery Allowance Assistant Surgeon Fees: 75% of Surgery Allowance Surgery: 50% Coins	none	
If you need immediate medical attention	Emergency room care	\$200 <u>Copay</u> per visit; 30% <u>Coins</u>	\$200 <u>Copay</u> per visit; 30% <u>Coins</u>	May be limited to use of emergency room and supplies. The Copay will be waived if admitted to the Hospital.	
	Emergency medical transportation	30% <u>Coins</u>	30% <u>Coins</u>	none	
	<u>Urgent care</u>	30% <u>Coins</u>	50% <u>Coins</u>	May be limited to facility fees.	
	Facility fee (e.g., hospital room)	30% <u>Coins</u>	50% <u>Coins</u>	none	
If you have a hospital stay	Physician/surgeon fees	Anesthetist Services: 75% of Surgery Allowance Assistant Surgeon Fees: 75% of Surgery Allowance Physician's Visits: 30% Coins Surgery: 30% Coins	Anesthetist Services: 75% of Surgery Allowance Assistant Surgeon Fees: 75% of Surgery Allowance Physician's Visits: 50% Coins Surgery: 50% Coins	none	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Laboratory Procedures: \$50 Copay per visit; Laboratory Procedures: No Charge Physician's Visits:	Laboratory Procedures: \$50 Copay per visit; Laboratory Procedures: 25% Coins Physician's Visits: \$30 Copay per visit; ded does not apply	none	

	Services You May Need	What Y	ou Will Pay		
Common Medical Event		Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
		\$30 Copay per visit; ded does not apply Physician's Visits: No Charge	Physician's Visits: 25% Coins		
	Inpatient services	30% <u>Coins</u>	50% <u>Coins</u>	none	
If you are pregnant	Office visits	\$30 <u>Copay</u> per visit; <u>ded</u> does not apply	25% <u>Coins</u> \$30 <u>Copay</u> per visit; <u>ded</u> does not apply	Cost sharing does not apply for preventive services when provided by a preferred provider. Depending on the type of	
	Childbirth/delivery professional services	30% <u>Coins</u>	50% <u>Coins</u>	services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).	
	Childbirth/delivery facility services	30% <u>Coins</u>	50% <u>Coins</u>	none	
	Home health care	30% <u>Coins</u>	50% <u>Coins</u>	none	
If you need help recovering or have other special health needs	Rehabilitation services	Inpatient Rehabilitation Facility: 30% <u>Coins</u> Physiotherapy: \$30 <u>Copay</u> per visit; Physiotherapy: No Charge	Inpatient Rehabilitation Facility: 50% <u>Coins</u> Physiotherapy: \$30 <u>Copay</u> per visit; Physiotherapy: 25% <u>Coins</u>	Outpatient: 30 visits for any combination of physical therapy, occupational therapy, and speech therapy Outpatient: 30 visits of manipulative therapy Outpatient: Separate physical, occupational and speech therapy limits apply to rehabilitative and Habilitative Services	
	Habilitation services	\$30 <u>Copay</u> per visit;	25% <u>Coins</u> \$30 <u>Copay</u> per visit;	Outpatient: 30 visits for any combination of physical therapy, occupational therapy, and speech therapy Outpatient: 30 visits of manipulative therapy Outpatient: Separate physical, occupational and speech therapy limits apply to rehabilitative and Habilitative Services	

	Services You May Need	What Y	ou Will Pay	
Common Medical Event		Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Skilled nursing care	30% <u>Coins</u>	50% <u>Coins</u>	none
	Durable medical equipment	30% <u>Coins</u>	30% <u>Coins</u>	none
	Hospice services	Paid as any other Sickness	Paid as any other Sickness	none
If your child needs dental or eye care	Children's eye exam	\$20 <u>Copay</u> per exam; <u>ded</u> does not apply	50% Coins; ded does not apply	See your <u>plan's</u> Pediatric Vision Benefit Details. Age limits apply.*
	Children's glasses	Lens: \$40 <u>Copay</u> ; <u>ded</u> does not apply Frames: Tiered <u>Copay</u> s from no charge to 40% based on retail cost. <u>ded</u> does not apply	50% <u>Coins;</u> <u>ded</u> does not apply	See your <u>plan's</u> Pediatric Vision Benefit Details. Age limits apply.*
	Children's dental check-up	50% <u>Coins</u>	50% Coins	See your <u>plan's</u> Pediatric Dental Benefit Details. Age limits apply.*

# **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.)

Acupuncture

Bariatric surgery

Cosmetic surgery

Dental care (Adult)

- Hearing aids except as noted in the policy
- Infertility treatment except as noted in the policy

Long-term care

- Routine eye care (Adult) except as noted in the policy
- Routine foot care

Weight loss programs

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

Chiropractic care

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

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: Arkansas Insurance Department at 1-501-371-2640 or 1-800-852-5494 or visit http://www.insurance.arkansas.gov/. 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: Arkansas Insurance Department at 1-501-371-2640 or 1-800-852-5494 or visit http://www.insurance.arkansas.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 the 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.

# **Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-260-2723.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-260-2723.

Chinese (中文): 如果需要中文的帮助,请拨打这个号码 1-866-260-2723.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-260-2723.

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)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well- controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
<ul> <li>The <u>plan's</u> overall <u>deductible</u></li> <li><u>Specialist copayment</u></li> <li>Hospital (facility) <u>coinsurance</u></li> <li>Other <u>coinsurance</u></li> </ul>	\$1,000 \$30 30% 30%	<ul> <li>The plan's overall deductible</li> <li>Specialist copayment</li> <li>Hospital (facility) coinsurance</li> <li>Other coinsurance</li> </ul>	\$1,000 \$30 30% 30%	<ul> <li>The plan's overall deductible</li> <li>Specialist copayment</li> <li>Hospital (facility) coinsurance</li> <li>Other coinsurance</li> </ul>	\$1,000 \$30 30% 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)		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)		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	\$12,800	Total Example Cost	\$7,400	Total Example Cost	\$1,900
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
Cost Sharing		Cost Sharing		Cost Sharing	
Deductibles	\$1,000	Deductibles	\$1,000	Deductibles	\$1,000
Copayments	\$50	Copayments	\$1,000	Copayments	\$90
Coinsurance	\$2,800	Coinsurance	\$200	Coinsurance	\$100
What isn't covered		What isn't covered		What isn't covered	
Limits or exclusions	\$60	Limits or exclusions	\$60	Limits or exclusions	\$0
The total Peg would pay is	\$3,910	The total Joe would pay is	\$2,260	The total Mia would pay is	\$1,190

# NON-DISCRIMINATION NOTICE

UnitedHealthcare StudentResources does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator
United HealthCare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130
UHC\_Civil\_Rights@uhc.com

You must send the written complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free member phone number listed on your health plan ID card, Monday through Friday, 8 a.m. to 8 p.m. ET.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

**Mail:** U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We also provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for free language services such as speaking with an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan ID card, Monday through Friday, 8 a.m. to 8 p.m. ET.

### LANGUAGE ASSISTANCE PROGRAM

We provide free services to help you communicate with us, such as, letters in other languages or large print. Or, you can ask for free language services such as speaking with an interpreter. To ask for help, please call toll-free 1-866-260-2723, Monday through Friday, 8 a.m. to 8 p.m. ET.

#### **English**

Language assistance services are available to you free of charge. Please call 1-866-260-2723.

#### Albanian

Shërbimet e ndihmës në gjuhën amtare ofrohen falas. Ju lutemi telefononi në numrin 1-866-260-2723.

### **Amharic**

የቋንቋ እርዳታ አንልግሎቶች በነጻ ይንኛሉ። እባክዎ ወደ 1-866-260-2723 ይደውሉ።

#### Arabic

تتوفر لك خدمات المساعدة اللغوية مجانًا. اتصل على الرقم 2723-260-1.

#### Armenian

Ձեզ մատչելի են անվձար լեզվական օգնության ծառայություններ։ Խնդրում ենք զանգահարել 1-866-260-2723 համարով։

#### Bantu- Kirundi

Uronswa ku buntu serivisi zifatiye ku rurimi zo kugufasha. Utegerezwa guhamagara 1-866-260-2723.

### Bisayan- Visayan (Cebuano)

Magamit nimo ang mga serbisyo sa tabang sa lengguwahe nga walay bayad. Palihug tawag sa 1-866-260-2723.

#### Bengali- Bangala

ঘোষণা : ভাষা সহায়তা পরিষেবা আপনি বিনামূল্যে পেতে পারেন। দ্যা করে 1-866-260-2723-তে কল করুন।

### Burmese

## Cambodian- Mon-Khmer

សេវាជំនួយផ្នែកភាសាដែលឥតគិតថ្លៃ មានសម្រាប់អ្នក។ សូមទូរស័ព្ទទៅលេខ 1-866-260-2723។

### Cherokee

### Chinese

您可以免費獲得語言援助服務。請致電 1-866-260-2723。

#### Choctay

Chahta anumpa ish anumpuli hokmvt tohsholi yvt peh pilla hochi apela hinla. I paya 1-866-260-2723.

### **Cushite- Oromo**

Tajaajilliwwan gargaarsa afaanii kanfalttii malee siif jira. Maaloo karaa lakkoofsa bilbilaa 1-866-260-2723 bilbili.

#### **Dutch**

Taalbijstandsdiensten zijn gratis voor u beschikbaar. Gelieve 1-866-260-2723 op te bellen.

#### French

Des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-260-2723.

### French Creole- Haitian Creole

Gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-866-260-2723.

#### German

Sprachliche Hilfsdienstleistungen stehen Ihnen kostenlos zur Verfügung. Bitte rufen Sie an unter: 1-866-260-2723.

#### Greek

Οι υπηρεσίες γλωσσικής βοήθειας σας διατίθενται δωρεάν. Καλέστε το 1-866-260-2723.

### Gujarati

ભાષા સહાય સેવાઓ તમારા માટે નિઃશુલ્ક ઉપલબ્ધ છે. કૃપા કરીને 1-866-260-2723 પર કૉલ કરો.

### Hawaiian

Kōkua manuahi ma kāu 'ōlelo i loa'a 'ia. E kelepona i ka helu 1-866-260-2723.

#### Hindi

आप के लिए भाषा सहायता सेवाएं निःशुल्क उपलब्ध हैं। कृपया 1-866-260-2723 पर कॉल करें।

#### Hmong

Muaj cov kev pab txhais lus pub dawb rau koj. Thov hu rau 1-866-260-2723.

#### Tho

Enyemaka na-ahazi asusu, bu n'efu, diri gi. Kpoo 1-866-260-2723.

#### Ilocano

Adda awan bayadna a serbisio para iti language assistance. Pangngaasim ta tawagam ti 1-866-260-2723.

## Indonesian

Layanan bantuan bahasa bebas biaya tersedia untuk Anda. Harap hubungi 1-866-260-2723.

#### Italian

Sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-260-2723.

# **Japanese**

無料の言語支援サービスをご利用いただけます。 1-866-260-2723 までお電話ください。

### Karen

usdmw>rRpXRt\*D>erRM>tDRoh0J vXwvd.[h.tyORb. (cDvD) M.vDRI

0Ho;plRqJ;usd;b. 1-866-260-2723 wuh>l

#### Korean

언어 지원 서비스를 무료로 이용하실 수 있습니다.

1-866-260-2723 번으로 전화하십시오.

#### Kru- Rassa

Bot ba hola ni kobol mahop ngui nsaa wogui wo ba yé ha i nyuu yon. Sebel i nsinga ini 1-866-260-2723.

### **Kurdish Sorani**

خزمەتەكانى يارمەتيىي زمانى بەخۆړ ايى بۆ تۆ دابين دەكريێن. تكايە تەلمەڧۆن بكە بۆ ڑمارەي 2723-866-16.

### Laotian

ີ່ມີບໍລິການທາງດ້ານພາສາບໍ່ເສຍຄ່າໃຫ້ແກ່ທ່ານ. ກະລຸນາໂທຫາເບີ

SR LAP 64 (6-18)

1-866-260-2723.

#### Marathi

भाषेच्या मदतीची सुविधा आपल्याला विनामूल्य उपलब्ध आहे. त्यासाठी 1-866-260-2723 या क्रमांकावर संपर्क करा.

#### Marshallese

Kwomaroñ bōk jerbal in jipañ in kajin ilo ejjelok wōṇāān. Jouj im kallok 1-866-260-2723.

### Micronesian-Pohnpeian

Mie sawas en mahsen ong komwi, soh isepe. Melau eker 1-866-260-2723.

#### Navajo

Saad bee áka'e'eyeed bee áka'nída'wo'ígíí t'áá jíík'eh bee nich'į' bee ná'ahoot'i'. T'áá shoodí kohjį' 1-866-260-2723 hodíilnih.

### Nepali

भाषा सहायता सेवाहरू निःशुल्क उपलब्ध छन्। कृपया 1-866-260-2723 मा कल गर्न्होस्।

#### Nilotic-Dinka

Käk ë kuny ajuεεr ë thok atö tïnë yïn abac të cïn wëu yeke thiëëc. Yïn col 1-866-260-2723.

## Norwegian

Du kan få gratis språkhjelp. Ring 1-866-260-2723.

### Pennsylvania Dutch

Schprooch iwwesetze Hilf kannscht du frei hawwe. Ruf 1-866-260-2723.

#### Persian-Farsi

خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره 1-866-260-2723 تماس بگیرید

### **Polish**

Możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-260-2723.

# **Portuguese**

Oferecemos serviço gratuito de assistência de idioma. Ligue para 1-866-260-2723.

#### **Puniab**

ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹਨ। ਕਿਰਪਾ ਕਰਕੇ 1-866-260-2723 'ਤੇ ਕਾਲ ਕਰੋ।

#### Romanian

Vi se pun la dispoziție, în mod gratuit, servicii de traducere. Vă rugăm să sunați la 1-866-260-2723.

### Russian

Языковые услуги предоставляются вам бесплатно. Звоните по телефону 1-866-260-2723.

## Samoan- Fa'asamoa

O loo maua fesoasoani mo gagana mo oe ma e lē totogia. Faamolemole telefoni le 1-866-260-2723.

### Serbo- Croatian

Možete besplatno koristiti usluge prevodioca. Molimo nazovite 1-866-260-2723.

#### Somali

Adeegyada taageerada luqadda oo bilaash ah ayaa la heli karaa. Fadlan wac 1-866-260-2723.

### Spanish

Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-866-260-2723.

#### **Sudanic- Fulfulde**

E woodi walliinde dow wolde caahu ngam maaɗa. Noodu 1-866-260-2723.

### Swahili

Huduma za msaada wa lugha zinapatikana kwa ajili yako bure. Tafadhali piga simu 1-866-260-2723.

### Syriac- Assyrian

چەرەئىقە ئۇنىزىلى دۇنىزىكى ئېرىكى ئىلىدى . كېيىزى ئىلىدى . كېيىزى ئىلىدى . كېيىزى ئىلىدى . كېيىزى ئىلىدى . كېي ئەنى خىد مىنىكە 2723-866-10.

### Tagalog

Ang mga serbisyo ng tulong sa wika ay available para sa iyo ng walang bayad. Mangyaring tumawag sa 1-866-260-2723.

### Telugu

లాంగ్వేజ్ అసిస్టెంట్ సర్వీసెస్ మీకు ఉచితంగా అందుబాటులో ఉన్నాయి.

దయ చేసి 1-866-260-2723 కి కాల్ చేయండి.

#### Thai

# มีบริการความช่วยเหลือด้านภาษาให้โดยที่คุณไม่ต้องเสียค่าใช้จ่า ยแต่อย่างใด โปรดโทรศัพท์ถึงหมายเลข

1-866-260-2733

# Tongan- Fakatonga

'Oku 'i ai pē 'a e sēvesi ki he lea' ke tokoni kiate koe pea 'oku 'atā ia ma'au 'o 'ikai ha totongi. Kātaki 'o tā ki he 1-866-260-2723.

## Trukese (Chuukese)

En mei tongeni angei aninisin emon chon chiakku, ese kamo. Kose mochen kopwe kokkori 1-866-260-2723.

### Turkish

Dil yardım hizmetleri size ücretsiz olarak sunulmaktadır. Lütfen 1-866-260-2723 numarayı arayınız.

### Ukrainian

Послуги перекладу надаються вам безкоштовно. Дзвоніть за номером 1-866-260-2723.

### Urdu

زبان کے حوالے سے معاونتی خدمات آپ کے لیے بلامعاوضہ دستیاب ہیں۔ براہ مہربانی 2723-266-186-1 پر کال کریں۔

## Vietnamese

Dịch vụ hỗ trợ ngôn ngữ, miễn phí, dành cho quý vị. Xin vui lòng gọi 1-866-260-2723.

#### Yiddish

שפראך הילף סערוויסעס זענען אוועילעבל פאר אייך פריי פון אפצאל. ביטע רופט 1-866-260-2723

#### Yoruba

Isé ìrànlówó èdè tí ó jé òfé, wà fún ó. Pe 1-866-260-2723.

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