UnitedHealthcare: Western Kentucky University 2020-1644-4

Coverage Period: 08/01/2020 - 07/31/2021

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/wku 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 \$500 (Person) Out of Network \$1,000 (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 and categories that specify <u>ded</u> does not apply. | 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? | Yes. Pediatric Dental \$500. 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 \$6,850 (Person) Preferred Providers \$12,000 (Family) | 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? | <u>Premiums</u> , <u>balance-billing</u> charges, and 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 www.uhcsr.com/wku or call 1-800-767-0700 for a list of 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 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 | | Services You May Need Preferred Pro (You will pay 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 | \$50 <u>Copay</u> per visit 20% <u>Coins</u> | \$50 <u>Copay</u> per visit 40% <u>Coins</u> | May not apply when related to surgery or | |
| | <u>Specialist</u> visit | \$50 <u>Copay</u> per visit 20% <u>Coins</u> | \$50 <u>Copay</u> per visit 40% <u>Coins</u> | Physiotherapy. | |
| | Preventive care/screening/immunization | No Charge | 40% <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) | Diagnostic X-ray Services: 20% Coins \$50 Copay per visit Laboratory Procedures: \$50 Copay per visit No Charge | Diagnostic X-ray Services: 40% <u>Coins</u> \$50 <u>Copay</u> per visit Laboratory Procedures: 25% <u>Coins</u> \$50 <u>Copay</u> per visit | none | |
| | Imaging (CT/PET scans, MRIs) | 20% <u>Coins</u> \$50 <u>Copay</u> per visit | 40% <u>Coins</u> \$50 <u>Copay</u> per visit | none | |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.uhcsr.com/pdl | Tier 1 - Your Lowest-Cost Option | \$20 <u>Copay</u> per prescription Tier 1 <u>ded</u> does not apply | ded does not apply \$20 Copay per prescription generic drug \$35 Copay per prescription brand-name drug | Preferred Providers: up to a 31 day supply per prescription Preferred Providers: Mail order Prescription Drugs through UHCP at 2.5 times the retail Copay up to a 90 day supply | |
| | Tier 2 - Your Midrange-Cost Option | \$35 <u>Copay</u> per prescription Tier 2 <u>ded</u> does not apply | ded does not apply \$20 Copay per prescription generic drug | Out of Network: up to a 31 day supply per prescription You may need to obtain certain specialty | |

| | 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 | |
| | | | \$35 <u>Copay</u> per prescription brand-name drug | drugs from a pharmacy designated by us. The Insured Person is not responsible for paying a Copay and/or Coins for | |
| | Tier 3 - Your Highest-Cost Option | \$60 <u>Copay</u> per prescription Tier 3 <u>ded</u> does not apply | ded does not apply \$20 Copay per prescription generic drug \$35 Copay per prescription brand-name drug | Preventive Care Medications including contraceptives. | |
| | Tier 4 - Additional High-Cost Option | Not Covered | Not Covered | | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% <u>Coins</u> | 40% <u>Coins</u> | none | |
| | Physician/surgeon fees | 20% <u>Coins</u> | 40% <u>Coins</u> | none | |
| If you need immediate | Emergency room care | \$250 <u>Copay</u> per visit 20% <u>Coins</u> | \$250 <u>Copay</u> per visit 40% <u>Coins</u> | May be limited to use of emergency room and supplies. The Copay will be waived if admitted to the Hospital. | |
| medical attention | Emergency medical transportation | 20% <u>Coins</u> | 20% <u>Coins</u> | none | |
| | Urgent care | \$50 <u>Copay</u> per visit | 25% <u>Coins</u> \$50 <u>Copay</u> per visit | May be limited to facility fees. | |
| If you have a hospital | Facility fee (e.g., hospital room) | 20% <u>Coins</u> | 40% <u>Coins</u> | none | |
| stay | Physician/surgeon fees | 20% <u>Coins</u> | 40% <u>Coins</u> | none | |
| If you need mental health, behavioral health, or substance | Outpatient services | Office Visits: \$50 <u>Copay</u> per visit 20% <u>Coins</u> Other: 20% <u>Coins</u> | Office Visits: \$50 <u>Copay</u> per visit 40% <u>Coins</u> Other: 40% <u>Coins</u> | none | |
| abuse services | Inpatient services | 20% <u>Coins</u> | 40% <u>Coins</u> | none | |
| If you are pregnant | Office visits | 20% <u>Coins</u> \$50 <u>Copay</u> per visit | 40% <u>Coins</u> \$50 <u>Copay</u> per visit | Cost sharing does not apply for preventive services when provided by a preferred | |
| | Childbirth/delivery professional services | 20% <u>Coins</u> | 40% <u>Coins</u> | <u>provider</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may | |

| Common Medical Event | Services You May Need | What Y | ou Will Pay | Limitations, Exceptions, & Other | |
|---|---------------------------------------|---|---|--|--|
| | | Preferred Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | Important Information | |
| | | | | include tests and services described elsewhere in the SBC (i.e. ultrasound). | |
| | Childbirth/delivery facility services | 20% <u>Coins</u> | 40% <u>Coins</u> | none | |
| | Home health care | 20% <u>Coins</u> | 40% <u>Coins</u> | none | |
| | Rehabilitation services | 20% <u>Coins</u> | 40% <u>Coins</u> | none | |
| If you need help | Habilitation services | 20% <u>Coins</u> | 40% <u>Coins</u> | none | |
| recovering or have | Skilled nursing care | 20% <u>Coins</u> | 40% <u>Coins</u> | none | |
| other special health | Durable medical equipment | 20% <u>Coins</u> | 40% <u>Coins</u> | none | |
| needs | Hospice services | Paid at least equal to the Medicare benefits for Hospice Care | Paid at least equal to the Medicare benefits for Hospice Care | 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 | 25% <u>Coins</u> ; <u>ded</u> 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 | 25% <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) except as specifically provided in the policy

Infertility treatment

• Long-term care

Routine eye care (Adult)

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

Hearing aids

Non-emergency care when traveling outside the U.S.

Private-duty nursing

Routine foot 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: Kentucky Department of Insurance at 1-800-595-6053 or visit http://insurance.ky.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: Kentucky Department of Insurance at 1-800-595-6053 or visit http://insurance.ky.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) | |
|--|----------|--|---------|--|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> \$500 ■ <u>Specialist copayment</u> \$50 ■ Hospital (facility) <u>coinsurance</u> 20% ■ Other <u>coinsurance</u> 20% | | ■ The <u>plan's</u> overall <u>deductible</u> \$500 ■ <u>Specialist copayment</u> \$50 ■ Hospital (facility) <u>coinsurance</u> 20% ■ Other <u>coinsurance</u> 20% | | The <u>plan's</u> overall <u>deductible</u> <u>Specialist copayment</u> Hospital (facility) <u>coinsurance</u> Other <u>coinsurance</u> | |
| This EXAMPLE event includes set Specialist office visits (prenatal care) Childbirth/Delivery Professional Serv Childbirth/Delivery Facility Services Diagnostic tests (ultrasounds and blo Specialist visit (anesthesia) | ices | 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 | \$500 | Deductibles | \$500 | Deductibles | \$500 |
| Copayments | \$70 | Copayments | \$1,500 | Copayments | \$200 |
| Coinsurance | \$2,300 | Coinsurance | \$300 | 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 | |
| The total Peg would pay is | \$2,930 | The total Joe would pay is | \$2,360 | The total Mia would pay is | \$800 |

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 አርዳታ አንልማሎተች በነጻ ይነኛሱ። አባከዎ ወደ 1-866-260-2723 ይደውሱ።

Arabic

تنزفر الله خدمات المصاعدة اللغوية مجانًا. تصل على الرقم 2723-260-866-1.

Armenian

Ձեզ մատչելի են անվճար լեզվական օգնության Նառայություններ։ 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 বিনামূল্য পেতে পারেন। দ্য়া করে 1-866-260-2723-তে কল করুন।

Burmese

ဘာသာစကား အကူအညီ ဝန်ဆောင်မှုများ သင့် အတွက် အခမဲ့ရရှိနိုင်သည်။ ကျေးဇူးပြု၍ ဖုန်း 1-866-260-2723 ကိုခေါ် ပါ။

Cambodian- Mon-Khmer

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

Cherokee

SYNLOW OPLOSA OPLOET IN RECOVERLANT THEGGOOD DAGE. IGGO DE OBWOS 1-866-260-2723.

Chinese

您可以免費獲得語言援助服務。請致電 1-866-260-2723。

Choctan

Chahta anumpa ish anumpuli hokmyt tohsholi yyt peh pilla ho chi 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 sévis éd 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.

Guiarati

ભાષા સહાય સેવાઓ તમારા માટે નિ:શુલ્ક ઉપલબ્ધ છે. કૂપા કરીને 1-866-260-2723 પર ક્રૅલ કરો.

Hawaiian

Kökua manuahi ma kāu 'ölelo 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.

Ibo

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

Hocano

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.

Italiar

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

ကျိုင်တာမှာ ကေဆက်နေမာ ရုံဆီးသည်လာသက်ပိုးဘုိဆုံးကျာပို့ခြီလီ) နှစ်လီး ငံသာရာသံလျှိုးတာ§ 1-866-260-2723တတုံး

Korean

언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-260-2723 번으로 선회하십시오.

Kru- Bassa

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

خۇمەتكىكى يارمەتنى زماتى بەخۇر. يى بۇ ئۇ دابىن دەكرېن. ئىكايە ئەللەقن بىكە بۇ زمار دى 272-260-1-866.

Lagtiar

ມືບໍລິການທາງດ້ານພາສາບໍ່ເສຍຄ່າໃຫ້ແກ່ທ່ານ, ກະລຸນາໂທຫາເປີ 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'ígíi t'áá jiík'eh bee nich'i' bee ná'ahoot'i'. T'áá shoodi kohj! 1-866-260-2723 hodíilnih.

Nepali

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

Nilotic-Dinka

Kāk ē kuny ajuser ē thok atā tīnē yīn abac tē cīn wēu yeke thiēēc. Yīn 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 زباتی به طور رایگان در اختیار شما می باشد. لطفاً با شمار ه 2723-(666-260) 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.

Punjabi

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 le 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 waa 1-866-260-2723.

Spanish

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

Sudanic- Fulfulde

B woodi walliinde dow wolde caahu ngam maada. Noodu 1-866-260-2723.

Swahil

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

Syriac- Assyrian

جوهواتك من المنافق والمنافق والمنافق من المنافق من المنافق و المنافق و المنافق و المنافق و المنافق و المنافق و منافي بل وجود المنافق (272-360-16)

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

มีบริการความช่วยเหลือด้านภาษาให้โดยที่คุณไม่ต้องเสียค่าใช้จา 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 I-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 падаються вам безкоштовно. Дзвоніть за номером 1-866-260-2723.

Urdu

زبان کے حوالے سے معارفتی خدمات آپ کے لیے بلامعارضہ دستیاب ہیں۔ ہر ممہرمانی 2723-260-1864 ہر کال کریں۔

Vietnamese

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

Yiddish

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

Yoruba

Isệ ìránlówó èdè ti ở jệ ôfé, wà fún ở. Pe 1-866-260-2723.