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/wiu 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.healthcare.gov/sbc-glossary/ 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) Preferred Providers \$1,500 / (Family) Out-of-Network Provider \$1,000 / (Person) Out-of-Network Provider \$3,000 / (Family)	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 deductible?	Yes. Preventive care, Pediatric Dental, Pediatric Vision and categories that specify ded 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 \$50. 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 \$7,200 / (Person) Preferred Providers \$13,200 / (Family) Out-of-Network Provider \$20,000 / (Person) Out-of-Network Provider \$38,400 / (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/wiu 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</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All $\underline{\textbf{copayment}}$ and $\underline{\textbf{coinsurance}}$ costs shown in this chart are after your $\underline{\textbf{deductible}}$ has been met, if a $\underline{\textbf{deductible}}$ applies.

	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
	Primary care visit to treat an injury or illness	\$25 <u>Copay</u> per visit <u>ded</u> does not apply	50% Coins	May not apply when related to surgery or
	Specialist visit	\$25 <u>Copay</u> per visit <u>ded</u> does not apply	50% <u>Coins</u>	Physiotherapy.
If you visit a health care provider's office or clinic	Preventive care/screening/immunization	No Charge	20% <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	Diagnostic test (x-ray, blood work)	20% <u>Coins</u>	50% <u>Coins</u>	none
ii you nave a test	Imaging (CT/PET scans, MRIs)	20% <u>Coins</u>	50% <u>Coins</u>	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	\$30 <u>Copay</u> per prescription Tier 1 <u>ded</u> does not apply	50% <u>Coins</u> \$60 <u>Copay</u> per prescription generic drug \$80 <u>Copay</u> per prescription brand-name drug	Preferred Providers: up to a 30 day supply per prescription Out-of-Network Provider: up to a 30 day supply per prescription You may need to obtain certain specialty drugs from a pharmacy designated by us. You may need to obtain prior authorization for certain prescription drugs. You may pay more if prior authorization is not obtained. For insulin drugs, the total amount of Copayments or Coinsurance shall not exceed \$100 for an individual prescription of up to a 30-day supply.

		What You Will Pay		
Common Medical Event	Services You May Need	Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Tier 2 - Your Midrange-Cost Option	\$60 <u>Copay</u> per prescription Tier 2 <u>ded</u> does not apply	50% <u>Coins</u> \$60 <u>Copay</u> per prescription generic drug \$80 <u>Copay</u> per prescription brand-name drug	Preferred Providers: up to a 30 day supply per prescription Out-of-Network Provider: up to a 30 day supply per prescription You may need to obtain certain specialty drugs from a pharmacy designated by us.
	Tier 3 - Your Highest-Cost Option	\$80 <u>Copay</u> per prescription Tier 3 <u>ded</u> does not apply	50% <u>Coins</u> \$60 <u>Copay</u> per prescription generic drug \$80 <u>Copay</u> per prescription brand-name drug	Preferred Providers: up to a 30 day supply per prescription Out-of-Network Provider: up to a 30 day supply per prescription You may need to obtain certain specialty drugs from a pharmacy designated by us.
	Tier 4 - Additional High-Cost Option	Not Covered	Not Covered	Preferred Providers: up to a 30 day supply per prescription Out-of-Network Provider: up to a 30 day supply per prescription You may need to obtain certain specialty drugs from a pharmacy designated by us.
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	20% <u>Coins</u>	50% <u>Coins</u>	none
surgery	Physician/surgeon fees	20% <u>Coins</u>	50% Coins	none
If you need immediate medical attention	Emergency room care	20% <u>Coins</u> \$300 <u>Copay</u> per visit	20% <u>Coins</u> \$300 <u>Copay</u> per visit	May be limited to use of emergency room and supplies. The <u>Copay</u> will be waived if admitted to the Hospital.
	Emergency medical transportation	20% <u>Coins</u>	20% <u>Coins</u>	none
	<u>Urgent care</u>	20% <u>Coins</u>	50% <u>Coins</u>	May be limited to facility fees.
If you have a hospital	Facility fee (e.g., hospital room)	20% <u>Coins</u>	50% Coins	none
stay	Physician/surgeon fees	20% <u>Coins</u>	50% Coins	none
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visits: \$25 Copay per visit ded does not apply Other: 20% Coins	Office Visits: 50% Coins Other: 50% Coins	none

	Services You May Need	What You Will Pay		Livitations Franctions 9 Other
Common Medical Event		Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Inpatient services	20% <u>Coins</u>	50% <u>Coins</u>	none
If you are pregnant	Office visits	\$25 <u>Copay</u> per visit <u>ded</u> does not apply	50% Coins	Cost-sharing does not apply for preventive services when provided by a preferred
	Childbirth/delivery professional services	20% <u>Coins</u>	50% <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 ma include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery facility services	20% <u>Coins</u>	50% <u>Coins</u>	none

		What You Will Pay			
Common Medical Event	Services You May Need	Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
	Home health care	20% <u>Coins</u>	50% <u>Coins</u>	none	
If you need help	Rehabilitation services	20% <u>Coins</u>	50% Coins	Outpatient 25 visits of manipulative therapy	
recovering or have other special health needs	Habilitation services	20% <u>Coins</u>	50% Coins	Outpatient 25 visits of manipulative therapy	
	Skilled nursing care	20% <u>Coins</u>	50% <u>Coins</u>	none	
	Durable medical equipment	20% <u>Coins</u>	50% <u>Coins</u>	none	
	Hospice services	20% <u>Coins</u>	50% <u>Coins</u>	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	20% <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 Copay; ded does not apply Frames: Tiered Copays from no charge to 40% based on retail cost. ded does not apply		See your <u>plan's</u> Pediatric Vision Benefit Details. Age limits apply.*	
	Children's dental check-up	50% Coins	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

Cosmetic surgery

Dental care (Adult)

Hearing aids

• Long-term care

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

Routine eye care (Adult)

Routine foot care

• Weight loss programs

•

•

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

Abortion care services

Chiropractic care

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: UnitedHealthcare Student Resources at 1-800-767-0700 and Illinois Department of Insurance at 1-866-445-5364 or visit http://www.insurance.illinois.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 on how 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: Illinois Department of Insurance at 1-866-445-5364 or visit http://www.insurance.illinois.gov/.

Additionally, a consumer assistance program can help you file your <u>appeal</u>, contact Illinois Department of Insurance, Office of Consumer Health Insurance at 1-877-527-9431 or visit http://insurance.illinois.gov/.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes <u>plans</u>, <u>health insurance</u> available through the <u>Marketplace</u> or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of <u>Minimum Essential Coverage</u>, you may not be eligible for the <u>premium tax credit</u>.

Does this plan meet Minimum Value Standards? Not Applicable

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)

■ The <u>plan's</u> overall <u>deductible</u>	\$500
Specialist copayment	\$25
■ Hospital (facility) coinsurance	20%
■ Other <u>coinsurance</u>	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)

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>	\$500
■ Specialist copayment	\$25
■ 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)

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$500
Specialist copayment	\$25
■ Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

Diagnostic test (x-ray)

Durable medical equipment (crutches)

Rehabilitation services (physical therapy)

In this example, Peg would pay:		
Cost-Sharing		
<u>Deductibles</u>	\$500	
<u>Copayments</u>	\$30	
<u>Coinsurance</u>	\$1,900	
What isn't covered		
Limits or exclusions \$60		

\$2,490

Total Example Cost	\$5,600
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In this example, Joe would pay:		
Cost-Sharing		
<u>Deductibles</u>	\$500	
<u>Copayments</u>	\$1,100	
Coinsurance	\$100	
What isn't covered		
Limits or exclusions	\$20	
The total Joe would pay is \$1,7		

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost-Sharing	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$700
<u>Coinsurance</u>	\$300
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,500

COL-17-IL (PY22) SBC (270-1)

The total Peg would pay is

UnitedHealthcare Insurance Company

NON-DISCRIMINATION NOTICE

UnitedHealthcare Student Resources 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 2723-260-866.

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

ဘာသာစကား အကူအညီ ဝန္ေဆာင္မႈမ်ား သင့္ အတြက္ အခမဲ့ရရွိႏိုင္သည္။ ေက်းဇူးျပဳ၍ ဖုန္း 1-866-260-2723 ကိုေခၚပါ။

Cambodian- Mon-Khmer

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

Cherokee

\$ሚኬብፙቭ ውፀ៤ፙ\$ጓቭ ውፀ៤ሚET ኬብ RGሮሚተመቴብጓፐ ከ៤EGGሮ D4ωT. FGω Dh ወbWሮ\$ 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。

Choctaw

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 ક્રૉલ 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.

Ibo

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

OHo;plRqJ;usd;b. 1-866-260-2723 wuh>I

Korean

언어 지원 서비스를 무료로 이용하실 수 있습니다.

1-866-260-2723 번으로 전화하십시오.

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

خزمەتەكانى يارمەتىي زمانى بەخۆر ايى بۆ تۆ دابين دەكرين. تكايە تەلەفۆن بكە بۆ رەمارەي 2723-866-16.

Laotian

SR LAP 64 (6-18) 1 of 2

ມີບໍລິການທາງດ້ານພາສາບໍ່ເສຍຄ່ຳໃຫ້ແກ່່ທ່ຳນ. ກະລຸນາໂທຫາເບີ 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 गर्नुहोस्।

Nilotic-Dinka

Käk ë kuny ajuɛɛr ë thok atö tïnë yïn abac të cïn wëu yeke thiëëc. Yïn cəl 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 1-866-260-1 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 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

چەرەخىنىك دۇندۇكى بىلىد ئەبىرىنى بىلىدىكى ، مىنىدۇكى ، مىنىكە دەنىكە كەرەخەكە-1. مەنى خىد مىنىكە 2723-866-1.

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، 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 1-866-260-2723 רופט

Yoruba

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

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