United Healthcare : University of Louisville 2024-382-1

Coverage Period: 08/01/2024 - 07/31/2025

Coverage for: Student/Family | Plan Type: PPO

**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) 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/louisville or call 1-866-907-6342. For general definitions of common terms, such as allowed amount, balance billing, coinsurance (coins), copayment (copay), deductible (ded), provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-866-907-6342 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | Select Providers $200 / (Person)<br>Preferred Providers $700 / (Person)<br>Out-of-Network Provider $1,000 / (Person) | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. |
| **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 plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | Yes. Pediatric Dental $500. There are no other specific deductibles. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| **What is the out–of–pocket limit for this plan?** | Select Providers $5,000 / (Person)<br>Select Providers $10,000 / (Family)<br>Preferred Providers $5,000 / (Person)<br>Preferred Providers $10,000 / (Family)<br>Out-of-Network Provider $5,000 / (Person)<br>Out-of-Network Provider $10,000 / (Family) | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit 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 out–of–pocket limit. |
| **Will you pay less if you use a network provider?** | Yes. See www.uhcsr.com/louisville or call 1-866-907-6342 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out–of–network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Select Provider | Preferred Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | 20% Coins<br>$30 Copay/per visit; ded does not apply | 30% Coins<br>$30 Copay/per visit; ded does not apply | 50% Coins<br>$30 Copay/per visit; ded does not apply | May not apply when related to surgery or Physiotherapy.<br>**University of Louisville Campus Health Services (ULCHS) Benefits:** The Deductible and Copays will be waived and benefits will be paid at 100% for Covered Medical Expenses incurred when treatment is rendered at the Student Health Services. Policy Exclusions and Limitations do not apply. Quest Diagnosis: Labs referred by the SHS to Quest will be paid at 100%, not subject to deductible. Policy Exclusions and Limitations do not apply. |
| | Specialist visit | 20% Coins<br>$30 Copay/per visit<br>ded does not apply | 30% Coins<br>$30 Copay/per visit<br>ded does not apply | 50% Coins<br>$30 Copay/per visit<br>ded does not apply | |
| | Preventive care/screening/immunization | No Charge | No Charge | 25% Coins | Includes preventive services specified in the health care reform law or benefits provided as mandated by state law.<br>You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work) | Diagnostic X-ray Services: 20% Coins; $25 Copay/per visit; ded does not apply<br>Laboratory Procedures: No Charge; ded does not apply | Diagnostic X-ray Services: 30% Coins; $25 Copay/per visit; ded does not apply<br>Laboratory Procedures: No Charge; | Diagnostic X-ray Services: 25% Coins; $25 Copay/per visit; ded does not apply<br>Laboratory Procedures: 25% Coins; $20 Copay/per visit; | ——————none—————— |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Select Provider | Preferred Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | | | ded does not apply | ded does not apply | |
| | Imaging (CT/PET scans, MRIs) | 20% Coins; $25 Copay/per visit; ded does not apply | 30% Coins; $25 Copay/per visit; ded does not apply | 50% Coins; $25 Copay/per visit; ded does not apply | ——————none—————— |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.uhcsr.com/pdl | Tier 1 - Your Lowest-Cost Option | $15 Copay per prescription Tier 1; ded does not apply | $15 Copay per prescription Tier 1; ded does not apply | 25% Coins ded does not apply | Select Providers and Preferred Providers: up to a 31 day supply per prescription<br>Select Providers: Mail Order Network Pharmacy<br>Select Providers and Preferred Providers: Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy at 2 times the retail Copay up to a 90-day supply<br>Out-of-Network Provider: up to a 31 day supply per prescription<br>You may need to obtain certain specialty drugs from a pharmacy designated by us.<br>You may need to obtain prior authorization for certain prescription drugs.<br>You may pay more if prior authorization is not obtained.<br>For insulin drugs, the total amount of Copays or Coins shall not exceed $30 for an individual prescription of up to a 30-day supply. |
| | Tier 2 - Your Midrange-Cost Option | $30 Copay per prescription Tier 2; ded does not apply | $30 Copay per prescription Tier 2; ded does not apply | | |
| | Tier 3 - Your Highest-Cost Option | 80% Coins per prescription Tier 3; ded does not apply | 80% Coins per prescription Tier 3; ded does not apply | | |
| | Tier 4 - Additional High-Cost Option | Not Covered | Not Covered | Not Covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% Coins | 30% Coins | 50% Coins | ——————none—————— |
| | Physician/surgeon fees | 20% Coins | 30% Coins | 50% Coins | ——————none—————— |
| **If you need immediate medical attention** | Emergency room care | 30% Coins; $150 Copay/per visit; | 30% Coins; $150 Copay/per | 50% Coins; $150 Copay/per | May be limited to use of emergency room and supplies.<br>The Select Provider, Preferred Provider, |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Select Provider | Preferred Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | | ded does not apply | visit; ded does not apply | visit; ded does not apply | and Out-of-Network Provider Copay will be waived if admitted to the Hospital. |
| | Emergency medical transportation | No Benefit | 30% Coins | 30% Coins | ——————none—————— |
| | Urgent care | 20% Coins; $50 Copay/per visit; ded does not apply | 30% Coins; $50 Copay/per visit; ded does not apply | 35% Coins; $50 Copay/per visit; ded does not apply | May be limited to facility fees. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% Coins | 30% Coins | 50% Coins | ——————none—————— |
| | Physician/surgeon fees | 20% Coins | 30% Coins | 50% Coins | ——————none—————— |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Office Visits: 20% Coins $30 Copay/per visit; ded does not apply Other: 20% Coins | Office Visits: 30% Coins; $30 Copay/per visit; ded does not apply Other: 30% Coins | Office Visits: 50% Coins; $30 Copay/per visit; ded does not apply Other: 35% Coins | ——————none—————— |
| | Inpatient services | 20% Coins | 30% Coins | 50% Coins | ——————none—————— |
| **If you are pregnant** | Office visits | 20% Coins; $30 Copay/per visit; ded does not apply | 30% Coins; $30 Copay/per visit; ded does not apply | 50% Coins; $30 Copay/per visit; ded does not apply | Cost-sharing does not apply for preventive services when provided by a preferred provider. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |
| | Childbirth/delivery professional services | 20% Coins | 30% Coins | 50% Coins | |
| | Childbirth/delivery facility services | 20% Coins | 30% Coins | 50% Coins | ——————none—————— |
| **If you need help recovering or have other special health needs** | Home health care | 20% Coins | 30% Coins | 50% Coins | 120 visits maximum (Per Policy Year) |
| | Rehabilitation services | Physiotherapy: $20 Copay/per visit; ded does not apply | 30% Coins | 50% Coins | Inpatient 90 days maximum (Per Policy Year)<br>Outpatient 25 visits of physical therapy<br>Outpatient 25 visits of occupational therapy |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Select Provider | Preferred Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | | Inpatient Rehabilitation Facility: 20% Coins | | | Outpatient 25 visits of speech therapy<br>Outpatient 20 visits of manipulative therapy<br>Outpatient 36 visits of cardiac rehabilitation therapy<br>Outpatient Separate physical, occupational and speech therapy limits apply to rehabilitative and Habilitative Services |
| | Habilitation services | $20 Copay/per visit; ded does not apply | 30% Coins | 50% Coins | |
| | Skilled nursing care | 20% Coins | 30% Coins | 50% Coins | 90 days maximum (Per Policy Year) |
| | Durable medical equipment | 20% Coins | 30% Coins | 50% Coins | ——————none—————— |
| | Hospice services | Paid at least equal to the Medicare benefits for Hospice Care | 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 | See your plan's Pediatric Vision Benefit Details | $20 Copay per exam; ded does not apply | 25% Coins; ded does not apply | See your plan's Pediatric Vision Benefit Details. Age limits apply.* |
| | Children's glasses | See your plan's Pediatric Vision Benefit Details | Lens: $40 Copay; ded does not apply<br>Frames: Tiered Copays from no charge to 40% based on retail cost. ded does not apply | 25% Coins; ded does not apply | See your plan's Pediatric Vision Benefit Details. Age limits apply.* |
| | Children's dental check-up | See your plan's Pediatric Dental Benefit Details | No Charge; ded does not apply | No Charge; ded does not apply | See your plan's Pediatric Dental Benefit Details. Age limits apply.* |

*For more information about limitations and exceptions, see plan or policy document at www.uhcsr.com/louisville

## 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 except as specifically provided in the Policy
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult) except as specifically provided in the Policy
- Infertility treatment
- Long-term care except as specifically provided in the Policy
- 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.)**

- Chiropractic care
- Hearing aids
- 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: UnitedHealthcare Student Resources at 1-866-907-6342 and 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 plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Kentucky Department of Insurance at 1-800-595-6053 or visit http://insurance.ky.gov/.

**Does this plan provide Minimum Essential Coverage? Yes.**

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

**Does this plan meet Minimum Value Standards? 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 plan 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 plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. 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 plan's overall deductible** **$700**
- **Specialist copayment** **$30**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **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)*

| **Total Example Cost** | **$12,700** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $700 |
| Copayments | $40 |
| Coinsurance | $3,300 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$4,100** |

### Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$700**
- **Specialist copayment** **$30**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

**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** | **$5,600** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $700 |
| Copayments | $800 |
| Coinsurance | $300 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,820** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$700**
- **Specialist copayment** **$30**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

**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** | **$2,800** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $700 |
| Copayments | $400 |
| Coinsurance | $500 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,600** |

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

# 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: https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/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 አገልግሎቶች በነጻ ይገኛሉ። እባክዎ ወደ 1-866-260-2723 ይደውሉ።

**Arabic**
تتوفر لك خدمات المساعدة اللغوية مجانًا. اتصل على الرقم 1-866-260-2723.

**Armenian**
Ձեզ մատչելի են անվճար 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। দয়া করে 1-866-260-2723–তে কল করুন।

**Burmese**
ဘာသာစကား အကူအညီ ဝန်ဆောင်မှုများ သင့် အတွက် အခမဲ့ရရှိနိုင်သည်။ ကျေးဇူးပြု၍ ဖုန်း 1-866-260-2723 ကိုခေါ်ပါ။

**Cambodian- Mon-Khmer**
សេវាជំនួយផ្នែកភាសាដែលឥតគិតថ្លៃ មានសម្រាប់អ្នក។ សូមទូរស័ព្ទទៅលេខ 1-866-260-2723។

**Cherokee**
ᎦᏬᏂᎯᏍᏗ ᎤᎾᏓᏍᏕᎸᏗ ᎤᎾᏓᏡᎬᎢ ᏂᎯ ᎡᏣᏪᏅᎢᏍᏓᏁᎸᎯᎢ ᏂᏓᎬᏳᏣᏪᎾ ᎠᏎᏊᎢ. ᏰᏣᏊ ᎠᏂ ᏫᏏᎳᏪᏍ 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 ho̱ 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 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 નિ:શુલ્ક ઉપલબ્ધ છે. કૃપા કરીને 1-866-260-2723 પર કૉલ કરો.

**Hawaiian**
Kōkua manuahi ma kāu ʻōlelo i loaʻa ʻia. 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 asụsụ, bu n'efu, dịrị gị. Kpọọ 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>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 yoŋ. Sebel i nsinga ini 1-866-260-2723.

**Kurdish Sorani**
خزمەتەکانی یارمەتیی زمانی بەخۆڕایی بۆ تۆ دابین دەکرێن. تکایە تەلەفۆن بکە بۆ ژمارەی 1-866-260-2723.

**Laotian**
ມີບໍລິການທາງດ້ານພາສາບໍ່ເສຍຄ່າໃຫ້ແກ່ທ່ານ. 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 ejjeļọk wōņāān. Jouj im kalļọk 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 shǫǫdí kohjį' 1-866-260-2723 hodíílnih.

**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 cɔl 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.

**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**
ܚܕ̈ܡܬܐ ܕܡܬܪܓܡܢܘܬܐ ܕܠܫܢܐ، ܡܛܝܒܬܐ ܐܝܠܗ̇ ܩܬܝܟ ܡܓܢܐܝܬ. ܒܒܥܘܬܐ
ܩܪܝ ܥܠ ܡܢܝܢܐ 1-866-260-2723.

**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**
มีบริการความช่วยเหลือด้านภาษาให้โดยที่คุณไม่ต้องเสียค่าใช้จ่ายแต่อย่างใด 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 1-866-260-2723 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**
Isẹ̀ ìrànlọ́wọ́ èdè tí ó jẹ́ ọ̀fẹ́, wà fún ọ. Pe 1-866-260-2723.

**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) 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/louisville or call 1-866-907-6342. For general definitions of common terms, such as allowed amount, balance billing, coinsurance (coins), copayment (copay), deductible (ded), provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-866-907-6342 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | Select Providers $200 / (Person)<br>Preferred Providers $700 / (Person)<br>Out-of-Network Provider $1,000 / (Person) | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. |
| **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 plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | Yes. Pediatric Dental $500. There are no other specific deductibles. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| **What is the out–of–pocket limit for this plan?** | Select Providers $5,000 / (Person)<br>Select Providers $10,000 / (Family)<br>Preferred Providers $5,000 / (Person)<br>Preferred Providers $10,000 / (Family)<br>Out-of-Network Provider $5,000 / (Person)<br>Out-of-Network Provider $10,000 / (Family) | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit 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 out–of–pocket limit. |
| **Will you pay less if you use a network provider?** | Yes. See www.uhcsr.com/louisville or call 1-866-907-6342 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out–of–network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Select Provider | Preferred Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | 20% Coins $30 Copay/per visit; ded does not apply | 30% Coins $30 Copay/per visit; ded does not apply | 50% Coins $30 Copay/per visit; ded does not apply | May not apply when related to surgery or Physiotherapy. **University of Louisville Campus Health Services (ULCHS) Benefits:** The Deductible and Copays will be waived and benefits will be paid at 100% for Covered Medical Expenses incurred when treatment is rendered at the Student Health Services. Policy Exclusions and Limitations do not apply. Quest Diagnosis: Labs referred by the SHS to Quest will be paid at 100%, not subject to deductible. Policy Exclusions and Limitations do not apply. |
| | Specialist visit | 20% Coins $30 Copay/per visit ded does not apply | 30% Coins $30 Copay/per visit ded does not apply | 50% Coins $30 Copay/per visit ded does not apply | |
| | Preventive care/screening/immunization | No Charge | No Charge | 25% Coins | Includes preventive services 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 provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | Diagnostic X-ray Services: 20% Coins; $25 Copay/per visit; ded does not apply Laboratory Procedures: No Charge; ded does not apply | Diagnostic X-ray Services: 30% Coins; $25 Copay/per visit; ded does not apply Laboratory Procedures: No Charge; | Diagnostic X-ray Services: 25% Coins; $25 Copay/per visit; ded does not apply Laboratory Procedures: 25% Coins; $20 Copay/per visit; | ——————none—————— |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Select Provider | Preferred Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | | | ded does not apply | ded does not apply | |
| | Imaging (CT/PET scans, MRIs) | 20% Coins; $25 Copay/per visit; ded does not apply | 30% Coins; $25 Copay/per visit; ded does not apply | 50% Coins; $25 Copay/per visit; ded does not apply | ——————none—————— |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.uhcsr.com/pdl | Tier 1 - Your Lowest-Cost Option | $15 Copay per prescription Tier 1; ded does not apply | $15 Copay per prescription Tier 1; ded does not apply | 25% Coins ded does not apply | Select Providers and Preferred Providers: up to a 31 day supply per prescription<br>Select Providers: Mail Order Network Pharmacy<br>Select Providers and Preferred Providers: Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy at 2 times the retail Copay up to a 90-day supply<br>Out-of-Network Provider: up to a 31 day supply per prescription<br>You may need to obtain certain specialty drugs from a pharmacy designated by us.<br>You may need to obtain prior authorization for certain prescription drugs.<br>You may pay more if prior authorization is not obtained.<br>For insulin drugs, the total amount of Copays or Coins shall not exceed $30 for an individual prescription of up to a 30-day supply. |
| | Tier 2 - Your Midrange-Cost Option | $30 Copay per prescription Tier 2; ded does not apply | $30 Copay per prescription Tier 2; ded does not apply | | |
| | Tier 3 - Your Highest-Cost Option | 80% Coins per prescription Tier 3; ded does not apply | 80% Coins per prescription Tier 3; ded does not apply | | |
| | Tier 4 - Additional High-Cost Option | Not Covered | Not Covered | Not Covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% Coins | 30% Coins | 50% Coins | ——————none—————— |
| | Physician/surgeon fees | 20% Coins | 30% Coins | 50% Coins | ——————none—————— |
| **If you need immediate medical attention** | Emergency room care | 30% Coins; $150 Copay/per visit; | 30% Coins; $150 Copay/per | 50% Coins; $150 Copay/per | May be limited to use of emergency room and supplies.<br>The Select Provider, Preferred Provider, |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Select Provider | Preferred Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | | ded does not apply | visit; ded does not apply | visit; ded does not apply | and Out-of-Network Provider Copay will be waived if admitted to the Hospital. |
| | Emergency medical transportation | No Benefit | 30% Coins | 30% Coins | ——————none—————— |
| | Urgent care | 20% Coins; $50 Copay/per visit; ded does not apply | 30% Coins; $50 Copay/per visit; ded does not apply | 35% Coins; $50 Copay/per visit; ded does not apply | May be limited to facility fees. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% Coins | 30% Coins | 50% Coins | ——————none—————— |
| | Physician/surgeon fees | 20% Coins | 30% Coins | 50% Coins | ——————none—————— |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Office Visits: 20% Coins $30 Copay/per visit; ded does not apply Other: 20% Coins | Office Visits: 30% Coins; $30 Copay/per visit; ded does not apply Other: 30% Coins | Office Visits: 50% Coins; $30 Copay/per visit; ded does not apply Other: 35% Coins | ——————none—————— |
| | Inpatient services | 20% Coins | 30% Coins | 50% Coins | ——————none—————— |
| **If you are pregnant** | Office visits | 20% Coins; $30 Copay/per visit; ded does not apply | 30% Coins; $30 Copay/per visit; ded does not apply | 50% Coins; $30 Copay/per visit; ded does not apply | Cost-sharing does not apply for preventive services when provided by a preferred provider. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |
| | Childbirth/delivery professional services | 20% Coins | 30% Coins | 50% Coins | |
| | Childbirth/delivery facility services | 20% Coins | 30% Coins | 50% Coins | ——————none—————— |
| **If you need help recovering or have other special health needs** | Home health care | 20% Coins | 30% Coins | 50% Coins | 120 visits maximum (Per Policy Year) |
| | Rehabilitation services | Physiotherapy: $20 Copay/per visit; ded does not apply | 30% Coins | 50% Coins | Inpatient 90 days maximum (Per Policy Year)<br>Outpatient 25 visits of physical therapy<br>Outpatient 25 visits of occupational therapy |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Select Provider | Preferred Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | | Inpatient Rehabilitation Facility: 20% Coins | | | Outpatient 25 visits of speech therapy<br>Outpatient 20 visits of manipulative therapy<br>Outpatient 36 visits of cardiac rehabilitation therapy<br>Outpatient Separate physical, occupational and speech therapy limits apply to rehabilitative and Habilitative Services |
| | Habilitation services | $20 Copay/per visit; ded does not apply | 30% Coins | 50% Coins | |
| | Skilled nursing care | 20% Coins | 30% Coins | 50% Coins | 90 days maximum (Per Policy Year) |
| | Durable medical equipment | 20% Coins | 30% Coins | 50% Coins | ——————none—————— |
| | Hospice services | Paid at least equal to the Medicare benefits for Hospice Care | 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 | See your plan's Pediatric Vision Benefit Details | $20 Copay per exam; ded does not apply | 25% Coins; ded does not apply | See your plan's Pediatric Vision Benefit Details. Age limits apply.* |
| | Children's glasses | See your plan's Pediatric Vision Benefit Details | Lens: $40 Copay; ded does not apply<br>Frames: Tiered Copays from no charge to 40% based on retail cost. ded does not apply | 25% Coins; ded does not apply | See your plan's Pediatric Vision Benefit Details. Age limits apply.* |
| | Children's dental check-up | See your plan's Pediatric Dental Benefit Details | No Charge; ded does not apply | No Charge; ded does not apply | See your plan's 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 except as specifically provided in the Policy | • Bariatric surgery | • Cosmetic surgery |
| • Dental care (Adult) except as specifically provided in the Policy | • Infertility treatment | • Long-term care except as specifically provided in the Policy |
| • 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.) | | |
|---|---|---|
| • Chiropractic care | • Hearing aids | • 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: UnitedHealthcare Student Resources at 1-866-907-6342 and 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 plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Kentucky Department of Insurance at 1-800-595-6053 or visit http://insurance.ky.gov/.

**Does this plan provide Minimum Essential Coverage? Yes.**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**Does this plan meet Minimum Value Standards? 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 plan 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 plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. 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 plan's overall deductible** **$700**
- **Specialist copayment** **$30**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **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)*

| **Total Example Cost** | **$12,700** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $700 |
| Copayments | $40 |
| Coinsurance | $3,300 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$4,100** |

### Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$700**
- **Specialist copayment** **$30**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

**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** | **$5,600** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $700 |
| Copayments | $800 |
| Coinsurance | $300 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,820** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$700**
- **Specialist copayment** **$30**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

**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** | **$2,800** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $700 |
| Copayments | $400 |
| Coinsurance | $500 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,600** |

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

# 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: https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/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 አገልግሎቶች በነጻ ይገኛሉ። እባክዎ ወደ 1-866-260-2723 ይደውሉ።

**Arabic**
تتوفر لك خدمات المساعدة اللغوية مجانًا. اتصل على الرقم 1-866-260-2723.

**Armenian**
Ձեզ մատչելի են անվճար 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। দয়া করে 1-866-260-2723–তে কল করুন।

**Burmese**
ဘာသာစကား အကူအညီ ဝန်ဆောင်မှုများ သင့် အတွက် အခမဲ့ရရှိနိုင်သည်။ ကျေးဇူးပြု၍ ဖုန်း 1-866-260-2723 ကိုခေါ်ပါ။

**Cambodian- Mon-Khmer**
សេវាជំនួយផ្នែកភាសាដែលឥតគិតថ្លៃ មានសម្រាប់អ្នក។ សូមទូរស័ព្ទទៅលេខ 1-866-260-2723។

**Cherokee**
ᎦᏬᏂᎯᏍᏗ ᎤᎾᏓᏍᏕᏘᏗ ᎤᎾᏓᏘᎬᎢ ᏂᎯ ᎡᏣᏯᏅᎢᏍᏓᏁᏘᎢ ᏂᏓᎬᏀᎶᏯᎾ ᎠᏎᏫᎢ. ᏲᏣᏫ ᎠᏂ ᏩᏏᏔᏯᎦ 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 ho̱ 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 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 ʻōlelo i loaʻa ʻia. 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 asụsụ, bu n'efu, dịrị gị. Kpọọ 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>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 yoŋ. Sebel i nsinga ini 1-866-260-2723.

**Kurdish Sorani**
خزمەتەکانی یارمەتیی زمانی بەخۆڕایی بۆ تۆ دابین دەکرێن. تکایە تەلەفۆن بکە بۆ ژمارەی 1-866-260-2723.

**Laotian**
ມີບໍລິການທາງດ້ານພາສາບໍ່ເສຍຄ່າໃຫ້ແກ່ທ່ານ. 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 ejjeļọk wōņāān. Jouj im kaļļọk 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 shǫǫdí kohjį' 1-866-260-2723 hodíílnih.

**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 cɔl 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.

**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**
ܚܕܡܬܐ ܕܗܝܪܐ ܒܠܫܢܐ ܡܨܝܐ ܠܟܘܢ ܡܓܢ. ܩܪܘ ܥܠ ܡܢܝܢܐ 1-866-260-2723.

**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**
มีบริการความช่วยเหลือด้านภาษาให้โดยที่คุณไม่ต้องเสียค่าใช้จ่ายแต่อย่างใด 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 1-866-260-2723 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**
Isẹ̀ ìrànlọ́wọ́ èdè tí ó jẹ́ ọ̀fẹ́, wà fún ọ. Pe 1-866-260-2723.