UnitedHealthcare*: Saint Xavier University 2021-1330-61

Coverage Period: 05/18/2021 - 07/31/2022

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/sxu or call 1-800-505-4160. 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 1-800-505-4160 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Preferred Providers \$250 (Person) Out of Network \$600 (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 \$13,700 (Family) Out of Network \$15,000 (Person)	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<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/sxu or call 1-800-505-4160 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</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 specialist you choose without a referral.

		What Y	ou 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	
	Primary care visit to treat an injury or illness	\$25 <u>Copay</u> per visit <u>ded</u> does not apply	40% Coins	May not apply when related to surgery or	
	Specialist visit	\$25 <u>Copay</u> per visit <u>ded</u> does not apply	40% <u>Coins</u>	Physiotherapy.	
If you visit a health care provider's office or clinic	Preventive care/screening/immunization	No Charge	Not Covered	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>	40% <u>Coins</u>	none	
	Imaging (CT/PET scans, MRIs)	20% <u>Coins</u>	40% <u>Coins</u>	none	
If you need drugs to treat your illness or	Tier 1 - Your Lowest-Cost Option	\$20 <u>Copay</u> per prescription Tier 1 <u>ded</u> does not apply	Not Covered	Preferred Providers: up to a 31 day supply per prescription Preferred Providers: UHCP Mail Order	
condition More information about prescription drug coverage is available at www.uhcsr.com/pdl	Tier 2 - Your Midrange-Cost Option	\$40 <u>Copay</u> per prescription Tier 2 <u>ded</u> does not apply	Not Covered	Network Pharmacy or Preferred 90 Day Retail Network Pharmacy at 2.5 times the retail Copay up to a 90-day supply.	
	Tier 3 - Your Highest-Cost Option	\$60 <u>Copay</u> per prescription Tier 3 <u>ded</u> does not apply	Not Covered	You may need to obtain certain <u>specialty</u> <u>drugs</u> from a pharmacy designated by us. You may need to obtain <u>prior authorization</u>	
	Tier 4 - Additional High-Cost Option	Not Covered	Not Covered	for certain <u>prescription drugs.</u>	
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	20% <u>Coins</u>	40% <u>Coins</u>	none	
surgery	Physician/surgeon fees	20% <u>Coins</u>	40% <u>Coins</u>	none	
If you need immediate medical attention	Emergency room care	\$150 <u>Copay</u> per visit 20% <u>Coins</u> <u>ded</u> does not apply	\$150 <u>Copay</u> per visit 20% <u>Coins</u> <u>ded</u> does not apply	May be limited to use of emergency room and supplies.	

		What Y	ou 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	
				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>	\$50 <u>Copay</u> per visit 20% <u>Coins</u> <u>ded</u> does not apply	\$50 <u>Copay</u> per visit 40% <u>Coins</u> <u>ded</u> does not apply	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		none			
If you need mental health, behavioral health, or substance	Outpatient services	Office Visits: \$25 Copay per visit ded does not apply Other: 20% Coins	Office Visits: 40% Coins Other: 40% Coins	none	
abuse services	Inpatient services	20% <u>Coins</u>	40% <u>Coins</u>	none	
	Office visits	\$25 <u>Copay</u> per visit <u>ded</u> does not apply	40% <u>Coins</u>	Cost sharing does not apply for preventive services when provided by a preferred	
If you are pregnant	Childbirth/delivery professional services	20% <u>Coins</u>	40% <u>Coins</u>	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 facility services	20% <u>Coins</u>	40% <u>Coins</u>	none	
	Home health care	20% <u>Coins</u>	40% <u>Coins</u>	none	
If you need help	Rehabilitation services	20% <u>Coins</u>	40% <u>Coins</u>	none	
recovering or have	Habilitation services	20% <u>Coins</u>	40% <u>Coins</u>	none	
other special health needs	Skilled nursing care	20% <u>Coins</u>	40% <u>Coins</u>	none	
	<u>Durable medical equipment</u>	20% <u>Coins</u>	20% <u>Coins</u>	none	
	<u>Hospice services</u>	20% <u>Coins</u>	40% <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	50% <u>Coins;</u> <u>ded</u> does not apply	See your <u>plan's</u> Pediatric Vision Benefit Details. Age limits apply.*	

Common Medical Event	Services You May Need	What Y	ou Will Pay	Limitediana Francisco 9 Other	
		Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
	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	50% <u>Coins;</u> <u>ded</u> does not apply	See your <u>plan's</u> Pediatric Vision Benefit Details. Age limits apply.*	
	Children's dental check-up	50% 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 • Bariatric surgery • Cosmetic surgery • Infertility treatment the Policy • Long-term care • Routine eye care (Adult) • Routine foot care • Weight loss programs

Other Covered Services (Limitation services. This isn't a complete list document.)			
Chiropractic care	Infertility treatment	 Non-emergency care when traveling outside t U.S. 	he

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: 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 appeal, 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:

Peg is Having a Baby

(9 months of in-network pre-natal care and a



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.

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-

hospital delivery)		controlled condition)		care)		
 The <u>plan's</u> overall <u>deductible</u> <u>Specialist copayment</u> Hospital (facility) <u>coinsurance</u> Other <u>coinsurance</u> 	\$250 \$25 20% 20%	 The <u>plan's</u> overall <u>deductible</u> <u>Specialist copayment</u> Hospital (facility) <u>coinsurance</u> Other <u>coinsurance</u> 	\$250 \$25 20% 20%	 The <u>plan's</u> overall <u>deductible</u> <u>Specialist copayment</u> Hospital (facility) <u>coinsurance</u> Other <u>coinsurance</u> 	\$250 \$25 20% 20%	
<u>Specialist office visits (prenatal care)</u> Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (ultrasounds and blood work) Primary care physician office disease education) Diagnostic tests (blood work) Prescription drugs		Diagnostic tests (blood work)	including	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	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800	
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:		
Cost Sharing		Cost Sharing		Cost Sharing		
<u>Deductibles</u>	\$250	<u>Deductibles</u>	\$250	<u>Deductibles</u>	\$250	
Copayments	\$30	Copayments	\$900	Copayments	\$80	
Coinsurance	\$1,900	Coinsurance	\$100	Coinsurance	\$400	
What isn't covered	What isn't covered		What isn't covered		What isn't covered	
Limits or exclusions	\$60	Limits or exclusions	\$20	Limits or exclusions	\$0	
The total Peg would pay is	\$2,240	The total Joe would pay is	\$1,270	The total Mia would pay is	\$730	

Mia's Simple Fracture

(in-network emergency room visit and follow up

NON-DISCRIMINATION NOTICE

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

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

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

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

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

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

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

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

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

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

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

LANGUAGE ASSISTANCE PROGRAM

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

English

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

Albanian

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

Amharic

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

Arabic

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

Armenian

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

Bantu- Kirundi

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

Bisayan- Visayan (Cebuano)

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

Bengali- Bangala

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

Burmese

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

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 કૉલ કરો.

Hawaiian

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

Hindi

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

Hmong

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

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

ကြိဘ်၏ မောကာကို နမာနှစ်အီးသူ ပဲလာတလိဉ်ဟု ဉ်အပ္ပားဘဉ်(စီလီ) နှဉ်လီးဝံသးရှားဆုံးကြိုးဘဉ် 1-866-260-2723တက္ကာ်

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 دەكريّن. تكايە تەلمەقۆن بكە بۆ رەمارەي 2723-866-1.

Laotian

ມີບໍລິການທາງດ້ານພາສາບໍ່ເສຍຄ່ຳໃຫ້ແກ່່ທ່ຳນ. ກະລຸນາໂທຫາເບີ 1-866-260-2723.

SR LAP 64 (6-18) 1 of 2

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 kohjj' 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 col 1-866-260-2723.

Norwegian

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

Pennsylvania Dutch

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

Persian-Farsi

خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. کشت است. المداد تا ماس بگیرید.

Polish

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

Portuguese

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

Puniab

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

Romanian

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

Russian

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

Samoan- Fa'asamoa

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

Serbo- Croatian

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

Somali

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

Spanish

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

Sudanic- Fulfulde

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

Swahili

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

Syriac- Assyrian

چەرچەتىكە دۇبغى ئىكىكە، كېكىكەبىلا، كەبلىر ھۆتىكە كىلەمەر مىدىكە دەرۇخەكەرلى مەنى كەركەرگەكىكەرلىكى خىرىكە كەركى

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 2723-266-168-1 پر کال کریں۔

Vietnamese

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

Yiddish

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

Yoruba

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

SR LAP 64 (6-18) 2 of 2