UnitedHealthcare®: Vanderbilt University 2019-99-2

Coverage Period: 07/01/2019 - 08/11/2020
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 or call (844) 210-0545. 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.cciio.cms.gov or call (844) 210-0545 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Select Providers $250 (Person) Preferred Providers $250 (Person) Out of Network $500 (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 with copay are covered before you meet your deductible.	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 and Prescription Drugs $100. 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?	Preferred Providers & In-Network Providers $5,000 (Person) Preferred Providers & In-Network Providers $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 or call (844) 210-0545 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?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist. The referral requirement may not apply to dependents.

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	10% Coins	20% Coins	40% Coins	May not apply when related to surgery or Physiotherapy.
	Specialist visit	10% Coins	20% Coins	40% Coins	
	Preventive care/screening/immunization	No Charge	No Charge	40% 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)	10% Coins	20% Coins	40% Coins	——————none——————
	Imaging (CT/PET scans, MRIs)	10% Coins	20% Coins	40% Coins	——————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	$15 Copay per prescription Tier 1	$15 Copay per prescription Tier 1	Not Covered	Select Providers: up to a 30 day supply per prescription Preferred Providers: up to a 30 day supply per prescription You may need to obtain certain specialty drugs from a pharmacy designated by us. Select: $100 Ded (per Policy Year) does not apply to Policy Ded. Mail order Prescription Drugs through Express Scripts network pharmacy at 2 times the retail Copay up to a 90-day supply. Preferred: $100 Ded (per Policy Year) does not apply to Policy Ded. Mail order Prescription Drugs through Express Scripts network pharmacy at 2 times the retail Copay up to a 90-day supply. Out: No Benefits
	Tier 2 - Your Midrange-Cost Option	$50 Copay per prescription Tier 2	$50 Copay per prescription Tier 2	Not Covered	
	Tier 3 - Your Highest-Cost Option	$75 Copay per prescription Tier 3	$75 Copay per prescription Tier 3	Not Covered	
	Tier 4 - Additional High-Cost Option	Not Covered	Not Covered	Not Covered	

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% Coins	20% Coins	40% Coins	——————none——————
	Physician/surgeon fees	10% Coins	20% Coins	40% Coins	——————none——————
If you need immediate medical attention	Emergency room care	10% Coins $100 Copay per visit; ded does not apply	10% Coins $100 Copay per visit; ded does not apply	10% Coins $100 Copay per visit; ded does not apply	May be limited to use of emergency room and supplies. The Copay will be waived if admitted to the Hospital.
	Emergency medical transportation	No Charge	No Charge	No Charge	——————none——————
	Urgent care	10% Coins	20% Coins	40% Coins	May be limited to facility fees.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% Coins	20% Coins	40% Coins	——————none——————
	Physician/surgeon fees	10% Coins	20% Coins	40% Coins	——————none——————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% Coins	20% Coins	40% Coins	——————none——————
	Inpatient services	10% Coins	20% Coins	40% Coins	——————none——————
If you are pregnant	Office visits	10% Coins	20% Coins	40% Coins	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	10% Coins	20% Coins	40% Coins	
	Childbirth/delivery facility services	10% Coins	20% Coins	40% Coins	——————none——————
If you need help recovering or have other special health needs	Home health care	20% Coins	20% Coins	20% Coins	——————none——————
	Rehabilitation services	10% Coins	20% Coins	40% Coins	——————none——————
	Habilitation services	10% Coins	20% Coins	40% Coins	——————none——————
	Skilled nursing care	10% Coins	20% Coins	40% Coins	——————none——————
	Durable medical equipment	20% Coins	20% Coins	20% Coins	——————none——————
	Hospice services	10% Coins	20% Coins	40% Coins	——————none——————

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

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 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	50% Coins	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 Frames: Tiered Copays from no charge to 40% based on retail cost. ded does not apply	50% Coins	See your plan's Pediatric Vision Benefit Details. Age limits apply.*
	Children's dental check-up	See your plan's Pediatric Dental Benefit Details	50% Coins	50% Coins	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

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.)

- Bariatric surgery
- Cosmetic surgery except as noted in the policy
- Dental care (Adult) except as noted in the policy
- Hearing aids except as noted in the policy
- Infertility treatment
- Long-term care
- Routine eye care (Adult) except as noted in the policy
- Weight loss programs

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

- Acupuncture
- Chiropractic care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Tennessee Department of Commerce & Insurance at 1-800-342-4029 or visit http://www.tn.gov/commerce. 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 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: Tennessee Department of Commerce & Insurance at 1-800-342-4029 or visit http://www.tn.gov/commerce.

Does this plan provide Minimum Essential Coverage? **Yes**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

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

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

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

To see examples of how this 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	$250
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	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)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$20
Coinsurance	$2,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,830**

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

The plan's overall deductible	$250
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$250
Copayments	$700
Coinsurance	$400
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,410**

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

The plan's overall deductible	$250
Specialist coinsurance	20%
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)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$0
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$450**

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

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

Cherokee
ᏎᏍᏂᎯᏍᏗ ᎤᎾᏓᏛᏕᎵᏗ ᎤᎾᏓᏡᎬᎢ ᏂᎯ ᏒᏣᏛᏙᎢᏍᏓᏁᎸᎢ ᏂᏓᎬᏩᏛᎾ ᎠᏎᏍᎢ. ᎰᏩᏍ ᎠᏂ ᏫᏓᎳᏛᏕ 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
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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 ejjeḷọk wōṇāān. Jouj im kalḷọk 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 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 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
ܚܕ̈ܡܬܘܬܐ ܕܗܝܪܬܐ ܕܠܫܢܐ، ܡܓܢܐܝܬ، ܐܝܠܗ̇ ܦܬܝܚܐ ܠܐܘܚܕܢܘܟ. 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
שפּראַך הילף סערוויסעס זענען אוועילעבל פאַר אייך פריי פון אפצאל. ביטע רופט 1-866-260-2723.

Yoruba
Isẹ́ ìrànlọ́wọ́ èdè tí ó jẹ́ ọ̀fẹ́, wà fún ọ. Pe 1-866-260-2723.