



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/odu](http://www.uhcsr.com/odu) or call 1-800-767-0700. 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](http://www.cciio.cms.gov) or call 1-800-767-0700 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	<u>Preferred Providers</u> \$250 / (Person) <u>Out-of-Network Provider</u> \$500 / (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.
<b>Are there services covered before you meet your deductible?</b>	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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	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.
<b>What is the out-of-pocket limit for this plan?</b>	<u>Preferred Providers</u> \$4,000 / (Person) <u>Preferred Providers</u> \$8,000 / (Family) <u>Out-of-Network Provider</u> \$7,000 / (Person) <u>Out-of-Network Provider</u> \$14,000 / (Family)	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the out-of-pocket limit?</b>	<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> .
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.uhcsr.com/odu">www.uhcsr.com/odu</a> or call 1-800-767-0700 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.
<b>Do you need a referral to see a specialist?</b>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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
		Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$20 <u>Copay</u> per visit <u>ded</u> does not apply	50% <u>Coins</u> \$20 <u>Copay</u> per visit <u>ded</u> does not apply	Deductible will be waived and benefits will be paid at 100% for Covered Medical Expenses incurred when treatment is rendered at the Student Health Center.  May not apply when related to surgery or Physiotherapy.
	<u>Specialist</u> visit	\$20 <u>Copay</u> per visit <u>ded</u> does not apply	50% <u>Coins</u> \$20 <u>Copay</u> per visit <u>ded</u> does not apply	
	<u>Preventive care/screening/immunization</u>	No Charge	0% <u>Coins</u>	Includes <u>preventive services</u> specified in the health care reform law or benefits provided as mandated by state law. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>Coins</u>	50% <u>Coins</u>	—————none—————
	Imaging (CT/PET scans, MRIs)	20% <u>Coins</u>	50% <u>Coins</u>	—————none—————
<b>If you need drugs to treat your illness or condition</b>  More information about <b>prescription drug coverage</b> is available at <a href="http://www.uhcsr.com/pdl">www.uhcsr.com/pdl</a>	Tier 1 - Your Lowest-Cost Option	\$15 <u>Copay</u> per prescription Tier 1 <u>ded</u> does not apply	Not Covered	<u>Preferred Providers</u> : up to a 31 day supply per prescription <u>Preferred Providers</u> : Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy at 2.5 times the retail <u>Copay</u> up to a 90-day supply
	Tier 2 - Your Midrange-Cost Option	\$40 <u>Copay</u> per prescription Tier 2 <u>ded</u> does not apply	Not Covered	You may need to obtain certain <u>specialty drugs</u> from a pharmacy designated by us. You may need to obtain <u>prior authorization</u> for certain <u>prescription drugs</u> .
	Tier 3 - Your Highest-Cost Option	\$50 <u>Copay</u> per prescription Tier 3 <u>ded</u> does not apply	Not Covered	You may pay more if <u>prior authorization</u> is not obtained.
	Tier 4 - Additional High-Cost Option	Not Covered	Not Covered	For insulin drugs the total amount of <u>Ded</u> ,

\*For more information about limitations and exceptions, see plan or policy document at [www.uhcsr.com/odu](http://www.uhcsr.com/odu)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				<u>Copays</u> or <u>Coins</u> shall not exceed \$50 for an individual prescription of up to a 30-day supply. Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy for insulin drugs the total amount of <u>Ded.</u> , <u>Copays</u> or <u>Coins</u> shall not exceed \$150 for an individual prescription of up to a 90-day supply.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <u>Coins</u>	50% <u>Coins</u>	—————none—————
	Physician/surgeon fees	20% <u>Coins</u>	50% <u>Coins</u>	—————none—————
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	20% <u>Coins</u> \$100 <u>Copay</u> per visit <u>ded</u> does not apply	20% <u>Coins</u> \$100 <u>Copay</u> per visit <u>ded</u> does not apply	May be limited to use of emergency room and supplies. The <u>Copay</u> will be waived if admitted to the Hospital.
	<u>Emergency medical transportation</u>	20% <u>Coins</u>	20% <u>Coins</u>	—————none—————
	<u>Urgent care</u>	20% <u>Coins</u>	50% <u>Coins</u>	May be limited to facility fees.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <u>Coins</u>	50% <u>Coins</u>	—————none—————
	Physician/surgeon fees	20% <u>Coins</u>	50% <u>Coins</u>	—————none—————
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Office Visits: \$20 <u>Copay</u> per visit <u>ded</u> does not apply Other: 20% <u>Coins</u>	Office Visits: 50% <u>Coins</u> \$20 <u>Copay</u> per visit <u>ded</u> does not apply Other: 50% <u>Coins</u>	—————none—————
	Inpatient services	20% <u>Coins</u>	50% <u>Coins</u>	—————none—————
<b>If you are pregnant</b>	Office visits	\$20 <u>Copay</u> per visit <u>ded</u> does not apply	50% <u>Coins</u> \$20 <u>Copay</u> per visit <u>ded</u> does not apply	<u>Cost-sharing</u> does not apply for <u>preventive services</u> when provided by a <u>preferred provider</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% <u>Coins</u>	50% <u>Coins</u>	
	Childbirth/delivery facility services	20% <u>Coins</u>	50% <u>Coins</u>	—————none—————

\*For more information about limitations and exceptions, see [plan](#) or policy document at [www.uhcsr.com/odu](http://www.uhcsr.com/odu)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>Coins</u>	50% <u>Coins</u>	_____none_____
	<u>Rehabilitation services</u>	20% <u>Coins</u>	50% <u>Coins</u>	_____none_____
	<u>Habilitation services</u>	20% <u>Coins</u>	50% <u>Coins</u>	_____none_____
	<u>Skilled nursing care</u>	20% <u>Coins</u>	50% <u>Coins</u>	_____none_____
	<u>Durable medical equipment</u>	20% <u>Coins</u>	50% <u>Coins</u>	_____none_____
	<u>Hospice services</u>	Paid as any other Sickness	Paid as any other Sickness	_____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.*
	Children's glasses	Lens: \$40 <u>Copay</u> ; <u>ded</u> does not apply Frames: Tiered <u>Copays</u> from no charge to 40% based on retail cost. <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.*
	Children's dental check-up	50% <u>Coins</u>	50% <u>Coins</u>	See your <u>plan's</u> Pediatric Dental Benefit Details. Age limits apply.*

\*For more information about limitations and exceptions, see plan or policy document at [www.uhcsr.com/odu](http://www.uhcsr.com/odu)

## 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
- Dental care (Adult) except as specifically provided in the Policy
- Non-emergency care when traveling outside the U.S. except as specifically provided in the Policy
- Bariatric surgery
- Hearing aids
- Routine eye care (Adult)
- Cosmetic surgery
- Long-term care except as specifically provided 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.)

- Chiropractic care
- Routine foot care
- Infertility treatment
- Private-duty nursing

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: UnitedHealthcare Student Resources at 1-800-767-0700 and Virginia Bureau of Insurance at 1-800-552-7945 (Virginia only) or 1-804-371-9741 or visit <http://www.scc.virginia.gov/boi/index.aspx>. 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](http://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: Virginia Bureau of Insurance at 1-800-552-7945 (Virginia only) or 1-804-371-9741 or visit <http://www.scc.virginia.gov/boi/index.aspx>.

**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, kwijigo 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)		Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The <u>plan's overall deductible</u>	\$250	■ The <u>plan's overall deductible</u>	\$250	■ The <u>plan's overall deductible</u>	\$250
■ <u>Specialist copayment</u>	\$20	■ <u>Specialist copayment</u>	\$20	■ <u>Specialist copayment</u>	\$20
■ Hospital (facility) <u>coinsurance</u>	20%	■ Hospital (facility) <u>coinsurance</u>	20%	■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%	■ Other <u>coinsurance</u>	20%	■ Other <u>coinsurance</u>	20%
<p><b>This EXAMPLE event includes services like:</b>  <u>Specialist</u> office visits (<i>prenatal care</i>)            Childbirth/Delivery Professional Services            Childbirth/Delivery Facility Services  <u>Diagnostic tests</u> (<i>ultrasounds and blood work</i>)  <u>Specialist</u> visit (<i>anesthesia</i>)</p>		<p><b>This EXAMPLE event includes services like:</b>  <u>Primary care physician</u> office visits (<i>including disease education</i>)  <u>Diagnostic tests</u> (<i>blood work</i>)  <u>Prescription drugs</u>  <u>Durable medical equipment</u> (<i>glucose meter</i>)</p>		<p><b>This EXAMPLE event includes services like:</b>  <u>Emergency room care</u> (<i>including medical supplies</i>)  <u>Diagnostic test</u> (<i>x-ray</i>)  <u>Durable medical equipment</u> (<i>crutches</i>)  <u>Rehabilitation services</u> (<i>physical therapy</i>)</p>	
<b>Total Example Cost</b>	<b>\$12,700</b>	<b>Total Example Cost</b>	<b>\$5,600</b>	<b>Total Example Cost</b>	<b>\$2,800</b>
<b>In this example, Peg would pay:</b>		<b>In this example, Joe would pay:</b>		<b>In this example, Mia would pay:</b>	
<i>Cost-Sharing</i>		<i>Cost-Sharing</i>		<i>Cost-Sharing</i>	
<u>Deductibles</u>	\$250	<u>Deductibles</u>	\$250	<u>Deductibles</u>	\$250
<u>Copayments</u>	\$30	<u>Copayments</u>	\$700	<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$1,900	<u>Coinsurance</u>	\$100	<u>Coinsurance</u>	\$400
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$20	Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$2,240</b>	<b>The total Joe would pay is</b>	<b>\$1,070</b>	<b>The total Mia would pay is</b>	<b>\$950</b>

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](mailto: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 լեզվակցան օգնությունն ծառայությունները: 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 သင့်အကြံအစဉ်အတွက် အခမဲ့ရရှိနိုင်ပါသည်။ ဝက်စ်ဇ်ပေါ်၌ ဖုန်း 1-866-260-2723 ကိုခေါ်ဆိုပါ။

**Cambodian- Mon-Khmer**

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

**Cherokee**

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**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 ho chi apela hinla. I paya 1-866-260-2723.

**Cushite- Oromo**

Tajaajilliwwan gargaarsa afaanii kanfalttii malee siif jira. Maaloo karaa lakkoofsa bilbilaa 1-866-260-2723 bilbili.

**Dutch**

Taalbijstandsdiensten zijn gratis voor u beschikbaar. Gelieve 1-866-260-2723 op te bellen.

**French**

Des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-260-2723.

**French Creole- Haitian Creole**

Gen 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 કોલ 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 नि:शुल्क उपलब्ध हैं। कृपया 1-866-260-2723 पर कॉल करें।

**Hmong**

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

**Ibo**

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

**Ilocano**

Adda awan bayadna a serbisio para iti language assistance. Pangngaasim ta tawagam ti 1-866-260-2723.

**Indonesian**

Layanan bantuan bahasa bebas biaya tersedia untuk Anda. Harap hubungi 1-866-260-2723.

**Italian**

Sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-260-2723.

**Japanese**

無料の言語支援サービスをご利用いただけます。1-866-260-2723 までお電話ください。

**Karen**

usdmw>rRpXRt\*D>erRM>tDRoh0J vXwvd.h.tyORb. (cDvD) M.vDRI 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 ye ha i nyuu yoy. Sebel i nsinga ini 1-866-260-2723.

**Kurdish Sorani**

خزمهتگهانی یارمهتی زمانی بهخواری بی بو تو دابین دمکرین. تکایه تلهفون بکه بو ژماره 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 jërbaļ in jipañ in kajin ilo ejjelōk wōñāān. Jouj  
im kallōk 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 jíik'eh bee nich'i'  
bee ná'ahoot'i'. T'áá shqódi kohji' 1-866-260-2723 hodíilnih.

**Nepali**

भाषा सहायता सेवाहरू नि:शुल्क उपलब्ध छन्। कृपया

1-866-260-2723 मा कल गर्नुहोस्।

**Nilotic-Dinka**

Kāk ē kuny ajuær ē thok atō tūnē yin abac tē cīn wēu yeke  
thiēēc. Yin col 1-866-260-2723.

**Norwegian**

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

**Pennsylvania Dutch**

Schprooch iwwe-setze Hilf kansch 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 tolotogia.  
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- Ffulfulde**

E woodi walliinde dow wolde caahu ngam maada. 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**

ܟܘܡܪܘܢ ܒܘܟ ܝܪܒܐ ܝܢ ܝܦܐܢ ܝܢ ܟܝܝܢ ܝܠܘ ܝܟܠܘܟ ܘܘܢܐܢܐܢ. ܝܘܝܟ  
ܝܡ ܟܠܠܘܟ 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**

లాంగ్విజ్ అసిస్ట్‌లెంట్ సర్వీసెస్ మీకు ఉచితంగా

అందుబాటులో ఉన్నాయి.

దయ చేసి 1-866-260-2723 కి కాల్ చేయండి.

**Thai**

มีบริการความช่วยเหลือด้านภาษาให้โดยที่คุณไม่ต้องเสียค่าใช้จ่าย  
แต่อย่างใด 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 بلا معاوضہ 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**

Isẹ irànlọwọ èdè tí ó jẹ òfẹ́, wà fún ọ. Pe 1-866-260-2723.