



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/xavier 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 or call 1-800-767-0700 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	<u>Preferred Providers</u> \$500 / (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.
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 deductibles 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 out-of-pocket limit for this plan?	<u>Preferred Providers</u> \$7,150 / (Person) <u>Out-of-Network Provider</u> \$7,150 / (Person)	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services.
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 network provider?	Yes. See www.uhcsr.com/xavier 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.
Do you need a referral to see a specialist?	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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% <u>Coins</u> \$35 <u>Copay</u> per visit <u>ded</u> does not apply	50% <u>Coins</u> \$35 <u>Copay</u> per visit <u>ded</u> does not apply	Student Health Center Benefits: The Deductible will be waived and benefits will be paid at 100% for Covered Medical Expenses after a \$30 Copay per visit incurred when treatment is rendered at the Student Health Center. May not apply when related to surgery or Physiotherapy. 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.
	<u>Specialist</u> visit	20% <u>Coins</u> \$35 <u>Copay</u> per visit <u>ded</u> does not apply	50% <u>Coins</u> \$35 <u>Copay</u> per visit <u>ded</u> does not apply	
	<u>Preventive care/screening/immunization</u>	No Charge	50% <u>Coins</u>	
If you have a test	<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—————
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	\$20 <u>Copay</u> per prescription Tier 1 <u>ded</u> does not apply	50% <u>Coins</u>	Preferred Providers: up to a 31 day supply per prescription Preferred Providers: 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 Out-of-Network Provider: up to a 31 day supply per prescription 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>
	Tier 2 - Your Midrange-Cost Option	\$50 <u>Copay</u> per prescription Tier 2 <u>ded</u> does not apply	50% <u>Coins</u>	
	Tier 3 - Your Highest-Cost Option	\$75 <u>Copay</u> per prescription Tier 3 <u>ded</u> does not apply	50% <u>Coins</u>	
	Tier 4 - Additional High-Cost Option	Not Covered	Not Covered	

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

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)	
				for certain <u>prescription drugs</u> . You may pay more if <u>prior authorization</u> is not obtained.
If you have outpatient surgery	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_____
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>Coins</u> \$250 <u>Copay</u> per visit <u>ded</u> does not apply	20% <u>Coins</u> \$250 <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> \$35 <u>Copay</u> per visit <u>ded</u> does not apply	50% <u>Coins</u> \$35 <u>Copay</u> per visit <u>ded</u> does not apply	May be limited to facility fees.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>Coins</u>	50% <u>Coins</u>	_____none_____
	Physician/surgeon fees	20% <u>Coins</u>	Anesthetist Services: 50% <u>Coins</u> Assistant Surgeon Fees: 40% <u>Coins</u> Physician's Visits: 50% <u>Coins</u> Surgery: 50% <u>Coins</u>	_____none_____
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visits: 20% <u>Coins</u> \$35 <u>Copay</u> per visit <u>ded</u> does not apply Other: 20% <u>Coins</u>	Office Visits: 50% <u>Coins</u> \$35 <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_____
If you are pregnant	Office visits	Based on setting where service is performed	Based on setting where service is performed	<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
	Childbirth/delivery professional services	Based on setting where service is	Based on setting where service is performed	

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

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)	
		performed		include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery facility services	Based on setting where service is performed	Based on setting where service is performed	_____none_____
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>	Inpatient Rehabilitation Facility: 20% <u>Coins</u> Physiotherapy: 20% <u>Coins</u> \$35 <u>Copay</u> per visit <u>ded</u> does not apply	Inpatient Rehabilitation Facility: 50% <u>Coins</u> Physiotherapy: 50% <u>Coins</u> \$35 <u>Copay</u> per visit <u>ded</u> does not apply	Inpatient 60 days maximum per Policy Year Outpatient 36 visits of cardiac rehabilitation therapy Outpatient Separate physical, occupational and speech therapy limits apply to rehabilitative and Habilitative Services
	<u>Habilitation services</u>	20% <u>Coins</u> \$35 <u>Copay</u> per visit <u>ded</u> does not apply	50% <u>Coins</u> \$35 <u>Copay</u> per visit <u>ded</u> does not apply	Outpatient 36 visits of cardiac rehabilitation therapy Outpatient Separate physical, occupational and speech therapy limits apply to rehabilitative and Habilitative Services
	<u>Skilled nursing care</u>	20% <u>Coins</u>	50% <u>Coins</u>	90 days maximum (Per Policy Year)
	<u>Durable medical equipment</u>	20% <u>Coins</u>	50% <u>Coins</u>	_____none_____
	<u>Hospice services</u>	20% <u>Coins</u>	50% <u>Coins</u>	_____none_____
If your child needs dental or eye care	Children's eye exam	\$20 <u>Copay</u> per exam; <u>ded</u> does not apply	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.*

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

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)	
	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/xavier

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 except as specifically provided in the Policy.
- Dental care (Adult) except as specifically provided in the Policy.
- Hearing aids
- Infertility treatment
- Long-term care except as specifically provided in the Policy.
- Non-emergency care when traveling outside the U.S.
- 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
- Private-duty nursing
- Routine eye care (Adult)

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 Ohio Department of Insurance at 1-800-686-1526 or visit <http://www.insurance.ohio.gov/Pages/default.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 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: Ohio Department of Insurance at 1-800-686-1526 or visit <http://www.insurance.ohio.gov/Pages/default.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 plan's overall deductible	\$500	■ The plan's overall deductible	\$500	■ The plan's overall deductible	\$500
■ Specialist copayment	\$35	■ Specialist copayment	\$35	■ Specialist copayment	\$35
■ Hospital (facility) coinsurance	20%	■ Hospital (facility) coinsurance	20%	■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%	■ Other coinsurance	20%	■ Other coinsurance	20%
This EXAMPLE event includes services like: <u>Specialist office visits (prenatal care)</u> Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests (ultrasounds and blood work)</u> <u>Specialist visit (anesthesia)</u>		This EXAMPLE event includes services like: <u>Primary care physician office visits (including disease education)</u> <u>Diagnostic tests (blood work)</u> <u>Prescription drugs</u> <u>Durable medical equipment (glucose meter)</u>		This EXAMPLE event includes services like: <u>Emergency room care (including medical supplies)</u> <u>Diagnostic test (x-ray)</u> <u>Durable medical equipment (crutches)</u> <u>Rehabilitation services (physical therapy)</u>	
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:	
<i>Cost-Sharing</i>		<i>Cost-Sharing</i>		<i>Cost-Sharing</i>	
<u>Deductibles</u>	\$500	<u>Deductibles</u>	\$500	<u>Deductibles</u>	\$500
<u>Copayments</u>	\$40	<u>Copayments</u>	\$1,000	<u>Copayments</u>	\$800
<u>Coinsurance</u>	\$2,400	<u>Coinsurance</u>	\$200	<u>Coinsurance</u>	\$300
<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
The total Peg would pay is	\$3,000	The total Joe would pay is	\$1,720	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 <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 լեզվախոս օգնություններ: 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 သင့်အကြံအစည်အတွက် အခမဲ့ရရှိနိုင်ပါသည်။ ဝက်စ်ဘ်ဆိုက် ဖုန်းနံပါတ် 1-866-260-2723 ကို ခေါ်ဆိုပါ။

Cambodian- Mon-Khmer

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

Cherokee

ᏍᏈᏅᏍᏏᏁᏍᏏ ᏃᏍᏏᏁᏍᏏ ᏃᏍᏏᏁᏍᏏ ᏅᏍᏏ ᏃᏍᏏᏁᏍᏏ ᏃᏍᏏ ᏃᏍᏏᏁᏍᏏ ᏃᏍᏏ ᏃᏍᏏᏁᏍᏏ 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 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, dirị gi. 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 ye ha i nyuu yonj. Sebel i nsinga ini 1-866-260-2723.

Kurdish Sorani

خزمهتگهانی یارمهتیی زمانی بهخواری بی بو تو دابین دمکرین. تکایه تلهفون بکه بو ژماره 1-866-260-2723.

Laotian

ມີບໍລິການທາງດ້ານພາສາບໍ່ເສຍຄ່າໃຫ້ແກ່ທ່ານ. ກະລຸນາໃຫ້ຫາຕົວ
1-866-260-2723.

Marathi

भाषेच्या मदतीची सुविधा आपल्याला विनामूल्य उपलब्ध आहे.
त्यासाठी 1-866-260-2723 या क्रमांकावर संपर्क करा.

Marshallese

Kwomaroñ bōk jerbāl 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'í'
bee ná'ahoot'i'. T'áá shōqdí kohjí' 1-866-260-2723 hod'ílnih.

Nepali

भाषा सहायता सेवाहरू नि:शुल्क उपलब्ध छन्। कृपया
1-866-260-2723 मा कल गर्नुहोस्।

Nilotic-Dinka

Kāk ē kuny ajuēr ē thok atō tūnē yīn abac tē cīn wēu yeke
thiēēc. Yīn cōl 1-866-260-2723.

Norwegian

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

Pennsylvania Dutch

Schprooch iwwesetze Hilf kanschd 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.

Samoaan- 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 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

ܕܡܘܨܚܐܘܬܐ ܕܡܘܨܚܐܘܬܐ ܕܡܘܨܚܐܘܬܐ ܕܡܘܨܚܐܘܬܐ ܕܡܘܨܚܐܘܬܐ
.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

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 אוועילעביל 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.