UnitedHealthcare: Texas Southern University 2023-1350-1

Coverage Period: 8/11/2023 – 8/10/2024

Coverage for: Student | 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 or call 1-888-799-7716. 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.healthcare.gov/sbc-glossary/ or call 1-866-948-8472 to request a copy.

| Important Questions  | Answers   | Why This Matters:   |
|--|---|---|
| What is the overall deductible?                                      | Preferred Providers \$500 (Person) Out of Network \$1,000 (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,<br>Pediatric Vision and categories that specify<br><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> .  |
| 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 \$7,900 (Person) Out of Network \$15,800 (Person)   | The out-of-pocket limit is the most you could pay in a year for covered services.   |
| What is not included in the<br>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 or call 1-866-948-8472 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 <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.

|   |  | What Y  | ou Will Pay   |  |
|---|--|---|---|--|
| Common Medical Event  | Services You May Need                            | Preferred Provider<br>(You will pay the<br>least)                   | Out-of-Network<br>Provider (You will pay<br>the most)   | Limitations, Exceptions, & Other Important Information   |
|   | Primary care visit to treat an injury or illness | \$35 <u>Copay</u> per visit <u>ded</u> does not apply               | 40% <u>Coins</u><br>\$35 <u>Copay</u> per visit<br><u>ded</u> does not apply  | May not apply when related to surgery or   |
| If you visit a health care  | <u>Specialist</u> visit                          | \$35 <u>Copay</u> per visit <u>ded</u> does not apply               | 40% <u>Coins</u><br>\$35 <u>Copay</u> per visit<br><u>ded</u> does not apply  | Physiotherapy.   |
| <u>provider's</u> office or clinic  | Preventive care/screening/immunization           | No Charge   | 40% <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. |
| If you have a test  | Diagnostic test (x-ray, blood work)              | 20% <u>Coins</u>  | 40% <u>Coins</u>  | none   |
| ii you nave a test  | Imaging (CT/PET scans, MRIs)                     | 20% <u>Coins</u>  | 40% <u>Coins</u>  | none   |
| If you need drugs to treat your illness or condition                                  | Tier 1 - Your Lowest-Cost Option                 | \$10 <u>Copay</u> per prescription Tier 1 <u>ded</u> does not apply | \$35 <u>Copay</u> per prescription generic drug \$60 <u>Copay</u> per prescription brand-name drug <u>ded</u> does not apply                | Preferred Providers: up to a 31-day supply per prescription Preferred Providers: Mail Order Network Pharmacy or Preferred 90 Day Retail Pharmacy at 2.5 times the retail Copay up to a 90-day supply   |
| More information about prescription drug coverage is available at www.uhcsr.com/txpdl | Tier 2 - Your Midrange-Cost Option               | \$35 <u>Copay</u> per prescription Tier 2 <u>ded</u> does not apply | \$35 <u>Copay</u> per<br>prescription generic drug<br>\$60 <u>Copay</u> per<br>prescription brand-name<br>drug<br><u>ded</u> does not apply | Out of Network Providers: up to a 31-day supply per prescription You may need to obtain certain specialty drugs from a pharmacy designated by us. You may need to obtain prior authorization for certain prescription drugs.   |

|  |  | What Y  | ou Will Pay  |   |
|--|--|---|--|---|
| Common Medical Event   | Services You May Need                          | Preferred Provider<br>(You will pay the<br>least)                             | Out-of-Network<br>Provider (You will pay<br>the most)  | Limitations, Exceptions, & Other Important Information  |
|  | Tier 3 - Your Highest-Cost Option              | \$60 <u>Copay</u> per prescription Tier 3 <u>ded</u> does not apply           | \$35 <u>Copay</u> per prescription generic drug \$60 <u>Copay</u> per prescription brand-name drug <u>ded</u> does not apply | You may pay more if <u>prior authorization</u> is not obtained. For insulin drugs, the total amount of <u>Copayments</u> or <u>Coinsurance</u> shall not exceed \$25 for an individual prescription of up to a 30-day supply. |
|  | Tier 4 - Additional High-Cost Option           | Not Covered   | Not Covered  |   |
| 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                            | 20% <u>Coins</u><br>\$150 <u>Copay</u> per visit<br><u>ded</u> does not apply | 20% <u>Coins</u><br>\$150 <u>Copay</u> per visit<br><u>ded</u> does not apply  | May be limited to use of emergency room and supplies. The Preferred Provider Copay will be waived if admitted to the Hospital.  |
|  | Emergency medical transportation               | 20% <u>Coins</u>  | 20% <u>Coins</u>   | none  |
|  | <u>Urgent care</u>                             | 20% <u>Coins</u>  | 40% <u>Coins</u>   | 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   | Physician/surgeon fees                         | 20% <u>Coins</u>  | 40% <u>Coins</u>   | none  |
| If you need mental<br>health, behavioral<br>health, or substance<br>abuse services | Outpatient services                            | Office Visits: \$35 Copay per visit ded does not apply Other: 20% Coins       | Office Visits: 40% Coins<br>\$35 Copay per visit<br>ded does not apply<br>Other: 40% Coins                                   | none  |
| abuse services   | Inpatient services                             | 20% <u>Coins</u>  | 40% <u>Coins</u>   | none  |
|  | Office visits                                  | \$35 <u>Copay</u> per visit <u>ded</u> does not apply                         | 40% <u>Coins</u><br>\$35 <u>Copay</u> per visit<br><u>ded</u> does not apply   | Cost sharing does not apply for preventive services when provided by a preferred provider. Depending on the type of   |
| If you are pregnant  | Childbirth/delivery professional services      | 20% <u>Coins</u>  | 40% <u>Coins</u>   | 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 facility services          | 20% <u>Coins</u>  | 40% <u>Coins</u>   | none  |

|   |                            | What You Will Pay                                 |   |  |  |
|---|----------------------------|---|---|--|--|
| Common Medical Event                      | Services You May Need      | Preferred Provider<br>(You will pay the<br>least) | Out-of-Network<br>Provider (You will pay<br>the most) | Limitations, Exceptions, & Other Important Information                         |  |
|   | 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 other special health   | Habilitation services      | 20% <u>Coins</u>                                  | 40% <u>Coins</u>                                      | none   |  |
| needs                                     | Skilled nursing care       | 20% <u>Coins</u>                                  | 40% <u>Coins</u>                                      | none   |  |
|   | Durable medical equipment  | 20% <u>Coins</u>                                  | 40% <u>Coins</u>                                      | none   |  |
|   | Hospice services           | 20% <u>Coins</u>                                  | 40% <u>Coins</u>                                      | none   |  |
|   | Children's eye exam        |   | 50% Coins; ded does not apply                         | See your <u>plan's</u> Pediatric Vision Benefit Details. Age limits apply.*    |  |
| If your child needs<br>dental or eye care | Children's glasses         | Lonavs from no                                    | 50% <u>Coins;</u> <u>ded</u> does not<br>apply        | See your <u>plan's</u> Pediatric Vision Benefit<br>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

• Long-term care

- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)

Routine foot care

Weight loss programs

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

Chiropractic care

- Dental care (Adult) for Injury to Sound, Natural teeth and removal of complete bony impacted teeth only
- Hearing aids, 1 per ear every 36 months

Infertility

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 Texas Department of Insurance at 1-800-252-3439 or visit http://www.tdi.texas.gov/. Other coverage options may be available to you, too, including buying individual insurance coverage through the <a href="Health Insurance Marketplace">Health Insurance Marketplace</a>. 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: Texas Department of Insurance at 1-800-252-3439 or visit http://www.tdi.texas.gov/.

# Does this plan provide Minimum Essential Coverage? Yes

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

# Does this plan meet Minimum Value Standards? Not Applicable

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

# **Language Access Services:**

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

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

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

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

To see examples of how this <u>plan</u> 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   | \$500 |
|-----------------------------------|-------|
| Specialist copayment              | \$35  |
| ■ 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)

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

| ■ The <u>plan's</u> overall <u>deductible</u> | \$500 |
|---|-------|
| ■ Specialist copayment                        | \$35  |
| ■ 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)

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

| ■ The <u>plan's</u> overall <u>deductible</u> | \$500 |
|---|-------|
| Specialist copayment                          | \$35  |
| ■ 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 | \$12,700 |
|--------------------|----------|
|--------------------|----------|

| In this example, Peg would pay: |         |
|---------------------------------|---------|
| Cost Sharing                    |         |
| <u>Deductibles</u>              | \$500   |
| <u>Copayments</u>               | \$40    |
| Coinsurance                     | \$1,900 |
| What isn't covered              |         |
| Limits or exclusions            | \$60    |
| The total Peg would pay is      | \$2,500 |

| Total Example Cost | \$5,600 |
|--------------------|---------|
|--------------------|---------|

| In this example, Joe would pay: |         |  |
|---------------------------------|---------|--|
| Cost Sharing                    |         |  |
| <u>Deductibles</u>              | \$500   |  |
| <u>Copayments</u>               | \$700   |  |
| <u>Coinsurance</u>              | \$100   |  |
| What isn't covered              |         |  |
| Limits or exclusions            | \$20    |  |
| The total Joe would pay is      | \$1,320 |  |

| Total Example Cost | \$2,800 |
|--------------------|---------|
|--------------------|---------|

In this example Mis would nave

| \$500   |
|---------|
| \$500   |
| \$300   |
|         |
| \$0     |
| \$1,300 |
|         |

# 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 <a href="https://ocrportal.hhs.gov/ocr/portal/lobby.jsf">https://ocrportal.hhs.gov/ocr/portal/lobby.jsf</a>

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 አገልግሎቶች በነጻ ይገኛሉ። እባክዎ ወደ 1-866-260-2723 ይደውሉ።

#### Arabic

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

#### 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। দয়া করে 1-866-260-2723-তে কল করুন।

#### **Burmese**

ဘာသာစကား အကူအညီ ဝန္ေဆာင္မႈမ်ား သင့္ အတြက္ အခမဲ့ရရွိႏိုင္သည္။ ေက်းဇူးျပဳ၍ ဖုန္း 1-866-260-2723 ကိုေခၚပါ။

## 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.

#### Gujarat

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 2723-260-866-1 पर कॉल करें।

## **Hmong**

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

#### Tho

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

OHo;plRqJ;usd;b. 1-866-260-2723 wuh>I

## Korean

언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-260-2723 번으로 전화하십시오.

#### Kru- Bassa

Bot ba hola ni kobol mahop ngui nsaa wogui wo ba yé ha i nyuu yon. Sebel i nsinga ini 1-866-260-2723.

## **Kurdish Sorani**

خزمەتمكانى يارمەتىيى زمانى بەخۆر ايى بۆ تۆ دابين دەكريْن. تكايە تەلمەڧۆن بكە بۆ ژمارەي 2723-260-866-1.

#### Laotian

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ມີບໍລິການທາງດ້ານພາສາບໍ່ເສຍຄ່ຳໃຫ້ແກ່່ທ່່ານ. 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 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 ajuεεr ë thok atö tinë yin abac të cin wëu yeke thiëëc. Yin 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 272-260-186-1 تماس بگیر بد

## **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

جدهدة ألا مدينكم دائيتكم، وكتكمبلا، كمبلر في يم بالمدم وسرعة وجم عدد مدينة والمدائدة مدينة والمدائدة والم

#### 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 2723-266-166، 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 הילף סערוויסעס זענען אוועילעבל 1-866-260-2723 רופט

#### Yoruba

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

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