UnitedHealthcare²: Biola University 2020-319-4

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 (866) 948-8472. 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>, provider, or other <u>underlined</u> terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or call (866) 948-8472 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	<u>Preferred Providers</u> \$300 (Person) <u>Preferred Providers</u> \$600 (Family) Out of Network \$900 (Family) Out of Network \$450 (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. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible?</u>	Yes. <u>Preventive care</u> , Pediatric Dental Preventive and Diagnostic Services, Pediatric Vision and categories that specify <u>ded</u> does not apply are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other <u>deductibles</u> for specific services?	Yes. Pediatric Dental \$500. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out–of–pocket</u> <u>limit</u> for this <u>plan</u> ?	<u>Preferred Providers</u> \$6,850 (Person) <u>Preferred Providers</u> \$13,700 (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.
What is not included in the <u>out–of–pocket limit</u> ?	Premiums, <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 (866) 948- 8472 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider</u> <u>network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's</u> <u>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 **<u>copayment</u>** and **<u>coinsurance</u>** costs shown in this chart are after your **<u>deductible</u>** has been met, if a **<u>deductible</u>** applies.

		What Y	′ou Will Pay		
Common Medical Even	Services You May Need	vices You May Need Preferred Provider Out-of-Network (You will pay the Provider (You will pay the least) the most)		 Limitations, Exceptions, & Other Important Information 	
1	Primary care visit to treat an injury or illness	\$20 <u>Copay</u> per visit; <u>ded</u> does not apply	40% <u>Coins</u>	May not apply when related to surgery or	
	<u>Specialist</u> visit	\$20 <u>Copay</u> per visit; <u>ded</u> does not apply	40% <u>Coins</u>	Physiotherapy.	
If you visit a health care <u>provider's</u> office or clinic	Preventive care/screening/immunization	No Charge	e Not Covered You may have to pay for services aren't preventive. Ask your provided are preventive.	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.	
lf you have a test	Diagnostic test (x-ray, blood work)	20% <u>Coins</u>	40% <u>Coins</u>	none	
lf you have 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	Tier 1 - Your Lowest-Cost Option	\$25 <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	
Condition More information about prescription drug <u>coverage</u> is available at www.uhcsr.com/capdl	Tier 2 - Your Midrange-Cost Option	\$35 <u>Copay</u> per prescription Tier 2; <u>ded</u> does not apply	Not Covered	<u>Preferred Providers</u> : Mail order <u>Prescription Drugs</u> through UHCP at 2.5 times the retail Copay up to a 90 day	
	Tier 3 - Your Highest-Cost Option	\$60 <u>Copay</u> per prescription Tier 3; <u>ded</u> does not apply	Not Covered	supply You may need to obtain certain <u>specialty</u> <u>drugs</u> from a pharmacy designated by us.	
	Tier 4 - Additional High-Cost Option	Not Applicable	Not Applicable		
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	\$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 20% <u>Coins</u>	May be limited to use of emergency room and supplies. The Preferred Provider and Out-of-	

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

Common Medical Event	Services You May Need	What Y	′ou Will Pay		
		Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
				Network <u>Copay</u> will be waived if admitted to the Hospital. Out: The Insured's expense shall not exceed the amount payable for Preferred Provider Medical Emergency Expenses.	
	Emergency medical transportation	20% <u>Coins</u>	20% <u>Coins</u>	Out: The Insured's air ambulance expense shall not exceed the amount payable for Preferred Provider air ambulance services.	
	Urgent care	20% <u>Coins</u>	40% <u>Coins</u>	May be limited to facility fees.	
lf you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>Coins</u>	Hospital Miscellaneous Expenses: 40% <u>Coins</u> Room and Board Expense: \$500 <u>Copay</u> per Hospital Confinement; <u>ded</u> does not apply Room and Board Expense: 40% <u>Coins</u>	none	
	Physician/surgeon fees	20% <u>Coins</u>	40% <u>Coins</u>	none	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visits: \$20 <u>Copay</u> per visit; <u>ded</u> does not apply Other:	Office Visits: 40% <u>Coins</u> Other:	none	
	Inpatient services	20% <u>Coins</u> 20% <u>Coins</u>	40% <u>Coins</u> \$500 <u>Copay</u> per Hospital Confinement; <u>ded</u> does not apply; 40% <u>Coins</u>	none	
If you are pregnant	Office visits	\$20 <u>Copay</u> per visit; <u>ded</u> does not apply	40% <u>Coins</u>	Cost sharing does not apply for preventive services (routine pre-natal care and first	
	Childbirth/delivery professional services	20% <u>Coins</u>	40% <u>Coins</u>	post-natal visit) when provided by a	

Common Medical Event	Services You May Need	What Y	ou Will Pay		
		Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
				preferred provider. 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 facility services	20% <u>Coins</u>	Hospital Miscellaneous Expenses: 40% <u>Coins</u> Room and Board Expense: \$500 <u>Copay</u> per Hospital Confinement; <u>ded</u> does not apply Room and Board Expense: 40% <u>Coins</u>	none	
	Home health care	20% <u>Coins</u>	40% <u>Coins</u>	100 visits maximum (Per Policy Year)	
lf you need help	Rehabilitation services	20% <u>Coins</u>	40% <u>Coins</u>	none	
recovering or have	Habilitation services	20% <u>Coins</u>	40% <u>Coins</u>	none	
other special health	Skilled nursing care	20% <u>Coins</u>	40% <u>Coins</u>	100 visits maximum (Per Policy Year)	
needs	Durable medical equipment	20% <u>Coins</u>	40% <u>Coins</u>	none	
	Hospice services	20% <u>Coins</u>	20% <u>Coins</u>	none	
	Children's eye exam	\$20 <u>Copay</u> per exam; <u>ded</u> does not apply	50% <u>Coins; ded</u> does not apply	See your <u>plan's</u> Pediatric Vision Benefit Details. Age limits apply.*	
lf your child needs dental or eye care	Children's glasses	Lens: \$40 <u>Copay;</u> <u>ded</u> does not apply Frames: Tiered <u>Copay</u> s from no charge to 40% based on retail cost. <u>ded</u> does not apply	50% <u>Coins; ded</u> does not apply	See your <u>plan's</u> Pediatric Vision Benefit Details. Age limits apply.*	
	Children's dental check-up	No Charge; <u>ded</u> does not apply	50% <u>Coins; ded</u> does not apply	See your <u>plan's</u> Pediatric Dental Benefit Details. Age limits apply.*	

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)						
 Bariatric surgery except as specifically provided in the policy 	Cosmetic surgery	 Dental care (Adult) except as specifically provided in the policy 				
Hearing aids	Infertility treatment	Long-term care				
 Non-emergency care when traveling outside the U.S. 	Routine eye care (Adult)	Weight loss programs				
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)						
Acupuncture	Chiropractic care	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: California Department of Insurance at 1-800-927-4357 or visit http://www.insurance.ca.gov/. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information 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: California Department of Insurance at 1-800-927-4357 or visit http://www.insurance.ca.gov/.

Additionally, a consumer assistance program can help you file your appeal, contact California Department of Insurance Consumer Communications Bureau at 300 South Spring Street, South Tower, Los Angeles, CA 90013 or call 1-800-927-4357 or 1-800-482-4TDD (4833) or visit http://www.insurance.ca.gov/.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have <u>Minimum Essential Coverage</u> 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 <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 <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage.

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</u> overall <u>deductible</u> <u>Specialist copayment</u> Hospital (facility) <u>coinsurance</u> Other <u>coinsurance</u> 	\$300 \$20 20% 20%	 The <u>plan's</u> overall <u>deductible</u> <u>Specialist copayment</u> Hospital (facility) <u>coinsurance</u> Other <u>coinsurance</u> 	\$300 \$20 20% 20%	 The <u>plan's</u> overall <u>deductible</u> <u>Specialist copayment</u> Hospital (facility) <u>coinsurance</u> Other <u>coinsurance</u> 	\$300 \$20 20% 20%
This EXAMPLE event includes se Specialist office visits (prenatal care) Childbirth/Delivery Professional Serv Childbirth/Delivery Facility Services Diagnostic tests (ultrasounds and blo Specialist visit (anesthesia)	vices	This EXAMPLE event includes services like: Primary care physician office visits <i>(including disease education)</i> Diagnostic tests <i>(blood work)</i> Prescription drugs Durable medical equipment <i>(glucose meter)</i>		This EXAMPLE event includes services like: Emergency room care <i>(including medical supplies)</i> Diagnostic test <i>(x-ray)</i> Durable medical equipment <i>(crutches)</i> Rehabilitation services <i>(physical therapy)</i>	
Total Example Cost	\$12,800	Total Example Cost	\$7,400	Total Example Cost	\$1,900
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
Cost Sharing		Cost Sharing		Cost Sharing	
Deductibles	\$300	Deductibles	\$300	Deductibles	\$300
Copayments	\$40	Copayments	\$1,300	Copayments	\$60
Coinsurance	\$2,000	Coinsurance	\$200	Coinsurance	\$300
What isn't covered		What isn't covered		What isn't covered	
Limits or exclusions	\$60	Limits or exclusions	\$60	Limits or exclusions	\$0
The total Peg would pay is	\$2,400	The total Joe would pay is	\$1,860	The total Mia would pay is	\$660

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 አርዳታ አንልግሎቶች በነጻ ይንኛሉ። እባከዎ ወደ 1-866-260-2723 ይደውሉ።

Arabic

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

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

ဘာသာစကား အကူအညီ ဝန်ဆောင်မှုများ သင့် အတွက်

အခမဲ့ရရှိနိုင်သည်။ ကျေးဇူးပြု၍ ဖုန်း 1-866-260-2723 ကိုခေါ် ပါ။

Cambodian- Mon-Khmer

សេវាជំនួយផ្នែកភាសាដែលឥតគិតថ្លៃ មានសម្រាប់អ្នក។

សូមទូរស័ព្ទទៅលេខ 1-866-260-2723។

Cherokee

\$ይንኬመመ*I* ወፀሀመያዝ ወፀሀመደፐ ኬወ RG©ውፐመሀብዝT ከሀደርናው D4(ወፐ. ዙር(ወ Dh ወচ₩ው\$ 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.

SR LAP 64 (6-18)

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 સહ્યચ સેવાઓ તમારા માટે નિઃશુલ્ક ઉપલબ્ધ છે. કૃપા કરીને

1-866-260-2723 पर डॉल डरो.

Hawaiian

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

Hindi

आप के लिए भाषा सहायता सेवाएं निःशुल्क उपलब्ध हैं। कृपया

1-866-260-2723 पर कॉल करें।

Hmong

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

Ibo

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

Ilocano

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

Indonesian

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

Italian

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

Japanese

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

Karen

ကိုဉ်တာ်မၤစၢၤအင်္ကိုနမၤနု၊်အီးသ့ဝဲလ၊တလိဉ်ဟ္ဉာ်အပူးဘဉ်(ခီလီ)နှဉ်လီး. ဝံသးစူးဆံးကိုးဘဉ်1-866-260-2723တက္i.

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

خزمەتەكلتى يارمەتيى زمانى بەخۆر ايى بۆ تۆ دابين دەكرىز. تكايە تەلەفزن بكە بۆ ژمار «ى 2723-266-1.

Laotian

ມີບໍລິການທາງດ້ານພາສາບໍ່ເສຍຄ່ຳໃຫ້ແກ່່ທໍ່ານ. 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 wonāān. 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 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 ajuser 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 2723-266-866-1 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.

SR LAP 64 (6-18)

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

چەھەلىقە مەنباقە دىلىنە، ھەختىمىد، سېلرەتى سىلەممى مىيدەممەر. مەنى جا ھىتتە 1-866-202-2723 مەنى جا ھەت

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 2723-266-16 پر کال کریں۔

Vietnamese

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

Yiddish

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

Yoruba

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