UnitedHealthcare: Biola University 2023-319-4

Coverage Period: 08/01/2023 - 07/31/2024

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/biola or call 1-800-767-0700. 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 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?	Preferred Providers \$300 (Person) Out-of-Network Providers \$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.				
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> , Pediatric Dental Preventive and Diagnostic Services, 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 <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 \$8,000 (Person)	The out-of-pocket limit is the most you could pay in a year for covered services.				
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out–of–pocket limit</u> .				
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.uhcsr.com/biola or call 1-800-767-0700 for a list of network providers.	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 specialist you choose without a referral.				

COL-17-CA (PY23) SBC (319)



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

	Services You May Need	What You Will Pay			
Common Medical Event		Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
	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>	The <u>Deductible</u> will be waived and benefits will be paid at 100% for Covered	
If you visit a health care	<u>Specialist</u> visit	\$20 <u>Copay</u> per visit <u>ded</u> does not apply	40% Coins	Medical Expenses incurred when treatment is rendered at the Student Health Center or Counseling Center.	
provider's office or clinic	Preventive care/screening/immunization	No Charge	Not Covered	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	Tier 1 - Your Lowest-Cost Option	\$25 <u>Copay</u> per prescription Tier 1 <u>ded</u> does not apply	Not Covered	Preferred Providers: up to a 31 day supply per prescription Preferred Providers: Mail order	
treat your illness or condition	Tier 2 - Your Midrange-Cost Option	\$35 <u>Copay</u> per prescription Tier 2 <u>ded</u> does not apply	Not Covered	prescription drugs are available at 2.5 times the retail <u>Copay</u> up to a 90 day supply.	
More information about prescription drug coverage is available at	Tier 3 - Your Highest-Cost Option	\$60 <u>Copay</u> per prescription Tier 3 <u>ded</u> does not apply	Not Covered	You may need to obtain certain specialty drugs from a pharmacy designated by us. You may need to obtain prior authorization	
www.uhcsr.com/capdl	Tier 4 - Additional High-Cost Option Not Applic	Not Applicable	Not Applicable	for certain <u>prescription drugs.</u> You may pay more if <u>prior authorization</u> is not obtained.	
16 1 (1)	Facility fee (e.g., ambulatory surgery center)	20% <u>Coins</u>	40% <u>Coins</u>	none	
If you have outpatient surgery	Physician/surgeon fees	20% Coins	40% Coins	If two or more procedures are performed through the same incision or in immediate succession at the same operative	

COL-17-CA (PY23) SBC (319) *For more information about limitations and exceptions, see <u>plan</u> or policy document at www.uhcsr.com/biola

	Services You May Need	What Y	ou Will Pay		
Common Medical Event		Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
				session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	
If you need immediate medical attention	Emergency room care	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 Preferred Provider and Out-of-Network Provider Copay will be waived if admitted to the Hospital. Out-of-Network Provider: (The Insured's expense shall not exceed the amount payable for Preferred Provider Medical Emergency Expenses.)	
	Emergency medical transportation	20% Coins	20% <u>Coins</u>	Out-of-Network Provider: (The Insured's air ambulance expense shall not exceed the amount payable for Preferred Provider air ambulance services.)	
	<u>Urgent care</u>	20% <u>Coins</u>	40% <u>Coins</u>	May be limited to facility fees.	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>Coins</u>	Hospital Miscellaneous Expenses: 40% Coins Room and Board Expense: 40% Coins \$500 Copay per Hospital Confinement ded does not apply	none	
	Physician/surgeon fees	20% <u>Coins</u>	40% <u>Coins</u>	If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visits: \$20 Copay per visit ded does not apply Other: 20% Coins	Office Visits: 40% Coins Other: 40% Coins	none	

		What Y	ou Will Pay		
Common Medical Event	Services You May Need	rvices You May Need Preferred Provider Out-of-Network (You will pay the least) the most)		Limitations, Exceptions, & Other Important Information	
	Inpatient services	20% <u>Coins</u>	40% <u>Coins</u>	none	
	Office visits	Routine Office Visit: No charge Office visit related to complications: \$20 Copay per visit ded does not apply	40% <u>Coins</u>	Cost sharing does not apply for preventive services when provided by a Preferred Provider. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include	
If you are pregnant	Childbirth/delivery professional services	20% <u>Coins</u>	40% Coins	tests and services described elsewhere in the SBC (i.e. ultrasound).	
	Childbirth/delivery facility services	20% <u>Coins</u>	Hospital Miscellaneous Expenses: 40% Coins Room and Board Expense: 40% Coins \$500 Copay per Hospital Confinement ded does not apply	none	
	Home health care	20% <u>Coins</u>	40% <u>Coins</u>	100 visits maximum (Per Policy Year)	
If you need help	Rehabilitation services	20% <u>Coins</u>	40% Coins	Review of Medical Necessity will be performed after 12 visits per Injury or Sickness.	
recovering or have other special health needs	Habilitation services	20% <u>Coins</u>	40% Coins	Review of Medical Necessity will be performed after 12 visits per Injury or Sickness.	
nccus	Skilled nursing care	20% <u>Coins</u>	40% <u>Coins</u>	100 days maximum (Per Policy Year)	
	<u>Durable medical equipment</u>	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;</u> <u>ded</u> does not apply	See your <u>plan's</u> Pediatric Vision Benefit Details. Age limits apply.*	
If 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	50% <u>Coins;</u> <u>ded</u> does not apply	See your <u>plan's</u> Pediatric Vision Benefit Details. Age limits apply.*	

	t Services You May Need	What Y	ou Will Pay	Limitations, Exceptions, & Other Important Information	
Common Medical Event		Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)		
		on retail cost. <u>ded</u> does not apply			
	Children's dental check-up			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.)

Cosmetic surgery

Dental care (Adult)

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

Bariatric surgery

• Chiropractic care

Private duty nursing

Routine foot care

COL-17-CA (PY23) SBC (319)

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 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 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: 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

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.

COL-17-CA (PY23) SBC (319) Page 7 of 8

About these Coverage Examples:

Peg is Having a Baby

(9 months of in-network pre-natal care and a



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.

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-

hospital delivery)		controlled condition)		care)	
■ The plan's overall deductible \$300 ■ Specialist copayment \$20 ■ Hospital (facility) coinsurance 20% ■ Other coinsurance 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 plan's overall deductible Specialist copayment Hospital (facility) coinsurance Other coinsurance 	\$300 \$20 20% 20%
This EXAMPLE event includes ser 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 (including disease education) Diagnostic tests (blood work) Prescription drugs Durable medical equipment (glucose meter)		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	Total Example Cost	\$4,800	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
Cost Sharing		Cost Sharing		Cost Sharing	
<u>Deductibles</u>	\$300	<u>Deductibles</u>	\$300	<u>Deductibles</u>	\$300
<u>Copayments</u>	\$20	<u>Copayments</u>	\$800	Copayments	\$80
Coinsurance	\$2,000	Coinsurance	\$100	Coinsurance	\$400
What isn't covered		What isn't covered		What isn't covered	
Limits or exclusions	\$60	Limits or exclusions	\$20	Limits or exclusions	\$0
The total Peg would pay is	\$2,380	The total Joe would pay is	\$1,220	The total Mia would pay is	\$780

Mia's Simple Fracture

(in-network emergency room visit and follow up

UNITEDHEALTHCARE INSURANCE COMPANY

NON-DISCRIMINATION AND LANGUAGE ASSISTANCE PROGRAM

NON-DISCRIMINATION NOTICE

UnitedHealthcare Student Resources does not discriminate or treat Insureds differently on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

If you think you were treated unfairly for any of these reasons, 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.

If you think you were treated unfairly because of your ancestry, religion, marital status, gender, gender identity, or sexual orientation, you can also send a complaint to the California Department of Insurance:

California Department of Insurance Consumer Communications Bureau 300 South Spring Street, South Tower Los Angeles, CA 90013

Toll-Free Consumer Hotline: 1-800-927-HELP (4357) or 1-213-897-8921

TDD Number: 1-800-482-4TDD (4833)

http://www.insurance.ca.gov

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, 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

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 2723-260-1-866.

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

សេវាជំនួយផ្នែកភាសាដែលឥតគិតផ្នៃ 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 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 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

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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

خزمەتەكانى يارمەتىي زمانى بەخۆر ايى بۆ تۆ دابين دەكريّن. تكايە تەلەفۆن بكە بۆ ژمارەي 2723-260-866-1.

Laotian

ມີບໍລິການທາງດ້ານພາສາບໍ່ເສຍຄ່ຳໃຫ້ແກ່່ທ່ຳນ. ກະລຸນາໂທຫາເບີ 1-866-260-2723.

SR LAP 64 (6-18) 1 of 2

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 kohjį' 1-866-260-2723 hodíilnih.

Nepali

भाषा सहायता सेवाहरू निःशुल्क उपलब्ध छन्। कृपया 1-866-260-2723 मा कल गर्नुहोस्।

Nilotic-Dinka

Käk ë kuny ajuɛɛr ë thok atö tïnë yïn abac të cïn wëu yeke thiëëc. Yïn 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 8-260-264-1 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

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 بر 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 פריי פון אפצאל. ביטע אוועילעבל פאר אייך פריי פון שפראך. ביטע 1-866-260-2723 רופט

Yoruba

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

SR LAP 64 (6-18) 2 of 2