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/LUC or call 1-866-808-8389. 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 1-866-808-8389 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
</table>
| What is the overall deductible? | Preferred Providers $250 (Person)  
Preferred Providers $500 (Family)  
Out of Network $450 (Person)  
Out of Network $900 (Family) | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| Are there services covered before you meet your deductible? | Yes. Preventive care, Pediatric Dental, Pediatric Vision and categories that specify ded do not apply. | This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services 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 deductibles. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| What is the out-of-pocket limit for this plan? | Preferred Providers $6,350 (Person)  
Preferred Providers $12,700 (Family)  
Out of Network $12,700 (Person)  
Out of Network $25,400 (Family) | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| 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 out-of-pocket limit. |
| Will you pay less if you use a network provider? | Yes. See www.uhcsr.com/LUC or call 1-866-808-8389 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| Do you need a referral to see a specialist? | No. | You can see the specialist you choose without a referral. |
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Preferred Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>20% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>20% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No Charge</td>
<td>40% Coins</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>May not apply when related to surgery or Physiotherapy.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Includes preventive services 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 provider if the services needed are preventive. Then check what your plan will pay for.</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Tier 1 - Your Lowest-Cost Option</td>
<td>$20 Copay per prescription</td>
<td>$20 Copay per prescription generic drug</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$40 Copay per prescription</td>
<td>$40 Copay per prescription brand-name drug</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tier 2 - Your Midrange-Cost Option</td>
<td>$40 Copay per prescription</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$40 Copay per prescription</td>
<td>$40 Copay per prescription brand-name drug</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tier 3 - Your Highest-Cost Option</td>
<td>$60 Copay per prescription</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$60 Copay per prescription</td>
<td>$60 Copay per prescription brand-name drug</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Preferred Providers: up to a 31 day supply per prescription</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Preferred Providers: Mail order Prescription Drugs through UHCP at 2.5 times the retail Copay up to a 90 day supply</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Out of Network: up to a 31 day supply per prescription</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>You may need to obtain certain specialty drugs from a pharmacy designated by us.</td>
</tr>
</tbody>
</table>

*For more information about limitations and exceptions, see plan or policy document at www.uhcsr.com/LUC*
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Preferred Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Tier 4 - Additional High-Cost Option</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>20% Coins $100 Copay per visit deductible does not apply</td>
<td>20% Coins $100 Copay per visit deductible does not apply</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% Coins</td>
<td>20% Coins</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>20% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office Visits: 20% Coins Other: 20% Coins</td>
<td>Office Visits: 40% Coins Other: 40% Coins</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>20% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>20% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>20% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>20% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>20% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>20% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>20% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>20% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>20% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td>If your child needs</td>
<td>Children’s eye exam</td>
<td>$20 Copay per exam; 50% Coins; deductible does not apply</td>
<td></td>
</tr>
</tbody>
</table>

*For more information about limitations and exceptions, see plan or policy document at www.uhcsr.com/LUC*
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td><em>dental or eye care</em></td>
<td><em>Children’s glasses</em></td>
<td>Preferred Provider (You will pay the least): <strong>ded</strong> does not apply&lt;br&gt;Lens: $40 <strong>Copay</strong>; <strong>ded</strong> does not apply&lt;br&gt;Frames: Tiered <strong>Copays</strong> from no charge to 40% based on retail cost, <strong>ded</strong> does not apply</td>
<td>Out-of-Network Provider (You will pay the most): 50% <strong>Coins</strong>; <strong>ded</strong> does not apply</td>
</tr>
<tr>
<td><em>Children’s dental check-up</em></td>
<td></td>
<td>50% <strong>Coins</strong></td>
<td>50% <strong>Coins</strong></td>
</tr>
</tbody>
</table>
# 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.)

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
<td></td>
</tr>
<tr>
<td>Dental care (Adult) except as specifically provided in the policy</td>
<td></td>
</tr>
<tr>
<td>Long-term care</td>
<td></td>
</tr>
<tr>
<td>Routine foot care</td>
<td></td>
</tr>
<tr>
<td>Bariatric surgery except as specifically provided in the policy</td>
<td></td>
</tr>
<tr>
<td>Hearing aids except as specifically provided in the policy</td>
<td></td>
</tr>
<tr>
<td>Non-emergency care when traveling outside the U.S.</td>
<td></td>
</tr>
<tr>
<td>Weight loss programs except as specifically provided in the policy</td>
<td></td>
</tr>
<tr>
<td>Cosmetic surgery</td>
<td></td>
</tr>
<tr>
<td>Infertility treatment</td>
<td></td>
</tr>
<tr>
<td>Routine eye care (Adult)</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractic care</td>
<td></td>
</tr>
<tr>
<td>Private-duty nursing</td>
<td></td>
</tr>
</tbody>
</table>
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: Illinois Department of Insurance at 1-866-445-5364 or visit http://www.insurance.illinois.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 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 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: Illinois Department of Insurance at 1-866-445-5364 or visit http://www.insurance.illinois.gov/.

Additionally, a consumer assistance program can help you file your appeal, contact Illinois Department of Insurance, Office of Consumer Health Insurance at 1-877-527-9431 or visit http://insurance.illinois.gov/.

Does this plan provide Minimum Essential Coverage? Yes
If you don’t have Minimum Essential Coverage 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:
Navajo (Dine): Dinek’ehgo shika at’ohwol ninisingo, kwiijigo 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)** |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The plan’s overall deductible</strong></td>
<td><strong>The plan’s overall deductible</strong></td>
<td><strong>The plan’s overall deductible</strong></td>
</tr>
<tr>
<td><strong>Specialist coinsurance</strong></td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Hospital (facility) coinsurance</strong></td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Other coinsurance</strong></td>
<td>20%</td>
<td>20%</td>
</tr>
</tbody>
</table>
| 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)* | 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** | $12,800 | $7,400 | $1,900 |
| In this example, Peg would pay:  
Cost Sharing | In this example, Joe would pay:  
Cost Sharing | In this example, Mia would pay:  
Cost Sharing |
| **Deductibles** | **Deductibles** | **Deductibles** | $250 |
| **Copayments** | **Copayments** | **Copayments** | $20 |
| **Coinsurance** | **Coinsurance** | **Coinsurance** | $2,500 |
| **What isn’t covered** | **What isn’t covered** | **What isn’t covered** | 
Limits or exclusions | Limits or exclusions | Limits or exclusions | $60 |
| **The total Peg would pay is** | **The total Joe would pay is** | **The total Mia would pay is** | $2,830 |

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The plan would be responsible for the other costs of these EXAMPLE covered services.
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: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf


Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)


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**

**Amharic**
አገልግሎቶች ከሸላክ ከምስክር ያቀረባት በስፋህምን በክፋል ያሇባል። በክፋል ከም ያላቅርብ 1-866-260-2723 ከወንወን።

**Arabic**
توفر لك خدمات المساعدة اللغوية مجانية. اتصل على الرقم 2723-1-866-260-2723.

**Armenian**
2723 Էիրիքություն տեղեկագործություն մատուցնենք: Էիրիքություն կարելի է կատարել 1-866-260-2723 համարով:

**Bantu- Kirundi**
Uronswa ku buntu servisi zifatiye ku rurimi zo kugufasha. Utegerezwa guhamburgera 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। দাও করুন 1-866-260-2723 তে কল করুন।

**Burmese**
သင်များ နေပြီး အသုံးပြုထားသော ဘာသာစကားအဆင့် များသော 1-866-260-2723 ကို တင်ပြပါတယ်။

**Cambodian- Mon-Khmer**
កម្ពុជាត្រូវបានផ្តល់ជូននូវបទពីរូបស្សីនិងបញ្ហាស្តង់ដាយដែល កើតមានបានដូចជា 1-866-260-2723 ។

**Cherokee**
\( \_{\text{ sıw̃ęh}̃ęmban an i ọọtę ọọ́tę həŋę ŋędáną dęx̘o tà\\ ọdą̞nt \ hę̞ęęą̣́ dəc̘ o̞tt. hę̞ęęę Đ ọ̞wə́ s 1-866-260-2723. \)

**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 anumpili hoikmv toshhola yvt peh pilla hō chi apela hinla. I paya 1-866-260-2723.

**Cushite- Oromo**
Tajaaqjilliwwan gargaarsa afaani kanfaltii malee siif jira. Maaloo karaa lakoofsa bibilaa 1-866-260-2723 bilibili.

**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. Apprenez le 1-866-260-2723.

**French Creole- Haitian Creole**

**German**

**Gujarati**
ભાષા સહાયતા સેવાઓ તમારા માટે નિશ્ચિત ઉપલબ્ધ છે. કૃપા કરીને 1-866-260-2723 પર કોલ કરો.

**Hawaiian**
Kūkua manuahi ma kāu ‘ōlelo i loa’a ‘ia. E kelepona i ka helu 1-866-260-2723.

**Hindi**
आप के लिए भाषा सहायता सेवाएं निश्चित उपलब्ध हैं। कृपया 1-866-260-2723 पर कॉल करें।

**Hmong**
Muaj cov kev tì xhais lus pub dawb rau koj. Thov hau rau 1-866-260-2723.

**Ibo**

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

**Indonesian**

**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 まで電話ください。

**Karen**
usdmwvr+rRpxXRt"+erRM>tDROhOJ vXwv{\h.tyORb. (cDvD) M.vDRI 0Ho;plRqJ:usdbD. 1-866-260-2723 wuh>1

**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 há i nyuu yon. Sebel i nsinga ini 1-866-260-2723.

**Kurdish Sorani**
خزمهکشی بازمرینی زمانی مختصری بو تو دابین دمکراين. نکبه کله عون که بو زمراهی 2723-1-866-260-2723.

**Laotian**
ມີບໍລິສັດທິດຫຼາຍນິສ຺ງລະບອບເຫດໃຊ້ໄດ້. ນາຍທີ່ໃຫຍ່ 1-866-260-2723.
Marathi
भाषेच्या मदतीनी सुविधा आपल्याला विनामूल्य उपलब्ध आहे. त्यासाठी 1-866-260-2723 या क्रमांकावर संपर्क करा.

Marshallese

Micronesian- Pohnpeian
Mie sasaw en mahnos ong komwi, soh isepe. Melau eker 1-866-260-2723.

Navajo
Saad bee äka'eeyed bee äka'ñida'wo'igi òtá jiik'eh bee nich'j'í bee nā'ahoot'i'. Òtá shqódi kohjí' 1-866-260-2723 hodíilnih.

Nepali
भाषाच्या सहायता सेवाहृत निषुल्क उपलब्ध छन्। कृपया 1-866-260-2723 मा कल गुन्होस्।

Nilotic-Dinka

Norwegian

Pennsylvania Dutch

Persian-Farsi
خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا 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
ਦੋਨ ਮਾਧਿਮ ਮੇਲੜਾਂ ਨੁੰਦ ਸਰੀ ਭੁਗਾ ਥਿੰਕਾਪਣ ਉਠਾਈ। ਵਿਚਕਾਰ ਬਣਾਇਆ 1-866-260-2723 'ਤੇ ਕਲਾ ਬਣਾਈ।

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 le totoia. Faamolemale leoni le 1-866-260-2723.

Serbo- Croatian

Somali
Adeegyada taageerada luqadda oo bilaash ah aayaa 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

Swahili
Huduma za msada wa lugha zinapatikana kwa ajili yako bure. Tafadhali piga simu 1-866-260-2723.

Syriac- Assyrian
Jamājjan, 2habēnītak, 2kāfīma, 2małakāt; 2nāma, 2nīšāma; 2liyāmītak. 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
వాచిక మాధ్యమాల మధ్య నిశాచరించడానికి ఇంద్రియాల ప్రత్యేక మాధ్యమాలు 1-866-260-2723

Tongan- Fakatonga
‘Oko ‘i ai pē ‘a e sēvesi ki he lea’ ke tokoni kiate koe pea ‘oku ‘aātu ia ma’au’ o ‘i ikai hata totongi. Kātaki ‘o tā ki he 1-866-260-2723.

Trukese (Chuukese)
En mei tongeni anininisin 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 کی حوصلہ سے معاونتی خدمات آپ کے لئے بلا قیمت سندیبا پی پر کال کریں۔ 1-866-260-2723

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

Yiddish
שפראַַה ווילַך טעַיירטועם זעַַנַַָנװ אָוַַ לַעַלטַַװ פאַַר אֶירַַ פּרַַומַַ פר אַַָ פּרַַים פּר אַַָ פּרַַים 1-866-260-2723

Yoruba