

## LifeWise Assurance Company : UW ISHIP Gold + Vision/Dental

Coverage for: Individual or Family | Plan Type: PPO



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, call 1-800-971-1491 or visit us at <https://students.lifewiseac.com/iship/>. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-800-971-1491 to request a copy.

| Important Questions                                                | Answers                                                                                                                                                                                                      | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|--------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall deductible?</b>                             | \$125 Individual / \$250 Family per quarter, up to \$500 Individual / \$1,000 Family per <u>plan</u> year. Copays are not applied to the <u>deductible</u> . Doesn't apply to services at the campus clinic. | 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> .                                                                                                                                                              |
| <b>Are there services covered before you meet your deductible?</b> | Yes. Does not apply to <u>Preventive care</u> , <u>copayments</u> , <u>prescription drugs</u> and services listed below as "No charge"                                                                       | 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> .                                           |
| <b>Are there other deductibles for specific services?</b>          | Yes. Adult Dental \$25 Individual/\$75 Family                                                                                                                                                                | 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.                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>What is the out-of-pocket limit for this plan?</b>              | In-network: \$3,400 Individual / \$6,800 Family, Out-of-network: \$6,400 Individual / \$12,800 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.                                                                                                                                                                                                                                                                                    |
| <b>What is not included in the out-of-pocket limit?</b>            | <u>Premium</u> , <u>balance-billed</u> charges, penalties for failure to obtain <u>prior authorization</u> for services, 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> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Will you pay less if you use a network provider?</b>            | Yes. See <a href="https://students.lifewiseac.com/iship/">https://students.lifewiseac.com/iship/</a> or call 1-800-971-1491 for a list of <u>in-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. |
| <b>Do you need a referral to see a specialist?</b>                 | No.                                                                                                                                                                                                          | You can see the <u>specialist</u> you choose without a <u>referral</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |



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

| Common Medical Event                                                                                                                                                                                                                                                          | Services You May Need                            | What You Will Pay                                                                      |                                                                                | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                 |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                               |                                                  | <u>Network Provider</u><br>(You will pay the least)                                    | <u>Out-of-Network Provider</u><br>(You will pay the most)                      |                                                                                                                                                                                                                                        |
| <b>If you visit a health care provider's office or clinic</b>                                                                                                                                                                                                                 | Primary care visit to treat an injury or illness | <u>Deductible</u> , then 25% <u>coinsurance</u>                                        | <u>Deductible</u> , then 40% <u>coinsurance</u>                                | None                                                                                                                                                                                                                                   |
|                                                                                                                                                                                                                                                                               | <u>Specialist</u> visit                          | <u>Deductible</u> , then 25% <u>coinsurance</u>                                        | <u>Deductible</u> , then 40% <u>coinsurance</u>                                | None                                                                                                                                                                                                                                   |
|                                                                                                                                                                                                                                                                               | <u>Preventive care/screening/immunization</u>    | No charge                                                                              | Not covered                                                                    | No charge for out-of-network immunizations                                                                                                                                                                                             |
| <b>If you have a test</b>                                                                                                                                                                                                                                                     | <u>Diagnostic test</u> (x-ray, blood work)       | 25% <u>coinsurance</u> , <u>deductible</u> waived                                      | <u>Deductible</u> , then 40% <u>coinsurance</u>                                | None                                                                                                                                                                                                                                   |
|                                                                                                                                                                                                                                                                               | Imaging (CT/PET scans, MRIs)                     | <u>Deductible</u> , then 25% <u>coinsurance</u>                                        | <u>Deductible</u> , then 40% <u>coinsurance</u>                                | <u>Prior authorization</u> is required for certain outpatient imaging tests.                                                                                                                                                           |
| <b>If you need drugs to treat your illness or condition</b><br><br>More information about <u>prescription drug coverage</u> is available at <a href="https://student.lifewiseacc.com/documents/054567_2026.pdf">https://student.lifewiseacc.com/documents/054567_2026.pdf</a> | Preferred generic drugs                          | \$20 <u>copay</u> /prescription, <u>deductible</u> waived (retail), not covered (mail) | 50% <u>coinsurance</u> , <u>deductible</u> waived (retail), not covered (mail) | Covers up to a 30 day supply. <u>Prior authorization</u> is required for certain drugs. Maximum <u>coinsurance</u> of up to \$150/prescription for all out-of-network prescriptions as well as for in-network <u>Specialty drugs</u> . |
|                                                                                                                                                                                                                                                                               | Preferred brand drugs                            | \$30 <u>copay</u> /prescription, <u>deductible</u> waived (retail), not covered (mail) | 50% <u>coinsurance</u> , <u>deductible</u> waived (retail), not covered (mail) |                                                                                                                                                                                                                                        |
|                                                                                                                                                                                                                                                                               | Non-preferred drugs                              | \$45 <u>copay</u> /prescription, <u>deductible</u> waived (retail), not covered (mail) | 50% <u>coinsurance</u> , <u>deductible</u> waived (retail), not covered (mail) |                                                                                                                                                                                                                                        |
|                                                                                                                                                                                                                                                                               | <u>Specialty drugs</u>                           | 50% <u>coinsurance</u> , <u>deductible</u> waived (retail), not covered (mail)         | 50% <u>coinsurance</u> , <u>deductible</u> waived (retail), not covered (mail) |                                                                                                                                                                                                                                        |
| <b>If you have outpatient surgery</b>                                                                                                                                                                                                                                         | Facility fee (e.g., ambulatory surgery center)   | <u>Deductible</u> , then 25% <u>coinsurance</u>                                        | <u>Deductible</u> , then 40% <u>coinsurance</u>                                | <u>Prior authorization</u> is required for certain outpatient services.                                                                                                                                                                |
|                                                                                                                                                                                                                                                                               | Physician/surgeon fees                           | <u>Deductible</u> , then 25% <u>coinsurance</u>                                        | <u>Deductible</u> , then 40% <u>coinsurance</u>                                | None                                                                                                                                                                                                                                   |

| Common Medical Event                                                      | Services You May Need                     | What You Will Pay                                                                                                                                                |                                                                                                                                                                  | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                     |
|---------------------------------------------------------------------------|-------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                           | Network Provider<br>(You will pay the least)                                                                                                                     | Out-of-Network Provider<br>(You will pay the most)                                                                                                               |                                                                                                                                                                                                                                            |
| If you need immediate medical attention                                   | <u>Emergency room care</u>                | \$100 <u>copay/visit</u> , <u>deductible</u> then 25% <u>coinsurance</u>                                                                                         | \$100 <u>copay/visit</u> , <u>deductible</u> then 25% <u>coinsurance</u>                                                                                         | None                                                                                                                                                                                                                                       |
|                                                                           | <u>Emergency medical transportation</u>   | <u>Deductible</u> , then 25% <u>coinsurance</u>                                                                                                                  | <u>Deductible</u> , then 25% <u>coinsurance</u>                                                                                                                  | None                                                                                                                                                                                                                                       |
|                                                                           | <u>Urgent care</u>                        | Hospital-based: \$100 <u>copay/visit</u> , <u>deductible</u> then 25% <u>coinsurance</u><br>Freestanding center: <u>Deductible</u> , then 25% <u>coinsurance</u> | Hospital-based: \$100 <u>copay/visit</u> , <u>deductible</u> then 25% <u>coinsurance</u><br>Freestanding center: <u>Deductible</u> , then 40% <u>coinsurance</u> | None                                                                                                                                                                                                                                       |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)        | <u>Deductible</u> , then 25% <u>coinsurance</u>                                                                                                                  | <u>Deductible</u> , then 40% <u>coinsurance</u>                                                                                                                  | <u>Prior authorization</u> is required for certain inpatient services.                                                                                                                                                                     |
|                                                                           | Physician/surgeon fees                    | <u>Deductible</u> , then 25% <u>coinsurance</u>                                                                                                                  | <u>Deductible</u> , then 40% <u>coinsurance</u>                                                                                                                  | None                                                                                                                                                                                                                                       |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | No charge                                                                                                                                                        | No charge                                                                                                                                                        | None                                                                                                                                                                                                                                       |
|                                                                           | Inpatient services                        | <u>Deductible</u> , then 25% <u>coinsurance</u>                                                                                                                  | <u>Deductible</u> , then 40% <u>coinsurance</u>                                                                                                                  | <u>Prior authorization</u> is required for certain inpatient services.                                                                                                                                                                     |
| If you are pregnant                                                       | Office visits                             | <u>Deductible</u> , then 25% <u>coinsurance</u>                                                                                                                  | <u>Deductible</u> , then 40% <u>coinsurance</u>                                                                                                                  | <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (such as, ultrasound). |
|                                                                           | Childbirth/delivery professional services | <u>Deductible</u> , then 25% <u>coinsurance</u>                                                                                                                  | <u>Deductible</u> , then 40% <u>coinsurance</u>                                                                                                                  |                                                                                                                                                                                                                                            |
|                                                                           | Childbirth/delivery facility services     | <u>Deductible</u> , then 25% <u>coinsurance</u>                                                                                                                  | <u>Deductible</u> , then 40% <u>coinsurance</u>                                                                                                                  |                                                                                                                                                                                                                                            |

| Common Medical Event                                                  | Services You May Need            | What You Will Pay                            |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                      |
|-----------------------------------------------------------------------|----------------------------------|----------------------------------------------|----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                       |                                  | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                             |
| <b>If you need help recovering or have other special health needs</b> | <u>Home health care</u>          | <u>Deductible</u> , then 25% coinsurance     | <u>Deductible</u> , then 40% coinsurance           | Limited to 130 visits per <u>plan</u> year                                                                                                                                                                                                                                                                                  |
|                                                                       | <u>Rehabilitation services</u>   | <u>Deductible</u> , then 25% coinsurance     | <u>Deductible</u> , then 40% coinsurance           | Limited to 25 outpatient visits per <u>plan</u> year, limited to 30 inpatient days per <u>plan</u> year. Includes physical therapy, speech therapy, and occupational therapy. <u>Prior authorization</u> required for all planned inpatient stays. Penalty for out-of-network: 50% of allowable charge to \$1,500 per stay. |
|                                                                       | <u>Habilitation services</u>     | <u>Deductible</u> , then 25% coinsurance     | <u>Deductible</u> , then 40% coinsurance           | Limited to 25 outpatient visits per <u>plan</u> year, limited to 30 inpatient days per <u>plan</u> year. Includes physical therapy, speech therapy, and occupational therapy. <u>Prior authorization</u> required for all planned inpatient stays. Penalty for out-of-network: 50% of allowable charge to \$1,500 per stay. |
|                                                                       | <u>Skilled nursing care</u>      | <u>Deductible</u> , then 25% coinsurance     | <u>Deductible</u> , then 40% coinsurance           | Limited to 60 days per <u>plan</u> year. <u>Prior authorization</u> is required for certain inpatient services.                                                                                                                                                                                                             |
|                                                                       | <u>Durable medical equipment</u> | <u>Deductible</u> , then 25% coinsurance     | <u>Deductible</u> , then 40% coinsurance           | <u>Prior authorization</u> is required for purchase of some durable medical equipment.                                                                                                                                                                                                                                      |
|                                                                       | <u>Hospice services</u>          | <u>Deductible</u> , then 25% coinsurance     | <u>Deductible</u> , then 40% coinsurance           | Limited to 14 inpatient days                                                                                                                                                                                                                                                                                                |
| <b>If your child needs dental or eye care</b>                         | Children's eye exam              | <u>Deductible</u> , then 25% coinsurance     | <u>Deductible</u> , then 40% coinsurance           | Limited to one exam per <u>plan</u> year (under age 19).                                                                                                                                                                                                                                                                    |
|                                                                       | Children's glasses               | No charge                                    | No charge                                          | Frames and lenses limited to 1 pair per <u>plan</u> year (under age 19).                                                                                                                                                                                                                                                    |
|                                                                       | Children's dental check-up       | No charge                                    | <u>Deductible</u> , then 30% coinsurance           | Limited to two exams per <u>plan</u> year (under age 19).                                                                                                                                                                                                                                                                   |

## 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                                                                                                                                                    | • Infertility treatment                   | • Private-duty nursing                               |
| • Cosmetic surgery                                                                                                                                                     | • Long-term care                          | • 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.)                                    |                                           |                                                      |
| • Abortion                                                                                                                                                             | • Dental care (Adult, limited to \$1,500) | • Non-emergency care when traveling outside the U.S. |
| • Acupuncture                                                                                                                                                          | • Foot care                               | • Routine eye care (Adult)                           |
| • Chiropractic care or other spinal manipulations                                                                                                                      | • Hearing aids                            |                                                      |

**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: 1-800-562-6900 for the state insurance department, or the insurer at 1-800-971-1491. 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](http://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: your [plan](#) at 1-800-971-1491.

**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 [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 1-800-722-1471.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-722-1471.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-722-1471.

Navajo (Dine): Dine'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-722-1471.

—————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)

|                                               |       |
|-----------------------------------------------|-------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$500 |
| ■ <u>Specialist</u> coinsurance               | 25%   |
| ■ Hospital (facility) <u>coinsurance</u>      | 25%   |
| ■ Other <u>coinsurance</u>                    | 25%   |

#### 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

#### In this example, Peg would pay:

| <u>Cost Sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$500          |
| <u>Copayments</u>                 | \$0            |
| <u>Coinsurance</u>                | \$2,900        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$3,460</b> |

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|                                               |       |
|-----------------------------------------------|-------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$500 |
| ■ <u>Specialist</u> coinsurance               | 25%   |
| ■ Hospital (facility) <u>coinsurance</u>      | 25%   |
| ■ Other <u>coinsurance</u>                    | 25%   |

#### 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

#### In this example, Joe would pay:

| <u>Cost Sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$500          |
| <u>Copayments</u>                 | \$500          |
| <u>Coinsurance</u>                | \$400          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,420</b> |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

|                                               |       |
|-----------------------------------------------|-------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$500 |
| ■ <u>Specialist</u> coinsurance               | 25%   |
| ■ Hospital (facility) <u>coinsurance</u>      | 25%   |
| ■ Other <u>coinsurance</u>                    | 25%   |

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

#### In this example, Mia would pay:

| <u>Cost Sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$500          |
| <u>Copayments</u>                 | \$100          |
| <u>Coinsurance</u>                | \$600          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,200</b> |

## Notice of availability and nondiscrimination 800-971-1491 | TTY: 711

Call for free language assistance services and appropriate auxiliary aids and services.

Llame para obtener servicios gratuitos de asistencia lingüística, y ayudas y servicios auxiliares apropiados.

呼吁提供免费的语言援助服务和适当的辅助设备及服务。

呼籲提供免費的語言援助服務和適當的輔助設備及服務。

Gọi cho các dịch vụ hỗ trợ ngôn ngữ miễn phí và các hỗ trợ và dịch vụ phụ trợ thích hợp.

무료 언어 지원 서비스와 적절한 보조 도구 및 서비스를 신청하십시오.

Звоните для получения бесплатных услуг по переводу и других вспомогательных средств и услуг.

Tumawag para sa mga libreng serbisyo ng tulong sa wika at angkop na mga karagdagang tulong at serbisyo.

Звертайте за безкоштовною мовною підтримкою та відповідними додатковими послугами.

សូមហៅទូរសព្ទទៅសេវាជំនួយភាសាដោយឥតគិតថ្លៃ ព្រមទាំងសេវាផ្សេងៗ និងជំនួយចាំបាច់ដែលសមរម្យផ្សេងៗ។

無料言語支援サービスと適切な補助器具及びサービスをお求めください。

ለነፃ የቋንቋ እርዳታ አገልግሎቶች እና ተገቢ ድጋፍ ሰጪ አጋዥ ማሳሰቢያዎችን እና አገልግሎቶችን ለማግኘት በስልክ ቁጥር

Tajaajiloota deeggarsa afaan bilisaa fi gargaarsaa fi tajaajiloota barbaachisaa ta'an argachuuf bilbilaa.

ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਅਤੇ ਉਚਿਤ ਸਹਾਇਕ ਚੀਜ਼ਾਂ ਅਤੇ ਸੇਵਾਵਾਂ ਵਾਸਤੇ ਕਾਲ ਕਰੋ।

Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.

ໂທເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການບໍລິການ ແລະ ການຊ່ວຍເຫຼືອພິເສດທີ່ເໝາະສົມແບບບໍ່ເສຍຄ່າ.

Rele pou w jwenn sèvis asistans lengwistik gratis ak èd epi sèvis oksilyè ki apwopriye.

Appelez pour obtenir des services gratuits d'assistance linguistique et des aides et services auxiliaires appropriés.

Zadzwonić, aby uzyskać bezpłatną pomoc językową oraz odpowiednie wsparcie i usługi pomocnicze.

Ligue para serviços gratuitos de assistência linguística e auxiliares e serviços auxiliares adequados.

Chiama per i servizi di assistenza linguistica gratuiti e per gli ausili e i servizi ausiliari appropriati.

اتصل للحصول على خدمات المساعدة اللغوية المجانية والمساعدات والخدمات المناسبة.

برای خدمات کمک زبانی رایگان و کمک‌ها و خدمات امدادی مقتضی، تماس بگیرید.

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