Who is eligible to enroll?

All Domestic undergraduate students taking 12 or more credit hours and all Domestic graduate students and professional students taking nine or more credit hours are automatically enrolled in this insurance plan, unless proof of comparable coverage is furnished. All part-time non matriculated students taking six or more hours and all part-time matriculated students taking one or more credit hours are eligible to enroll in this insurance plan. Eligible students may also insure their Dependents. Eligible Dependents are the student’s spouse or domestic partner and dependent children under 26 years of age. See the Who is Covered section of the Certificate of Coverage for the specific requirements needed to meet domestic partner eligibility.

Where can I get more information about the benefits available?

Please read the certificate of coverage to determine whether this plan is right before you enroll. The certificate of coverage provides details of the coverage including benefits, exclusions, and reductions or limitations and the terms under which the coverage may be continued in force. Copies of the certificate of coverage are available from the University and may be viewed at www.uhcsr.com. This plan is underwritten by UnitedHealthcare Insurance Company of New York and is based on policy number 2023-202767-1. The Policy is a Non-Renewable One-Year Term Policy.

Who can answer questions I have about the plan?

If you have questions please contact Customer Service at 1-800-767-0700 or customerservice@uhcsr.com.

Highlights of Coverage offered by UnitedHealthcare Student Resources

<table>
<thead>
<tr>
<th>Coverage Dates, Plan Costs and Premium Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Total Cost of the plan noted below includes premium and fees.</td>
</tr>
<tr>
<td><strong>Total Plan Cost and Coverage Dates</strong></td>
</tr>
<tr>
<td>Student</td>
</tr>
<tr>
<td>Spouse</td>
</tr>
<tr>
<td>One Child</td>
</tr>
<tr>
<td>Two or More Children</td>
</tr>
<tr>
<td>Spouse and Two or More Children</td>
</tr>
</tbody>
</table>
See the information below for the breakdown of premium and fees.

<table>
<thead>
<tr>
<th>Premium Rates*</th>
<th>Annual Premium**</th>
<th>Fall Premium**</th>
<th>Spring/Summer Premium**</th>
<th>Summer Premium**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student</td>
<td>$2,840.62</td>
<td>$1,187.48</td>
<td>$1,653.14</td>
<td>$714.03</td>
</tr>
<tr>
<td>Spouse</td>
<td>$2,840.62</td>
<td>$1,187.48</td>
<td>$1,653.14</td>
<td>$714.03</td>
</tr>
<tr>
<td>One Child</td>
<td>$2,840.62</td>
<td>$1,187.48</td>
<td>$1,653.14</td>
<td>$714.03</td>
</tr>
<tr>
<td>Two or More Children</td>
<td>$5,681.24</td>
<td>$2,374.96</td>
<td>$3,306.28</td>
<td>$1,428.06</td>
</tr>
<tr>
<td>Spouse and Two or More Children</td>
<td>$8,521.86</td>
<td>$3,562.44</td>
<td>$4,959.42</td>
<td>$2,142.09</td>
</tr>
</tbody>
</table>

*The premium is for the insurance coverage underwritten by UnitedHealthcare Insurance Company of New York and does not include the following fees:

- Annual **Service fee of $2.38 for UHC Global administration of the Assistance and Evacuation Benefits.
- Annual **Service fee of $60.00 charged by or at the direction of the school you are receiving coverage through to cover the costs of services provided by a non-insurer vendor or consultant.

**Note: Fees are prorated for the coverage dates other than annual.

The Member must meet the eligibility requirements each time a premium payment is made. To avoid a lapse in coverage, the Member’s premium must be received within 30 days after the coverage expiration date. It is the Member’s responsibility to make timely premium payments to avoid a lapse in coverage.

### Highlights of the Student Health Insurance Plan Benefits

**METALLIC LEVEL – GOLD WITH ACTUARIAL VALUE OF 79.920%

**In-Network Benefits**
In-Network benefits apply when your care is provided by Participating Providers in our UnitedHealthcare Choice Plus network. Participating Providers can be found using the following link: UHC Choice Plus

<table>
<thead>
<tr>
<th>Overall Plan Maximum</th>
<th>In Network Participating Provider Member Cost-Share</th>
<th>Out-of-Network Non-Participating Provider Member Cost-Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Deductible</td>
<td>$100 Per Member, Per Plan Year</td>
<td>$5,000 Per Member, Per Plan Year</td>
</tr>
<tr>
<td></td>
<td>$200 For all Members in a Family, Per Plan Year</td>
<td>$10,000 For all Members in a Family, Per Plan Year</td>
</tr>
</tbody>
</table>

**Out-of-Pocket Limit**
*After the Out-of-Pocket Limit has been satisfied, Covered Expenses will be paid at 100% for the remainder of the Plan Year subject to any applicable benefit maximums. Refer to the plan Certificate for details about how the Out-of-Pocket Limit applies.*

|                      | $8,500 Per Member, Per Plan Year                       | $17,000 Per Member, Per Plan Year                           |
|                      | $17,000 For all Members in a Family, Per Plan Year    | $34,000 For all Members in a Family, Per Plan Year          |

**Coinsurance**
All benefits are subject to satisfaction of the Deductible, specific benefit limitations, maximums and Copayments as described in the plan Certificate.

|                      | 20% of Allowed Amount¹ for Covered Expenses         | 40% of Allowed Amount¹ for Covered Expenses                |

**Prescription Drugs**
Prescriptions must be filled at a UHCP network pharmacy. UHCP Mail Order Network Pharmacy or Maintenance Drugs from a Designated Retail Pharmacy at 2.5 times the retail Copay up to a 90-day supply.

|                      | $30 Copayment for Tier 1                           | Out-of-Network Prescription Drugs are not covered and you pay the full cost. |
|                      | $50 Copayment for Tier 2                           |                                                                           |
|                      | 50% Coinsurance for Tier 3                         |                                                                           |
|                      | Up to a 30-day supply per prescription filled at a  |                                                                           |
|                      | UnitedHealthcare Pharmacy (UHCP) after $200 Prescription Drug Deductible |                                                                           |
### Preventive Care
*Including but not limited to: annual physicals, GYN exams, routine screenings and immunizations. Please see https://www.healthcare.gov/preventive-care-benefits/ for complete details of the services provided for specific age and risk groups.*

<table>
<thead>
<tr>
<th>Covered in full</th>
<th>30% of Allowed Amount¹ after Deductible</th>
</tr>
</thead>
</table>

### The following services have per service Copayments
*This list is not all inclusive. Please read the plan Certificate for complete listing of Copayments.*

<table>
<thead>
<tr>
<th>Office Visits: $30 not subject to Deductible</th>
<th>Emergency Care in an Emergency Department: $250 not subject to Deductible Copayment waived if admitted to Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic X-rays: $30 not subject to Deductible</td>
<td>Emergency Care in an Emergency Department: $250 not subject to Deductible Copayment waived if admitted to Hospital</td>
</tr>
<tr>
<td>Emergency Care in an Emergency Department: $250 not subject to Deductible Copayment waived if admitted to Hospital</td>
<td></td>
</tr>
</tbody>
</table>

### Outpatient Mental Health Care/Substance Use Disorder Services, except Emergency Services and Prescription Drugs

| Office Visits: $30 Copayment then 20% Coinsurance not subject to Deductible | Office Visits: 40% Coinsurance after Deductible |
| Other Outpatient Services: $30 Copayment then 20% Coinsurance not subject to Deductible | Other Outpatient Services: 40% Coinsurance after Deductible |

### Pediatric Dental and Vision Benefits

Refer to the plan Certificate of Coverage for details (age limits apply).

---

¹The Allowed Amount for Participating Providers is the amount we have negotiated with the Participating Providers. The Allowed Amount for Non-Participating Providers will be the lesser of: 1) the Medicare amount; 2) the amount based on cost information from the Centers for Medicare and Medicaid services; 3) The facility or provider’s charge; 4) a rate based on information provided by a third-party vendor; or 5) The amount negotiated with the Provider. We reserve the right to negotiate a lower rate with Non-Participating Providers.

### Exclusions and Limitations

No coverage is available under this Certificate for the following:

**A. Aviation.**
We do not Cover services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.

**B. Convalescent and Custodial Care.**
We do not Cover services related to rest cures, custodial care or transportation. “Custodial care” means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered Services determined to be Medically Necessary.

**C. Conversion Therapy.**
We do not Cover conversion therapy. Conversion therapy is any practice by a mental health professional that seeks to change the sexual orientation or gender identity of a Member under 18 years of age, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. Conversion therapy does not include counseling or therapy for an individual who is seeking to undergo a gender transition or who is in the process of undergoing a gender transition, that provides acceptance, support and understanding of an individual or the facilitation of an individual’s coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, provided that the counseling or therapy does not seek to change sexual orientation or gender identity.

**D. Cosmetic Services.**
We do not Cover cosmetic services, Prescription Drugs, or surgery, unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of
a covered Child which has resulted in a functional defect. We also Cover services in connection with reconstructive surgery following a mastectomy, as provided elsewhere in this Certificate. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the Utilization Review and External Appeal sections of this Certificate unless medical information is submitted.

E. Coverage Outside of the United States, Canada or Mexico.
We do not Cover care or treatment provided outside of the United States, its possessions, Canada or Mexico except for Emergency Services, Pre-Hospital Emergency Medical Services and ambulance services to treat Your Emergency Condition.

F. Dental Services.
We do not Cover dental services except for: care or treatment due to accidental injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or dental care or treatment specifically stated in the Outpatient and Professional Services and Pediatric Dental Care sections of this Certificate.

G. Experimental or Investigational Treatment.
We do not Cover any health care service, procedure, treatment, device, or Prescription Drug that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial as described in the Outpatient and Professional Services section of this Certificate when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, We will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under this Certificate for non-investigational treatments. See the Utilization Review and External Appeal sections of this Certificate for a further explanation of Your Appeal rights.

H. Felony Participation.
We do not Cover any illness, treatment or medical condition due to Your participation in a felony, riot or insurrection. This exclusion does not apply to Coverage for services involving injuries suffered by a victim of an act of domestic violence or for services as a result of Your medical condition (including both physical and mental health conditions).

I. Foot Care.
We do not Cover routine foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. However, we will Cover foot care when You have a specific medical condition or disease resulting in circulatory deficits or areas of decreased sensation in Your legs or feet.

J. Government Facility.
We do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law.

K. Medically Necessary.
In general, We will not Cover any health care service, procedure, treatment, test, device or Prescription Drug that We determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns Our denial, however, We will Cover the service, procedure, treatment, test, device or Prescription Drug for which coverage has been denied, to the extent that such service, procedure, treatment, test, device or Prescription Drug is otherwise Covered under the terms of this Certificate.

L. Medicare or Other Governmental Program.
We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).

M. Military Service.
We do not Cover an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.

N. No-Fault Automobile Insurance.
We do not Cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.

O. Services Not Listed.
We do not Cover services that are not listed in this Certificate as being Covered.
P. Services Provided by a Family Member.
We do not Cover services performed by a covered person’s immediate family member. “Immediate family member” means a child, stepchild, spouse, parent, stepparent, sibling, stepsibling, parent-in-law, child-in-law, sibling-in-law, grandparent, grandparent’s spouse, grandchild, or grandchild’s spouse.

Q. Services Separately Billed by Hospital Employees.
We do not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

R. Services With No Charge.
We do not Cover services for which no charge is normally made.

S. Vision Services.
We do not Cover the examination or fitting of eyeglasses or contact lenses, except as specifically stated in the Pediatric Vision Care section of this Certificate.

T. War.
We do not Cover an illness, treatment or medical condition due to war, declared or undeclared.

U. Workers’ Compensation.
We do not Cover services if benefits for such services are provided under any state or federal Workers’ Compensation, employers’ liability or occupational disease law.

Highlights of Assistance and Evacuation Benefits
Medical Evacuation and Repatriation

If you are a student insured with this insurance plan, you and your insured Spouse and insured Child(ren) are eligible for Medical Evacuation and Repatriation Benefits. The requirements to receive these services are as follows:

A domestic Student (whose Home Country is the United States), and their insured Spouse and insured child(ren): you are eligible for Medical Evacuation and Repatriation Benefits when 100 miles or more away from your campus address or 100 miles or more away from your permanent home address or while participating in a Study Abroad program.

The Medical Evacuation and Repatriation Benefits and related services are not meant to be used in lieu of or replace local emergency services such as an ambulance requested through emergency 911 telephone assistance. If the condition is an emergency, you should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Emergency Response Center. UnitedHealthcare Global will then take the appropriate action to assist you and monitor your care until the situation is resolved.

Key Assistance Benefits include:
- Emergency Medical Evacuation
- Dispatch of Doctors/Specialists
- Medical Repatriation
- Transportation After Stabilization
- Transportation to Join a Hospitalized Insured Person
- Return of Minor Children
- Repatriation of Mortal Remains

Check your certificate of coverage for details, descriptions and program exclusions and limitations.

Highlights of Services offered by UnitedHealthcare Student Resources

Healthiest You: 24/7 Doctor Access

Starting on the effective date of your coverage under the student insurance plan, you have 24/7 access to medical advice through HealthiestYou, a national telehealth service.* By visiting www.telehealth4students.com, you have access to board-certified physicians via phone and/or video, where permitted. This service is especially helpful for minor illnesses, such as allergies, sore throat, earache, pink eye, etc. Based on the condition being treated, the doctor can also prescribe certain medications, saving you a trip to the doctor’s office. Using HealthiestYou can save you money and time, while avoiding costly trips to a doctor’s office, urgent care facility, or emergency room. As a Member with Student Resources, there is no consultation fee for this service.* Every call with a HealthiestYou doctor is covered 100% during your policy period. You can learn more about this benefit ad how to use it in My Account.
This service is meant to complement your Student Health Center. If possible, we encourage you to visit your Student Health Center first before using this service.

HealthiestYou is not health insurance. HealthiestYou is designed to complement, and not replace, the care you receive from your primary care physician. HealthiestYou physicians are an independent network of doctors who advise, diagnose, and prescribe at their own discretion. HealthiestYou physicians provide cross coverage and operate subject to state regulations. Physicians in the independent network do not prescribe DEA controlled substances, non-therapeutic drugs and certain other drugs which may be harmful because of their potential for abuse. HealthiestYou does not guarantee that a prescription will be written. Services may vary by state.

*Available to Member students and their covered Dependents; age restrictions may apply. If you call prior to your effective date of your coverage under the insurance plan, you will be charged a service fee before being connected to a board-certified physician.

**HealthiestYou: Virtual Counselor Access**

Starting on the effective date of your coverage under the student insurance plan, you have access to mental health providers through a national virtual counseling service.* Psychiatrists, psychologists and licensed therapists are available to you through a variety of communication methods, including phone and video.

When you sign up, you'll complete a questionnaire, choose your provider and select a date and time for your appointment. Appointments are available 7 days a week. Visits are secure, discreet and confidential, and you have ongoing support with the same provider.

As a Member with Student Resources, there is no consultation fee for this service. Every communication with a provider is covered 100% during your policy period.

*Available to Member students and their covered Dependents; age restrictions may apply, depending on your state.

**24/7 Student Support**

Members have immediate access to the Student Assistance Program, a service that coordinates counseling services offered by Master's Licensed Clinicians who can provide Members with someone to talk to when everyday issues become overwhelming. More information about these counseling services is available by logging into My Account at www.uhcsr.com/MyAccount.

This Summary Brochure is based on Policy #2023-202767-1.

NOTE: The information contained herein is a summary of certain benefits which are offered under a student health insurance policy issued by UnitedHealthcare. This document is a summary only and may not contain a full or complete recitation of the benefits and restrictions/exclusions associated with the relevant policy of insurance. This document is not an insurance policy document and your receipt of this document does not constitute the issuance or delivery of a policy of insurance. Neither you nor UnitedHealthcare has any rights or responsibilities associated with your receipt of this document. Changes in federal, state or other applicable legislation or regulation or changes in Plan design required by the applicable state regulatory authority may result in differences between this summary and the actual policy of insurance.
NON-DISCRIMINATION NOTICE

UnitedHealthcare Student Resources 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)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW
Room 509F, HHH Building Washington, D.C. 20201

We also provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for free language services such as speaking with an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan ID card, Monday through Friday, 8 a.m. to 8 p.m. ET.
LANGUAGE ASSISTANCE PROGRAM

We provide free services to help you communicate with us, such as, letters in other languages or large print. Or, you can ask for free language services such as speaking with an interpreter. To ask for help, please call toll-free 1-866-260-2723, Monday through Friday, 8 a.m. to 8 p.m. ET.

English
Language assistance services are available to you free of charge. Please call 1-866-260-2723.

Albanian
Shërbimet e ndihjes në gjuhën e mësues kërkon në faltë. Ju lutemi telefononi në numrin 1-866-260-2723

Amharic
አማርኛ እንደች ያስገነዝቡ ከማህሰብ ሀገር ከ1-866-260-2723 ዳኔ

Arabic
تقدم لنا خدمات المساعدة اللغوية مجاناً. يرجى الاتصال 1-866-260-2723.

Armenian
Անվճար լեզվաբանական ընդիորման ծրագրերը եկեք. Համարի լուծում 1-866-260-2723

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
তালিকা যোগ্যতা কেরিয়ার একটি কর্মজীবন ভাষা ব্যাখ্যা দেওয়া। এর জন্য 1-866-260-2723-ভাষায় কল করুন।

Burmese
များစွာ ပါဝင်သော အခြေစိုက်ပျိုး စိတ်ကူးစိုက်စိုက် ဖိုးဖိုး ကူညီပါသည်။ 1-866-260-2723

Cambodian-Mon-Khmer
សេវាកម្មប្រធានបទសំខាន់ៗ មានការជាមួយសំខាន់។ 1-866-260-2723

Cherokee
 Cherokee language services are available to you free of charge. Please call 1-866-260-2723.

Chinese
您可以免费获得语言援助服务。请致电 1-866-260-2723。

Chontaw
Chaha anumpa ish anumpul hokmvt toshkol yv tief pilla hq chi apela hina. 1 paysa 1-866-260-2723.

Cushite-Oromo

Dutch
Taalbijstandsdiens ten zijn gratis voor u beschikbaar. Gelieve 1-866-260-2723 op te bellen.

French

French Creole-Haitian Creole

German

Greek
Oι υπηρεσίες γλωσσικής βοήθειας σας διατίθενται δωρεάν. Καλέστε το 1-866-260-2723.

Gujarati
ભાષા સહાયના સેવાઓ તમામ માહિતી લેખન ઉપલબ્ધ છે. ચાલુ કરીને 1-866-260-2723 પર ક્રમ કરો.

Hawaiian
Kūkua manuahi ma kāu ‘olelo i loa ‘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 कीजिए।

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

Ibo
Ibo

Ilocano
Adda awan bayadna a serbisio para iti language assistance. Panggangasim ta tawagam ni 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 までお電話ください。

Karen

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

Kru-Bassa
Bot ba hola ni kobol mahop ngu nsa wogoi wu ba ye hu i nyu yon. Sebel i nsinga imi 1-866-260-2723.

Kurdish Sorani
خزماكالي یزرماني زماني کهیراییز دو تو داون دکاریز. دیکه کاماتو دو یکه یکه زمیک 1-866-260-2723.

Laotian
Mùbì sînhã hûông nhânh kàp hâmûông dành cho nhân dân. 1-866-260-2723.
Marathi
मराठीतील सूचित व संगणकातील उपलब्ध आहेत.
तासाठी 1-866-260-2723 या कंपनीसल्या संपर्क करा.

Marshallese
Kwomarón bôlk jërlal in jipan in kajin ilo ejjok wênûnîn. Jouj
im kallôk 1-866-260-2723.

Micronesian- Polynesian
Mie sawas en mahsen ong komwi, sch isepe. Melau eker
1-866-260-2723.

Navajo
Saad bee ákʰ eeyeeed bee ákʰ nídi'wo'jííjí t'áá jiíj'eh bee nííhóót'í'. T'áá shóójíí kohjíí 1-866-260-2723 hóódlhíihł.

Nepali
बाषा सहायता सेवाहरू लिनरुक उपलब्ध छ। कृपया
1-866-260-2723 भएका गर्नुहोस्।

Nilotic-Dinka
Kálc e kuny ajeez ñ' thok åt? tinë yín abac tê cín wëye

Norwegian

Pennsylvania Dutch
Spröoch iwwesetze Hilf kann scht du frei hawwe. Ruf
1-866-260-2723.

Persian-Farsi
خدمات امداد زیاتی به طور رایگان بر انتخاب شما بسته است. تماس با شماره
1-866-260-2723.

Polish
Mozesz 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
3Tl:r"F!cl'fu3r~~~~~cJol fc;@Lrr
1-866-26 0-2723

Romanian
Vi se pun la dispoziție, în mod gratuit, servicii de traducere. Vă
recomand să sunți la 1-866-260-2723.

Russian
Языковые услуги предоставляются вам бесплатно. Звоните
по телефону 1-866-260-2723.

Samoan- Fa'asamoa
O loo maua fesasayo mo gagana mo oe ma e le tootoga.
Fiafia'amole mo telefoni le 1-866-260-2723.

Serbo-Croatian
Možete besplatno koristiti usluge prevodioaca. 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

Sudanese- Fulfulde
E woodi willande dow wolde caahu ngam maadda. Noodoo
1-866-260-2723.

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

Syriac- Assyrian
خدمات مترجم مجاناً. تماس مع رقم 1-866-260-2723
للتواصل.

Tagalog
Ang mga serbisyo ng tulong sa wika ay available para sa iyo ng

Telugu
మీకు సేవలు అందమైందనే లోకపాయి సేవలను నిర్మించబడిన
తెలుగు సాహిత్య కార్యక్రమాలు ఉన్నాయి. తపిండి తపిండి
1-866-260-2723 తో తపిండి తపిండి.

Thai
มีบริการคำแปลและบริการอื่น ๆ ในภาษาไทยให้ฟรี
โดยตรงจาก โปรดติดต่อกับหมายเลข
1-866-260-2733.

Tongan- Fakatonga
‘Oku ‘i ai pê ‘a e sëvesi ki he lea’ ke tokoni kiate koe pea ‘oku
‘atî 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 koplwe kokkóri 1-866-260-2723.

Turkish
Dil yardımı hizmetleri size ücretsiz olarak sunulmaktadır . Lütfen
1-866-260-2723 numaranın arayınız.

Ukrainian
Посути перекладяться вам безкоштовно. Дзвоніть за
номером 1-866-260-2723.

Urdu
زبان کی حولی سے معافی خدمات آپ کی لئی بالخصوص دستیاب ہیں۔
براء میں ریس کو 1-866-260-2723 اپ کر کریں۔

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

Yiddish
לעבנד מילוגים מומלצים תועדו ראוועיטבר מאר. אַ יי פאַר ליטֶר. מעיר
1-866-260-2723 נייט.

Yoruba