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/osu or call 1-844-206-0374. 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 1-844-206-0374 to request a copy.

### Important Questions

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>Select Providers $150 (Person) &lt;br&gt; Select Providers $350 (Family) &lt;br&gt; Preferred Providers $500 (Person) &lt;br&gt; Preferred Providers $1,500 (Family) &lt;br&gt; Out of Network $500 (Person) &lt;br&gt; Out of Network $1,500 (Family)</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes. Preventive care, Pediatric Dental, Pediatric Vision and categories that specify does not apply.</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>Yes. Pediatric Dental $500. There are no other specific deductibles.</td>
<td>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.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>Select Providers $3,000 (Person) &lt;br&gt; Select Providers $6,000 (Family) &lt;br&gt; Preferred Providers $6,000 (Person) &lt;br&gt; Preferred Providers $12,000 (Family) &lt;br&gt; Out of Network $6,000 (Person) &lt;br&gt; Out of Network $12,000 (Family)</td>
<td>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.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Premiums, balance-billing charges, and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td><strong>Will you pay less if you use a network provider?</strong></td>
<td>Yes. See <a href="http://www.uhcsr.com/osu">www.uhcsr.com/osu</a> or call 1-844-206-0374 for a list of network providers.</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Do you need a referral to see a specialist?</strong></td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
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>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 Copay per visit <strong>ded</strong> does not apply</td>
<td>May not apply when related to surgery or physiotherapy.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$20 Copay per visit <strong>ded</strong> does not apply</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No Charge</td>
<td></td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>10% <strong>Coins</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>10% <strong>Coins</strong></td>
<td></td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>10% <strong>Coins</strong></td>
<td>Minimum cost to the insured is $10 or the cost of the drug, whichever is less. Limited up to a 31 day supply per prescription.</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>20% <strong>Coins</strong></td>
<td>Minimum cost to the insured is $10 or the cost of the drug, whichever is less. Limited up to a 31 day supply per prescription.</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>50% <strong>Coins</strong></td>
<td>Minimum cost to the insured is $10 or the cost of the drug, whichever is less.</td>
</tr>
</tbody>
</table>

*For more information about limitations and exceptions, see **plan** or policy document at www.uhcsr.com/osu*
<table>
<thead>
<tr>
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<th>Services You May Need</th>
<th>Select Provider</th>
<th>Preferred Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have outpatient surgery</td>
<td>Specialty drugs</td>
<td>Same as above; ded does not apply</td>
<td>Same as above; ded does not apply</td>
<td>Same as above; ded does not apply</td>
<td>Limited up to a 31 day supply per prescription.</td>
</tr>
<tr>
<td></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>10% Coins</td>
<td>40% Coins</td>
<td>40% Coins</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>10% Coins</td>
<td>10% Coins</td>
<td>10% Coins</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$25 Copay per visit; ded does not apply</td>
<td>40% Coins</td>
<td>40% Coins</td>
<td>May be limited to facility fees.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>10% Coins</td>
<td>40% Coins</td>
<td>40% Coins</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% Coins</td>
<td>40% Coins</td>
<td>40% Coins</td>
<td></td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office Visits $20 Copay per visit; ded does not apply</td>
<td>Office Visits: 40% Coins</td>
<td>Office Visits: 40% Coins</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other: 10% Coins</td>
<td>Other: 40% Coins</td>
<td>Other: 40% Coins</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>10% Coins</td>
<td>40% Coins</td>
<td>40% Coins</td>
<td></td>
</tr>
</tbody>
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*For more information about limitations and exceptions, see [plan](#) or policy document at [www.uhcsr.com/osu](#)
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<tr>
<td></td>
<td></td>
<td>Select Provider</td>
<td>Preferred Provider (You will pay the least)</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>Based on setting where service is performed</td>
<td>Based on setting where service is performed</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>Based on setting where service is performed</td>
<td>Based on setting where service is performed</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>Based on setting where service is performed</td>
<td>Based on setting where service is performed</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>10% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>10% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>10% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>10% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>10% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>10% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>50% Coins; ded does not apply</td>
<td>50% Coins; ded does not apply</td>
</tr>
</tbody>
</table>

*For more information about limitations and exceptions, see plan or policy document at www.uhcsr.com/osu
<table>
<thead>
<tr>
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<th>Select Provider</th>
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<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s glasses</td>
<td>50% Coins; ded does not apply</td>
<td>50% Coins; ded does not apply</td>
<td>50% Coins; ded does not apply</td>
<td>See your plan’s Pediatric Vision Benefit Details. Age limits apply.*</td>
<td></td>
</tr>
<tr>
<td>Children’s dental check-up</td>
<td>50% Coins</td>
<td>50% Coins</td>
<td>50% Coins</td>
<td>See your plan’s Pediatric Dental Benefit Details. Age limits apply.*</td>
<td></td>
</tr>
</tbody>
</table>

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

- Bariatric surgery
- Hearing aids
- Routine foot care
- Cosmetic surgery except as specifically provided in the Policy
- Infertility treatment
- Weight loss programs
- Dental care (Adult) except as specifically provided in the Policy
- Long-term care

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

- Acupuncture
- Private-duty nursing
- Chiropractic care
- Routine eye care (Adult)
- Non-emergency care when traveling outside the U.S.
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: Ohio Department of Insurance at 1-800-686-1526 or visit http://www.insurance.ohio.gov/Pages/default.aspx. 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 on how 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: Ohio Department of Insurance at 1-800-686-1526 or visit http://www.insurance.ohio.gov/Pages/default.aspx.

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Not Applicable
If your plan doesn’t meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Navajo (Dine): Dinek’ehgo shika at’ohwol ninisingo, kwijiigo 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)

- The plan’s overall deductible: $500
- Specialist coinsurance: 40%
- Hospital (facility) coinsurance: 40%
- Other coinsurance: 40%

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)

**Total Example Cost**: $12,700

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$4,800</td>
</tr>
<tr>
<td>What isn’t covered</td>
<td></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$60</td>
</tr>
</tbody>
</table>

The total Peg would pay is **$5,360**

### Managing Joe’s Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan’s overall deductible: $500
- Specialist coinsurance: 40%
- Hospital (facility) coinsurance: 40%
- Other coinsurance: 40%

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)

**Total Example Cost**: $5,600

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$600</td>
</tr>
<tr>
<td>What isn’t covered</td>
<td></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$20</td>
</tr>
</tbody>
</table>

The total Joe would pay is **$1,120**

### Mia’s Simple Fracture
(in-network emergency room visit and follow up care)

- The plan’s overall deductible: $500
- Specialist coinsurance: 40%
- Hospital (facility) coinsurance: 40%
- Other coinsurance: 40%

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**: $2,800

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$200</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$500</td>
</tr>
<tr>
<td>What isn’t covered</td>
<td></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$0</td>
</tr>
</tbody>
</table>

The total Mia would pay is **$1,200**

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
ይếc ከወጣ ከተማ ትእዛዝ ያወጣ ያለUED ል ሊ ወ እ 866-260-2723 ያድለል።

Arabic
تتوفر لك خدمات المساعدة اللغوية مجانًا. اتصل على الرقم 1-866-260-2723.

Armenian
2ք ծառայություններ եւ անարդաշխատությունը զանգահարել 1-866-260-2723 համարով:

Bantu- Kirundi
Uronswa ku buntu serivisi zifatiye ku rurimi zo kugufasha. Utegereza 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
জোটান্ত্রের মাধ্যমে আপনার কথার ব্যাখ্যা করা যাবে। এখানে কেন্দ্রে 1-866-260-2723 নম্বর দিয়ে কথা বলুন।

Burmese
ဝန္႔ဆာင္မႈမားသင္္ ကားဇူး ပဳ၍ စရာများ သင္္ကီး 1-866-260-2723 အတြက္ အကူအညီ ခန်းချင်း သင္္ကီး:

Cambodian- Mon-Khmer
ដំណើរការមើលប្រការមួយជាការជួបជូនស្ថានភាពដូចគ្នាគឺ 1-866-260-2723 ជាច្រើន

Cherokee
599.706.8311 704-957-5067 599.833.3137 $125.00 $125.00. 1-866-260-2723.

Chinese
您可以免费獲得語言援助服務，請致電 1-866-260-2723。

Chocitaw
Chaha tunampa ish anumpuli hokmvl tohsholi yvt peh pilla hq chi apela hinla. I paya 1-866-260-2723.

Cushite- Oroomo

Dutch

French
Des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-260-2723.

French Creole- Haitian Creole

German

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

Gujarati
ભાષા સહાય સેવાઓ તમારા માટે નિશ્ચય ઉપલબ્ધ છે. કોપ કરો 1-866-260-2723 પર વીએલ કરો।

Hawaiian
Ju lutemi 1-866-260-2723 palihug tawag.

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

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

Ibo

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

Karen
usdmw3>rvR3t^>erRM1f>DRoh0J vXwvdj/h妤ORb. (cDVd) M.vDRI 0H0iPlRq.1.usd.b. 1-866-260-2723 wuh>I

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

Kru- Bassa
Bot ba hola ni kobol mahop ngui nsaa wogui wo ba yé ha i nyuu yon. Sebele i nisinga ini 1-866-260-2723.

Kurdish Sorani
خزمه، كهارتيا بەرەمەی زەمانی بەکەنی دەکەن. تەکیەبەت تەمەنەیە، بەکەی پۆژەمار 260-266-1866.

Laotian

SR LAP 64 (6-18) 1 of 2
반영 가능한 언어 서비스를 대화 중인 것으로 보입니다. 전화번호는 1-866-260-2723.

Marathi
भाषाच्या मदतीकी सुविधा आपल्याला विनामुद्द उपलब्ध आहे. 
या साधनी 1-866-260-2723 या क्रमांकावर संपर्क करा.

Marshallese

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

Navajo
Saad bee āka'eeyee bee ākā'nida'wo'igii t'āā jïik'eh bee nich'i' bee nā'hoot'i'. T'āā shqoɔdi kohji' 1-866-260-2723 hodūlnih.

Nepali
भाषा सहायता सेवाहतुरु निःशुल्क उपलब्ध छन्। कृपया 1-866-260-2723 मा कल गन्तूलेसू।

Nileot-Dinka

Norwegian

Pennsylvania Dutch

Persian-Farsi
خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره 1-866-260-2723 تماس بگیرید.

Polish
Móžesz 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
ਭਾਸਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਨਿਹ ਸ਼ਲੁਕ ਉਪਲਾਧ ਛੋਨਾ। ਕੁਝ ਪ੍ਰਾਪਤੀ 1-866-260-2723 ਮਾ ਕਲ ਗੁਨਾਲੀਕਾਂ।

Romanian
Vi se pun la dispoziţie, 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.

Samoa- Fa'asamoa
O loo maua fesoasoani mo gagana mo oe ma e lē tofia. Faamolemole telefoni le 1-866-260-2723.

Serbo- Croatian

Somali
Adeegyada taageerada luqadda oo bilaash ah ayaa la heli karaa. Fadlan wac 1-866-260-2723.

Spanish
Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-866-260-2723.

Sudanic- Fulfulde

Swhahili
Huduma za msada wa lugha zinapatikana kwa ajili yako yake buna. Tafadhali piga simu 1-866-260-2723.

Syriac- Assyrian
Christian Assyrians, please call 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
తెలుగు భాషా సహాయ సేవలు కొని లింగపరిధి ఎంతగణి కవల క్రమాంకం 1-866-260-2723.

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

Trukese (Chuukese)
En mei toneni aninisin emon chon chiakku, ese kamo. Kose mochen kopwe kokkori 1-866-260-2723.

Turkish
Dil yardım hizmetleri size ücretsiz olarak sunulmaktadır. Lütfen 1-866-260-2723 numarayi arayınız.

Ukrainian
Послуги перекладу надаються вам безкоштовно. Дзвоніть за номером 1-866-260-2723.

Urdu
زبان کے حوالے سے معاونتی خدمات آپ کے لیے بلامعاوضہ دستیاب ہیں۔ براہ مہربانی 260-2723-1-866.

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

Yiddish
שפתtrerות סרביעית-__; התאמה לאוניברסלי פאראא הארט פון פון אוניברסלי. ברך 1-866-260-2723.

Yoruba
Isẹ́ irinlọ́wọ́ èdè ti ó jẹ́ ọ̀fẹ́, wà fún ó. Pe 1-866-260-2723.