### Important Questions

| What is the overall deductible? | Preferred Providers $150 (Person)  
Out of Network Providers $300 (Person) | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Preventive care, Pediatric Dental, Pediatric Vision and categories that specify deductible do 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>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
</tbody>
</table>
| What is the out-of-pocket limit for this plan? | Preferred Providers $8,550 (Person)  
Preferred Providers $8,550 (Family) | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| What is not included in the out-of-pocket limit? | Premiums, balance-billing charges, and health care this plan doesn’t cover. | Even though you pay these expenses, they don’t count toward the out-of-pocket limit. |
| Will you pay less if you use a network provider? | Yes. See www.uhcsr.com/newschool or call 1-800-767-0700 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| Do you need a referral to see a specialist? | No. | You can see the specialist you choose without a referral. |
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>Preferred Provider (You will pay the least) $15 Copay per visit; ded does not apply</td>
<td>Out-of-Network Provider (You will pay the most) $15 Copay per visit; 40% Coins</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$15 Copay per visit; ded does not apply</td>
<td>$15 Copay per visit; 40% Coins</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No Charge</td>
<td>30% Coins</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>15% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>15% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Tier 1 - Your Lowest-Cost Option</td>
<td>$15 Copay per prescription Tier 1; ded does not apply</td>
<td>30% Coins</td>
</tr>
<tr>
<td>More information about <strong>prescription drug coverage</strong> is available at <a href="http://www.uhcsr.com/pdl">www.uhcsr.com/pdl</a></td>
<td>Tier 2 - Your Midrange-Cost Option</td>
<td>$40 Copay per prescription Tier 2; ded does not apply</td>
<td>30% Coins</td>
</tr>
<tr>
<td></td>
<td>Tier 3 - Your Highest-Cost Option</td>
<td>$50 Copay per prescription Tier 3</td>
<td>30% Coins</td>
</tr>
<tr>
<td></td>
<td>Tier 4 - Additional High-Cost Option</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>15% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>15% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency room care</td>
<td>15% Coins</td>
<td>15% Coins</td>
</tr>
</tbody>
</table>

*For more information about limitations and exceptions, see plan or policy document at www.uhcsr.com/newschool*
<table>
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</thead>
<tbody>
<tr>
<td><strong>Preferred Provider (You will pay the least)</strong></td>
<td><strong>Out-of-Network Provider (You will pay the most)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility fee (e.g., hospital room)</td>
<td>15% Coins</td>
<td>40% Coins</td>
<td>May be limited to facility fees.</td>
</tr>
<tr>
<td>Physician/surgeon fees</td>
<td>15% Coins</td>
<td>40% Coins</td>
<td></td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient services</td>
<td>Office Visits: $15 Copay per visit</td>
<td>40% Coins</td>
<td></td>
</tr>
<tr>
<td>Inpatient services</td>
<td>15% Coins</td>
<td>40% Coins</td>
<td></td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office visits</td>
<td>$15 Copay per visit; ded does not apply</td>
<td>30% Coins</td>
<td>Cost sharing does not apply for preventive services when provided by a preferred provider. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).</td>
</tr>
<tr>
<td>Childbirth/delivery professional services</td>
<td>15% Coins</td>
<td>40% Coins</td>
<td></td>
</tr>
<tr>
<td>Childbirth/delivery facility services</td>
<td>15% Coins</td>
<td>40% Coins</td>
<td></td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home health care</td>
<td>15% Coins</td>
<td>40% Coins</td>
<td>40 visits per plan year</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>15% Coins</td>
<td>$15 Copay per visit</td>
<td></td>
</tr>
<tr>
<td>Habilitation services</td>
<td>15% Coins</td>
<td>$15 Copay per visit</td>
<td></td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>45% Coins</td>
<td>40% Coins</td>
<td>365 days per plan year</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>15% Coins</td>
<td>40% Coins</td>
<td></td>
</tr>
<tr>
<td>Hospice services</td>
<td>0% Coins</td>
<td>0% Coins</td>
<td></td>
</tr>
<tr>
<td><strong>If your child needs dental or eye care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children’s eye exam</td>
<td>$20 Copay per exam; 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>
</tr>
<tr>
<td>Children’s glasses</td>
<td>Lens: $40 Copay; 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>
</tr>
</tbody>
</table>

*For more information about limitations and exceptions, see [plan or policy document at www.uhcsr.com/newschool](http://www.uhcsr.com/newschool)*
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Preferred Provider</td>
<td>Out-of-Network Provider</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
</tr>
<tr>
<td>Children’s dental check-up</td>
<td>Exam &amp; Cleaning: $35 Copay; ded does not apply</td>
<td>Exam &amp; Cleaning: $35 Copay; ded does not apply</td>
<td>Routine Xrays: $100 Copay; ded does not apply</td>
</tr>
</tbody>
</table>

*For more information about limitations and exceptions, see plan or policy document at www.uhcsr.com/newschool*
### Excluded Services & Other Covered Services:

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Cosmetic surgery</td>
</tr>
<tr>
<td>• Private-duty nursing</td>
</tr>
<tr>
<td>• Weight loss programs</td>
</tr>
<tr>
<td>• Dental care (Adult)</td>
</tr>
<tr>
<td>• Routine eye care (Adult)</td>
</tr>
<tr>
<td>• Long-term care</td>
</tr>
<tr>
<td>• Routine foot care</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Acupuncture</td>
</tr>
<tr>
<td>• Hearing aids</td>
</tr>
<tr>
<td>• Bariatric surgery</td>
</tr>
<tr>
<td>• Infertility treatment</td>
</tr>
<tr>
<td>• Chiropractic care</td>
</tr>
<tr>
<td>• Non-emergency care when traveling outside the U.S.</td>
</tr>
</tbody>
</table>
Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: New York Department of Financial Services at 1-800-342-3736 or visit http://www.dfs.ny.gov/index.html. 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: New York Department of Financial Services at 1-800-342-3736 or visit http://www.dfs.ny.gov/index.html.

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, kwijjigo 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: $150
- Specialist copayment: $15
- Hospital (facility) coinsurance: 0%
- Other coinsurance: 15%

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>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$150</td>
</tr>
<tr>
<td>Copayments</td>
<td>$20</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$10</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td><strong>$60</strong></td>
</tr>
</tbody>
</table>

The total Peg would pay is $240

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

- The plan’s overall deductible: $150
- Specialist copayment: $15
- Hospital (facility) coinsurance: 0%
- Other coinsurance: 15%

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>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$150</td>
</tr>
<tr>
<td>Copayments</td>
<td>$700</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$10</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td><strong>$20</strong></td>
</tr>
</tbody>
</table>

The total Joe would pay is $880

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

- The plan’s overall deductible: $150
- Specialist copayment: $15
- Hospital (facility) coinsurance: 0%
- Other coinsurance: 15%

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>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$150</td>
</tr>
<tr>
<td>Copayments</td>
<td>$50</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td><strong>$0</strong></td>
</tr>
</tbody>
</table>

The total Mia would pay is $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
Shërbimet e ndihmës në gjuhën amtare ofrohen falas. Jë lu temi
telefononi në numrin 1-866-260-2723.

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

Bantu- Kirundi
Uronswe ku buntu servisi zifatiye ku rurimi zo kugufasha.
Utegereza guhamagara 1-866-260-2723.

Bisayan- Cebuano
Magamit mimo ang mga serbisyo sa tabang sa lengguwahe nga

Bengali- Bangala
ঘোষণা : ভাষা সহায়তা পরিষেবা আপনি বিনামূল্যে পেতে
পারেন। দয়া করে 1-866-260-2723-তে কল করুন।

Burmese
သင်ရွေးစိတ်ကွေးကြည့်ရာသူကို ဖောင်ဝင်ရောက်ပါအပ်
1-866-260-2723

Cambodian- Mon-Khmer
សិរៈសិនប្រើប្រាស់ការជួយសិក្សានៅប្រទេសប្រទេស
ប្រែសម្រាប់ឥណ្ឌាប្រទេស 1-866-260-2723

Cherokee
sDysLYeO ʔOɬeSli ʔOɬeSli ET h.ə RG6o'TaʔənəST
h.əEggəo'T D4cəT. Hgo Dh ʔəWəS 1-866-260-2723.

Chinese
您可獲得語言援助服務・請致電 1-866-260-2723。

Chocotaw
Chahta anumpa ish anumpuli hokmvt toshholi yvt peh pilla ho
chi apela hinla. I paya 1-866-260-2723.

Cushite- Oromo
Tajajjililwan gargaarsa afaanii kanfaltii malee siif jira.
Maaloo karaa lakkoofsa bilbilaa 1-866-260-2723 bilibli.

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

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

French Creole- Haitian Creole
Gen sèvis e pòt lan ki disponib gratis pou ou. Rele
1-866-260-2723.

German
Sprachliche Hilfsdienstleistungen stehen Ihnen kostenlos zur

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

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

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

Hmong
Muav cov kev txhais lus pub dawb rau køj. Thov hau rau
1-866-260-2723.

Ibo
Enyemaka na-ahazi asusu, bu n’efu, diri gi. Kpo
1-866-260-2723.

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

Indonesian
Layanan bantuan bahasa bebas biaya tersedia untuk Anda.
Harap hubungi 1-866-260-2723.

Italian
Sono disponibili servizi di assistenza linguistica gratuiti.
Chiamare il numero 1-866-260-2723.

Japanese
無料の言語支援サービスをご利用いただけます。
1-866-260-2723 までお電話ください。

Karen
usdmw>srRxt*D>erRM>tDrOh0J vXwvd[h.tyORb.
(cDvD) M.vDrI
0Ho:plRqJ:usdb.b. 1-866-260-2723 wuh>l

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

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

Kurdish Sorani
خزماختانی یارمەتیی زمانی مەخۆرایەوە بۆ تور دەیەکەن. تەکایە تەلەفۆن بکە بۆ
زمانەی 260-260-2723.

Laotian
={[1866-260-2723 op te bellen}.
Marathi
भाषेच्या मदतीची सुविधा आपूर्तीच्या विनामूल्य उपलब्ध आहे.
लासाठी 1-866-260-2723 या क्रमांकावर संपर्क करा.

Marshallese

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

Navajo
Saad bee āk’a’eeedee āk’a’āndu’wo’igíí t’áá jíik’eh bee nich’ì’ bee na’ahoot’ì’. T’áá shqódí kohjí’ 1-866-260-2723 hodilihii.

Nepali
भाषासहायता सेवाहरू निःशुल्क उपलब्ध छन्। कृपया 1-866-260-2723 मा कल गुनहौस्।

Nilotic-Dinka
Kák e kuny ajurrë ë thok atë tînë yìn abac të cîn wëu yeke thiëc. Yìn col 1-866-260-2723.

Norwegian

Pennsylvania Dutch

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

Polish
Możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-260-2723.

Portuguese
Oferecemos serviço gratuito de assistência de idioma. Ligue para 1-866-260-2723.

Punjabi
ਭਾਸਾ ਸਹਾਇਤਾ ਦਾ ਸੇਵਾ ਵਿਅਕਤ ਨਾਲ ਉਪਲਬਧ हਨ। ਤਕਸ਼ਾ ਤਹਾਂ ਦੇਖੋ 1-866-260-2723.

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

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

Samoan- Fa’asamoa
O loo maua fesoasoani mo gagana mo oe ma e le totogia.
Faamolemo 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

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

Syriac- Assyrian
خضوعك في ترجمة في اللغة العربية، جمع بينك 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
భాషా సహాయాలు ఫౌండేషన్ ఒప్పందంలో ఉన్నాయి. 1-866-260-2723.

Thai
มีบริการความช่วยเหลือด้านภาษาให้โดยที่คุณไม่ต้องเสียค่าใช้จ่าย โปรดโทรศัพท์ถึงหมายเลข 1-866-260-2723.

Trukese (Chuukese)
En mei tongeni angei animisin emon chiakku, ese kamo. Kose mochen kopwe kokkori 1-866-260-2723.

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

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

Urdu
زبان کی حوالے سے معاونتی خدمات آپ کی لیے بہت مفید ہیں۔ 1-866-260-2723.

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

Yiddish
שופרניך תודעה תינעתי ומא管线ה תארך פטריא פול פאלא פון פשא. רופט 1-866-260-2723.

Yoruba
Ise iranlọwọ èdè tí ó jẹ ọfẹ, wà fún ò. Pe 1-866-260-2723.