### Important Questions | Answers | Why This Matters:
--- | --- | ---
What is the overall deductible? | Preferred Providers $250 (Person)  
Out of Network $500 (Person) | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.

Are there services covered before you meet your deductible? | Yes. Preventive care, Pediatric Dental,  
Pediatric Vision and categories that specify ded does not apply. | This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at [https://www.healthcare.gov/coverage/preventive-care-benefits/](https://www.healthcare.gov/coverage/preventive-care-benefits/).

Are there other deductibles for specific services? | Yes. Pediatric Dental $500. There are no other specific deductibles. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.

What is the out-of-pocket limit for this plan? | Preferred Providers $7,000 (Person)  
Preferred Providers $14,000 (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/calvin or call 1-888-643-6774 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): 20% Coins $50 Copay per visit ded does not apply</td>
<td>Out-of-Network Provider (You will pay the most): 40% Coins $50 Copay per visit ded does not apply</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>20% Coins $50 Copay per visit ded does not apply</td>
<td>40% Coins $50 Copay per visit ded does not apply</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>Diagnostic X-ray Services: 20% Coins Laboratory Procedures: 20% Coins $50 Copay per visit ded does not apply</td>
<td>Diagnostic X-ray Services: 40% Coins Laboratory Procedures: 40% Coins $50 Copay per visit ded does not apply</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% 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>$25 Copay per prescription Tier 1 ded does not apply</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Tier 2 - Your Midrange-Cost Option</td>
<td>$50 Copay per prescription Tier 2 ded does not apply</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

*For more information about limitations and exceptions, see plan or policy document at www.uhcsr.com/calvin*
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</thead>
<tbody>
<tr>
<td><strong>coverage</strong> is available at <a href="http://www.uhcsr.com/pdl">www.uhcsr.com/pdl</a></td>
<td>Tier 3 - Your Highest-Cost Option</td>
<td>$150 Copay per prescription Tier 3 ded does not apply</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Tier 4 - Additional High-Cost Option</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>20% Coins</td>
<td>20% Coins</td>
</tr>
<tr>
<td></td>
<td>$100 Copay per visit ded does not apply</td>
<td></td>
<td>May be limited to use of emergency room and supplies. The Copay will be waived if admitted to the Hospital.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% Coins</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>20% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>Hospital Miscellaneous Expenses: 20% Coins</td>
<td>Hospital Miscellaneous Expenses: 40% Coins Room and Board Expense: 40% Coins $300 Copay per Hospital Confinement ded does not apply</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>Anesthetist Services: 75% of Surgery Allowance Assistant Surgeon Fees: 75% of Surgery Surgery: 20% Coins</td>
<td>Anesthetist Services: 75% of Surgery Allowance Assistant Surgeon Fees: 75% of Surgery Surgery: 40% Coins</td>
</tr>
</tbody>
</table>

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<tbody>
<tr>
<td></td>
<td></td>
<td>Preferred Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Allowance</td>
<td>Allowance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Physician’s Visits: 20% Coins</td>
<td>Physician’s Visits: 40% Coins</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Surgery: 20% Coins</td>
<td>Surgery: 40% Coins</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office Visits: 20% Coins</td>
<td>Office Visits: 40% Coins</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$50 Copay per visit</td>
<td>$50 Copay per visit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ded does not apply</td>
<td>ded does not apply</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other: 20% Coins</td>
<td>Other: 40% Coins</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Inpatient services</td>
<td>20% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$300 Copay per Hospital Confinement</td>
<td>$300 Copay per Hospital Confinement</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ded does not apply</td>
<td>ded does not apply</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have</td>
<td>Office visits</td>
<td>20% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$50 Copay per visit</td>
<td>$50 Copay per visit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ded does not apply</td>
<td>ded does not apply</td>
</tr>
<tr>
<td>If you need help recovering or have</td>
<td>Childbirth/delivery professional services</td>
<td>20% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have</td>
<td>Childbirth/delivery facility services</td>
<td>Hospital Miscellaneous Expenses: 20% Coins</td>
<td>Hospital Miscellaneous Expenses: 40% Coins</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Room and Board Expense: 20% Coins</td>
<td>Room and Board Expense: 40% Coins</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$300 Copay per Hospital Confinement</td>
<td>$300 Copay per Hospital Confinement</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ded does not apply</td>
<td>ded does not apply</td>
</tr>
<tr>
<td>If you need help recovering or have</td>
<td>Home health care</td>
<td>20% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>20% Coins</td>
<td>40% Coins</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>20% Coins</td>
<td>40% Coins</td>
</tr>
</tbody>
</table>

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<table>
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<tr>
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<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>other special health needs</td>
<td>Skilled nursing care</td>
<td>20% Coins</td>
<td>40% Coins</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% Coins</td>
<td>40% Coins</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>20% Coins</td>
<td>40% Coins</td>
<td>none</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<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></td>
<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>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>50% Coins</td>
<td>50% Coins</td>
<td>See your plan’s Pediatric Dental Benefit Details. Age limits apply.*</td>
</tr>
</tbody>
</table>

*For more information about limitations and exceptions, see [plan](https://www.uhcsr.com/calvin) or policy document at [www.uhcsr.com/calvin](http://www.uhcsr.com/calvin)
### 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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult) except as noted in the policy
- Infertility treatment
- Long-term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Chiropractic care
- Hearing aids
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
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: Michigan Department of Insurance and Financial Services at 1-877-999-6442 or visit http://www.michigan.gov/difs. 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: Michigan Department of Insurance and Financial Services at 1-877-999-6442 or visit http://www.michigan.gov/difs.

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, kwiijigo holne’ 1-866-260-2723.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.
About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments, and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

<table>
<thead>
<tr>
<th>Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)</th>
<th>Managing Joe’s Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)</th>
<th>Mia’s Simple Fracture (in-network emergency room visit and follow up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cost Sharing</strong></td>
<td><strong>Cost Sharing</strong></td>
<td><strong>Cost Sharing</strong></td>
</tr>
<tr>
<td>Deductibles</td>
<td>$250</td>
<td>$250</td>
</tr>
<tr>
<td>Specialist copayment</td>
<td>$50</td>
<td>$50</td>
</tr>
<tr>
<td>Hospital (facility) coinsurance</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Other coinsurance</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Total Example Cost</strong></td>
<td>$12,700</td>
<td>$5,600</td>
</tr>
<tr>
<td><strong>In this example, Peg would pay:</strong></td>
<td><strong>In this example, Joe would pay:</strong></td>
<td><strong>In this example, Mia would pay:</strong></td>
</tr>
<tr>
<td>Deductibles</td>
<td>$250</td>
<td>$250</td>
</tr>
<tr>
<td>Copayments</td>
<td>$60</td>
<td>$1,200</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$2,200</td>
<td>$200</td>
</tr>
<tr>
<td>What isn’t covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$60</td>
<td>$20</td>
</tr>
<tr>
<td>The total Peg would pay is</td>
<td>$2,570</td>
<td>$1,670</td>
</tr>
</tbody>
</table>

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**
 whence ከፋህፃ ኢንጩት በልክ ያጠበቃ እንግሊዘኛ በ1-866-260-2723 ይታፈለጋል።

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

**Armenian**
2ք ձայնագրով են անհրաժեշտ բանակցությունները ծանոթանական են։ Համաձայնել նախ քվեարկությունը 1-866-260-2723 համարումներին՝

**Bantu-Kirundi**
Uronswa ku buntu serivisi zifatiye ku rurimi zo kugufasha. Utegereza guhamagara 1-866-260-2723.

**Bisayan-Visayan (Cebuano)**

**Bengali-Bangala**
ঘোষণা : ভাষা সহায়তা পরিষেবা আপনি বিনামূল্যে পেতে পাবেন। পার্শ্বে 1-866-260-2723-তে কল করুন।

**Burmese**
ဗြိတိန်မှာ အခြေခံ သို့မဟုတ် ပြောဆဣရွက် စီမံခန့်ခွဲရန် 1-866-260-2723 ကြည့်ပါ။

**Cambodian-Mon-Khmer**
អត្ថបទមូលដ្លានសម្រាប់អ្នកប្រើប្រាស់ប្រារពណ៍វិញ ទែទេសប្រើប្រាស់ចាំ 1-866-260-2723 ។

**Cherokee**
5を行いし、オレンジおよびオレンジ h.3 RG60H76D073460T hEG660D4643F H G60 DH 0b W6D5 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。

**Choctaw**
Chahta anumpa ish anumpuli hokmvt tohsholi yvt peh pilla hó chi apela hinl. Í paya 1-866-260-2723.

**Cushite-Oromo**
Tajaajjiliwam gargaarsa afaanii kanfaltii malee siif jira. Maaloo karaa lakoofsha bilbila 1-866-260-2723 bilbili.

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

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

**French Creole-Haitian Creole**

**German**

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

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

**Hawaiian**
Kākua manoahia ma kāu ʻōlelo i loa’a ʻia. E kelepona i ka helu 1-866-260-2723.

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

**Hmong**
Mujav cov kev pab txhais lus pub dawb rau koj. Thov huu 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**
usdmwïr>RpRyI>D-erRM>1DpRoh0J vXwvD[h.tyORb. (cDvD) M.vDRI 0Ho;plRqu;usd.b. 1-866-260-2723 wuh>l

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

**Kru-Bassa**
Bot bo hola ni kobol mahop ngu nsaa wogui wo ba yë hë a nyu yon. Sebel i nisngi ini 1-866-260-2723.

**Kurdish Sorani**
خزمەتکاری زمانی بەمەبەریەی بو تر دابین دەکرێن. تەکیهە کەلەیەیە بەکەی بە زماری 2723-66-260-2723.

**Laotian**
Taalbijstandsdiensten zijn gratis voor u beschikbaar. Gelieve 1-866-260-2723 op te bellen.

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

**Maori**
Māori ki a koe e tātakawa ki te noho mātou i wairua hou. Tō te whakanui te wero katoa 1-866-260-2723 ouno.
Marathi
भाषेच्या मदतीवी वसिधा आपल्याला विनामूल्य उपलब्ध आहे. त्यासाठी 1-866-260-2723 या क्रमांकावर संपर्क करा.

Marshallese
Kwomarōn bōk jerbal in jipa'n in kajin ilo ejelok wōnān. Jouj im kalli 1-866-260-2723.

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

Navajo
Saad bee åka'e'eyedt bee åka'nida'wo'igii t'áá jîk'eh bee nich'i' bee nā'hoort'i', T'áá shóodí kohjí 1-866-260-2723 hodúlnih.

Nepali
भाषा सहायता सेवाहरू निश्चयौंक उपलब्ध छन्। कृपया 1-866-260-2723 मा कल गन्तूहेंस।

Nolitic-Dinka
Kâk ê kuny ajurr è thok atô tînê yin abac ë cîn wëu yeke thîêène. Yin cöl 1-866-260-2723.

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
Móżesz 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 ਕੋਸ਼ਿਸ਼ ਦਿੰ ਕੇ ਜਿਹਾ ਵੀ ਖੁਤਾ ਲਈ ਮੱਟੇ ਵਿਚ ਦਿੱਤੀ ਗਏ ਹਨ।

Romanian
Vă 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.

Samoaan- Fa’asamoa
O loo maua fesoasiomai mo gagana mo oe ma e lē 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- Fululde

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

Syriac- Assyrian
خدمات الرسالة اللغة متوفرة لكل منكم مجاناً. اتصل بنا المقام 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 సేవాలు నడిగా మేలుకోవడానికి ఆంధ్రప్రదేశ్ రాష్ట్రం భాషా విభాగం 1-866-260-2733.

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 tongot. Kātaki ‘o tā ki he 1-866-260-2723.

Trukese (Chuukese)
En mei togiangi anisi e fetai koa, 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 کے حوالے سے معاونت خدمات آپ کے لئے مانگوئے دستیاب بہت

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

dyshs
שפתן חיה ספרידיאס ותננוי סערויוול פאר ארי פיס פאראום. באתי

Yoruba