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/anschutz or call 1-800-767-0700. 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 1-800-767-0700 to request a copy.

<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>Preferred Providers $500 (Person) Out of Network $1,000 (Person)</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.</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 ded 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>Preferred Providers $6,000 (Person) Out of Network $12,000 (Person)</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services.</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/anschutz">www.uhcsr.com/anschutz</a> or call 1-800-767-0700 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></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>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$25 Copay per visit deducted does not apply</td>
<td>50% Coins</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$25 Copay per visit deducted does not apply</td>
<td>50% Coins</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No Charge</td>
<td>50% Coins</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% Coins</td>
<td>50% Coins</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% Coins</td>
<td>50% Coins</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Tier 1 - Your Lowest-Cost Option</td>
<td>$15 Copay per prescription Tier 1 deducted does not apply</td>
<td>0% Coins</td>
</tr>
<tr>
<td></td>
<td>Tier 2 - Your Midrange-Cost Option</td>
<td>20% Coins per prescription Tier 2 deducted does not apply</td>
<td>20% Coins</td>
</tr>
<tr>
<td></td>
<td>Tier 3 - Your Highest-Cost Option</td>
<td>20% Coins per prescription Tier 3 deducted 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>
</tbody>
</table>

*For more information about limitations and exceptions, see plan or policy document at www.uhcsr.com/anschutz*
<table>
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<tr>
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<th>What You Will Pay</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td><strong>Preferred Provider (You will pay the least)</strong>: 20% Coins</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td><strong>Out-of-Network Provider (You will pay the most)</strong>: 50% Coins</td>
<td></td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency room care</td>
<td><strong>Preferred Provider (You will pay the least)</strong>: 20% Coins $100 Copay per visit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td><strong>Out-of-Network Provider (You will pay the most)</strong>: 20% Coins</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td><strong>Preferred Provider (You will pay the least)</strong>: 20% Coins $50 Copay per visit</td>
<td></td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td><strong>Preferred Provider (You will pay the least)</strong>: 20% Coins</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td><strong>Out-of-Network Provider (You will pay the most)</strong>: 50% Coins</td>
<td></td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td>Outpatient services</td>
<td><strong>Preferred Provider (You will pay the least)</strong>: Office Visits: $25 Copay per visit ded does not apply Other: 20% Coins</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td><strong>Out-of-Network Provider (You will pay the most)</strong>: Office Visits: 50% Coins Other: 50% Coins</td>
<td></td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Office visits</td>
<td><strong>Preferred Provider (You will pay the least)</strong>: $25 Copay per visit ded does not apply</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td><strong>Out-of-Network Provider (You will pay the most)</strong>: 50% Coins</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td><strong>Preferred Provider (You will pay the least)</strong>: 20% Coins</td>
<td></td>
</tr>
<tr>
<td><strong>If you need help recovering or have</strong></td>
<td>Home health care</td>
<td><strong>Out-of-Network Provider (You will pay the most)</strong>: 50% Coins</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td><strong>Preferred Provider (You will pay the least)</strong>: Inpatient Rehabilitation Facility: 50% Coins</td>
<td></td>
</tr>
</tbody>
</table>

*For more information about limitations and exceptions, see [plan](#) or policy document at [www.uhcsr.com/anschutz](http://www.uhcsr.com/anschutz)*
<table>
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<tr>
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<th>What You Will Pay</th>
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</tr>
</thead>
<tbody>
<tr>
<td>other special health needs</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Habilitation services | 0% Coins $25 Copay per visit | 50% Coins | Outpatient 40 visits of speech therapy  
Outpatient 40 visits of manipulative therapy  
Outpatient Separate physical, occupational and speech therapy limits apply to rehabilitative and Habilitative Services |
| Skilled nursing care | 20% Coins | 50% Coins | ——none——— |
| Durable medical equipment | 20% Coins | 50% Coins | ——none——— |
| Hospice services | 20% Coins | 50% Coins | ——none——— |
| **If your child needs dental or eye care** | | | |
| Children’s eye exam | $20 Copay per exam; ded does not apply | 50% Coins; ded does not apply | See your plan’s Pediatric Vision Benefit Details. Age limits apply.* |
| Children’s glasses | Lens: $40 Copay; ded does not apply  
Frames: Tiered Copays from no charge to 40% based on retail cost. ded does not apply | 50% Coins; ded does not apply | See your plan’s Pediatric Vision Benefit Details. Age limits apply.* |
| Children’s dental check-up | 50% Coins | 50% Coins | See your plan’s Pediatric Dental Benefit Details. Age limits apply.* |

*For more information about limitations and exceptions, see plan or policy document at www.uhcsr.com/anschutz
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 | • Cosmetic surgery | • Dental care (Adult) |
| • Hearing aids | • Infertility treatment | • Long-term care |
| • Routine eye care (Adult) except as noted in the policy | • Routine foot care | • Weight loss programs except as noted in the policy |

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

| • Acupuncture | • Chiropractic care | • 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: Colorado Division of Insurance at 1-303-894-7490 or visit http://www.dora.state.co.us/insurance/. 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: Colorado Division of Insurance at 1-303-894-7490 or visit http://www.dora.state.co.us/insurance/.

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.

<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>The plan’s overall deductible</strong></td>
<td>$500</td>
<td>$500</td>
</tr>
<tr>
<td><strong>Specialist copayment</strong></td>
<td>$25</td>
<td>$25</td>
</tr>
<tr>
<td><strong>Hospital (facility) coinsurance</strong></td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Other coinsurance</strong></td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>This EXAMPLE event includes services like:</strong></td>
<td><strong>This EXAMPLE event includes services like:</strong></td>
<td><strong>This EXAMPLE event includes services like:</strong></td>
</tr>
<tr>
<td>Specialist office visits (prenatal care)</td>
<td>Primary care physician office visits (including disease education)</td>
<td>Emergency room care (including medical supplies)</td>
</tr>
<tr>
<td>Childbirth/Delivery Professional Services</td>
<td>Diagnostic tests (blood work)</td>
<td>Diagnostic test (x-ray)</td>
</tr>
<tr>
<td>Childbirth/Delivery Facility Services</td>
<td>Prescription drugs</td>
<td>Durable medical equipment (crutches)</td>
</tr>
<tr>
<td>Diagnostic tests (ultrasounds and blood work)</td>
<td>Durable medical equipment (glucose meter)</td>
<td>Rehabilitation services (physical therapy)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$12,700</th>
<th>$5,600</th>
<th>$2,800</th>
</tr>
</thead>
<tbody>
<tr>
<td>In this example, Peg would pay:</td>
<td><strong>Cost Sharing</strong></td>
<td><strong>Cost Sharing</strong></td>
<td><strong>Cost Sharing</strong></td>
</tr>
<tr>
<td><strong>Deductibles</strong></td>
<td>$500</td>
<td>$500</td>
<td>$500</td>
</tr>
<tr>
<td><strong>Copayments</strong></td>
<td>$30</td>
<td>$800</td>
<td>$80</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>$1,900</td>
<td>$2,400</td>
<td>$300</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$60</td>
<td>$20</td>
<td>$0</td>
</tr>
<tr>
<td><strong>The total Peg would pay is</strong></td>
<td>$2,490</td>
<td>$3,720</td>
<td>$880</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
የአማርኛ እንጨት እንከፋፋት ያለበት ከፋለ ከፋለ 1-866-260-2723 ያለበት.

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

Armenian
Թեք մատչելի են պատմել վերնագրական օգնություններ: կարևոր են տեղականությունը 1-866-260-2723 համար:

Bantu- Kirundi
Uroneswa ku bantu serivisi zifatiye ku rumire zo kugufasha. Utegereza guhamagara 1-866-260-2723.

Bisayan- Visayan (Cebuano)
Magamit nimo ang mga serbisyo sa tabang sa lenggwohe nga walay bayad. Palihiw tawag sa 1-866-260-2723.

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

Burmese
သို့လည်း စျေးရင်းပြီးမှ သို့ထောက်ပြောက်ညီစေပါသည်။ အများစွာ 1-866-260-2723 သို့ကြည့်ပါ။

Cambodian- Mon-Khmer
អោយប្រឈមប្រាក់ឤប្រាក多名នឹងប្រឈមប្រាក់ សូមប្រឈមប្រាកុង្អូល 1-866-260-2723។

Cherokee
Sustaawal ÒÒ€ÒÌÀí ÒÒ€ÒJET h.İ RÇÉÔºÝ Toßë¹ającë hÉGÇÉÔº DÇÉÔÝ T. Françêh Dh Ûh WÇÉÔº 1-866-260-2723.

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

Choclaw

Cushite- Oromo
Tajajjilliwan gargaarsa afaanii kanfaltii malee siif jira. Maaloo karaa lakkoofsa bilbilaa 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 υπηρεσίες γλωσσικής βοήθειας σας διατίθενται δωρεάν. Καλέστε το 1-866-260-2723.

Gujarati
ભાષા સહયોગ સેવાઓ તમારા માટે નિશ્ચિત ઉપલબ્ધ છે. કૂપા કરો 1-866-260-2723 પર કોલ કરો।

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

Hmong
Muj 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
Sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 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>rRpXRt*D>erRM>tDRoh0J vXwvd.[h.łyORb. (cDvD) M.vDRI 0Họ;plRQJ;usd.b. 1-866-260-2723 wuh>1

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 yoŋ. Sebel i nisinga ini 1-866-260-2723.

Kurdish Sorani
خزمانه کانی بارمانی زمانی بی‌گیریابی بو تر دابین دمکرین. تکایه تعلق‌رفتن به بو زمان‌می 260-260-2723-1.

Laotian

SR LAP 64 (6-18) 1 of 2
Мы предлагаем услуги перевода бесплатно. Звоните по 1-866-260-2723.

Marathi
भाषाच्या मदतीस सुविधा आप्ल्याला विनमूळ्य उपलब्ध आहे. त्यासाठी 1-866-260-2723 या क्रमांकावर संपर्क करा.

Marshallese

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

Navajo
Saad bee aká'ee'edee bee aká'nida'wo'íji t'áá jik'ëh bee nich'íí bee ná'hooí'í. T'áá shòqódi kohji'í 1-866-260-2723 hodûlínih.

Nepali
भाषा सहायता सेवाहरू निःशुल्क उपलब्ध छन्। कृपया 1-866-260-2723 मा कल गन्तूहोस्।

Niloric-Dinka
Kâk ê kuny ajurer ê thok atô tîné yin abac tê cin wëu yeke thiëéc. Yin cîl 1-866-260-2723.

Norwegian

Pennsylvanian Dutch

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

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
ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਹਰ ਨਾਲ ਅਭਿਆਂਤ ਉਪਲਬਧ ਛਨਾ। ਕੁਰਾਨਾ 1-866-260-2723 ਦੇ ਦਾਖਲ ਕਰੋ!

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.

Samoaan- Fa’asamoa
O loo maiw fesasoani mo gagana mo oe ma e lē totoga. Faamalomele 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 maada wa lugha zinapatikana kwa ajili yako bure. Tafadhali piga simu 1-866-260-2723.

Syriac- Assyrian
اللغة العربية متوفرة مجاناً. الرجاء الاتصال 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 సహాయశాత్యాన్ని క్రమాంకంలో లేదా మత్తు బయలు పొందండే విధానంలో 1-866-260-2723.

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

Trukese (Chuukese)

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 معاونتی خدمات آپ کے لیے بلامعاوضہ دستیاب ہیں۔ مسئلہ کیلئے 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
שפארד הלק זמרוייטס זאנס און דאגלס פאר איטי פורח פון פאר. ברך 1-866-260-2723.

Yoruba