



## 2020-2021 Student Health Insurance Plan for State University of New York

### Who is eligible to enroll?

All international students and scholars, all students and scholars traveling abroad on approved SUNY academic programs and exchanges, and students participating in Optional Practical Training programs are eligible and must be enrolled in the plan, with the exception of those who meet the SUNY specified mandatory enrollment exemptions. Eligible Dependents of students enrolled in the plan may enroll on a voluntary basis. 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 costs, 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](http://www.uhcsr.com). This plan is underwritten by UnitedHealthcare Insurance Company of New York and is based on policy number 2020-203415-41. 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 1-888-714-6544 or [customerservice@uhcsr.com](mailto:customerservice@uhcsr.com).

## Highlights of Coverage offered by UnitedHealthcare StudentResources

### Coverage Dates, Plan Costs and Premium Rates

The Total Cost of the plan noted below includes premium and fees.

| Total Plan Cost and Coverage Dates | Annual<br>8-15-20 to<br>8-14-21 | Fall<br>8-15-20 to<br>1-14-21 | Spring<br>1-15-21 to<br>6-14-21 | Spring/Summer<br>1-15-21 to<br>8-14-21 | Summer<br>5-15-21 to<br>8-14-21 |
|------------------------------------|---------------------------------|-------------------------------|---------------------------------|----------------------------------------|---------------------------------|
| Student                            | \$1,792.28                      | \$750.45                      | \$740.45                        | \$1,041.83                             | \$450.07                        |
| Spouse                             | \$1,544.00                      | \$647.00                      | \$637.00                        | \$897.00                               | \$388.00                        |
| One Child                          | \$1,544.00                      | \$647.00                      | \$637.00                        | \$897.00                               | \$388.00                        |
| Two or More Children               | \$3,088.00                      | \$1,294.00                    | \$1,274.00                      | \$1,794.00                             | \$776.00                        |
| Spouse and Two or More Children    | \$4,632.00                      | \$1,941.00                    | \$1,911.00                      | \$2,691.00                             | \$1,164.00                      |

See the information below for the breakdown of premium and fees.

| Premium Rates                   | Annual Premium** | Fall Premium** | Spring Premium** | Spring/Summer Premium** | Summer Premium** |
|---------------------------------|------------------|----------------|------------------|-------------------------|------------------|
| Student                         | \$1,541.62       | \$644.62       | \$634.62         | \$894.62                | \$385.62         |
| Spouse                          | \$1,541.62       | \$644.62       | \$634.62         | \$894.62                | \$385.62         |
| One Child                       | \$1,541.62       | \$644.62       | \$634.62         | \$894.62                | \$385.62         |
| Two or More Children            | \$3,085.62       | \$1,291.62     | \$1,271.62       | \$1,791.62              | \$773.62         |
| Spouse and Two or More Children | \$4,629.62       | \$1,938.62     | \$1,908.62       | \$2,688.62              | \$1,161.62       |

\*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 \*\*Administrative fee of \$248.28 charged by the school you are receiving coverage through which may, for example, cover your school's administrative costs associated with offering this health plan.

\*\*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 – PLATINUM WITH ACTUARIAL VALUE OF 97.350%                                                                                                                                                                                                                                        |                                                                                                                                               |                                                                                                                                           |                                                                                                                                           |
| <b>In-Network Benefits</b><br>In-Network benefits apply when your care is provided by Participating Providers in our UnitedHealthcare Options PPO network. Participating Providers can be found using the following link: <a href="#">UHC Options PPO</a>                                        |                                                                                                                                               |                                                                                                                                           |                                                                                                                                           |
| <b>In-Network Preferred Provider Benefits</b><br>In-Network Preferred Provider benefits apply when your care is provided by the Student Health Center.                                                                                                                                           |                                                                                                                                               |                                                                                                                                           |                                                                                                                                           |
|                                                                                                                                                                                                                                                                                                  | In-Network Preferred Provider Member Cost-Share                                                                                               | In Network Participating Provider Member Cost-Share                                                                                       | Out-of-Network Non-Participating Provider Member Cost-Share                                                                               |
| <b>Overall Plan Maximum</b>                                                                                                                                                                                                                                                                      | There is no overall maximum dollar limit on the policy                                                                                        |                                                                                                                                           |                                                                                                                                           |
| <b>Plan Deductible</b>                                                                                                                                                                                                                                                                           | \$0 Per Member, Per Plan Year                                                                                                                 | \$50 Per Member, Per Plan Year                                                                                                            | \$50 Per Member, Per Plan Year                                                                                                            |
| <b>Out-of-Pocket Limit</b><br><i>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.</i> | \$7,350 Per Member, Per Plan Year<br>\$14,700 For all Members in a Family, Per Plan Year                                                      | \$7,350 Per Member, Per Plan Year<br>\$14,700 For all Members in a Family, Per Plan Year                                                  | \$14,700 Per Member, Per Plan Year<br>\$28,400 For all Members in a Family, Per Plan Year                                                 |
| <b>Coinsurance</b><br><i>All benefits are subject to satisfaction of the Deductible, specific benefit limitations, maximums and Copayments as described in the plan Certificate.</i>                                                                                                             | 0% of Allowed Amount <sup>1</sup> for Covered Expenses                                                                                        | 0% of Allowed Amount <sup>1</sup> for Covered Expenses                                                                                    | 0% of Allowed Amount <sup>1</sup> for Covered Expenses                                                                                    |
| <b>Prescription Drugs</b><br><i>Mail order through UHCP at 2.5 times the retail Copayment up to a 90-day supply.</i>                                                                                                                                                                             | \$10 Copayment for Tier 1<br>\$20 Copayment for Tier 2<br>Up to a 30 day supply per prescription filled at a UnitedHealthcare Pharmacy (UHCP) | \$10 Copayment for Tier 1<br>\$20 Copayment for Tier 2<br>\$20 Copayment for Tier 3<br>Up to a 30 day supply per prescription filled at a | \$10 Copayment for Generic Drug<br>\$20 Copayment for Brand Name Drug<br>Up to a 30 day supply per prescription not subject to Deductible |

|                                                                                                                                                                                                                                                                                                                                                      |                                                                                                |                                                                                                                                  |                                                                                                                                                  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                                                                                                      |                                                                                                | UnitedHealthcare Pharmacy (UHCP)<br>not subject to Deductible                                                                    |                                                                                                                                                  |
| <b>Preventive Care</b><br><i>Including but not limited to: annual physicals, GYN exams, routine screenings and immunizations. Please see <a href="https://www.healthcare.gov/preventive-care-benefits/">https://www.healthcare.gov/preventive-care-benefits/</a> for complete details of the services provided for specific age and risk groups.</i> | Covered in full                                                                                | Covered in full                                                                                                                  | 0% of Allowed Amount <sup>1</sup>                                                                                                                |
| <b>Outpatient Mental Health Care/Substance Use Disorder Services, except Emergency Services and Prescription Drugs</b>                                                                                                                                                                                                                               | Office Visits:<br>Preferred Allowance<br><br>Other Outpatient Services:<br>Preferred Allowance | Office Visits:<br>Preferred Allowance after Deductible<br><br>Other Outpatient Services:<br>Preferred Allowance after Deductible | Office Visits:<br>Usual and Customary Charges after Deductible<br><br>Other Outpatient Services:<br>Usual and Customary Charges after Deductible |
| <b>Pediatric Dental and Vision Benefits</b>                                                                                                                                                                                                                                                                                                          | Refer to the plan Certificate of Coverage for details (age limits apply).                      | Refer to the plan Certificate of Coverage for details (age limits apply).                                                        | Refer to the plan Certificate of Coverage for details (age limits apply).                                                                        |

<sup>1</sup>The Allowed Amount for Preferred and Participating Providers is the amount we have negotiated with the Preferred and Participating Providers. The Allowed Amount for Non-Participating Providers will be determined on the Usual, Customary and Reasonable charge using the lesser of: 1) the 80<sup>th</sup> percentile of the Fair Health rate; 2) the facility or provider's charge; or 3) a rate based on information provided by a third-party vendor. 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. 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.

**F. 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.

**G. 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).

**H. 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.

**I. 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.

**J. 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.

**K. 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).

**L. Military Service.**

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

**M. 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.

**N. Services Not Listed.**

We do not Cover services that are not listed in this Certificate as being Covered.

**O. Services Provided by a Family Member.**

We do not Cover services performed by a member of the covered person's immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister or brother of You or Your Spouse.

**P. Services Separately Billed by Hospital Employees.**

We do not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

**Q. Services With No Charge.**

We do not Cover services for which no charge is normally made.

#### **R. 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.

#### **S. War.**

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

#### **T. 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

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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:

An international Student (whose Home Country is not the United States), and their insured Spouse and insured Child(ren): you are eligible to receive Medical Evacuation and Repatriation Benefits worldwide, except in your home country.

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 StudentResources

#### HealthiestYou: 24/7 Doctor Access

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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 calling the toll-free number listed on the front of your medical ID card or visiting [www.telehealth4students.com](http://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 StudentResources, there is no consultation fee for this service.\* Every call with a HealthiestYou doctor is covered 100% during your policy period.

This service is meant to complement your Student Health Center. If possible, we encourage you to visit your SHC 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 ages 18 and over. If you call prior to your effective date of your coverage under the insurance plan, you will be charged a \$40 service fee before being connected to a board-certified physician.**

## 24/7 Student Support

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Members have immediate access to the Student Assistance Program, a service that coordinates counseling services offered by 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](http://www.uhcsr.com/MyAccount).

## HealthiestYou:Virtual Counselor Access

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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 an insured with **StudentResources**, 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 Dependent; age restrictions may apply, depending on your state.

This Summary Brochure is based on Policy #2020-203415-41

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](mailto: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>

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

**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 ndihmës në gjuhën amtare ofrohen falas. Ju lutemi telefononi në numrin 1-866-260-2723.

### Amharic

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### Arabic

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

### Armenian

Ձեզ մատչելի են անվճար լեզվական օգնություն ծառայություններ: Խնդրում ենք զանգահարել 1-866-260-2723 համարով:

### 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

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

### Burmese

ဘာသာစကား အကူအညီ ဝန်ဆောင်မှုများ သင့် အတွက် အခမဲ့ရရှိနိုင်သည်။ ကျေးဇူးပြု၍ ဖုန်း 1-866-260-2723 ကိုခေါ်ပါ။

### Cambodian- Mon-Khmer

សេវាជំនួយផ្នែកភាសាដែលឥតគិតថ្លៃ មានសម្រាប់អ្នក។ សូមទូរស័ព្ទទៅលេខ 1-866-260-2723។

### Cherokee

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### Chinese

您可以免費獲得語言援助服務。請致電 1-866-260-2723。

### Choctaw

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

### Cushite- Oromo

Tajaajilliwwan gargaarsa afaanii kanfalttii 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

Gen sèvis ed pou lang ki disponib gratis pou ou. Rele 1-866-260-2723.

### German

Sprachliche Hilfsdienstleistungen stehen Ihnen kostenlos zur Verfügung. Bitte rufen Sie an unter: 1-866-260-2723.

### Greek

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

### Gujarati

ભાષા સહાય સેવાઓ તમારા માટે નિ:શુલ્ક ઉપલબ્ધ છે. કૃપા કરીને 1-866-260-2723 પર કોલ કરો.

### Hawaiian

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

### Hindi

आप के लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। कृपया 1-866-260-2723 पर कॉल करें।

### Hmong

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

### Ibo

Enyemaka na-ahazi asusu, bu n'efu, diri gi. Kpoo 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

ကျိတ်တၢ်စၢၤအကူအညီနီၤသ့ၤလၢတၢ်လိၤဟ့ၣ်အပူၤဘၣ်(ခိၣ်)နီၣ်လီၤ. ဝံသးစူးဆဲးကျိတ်ဘၣ်1-866-260-2723တက့ၢ်.

### 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 yonj. Sebel i nsinga ini 1-866-260-2723.

### Kurdish Sorani

خزمەتگه‌ڵی یارمەتی زمانی به‌خۆڕای بۆ تۆ دابین ده‌کری‌ن. تکایه تەله‌فۆن بکه بۆ ژماره‌ی 1-866-260-2723.

### Laotian

ມີບໍລິການທາງດ້ານພາສາບໍ່ເສຍຄ່າໃຫ້ແກ່ທ່ານ. ກະລຸນາໂທຫາເບີ 1-866-260-2723.

