2024-2025 Student Health Insurance Plan for Western Illinois University

Who is eligible to enroll?

Students taking nine class hours or more are automatically enrolled in the Student Health Insurance program, unless proof of comparable coverage is furnished. Credit hours must be met with at least 50% on campus classes. All Graduate Assistants under contract with the University and enrolled in classes and Spoon River College students residing in University housing are also assessed the fee for this coverage. All international students in the US are required to have this plan, unless they have employer or embassy coverage.

Students from the WIU Quad Cities campus are eligible to opt into the program.

Eligible students who do enroll may also insure their Dependents. Eligible Dependents are the student's legal spouse, Civil Union partner or Domestic Partner and dependent children under 26 years of age. See the Definitions section of the Certificate for the specific requirements needed to meet Domestic Partner eligibility.

The student (Named Insured, as defined in the Certificate) must actively attend classes for at least the first 31 days after the date for which coverage is purchased. Home study, correspondence, and online courses do not fulfill the eligibility requirements that the student actively attend classes. The Company maintains its right to investigate eligibility or student status and attendance records to verify that the Policy eligibility requirements have been met. If and whenever the Company discovers that the Policy eligibility requirements have not been met, its only obligation is refund of premium.

The eligibility date for Dependents of the Named Insured shall be determined in accordance with the following:

1. If a Named Insured has Dependents on the date he or she is eligible for insurance.
2. If a Named Insured acquires a Dependent after the Effective Date, such Dependent becomes eligible:
   a. On the date the Named Insured acquires a legal spouse, Civil Union partner or a Domestic Partner who meets the specific requirements set forth in the Definitions section of the Certificate.
   b. On the date the Named Insured acquires a dependent child who is within the limits of a dependent child set forth in the Definitions section of the Certificate.

Dependent eligibility expires concurrently with that of the Named Insured.

Medicare Eligibility

Any person who has Medicare at the time of enrollment in this student insurance plan is not eligible for coverage under the Master Policy.

If an Insured Person obtains Medicare after the Insured Person is covered under the Master Policy, the Insured Person's coverage will not end due to obtaining Medicare.

As used here, "has Medicare" means that an individual is entitled to benefits under Part A (receiving free Part A) or enrolled in Part B or Premium Part A.

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 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. This plan is underwritten by UnitedHealthcare Insurance Company and is based on policy number 2024-270-1. 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 1-800-767-0700 or customerservice@uhcsr.com.

Highlights of Coverage offered by UnitedHealthcare Student Resources

Coverage Dates and Plan Cost

Rates	Fall 8/1/24 to 1/31/25	Spring Matriculates 1/1/25 to 7/31/25	Spring/Summer 2/1/25 to 7/31/25	Summer Matriculates 6/1/25 to 7/31/25
Student	$1,061.00	$1,232.00	$1,061.00	$355.00
Spouse	$1,061.00	$1,232.00	$1,061.00	$355.00
One Child	$1,061.00	$1,232.00	$1,061.00	$355.00
Two or More Children	$2,122.00	$2,464.00	$2,122.00	$710.00
Spouse and Two or More Children	$3,183.00	$3,696.00	$3,183.00	$1,065.00

NOTE: The amounts stated above include certain fees charged by the school you are receiving coverage through. Such fees may include amounts which are retained by your school (to, for example, cover your school's administrative costs associated with offering this health plan) as well as amounts which are paid to certain non-insurer vendors or consultants by, or at the direction of, your school.

The Insured Person must meet the eligibility requirements each time a premium payment is made. To avoid a lapse in coverage, the Insured Person's premium must be received within 10 days for monthly premium payment Policies and 31 days for all other premium payment Policies after the coverage expiration date. It is the Insured Person's responsibility to make timely premium payments to avoid a lapse in coverage.

Highlights of the Student Health Insurance Plan Benefits		
METALLIC LEVEL - GOLD WITH ACTUARIAL VALUE OF 84.180%		
Preferred Providers: The Preferred Provider Network for this plan is UnitedHealthcare Choice Plus. Preferred Providers can be found using the following link: UHC Choice Plus.		
Student Health Center Benefits: The Deductible will be waived and benefits will be paid at 100% for Covered Medical Expenses incurred when treatment is rendered at the Beu Health Center. The Copayment will be waived for Covered Medical Expenses incurred at the Beu Health Center for the following services: Physician's Visits and Prescription Drugs. Policy Exclusions and Limitations do not apply.		
	Preferred Providers	**Out-of-Network Providers**
Overall Plan Maximum	There is no overall maximum dollar limit on the policy	
Plan Deductible	$500 Per Insured Person, Per Policy Year $1,500 For all Insureds in a Family, Per Policy Year	$1,000 Per Insured Person, Per Policy Year $3,000 For all Insureds in a Family, Per Policy Year
Out-of-Pocket Maximum *After the Out-of-Pocket Maximum has been satisfied, Covered Medical Expenses will be paid at 100% for the remainder of the Policy Year subject to any applicable benefit maximums. Refer to the plan certificate for details about how the Out-of-Pocket Maximum applies.*	$7,200 Per Insured Person, Per Policy Year $13,200 For all Insureds in a Family, Per Policy Year	$20,000 Per Insured Person, Per Policy Year $38,400 For all Insureds in a Family, Per Policy Year

Coinsurance *All benefits are subject to satisfaction of the Deductible, specific benefit limitations, maximums and Copays as described in the plan certificate.*	80% of Allowed Amount for Covered Medical Expenses	50% of Allowed Amount for Covered Medical Expenses
Prescription Drugs *For insulin drugs, the total amount of Copayments or Coinsurance shall not exceed $35 for an individual prescription of up to a 31-day supply.*	$30 Copay for Tier 1 $60 Copay for Tier 2 $80 Copay for Tier 3 Up to a 30-day supply per prescription filled at a UnitedHealthcare Pharmacy (UHCP) Retail Network Pharmacy not subject to Deductible	$60 Copay for generic drugs $80 Copay for brand name drugs Up to a 30-day supply per prescription 50% of billed charge after Deductible
Preventive Care Services *Including but not limited to: annual physicals, GYN exams, routine screenings and immunizations. No Deductible, Copays, or Coinsurance will be applied when the services are received from a Preferred Provider. Please visit www.healthcare.gov/preventive-care-benefits/ for a complete list of the services provided for specific age and risk groups.*	100% of Allowed Amount	80% of Allowed Amount after Deductible
The following services have per service Copays *This list is not all inclusive. Please read the plan certificate for complete listing of Copays.*	Physician's Visits: $25 not subject to Deductible Medical Emergency Expenses: $300 after Deductible The Copay will be waived if admitted to the Hospital.	Medical Emergency Expenses: $300 after Deductible The Copay will be waived if admitted to the Hospital.
Outpatient Mental Illness/Substance Use Disorder Treatment, except Medical Emergency and Prescription Drugs	Office Visits: $25 Allowed Amount not subject to Deductible Other Outpatient Services: Allowed Amount after Deductible	Office Visits: Allowed Amount after Deductible Other Outpatient Services: Allowed Amount after Deductible
Pediatric Dental and Vision Benefits	Refer to the plan certificate for details (age limits apply).	

Exclusions and Limitations

No benefits will be paid for: a) loss or expense caused by, or resulting from; or b) treatment, services or supplies for, at, or related to any of the following:

1. Acne, except as specifically provided in the Policy.
2. Acupuncture.
3. Addiction, such as:
   - Caffeine addiction.
   - Non-chemical addiction, such as: gambling, sexual, spending, shopping, working and religious.
   - Codependency.
4. Behavioral problems. Conceptual disability. Developmental delay or disorder or intellectual disability. Learning disabilities. Milieu therapy. Parent-child problems.
   This exclusion does not apply to benefits specifically provided in the Policy.
5. Biofeedback.
6. Chronic pain disorders.
7. Circumcision, except if Medically Necessary due to Injury, Sickness, or functional Congenital Condition.
8. Cosmetic procedures, except as specifically provided in the Policy or reconstructive procedures to:
   - Correct an Injury or treat a Sickness for which benefits are otherwise payable under the Policy. The primary result of the procedure is not a changed or improved physical appearance.
   - Treat or correct Congenital Conditions.
9. Custodial Care.
   - Care provided in: rest homes, health resorts, homes for the aged, halfway houses, college infirmaries or places mainly for domiciliary or Custodial Care.
   - Extended care in treatment or substance use facilities for domiciliary or Custodial Care.

10. Dental treatment, except:
    - As described under Dental Treatment in the Policy.

    This exclusion does not apply to benefits specifically provided in Pediatric Dental Services.
11. Elective Surgery or Elective Treatment.
12. Foot care for the following, except as specifically provided in the Policy:
    - Flat foot conditions.
    - Supportive devices for the foot.
    - Subluxations of the foot.
    - Fallen arches.
    - Weak feet.
    - Chronic foot strain.
    - Routine foot care including the care, cutting and removal of corns, calluses, toenails, and bunions (except capsular or bone surgery).

    This exclusion does not apply to preventive foot care due to conditions associated with metabolic, neurologic, or peripheral vascular disease.
13. Health spa or similar facilities. Strengthening programs.
14. Hearing examinations. Hearing aids, except as specifically provided for in the Policy. Other treatment for hearing defects and hearing loss. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process.
    This exclusion does not apply to:
    - Hearing defects or hearing loss as a result of a Congenital Condition, infection, or Injury.
    - Benefits specifically provided in the Policy.
    - Cochlear hearing aids.
    - A bone anchored hearing aid for an Insured Person with: a) craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or b) hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.
15. Hirsutism. Alopecia.
16. Hypnosis.
17. Immunizations, except as specifically provided in the Policy. Preventive medicines or vaccines, except where required for treatment of a covered Injury or as specifically provided in the Policy.
18. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation.
19. Injury or Sickness outside the United States and its possessions, Canada or Mexico, except for a Medical Emergency when traveling for academic study abroad programs, business or pleasure.
20. Injury sustained while:
    - Participating in any intercollegiate or professional sport, contest or competition.
    - Traveling to or from such sport, contest or competition as a participant.
    - Participating in any practice or conditioning program for such sport, contest or competition.
21. Injury sustained while:
    - Participating in any contest or competition of intercollegiate football, etc.
    - Traveling to or from such sport, contest or competition as a participant.
    - Participating in any practice or conditioning program for such sport, contest or competition.
22. Investigational services.
23. Lipectomy.
24. Marital or family counseling.
25. Participation in a riot or civil disorder. Any loss to which a contributing cause was the Insured’s commission of or attempt to commit a felony or to which a contributing cause was the Insured being engaged in an illegal occupation. Fighting.
26. Prescription Drugs, services or supplies as follows, except as specifically provided in the Policy:
    - Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use, except as specifically provided in the Policy.
    - Immunization agents, except as specifically provided in the Policy.
    - Drugs labeled, “Caution - limited by federal law to investigational use” or experimental drugs.
    - Products used for cosmetic purposes.
    - Drugs used to treat or cure baldness. Anabolic steroids used for body building.
    - Anorectics - drugs used for the purpose of weight control.
    - Fertility agents or sexual enhancement drugs.
    - Growth hormones, except when a Medical Necessity.
    - Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.

27. Reproductive services for the following, except as specifically provided in the Policy:
    - Procreative counseling.
    - Genetic counseling and genetic testing.
    - Cryopreservation of reproductive materials and storage of reproductive materials, except as specifically provided in the Policy.
    - Premarital examinations.
    - Impotence, organic or otherwise.
    - Reversal of sterilization procedures.
28. Research or examinations relating to research studies, or any treatment for which the patient or the patient's representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study, except as specifically provided in the Policy.
29. Routine eye examinations. Eye refractions. Eyeglasses. Contact lenses. Prescriptions or fitting of eyeglasses or contact lenses. Vision correction surgery. Treatment for visual defects and problems.
    This exclusion does not apply as follows:
    - When due to a covered Injury or disease process.
    - To benefits specifically provided in Pediatric Vision Services.
30. Routine Newborn Infant Care and well-baby nursery and related Physician charge, except as specifically provided in the Policy.
31. Preventive care services which are not specifically provided in the Policy, including:
    - Routine physical examinations and routine testing.
    - Preventive testing or treatment.
    - Screening exams or testing in the absence of Injury or Sickness.
32. Services provided normally without charge by the Health Service of the Policyholder. Services covered or provided by the student health fee.
33. Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia, except for treatment of temporomandibular joint dysfunction and craniomandibular disorders. Deviated nasal septum, including submucous resection and/or other surgical correction thereof. Nasal and sinus surgery, except for treatment of a covered Injury or treatment of chronic sinusitis. This exclusion does not apply to benefits specifically provided in the Policy.
34. Sleep disorders, except as specifically provided in the Policy.
35. Speech therapy, except as specifically provided in the Policy. Naturopathic services.
36. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional.
37. Supplies, except as specifically provided in the Policy.
38. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except as specifically provided in the Policy.
39. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment.
40. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered).
41. Weight management. Weight reduction. Nutrition programs. Treatment for obesity (except surgery for morbid obesity). Surgery for removal of excess skin or fat. This exclusion does not apply to benefits specifically provided in the Policy.

Important Terms

ALLOWED AMOUNT means the maximum amount the Company is obligated to pay for Covered Medical Expenses. Allowed amounts are determined by the Company or determined as required by law, as described below.

COINSURANCE means the percentage of Covered Medical Expenses that the Company pays.

COPAY/COPAYMENT means a specified dollar amount that the Insured is required to pay for certain Covered Medical Expenses.

COVERED MEDICAL EXPENSES means health care services and supplies which are all of the following:

1. Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness or Injury.
2. Medically Necessary.
3. Specified as a covered medical expense in the Certificate under the Medical Expense Benefits or in the Schedule of Benefits.
4. Not in excess of the Allowed Amount or the Recognized Amount when applicable.

5. Not in excess of the maximum benefit payable per service as specified in the Schedule of Benefits.
6. Not excluded in the Certificate under the Exclusions and Limitations.
7. In excess of the amount stated as a Deductible, if any.

DEDUCTIBLE means an amount to be subtracted from the amount or amounts otherwise payable as Covered Medical Expenses before payment of any benefit is made.

HOSPITAL means a licensed or properly accredited general hospital which is all of the following:

1. Open at all times.
2. Operated primarily and continuously for the treatment of and surgery for sick and injured persons as inpatients.
3. Under the supervision of a staff of one or more legally qualified Physicians available at all times.
4. Continuously provides on the premises 24 hour nursing service by Registered Nurses.
5. Provides organized facilities for diagnosis and major surgery on the premises or in facilities available to the Hospital on a pre-arranged basis.
6. Not primarily a clinic, nursing, rest or convalescent home.

The requirement for major surgery facilities does not apply to treatment or services for rehabilitation or mental illness rendered in a hospital.

MEDICAL EMERGENCY means a medical condition (including Mental Illness and Substance Use Disorder) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention, regardless of the final diagnosis given would result in any of the following:

1. Placement of the Insured's health in jeopardy.
2. Serious impairment of bodily functions.
3. Serious dysfunction of any body organ or part.
4. Inadequately controlled pain.
5. In the case of a pregnant woman, serious jeopardy to the health of the woman or unborn child.
6. With respect to a pregnant woman who is having contractions: (a) inadequate time to complete a safe transfer to another Hospital before delivery; or (b) a transfer to another Hospital may pose a threat to the health or safety of the woman or unborn child.

MEDICAL NECESSITY/MEDICALLY NECESSARY means those services or supplies provided or prescribed by a Hospital or Physician which are all of the following:

1. Essential for the symptoms and diagnosis or treatment of the Sickness or Injury.
2. Provided for the diagnosis, or the direct care and treatment of the Sickness or Injury.
3. In accordance with the standards of good medical practice.
4. Not primarily for the convenience of the Insured, or the Insured's Physician.
5. The most appropriate supply or level of service which can safely be provided to the Insured.

The Medical Necessity of being confined as an Inpatient means that both:

1. The Insured requires acute care as a bed patient.
2. The Insured cannot receive safe and adequate care as an outpatient.

The Policy only provides payment for services, procedures and supplies which are a Medical Necessity. No benefits will be paid for expenses which are determined not to be a Medical Necessity, including any or all days of Inpatient confinement.

OUT-OF-NETWORK PROVIDER means a provider who does not have a contract with the Company to provide services to Insured Persons.

OUT-OF-POCKET MAXIMUM means the amount of Covered Medical Expenses that must be paid by the Insured Person before Covered Medical Expenses will be paid at 100% for the remainder of the Policy Year.

PREFERRED PROVIDER means a provider that has a participation agreement in effect (either directly or indirectly) with the Company or Our affiliates to participate in Our preferred provider network.

This Summary Brochure is based on Policy #2024-270-1.

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. The Policy should be consulted to determine the governing contractual provisions.

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

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 https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/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
የቋንቋ እርዳታ አገልግሎቶች በነጻ ይገኛሉ። እባክዎ ወደ 1-866-260-2723 ይደውሉ።

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

Armenian
Ձեզ մատչելի են անվճար լեզվական օգնության 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
ᏕᏬᏂᏓᏍᏗ ᎤᎾᏓᏡᏍᎦᏗ ᎤᎾᏓᏈᎬᎢ ᏂᏓ ᎡᏩᏍᏅᎢᏍᏓᏗᏄᎢ ᏂᏓᎬᏩᏍᎾ ᎠᏎᏍᎢ. ᎰᏩᏍ ᎠᏂ ᎯᏏᎳᏍᏕ 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。

Choctaw
Chahta anumpa ish anumpuli hokmvt tohsholi yvt peh pilla h<u>o</u> 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 èd 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 કૉલ કરો.

Hawaiian
Kōkua manuahi ma kāu ʻōlelo i loaʻa ʻia. E kelepona i ka helu 1-866-260-2723.

Hindi
आप के लिए भाषा सहायता सेवाएं निःशुल्क 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 asụsụ, bu n'efu, dịrị gị. Kpọọ 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
ကျိာ်တၢ်မၤစၢၤအဂီၢ်နမၤန့ၢ်အီၤသ့ဝဲလၢတလိာ်ဟ့ာ်အပှ့ၤဘၣ်(ခီလီ)န့ၣ်လီၤ. ဝံသးစူၤဆဲးကျိးဘၣ်1-866-260-2723တက့ၢ်.

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

Kurdish Sorani
خزمەتەکانی یارمەتیی زمانی بەخۆڕایی بۆ تۆ دابین دەکرێن. تکایە تەلەفۆن بکە بۆ ژمارەی 1-866-260-2723.

Laotian
ມີບໍລິການທາງດ້ານພາສາບໍ່ເສຍຄ່າໃຫ້ແກ່ທ່ານ. ກະລຸນາໂທຫາເບີ 1-866-260-2723.

Marathi
भाषेच्या मदतीची सुविधा आपल्याला विनामूल्य उपलब्ध आहे. त्यासाठी 1-866-260-2723 या क्रमांकावर संपर्क करा.

Marshallese
Kwomaroñ bōk jerbal in jipañ in kajin ilo ejjeļọk wōņāān. Jouj im kallọk 1-866-260-2723.

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

Navajo
Saad bee áka'e'eyeed bee áka'nída'wo'ígíí t'áá jíík'eh bee nich'į' bee ná'ahoot'i'. T'áá shọọdí kohjį' 1-866-260-2723 hodíilnih.

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

Nilotic-Dinka
Käk ë kuny ajuɛɛr ë thok atö tïnë yïn abac të cïn wëu yeke thiëëc. Yïn cɔl 1-866-260-2723.

Norwegian
Du kan få gratis språkhjelp. Ring 1-866-260-2723.

Pennsylvania Dutch
Schprooch iwwesetze Hilf kannscht du frei hawwe. Ruf 1-866-260-2723.

Persian-Farsi
خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. 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 ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹਨ। ਕਿਰਪਾ ਕਰਕੇ 1-866-260-2723 'ਤੇ ਕਾਲ 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.

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

Serbo- Croatian
Možete besplatno koristiti usluge prevodioca. Molimo nazovite 1-866-260-2723.

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
E woodi walliinde dow wolde caahu ngam maaɗa. Noodu 1-866-260-2723.

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

Syriac- Assyrian
ܚܸܕܡܵܬܵܐ ܕܗܲܝܵܪܬܵܐ ܕܠܸܫܵܢܵܐ، ܡܲܓܵܢܵܐܝܼܬ، ܐܝܼܬܸܠܗܘܿܢ ܩܵܐ ܕܝܼܠܘܼܟ݂ܘܿܢ. ܒܒܥܵܘܬܵܐ ܩܪܝܼ ܥܲܠ ܡܸܢܝܵܢܵܐ 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
లాంగ్వేజ్ అసిస్టెంట్ సర్వీసెస్ మీకు ఉచితంగా అందుబాటులో ఉన్నాయి. దయ చేసి 1-866-260-2723 కి కాల్ చేయండి.

Thai
มีบริการความช่วยเหลือด้านภาษาให้โดยที่คุณไม่ต้องเสียค่าใช้จ่ายแต่อย่างใด โปรดโทรศัพท์ถึงหมายเลข 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 totongi. Kātaki 'o tā ki he 1-866-260-2723.

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

Turkish
Dil yardım hizmetleri size ücretsiz olarak sunulmaktadır. Lütfen 1-866-260-2723 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۔ براہ مہربانی 1-866-260-2723 پر کال کریں۔

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

Yiddish
שפראך הילף סערוויסעס זענען אוועילעבל פאר אייך פריי פון אפצאל. ביטע רופט 1-866-260-2723.

Yoruba
Isẹ̀ ìrànlọ́wọ́ èdè tí ó jẹ́ ọ̀fẹ́, wà fún ọ. Pe 1-866-260-2723.