# Voluntary Options PPO/covered dental services

NON-ORTHODONTICS					
	NETWORK		NON-NETWORK		
Individual Plan Year Deductible	\$0	\$0			
Family Plan Year Deductible  Maximum (the sum of all Network and	\$0	\$0			
Non-Network benefits will not exceed plan year maximum)	\$500 per person per Plan	Year \$5	00 per person per Plan Year		
New enrollee's waiting period:		·			
Plan year deductible applies to preventive and diagnostic services  No (In Network)  No (Out Network)					
COVERED SERVICES*		NETWORK PLAN PAYS**	NON-NETWORK PLAN PAYS***	BEN	ENEFIT GUIDELINES
DIAGNOSTIC SERVICES					
Periodic Oral Evaluation		100%	60%	Lim	mited to 2 times per consecutive 12 months.
Radiographs		100%	60%		ite-wing: Limited to 1 series of films per Plan Year. omplete/Panorex: Limited to 1 time per consecutive 36 months.
Lab and Other Diagnostic Tests		100%	60%		
PREVENTIVE SERVICES					
Prophylaxis (Cleanings)		100%	60%	Lim	mited to 2 times per consecutive 12 months.
Fluoride Treatment (Preventive)		100%	60%		mited to Covered Persons under the age of 16 years, and limited to 2 tirer consecutive 12 months.
Sealants		100%	60%		mited to Covered Persons under the age of 16 years and once per first decond permanent molar every consecutive 36 months.
Space Maintainers		100%	60%		or Covered Persons under the age of 16 years, limited to 1 per consecut 0 months.
BASIC SERVICES					
Restorations (Amalgam or Anterior Composite)*		100%	60%	Mul	lultiple restorations on one surface will be treated as a single filling.
Emergency Treatment / General Services		0%	0%	the	alliative Treatment: Covered as a separate benefit only if no other service was done duri e visit other than X-rays. eneral Anesthesia: When clinically necessary.
MAJOR SERVICES					
Simple Extractions		0%	0%	Lim	mited to 1 time per tooth per lifetime.
Oral Surgery (includes surgical extractions	5)	0%	0%		
Periodontics		0%	0%	Sur Sca mon Per follo	erio Surgery: Limited to 1 quadrant or site per consecutive 36 months per urgical area. caling and Root Planing: Limited to 1 time per quadrant per consecutive onths. eriodontal Maintenance: Limited to 2 times per consecutive 12 months illowing active and adjunctive periodontal therapy, exclusive of gross ebridement.
Endodontics		0%	0%	Roo	oot Canal Therapy: Limited to 1 time per tooth per lifetime.
Inlays/Onlays/Crowns*		0%	0%		mited to 1 time per tooth per consecutive 60 months.
Dentures and other Removable Prosthetics	•	0%	0%		ull Denture/Partial Denture: Limited to 1 per consecutive 60 months. No dditional allowances for precision or semi-precision attachments.
Fixed Partial Dentures (Bridges)*		0%	0%	One	nce per tooth per consecutive 60 months.

<sup>\*</sup> Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement on the least costly treatment alternative. If you and your dentist agreed on a treatment which is more costly than the treatment on which the plan benefit is based, you will be responsible for the difference between the fee for service rendered and the fee covered by the plan. In addition, a agreed on a treatment which is more costly than the treatment of which the provider and the treatment estimate is recommended for any service estimated to cost over \$500; please consult your dentist.

\*\*The network percentage of benefits is based on the discounted fees negotiated with the provider.

\*\*\*The benefit percentage applies to the schedule of maximum allowable charges. Maximum allowable charges are limitations on billed charges in the geographic area in which the expenses are incurred.

In accordance with the Illinois state requirement, a partner in a Civil Union is included in the definition of Dependent. For a complete description of Dependent Coverage, please refer to your Certificate of Coverage.

The Prenatal Dental Care (not available in WA) and Oral Cancer Screening programs are covered under this plan.

The material contained in the above table is for informational purposes only and is not an offer of coverage. Please note that the above table provides only a brief, general description of coverage and does not constitute a contract. For a complete listing of your coverage, including exclusions and limitations relating to your coverage, please refer to your Certificate of Coverage or contact your benefits administrator. If differences exist between this Summary of Benefits and your Certificate of Coverage/benefits administrator, the certificate/benefits administrator will govern. All terms and conditions of coverage are subject to applicable state and federal laws. State mandates regarding benefit levels and age limitations may supersede plan design features.

UnitedHealthCare Dental Options PPO Plan is either underwritten or provided by: United HealthCare Insurance Company, Hartford, Connecticut; United HealthCare Insurance Company of New York, Hauppauge, New York; Unimerica Insurance Company, Milwaukee, Wisconsin; Unimerica Life Insurance Company of New York, New York or United HealthCare Services, Inc.

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# UnitedHealthcare/Dental Exclusions and Limitations

# General Limitations

PERIODIC ORAL EVALUATION Limited to 2 times per consecutive 12 months

COMPLETE SERIES OR PANOREX RADIOGRAPHS Limited to one time per consecutive 36 months. Exception to this limit will be made for Paronex Radiograph if taken for diagnosis of molars, Cysts or neoplasms

BITEWING RADIOGRAPHS Limited to 1 series of films per PlanYear

EXTRAORAL RADIOGRAPHS Limited to 2 films per PlanYear

DENTAL PROPHYLAXIS Limited to 2 times per consecutive 12 months

FLUORIDE TREATMENTS Limited to Covered Persons under the age of 16 years, and limited to 2 times per consecutive 12

SEALANTS Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.

SPACE MAINTAINERS Limited to Covered Persons under the age of 16 years. Limited to 1 per consecutive 60 months. Benefit includes all adjustment within 6 months of installation

RESTORATIONS Multiple restorations on 1 surface will be treated as a single filling.

PIN RETENTION Limited to 2 pins per tooth; not covered in addition to cast restoration

INLAYS AND ONLAYS Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.

CROWNS Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.

POST AND CORES Covered only for teeth that have had root

SEDATIVE FILLINGS Covered as a separate benefit only if no other service, other than x-rays and exam were performed on the same tooth during the visit.

SCALING AND ROOT PLANING Limited to 1 time per quadrant per consecutive 24 months.

ROOT CANAL THERAPY Limited to 1 time per tooth per

PERIODONTAL MAINTENANCE Limited to 2 times per consecutive 12 months following active or adjunctive periodontal therapy, exclusive of gross debridement.

FULL DENTURES Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.

PARTIAL DENTURES Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.

RELINING AND REBASING DENTURES Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.

REPAIRS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 time per consecutive 6 months.

PALLIATIVE TREATMENT Covered as a separate benefit only if no other service, other than exam and radiographs, were performed on the same tooth during the visit.

OCCLUSAL GUARDS Limited to 1 guard every consecutive 36 months and only if prescribe to control habitual grinding.

FULL MOUTH DEBRIDMENT Limited to 1 time every

GENERAL ANESTHESIA Covered only when clinically

OSSEOUS GRAFTS Limited to 1 per quadrant or site per consecutive 36 months.

PERIODONTAL SURGERY Hard tissue and soft tissue periodontal surgery are limited to 1 per quadrant or site per consecutive 36 months per surgical area

REPLACEMENT OF COMPLETE DENTURES, FIXED OR REMOVABLE PARTIAL DENTURES, CROWNS, INLAYS OR ONLAYS Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.

# **General Exclusions**

The following are not covered:

- 1. Dental Services that are not necessary.
- 2. Hospitalization or other facility charges.
- 3. Any dental procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
- 4. Reconstructive Surgery regardless of whether or not the surgery which is incidental to a dental disease, injury, or Congenital Anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.
- Any dental procedure not directly associated with dental disease.
- 6. Any procedure not performed in a dental setting.
- 7. Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
- 8. Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
- Expenses for dental procedures begun prior to the covered person becoming enrolled under the policy.
- 10. Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.
- 11. Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.
- 12. Foreign services are not covered unless required as an Emergency.
- 13. Replacement of crowns, bridges, and fixed or removable prosthetic appliances inserted prior to plan coverage unless the patient has been eligible under the plan for 12 continuous months. If loss of a tooth requires the addition of a clasp, pontic, and/or abutment(s) within this 12 month period, the plan is responsible only for the procedures associated with the addition.
- 14. Replacement of missing natural teeth lost prior to the onset of plan coverage until the patient has been covered under the policy for 12 continuous months.

- 15. Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is necessary because of patient non-compliance, the patient is liable for the cost of replacement.
- 16. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
- 17. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
- 18. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
- 19. Placement of dental implants, implants-supported abutments and prostheses. (Not applicable for plans with implants)
- 20. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
- 21. Treatment of benign neoplasms, cysts or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
- 22. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue
- 23. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jawbone surgery (including that related to the temporomandibular joint). No coverage is provided for orthognathic surgery, jaw alignment or treatment for the temporomandibular joint. (Not Applicable for Plans with TMJ).
- 24. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia
- 25. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
- 26. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
- 27. Occlusal guard used as safety items or to affect performance primarily in sports-related activities
- 28. Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
- 29. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.

## 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 <a href="https://ocrportal.hhs.gov/ocr/portal/lobby.jsf">https://ocrportal.hhs.gov/ocr/portal/lobby.jsf</a>

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 አርዳታ አንልማሎዮች በነጻ ይንኛሉ። አባቴዎ ወደ 1-866-260-2723 ይደውሉ።

#### Arabic

تتوفر الله خدمات المساعدة اللغوية مجانًا. تصل على الرقم 2723-266-1.

#### Armenian

Ձեզ մատչելի են անվճար լեզվական օգնության Նառայություններ։ 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 বিনামূল্য পেতে পারেন। দ্যা করে 1-866-260-2723-তে কল করুন।

# Burmese

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

# Cambodian- Mon-Khmer

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

#### Cherokee

\$\text{\$\text{Policy}\$.} \text{\$\text{\$\text{\$\text{\$\delta}\$} \text{\$\text{\$\delta}\$} \text{\$\text{\$\delta}\$} \text{\$\text{\$\delta}\$} \text{\$\text{\$\delta}\$} \text{\$\text{\$\delta}\$} \text{\$\text{\$\delta}\$} \text{\$\text{\$\delta}\$} \text{\$\text{\$\delta}\$} \text{\$\delta}\$ \text{\$\delta}\$

## 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 hokmyt tohsholi yyt 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 éd 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 βοήθειως σας διατίθενται δωρεάν. Καλέστε το 1-866-260-2723.

## Gujarati

ભાષા સહાથ સેવાઓ તમારા માટે નિ:શુલ્ક ઉપલબ્ધ છે. કુપા કરીને 1-866-260-2723 પર ક્રેલ કરો.

#### Hawaiian

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

#### Hind

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.

#### Ibe

Enyemaka na-ahazi asusu, bu n'efu, diri gi. Kpoo 1-866-260-2723.

### Hocano

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

ကိုဂ်တါခု၊ ဧကန္အ ကိုနမာနှုပ်နှီးသူဂဲလာတလိုင်းကိုအပ္ပူတာရှိ(ခိုလို)ရှင်လီး . ငဲသရာလက်လိုးတန် 1-866-260-2723တကုန်.

#### Korear

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

#### Kru- Bassa

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

## Kurdish Sorani

خۇسەئىكىلى يازمەنئىي زمانى بەخۇر يى بۇ ئۇ دايىن دەكرىن. ئىكايە ئەلەقۇن بىكە بۇ زىداردى 2723-660-866-1.

#### Laotian

ມືບໍລິການທາງດ້ານພາສາບໍ່ເສຍຄ່າໃຫ້ແກ່ທ່ານ. ກະລຸນາໂທຫາເປີ I-866-260-2723

#### Marathi

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

#### Marshallese

Kwomaroň bök jerbal in jipaň in kajin ilo ejjelok wönään. Jouj im kallok 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'nida'wo'igii t'áá jiik'eh bee nich'i' bee ná'ahoot'i'. T'áá shọọdi kohji! 1-866-260-2723 hodiilnih.

#### Nepali

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

## Nilotic-Dinka

Kāk ē kuny ajuser ē thok atō tīnē yīn abac tē cīn wēu yeke thiēēc. Yīn col 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 زباتی به طور رایگان در اختیار شما می باشد. لطفاً با شماره 2723-660-1866 تصلس مگیرید.

#### 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 le totogia.
 Faamolemole telefoni le 1-866-260-2723.

### Serbo-Croatian

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

#### Samali

Adeegyada taageerada luqadda oo hilaash 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

B woodi walliinde dow wolde caahu ngam maada. 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

جەمەلىقى سەتىنىدەت مۇغۇم، ئۆركىكىسىدا، ئىسىلىر ھەنىپ ئىللىقىدى . ئىنىدەنجى . ھەنى خىلەردىنىڭ 2723-260-266-1.

## Tagalog

Ang mga serbisyo ng tulong sa wika ay available para sa iyo ng walang bayad. Mangyaring tumawag sa 1-866-260-2723.

#### Telugi

లాంగ్వేజ్ అసిస్టెంట్ సర్వీసెస్ మీకు ఉచితంగా అందుబాటులో ఉన్నాయి. దయ చేసి 1-866-260-2723 కి కాల్ చేయండి.

### Thai

มีบริการความช่วยเหลือด้านภาษาให้โดยที่คุณไม่ต้องเสียค่าใช้จา ยแต่อย่างใด 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 I-866-260-2723.

## Trukese (Chuukese)

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

#### Turkisl

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

# Ukrainian

Послуги перекладу падаються вам безкоштовно. Дэвопіть за номером 1-866-260-2723.

### Urdu

زبان کے حوالے سے معارفتی خدمات آپ کے لیے بلامعاوسہ دستیاب ہیں۔ ہر ہ میردقی 2723-260-166 پر کان کریں۔

#### Vietname

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

## Yiddish

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

#### Voruha

Isệ ìránlówó èdè tỉ ở jệ ởfé, wá fún ở. Pe 1-866-260-2723.