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PART I
ELIGIBILITY AND TERMINATION PROVISIONS

Eligibility: Each person who belongs to one of the "Classes of Persons To Be Insured" as set forth in the application is eligible to be insured under this policy. The Named Insured must actively attend classes for at least the first 31 days after the date for which coverage is purchased. Home study, correspondence, Internet, and television (TV) courses do not fulfill the eligibility requirements that the Named Insured 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.

Eligible persons may be insured under this policy subject to the following:

1) Payment of premium as set forth on the policy application; and,
2) Application to the Company for such coverage.

Effective Date: Insurance under this policy shall become effective on the later of the following dates:

1) The Effective Date of the policy; or
2) The date premium is received by the Administrator.

Termination Date: The coverage provided with respect to the Named Insured shall terminate on the earliest of the following dates:

1) The last day of the period through which the premium is paid; or
2) The date the policy terminates.

PART II
GENERAL PROVISIONS

ENTIRE CONTRACT CHANGES: This policy, including the endorsements and attached papers, if any, and the application of the Policyholder shall constitute the entire contract between the parties. No agent has authority to change this policy or to waive any of its provisions. No change in the policy shall be valid until approved by an executive officer of the Company and unless such approval be endorsed hereon or attached hereto. Such an endorsement or attachment shall be effective without the consent of the Insured Person but shall be without prejudice to any claim arising prior to its Effective Date.

STATEMENTS IN APPLICATIONS: All statements made by the Policyholder shall be deemed representations and not warranties.

PAYMENT OF PREMIUM: All premiums are payable in advance for each policy term in accordance with the Company's premium rates. The full premium must be paid even if the premium is received after the policy Effective Date. There is no pro-rata or reduced premium payment for late enrollees. There will be no refunds to students who cancel coverage under the policy; unless the Insured enters the armed forces.

Premium adjustments involving return of unearned premiums to the Policyholder will be limited to a period of 12 months immediately preceding the date of receipt by the Company of evidence that adjustments should be made. Premiums are payable to the Company, P.O. Box 809026, Dallas, Texas 75380-9026.

THIRD-PARTY NOTICE OF CANCELLATION: The Insured has the right: a) to designate a third party to receive notice of cancellation; b) to change the designation; and 3) to have the policy reinstated if the Insured suffers from Organic Brain Disease and the ground for cancellation was the Insured's nonpayment of premium or other lapse or default on the part of the Insured. Within 10 days following a request by an Insured, a Third Party Notice Request Form shall be mailed or personally delivered to the Insured. For purposes of this provision, Organic Brain Disease means a mental or nervous disorder with a demonstrable organic origin causing significant cognitive impairment, including, but not limited to Pick's Disease, Parkinson's Disease, Huntington's Chorea, and Alzheimer's Disease and related dementias.

NOTICE OF CLAIM: Written notice of claim must be given to the Company within 90 days after the occurrence or commencement of any loss covered by this policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Named Insured to the Company, P.O. Box 809025, Dallas, Texas 75380-9025 with information sufficient to identify the Named Insured shall be deemed notice to the Company.

CLAIM FORMS: Upon receipt of a notice of claim, the Company will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of written notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and extent of the loss for which claim is made.

PROOF OF LOSS: Written proof of loss must be furnished to the Company at its said office within 90 days after the date of such loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to furnish proof. In no event except in the absence of legal capacity shall written proofs of loss be furnished later than one year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIM: Indemnities payable under this policy for any loss will be paid upon receipt of due written proof of such loss.

PAYMENT OF CLAIMS: If the Named Insured requests in writing not later than the time of filing proofs of such loss, all or a portion of any indemnities provided by this policy will be paid directly to the Hospital or person rendering such service. Otherwise, accrued indemnities will be paid to the Named Insured or the estate of the Named Insured. Any payment so made shall discharge the Company's obligation to the extent of the amount of benefits so paid.

PHYSICAL EXAMINATION: As a part of Proof of Loss, the Company at its own expense shall have the right and opportunity: 1) to examine the person of any Insured Person when and as often as it may reasonably require during the pendency of a claim; and, 2) to have an autopsy made in case of death where it is not forbidden by law. The Company has the right to secure a second opinion regarding treatment or hospitalization. Failure of an Insured to present himself or herself for examination by a Physician when requested shall authorize the Company to: (1) withhold any payment of Covered Medical Expenses until such examination is performed and Physician's report received; and (2) deduct from any amounts otherwise payable hereunder any amount for which the Company has become obligated to pay to a Physician retained by the Company to make an examination for which the Insured failed to appear. Said deduction shall be made with the same force and effect as a Deductible herein defined.

LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proofs of loss have been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of 3 years after the time written proofs of loss are required to be furnished.

SUBROGATION: The Company may have a right of recovery which any Insured Person has against any person, firm or corporation to the extent of payments for benefits made by the Company to or for benefit of an Insured Person. The Company may not exercise this right of recovery without the prior written consent of the Insured. Allowances will be made for legal fees, court costs and compromise settlements.

RIGHT OF RECOVERY: Payments made by the Company which exceed the Covered Medical Expenses (after allowance for Deductible and coinsurance clauses, if any) payable hereunder shall be recoverable by the Company from or among any persons, firms, or corporations to or for whom such payments were made or from any insurance organizations who are obligated in respect of any covered Injury as their liability may appear.

MORE THAN ONE POLICY: Insurance effective at any one time on the Insured Person under a like policy, or policies in this Company is limited to the one such policy elected by the Insured Person, his beneficiary or his estate, as the case may be, and the Company will return all premiums paid for all other such policies.

PART III
DEFINITIONS

COVERED MEDICAL EXPENSES means reasonable charges which are: 1) not in excess of Usual and Customary Charges; 2) not in excess of the maximum benefit amount payable per service as specified in the Schedule of Benefits; 3) made for services and supplies not excluded under the policy; 4) made for services and supplies which are a Medical Necessity; 5) made for services included in the Schedule of Benefits; and 6) in excess of the amount stated as a Deductible, if any.

Covered Medical Expenses will be deemed "incurred" only: 1) when the covered services are provided; and 2) when a charge is made to the Insured Person for such services.

DEDUCTIBLE means if an amount is stated in the Schedule of Benefits or any endorsement to this policy as a deductible, it shall mean an amount to be subtracted from the amount or amounts otherwise payable as Covered Medical Expenses before payment of any benefit is made. The deductible will apply per policy year or per occurrence (for each Injury) as specified in the Schedule of Benefits.

ELECTIVE SURGERY OR ELECTIVE TREATMENT means those health care services or supplies that do not meet the health care need for an Injury. Elective surgery or elective treatment includes any service, treatment or supplies that: 1) are deemed by the Company to be research or experimental; or 2) are not recognized and generally accepted medical practices in the United States.

HOSPITAL means a licensed or properly accredited general hospital which: 1) is open at all times; 2) is operated primarily and continuously for the treatment of and surgery for sick and injured persons as inpatients; 3) is 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; and 6) is not primarily a clinic, nursing, rest or convalescent home.

HOSPITAL CONFINED/HOSPITAL CONFINEMENT means confined in a Hospital for at least 18 hours by reason of an Injury for which benefits are payable.

INJURY means bodily injury which is: 1) directly and independently caused by specific accidental contact with another body or object; 2) unrelated to any pathological, functional, or structural disorder; 3) a source of loss; 4) treated by a Physician within 30 days after the date of accident; and 5) sustained while the Insured Person is covered under this policy. All injuries sustained in one accident, including all related conditions and recurrent symptoms of these injuries will be considered one injury. Injury does not include loss which results wholly or in part, directly or indirectly, from disease or other bodily infirmity.

INSURED PERSON means the Named Insured. The term "Insured" also means Insured Person.

INTENSIVE CARE means: 1) a specifically designated facility of the Hospital that provides the highest level of medical care; and 2) which is restricted to those patients who are critically ill or injured. Such facility must be separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement. They must be: 1) permanently equipped with special life-saving equipment for the care of the critically ill or injured; and 2) under constant and continuous observation by nursing staff assigned on a full-time basis, exclusively to the intensive care unit. Intensive care does not mean any of these step-down units:

1) Progressive care;
2) Sub-acute intensive care;
3) Intermediate care units;
4) Private monitored rooms;
5) Observation units; or
6) Other facilities which do not meet the standards for intensive care.

MEDICAL EMERGENCY means the occurrence of a sudden, serious and unexpected Injury. In the absence of immediate medical attention, a reasonable person could believe this condition would result in:

1) Death;
2) Placement of the Insured's health in jeopardy;
3) Serious impairment of bodily functions;
4) Serious dysfunction of any body organ or part; or
5) In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Expenses incurred for "Medical Emergency" will be paid only for Injury which fulfills the above conditions. These expenses will not be paid for minor Injuries.

MEDICAL NECESSITY means health care services or products provided to an Insured for the purpose of preventing, diagnosing or treating an Injury or the symptoms of an Injury in a manner that is:

1) Consistent with generally accepted standards of medical practice;
2) Clinically appropriate in terms of type, frequency, extent, site and duration;
3) Demonstrated through scientific evidence to be effective in improving health outcomes;
4) Representative of "best practices" in the medical profession; and,
5) Not primarily for the convenience of the Insured, or the Insured's Physician.

The Medical Necessity of being Hospital Confined means that: 1) the Insured requires acute care as a bed patient; and, 2) the Insured cannot receive safe and adequate care as an outpatient.

This 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 Hospital Confinement.

NAMED INSURED means an eligible, registered student of the Policyholder, if: 1) the student is properly enrolled in the program; and 2) the appropriate premium for coverage has been paid.

NEGATIVE X-RAY means an X-ray that shows the absence of a fracture; pathology; or disease.

NEWBORN INFANT means any child born of an Insured while that person is insured under this policy. Newborn Infants will be covered under the policy for the first 31 days after birth. Coverage for such a child will be for Injury. Benefits will be the same as for the Insured Person who is the child's parent.

PHYSICIAN means a legally qualified licensed practitioner of the healing arts who provides care within the scope of his/her license, other than a member of the person's immediate family.

The term "member of the immediate family" means any person related to an Insured Person within the third degree by the laws of consanguinity or affinity.

PHYSIOTHERAPY means any form of the following: physical or mechanical therapy; diathermy; ultra-sonic therapy; heat treatment in any form; manipulation or massage administered by a Physician.

POSITIVE X-RAY means an X-ray that shows the presence of a fracture; pathology; or disease.

PRE-EXISTING CONDITION means: 1) the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within the 6 months immediately prior to the Insured's Effective Date under the policy; or, 2) any condition which originates, is diagnosed, treated or recommended for treatment within the 6 months immediately prior to the Insured's Effective Date under the policy.

PRESCRIPTION DRUGS means: 1) prescription legend drugs; 2) compound medications of which at least one ingredient is a prescription legend drug; 3) any other drugs which under the applicable state or federal law may be dispensed only upon written prescription of a Physician; and 4) injectable insulin.

REGISTERED NURSE means a professional nurse (R.N.) who is not a member of the Insured Person's immediate family.

SOUND, NATURAL TEETH means natural teeth, the major portion of the individual tooth is present, regardless of fillings or caps; and is not carious, abscessed, or defective.

TOTALLY DISABLED means a condition of a Named Insured which, because of Injury, renders the Named Insured unable to actively attend class.

USUAL AND CUSTOMARY CHARGES means a reasonable charge which is: 1) usual and customary when compared with the charges made for similar services and supplies; and 2) made to persons having similar medical conditions in the locality where service is rendered. No payment will be made under this policy for any expenses incurred which in the judgment of the Company are in excess of Usual and Customary Charges. The Insured may be billed for any charges which exceed the Usual and Customary Charges. The Insured may call the Company at 1-800-767-0700 for the maximum Usual and Customary Charge for a specified service.

PART IV
EXTENSION OF BENEFITS AFTER TERMINATION

The coverage provided under this policy ceases on the Termination Date. However, if an Insured is Totally Disabled on the Termination Date from a covered Injury for which benefits were paid before the Termination Date, Covered Medical Expenses for such Injury will continue to be paid as long as the condition continues but not to exceed 3 months after the Termination Date.

The total payments made in respect of the Insured for such condition both before and after the Termination Date will never exceed the Maximum Benefit.

PART V
SCHEDULE OF BENEFITS
MEDICAL EXPENSE BENEFITS-INJURY
UNIVERSITY OF MAINE SYSTEMS - STUDENT PLAN
2022-200202-48
INJURY ONLY BENEFITS

Maximum Benefit	**$5,000 (For Each Injury)**
Deductible	**$0**
Coinsurance	**100% except as noted below**

This policy provides benefits for Injury sustained by an Insured Person while: 1) actually engaged, as an official representative of the Policyholder, in the play or practice of an intercollegiate sport under the direct supervision of a regularly employed coach or trainer of the Policyholder; or 2) actually being transported as a member of a group under the direct supervision of a duly delegated representative of the Policyholder for the purpose of participating in the play or practice of a scheduled intercollegiate sport.

The benefits payable are as defined in and subject to all provisions of this policy and any endorsements thereto. Benefits will be paid up to the Maximum Benefit for each service as scheduled below.

Inpatient

Room & Board:	Usual and Customary Charges
Intensive Care:	Paid under Room & Board
Hospital Miscellaneous:	Usual and Customary Charges
Physiotherapy:	Usual and Customary Charges
Surgery:	Usual and Customary Charges
(Specified Surgery based on data provided by FAIR Health, Inc.)	
Assistant Surgeon:	Usual and Customary Charges
Anesthetist:	Usual and Customary Charges
Registered Nurse:	Usual and Customary Charges
Physician's Visits:	Usual and Customary Charges
Pre-admission Testing:	Usual and Customary Charges

Outpatient

Surgery:	Usual and Customary Charges
(Specified Surgery based on data provided by FAIR Health, Inc.)	
Day Surgery Miscellaneous:	Usual and Customary Charges
Assistant Surgeon:	Usual and Customary Charges
Anesthetist:	Usual and Customary Charges
Physician's Visits:	Usual and Customary Charges
Physiotherapy:	Usual and Customary Charges
(Review of Medical Necessity will be performed after 12 visits per Injury.)	
Medical Emergency:	Usual and Customary Charges
X-rays:	Usual and Customary Charges
Laboratory:	Usual and Customary Charges
Injections:	Usual and Customary Charges
Prescription Drugs:	No Benefits
Tests & Procedures	Usual and Customary Charges

SCHEDULE OF BENEFITS (CONTINUED)
MEDICAL EXPENSE BENEFITS-INJURY
UNIVERSITY OF MAINE SYSTEMS - STUDENT PLAN
2022-200202-48
INJURY ONLY BENEFITS

Other

Ambulance:	Usual and Customary Charges
Durable Medical Equipment:	Usual and Customary Charges
Consultant:	Usual and Customary Charges
Dental:	Usual and Customary Charges
(Benefits paid on Injury to Sound, Natural Teeth only.)	
Urgent Care Clinic Fee:	Usual and Customary Charges

(Benefits are limited to the Urgent Care Clinic fee billed by the Urgent Care Clinic/Hospital. All other services rendered during the visit are payable as specified in the Schedule of Benefits.)

MAJOR MEDICAL

Maximum Benefit **No Benefits**

CATASTROPHIC MEDICAL

Maximum Benefit **No Benefits**

***SHC Referral Required:** Yes ( ) No (X) **Pre Admission Notification:** Yes ( ) No (X)

( ) 52 Week Benefit Period or **(X) Extension of Benefits**

Other Insurance: ( ) *Excess Insurance ( ) Excess Motor Vehicle (X) Primary Insurance

*If benefit is designated, see endorsement attached.

PART VI
MEDICAL EXPENSE BENEFITS - INJURY

Benefits are payable for Covered Medical Expenses (see "Definitions") less any Deductible incurred by or for an Insured Person for loss due to Injury subject to: a) the Maximum Benefit for all services; b) the maximum amount for specific services; both as set forth in the Schedule of Benefits; and c) any coinsurance amount set forth in the Schedule of Benefits or any endorsement hereto. The total payable for all Covered Medical Expenses shall never exceed the Maximum Benefit stated in the Schedule of Benefits. Read the "Definitions" section and the "Exclusions and Limitations" section carefully.

No benefits will be paid for services designated as "No Benefits" in the Schedule of Benefits or for any matter described in "Exclusions and Limitations." If a benefit is designated, Covered Medical Expenses include:

1. **Room and Board Expense:** 1) daily semi-private room rate when Hospital Confined; and 2) general nursing care provided and charged by the Hospital.

2. **Intensive Care:** If provided in the Schedule of Benefits.

3. **Hospital Miscellaneous Expenses:** 1) while Hospital Confined; or 2) as a precondition for being Hospital Confined. Benefits will be paid for services and supplies such as: the cost of the operating room; laboratory tests; X-ray examinations; anesthesia; drugs (excluding take home drugs) or medicines; therapeutic services; and supplies. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.

4. **Physiotherapy (Inpatient):** See Schedule of Benefits.

5. **Surgery:** Physician's fees for inpatient surgery. Payment will be made based upon the surgical schedule as specified in the Schedule of Benefits. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.

6. **Assistant Surgeon Fees:** in connection with inpatient surgery, if provided in the Schedule of Benefits.

7. **Anesthetist Services:** professional services administered in connection with inpatient surgery.

8. **Registered Nurse's Services:** 1) private duty nursing care only; 2) while Hospital Confined; 3) ordered by a licensed Physician; and 4) a Medical Necessity. General nursing care provided by the Hospital is not covered under this benefit.

9. **Physician's Visits:** when Hospital Confined. Benefits do not apply when related to surgery.

10. **Pre-admission Testing:** limited to routine tests such as: complete blood count; urinalysis; and chest X-rays. If otherwise payable under the policy, major diagnostic procedures such as: cat-scans; NMR's; and blood chemistries will be paid under the "Hospital Miscellaneous" benefit. This benefit is payable within 3 working days prior to admission.

11. **Surgery (Outpatient):** Physician's fees for outpatient surgery. Payment will be made based upon the surgical schedule as specified in the Schedule of Benefits. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.

12. **Day Surgery Miscellaneous (Outpatient):** in connection with outpatient day surgery; excluding non-scheduled surgery; and surgery performed in a Hospital emergency room; trauma center; Physician's office; or clinic. Benefits will be paid for services and supplies such as: the cost of the operating room; laboratory tests and X-ray examinations, including professional fees; anesthesia; drugs or medicines; therapeutic services; and supplies.

13. **Assistant Surgeon Fees (Outpatient):** in connection with outpatient surgery, if provided in the Schedule of Benefits.

14. **Anesthetist (Outpatient):** professional services administered in connection with outpatient surgery.

15. **Physician's Visits (Outpatient):** Benefits do not apply when related to surgery or Physiotherapy.

16. **Physiotherapy (Outpatient):** See Schedule of Benefits.

17. **Medical Emergency Expenses (Outpatient):** only in connection with a Medical Emergency as defined. Benefits will be paid for the use of the emergency room and supplies. Treatment must be rendered within 72 hours from time of Injury.

18. **Diagnostic X-ray Services (Outpatient):** if so noted in the Schedule of Benefits, separate maximums apply to positive and negative X-rays. Diagnostic X-rays are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 70000 - 79999 inclusive.

19. **Laboratory Procedures (Outpatient):** Laboratory Procedures are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 80000 - 89999 inclusive.

20. **Tests and Procedures (Outpatient):** 1) diagnostic services and medical procedures; 2) performed by a Physician; 3) excluding Physician's Visits; Physiotherapy; X-Rays; and Laboratory Procedures.

21. **Injections (Outpatient):** 1) when administered in the Physician's office; and 2) charged on the Physician's statement.

22. **Prescription Drugs (Outpatient):** See Schedule of Benefits.

23. **Ambulance Services:** See Schedule of Benefits.

24. **Durable Medical Equipment:** 1) when prescribed by a Physician; and 2) a written prescription accompanies the claim when submitted. Replacements are never covered. Durable medical equipment includes equipment that: 1) is primarily and customarily used to serve a medical purpose; 2) can withstand repeated use; and 3) generally is not useful to a person in the absence of Injury. No benefits will be paid for rental charges in excess of purchase price.

25. **Consultant Physician Fees:** when requested and approved by the attending Physician.

26. **Dental Treatment:** 1) performed by a Physician; and, 2) made necessary by Injury to Sound, Natural Teeth. Breaking a tooth while eating is not covered. Routine dental care and treatment to the gums are not covered.

PART VI
EXCLUSIONS AND LIMITATIONS

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

1. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this policy or for newborn or adopted children; removal of warts, non-malignant moles and lesions;

2. 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 abuse facilities for domiciliary or custodial care;

3. Dental treatment, except for accidental Injury to Sound, Natural Teeth as specifically provided in the Schedule of Benefits;

4. Elective Surgery or Elective Treatment;

5. Eye examinations, eye refractions, eyeglasses, contact lenses, prescriptions or fitting of eyeglasses or contact lenses, vision correction surgery, or other treatment for visual defects and problems; except when due to a disease process;

6. Foot care including: flat foot conditions, supportive devices for the foot, subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toenails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet;

7. Health spa or similar facilities; strengthening programs;

8. Hearing examinations or hearing aids; or other treatment for hearing defects and problems. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;

9. Injury for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;

10. Injury sustained by reason of a motor vehicle accident to the extent that benefits are paid or payable by any other valid and collectible insurance;

11. Investigational services;

12. Participation in a riot or civil disorder; commission of or attempt to commit a felony; or fighting;

13. Prescription Drugs dispensed or purchased while not Hospital Confined; except when dispensed at the Student Health Center;

14. 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;

15. Routine physical examinations and routine testing; preventive testing or treatment; screening exams or testing in the absence of Injury; except as specifically provided in the policy;

16. Services provided normally without charge by the Health Service of the Policyholder; or services covered or provided by the student health fee;

17. Sickness or disease in any form; over-exertion; fainting; or hernia, regardless of how caused;

18. Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia; temporomandibular joint dysfunction; deviated nasal septum, including submucous resection and/or other surgical correction thereof; nasal and sinus surgery;

EXCLUSIONS AND LIMITATIONS *(Continued)*

19. Skydiving, parachuting, hang gliding, glider flying, parasailing, sail planing, bungee jumping, or flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline; or chartered aircraft only while participating in a school sponsored intercollegiate sport activity;

20. Supplies, except as specifically provided in the policy;

21. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;

22. 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);

POLICY ENDORSEMENT

In consideration of the premium charged, it is hereby understood and agreed that the policy to which this endorsement is attached is amended as follows:

UTILIZATION REVIEW, GRIEVANCE, AND EXTERNAL REVIEW PROCEDURES

The Utilization Review, Grievance and External Review Procedures apply to all Adverse Determinations and Adverse Health Care Treatment Decisions.

DEFINITIONS

For the purposes of this endorsement:

Adverse Determination or Adverse Health Care Treatment Decision means a health care treatment decision made by or on behalf of the Company offering a health plan denying in whole or in part payment for or provision of otherwise covered services requested by or on behalf of an Insured. Health care treatment decision means a decision regarding diagnosis, care or treatment when medical services are provided by a health plan, or a benefits decision involving determinations regarding medically necessary health care, preexisting condition determinations and determinations regarding experimental or investigational services.

Grievance means a written complaint submitted by or on behalf of an Insured Person regarding:
1. the Company's decisions, policies or actions related to availability, delivery or quality of health care services;
2. claims payment, handling or reimbursement for health care services;
3. the contractual relationship between an Insured Person and the Company; or
4. the outcome of an Adverse Determination.

UTILIZATION REVIEW PROCEDURES

1. **Procedures for Review Decisions**
   a. For initial determinations, the Company shall make the determination and notify the Insured and their provider within 2 working days of obtaining all necessary information regarding a proposed admission, procedure or service requiring a review determination.
   b. For concurrent review determinations, the Company shall make the determination within one working day of obtaining all necessary information.
      i. In the case of a determination to certify an extended stay or additional services, the Company shall notify the Insured and their provider within one working day. The written notification shall include the number of extended days or next review date, the new total number of days or services approved, and the date of admission or initiation of services.
      ii. In the case of an Adverse Determination, the Company shall notify the Insured and their provider within one working day. The service shall be continued without liability to the Insured until the Insured has been notified of the determination.
   c. For retrospective review determinations, the Company shall make the determination within 30 working days of receiving all necessary information.
      i. In the case of a certification, the Company may notify in writing the Insured and their provider.
      ii. In the case of an Adverse Determination, the Company shall within 5 working days of making the Adverse Determination notify in writing the provider and the Insured. The Company shall not without adequate written notice to the Insured prior to his or her receipt of previously authorized services render an Adverse Decision with regard to health care services authorized pursuant to prospective review, except where fraudulent or materially incorrect information was provided the Company at the time prior approval was granted, and the information was relied upon by the Company in rendering its approval.

A written notification of an Adverse determination shall include the principal reason or reasons for the determination, the instructions for initiating an appeal for reconsideration of the determination, and the instructions for requesting a written statement of the clinical rational, including the clinical review criteria used to make the determination. The notification will include the telephone number the Insured may call for information on and assistance with initiating an appeal or reconsideration and/or requesting clinical rational and review criteria. The Company shall respond expeditiously to such written requests.

2. **Requests for Reconsideration**
   a. In a case involving an initial determination or a concurrent review determination, the Company shall give the provider an opportunity to request by telephone, fax or in writing on behalf of the Insured a reconsideration of an Adverse Determination by the reviewer making the Adverse Determination.
   b. The reconsideration shall occur within one working day of the receipt of the request and shall be conducted between the provider and the reviewer who made the Adverse Determination or a clinical peer designated by the reviewer if the reviewer who made the Adverse Determination cannot be available within one working day.
   c. If the reconsideration process does not resolve the difference of opinion, the Adverse Determination may be appealed by the Insured or the provider on behalf of the Insured. Reconsideration is not a prerequisite to a standard appeal or an expedited appeal of an Adverse Determination.

3. **Appeals of Adverse Determinations**
   a. Standard Appeals
      i. The Company shall notify in writing both the Insured or the Insured's representative and their provider of the decision within 20 working days following the request for an appeal. Additional time is permitted where the Company can establish the 20 day time frame cannot reasonably be met due to the Company's inability to obtain necessary information from a person or entity not affiliated with or under contract with the Company. The Company shall provide written notice of the delay to the Insured or their representative and the provider. The notice shall explain the reasons for the delay. In such instances, a decision must be issued within 20 days of the Company's receipt of all necessary information.
      ii. An Adverse Decision shall contain:
         1. the names, titles and qualifying credentials of the person or persons evaluating the appeal;
         2. a statement of the reviewers' understanding of the reason for the Insured's request for an appeal;
         3. the reviewers' decision in clear terms and the clinical rationale in sufficient detail for the Insured to respond further to the Company's position;
         4. a reference to the evidence or documentation used as the basis for the decision, including the clinical review criteria used to make the determination. The decision shall include instructions for requesting copies of any referenced evidence, documentation or clinical review criteria not previously provided to the Insured. Where an Insured or their representative had previously submitted a written request for the clinical review criteria relied upon by the Company in rendering its initial Adverse Determination, the decision shall include copies of any additional clinical review criteria utilized in arriving at the decision.
         5. the notice will advise of any subsequent appeal rights, and the procedure and time limitation for exercising those rights including the notice of external review rights.

   b. Expedited Appeals
      i. Expedited Appeals shall be evaluated by an appropriate clinical peer or peers. The clinical peer shall not have been involved in the initial Adverse Determination.
      ii. Expedited review shall be available to all requests concerning an admission, availability of care, continued stay or health care service for an Insured who has received emergency services but has not been discharged from a facility.
      iii. The Company shall provide the Insured and the provider acting on behalf of the Insured all necessary information, including the Company's decision, by telephone, facsimile, electronic means or the most expeditious method available.
      iv. The Company shall make a decision and notify the Insured or the provider acting on behalf of the Insured via telephone as expeditiously as the Insured's medical condition requires, but in no event more than 72 hours after the review is initiated. If the expedited review is a concurrent review determination of emergency services or of an initially authorized admission or course of treatment, the service shall be continued without liability to the Insured until the Insured has been notified of the determination.
      v. If the initial notification was not in writing, the Company shall provide written confirmation of its decision concerning an expedited review within 2 working days of providing notification of that decision.

This endorsement takes effect and expires concurrently with the policy to which it is attached, and is subject to all of the terms and conditions of the policy not inconsistent therewith.

vi. An expedited review is not available for retrospective Adverse Determinations.

UTILIZATION REVIEW, GRIEVANCE AND EXTERNAL REVIEW PROCEDURES *(continued)*

4. Emergency Services
   a. The Company shall cover Medical Emergencies necessary to screen and stabilize an Insured and shall not require prior authorization of such services.

   b. If the Company authorizes emergency services, the Company shall not subsequently retract its authorization after the emergency services have been provided or reduce payment for an item or service furnished in reliance on approval, unless the approval was based on fraudulent or materially incorrect information.

GRIEVANCE PROCEDURES

1. **First Level Review**. Except for an Adverse Determination, an Insured Person, or his or her provider may submit a written Grievance to the Company for review. First Level Review of an Adverse Determination is subject to Section 3 above, Appeals of Adverse Determinations.

   The Insured Person will not be allowed to attend, or have a representative attend, a First Level Review. However, the Insured Person may submit written material for the review. Within 3 working days of the receipt of the Grievance by the Company, the Company shall provide the Insured the name, address and telephone number of the person who will coordinate the Grievance review.

   The Company shall issue a written decision to the Insured Person and, if applicable, to the provider within 20 days after receiving the Grievance. Additional time is permitted where the Company can establish the 20 day time frame cannot reasonably be met due to the Company's inability to obtain necessary information from a person or entity not affiliated with or under contract with the Company. The Company shall provide written notice of the delay to the Insured or their representative and the provider explaining the reasons for the delay. In such instances, decisions must be issued within 20 days of the Company's receipt of all necessary information. The person reviewing the Grievance shall not be the same person who made the initial determination that initiated the Grievance.
      i. The written decision shall contain:
         1. the names, titles and qualifying credentials of the person or persons evaluating the appeal;
         2. a statement of the reviewers' understanding of the reason for the Insured's request for an appeal;
         3. the reviewers' decision in clear terms and the basis of the decision in sufficient detail for the Insured to respond further to the Company's position;
         4. a reference to the evidence or documentation used as the basis for the decision;
         5. notice of the availability of the Superintendent's office for assistance, including the telephone number and address of the Bureau of Insurance.
         6. notice advising of any subsequent appeal rights, and the procedure and time limitation for exercising those rights including the notice of external review rights.

2. **Second Level Review**. A second level Grievance review is available to Insureds dissatisfied with the first level Grievance review decision. The Insured has the right to appear in person at a Second Level Review and present his or her case to the review panel. The Insured may submit supporting material both before and at the review meeting; ask questions of any representative f the Company; and be assisted or represented by a person of his or her choice. The Insured will be notified by the Company 15 days prior to the date of the Grievance review meeting. The Company shall not unreasonably deny a request by the Insured for postponement of the review.

   The Company will convene a second-level Grievance review panel for each request. The panel shall be comprised of health care professionals who are clinical peers and who were not previously involved in any matter giving rise to the second-level Grievance, are not employees of the Company, and do not have a financial interest in the outcome of the

review. A person who was previously involved in the matter may appear before the panel to present information or answer questions. All of the persons reviewing a second-level Grievance involving a Adverse Determination shall be providers who have appropriate expertise, including at least one clinical peer. Provided, however, if the Company used a clinical peer on an appeal on a first-level Grievance review panel then the Company may use one of its employees on the second-level Grievance review panel in the same matter if the second-level Grievance review panel comprises three or more persons.

UTILIZATION REVIEW, GRIEVANCE AND EXTERNAL REVIEW PROCEDURES *(continued)*

When the Insured requests to appear before the Company's Second Level panel review, the Company shall

1. Within 45 days of receipt of the second level review request, hold the second level Grievance review meeting during regular business hours at a location reasonably accessible to the Insured. When a face-to-face meeting is not practical for geographic reasons, the Company shall offer the Insured the opportunity to communicate with the review panel, at the Company's expense, by conference call, video conferencing, other appropriate technology.
2. Upon request by the Insured, the Company shall provide the Insured with all relevant, nonconfidential or privileged information.
3. If the Company will have an attorney present to argue its case against the Insured, the Company shall so notify the Insured at least 15 working days in advance of the second level Grievance review meeting date and shall advise the Insured of their right to obtain legal representation.
4. The Insured will have the right to full review without condition of his/her attendance at the meeting.
5. A written statement of the second level Grievance review panel's decision shall be issued to the Insured within 5 working days after the review meeting. The decision shall include:

    i. the names, titles and qualifying credentials of the person or persons evaluating the appeal;
    ii. a statement of the reviewers' understanding of the reason for the Insured's request for an appeal
    iii. the reviewers' decision in clear terms and the basis of the decision in sufficient detail for the Insured to respond further to the Company's position;
    iv. a reference to the evidence or documentation used as the basis for the decision;
    v. notice of the availability of the Superintendent's office for assistance, including the telephone number and address of the Bureau of Insurance;
    vi. notice advising of any subsequent appeal rights, and the procedure and time limitation for exercising those rights including the notice of external review rights.

EXTERNAL REVIEW PROCEDURES

An Insured may request an independent external review of the Company's Adverse Health Care Treatment decision. An Insured's failure to obtain authorization prior to receiving an otherwise Covered Medical Expense does not prevent the Insured from requesting an external review. An Insured will be notified of their right to an External Review on the written notice of an Adverse Health Care Treatment Decision. The Maine Bureau of Insurance administers this service.

1. **Request for external review.**
    a. An Insured or the Insured's authorized representative must make a written request for external review of an Adverse Health Care Treatment Decision to the Maine Bureau of Insurance. Except as provided for an Expedited Request for External Review, an Insured may not make a request for external review until the Insured has exhausted all levels of the Company's internal grievance procedure. A request for external review must be made within 12 months of the date an Insured has received a final Adverse Health Care Treatment Decision under the Company's internal grievance procedure. An Insured may not be required to pay any filing fee as a condition of processing a request for external review.

2. **Expedited request for external review**.
    a. An Insured or an Insured's authorized representative is not required to exhaust all levels of the Company's internal grievance procedure before filing a request for external review if

This endorsement takes effect and expires concurrently with the policy to which it is attached, and is subject to all of the terms and conditions of the policy not inconsistent therewith.

b. The Company has failed to make a decision on an internal Grievance within the time period required;
c. The Company and the Insured mutually agree to bypass the internal grievance procedure;

UTILIZATION REVIEW, GRIEVANCE AND EXTERNAL REVIEW PROCEDURES *(continued)*

d. The life or health of the Insured is in serious jeopardy; or
e. The Insured has died.

3. **External Review Decisions**

An external review decision must be made in accordance with the following requirements.

a. The independent review organization (IRO) must give consideration to the appropriateness of the requested covered service based on the following:
    i. All relevant clinical information relating to the Insured's physical and mental condition, including any competing clinical information;
    ii. Any concerns expressed by the Insured concerning the Insured's health status; and
    iii. All relevant clinical standards and guidelines, including, but not limited to, those standards and guidelines relied upon by the Company.

b. An external review decision must be issued in writing and must be based on the evidence presented by the Company and the Insured or the Insured's authorized representative. An Insured may submit and obtain evidence relating to the Adverse Health Care Treatment decision under review, attend the external review, ask questions of any representative of the Company present at the external review and use outside assistance during the review process at the Insured's own expense.
c. Except for Expedited External review, the external review decision must be made by the IRO within 30 days of receipt of a completed request for external review from the bureau.
d. Expedited External review decisions must be made as expeditiously as an Insured's medical condition requires but in no event more than 72 hours after receipt of a completed request.
e. The Company shall provide auxiliary telecommunications devices or qualified interpreter services by a person proficient in American Sign Language when requested by an Insured who is deaf or hard-of-hearing or printed materials in an accessible format, including Braille, large-print materials, computer diskette, audio cassette or a reader when requested by an Insured who is visually impaired.
f. An external review decision is binding on the Company. An Insured or the Insured's authorized representative may not file a request for a subsequent external review involving the same Adverse Health Care Treatment decision for which the Insured has already received an external review decision. However, an external review decision made under this provision is not considered final agency action.
g. The Company shall pay the cost of the independent external review to the bureau.

Insured Persons, his/her designated representative, or a provider may contact the Company at 2301 West Plano Parkway, Suite 300, Plano, Texas 75075 or at 1-800-767-0700.

Insured Persons, his/her designated representative, may also contact the State of Maine Bureau of Insurance for assistance at any time at 1-800-300-5000 or write to State of Maine, Bureau of Insurance, 34 State House Station, Augusta, Maine 04333-0034.

This endorsement takes effect and expires concurrently with the policy to which it is attached, and is subject to all of the terms and conditions of the policy not inconsistent therewith.

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 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
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
ᏍᏛᏂᎯᎲᏍᏗ ᎤᏬᏝᏍᏓᏛᏗ ᎤᏬᏝᏡᎬᎢ ᏂᎯ ᏒᎶᏙᏆᎢᏍᏓᏝᏗᏆᎢ ᏂᏝᎬᎶᏛᎾ ᎠᏎᏛᎢ. ᎨᎶᏩ ᎠᏂ ᏫᏏᏔᏅ 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 નિઃશુલ્ક 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
ကိုၢ်တၢ်မၤစၢၤအကိၢ်နမၤန့ၢ်အီၤသ့ဝဲလၢတလိၣ်ဟ့ၣ်အပှ့ၤဘၣ်(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 ejjeḷọk wōṇāān. Jouj im kaḷḷọk 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 shǫǫdí 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
ܚܕܡܬܐ ܕܗܝܪܬܐ ܕܠܫܢܐ، ܡܬܝܗܒܬܐ، ܐܝܬ ܒܐܝܕܐ ܕܐܠܘܟ. ܒܡܓܢܐ ܩܪܝ ܥܠ ܡܢܝܢܐ 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
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