



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-877-250-8188 or visit uhc.com/aca-sample-policy. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: \$0 Individual / \$0 Family	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at healthcare.gov/coverage/preventive-care-benefits .
Are there other deductibles for specific services?	Yes, Prescription drugs - \$4,500 Individual / \$9,000 Family Deductible does not apply to Tier 1 and Tier 2 drugs. There are no other deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Network: \$10,600 Individual / \$21,200 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See uhc.com/xtnodocfindoa2026 or call 1-877-250-8188 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

 All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25 <u>copay</u> /visit, <u>deductible</u> does not apply	Not Covered	None
	<u>Specialist</u> visit	\$100 <u>copay</u> /visit, <u>deductible</u> does not apply	Not Covered	None
	<u>Preventive care/ screening/ immunization</u>	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Lab Testing: Free Standing/Office: \$20 <u>copay</u> /service, <u>deductible</u> does not apply Hospital: \$150 <u>copay</u> /service, <u>deductible</u> does not apply X-Ray/Diagnostics: Free Standing/Office: \$100 <u>copay</u> /service, <u>deductible</u> does not apply Hospital: \$300 <u>copay</u> /service, <u>deductible</u> does not apply	Not Covered	None
	Imaging (CT/PET scans, MRIs)	Free Standing/Office: \$150 <u>copay</u> /service, <u>deductible</u> does not apply Hospital: \$750 <u>copay</u> /service, <u>deductible</u> does not apply	Not Covered	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at uhc.com/xtndruglist2	Tier 1 - \$0 Cost-share	No Charge	Not Covered	<u>Provider</u> means pharmacy for purposes of this section. Retail: One month supply up to a 30-day supply or a 90-day supply at 2.5x the 30-day cost-share. Mail-Order: Up to a 90-day supply at 2.5x the 30-day cost-share. <u>Specialty drugs</u> limited to a 30-day supply at a <u>network</u> pharmacy. Certain drugs may have a <u>preauthorization</u> requirement. If you don't get <u>preauthorization</u> , benefits will not be
	Tier 2 – Preferred Generic	\$25 <u>copay</u> /prescription, <u>deductible</u> does not apply	Not Covered	
	Tier 3 - Preferred Brand	40% <u>coinsurance</u>	Not Covered	
	Tier 4 – Non-Preferred Brand	45% <u>coinsurance</u>	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
026	Tier 5 - Specialty	50% <u>coinsurance</u>	Not Covered	covered. Certain preventive medications (including certain contraceptives) are covered at No Charge. See the website listed for information on drugs covered by your <u>plan</u> . Not all drugs are covered. Insulin products listed as Tier 1 on the <u>Prescription Drug List</u> are covered at No Charge at a <u>network pharmacy</u> .
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Free Standing/Office: \$500 <u>copay</u> /service, <u>deductible</u> does not apply Hospital: \$1,000 <u>copay</u> /service, <u>deductible</u> does not apply	Not Covered	None
	Physician/surgeon fees	Free Standing/Office: \$375 <u>copay</u> /date of service, <u>deductible</u> does not apply Hospital: \$500 <u>copay</u> /date of service, <u>deductible</u> does not apply	Not Covered	None
If you need immediate medical attention	<u>Emergency room care</u>	\$2,000 <u>copay</u> /visit, <u>deductible</u> does not apply	\$2,000 <u>copay</u> /visit, <u>deductible</u> does not apply	None
	<u>Emergency medical transportation</u>	\$2,000 <u>copay</u> /transport, <u>deductible</u> does not apply	\$2,000 <u>copay</u> /transport, <u>deductible</u> does not apply	None
	<u>Urgent care</u>	\$90 <u>copay</u> /visit, <u>deductible</u> does not apply	Not Covered	Virtual visits - No Charge by a Designated Virtual <u>Network Provider</u> .
If you have a hospital stay	Facility fee (e.g., hospital room)	\$3,000 <u>copay</u> /day up to 3 days /admission, <u>deductible</u> does not apply	Not Covered	None
	Physician/surgeon fees	No Charge	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: \$40 <u>copay</u> /visit, <u>deductible</u> does not apply Intensive Outpatient: \$140 <u>copay</u> /visit, <u>deductible</u> does not apply	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		Partial Hospitalization: \$225 <u>copay</u> /visit, <u>deductible</u> does not apply All Other Outpatient: \$75 <u>copay</u> /visit, <u>deductible</u> does not apply		
	Inpatient services	\$3,000 <u>copay</u> /day up to 3 days /admission, <u>deductible</u> does not apply	Not Covered	None
If you are pregnant	Office visits	No Charge	Not Covered	<u>Cost-sharing</u> does not apply for <u>preventive services</u> . Depending on the type of service, a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound.)
	Childbirth/delivery professional services	No Charge	Not Covered	
	Childbirth/delivery facility services	\$3,000 <u>copay</u> /day up to 3 days /admission, <u>deductible</u> does not apply	Not Covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	50% <u>coinsurance</u> , <u>deductible</u> does not apply	Not Covered	Limited to 60 visits/year.
	<u>Rehabilitation services</u>	\$100 <u>copay</u> /visit, <u>deductible</u> does not apply	Not Covered	Limits/year: Physical, Occupational, Speech: 20 visits each; Cardiac, Pulmonary: 36 visits each Visit limits do not apply for a primary diagnosis of Mental Health Care, Substance-Related and Addictive Disorders or Autism Spectrum Disorder.
	<u>Habilitative services</u>	\$100 <u>copay</u> /visit, <u>deductible</u> does not apply	Not Covered	Limits/year: Physical, Speech, Occupational: 20 visits each Visit limits do not apply for a primary diagnosis of Mental Health Care, Substance-Related and Addictive Disorders or Autism Spectrum Disorder.
	<u>Skilled nursing care</u>	\$3,000 <u>copay</u> /day up to 3 days /admission, <u>deductible</u> does not apply	Not Covered	Limited to 60 days/year (combined with inpatient rehabilitation)
	<u>Durable medical equipment</u>	50% <u>coinsurance</u> , <u>deductible</u> does not apply	Not Covered	None
	<u>Hospice services</u>	50% <u>coinsurance</u> , <u>deductible</u> does not apply	Not Covered	None
If your child needs	Children's eye exam	No Charge	Not Covered	Limited to 1 exam/12 months.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
dental or eye care	Children's glasses	50% <u>coinsurance</u> , <u>deductible</u> does not apply	Not Covered	Limited to 1 pair/12 months.
	Children's dental check-up	No Charge	Not Covered	Limited to 2 visits/12 months.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

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| • Abortion - (except in cases of rape, incest, or when the life of the mother is endangered) | • Dental care (Adult) | • Private-duty nursing |
| • Acupuncture | • Infertility treatment | • Routine eye care (Adult) |
| • Bariatric surgery | • Long-term care | • Routine foot care - except as covered for certain diseases |
| • Cosmetic surgery | • Non-emergency care when traveling outside the U.S. | • Weight loss programs |

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

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| • Chiropractic (manipulative) care - 20 visits/year | • Hearing aids - 1 per hearing impaired ear /3 years |
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Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: UnitedHealthcare Insurance Company at 1-877-250-8188 or U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa or Tennessee Department of Commerce and Insurance, Consumer Insurance Services, 500 James Robertson Parkway, Nashville, TN 37243, 1-800-342-4029 or tn.gov/commerce/insurance-division or Office of Personnel Management Multi State Plan Program: opm.gov/healthcare-insurance/multi-state-plan-program/external-review/. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Member Service number listed on the back of your ID card or myuhc.com/exchange or the Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa or Tennessee Department of Commerce and Insurance, Consumer Insurance Services at 1-800-342-4029 or tn.gov/commerce/insurance-division.

Additionally, a consumer assistance program may help you file your appeal. Contact dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Not Applicable.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-250-8188

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-250-8188

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-250-8188

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-250-8188

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$0
■ Specialist copayment	\$100
■ Hospital (facility) copayment	\$3,000
■ Other coinsurance	50%

This EXAMPLE event includes services like:

Specialist office visits (*pre-natal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$3,600
<u>Coinsurance</u>	\$0

<i>What isn't covered</i>	
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Limits or exclusions	\$60
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The total Peg would pay is	\$3,660
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Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$0
■ Specialist copayment	\$100
■ Hospital (facility) copayment	\$3,000
■ Other coinsurance	50%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$600
<u>Coinsurance</u>	\$0

<i>What isn't covered</i>	
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Limits or exclusions	\$0
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The total Joe would pay is	\$600
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Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$0
■ Specialist copayment	\$100
■ Hospital (facility) copayment	\$3,000
■ Other coinsurance	50%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$2,600
<u>Coinsurance</u>	\$20

<i>What isn't covered</i>	
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Limits or exclusions	\$0
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The total Mia would pay is	\$2,620
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Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

Nondiscrimination Notice and Notice of Availability of Language Assistance Services and Alternate Formats

The Company complies with applicable civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity). We do not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex. We provide free aids and services to help you communicate with us. You can ask for interpreters and/or for communications in other languages or formats such as large print. We also provide reasonable modifications for persons with disabilities.

If you need these services, call the toll-free number on your member ID card. (TTY 711).

If you believe that we failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can send a complaint to the Civil Rights Coordinator:

Mail: Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130

Email: UHC_Civil_Rights@uhc.com

If you need help with your complaint, please call the toll-free phone number listed on your ID card (TTY/RTT 711). We are available Monday through Friday, 8 a.m. to 8 p.m. E.T.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

Online: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Phone: [1-800-368-1019](tel:1-800-368-1019), [1-800-537-7697](tel:1-800-537-7697) (TDD)

Mail: U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

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

This notice is available at: <https://www.uhc.com/legal/nondiscrimination-and-language-assistance-notice>.

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請注意：如果您說中文 (Chinese - Traditional)，您可以獲得免費語言協助服務和大字體等其他格式的免費通訊。請致電您的會員身份卡上的免付費電話號碼。

AHVLLA: Hvsh asha **Chahta** anumpa (**Choctaw**), hochefo anumpa aiimpa kayvfi kiyo chi aiimpa, ilvppvt, haknip achuffa holisso kanahpesa holhtina kiyo, ilvmmito yvt chipisachi. Chipisachi hochefo kanahpesa holhtina i holisso illakmvt.

Asinei ngeni meininis: Ika pwe ka fos **Chuuk** (**Chuukese**), angangen anininis fosun fonu ese wor momon me pwan kakapas fengen ese wor momor non pwan ekkoch sakkun maak kena, usun chok watten maak, ra kan kaworeno ngonuk. Kori ewe nampa ese wor momon won noumuwe aiititin katon chon non.

PID: Naye guel ë Thuonjäŋ (**Dinka**), akuɔɔny ke thok kāk abac ku jemjiem abac to̞dhēl kōk yic, cīmēnē kāci go̞t dīt nyiīn, atɔ̞tēlon yin. Yuɔ̞p rākāmā ë majan to̞ kændun akut kōū.

LET OP: Als u **Nederlands (Dutch)** spreekt, zijn gratis taalondersteuningsdiensten en gratis communicatie in andere formaten, zoals met grote letters, voor u beschikbaar. Bel het gratis telefoonnummer dat op uw lidmaatschapskaart staat.

توجه: اگر به زبان فارسی (**Farsi**) صحبت می‌کنید، خدمات رایگان کمک زبانی و ارتباطات رایگان در قالب‌های دیگر، مانند چاپ بزرگ، در دسترس شما هستند. با شماره رایگان مندرج روی کارت شناسایی عضویت‌تان تماس بگیرید.

ATTENTION: Si vous parlez **français (French)**, des services d'assistance linguistique et des communications dans d'autres formats, notamment en gros caractères, sont mis à votre disposition gratuitement. Appelez le numéro gratuit figurant sur votre carte de membre.

HAKILU: So ada haala **Fulfulde (Fulani)**, sarwisaaɗi ballondiral demɗe ɗe njobetaake e jokkondiral ɗe njobetaake e nder mbaydiiji godɗi, ko wayi no binndi mawɗi, na ngoodi e juude maa. Noddu limoore nde njobataa e kartal tergal maa.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlose Sprachassistenzen und kostenlose Kommunikation in anderen Formaten, wie zum große Schrift, zur Verfügung. Rufen Sie die gebührenfreie Nummer auf Ihrer Mitgliedskarte an.

ΠΡΟΣΟΧΗ: Εάν μιλάτε **Ελληνικά (Greek)**, υπάρχουν διαθέσιμες δωρεάν υπηρεσίες γλωσσικής βοήθειας και δωρεάν επικοινωνία σε άλλες μορφοποιήσεις, όπως μεγάλα γράμματα. Καλέστε τον χωρίς χρέωση αριθμό στην κάρτα μέλους σας.

ધ્યાન આપો: જો તમે **ગુજરાતી (Gujarati)** બોલતા હો તો વનિ મૂલ્યે ભાષાકીય મદદરૂપ સેવાઓ અને અન્ય ફોર્મેટમાં વનિ મૂલ્યે સંચાર, જેમ કે મોટી પ્રિન્ટ, તમારા માટે ઉપલબ્ધ છે. તમારા સભ્ય ઓળખ કાર્ડ પરના ટોલ-ફ્રી નંબર પર કોલ કરો.

ATANSYON: Si w pale **Kreyòl Ayisyen (Haitian Creole)**, gen sèvis lang gratis ak kominikasyon nan lòt fòm lo disponib, tankou sa ki enprime ak gwo lèt. Rele nimewo gratis ki sou kat idantifikasyon manm ou an.

MALIU MAI! Inā ‘ōlelo ‘oe i ka ‘**ōlelo Hawai‘i (Hawaiian)**, loa‘a manuahi ke kōkua unuhi a me palapala i ho‘onohonoho ‘ia e like me i pa‘i ‘ia me nā huapalapala nūnui no ke kōkua ‘ana aku iā ‘oe. ‘Olu‘olu e kāhea aku i ka helu kelepona kāki ‘ole ma kou kāleka lālā.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते हैं, तो आपके लिए मुफ्त भाषा सहायता सेवाएँ और अन्य प्रारूपों में मुफ्त संचार, जैसे कबिड़े प्रिंट, उपलब्ध हैं। अपने सदस्य पहचान पत्र पर दिए गए टोल-फ्री नंबर पर कॉल करें।

LUS TSEEM CEEB: Yog tias koj hais **lus Hmoob (Hmong)**, cov kev pab cuam lus pub dawb thiab kev sib txuas lus dawb hauv lwm hom ntawv, xws li luam ntawv loj, muaj rau koj. Thov hu rau tus xov tooj hu dawb ntawm koj daim npav ID.

GEE NTI: Ọ bụrụ na ị na-asụ **asụsụ Igbo (Igbo)**, ọrụ enyemaka nkọwa asụsụ bụ n'efu yana inye nziritaozi n'ụdị ndị ọzọ dịjiri gi n'efu, dika e ji nha mkpụrụedemede buru ibu dee ya. Kpọọ akara ekwenti nke a na-anaghi akwụ ụgwọ di na kaadi njirimara onye otu gi.

PANANGIKASO: No agsasaoka iti Ilocano (Ilocano) , magun-odmo dagiti libre a serbisio ti tulong iti pagsasao ken libre a komunikasion iti dadduma a pormat, kas iti dadakkel a letra. Tawagan ti awan-bayadna a numero a masarakan iti kard a pakabigbigam kas miembro.
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ATTENZIONE: Se parla italiano (Italian) , può usufruire di servizi di assistenza linguistica gratuiti e comunicazioni gratuite in altri formati, come ad esempio la stampa a caratteri grandi. Chiami il numero verde riportato sul Suo tesserino identificativo.
注意事項： 日本語（ Japanese ）を話される場合、無料の言語支援サービスや、拡大文字など他の形式での無料コミュニケーションをご利用いただけます。[]にお電話ください。
ဟ်သူၣ်ဟ်သးတက့ၢ်-န့ၣ်မ့ၢ်စံးကတိၤကညိၣ်ကိၣ် (Karen) န့ၣ်,နဒိးန့ၣ်တၢ်တိၤစၢၤမၤစၢၤဘၣ်သးဒီးကိၣ်တၢ်ကတိၤဒီးတၢ်ဆဲးကျဲၤဆဲးကျိးလၢက့ၢ်ဂီၤအဂၤ,အဒိဒ်သိးလံာ်မဲၢ်ဖျါၣ်အဒိၣ်တဖၣ်လၢအဘူးလဲကလီၤသ့န့ၣ်လီၤ.ကိးဘၣ်လီၤကိၣ်အကလီၤနီၣ်ဂံၢ်လၢအိၣ်ဖျါဖဲကရူၢ်ဖိအတၢ်အုၣ်ကီၤကးက့အပူၤန့ၣ်တက့ၢ်.
ICITONDERWA: Nimba uyaga Ikirundi (Kirundi) , serevise y'ugufasha mu ndimi utariha n'itumanako mu bundi buryo, nk'ibicapo binini, wobironka. Tera akamo umuronko utariha ku bijanye n'ikarata yawe karanga y'umunyamuryango.
알림사항: 한국어(Korean) 를 사용하시는 경우 무료 언어 지원 서비스와 대형 활자체 등 다른 형식으로 된 의사 소통 매체를 이용하실 수 있습니다. 회원 ID 카드에 나와 있는 무료 전화번호로 전화해 주십시오.
ئاگاداری: ئمگەر تو به زمانی کوردی سۆرانی (Kurdish Sorani) قسه دهکهیت، ئهوه خزمهتگوزاری سیمبارهت به هاوکاری زمانی و پهیوهندیی به فۆرماتێکانی تر، وەک چاپی گموره، به بێبهرامبهر لهبهر دهست دادهبێت. پهیوهندی به ژماره تلهفونی بێبهرامبهرهکهی سهر کارتی ئهندهمائی خۆت بکه
ໝາຍເຫດສຳຄັນ: ຖ້າທ່ານເວົ້າພາສາລາວ (Lao), ພວກເຮົາມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາພຣີແລະ ການສື່ສານພຣີໃນຮູບແບບອື່ນໆໃຫ້ແກ່ທ່ານ, ເຊັ່ນ: ການພິມຂະໜາດໃຫຍ່. ໂທຫາເບີໂທພຣີທຶບັດປະຈຳຕົວສະມາຊິກຂອງທ່ານ.
लक्ष दया: जर तुम्ही मराठी (Marathi) बोलत असल्यास, तर मोफत भाषा सहाय्य सेवा आणडितर फॉर्मॅटमध्ये मोफत संप्रेषणे, जसे की मोठ्या प्रटि, तुमच्यासाठी उपलब्ध आहेत. तुमच्या सदस्य ओळखपत्रावरील टोल फ्री क्रमांकावर कॉल करा.
Nan: Ñe kwōj kenono Kajin Majol (Marshallese) , jibañ ko kōm maron im ejellok wonneir einwōt ukok im bōk melele ilo wāween ko jet, einwōt jeje ko relab, Kall ae nomba eo ejellok wonnen ebed itulikin kaat eo am.
BAA'ÁKONÍNÍZIN: Diné (Navajo) saad bee yáníłti'go, t'áá jíík'eh saad bee áka'e'eyeed bee áka'anída'wo'í dóó nááná łahgo át'éego bee hadadilyaa bee ahił hane'í, díí nitsaago bee ak'eda'ashchínígíí, náhóló. Bee atah nil'íní ninaaltsoos nitł'izí bee nééhoziní bąąh t'áá hiik'eh bee hane'í námboo bee hodíilnih.
ध्यान दनिहोस्: यदि तपाईंले नेपाली (Nepali) बोलनुहुन्छ भने, नःशिल्क भाषा सहायता सेवाहरू र अन्य ढाँचाहरूमा नःशिल्क संचारहरू, जस्तै ठूलो छाप, तपाईंका लागि उपलब्ध छन्। आफ्नो सदस्य पहिचान कार्डमा रहेको टोल फ्री नम्बरमा कल गर्नुहोस्।
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โปรดทราบ หากคุณพูดไทย (Thai) ได้ คุณสามารถใช้บริการช่วยเหลือด้านภาษาฟรีและการสื่อสารในรูปแบบอื่น ๆ ฟรี เช่น การพิมพ์ด้วยตัวอักษรขนาดใหญ่ โทรไปยังหมายเลขโทรฟรีสำหรับสมาชิกตามบัตรประจำตัวของคุณ

FAKATOKANGA: Kapau ‘oku ‘ke Lea Faka-Tonga (Tongan), ‘oku ‘i ‘ai ‘a e ngaahi tokoni ta‘etotongi ‘i he lea ‘ni pea mo e ngaahi founa kehe fakafetu‘utaki, hangē ko e ngaahi me‘a ‘oku paaki, ‘oku ‘ataa’ ma‘au. Fetu‘utaki ki he telefoni ta‘etotongi ‘oku hā ho kaati memipa.
DİKKAT: Türkçe (Turkish) konuşuyorsanız ücretsiz dil yardım hizmetlerinden ve büyük puntolu baskı gibi diğer formatlarda ücretsiz iletişimlerden yararlanabilirsiniz. Üye kimlik kartınızdaki ücretsiz hattı arayın.
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ÀKÌYÈSÍ: Tí o bá ń sọ Yorùbá (Yoruba), àwọn iṣẹ̀ àtìlẹ̀yìn èdè ọ̀fẹ́ àti àwọn ìbáńsọ̀rọ̀ nínú àwọn ìgúnrégé, bí àwọn àtẹ̀lẹ́jádẹ̀ ńlá, wà fún ọ. Pe nọmbà tí kò nílò owó lórí kààdì ìdánimọ̀ ọmọ egbẹ̀ rẹ.