



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 1-888-200-0325 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 <u>deductible</u> ?	Network: \$7,850 Individual / \$15,700 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Benefits available with no charge such as <u>Network Preventive care</u> services are covered before you meet your deductible. The <u>cost-sharing</u> below indicates whether the deductible applies for each benefit	This plan covers some items and services even if you haven't yet met the deductible amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your deductible. See a list of covered <u>preventive services</u> at healthcare.gov/coverage/preventive-care-benefits .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this plan?	Network: \$10,600 Individual / \$21,200 Family	The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, <u>balance-billing</u> charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See uhc.com/xildocfindoa2026 or call 1-888-200-0325 for a list of <u>network providers</u> .	This plan uses a <u>provider network</u> . You will pay less if you use a provider in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your plan pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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	\$30 <u>copay</u> /visit, <u>deductible</u> does not apply	Not Covered	None
	<u>Specialist</u> visit	40% <u>coinsurance</u>	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: 40% <u>coinsurance</u> Hospital: 50% <u>coinsurance</u>	Not Covered	None
	Imaging (CT/PET scans, MRIs)	Free Standing/Office: 40% <u>coinsurance</u> Hospital: 50% <u>coinsurance</u>	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/xildruglist2026	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 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.
	Tier 2 – Preferred Generic	\$10 <u>copay</u> /prescription, <u>deductible</u> does not apply	Not Covered	
	Tier 3 - Preferred Brand	\$200 <u>copay</u> /prescription, <u>deductible</u> does not apply	Not Covered	
	Tier 4 – Non-Preferred Brand	\$400 <u>copay</u> /prescription, <u>deductible</u> does not apply	Not Covered	
	Tier 5 - Specialty	\$500 <u>copay</u> /prescription, <u>deductible</u> does not apply	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
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				Insulin products listed as Tier 1 on the <u>Prescription Drug List</u> are covered at No Charge at a <u>network</u> pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% <u>coinsurance</u>	Not Covered	None
	Physician/surgeon fees	Free Standing/Office: 40% <u>coinsurance</u> Hospital: 50% <u>coinsurance</u>	Not Covered	None
If you need immediate medical attention	<u>Emergency room care</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Emergency medical transportation</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Urgent care</u>	\$75 <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)	40% <u>coinsurance</u>	Not Covered	None
	Physician/surgeon fees	40% <u>coinsurance</u>	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: 40% <u>coinsurance</u> , <u>deductible</u> does not apply Intensive Outpatient: 40% <u>coinsurance</u> Partial Hospitalization: 40% <u>coinsurance</u> All Other Outpatient: 40% <u>coinsurance</u>	Not Covered	None
	Inpatient services	40% <u>coinsurance</u>	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> .
	Childbirth/delivery professional services	40% <u>coinsurance</u>	Not Covered	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 facility services	40% <u>coinsurance</u>	Not Covered	
If you need help	<u>Home health care</u>	40% <u>coinsurance</u>	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)	
recovering or have other special health needs	<u>Rehabilitation services</u>	40% <u>coinsurance</u>	Not Covered	Limits/year: Physical, Occupational, Speech, Cardiac, Pulmonary: Unlimited visits each
	<u>Habilitative services</u>	40% <u>coinsurance</u>	Not Covered	Limits/year: Physical, Speech, Occupational: Unlimited visits each
	<u>Skilled nursing care</u>	40% <u>coinsurance</u>	Not Covered	None
	<u>Durable medical equipment</u>	40% <u>coinsurance</u>	Not Covered	None
	<u>Hospice services</u>	40% <u>coinsurance</u>	Not Covered	None
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Limited to 1 exam/12 months.
	Children's glasses	40% <u>coinsurance</u>	Not Covered	Limited to 1 pair/12 months.
	Children's dental check-up	No Charge	Not Covered	Limited to 1 visit/6 months.

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
• Acupuncture	• 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
• Dental care (Adult)	• Routine eye care (Adult)	
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
• Abortion	• Chiropractic (manipulative) care - 25 visits/year	• Infertility treatment - cycle limits may apply
• Bariatric surgery	• Hearing aids - 1 per hearing impaired ear /3 years	• Private-duty nursing - home health care only

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 of Illinois, Inc. at 1-888-200-0325 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 Illinois Department of Insurance Consumer Services Section, Chicago Office: 122 S. Michigan Ave., 19th Floor, Chicago, IL 60603, Springfield Office: 320 W. Washington Springfield, IL 62767, 1-877-527-9431 or doi.illinois.gov 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 Illinois Department of Insurance Consumer Services Section, at 1-877-527-9431 or doi.illinois.gov.

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 1-888-200-0325

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-200-0325

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-200-0325

Navajo (Dine): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-200-0325

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	\$7,850
■ Specialist coinsurance	40%
■ Hospital (facility) coinsurance	40%
■ Other coinsurance	40%

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
In this example, Peg would pay:	
<i>Cost Sharing</i>	
Deductibles	\$7,850
Copayments	\$200
Coinsurance	\$800
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$8,910

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$7,850
■ Specialist coinsurance	40%
■ Hospital (facility) coinsurance	40%
■ Other coinsurance	40%

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
In this example, Joe would pay:	
<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$700

Mia's Simple Fracture

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

■ The plan's overall deductible	\$7,850
■ Specialist coinsurance	40%
■ Hospital (facility) coinsurance	40%
■ Other coinsurance	40%

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
In this example, Mia would pay:	
<i>Cost Sharing</i>	
Deductibles	\$2,600
Copayments	\$70
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,670

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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-notices>.

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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 aiitiṭin katon chon non.
PID: Naye guel ë Thuonjān (Dinka), akuṛony ke thok kāk abac ku jemjiem abac to'dhēl kōk yic, cīmēnē kāci gōt dīt nyiīn, atō'tēlon yin. Yuṛp rākāmā ë majan to' kēndun akut kōū.
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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.
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GEE NTI! O buri na i na-asu asusu Igbo (Igbo) , oru enyemaka nkwa asusu bu n'efu yana inye nziritaozi n'udi ndi ozọ diiri gi n'efu, dike e ji nha mkpuru edemede buru ibu dee ya. Kpoo akara ekwenti nke a na-anaghi akwu ugwo di na kaadi njirimara onye otu gi.
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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، ئموه خزمهتگوزاری سمبارهت به هاوکاری زمانی و پهیوهندیی به فۆرماتهکانی تر، وەک چاپی گموره، به بێبهرامبهر لهبهر دهست دادهبێت. پهیوهندی به ژماره تلهفونی بێبهرامبهرهکهی سهر کارتی ئهندامتی خۆت بکه
ໝາຍເຫດສຳຄັນ: ຖ້າທ່ານເວົ້າ ພາສາລາວ (Lao) , ພວກເຮົາມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາພຣີແລະ ການສື່ສານພຣີໃນຮູບແບບອື່ນໆໃຫ້ແກ່ທ່ານ, ເຊັ່ນ: ການພິມຂະໜາດໃຫຍ່. ໃຫຫາເບີໂທພຣີຢູ່ຫົວໜ້າຂອງທ່ານ.
लक्ष दया: जर तुम्ही मराठी (Marathi) बोलत असल्यास, तर मोफत भाषा सहाय्य सेवा आणइतर 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 itulik in 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, náhólǫ́. 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।
OBS: Hvis du snakker norsk (Norwegian) , er gratis språkhjelpstjenester og gratis kommunikasjon i andre formater, for eksempel stor skrift, tilgjengelig for deg. Ring gratisnummeret som du finner på medlemskortet ditt.
XIYYEEFFANNOO: Yoo Afaan Oromoo (Oromo) dubbattu ta'e, tajaajilootni deeggarsa afaanii bilisaa fi waliin dubbiin bilisaa kan akka maxxansa gurguddaa afaan keessaniin ni jiraatu. Lakkoofsa bilbila bilisaa kaardii miseensummaa keessan irra jiru irratti bilbilaa.
GEB ACHT: Wann du Deutsch (Pennsylvania Dutch) schwetzscht, Schprooch Hilfe mitaus Koscht un Communications in annere Formats wie groosse Druck iss meeglich. Ruf die koschdelos Nummer uff dei Member Identification Kaart.
PAKAIR: Mah ke ese lokaian Pohnpei (Pohnpeian) , sahpis en sawas en lokaia oh mehn kapehse ni soangen mwohmw teikan kin sohte isepe, me duwehte inting lapala, kak kohda ohng kowe. Eker nempe ni sohte isepe me mih pohn noumw doaropwehn tohn pwi hn ID.

UWAGA: Dla osób mówiących po **polsku (Polish)** dostępne są bezpłatne usługi pomocy językowej i bezpłatne komunikaty w innych formatach, takich jak duży druk. Prosimy zadzwonić pod bezpłatny numer podany na karcie identyfikacyjnej.

ATENÇÃO: se você fala **português (Portuguese)**, tem à sua disposição serviços gratuitos de assistência linguística e comunicações gratuitas em outros formatos, como caracteres grandes. Ligue para o número gratuito que se encontra no seu cartão de identificação de membro.

ਧਿਆਨ ਦਫਿ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ (Punjabi) ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਅਤੇ ਹੋਰ ਫਾਰਮੈਟਾਂ, ਜਿਵੇਂ ਕਿ ਵੱਡੇ ਪ੍ਰਗਟ, ਵੱਧ ਮੁਫਤ ਸੰਚਾਰ ਉਪਲਬਧ ਹਨ। ਆਪਣੇ ਮੈਂਬਰ ਪਛਾਣ ਕਾਰਡ 'ਤੇ ਟੋਲ-ਫਰੀ ਨੰਬਰ 'ਤੇ ਕਾਲ ਕਰੋ।

ATENȚIE: Dacă vorbiți limba **română (Romanian)**, vă sunt disponibile servicii gratuite de asistență lingvistică și modalități gratuite de comunicare în alte formate, cum ar fi cu litere mărite. Apelați la numărul gratuit de pe legitimația dvs. de membru.

ВНИМАНИЕ: Если вы говорите на **русском** языке (**Russian**), вам доступны бесплатные услуги языковой поддержки и бесплатные материалы в других форматах, например, напечатанные крупным шрифтом. Звоните по бесплатному номеру телефона, указанному на вашей идентификационной карте участника.

FA'AALIGA: Afai e te tautala i le **Faa-Samoa (Samoan)**, o lo'o avanoa mo oe 'au'aunaga fesoasoani tau gagana e leai se totogi ma feso'ota'iga e leai se totogi i isi faiga, e pei o lomiga e lapopo'a mata'itusi. Valaau i le numera e leai se totogi i lau kata faailo o le sui auai (ID).

PAŽNJA: Ako govorite **srpski (Serbian)**, dostupne su vam besplatne usluge jezičke asistencije i besplatni načini komunikacije u drugim formatima, kao što je veliki format štampe. Pozovite besplatni broj koji se nalazi na vašoj članskoj identifikacionoj kartici.

FIIRO GAAR AH: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda bilaashka ah iyo isgaarsiino bilaash ah oo qaabab kale ah, sida far waaweyn, ayaa diyaar kuu ah. Ka wac lambarka wicitaanka bilaashka ah kaarkaaga aqoonsiga xubinta.

ZINGATIA: Ikiwa unazungumza **Kiswahili (Swahili)**, huduma za usaidizi wa lugha za bila malipo na mawasiliano ya bila malipo katika miundo mingine, kama vile maandishi makubwa, zinapatikana kwako. Piqa nambari isiyolipishwa ya simu kwenye kadi yako ya kitambulisho cha mwanachama.

[illegible]

PAUNAWA: Kung nagsasalita ka **ng Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika at libreng komunikasyon sa ibang mga format, tulad ng malalaking print. Tawagan ang walang bayad na numero na nasa iyong ID card ng miyembro.

శ్రీరదీధ: మేరు **తెలుగు (Telugu)** మాట్లాడేవరైతే, మేకు ఉచిత భష సహాయ నేవలు మరియు పిదద ముద్రణ వంటి ఇతర ఫర్మాట్లలో కమ్యూనికేషన్లు ఉచితంగా లభిస్తాయ్. మే మంబరు ఐడింటిఫికేషన్ కరెడ్డులోని టోల్-ఫ్రీ నంబరుకి కల్ చేయండి.

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.

УВАГА: Якщо ви розмовляєте **українською (Ukrainian)**, вам надаються безкоштовні мовні послуги та безкоштовні повідомлення в інших форматах, наприклад, крупним шрифтом. Зателефонуйте за безкоштовним номером телефону, позначеним на Вашій ідентифікаційній картці.

زبان بولتے ہیں تو آپ کے لیے زبان کی معاون خدمات اور دیگر فارمیٹ میں مفت مواصلات، جیسے بڑے پرنٹ، آپ کے لیے دستیاب ہیں۔ اپنے (Urdu) توجہ دیں: اگر آپ اردو ممبر شناختی کارڈ پر دیئے گئے ٹول فری نمبر پر کال کریں۔
LƯU Ý: Nếu quý vị nói Tiếng Việt (Vietnamese), quý vị sẽ được cung cấp các dịch vụ hỗ trợ ngôn ngữ miễn phí và các phương tiện trao đổi liên lạc miễn phí ở các định dạng khác, chẳng hạn như bản in chữ lớn. Gọi đến số điện thoại miễn phí có trên thẻ nhận dạng thành viên của quý vị.
ATENSYON: Kung ang imong sinultihan kay Visayan (Visayan), libre nga mga serbisyo sa tabang sa pinulongan ug libre nga komunikasyon sa ubang mga pormat, sama sa dagkong print, available kanimo. Tawage ang toll-free nga numero sa imong identipikasyon nga kard sa miyembro.
אכטונג: אויב איר רעדט אידיש (Yiddish), אומזיסטע שפראך הילף סערוויסעס און אומזיסטע קאמיוניקאציע אין אנדערע פארמאטן, ווי גרויסע אותיות זענען אוועילעבל פאר אייך. רופט די טאל פרייע נומער אויף אייער מעמבער אידענטיפיקאציע קארטל .
ÀKÌYÈSÍ: Tí o bá ń sọ Yorùbá (Yoruba), àwọn iṣẹ̀ àtìlẹ̀yìn èdè ọ̀fẹ́ àti àwọn ìbáńsọ̀rọ̀ nínú àwọn ìgúnrégé, bí àwọn àtẹ̀jádẹ̀ nílá, wà fún ọ. Pe nọmbà tí kò nílò owó lórí kààdì ìdánimọ̀ ọmọ egbé ẹ.