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 us at 1-855-453-0435. 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 https://member.brighthealthplan.com or call 1-855-453-0435 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$4,700 Individual or \$9,400 Family	Generally, you must pay all of the costs from <u>providers</u> up to the deductible amount before this <u>plan</u> begins to pay.
Are there services covered before you meet your deductible?	Yes. Primary Care, Urgent Care, some Prescription Drugs, and Pediatric Dental and Vision are covered before the deductible.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits.
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	\$8,150 Individual or \$16,300 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services.
What is not included in the <u>out-of-pocket limit?</u>	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 <u>network provider</u> ?	Yes. See https://member.brighthealthplan.c om/providers or call 1-855-453- 0435 for a list of network providers .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> 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 provider's charge and what your <u>plan</u> 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> .

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

Common		What Yo	ou Will Pay	Limitations, Exceptions, & Other	
Medical Event	Services You May Need	Network Provider (You will pay the least) (You will pay the most)		Important Information	
If you visit a health	Primary care visit to treat an injury or illness	\$40 copay/visit	Not Covered	None	
care <u>provider's</u> office	Specialist visit	40% coinsurance	Not Covered	None	
or clinic	Preventive care/screening/immunization	\$0 copay/visit	Not Covered	None	
If you have a test	Diagnostic test (x-ray, blood work)	40% coinsurance	Not Covered	None	
	Imaging (CT/PET scans, MRIs)	40% coinsurance	Not Covered	Services require pre-authorization.	
If you need drugs to treat your illness or	Generic drugs	\$15 copay/prescription	Not Covered	Covers up to a 30-day supply (retail	
condition	Preferred brand drugs	40% coinsurance	Not Covered	prescription); 31-90 day supply (mail order	
More information about	Non-preferred brand drugs	40% coinsurance	Not Covered	prescription).	
prescription drug coverage is available at https://member.brighthe althplan.com	Specialty drugs	\$680 copay/prescription	Not Covered	Copay shown is per retail prescription. Mail Order cost is 2.5 times the Retail cost.	
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	40% coinsurance	Not Covered	Services require pre-authorization.	
surgery	Physician/surgeon fees	40% coinsurance	Not Covered	Services require pre-authorization.	
	Emergency room care	40% coinsurance	40% coinsurance	None	
If you need immediate medical attention	Emergency medical transportation	40% coinsurance	40% coinsurance	None	
	Urgent care	\$75 copay/visit	Not Covered	None	
If you have a hospital	Facility fee (e.g., hospital room)	40% coinsurance	Not Covered	Services require pre-authorization.	
stay	Physician/surgeon fees	40% coinsurance	Not Covered	Services require pre-authorization.	
If you need mental health, behavioral	Outpatient services	40% coinsurance	Not Covered	None	
health, or substance abuse services	Inpatient services	40% coinsurance	Not Covered	Services require pre-authorization.	

^{*} For more information about limitations and exceptions, see the plan or policy document at https://member.brighthealthplan.com

Common		What Y	ou Will Pay	Limitations, Exceptions, & Other	
Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information	
	Office visits	40% coinsurance	Not Covered	None	
If you are pregnant	Childbirth/delivery professional services	40% coinsurance	Not Covered	Delivery stays exceeding 48 hours for vaginal delivery or 96 hours for a cesarean delivery	
	Childbirth/delivery facility services	40% coinsurance	Not Covered	require pre-authorization.	
	Home health care	40% coinsurance	Not Covered	Services require pre-authorization.	
If you need belo	Rehabilitation services	40% coinsurance	Not Covered	Limited to 30 visits combined between speech, occupational, and physical therapy. Visit limit does not apply to therapies for the treatment of autism. Services require pre-authorization.	
If you need help recovering or have other special health needs	Habilitation services	40% coinsurance	Not Covered	Limited to 30 visits combined between speech, occupational, and physical therapy. Visit limit does not apply to therapies for the treatment of autism. Services require pre-authorization.	
	Skilled nursing care	40% coinsurance	Not Covered	Limited to 100 days per year. Services require pre-authorization.	
	Durable medical equipment	40% coinsurance	Not Covered	Services require pre-authorization.	
	Hospice services	40% coinsurance	Not Covered	Services require pre-authorization.	
	Children's eye exam	\$0 copay/visit	Not Covered	Limited to 1 exam per year for members up to the end of the month in which they turn 19.	
If your child needs dental or eye care	Children's glasses	No charge up to the provider's contracted amount.	Not Covered	Limited to 1 pair of glasses, including standard frames and standard lenses or contact lenses, every year for members up to the end of the month in which they turn 19.	
	Children's dental check-up	\$0 copay/visit	\$0 copay/visit	Includes diagnostic and preventive services for members up to the end of the month in which the member turns 19. Refer to the Certificate of Coverage for covered services and limitations.	

^{*} For more information about limitations and exceptions, see the plan or policy document at https://member.brighthealthplan.com

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.)

- Abortion (except in cases of rape, incest, or when the life of the mother is endangered)
- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adults)

- Hearing Aids
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private-duty Nursing
- Routine eye care (Adults)
- Routine foot care
- Weight loss programs

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

Chiropractic Care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. You may contact your state insurance department at 334-241-4141 or via FAX 334-956-7932 or email at ConsumerServices@insurance.alabama.gov. Other coverage options may be available to you too, including buying individual insurance coverage through Healthcare.gov. For more information about Healthcare.gov, visit www.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 <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact Bright Health at <u>www.brighthealthplan.com</u> or 1-855-453-0435.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

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 1-855-453-0435.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-453-0435.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-453-0435.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-453-0435.

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

^{*} For more information about limitations and exceptions, see the plan or policy document at https://member.brighthealthplan.com

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)

Managing Joe's type 2 Diabetes

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

Mia's Simple Fracture

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

The	<u>plan's</u>	overa	ıll (<u>deductible</u>	
Spec	cialist	copay	m	ent	

40% ■ Hospital (facility) coinsurance 40% 40%

Other coinsurance

■ The	<u>plan's</u>	overall	<u>deductible</u>
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■ Specialist copayment

■ Hospital (facility) coinsurance

Other coinsurance

\$4.700

The	plan's	overall	deductible	\$4,	700

■ Specialist copayment 40%

■ Hospital (facility) coinsurance 40%

Other coinsurance 40%

This EXAMPLE event includes services like:

Specialist office visits (prenatal care) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (ultrasounds and blood work)

Specialist visit (anesthesia)

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)

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

Diagnostic test (x-ray)

\$4.700

40%

40%

40%

Durable medical equipment (crutches)

Rehabilitation services (physical therapy)

Total Example Cost \$12,800

In this example, Peg would pay:

Cost Sharing				
Deductibles	\$3,190			
Copayments	\$0			
Coinsurance	\$4,960			
What isn't covered				
Limits or exclusions	\$60			
The total Peg would pay is	\$8,210			

In this example, Joe would pay:

Cost Sharing				
Deductibles	\$3,430			
Copayments	\$790			
Coinsurance	\$2,290			
What isn't covered				
Limits or exclusions	\$60			
The total Joe would pay is	\$6,570			

Total Example Cost \$1,925

In this example Mia would nave

ili tilis example, ilila would pay	ili tilis example, illa would pay.			
Cost Sharing				
Deductibles	\$1,160			
Copayments	\$0			
Coinsurance	\$765			
What isn't covered				
Limits or exclusions				
The total Mia would pay is \$1,925				



Nondiscrimination Notice and Assistance with Communication

Bright Health does not exclude, deny benefits to, or otherwise discriminate against any individual on the basis of sex, age, race, color, national origin, or disability. "Bright Health" means Bright Health plans and their affiliates, which are listed below.

Language assistance and alternate formats:

Assistance is available at no cost to help you communicate with us. Services include, but are not limited to:

- Interpreters for languages other than English;
- Written information in alternative formats such as large print; and
- Assistance with reading Bright Health websites.

To ask for help with these services, please call the Member Services number on your member ID card.

If you think that we failed to provide language assistance or alternate formats, or you were discriminated against because of your sex, age, race, color, national origin, or disability, you can send a complaint to:

Bright Health Civil Rights Coordinator
Bright Health
P.O. Box 16275
Reading, PA 19612-6275
Phone: (844) 202-2154
Email: OAG@brighthealthplan.com

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

- 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

If you need help with your complaint, please call the Member Services number on your member ID card. You must send the complaint within 60 days of discovering the issue.

Language Assistance and Alternate Formats

This information is available in other formats like large print. To ask for another format, please call the Member Services number on your member ID card.



Language Assistance and Alternate Formats

This information is available in other formats like large print. To ask for another format, please call the Member Services number on your member ID card.

English ATTENTION: If you speak a language other than English, language assistance services, free

of charge, are available to you. Call the Member Services number on your ID card.

Arabic

انتباه: إذا كنت تتحدث لغة غير الإنجليزية، فخدمات المساعدة اللغوية متاحة من أجلك، دون تكلفة. اتصل برقم خدمات الأعضاء الموجود على بطاقة تعريف الهوية الخاصة بك.

Chinese (S) 注意:如果您使用的语言并非英语,则可获得免费的语言协助服务。请拨打身份证上

的会员服务号码。

French ATTENTION: Si vous parlez une autre langue que l'anglais, des services d'assistance

linguistique sont mis gratuitement à votre disposition. Appelez le numéro des services aux

membres figurant sur votre carte d'identification.

German ACHTUNG: Falls Sie eine andere Sprache als Englisch sprechen, steht Ihnen eine kostenfreie

fremdsprachliche Unterstützung zur Verfügung. Wählen Sie die Mitgliederservice-Nummer auf

Ihrer ID-Karte.

Greek ΠΡΟΣΟΧΗ: Αν μιλάτε κάποια γλώσσα διαφορετική από τα Αγγλικά, παρέχονται δωρεάν

υπηρεσίες γλωσσικής βοήθειας. Καλέστε τον αριθμό του Τμήματος Υπηρεσιών Μέλους

(Member Services) που αναγράφεται στην ταυτότητά σας (ID card).

Italian ATTENZIONE: se parla una lingua diversa dall'inglese, sono disponibili servizi di

assistenza linguistica gratuiti. Chiami il numero Member Services che trova sulla Sua tessera

identificativa.

Japanese ご注意:英語以外の言語を話される場合は、無料の言語支援サービスをご利用いただ

けます。IDカードに記載されているメンバーサービスの番号までお電話ください。

Korean 주의: 영어가 아닌 다른 언어를 사용할 경우 무료 언어 지원 서비스를 이용하실 수

있습니다. 신분증에 기재된 회원 서비스 번호로 연락하십시오.

Polish UWAGA: Jeśli nie mówisz po angielsku, możesz skorzystać z darmowych usług

tłumaczeniowych. Zadzwoń na numer obsługi podany na twojej karcie identyfikacyjnej.

Portuguese ATENÇÃO: Se falar um idioma que não o inglês, estão disponíveis serviços gratuitos de

assistência de idioma para si. Contacte o número de serviços para membros no seu cartão de

identificação.

Russian ВНИМАНИЕ: если вы не говорите на английском языке, вы можете воспользоваться

бесплатными услугами языковой поддержки. Позвоните в Отдел обслуживания участников программы по телефону, указанному на вашей идентификационной

карточке.

Spanish (US) ATENCIÓN: Si no habla inglés, tiene a su disposición servicios gratuitos de asistencia

lingüística. Comuníquese al número de Servicios para miembros que figura en su tajeta de ID.

Tagalog PAALALA: Kung nagsasalita ka ng isang wika bukod sa Ingles, magagamit mo ang mga

serbisyong tulong sa wika nang walang bayad. Tumawag sa numero ng Member Services na

nasa iyong ID card.



Urdu

توجہ دیں: اگر آپ انگریزی کے علاوہ کوئی اور زبان بولتے ہیں تو آپ کیلئے زبان کی معاونت کی خدمات مفت دستیاب ہیں۔ اپنے ID کارڈ پر موجود اراکین کی خدمات کے نمبر پر کال کریں۔

Vietnamese CHÚ Ý: Nếu bạn nói một thứ tiếng nào khác ngoài tiếng Anh, bạn sẽ được cấp các dịch vụ

hỗ trợ ngôn ngữ miễn phí. Gọi số Dịch vụ Hội viên trên Thẻ ID của bạn.

Navajo Shooh: Bilagáanaa bizaad doo doohts'a'góó, ata'hane', t'áá níík'eh, níká'adoojahígíí hóló.

Naaltsoos bee éédahózin bikáá' béésh bee hane' biká'ígíí bich'i' hodíílnih.

Amharic ማሳሰብያ: ከእንባሊዝኛ ውጪ የሆነ ቋንቋ የሚናንሩ ከሆነ ከክፍያ ነጻ የሆኑ የቋንቋ ድጋፍ አገልባሎሎችን ማባኘት

ይችላሉ፡፡ በመታወቂያ ላይ በሚገኝ የአባላት አገልባሎት ቁጥር ላይ ይደውሉ፡፡

Burmese သင္သသည္ အဂၤလိပ္စစကားမဟုတ္ေသာ အျခားဘာသာစကားတစ္ခုအား မျပာဆိုသူျဖစ္ပါက

ဘာသာစကားအခမဲ့ပံ့ပိုးသည္ ဝန္ေဆာင္မမႈအား သင္ရရရွိဳင္ပပါသည္။ သင္ ID (သက္ေသခံ)

ကတျပားပေၚရှိ အဖြဲြာင္မမ်ားဝန္ေဆာင္မမႈဌာနအား ဖုန္းခေၚဆိုပါ။

Cherokee of 0400t: FT SOHODY JOHOF BZ YPB, SOHJOOJ DPODSPODY TATO AJT, L

ALOJY GECCY PAR DACAL PHA KOOMLOJIL OOPAN WAS TO DEOLOGIA

 $J4\phi J$ O'OT GVP AC $\phi \Lambda J$ TO $\phi \phi J$.

Cushite-Oromo XIYYEEFFANNOO: Afaan Ingiliziin ala afaan kan biraa kan dubbattu yoo ta'e,

tajaajilliwwan gargaarsa afaanii, kan tolaa, siif ni jiru. Kaardii Waraqaa-eenyummeessaa

keerra kan jiru lakkoofsa Tajaajilawwan Miseensaatti bilbili.

French Creole ATANSYON : Si w pale yon lòt lang ke Angle, gen sèvis èd lengwistik ki disponib pou w

gratis. Rele nimewo Sèvis pou manm yo nan kat idantite w la.

Gujarti ધ્યાન આપો: જો તમે અંગ્રેજી સિવાયની અન્ય કોઈ ભાષા બોલો છો, તો તમારા માટે ભાષા

સહાય સેવાઓ નિ:શલ્ક ઉપલબ્ધ છે. તમારા આઈડી કાર્ડ પર રહેલા સદસ્થની સેવાઓનાં નંબર

પર ક્રૉલ કરો.

Hindi ध्यान दें: यदि आप अंग्रेजी के अलावा कोई अन्य भाषा बोलते हैं, तो आपके लिए म्फ़्त में

भाषा सहायता सेवाएं उपलब्ध हैं। आपके आईडी कार्ड पर दिए गए सदस्य सेवा नंबर पर

कॉल करें।

Hmong UA ZOO SAIB: Yog tias koj hais ib hom lus dhau ntawm lus As Kiv, muaj cov kev pab cuam

txhais lus uas tsis xam nqi dab tsi rau koj tau siv. Hu rau Lub Chaw Pab Cuam Tswv Cuab tus

nab npawb xov tooj nyob ntawm koj daim npav ID.

Karen တိုးနီဉ် – နမ္နာ်ကတီးကျိုာ်လာတမှုအဲ့ကလုံးကျိုာ်ဘဉ်နှဉ်, ကျိုာ်တာ်တိစားမာစားတာမာစားတဖဉ်, လာတလိဉ်ဟုဉ်အပူးတဖဉ်အိုဉ်လာနဂ်ိဳးနှဉ်

လီး. ကိုးကရာဖိတာ်မာစားတဖဉ် (နူနှာ်ဘနုမှနမလငှေနျ) အနိုဉ်က်စဲန တာ်အှဉ်သးနိုဉ်က်စားကုအဖိုခိုဉ်နှဉ်တကာ့်.

Kru / Bassa YI LE: I balè u mpot hop umpè èbes Ngissi, bot ba nhola ni kobol mahop bayé ha i nyuu yoñ,

ngui nsaa wogui wo. Sebel Ndap Mahola i nyuu Mbon i nsinga i yé ntilgaga munu i Kat yon i

Mbon.

Kurdish

ئاگادارى: ئەگەر بە زماننىكى ترى جگە ئە ئىنگلىزى قسە دەكەيت، خزمەتگوزاريە زمانەوانيەكان بەخۇرايى بۇ ئۆ بەدەستن. پەيوەندى بە ژمارەي خزمەتگوزارى ئەندامانى سەر ناسنامەكەت بىكە.



ໍໂປດຊາບ: ຖ້າທ່ານເວົ້າພາສາອື່ນນອກຈາກພາສາອັງກິດ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາທີ່ບໍ່ Laotian

ເສຍຄ່າແມ່ນມີພ້ອມໃຫ້ທ່ານ. ກະລຸນາໂທຫາ ໝາຍເລກການບໍລິການສະມາຊິກທີ່ຢູ່ເທິງ ບັດ ID

ຂອາທ່ານ.

ចាប់អារម្មណ៍៖ ប្រសិនបើលោកអ្នកនិយាយភាសាផ្សេង ក្រៅពីភាសាអង់គ្លេស នោះសេវា Mon-Khmer

ជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសម្រាប់លោកអ្នក។ សូមទូរស័ព្ទទៅលេខសេវាបម្រើ

សមាជិកដែលមាននៅលើកាតសម្គាល់របស់លោកអ្នក។

ध्यान दिनुहोस्: यदि तपाइँ अङ्ग्रेजी बाहेक अन्य भाषा बोल्नुहुन्छ भने तपाइँको लागि निःशुल्क रूपमा भाषा सहायता सेवा उपलब्ध छ। तपाइँको आइडी कार्डमा भएको सदस्य सेवा नम्बरमा कल गर्नुहोस्। Nepali

Persian Farsi

توجه: در صورتی که به زبانی غیر از انگلیسی صحبت می کنید خدمات کمکی زبانی به طور رایگان برای شما وجود دارد. برای این منظور با شماره خدمات اعضای موجود روی کارت شناسایی خود تماس بگیرید

Serbo-Croatian PAŽNJA: Ako govorite neki drugi jezik osim engleskog, dostupne su vam besplatne usluge

za jezičnu pomoć. Pozovite broj službe za članove na vašoj ličnoj karti.

Syriac أَنْوَهُوْ: أَى هُو وَحُرِي إِيدُ كُفُنَا اسْزُنَا هِأَ، هُو كُفُنَا أَنْكِهُمُ مَا الْكُونِ مَوْدُونَا وَصَفَعَنَا وَهُوَمُعَمَّا وَهُوَمُونَا اللهِ اللهِ اللهِ اللهِ اللهِ اللهِ اللهِ اللهُ اللهِ اللهُ اللهُ اللهُ (Member Services) وَمُنْ وَمُونِي مُونَا وَصَفَعَتْنَا وَكُونَا وَصَفَعَتْنَا وَكُونَا وَصَفَعَتْنَا وَكُونَا وَصَفَعَتْنَا وَكُونِ مَعْنَا وَكُونَا وَصَفَعَتْنَا وَكُونَا وَمُونِي اللهِ اللهِ اللهِ اللهِ اللهُ الل

ข้อควรทราบ: หากคุณใช้ภาษาอื่นที่ไม่ใช่ภาษาอังกฤษ เรามีบริการความช่วยเหลือทางภาษา Thai

็จัดให้แก่คุณโดยไม่คิดค่าใช้จ่ายใด ๆ ติดต่อหมายเลขให้บริการสมาชิกที่บัตรประจำตัวของคุณ

Turkish DİKKAT: İngilizce haricinde bir dil konuşuyorsanız, dil yardım hizmetlerinden ücretsiz

olarak faydalanabilirsiniz. Kimlik kartınızın üzerindeki numaradan Üye Hizmetlerini arayın.

Ukrainian УВАГА: якщо ви не розмовляєте англійською, то можете скористатися безкоштовними

послугами мовної підтримки. Зателефонуйте до Відділу обслуговування учасників

програми за телефоном, вказаним на вашій ідентифікаційній картці.