The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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 1-855-521-9345. For

general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms see the Glossary. You can view the Glossary at <u>http://www.brighthealthplan.com</u>or call 1-855-521-9345 to request a copy.

Important Questions	Answers	Why This Matters
What is the overall <u>deductible</u> ?	\$4,000 Individual or \$8,000 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. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. Primary Care, some Prescription Drugs, Urgent Care, 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</u> <u>services</u> at <u>https://www.healthcare.gov/coverage/preventive-care-benefits</u> .
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</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. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket</u> 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 <u>network provider</u> ?	Yes. See www.brighthealthplan.com or call 1-855-521-9345 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> .

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.					
		What You	ı Will Pay	Limitations, Exceptions, &	
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Other Important Information	
	Primary care visit to treat an injury or illness	\$35 copay/visit	Not Covered	None	
If you visit a health care provider's office or clinic	<u>Specialist</u> visit	40% coinsurance	Not Covered	None	
	Preventive care/screening/ immunization	No charge	Not Covered	None	
lf you have a test	<u>Diagnostic test</u> (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	Generic drugs	\$15 copay/prescription	Not Covered	Covers up to a 30-day supply (retail	
your illness or condition. More information about	Preferred brand drugs	40% coinsurance	Not Covered	prescription); 31-90 day supply (mail order	
prescription drug	Non-preferred brand drugs	40% coinsurance	Not Covered	prescription). Copay shown is per retail	
<u>coverage</u> is available at <u>www.brighthealthplan.com</u>	Specialty drugs	\$680 copay/prescription	Not Covered	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.	
If you need immediate medical attention	Emergency room care	40% coinsurance	40% coinsurance	None	
	Emergency medical transportation	40% coinsurance	40% coinsurance	None	
	<u>Urgent care</u>	\$75 copay/visit	\$75 copay/visit	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.	

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	Services You May Need	What You Will Pay		Limitations Exceptions 0
Common Medical Event		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need mental	Outpatient services	40% coinsurance	Not Covered	None
health, behavioral health, or substance abuse services	Inpatient services	40% coinsurance	Not Covered	Services require pre-authorization.
	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
	Childbirth/delivery facility services	40% coinsurance	Not Covered	or 96 hours for a cesarean delivery require pre- authorization.
	Home health care	40% coinsurance	Not Covered	Limited to 60 days per calendar year. Services require pre-authorization.
	Rehabilitation services	40% coinsurance	Not Covered	Limited to 45 combined visits per year for
If you need help recovering or have other special health needs	Habilitation services	40% coinsurance	Not Covered	Occupational Therapy, Physical Therapy, Speech Therapy and Chiropractic Manipulations. Services require pre-authorization.
	Skilled nursing care	40% coinsurance	Not Covered	Limited to 60 days per calendar 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.
If your child needs dental or eye care	Children's eye exam	No charge	Not Covered	Limited to 1 exam per year.
	Children's glasses	No charge	Not Covered	Limited to 1 pair of glasses, including standard frames and standard lenses every year. Contact lenses are limited to a one-year supply.
	Children's dental check-up	No charge	No charge	Refer to the Schedule of Benefits for covered services and limitations.

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 Dental Care (Adults) Private-duty nursing ٠ ٠ when the life of the mother is endangered) Hearing Aids Routine eye care (Adults) • Acupuncture Infertility Treatment Routine foot care . • **Bariatric Surgery** Long Term Care Weight loss programs . **Cosmetic Surgery** Non-emergency care when traveling outside the U.S.

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 the Nebraska Department of Insurance at P.O. Box 82089, Lincoln, NE 68501-2089, 402-471-2201 or 877-564-7323. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more about the Marketplace, 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 the Nebraska Department of Insurance at P.O. Box 82089, Lincoln, NE 68501-2089, 402-471-2201 or 877-564-7323.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have <u>Minimum Essential Coverage</u> 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 <u>plan</u> doesn't meet the <u>Minimum Value Standards</u>, you may be eligible for a <u>premium tax credit</u> to help you pay for a <u>plan</u> through the <u>Marketplace</u>.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-521-9345. Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-521-9345. Chinese (中文): 如果需要中文的帮助,请拨打这个号码 1-855-521-9345. Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijijgo holne' 1-855-521-9345.

—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)		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 plan's overall deductible\$4,000Specialist [cost sharing]40%Hospital (facility) [cost sharing]40%Other [cost sharing]40%		 The <u>plan's</u> overall <u>deductible</u> <u>Specialist</u> [cost sharing] Hospital (facility) [cost shari Other [cost sharing] 	40%	 The <u>plan's</u> overall <u>dedu</u> <u>Specialist</u> [cost sharing Hospital (facility) [cost sharing] Other [cost sharing] 	J 40%
This EXAMPLE event includes Specialist office visits (prenatal ca Childbirth/Delivery Professional S Childbirth/Delivery Facility Servic Diagnostic tests (ultrasounds and Specialist visit (anesthesia)	are) Services es	This EXAMPLE event includes s Primary care physician office visits disease education) Diagnostic tests (blood work) Prescription drugs Durable medical equipment (gluco	s (including	This EXAMPLE event inclu Emergency room care (inclu supplies) Diagnostic test (x-ray) Durable medical equipment Rehabilitation services (phy	iding medical (crutches)
Total Example Cost	\$12,800	Total Example Cost	\$7,400	Total Example Cost	\$1,925
In this example, Peg would pay	<i>'</i> :	In this example, Joe would pay:		In this example, Mia would	d pay:
Cost Sharing	1	Cost Sharing		Cost Sha	aring
Deductibles	\$3,190	Deductibles	\$3,430	Deductibles	\$1,160

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

This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)		
Total Example Cost\$7,400		
In this example, Joe would pay:		
Cost Sharing		
Deductibles \$3,430		
Copayments \$75		

\$2,290 Coinsurance What isn't covered Limits or exclusions \$60 The total Joe would pay is \$6,530 Copayments

Coinsurance

Limits or exclusions

The total Mia would pay is

What isn't covered

\$0

\$0

\$1,925

\$765

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: <u>https://ocrportal.hhs.gov/ocr/portal/lobby.jsf</u>
- 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	and a state a state of the stat
	انتباه: إذا كنت تتحدت 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۔ اینے 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'į' hodíílnih.
Amharic	ማሳሰብዖ፡ ከእንግሊዝኛ ውጪ የሆነ ቋንቋ የሚናገ∻ ከሆነ ከክፍዖ ነጻ የሆኑ የቋንቋ ድጋፍ አገልግሎቶችን ማግኝት ይችላሉ፡፡ በመታወቂያ ላይ በሚገኝ የአባላት አገልግሎት ቁጥር ላይ ይደውሉ፡፡
Burmese	သင့သည္ အဂၤလိပ္စစကားမဟုတ္ေသာ အျခားဘာသာစကားတစ္ခုအား မျပာဆိုသူျဖစ္ပါက ဘာသာစကားအခမဲ့ပံ့ပိုးသည္ ဝန္ေဆာင္မမႈအား သင္ရရရွိဳင္ပပါသည္။ သင့္ ID (သက္ေသခံ) ကတ္ျပားပေၚရွိအဖဲ႐ြာင္မမ်ားဝန္ေဆာင္မမႈဌာနအား ဖုန္းေခၚဆိုပါ။
Cherokee	ⅆ⅄ⅆՎԵՐ ԷԷ ՔԾℎⅆ℣ Ֆ℗ℎⅆŁ Ხℤ УℙЬ, ⅋℗ℎℬⅆ⅃ ⅅℙⅆℨℙⅆ℣ ℸ⅃ԼℰՂ⅃ℸ, Ը ⅄ℾⅆ⅃ ⅆℇĠĠ⅄ Ֆ℣ ⅅ4ⅆℾ, ℎℬ ℞Ġℰ℗ℸⅆ℄⅃℩֏ℸ. ፀⅆ℣ℤ ℒⅆⅆ℮ ℙℙ ⅅℙⅆℨℙⅆ℣ ⅃4ⅆℷ⅃ ℺℮ℸ Ġ⅌ℙ ⅄ℂⅆ℩⅄⅃ ℸ℮ℎⅆ⅃.
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 સહ્રાય સેવાઓ નિઃશુલ્ક ઉપલબ્ધ છે. તમારા આઈડી કાર્ડ પર રહેલા સદસ્થની સેવાઓનાં નંબર પર કૉલ કરો.
Hindi	ध्यान दें: यदि आप अंग्रेजी के अलावा कोई अन्य भाषा बोलते हैं, तो आपके लिए मुफ़्त 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	တိါနီဉ် – နမ့်၊ကတိးကျိဉ်လ၊တမ့၊်အဲကလံးကျိဉ်ဘဉ်နှဉ်, ကျိဉ်တါတိစၢၤမၤစၢၤတ၊မၤစၢၤတဖဉ်, လ၊တလိဉ်ဟ္ဉ်အပ္ပၤတဖဉ်အိဉ်လ၊နဂီ၊်နူဉ် လီၤ. ကိုးကရၢဖိတါမ၊စၢၤတဖဉ် (န္နနဉ်ဘနမှနမလငစန္ဒု) အနီဉိဂ်ၢဖဲန တါအုဉ်သးနီဉိဂ်ၢစ်းက့အဖီဓိဉ်နူဉ်တက္၊်.
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 زمانىّكى ترى جگە لە ئىنگلىزى قسە دەكەيت، خزمەتگوزاريە زمانەرانيەكان بەخۆرايى بۆ تۆ بەدەستن. يەيوەندى بە زمارەي خزمەنگوزارى ئەندامانى سەر ناسنامەكەت بكە

Laotian	ໂປດຊາບ: ຖ້າທ່ານເວົ້າພາສາອື່ນນອກຈາກພາສາອັງກິດ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາທີ່ບໍ ເສຍຄ່າແມ່ນມີພ້ອມໃຫ້ທ່ານ. ກະລຸນາໂທຫາ ໝາຍເລກການບໍລິການສະມາຊິກທີ່ຢູ່ເທິງ ບັດ ID ຂອງທ່ານ.	
Mon-Khmer	ចាប់អារម្មណ៍៖ ប្រសិនបើលោកអ្នកនិយាយភាសាផ្សេង ក្រៅពីភាសាអង់គ្លេស នោះសេវា ជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសម្រាប់លោកអ្នក។ ស្ទមទូរស័ព្ទទៅលេខសេវាបម្រើ សមាជិកដែលមាននៅលើកាតសម្គាល់របស់លោកអ្នក។	
Nepali	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।	
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 اعضبای 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	أَرَبَهُوَ: أَن هُو بِعَدِيمَ ايلُم كَفْنَا اسْنَنَا سَلَمَ، هُم كَفْنَا أُنْحِكَسْنَا: هُو أَنْكُفُون كَوميَا بُومِنْهُمَا بِعُرْهُماً! بِحَر هُيَبُوائِص. بِلَا لَمُنْخا حَقٍ هَدُبَنَّم وَحَقَيسَمٍ حَقَوضٍ هِدُبَرَّتَا وَهِفَضِعَتَا بِكَفْنَا (Member Services)	
Thai	ข้อควรทราบ: หากคุณใช้ภาษาอื่นที่ไม่ใช่ภาษาอังกฤษ เรามีบริการความช่วยเหลือทางภาษา 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.	