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 1-866-238-7195. 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 1-866-238-7195 to request a copy.

Important Questions	Answers	Why This Matters
What is the overall deductible?	$5,900 Individual or "$11,800 Family	Generally, you must pay all of the costs from providers up to the deductible 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 deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Primary Care, some Prescription Drugs, Urgent Care, and Pediatric Dental and Vision care are covered before the deductible.	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 https://www.healthcare.gov/coverage/preventive-care-benefits.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$8,150 Individual or $16,300 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 https://member.brighthealthplan.com or call 1-866-238-7195 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	$30 first 2 visits, then 40% after deductible	Not Covered	$30 first 2 visits, then 40% after deductible
	Specialist visit	40% coinsurance	Not Covered	None
	Preventive care/screening/ immunization	No charge	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 condition More information about **prescription drug coverage** is available at https://member.brighthealthplan.com	Generic drugs	$25 copay/prescription	Not Covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). Copay shown is per retail prescription. Mail Order cost is 2.5 times the Retail cost. Some specialty medications are available in other tiers. Review our formulary at https://member.brighthealthplan.com to determine what tier your specialty medication falls in.
	Preferred brand drugs	40% coinsurance	Not Covered	
	Non-preferred brand drugs	40% coinsurance	Not Covered	
	Specialty drugs	40% coinsurance	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance	Not Covered	Services require pre-authorization.
	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
	Urgent care	$75 copay/visit	Not Covered	Copay applies to facility charges. Ancillary charges such as lab or x-ray services will apply the plan's deductible and coinsurance.
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance	Not Covered	Services require pre-authorization.
	Physician/surgeon fees	40% coinsurance	Not Covered	Services require pre-authorization.

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
If you need mental health, behavioral health, or substance abuse services	Outpatient services	40% coinsurance	Not Covered	None
	Inpatient services	40% coinsurance	Not Covered	Services require pre-authorization.
If you are pregnant	Office visits	40% coinsurance	Not Covered	None
	Childbirth/delivery professional services	40% coinsurance	Not Covered	Delivery stays exceeding 48 hours for vaginal delivery or 96 hours for a cesarean delivery require pre-authorization.
	Childbirth/delivery facility services	40% coinsurance	Not Covered	
If you need help recovering or have other special health needs	Home health care	40% coinsurance	Not Covered	Limited to 60 visits per calendar year. Services require pre-authorization.
	Rehabilitation services	40% coinsurance	Not Covered	Limited to 20 Habilitative Outpatient Therapy visits per type per calendar year and 20 Rehabilitative Outpatient Therapy visits per type per calendar year. Visit limit is combined for all diagnoses, including autism. Services require pre-authorization.
	Habilitation services	40% coinsurance	Not Covered	
	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	Covered in full up to the provider's contracted amount.	Not Covered	Limited to 1 pair of glasses per calendar year, including frames and lenses; or a one-year supply of contact lenses per calendar year.
	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 when the life of the mother is endangered)
- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adults)
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adults)
- 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
- Hearing Aids
- Infertility Treatment (diagnosis only)
- Routine foot care (when provided in connection to treatment of diabetes 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: Tennessee Department of Commerce and Insurance at 1-800-342-4029. 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 http://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 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 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: Tennessee Department of Commerce and Insurance at 1-800-342-4029.

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 1-866-238-7195.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-238-7195.
Chinese（中文）：如果需要中文的帮助，请拨打这个号码 1-866-238-7195.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-238-7195.

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)

The plan's overall deductible	$5,900
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)*

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**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$5,900
Specialist *copayment*	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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,430
Copayments	$1,015
Coinsurance	$2,285
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$6,785**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$5,900
Specialist *copayment*	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	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,155
Copayments	$0
Coinsurance	$770
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,925**

The plan would be responsible for the other costs of these EXAMPLE covered services.

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 níik'eh, níká'adoojahígíí hóló. Naaltsoos bee éédahózin bikáá' béésh bee hane' biká'ígíí bich'į' hodíilnih.

Amharic

ማሳሰቢያ: ከእንግሊዝኛ ውጪ የሆነ ቋንቋ የሚናገሩ ከሆነ ከክፍያ ነጻ የሆኑ የቋንቋ ድጋፍ አገልግሎቶችን ማግኘት ይችላሉ:: በመታወቂያ ላይ በሚገኝ የአባላት አገልግሎት ቁጥር ላይ ይደውሉ::

Burmese

သင့်သည့် အဂၤလိပ်စကားမဟုတ်သော အျခားဘာသာစကားတစ်ခုအား ဖြာဆိုသျှဖစ်ပါက ဘာသာစကားအခမဲ့ပံ့ပိုးသည့် ဝန်ဆောင်မှုအား သင့်ရရှိနိုင်ပါသည်။ သင့် ID (သက်သေခံ) ကတ်ျပားပေၚရှိ အဖြ်ာင်မ်ားဝန်ဆောင်မှုဌာနအား ဖုန်းခေၚဆိုပါ။

Cherokee

ᎣᏍᏓᎾᏍᎩᏂ: ᎦᎢ ᎧᏅᏱᏂᏍᎩᏯ ᎯᏅᏱᏂᎭᏱ ᏏZ ᎩᎮᏏ, ᎧᏅᏱᏂᎯᏍᏍᎩᏗ DᎮᏍᎦᎮᏍᎩᏯ ᎢᏗᏓᏅᏁᏗᏜ, Ꮭ ᎪᎢᏍᎩᏗ ᏧEGᎶᏗ ᎯᎩ D4ᏩᎢ, ᏂᎯ RGᏅᏙᎢᏍᎩᏓᏁᏆᎢ. ᎾᏍᎩᏃZ ᏥᏍᏍᎾ ᏆP DᎮᏍᎦᎮᏍᎩᏯ Ꮧ4ᏍᎩᏗ ᎤᎾᎢ GᏃP ACᏍᎩᏁᏗ ᏆᎾᏂᏍᎩᏗ.

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 નિઃશુલ્ક ઉપલબ્ધ છે. તમારા આઈડી કાર્ડ પર રહેલા સદસ્યની 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

တိၢ်နှဉ် – နမ့ၢ်ကတိၤကျိာ်လၢတမ့ၢ်အဲကလံးကျိာ်ဘဉ်နွဉ်, ကျိာ်တၢ်တိစၢၤမၤစၢၤတၢ်မၤစၢၤတဖဉ်, လၢတလိဉ်ဟ့ဉ်အမှၤတဖဉ်အခိဉ်လၢနဂီၢ်နွဉ် လီၤ. ကိးကရၢဖိတၢ်မၤစၢၤတဖဉ် (ဆူနာ်ဘနမ့နမလၤဝခူ) အနိဉ်ဂံၢ်ဖဲန တၢ်အဉ်သးနိဉ်ဂံၢ်စးကွအဖိခိဉ်နွဉ်တကွၢ်.

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

ئاگاداری: ئەگەر بە زمانێکی تری جگە لە ئینگلیزی قسە دەکەیت، خزمەتگوزاریە زمانەوانیەکان بەخۆڕایی بۆ تۆ بەردەستن. پەیوەندی بە ژمارەی خزمەتگوزاری ئەندامانی سەر ناسنامەکەت بکە.

Laotian	ໄປດຊາບ: ຖ້າທ່ານເວົາພາສາອື່ນນອກຈາກພາສາອັງກິດ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາທີ່ບໍ່ເສຍຄ່າແມ່ນມີພ້ອມໃຫ້ທ່ານ. ກະລຸນາໄທຫາ ໝາຍເລກການບໍລິການສະມາຊິກທີ່ຢູ່ເທິງ ບັດ ID ຂອງທ່ານ.
Mon-Khmer	ចាប់អារម្មណ៍៖ ប្រសិនបើលោកអ្នកនិយាយភាសាផ្សេង ក្រៅពីភាសាអង់គ្លេស នោះសេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសម្រាប់លោកអ្នក។ សូមទូរស័ព្ទទៅលេខសេវាបម្រើសមាជិកដែលមាននៅលើកាតសម្គាល់របស់លោកអ្នក។
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 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	ܐܙܗܪܘ: ܐܢ ܗܘ ܕܡܡܠܠܝܬܘܢ ܐܝܠܝ ܠܫܢܐ ܐܚܪܢܐ ܣܛܪ ܡܢ ܠܫܢܐ ܐܢܓܠܝܙܝܐ: ܗܘܝ ܐܠܟܘܢ ܚܘܡܪܐ ܕܡܫܡܫܢܘܬܐ ܕܗܘܕܝܐ ܕܠܫܢܐ ܡܓܢܐܝܬ. ܘܠܐ ܡܫܐ ܠܟܘܢ ܡܚܪܘܡ ܩܥܝܬܐ ܠܡܢܝܢܐ ܕܡܫܡܫܢܘܬܐ ܕܗܕܡܐ (Member Services)
Thai	ข้อควรทราบ: หากคุณใช้ภาษาอื่นที่ไม่ใช่ภาษาอังกฤษ เรามีบริการความช่วยเหลือทางภาษาจัดให้แก่คุณโดยไม่คิดค่าใช้จ่ายใด 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.