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 1-866-239-7194. 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 <a href="https://member.brighthealthplan.com">https://member.brighthealthplan.com</a> or call 1-866-239-7194 to request a copy.

| Important Questions   | Answers   | Why This Matters  |
|---|---|---|
| What is the overall<br><u>deductible</u> ?                                | \$5,000 Individual or<br>\$10,000 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<br>covered before you meet<br>your <u>deductible</u> ? | Yes. Primary Care, Specialty Care,<br>some Prescription Drugs, Urgent<br>Care, Mental Health Outpatient Care,<br>and Pediatric Dental and Vision care<br>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><br>amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain<br><u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of<br>covered <u>preventive services</u> at <u>https://www.healthcare.gov/coverage/preventive-care-<br/>benefits</u> .  |
| Are there other<br>deductibles<br>for specific<br>services?               | No.   | You don't have to meet <u>deductibles</u> for specific services.  |
| What is the <u>out-of-pocket</u><br><u>limit</u> for this <u>plan</u> ?   | \$8,150 Individual or<br>\$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 <u>out-of-pocket limit</u> ?                  | Premiums, balance-billing charges,<br>and health care this <u>plan</u> doesn't<br>cover.  | Even though you pay these expenses, they don't count toward the out-of-pocket limit.  |
| Will you pay less if you<br>use a <u>network provider</u> ?               | Yes. See<br>https://member.brighthealthplan.com<br>or call 1-866-239-7194 for a list of<br><u>network providers</u> .   | 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</u> <u>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 specialist you choose without a referral.   |

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

| Common  |   | What Yo                                      | ou Will Pay  | Limitations, Exceptions, & Other   |  |
|---|---|--|--|--|--|
| Medical Event   | Services You May Need                               | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) | Important Information  |  |
| lf you visit a health   | Primary care visit to treat an<br>injury or illness | \$40 copay/visit                             | Not Covered  | None   |  |
| care provider's office  | <u>Specialist</u> visit                             | \$75 copay/visit                             | Not Covered  | None   |  |
| or clinic   | Preventive care/screening/<br>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  | Generic drugs                                       | \$25 copay/prescription                      | Not Covered  | Covers up to a 30-day supply (retail   |  |
| treat your illness or   | Preferred brand drugs                               | \$100 copay/prescription                     | Not Covered  | prescription); 31-90 day supply (mail order  |  |
| condition   | Non-preferred brand drugs                           | \$180 copay/prescription                     | Not Covered  | prescription). Copay shown is per retail prescription. Mail Order cost is 2.5 times the  |  |
| More information about<br>prescription drug<br><u>coverage</u> is available at<br><u>https://member.brighthe</u><br><u>althplan.com</u> | Specialty drugs                                     | \$650 copay/prescription                     | Not Covered  | Retail cost. Some specialty medications are<br>available in other tiers. Review our formulary<br>at https://member.brighthealthplan.com to<br>determine what tier your specialty<br>medication falls in. |  |
| If you have outpatient  | Facility fee (e.g., ambulatory<br>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   | Emergency medical<br>transportation                 | 40% coinsurance                              | 40% coinsurance                                    | None   |  |
| medical attention   | 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  | 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.  |  |

| All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies. |   |   |             |  |  |
|--|---|---|-------------|--|--|
| Common<br>Medical Event  | Services You May Need                     | What You Will Pay                                       |             | Limitations, Exceptions, & Other Important<br>Information  |  |
| lf you need mental<br>health, behavioral   | Outpatient services                       | \$75 copay/visit  | Not Covered | None   |  |
| health, or substance<br>abuse services   | Inpatient services                        | 40% coinsurance   | Not Covered | Services require pre-authorization.  |  |
|  | Office visits                             | 40% coinsurance   | Not Covered | None   |  |
| lf you are pregnant  | Childbirth/delivery professional services | 40% coinsurance   | Not Covered | Delivery stays exceeding 48 hours for vaginal  |  |
|  | Childbirth/delivery facility services     | 40% coinsurance   | Not Covered | delivery or 96 hours for a cesarean delivery require pre-authorization.  |  |
|  | Home health care                          | 40% coinsurance   | Not Covered | Limited to 60 visits per calendar year.<br>Services require pre-authorization.   |  |
| If you need help<br>recovering or have<br>other special health<br>needs  | Rehabilitation services                   | 40% coinsurance   | Not Covered | Limited to 20 Habilitative Outpatient Therapy<br>visits per type per calendar year and 20<br>Rehabilitative Outpatient Therapy visits per type<br>per calendar year. |  |
|  | Habilitation services                     | 40% coinsurance   | Not Covered | Visit limit is combined for all diagnoses, including autism.   |  |
|  | Skilled nursing care                      | 40% coinsurance   | Not Covered | Services require pre-authorization.<br>Limited to 60 days per calendar year.<br>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                       | No charge   | Not Covered | Limited to 1 exam per year.  |  |
| If your child needs<br>dental or eye care  | Children's glasses                        | Covered in full up to the provider's contracted amount. | Not Covered | Limited to 1 pair of glasses per calendar year,<br>including frames and lenses; or a one-year supply<br>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.) |            |  |   |                           |
|--|------------|--|---|---------------------------|
| <ul> <li>Abortion (except in cases of rape, incest, or when</li> </ul>   | <b>ו</b> ו | Cosmetic Surgery                                   | • | Private-duty nursing      |
| the life of the mother is endangered)  | ٠          | Dental Care (Adults)                               | • | Routine eye care (Adults) |
| Acupuncture  | ٠          | Long Term Care                                     | • | Weight loss programs      |
| <ul> <li>Bariatric Surgery</li> </ul>  | •          | 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  | <ul> <li>Infertility Treatment (diagnosis only)</li> </ul> | • | Routine foot care (when provided in connection |
| Hearing Aids   |  |   | 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 <u>Marketplace</u>. For more information about the <u>Marketplace</u>, visit <u>http://www.HealthCare.gov</u> 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: Tennessee Department of Commerce and Insurance at 1-800-342-4029.

### 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 1-866-239-7194. Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-239-7194. Chinese (中文): 如果需要中文的帮助,请拨打这个号码 1-866-239-7194. Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijijgo holne' 1-866-239-7194.

-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 <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage.

| Peg is Having a Baby   |
|--|
| and the set in the set of the set |

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

| The plan's overall deductible   | \$5,000 |
|---------------------------------|---------|
| Specialist copayment            | \$75    |
| 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*)

### In this example, Peg would pay:

| Cost Sharing               |         |  |  |
|----------------------------|---------|--|--|
| Deductibles                | \$3,100 |  |  |
| Copayments                 | \$1,050 |  |  |
| Coinsurance                | \$4,000 |  |  |
| What isn't covered         |         |  |  |
| Limits or exclusions       | \$60    |  |  |
| The total Peg would pay is | \$8,210 |  |  |

| Managing Joe's type 2 Diabetes<br>(a year of routine in-network care of a well-<br>controlled condition)  |                               |  |
|---|-------------------------------|--|
| <ul> <li>The <u>plan's</u> overall <u>deductible</u></li> <li><u>Specialist</u> copayment</li> <li>Hospital (facility) coinsurance</li> <li>Other coinsurance</li> </ul>  | \$5,000<br>\$75<br>40%<br>40% |  |
| This EXAMPLE event includes services<br>Primary care physician office visits (included<br>disease education)<br>Diagnostic tests (blood work)<br>Prescription drugs<br>Durable medical equipment (glucose meter | ling                          |  |

| Total Example Cost | \$7,400 |
|--------------------|---------|
|--------------------|---------|

### In this example, Joe would pay:

| Cost Sharing               |         |  |  |
|----------------------------|---------|--|--|
| Deductibles                | \$1,115 |  |  |
| Copayments                 | \$2,545 |  |  |
| Coinsurance                | \$745   |  |  |
| What isn't covered         |         |  |  |
| Limits or exclusions       | \$55    |  |  |
| The total Joe would pay is | \$4,460 |  |  |

### Mia's Simple Fracture

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

| The plan's overall deductible   | \$5,000 |
|---------------------------------|---------|
| Specialist copayment            | \$75    |
| 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                | \$980   |  |
| Copayments                 | \$225   |  |
| Coinsurance                | \$655   |  |
| What isn't covered         |         |  |
| Limits or exclusions       | \$0     |  |
| The total Mia would pay is | \$1,860 |  |

### **bright**<sup>M</sup>

### 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.

### **bright**<sup>M</sup>

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.<br>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<br>的会员服务号码。  |
| French       | ATTENTION : Si vous parlez une autre langue que l'anglais, des services d'assistance<br>linguistique sont mis gratuitement à votre disposition. Appelez le numéro des services aux<br>membres figurant sur votre carte d'identification.        |
| German       | ACHTUNG: Falls Sie eine andere Sprache als Englisch sprechen, steht Ihnen eine kostenfreie<br>fremdsprachliche Unterstützung zur Verfügung. Wählen Sie die Mitgliederservice-Nummer auf<br>Ihrer ID-Karte.                                      |
| Greek        | ΠΡΟΣΟΧΗ: Αν μιλάτε κάποια γλώσσα διαφορετική από τα Αγγλικά, παρέχονται δωρεάν<br>υπηρεσίες γλωσσικής βοήθειας. Καλέστε τον αριθμό του Τμήματος Υπηρεσιών Μέλους<br>(Member Services) που αναγράφεται στην ταυτότητά σας (ID card).             |
| Italian      | ATTENZIONE: se parla una lingua diversa dall'inglese, sono disponibili servizi di<br>assistenza linguistica gratuiti. Chiami il numero Member Services che trova sulla Sua tessera<br>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<br>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<br>있습니다. 신분증에 기재된 회원 서비스 번호로 연락하십시오.  |
| Polish       | UWAGA: Jeśli nie mówisz po angielsku, możesz skorzystać z darmowych usług<br>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<br>assistência de idioma para si. Contacte o número de serviços para membros no seu cartão de<br>identificação.   |
| Russian      | ВНИМАНИЕ: если вы не говорите на английском языке, вы можете воспользоваться<br>бесплатными услугами языковой поддержки. Позвоните в Отдел обслуживания<br>участников программы по телефону, указанному на вашей идентификационной<br>карточке. |
| Spanish (US) | ATENCIÓN: Si no habla inglés, tiene a su disposición servicios gratuitos de asistencia<br>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<br>serbisyong tulong sa wika nang walang bayad. Tumawag sa numero ng Member Services na<br>nasa iyong ID card.   |

# bright MEALTH

| Urdu<br>ہیں۔ اینے ID | توجہ دیں: اگر آپ انگریزی کے علاوہ کوئی اور زبان بولتے ہیں تو آپ کیلئے زبان کی معاونت کی خدمات مفت دستیاب ہ<br>کارڈ پر موجود ار اکین 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<br>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.<br>Naaltsoos bee éédahózin bikáá' béésh bee hane' biká'ígíí bich'į' hodíílnih.  |
| Amharic              | ማሳሰብያ፡ ከእንግሊዝኛ ውጪ የሆነ ቋንቋ የሚናገሩ ከሆነ ከክፍያ ነጻ የሆኑ የቋንቋ ድጋፍ አገልግሎቶችን ማግኘት<br>ይችላሉ፡፡ በመታወቂያ ላይ በሚገኝ የአባላት አገልግሎት ቁጥር ላይ ይደውሉ፡፡   |
| Burmese              | သင္သသည္ အဂၤလိပ္စစကားမဟုတ္ေသာ အျခားဘာသာစကားတစ္ခုအား မျပာဆိုသူျဖစ္ပါက<br>ဘာသာစကားအခမဲ့ပံ့ပိုးသည္ ဝန္ေဆာင္မမႈအား သင္ရရရှိိုင္ပပါသည္။ သင့္ ID (သက္ေသခံ)<br>ကတ္ျပားပေၚရွိအဖဲြျာင္မမ်ားဝန္ေဆာင္မမႈဌာနအား ဖုန္းေခၚဆိုပါ။                        |
| Cherokee             | Ժ℗4ၹԼ։ ԳТ ֍ಲҺၹ҄У ЉಲҺԺ ЬΖ УРЬ, ֍ಲҺѦፙ҄҄҄҄Л DPፙSPፙУ ТЛԼℰЛЛТ, Ĺ<br>АГፙ҄Л JEGGA ЉУ D4(∂T, ҺѦ RGℰ℗ТፙԼЛ҈℩T. Ѳፙ҄УΖ Ջŀ℗Ѳ ÞP DPፙSPፙӮ<br>Л4ፙЛ ѺѲТ GVP ACፙЛЛ IѲһ҃ѽӅ.   |
| Cushite-Oromo        | XIYYEEFFANNOO: Afaan Ingiliziin ala afaan kan biraa kan dubbattu yoo ta'e,<br>tajaajilliwwan gargaarsa afaanii, kan tolaa, siif ni jiru. Kaardii Waraqaa-eenyummeessaa<br>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<br>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<br>સહ્યય સેવાઓ નિઃશુલ્ક ઉપલબ્ધ છે. તમારા આઈડી કાર્ડ પર રહેલા સદસ્થની સેવાઓનાં નંબર<br>પર કૉલ કરો.   |
| Hindi                | ध्यान दें: यदि आप अंग्रेजी के अलावा कोई अन्य भाषा बोलते हैं, तो आपके लिए मुफ़्त में<br>भाषा सहायता सेवाएं उपलब्ध हैं। आपके आईडी कार्ड पर दिए गए सदस्य सेवा नंबर पर<br>कॉल करें।  |
| Hmong                | UA ZOO SAIB: Yog tias koj hais ib hom lus dhau ntawm lus As Kiv, muaj cov kev pab cuam<br>txhais lus uas tsis xam nqi dab tsi rau koj tau siv. Hu rau Lub Chaw Pab Cuam Tswv Cuab tus<br>nab npawb xov tooj nyob ntawm koj daim npav ID. |
| Karen                | တိါနီဉ် – နမ့ၢ်ကတိးကျိဉ်လ၊တမ့၊်အဲကလံးကျိဉ်ဘဉ်နှဉ်, ကျိဉ်တါတိစၢၤမၤစၢၤတ၊မၤစၢၤတဖဉ်, လ၊တလိဉ်ဟ္ဉ်အပူးတဖဉ်အိဉ်လ၊နဂီ၊်နူဉ်<br>လီၤ. ကိုးကရၢဖိတ်၊မၤစၢၤတဖဉ် (န္နနာ်ဘနမှနမလငေနျှ) အနီဉိဂ်ၢဖဲန တါအုဉ်သးနီဉိဂ်ၢစဴးက္အာဖီဓိဉ်န္ခဉ်တက္၊်.               |
| Kru / Bassa          | YI LE: I balè u mpot hop umpè èbes Ngissi, bot ba nhola ni kobol mahop bayé ha i nyuu yoñ,<br>ngui nsaa wogui wo. Sebel Ndap Mahola i nyuu Mbon i nsinga i yé ntilgaga munu i Kat yon i<br>Mbon.   |
| Kurdish              | ئاگادارى: ئەگەر بە زمانىّكى ترى جگە لە ئىنگلىزى قسە دەكەيت، خزمەتگوزاريە زمانەرانيەكان بەخۆرايى بۆ تۆ بەدەستن.<br>يەيوەندى بە زمارەي خزمەتگوزارى ئەندامانى سەر ناسنامەكەت بكە.   |

Urdu

## **bright**<sup>M</sup>

| Laotian  | ້ໄປດຊາບ: ຖ້າທ່ານເວົ້າພາສາອື່ນນອກຈາກພາສາອັງກິດ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາທີ່ບໍ<br>ເສຍຄ່າແມ່ນມີພ້ອມໃຫ້ທ່ານ. ກະລຸນາໂທຫາ ໝາຍເລກການບໍລິການສະມາຊິກທີ່ຢູ່ເທິງ ບັດ ID<br>ຂອງທ່ານ.  |
|--|--|
| Mon-Khmer  | ចាប់អារម្មណ៍៖ ប្រសិនបើលោកអ្នកនិយាយភាសាផ្សេង ក្រៅពីភាសាអង់គ្លេស នោះសេវា<br>ជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសម្រាប់លោកអ្នក។ ស្ទមទូរស័ព្ទទៅលេខសេវាបម្រើ<br>សមាជិកដែលមាននៅលើកាតសម្គាល់របស់លោកអ្នក។  |
| Nepali   | ध्यान दिनुहोस्: यदि तपाइँ अङ्ग्रेजी बाहेक अन्य भाषा बोल्नुहुन्छ भने तपाइँको लागि निःशुल्क रूपमा<br>भाषा सहायता सेवा उपलब्ध छ। तपाइँको आइडी कार्डमा भएको सदस्य सेवा नम्बरमा कल गर्नुहोस्।   |
| Persian Farsi<br>توجه: در صورتی که به زبانی غیر از انگلیسی صحبت می کنید خدمات کمکی زبانی به طور رایگان برای شما وجود دارد.<br>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<br>za jezičnu pomoć. Pozovite broj službe za članove na vašoj ličnoj karti.   |
| Syriac   | أَرَبَهُوَ: أَن هُو بِعَدِيمَ اللهُ اللهُ عَلَمَا اللهُ عَلَى عَمَدًا أَسِحَسَمُنَا: هُو أَلَّكُفُون حَمومُوا بُعضَعُمَا بِعُبْهُما ال<br>بِحَرِ هُبَيْمائِص. بِلَا لَمُنْعَا حَص عَدَبَرُم مُعَقَبِسُم حَصرَص عَدَبُوُنا مُعقَعَمُنَا بِكَمْنَا (Member Services) |
| Thai   | ข้อควรทราบ: หากคุณใช้ภาษาอื่นที่ไม่ใช่ภาษาอังกฤษ เรามีบริการความช่วยเหลือทางภาษา<br>จัดให้แก่คุณโดยไม่คิดค่าใช้จ่ายใด ๆ ติดต่อหมายเลขให้บริการสมาชิกที่บัตรประจำตัวของคุณ  |
| Turkish  | DİKKAT: İngilizce haricinde bir dil konuşuyorsanız, dil yardım hizmetlerinden ücretsiz<br>olarak faydalanabilirsiniz. Kimlik kartınızın üzerindeki numaradan Üye Hizmetlerini arayın.  |
| Ukrainian  | УВАГА: якщо ви не розмовляєте англійською, то можете скористатися безкоштовними<br>послугами мовної підтримки. Зателефонуйте до Відділу обслуговування учасників<br>програми за телефоном, вказаним на вашій ідентифікаційній картці.                              |