



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 1-866-283-9427. 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 1-866-283-9427 to request a copy.

| Important Questions                                                             | Answers                                                                                                                                                                 | Why This Matters                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|---------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | \$8,150 Individual or<br>\$16,300 Family                                                                                                                                | Generally, you must pay all of the costs from <a href="#">providers</a> up to the deductible amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .                                                                                                                                                                                                            |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. Primary Care is covered before the deductible.                                                                                                                     | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits">https://www.healthcare.gov/coverage/preventive-care-benefits</a> .                                                         |
| Are there other <a href="#">deductibles</a> for specific services?              | No.                                                                                                                                                                     | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | \$8,150 Individual or<br>\$16,300 Family                                                                                                                                | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket</a> limit has been met.                                                                                                                                                                                                                                                                                                                                             |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.                                            | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="https://member.brighthealthplan.com">https://member.brighthealthplan.com</a> or call 1-866-283-9427 for a list of <a href="#">network providers</a> . | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | No.                                                                                                                                                                     | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |



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<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>If you visit a health care <a href="#">provider's</a> office or clinic</b>                                                                                                                                                          | Primary care visit to treat an injury or illness       | \$20 first 3 visits, then 0% after deductible | Not Covered                                        | \$20 first 3 visits, then 0% after deductible                                                                                                                                                                                                                                                                                                                                                                           |
|                                                                                                                                                                                                                                        | <a href="#">Specialist</a> visit                       | 0% coinsurance                                | Not Covered                                        | None                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                                                                                                                        | <a href="#">Preventive care/screening/immunization</a> | No charge                                     | Not Covered                                        | None                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>If you have a test</b>                                                                                                                                                                                                              | <a href="#">Diagnostic test</a> (x-ray, blood work)    | 0% coinsurance                                | Not Covered                                        | None                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                                                                                                                        | Imaging (CT/PET scans, MRIs)                           | 0% coinsurance                                | Not Covered                                        | Services require pre-authorization.                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="https://member.brighthealthplan.com">https://member.brighthealthplan.com</a> | Generic drugs                                          | 0% coinsurance                                | 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 <a href="https://member.brighthealthplan.com">https://member.brighthealthplan.com</a> to determine what tier your specialty medication falls in. |
|                                                                                                                                                                                                                                        | Preferred brand drugs                                  | 0% coinsurance                                | Not Covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                                                                                                                                                                                        | Non-preferred brand drugs                              | 0% coinsurance                                | Not Covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                                                                                                                                                                                        | <a href="#">Specialty drugs</a>                        | 0% coinsurance                                | Not Covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>If you have outpatient surgery</b>                                                                                                                                                                                                  | Facility fee (e.g., ambulatory surgery center)         | 0% coinsurance                                | Not Covered                                        | Services require pre-authorization.                                                                                                                                                                                                                                                                                                                                                                                     |
|                                                                                                                                                                                                                                        | Physician/surgeon fees                                 | 0% coinsurance                                | Not Covered                                        | Services require pre-authorization.                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>If you need immediate medical attention</b>                                                                                                                                                                                         | <a href="#">Emergency room care</a>                    | 0% coinsurance                                | 0% coinsurance                                     | None                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                                                                                                                        | <a href="#">Emergency medical transportation</a>       | 0% coinsurance                                | 0% coinsurance                                     | None                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                                                                                                                        | <a href="#">Urgent care</a>                            | 0% coinsurance                                | Not Covered                                        | Copay applies to facility charges. Ancillary charges such as lab or x-ray services will apply the plan's deductible and coinsurance.                                                                                                                                                                                                                                                                                    |
| <b>If you have a hospital stay</b>                                                                                                                                                                                                     | Facility fee (e.g., hospital room)                     | 0% coinsurance                                | Not Covered                                        | Services require pre-authorization.                                                                                                                                                                                                                                                                                                                                                                                     |
|                                                                                                                                                                                                                                        | Physician/surgeon fees                                 | 0% 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                                                                                                      |
|----------------------------------------------------------------------------------|-------------------------------------------|-------------------|----------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                       | 0% coinsurance    | Not Covered    | None                                                                                                                                                        |
|                                                                                  | Inpatient services                        | 0% coinsurance    | Not Covered    | Services require pre-authorization.                                                                                                                         |
| <b>If you are pregnant</b>                                                       | Office visits                             | 0% coinsurance    | Not Covered    | None                                                                                                                                                        |
|                                                                                  | Childbirth/delivery professional services | 0% 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     | 0% coinsurance    | Not Covered    |                                                                                                                                                             |
| <b>If you need help recovering or have other special health needs</b>            | <a href="#">Home health care</a>          | 0% coinsurance    | Not Covered    | Limited to 60 visits per calendar year. Services require pre-authorization.                                                                                 |
|                                                                                  | <a href="#">Rehabilitation services</a>   | 0% 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. |
|                                                                                  | <a href="#">Habilitation services</a>     | 0% coinsurance    | Not Covered    | Visit limit is combined for all diagnoses, including autism.<br><br>Services require pre-authorization.                                                     |
|                                                                                  | <a href="#">Skilled nursing care</a>      | 0% coinsurance    | Not Covered    | Limited to 60 days per calendar year. Services require pre-authorization.                                                                                   |
|                                                                                  | <a href="#">Durable medical equipment</a> | 0% coinsurance    | Not Covered    | Services require pre-authorization.                                                                                                                         |
|                                                                                  | <a href="#">Hospice services</a>          | 0% coinsurance    | Not Covered    | Services require pre-authorization.                                                                                                                         |
|                                                                                  |                                           |                   |                |                                                                                                                                                             |
| <b>If your child needs dental or eye care</b>                                    | Children's eye exam                       | 0% coinsurance    | Not Covered    | Limited to 1 exam per year.                                                                                                                                 |
|                                                                                  | Children's glasses                        | 0% coinsurance    | 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                | 0% coinsurance    | 0% coinsurance | Refer to the Schedule of Benefits for covered services and limitations.                                                                                     |

### Excluded Services & Other Covered Services:

| Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a> .)            |                                                                                                                                                                                         |                                                                                                                                           |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"><li>• Abortion (except in cases of rape, incest, or when the life of the mother is endangered)</li><li>• Acupuncture</li><li>• Bariatric Surgery</li></ul> | <ul style="list-style-type: none"><li>• Cosmetic Surgery</li><li>• Dental Care (Adults)</li><li>• Long Term Care</li><li>• Non-emergency care when traveling outside the U.S.</li></ul> | <ul style="list-style-type: none"><li>• Private-duty nursing</li><li>• Routine eye care (Adults)</li><li>• Weight loss programs</li></ul> |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)                                                 |                                                                                                                                                                                         |                                                                                                                                           |
| <ul style="list-style-type: none"><li>• Chiropractic Care</li><li>• Hearing Aids</li></ul>                                                                                                   | <ul style="list-style-type: none"><li>• Infertility Treatment (diagnosis only)</li></ul>                                                                                                | <ul style="list-style-type: none"><li>• Routine foot care (when provided in connection to treatment of diabetes only)</li></ul>           |

**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 1-866-283-9427.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-283-9427.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-283-9427.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-283-9427.

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

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

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

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$8,150 |
| ■ <a href="#">Specialist</a> copayment                          | 0%      |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 0%      |
| ■ Other <a href="#">coinsurance</a>                             | 0%      |

#### 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,800</b> |
|---------------------------|-----------------|

#### In this example, Peg would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$8,150        |
| Copayments                        | \$0            |
| Coinsurance                       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$8,210</b> |

### Managing Joe's type 2 Diabetes

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

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$8,150 |
| ■ <a href="#">Specialist</a> copayment                          | 0%      |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 0%      |
| ■ Other <a href="#">coinsurance</a>                             | 0%      |

#### 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$7,400</b> |
|---------------------------|----------------|

#### In this example, Joe would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$6,395        |
| Copayments                        | \$160          |
| Coinsurance                       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$55           |
| <b>The total Joe would pay is</b> | <b>\$6,610</b> |

### Mia's Simple Fracture

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

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$8,150 |
| ■ <a href="#">Specialist</a> copayment                          | 0%      |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 0%      |
| ■ Other <a href="#">coinsurance</a>                             | 0%      |

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$1,925</b> |
|---------------------------|----------------|

#### In this example, Mia would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$1,925        |
| Copayments                        | \$0            |
| Coinsurance                       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,925</b> |

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.

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|              |                                                                                                                                                                                                                                        |
|--------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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 tarjeta 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** Shoooh: 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'í' hodíílnih.

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

**Burmese** သင့်သည့် အင်္ဂလိပ်စကားမဟုတ်သော အချားဘာသာစကားတစ်ခုအား ငျပာဆိုသူဖုတ်ပါက ဘာသာစကားအခွဲပိုင်းသည့် ဝန်ဆောင်မှုအား သင့်ရရှိနိုင်ပါသည်။ သင့် ID (သင်္ကေတသေခံ) ကတူညီပေးပေးမှု အဖျက်ပေးမှုအခွင့်အလမ်းများအား ဖုန်းခေါ်ဆိုပါ။

**Cherokee** ᄆᄆᄆᄆᄆᄆ: ᄆᄆ ᄆᄆᄆᄆᄆ ᄆᄆᄆᄆ ᄆᄆ ᄆᄆᄆ, ᄆᄆᄆᄆᄆᄆ ᄆᄆᄆᄆᄆᄆ ᄆᄆᄆᄆᄆᄆ, ᄆ ᄆᄆᄆ ᄆᄆᄆᄆ ᄆᄆ ᄆᄆᄆᄆ, ᄆᄆ ᄆᄆᄆᄆᄆᄆᄆᄆᄆᄆ. ᄆᄆᄆᄆ ᄆᄆᄆᄆ ᄆᄆ ᄆᄆᄆᄆᄆᄆ ᄆᄆᄆᄆ ᄆᄆᄆ ᄆᄆᄆ ᄆᄆᄆᄆ ᄆᄆᄆᄆ.

**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 lakkoofta 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:શુલ્ક ઉપલબ્ધ છે. તમારા આઈડી કાર્ડ પર રહેલા સદસ્યની સેવાઓનાં નંબર પર કોલ કરો.

**Hindi** ध्यान दें: यदि आप अंग्रेजी के अलावा कोई अन्य भाषा बोलते हैं, तो आपके लिए मुफ्त 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** ဝိုက်နီ - နမူကတိဝ်ကိတ်လၢတဖၢအဲကလံးကိတ်ဘၣ်န့ၣ်, ကိတ်တၢ်တိၤတၢ်မၤတၢ်မၤတၢ်မၤတဖၢ, လၢတလိၣ်ဟ့ၣ်အပူၤတဖၢအိၣ်လၢနီၣ်န့ၣ် လိၤ. ကိးကရၢဖိတၢ်မၤတၢ်တဖၢ (န့ၣ်ဘၣ်နမ့ၣ်မလၢစၢန့ၣ်) အနီၣ်ဂီၤဖဲန့ၣ် တၢ်အုၣ်သးနီၣ်ဂီၤစးက့ၢ်အဖိခိၣ်န့ၣ်တက့ၢ်.

**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، خزمەتگوزاری بە زمانێکی ئێوەمان بەخۆڕایی یۆ تۆ بە دەستێ. یەڕەبەندی بە زمانێکی خزمەتگوزاری ئێمانمانی سەر ناسنامەکت بەکە.

