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 1-866-569-3468 or visit uhc.com/aca-sample-policy. 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 www.healthcare.gov/sbc-glossary/ or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $3,000 Individual / $6,000 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. Benefits available with no charge such as Network Preventive care services are covered before you meet your deductible. The cost-sharing below indicates whether the deductible applies for each benefit	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 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?	Network: $7,400 Individual / $14,800 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 uhc.com/xwidocfindoa2026 or call 1-866-569-3468 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	$40 copay /visit, deductible does not apply	Not Covered	None
	Specialist visit	$80 copay /visit, deductible does not apply	Not Covered	None
	Preventive care/ screening/ immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
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	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at [uhc.com/xwidruglist 2026](uhc.com/xwidruglist2026)	Tier 1 - $0 Cost-share	No Charge	Not Covered	Provider means pharmacy for purposes of this section. Retail: One month supply up to a 30-day supply or a 90-day supply at 2.5x the 30-day cost-share. Mail-Order: Up to a 90-day supply at 2.5x the 30-day cost-share. Specialty drugs limited to a 30-day supply at a network pharmacy. Certain drugs may have a preauthorization requirement. If you don't get preauthorization, benefits will not be covered. Certain preventive medications (including certain contraceptives) are covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered. Insulin products listed as Tier 1 on the Prescription Drug List are covered at No Charge at a network pharmacy.
	Tier 2 – Preferred Generic	$20 copay /prescription, deductible does not apply	Not Covered	
	Tier 3 - Preferred Brand	$40 copay /prescription, deductible does not apply	Not Covered	
	Tier 4 – Non-Preferred Brand	$80 copay /prescription	Not Covered	
	Tier 5 - Specialty	$350 copay /prescription	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance	Not Covered	None
	Physician/surgeon fees	40% coinsurance	Not Covered	None
If you need immediate medical attention	Emergency room care	40% coinsurance	40% coinsurance	None
	Emergency medical transportation	40% coinsurance	40% coinsurance	None
	Urgent care	$60 copay /visit, deductible does not apply	Not Covered	Virtual visits - $60 copay /visit by a Designated Virtual Network Provider, deductible does not apply.

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 have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance	Not Covered	None
	Physician/surgeon fees	40% coinsurance	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: $40 copay /visit, deductible does not apply Intensive Outpatient: 40% coinsurance Partial Hospitalization: 40% coinsurance All Other Outpatient: 40% coinsurance	Not Covered	None
	Inpatient services	40% coinsurance	Not Covered	None
If you are pregnant	Office visits	No Charge	Not Covered	Cost-sharing does not apply for preventive services. Depending on the type of service, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound.)
	Childbirth/delivery professional services	40% coinsurance	Not Covered	
	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/year.
	Rehabilitation services	$40 copay /visit, deductible does not apply	Not Covered	Limits/year: Physical, Occupational, Speech, Pulmonary: 20 visits each; Cardiac: 36 visits Visit limits do not apply for a primary diagnosis of Mental Health Care, Substance-Related and Addictive Disorders or Autism Spectrum Disorder.
	Habilitative services	$40 copay /visit, deductible does not apply	Not Covered	Limits/year: Physical, Speech, Occupational: Unlimited visits each
	Skilled nursing care	40% coinsurance	Not Covered	Skilled Nursing is limited to 30 days/admission. Inpatient rehabilitation limited to 60 days/year.
	Durable medical equipment	40% coinsurance	Not Covered	None
	Hospice services	40% coinsurance	Not Covered	None
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Limited to 1 exam/12 months.
	Children's glasses	40% coinsurance	Not Covered	Limited to 1 pair/12 months.

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)	
	Children's dental check-up	No Charge	Not Covered	Limited to 2 visits/12 months.

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 (Adult) • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S.	• Private-duty nursing • Routine eye care (Adult) • Routine foot care - except as covered for certain diseases • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
• Chiropractic (manipulative) care	• Hearing aids - 1 per hearing impaired ear /3 years

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: UnitedHealthcare of Wisconsin, Inc. at 1-866-569-3468 or U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa or Wisconsin Office of the Commissioner of Insurance, 101 E Wilson Street, Madison, WI 53703, 608-266-3585 or oci.wi.gov or Office of Personnel Management Multi State Plan Program: opm.gov/healthcare-insurance/multi-state-plan-program/external-review/ . 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 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 on how 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: the Member Service number listed on the back of your ID card or myuhc.com/exchange or the Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa or Wisconsin Office of the Commissioner of Insurance at 608-266-3585 or oci.wi.gov.

Additionally, a consumer assistance program may help you file your appeal. Contact dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Not Applicable.

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 1-866-569-3468
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-569-3468
Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-569-3468
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-569-3468

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 plan's overall deductible** **$3,000**
- **Specialist copayment** **$80**
- **Hospital (facility) coinsurance** **40%**
- **Other coinsurance** **40%**

This EXAMPLE event includes services like:
Specialist office visits *(pre-natal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	**$3,000**
Copayments	**$0**
Coinsurance	**$3,300**
What isn't covered	
Limits or exclusions	**$60**
The total Peg would pay is	**$6,360**

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

- **The plan's overall deductible** **$3,000**
- **Specialist copayment** **$80**
- **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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	**$300**
Copayments	**$300**
Coinsurance	**$0**
What isn't covered	
Limits or exclusions	**$0**
The total Joe would pay is	**$600**

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

- **The plan's overall deductible** **$3,000**
- **Specialist copayment** **$80**
- **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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	**$2,200**
Copayments	**$300**
Coinsurance	**$0**
What isn't covered	
Limits or exclusions	**$0**
The total Mia would pay is	**$2,500**

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

Nondiscrimination Notice and Notice of Availability of Language Assistance Services and Alternate Formats

The Company complies with applicable civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity). We do not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex. We provide free aids and services to help you communicate with us. You can ask for interpreters and/or for communications in other languages or formats such as large print. We also provide reasonable modifications for persons with disabilities.

If you need these services, call the toll-free number on your member ID card. (TTY 711).

If you believe that we failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can send a complaint to the Civil Rights Coordinator:

Mail: Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130

Email: UHC_Civil_Rights@uhc.com
If you need help with your complaint, please call the toll-free phone number listed on your ID card (TTY/RTT 711). We are available Monday through Friday, 8 a.m. to 8 p.m. E.T.

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

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Phone: 1-800-368-1019, 1-800-537-7697 (TDD)

Mail: U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

This notice is available at: https://www.uhc.com/legal/nondiscrimination-and-language-assistance-notices.

ATTENTION: If you speak **English**, free language assistance services and free communications in other formats, such as large print, are available to you. Call the toll-free number on your member identification card.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas y comunicaciones en otros formatos como letra grande, sin cargo, a su disposición. Llame al número gratuito que figura en su tarjeta de identificación de miembro.

KUJDES: Nëse flisni **Shqip (Albanian)** shërbime falas për ndihmë gjuhësore dhe komunikime pa pagesë në formate të tjera, si p.sh. printime me shkronja të mëdha, janë të disponueshme për ju. Telefononi numrin pa pagesë në kartën tuaj të identifikimit të anëtarit.

ማስሰቢያ፦ አማርኛ (Amharic) የሚናገሩ ከሆነ፣ ነፃ የቋንቋ እገዛ አገልግሎቶች እና ነፃ ተግባቦቶች እንደ ትልቅ እትም ባሉ ሌሎች ቅርፀቶች ለእርስዎ ይገኛሉ። በአባልነት መታወቂያ ቋጥርዎ ላይ ያለውን ነፃ የስልክ ቁጥር ይደውሉ።

ملاحظة: إذا كنت تتحدث اللغة **العربية(Arabic)** ، ستتوفر لك خدمات المساعدة اللغوية المجانية والمراسلات المجانية بتنسيقات أخرى، مثل الطباعة بأحرف كبيرة .اتصل بالرقم المجاني المدون على بطاقة تعريف العضو خاصتك.

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Եթե դուք խոսում եք **հայերեն (Armenian)**, ապա ձեզ հասանելի են անվճար լեզվական աջակցության ծառայություններ և անվճար հաղորդակցություններ այլ ձևաչափերով, ինչպիսին է մեծատառ տպագրությունը: Զանգահարեք ձեր անդամի նույնականացման քարտի վրա նշված անվճար հեռախոսահամարով:

DYÉƉÉ-GBO-DÈ-ƉƐ̀: M̀ dyi **Ɓàsɔ́ɔ̀-wùɖù (Bassa)** po-nyɔ̀ jǔ ní, wuɖu xwíníín-mú-zà-zà kè bɔ̃̀ ɓě ɖé céè-dyèɖè kò-kò ɓě, hwɔ̀in-kà céè-dyèɖè vɛ̀nɛ̀-vɛ̀nɛ̀ ɓě se wíɖí pɛ́ɛ̀-pɛ́ɛ̀ dò kɔ̃̀ɛɛ nì ɓó m̀ bìì. Ɖá pídyi nɔ̀ɓà nìà nì ID káàɔ̀ kɔ̃̀ɛ.

দেখুন: আপনি যদি **বাংলায় (Bengali)** কথা বলেন, তাহলে বিনামূল্যে ভাষা সহায়তা পরিষেবা এবং বড় মুদ্রণের মতো অন্যান্য ফরম্যাটে যোগাযোগগুলি আপনার জন্য বিনামূল্যে উপলব্ধ। আপনার সদস্যের পরিচয়পত্রের কার্ডের টোল-ফ্রি নম্বরে কল করুন

သတိပေးချက်-သင်သည် ဗမာ **ဘာသာစကား (Burmese)** ကို ပြောဆိုလျှင် အခမဲ့ ဘာသာစကား ဝန်ဆောင်မှုများနှင့် စာလုံးကြီးဖြင့် ပုံနှိပ်ခြင်းကဲ့သို့ အခြားပုံစံများဖြင့် အခမဲ့ ပြောဆိုဆက်သွယ်မှုအား ရရှိနိုင်ပါသည်။ သင့်အိုင်ဒီကတ်ရှိ အခမဲ့ ဖုန်းခေါ်ဆိုနိုင်သည့် နံပါတ်သို့ ဖုန်းခေါ်ဆိုပါ။

ចំណាំ៖ ប្រសិនបើអ្នកនិយាយ**ភាសាខ្មែរ (Cambodian-Mon-Khmer)** សេវាជំនួយភាសាឥតគិតថ្លៃ និងការទំនាក់ទំនងឥតគិតថ្លៃក្នុងទម្រង់ផ្សេងទៀត ដូចជាពុម្ពអក្សរធំ មានសម្រាប់អ្នក។ ទូរសព្ទមកលេខឥតគិតថ្លៃនៅលើបណ្ណសម្គាល់សមាជិករបស់អ្នក។

ATENSHUN: Gare kapetal **Faluwasch (Carolinian)**, ye toore paliuwal kapetal Faluwasch lane sew me sew format, tapil lane fateofat, bwe bwale tepangiyom. Kol yegili nampa la ye toore paliuwal woal kard la laumw.

ATENSION: Yanggen fifino' hao **Chamoru (Chamorro)** guaha setbisio siha para hågu ni' mandibåtdi, i setbision fino' pat lengguåhi yan fina'uma'espiha gi otro na manera siha taiguihi i para mana'dångkolo i inemprenta. Ågang i dibåtdi na numiru gi kattå-mu aidentifikasion membro.

ᏅᏓᏳᏚᎢᏍ: ᏙᏗᏩ ᏧᏂᎩᏣᏛᏗ **ᏣᎳᎩ (Cherokee)**, ᏧᏂᎩᏣᏛᏗ ᎤᎵᎮᎵᏍᏗ ᎾᏍᎩ ᎾᎿ ᎢᎬᏱᏍᏗ ᏓᏂᏲᏍᏗᏍᏛ ᏗᏚᏓᏘᏗ, ᎢᏗᏎᏍᏗᏁᏗ, ᎠᏎᏍᏗ ᏄᎾᏙᏗᎢᏳᏒᎩ ᏧᏋᏋᏗ ᏧᏂᎩᏣᏛᏗᏍᏛ. ᎤᏙᎢ ᎢᎬᎢᏳᏍᏗᎢ ᏗᏈᏣᏍᏗ ᎾᏍᏗ ᏧᏂᎩᏣᏛᏗ ᎾᏍᎩ ᏧᏂᏲᎵᏍᏗ ᎠᏎᏍᏗ ᎤᏙᎢ.

请注意：如果您说中文 (Chinese - Simplified)，**我**们可以为您提供免费语言协助服务以及大字印刷本等其他格式的免费通信。请**致**电您**的会**员**身份卡上的免付**费电话号码。

請注意：如果您說**中文 (Chinese - Traditional)**，您可以獲得免費語言協助服務和大字體等其他格式的免費通訊。請致電您的會員身份卡上的免付費電話號碼。

AHVLLA: Hvsh asha **Chahta** anumpa **(Choctaw)**, hochefo anumpa aiimpa ka̱vvfi ki̱yo chi aiimpa, ilvppvt, haknip achuffa holisso ka̱nahpesa holhtina ki̱yo, ilvmmi̱to yvt chipisachi. Chipisachi hochefo ka̱nahpesa holhtina i holisso illakmvt.

Asinei ngeni meinisin: Ika pwe ka fos **Chuuk (Chuukese)**, angangen aninisin fosun fonu ese wor momon me pwan kakapas fengen ese wor momor non pwan ekkoch sakkun maak kena, usun chok watten maak, ra kan kaworeno ngonuk. Kori ewe nampa ese wor momon won noumuwe aiititin katon chon non.

PIŊ: Naye guɛl ë Thuɔŋjäŋ **(Dinka)**, akuɔɔny ke thok käk abac ku jɛmjiɛm abac tɔ̈ dhɛ̈l kɔ̈k ɣic, cïmënë käcï gɔ̈t dït nyïïn, atɔ̈ tëlɔŋ yin. Yuɔ̈p räkämä ë majan tɔ̈ kɛndun akut kɔ̈ü.

LET OP: Als u **Nederlands (Dutch)** spreekt, zijn gratis taalondersteuningsdiensten en gratis communicatie in andere formaten, zoals met grote letters, voor u beschikbaar. Bel het gratis telefoonnummer dat op uw lidmaatschapskaart staat.

توجه: اگر به زبان **فارسی (Farsi)** صحبت می‌کنید، خدمات رایگان کمک زبانی و ارتباطات رایگان در قالب‌های دیگر، مانند چاپ بزرگ، در دسترس شما هستند. با شماره رایگان مندرج روی کارت شناسایی عضویت‌تان تماس بگیرید.

ATTENTION: Si vous parlez **français (French)**, des services d’assistance linguistique et des communications dans d’autres formats, notamment en gros caractères, sont mis à votre disposition gratuitement. Appelez le numéro gratuit figurant sur votre carte de membre.

HAKILU: So aɗa haala **Fulfulde (Fulani)**, sarwisaaji ballondiral ɗemɗe ɗe njoɓetaake e jokkondiral ɗe njoɓetaake e nder mbaydiiji goɗɗi, ko wayi no binndi mawɗi, na ngoodi e juuɗe maa. Noddu limoore nde njoɓataa e kartal tergal maa.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlose Sprachassistenzdienste und kostenlose Kommunikation in anderen Formaten, wie zum große Schrift, zur Verfügung. Rufen Sie die gebührenfreie Nummer auf Ihrer Mitgliedskarte an.

ΠΡΟΣΟΧΗ: Εάν μιλάτε **Ελληνικά (Greek)**, υπάρχουν διαθέσιμες δωρεάν υπηρεσίες γλωσσικής βοήθειας και δωρεάν επικοινωνία σε άλλες μορφοποιήσεις, όπως μεγάλα γράμματα. Καλέστε τον χωρίς χρέωση αριθμό στην κάρτα μέλους σας.

ધ્યાન આપો: જો તમે **ગુજરાતી (Gujarati)** બોલતા હો તો વિના મૂલ્યે ભાષાકીય મદદરૂપ સેવાઓ અને અન્ય ફોર્મેટમાં વિના મૂલ્યે સંચાર, જેમ કે મોટી પ્રિન્ટ, તમારા માટે ઉપલબ્ધ છે. તમારા સભ્ય ઓળખ કાર્ડ પરના ટોલ-ફ્રી નંબર પર કૉલ કરો.

ATANSYON: Si w pale **Kreyòl Ayisyen (Haitian Creole),** gen sèvis lang gratis ak kominikasyon nan lòt fòma lo disponib, tankou sa ki enprime ak gwo lèt. Rele nimewo gratis ki sou kat idantifikasyon manm ou an.

MALIU MAI! Inā ʻōlelo ʻoe i ka **ʻōlelo Hawaiʻi (Hawaiian)**, loaʻa manuahi ke kōkua unuhi a me palapala i hoʻonohonoho ʻia e like me i paʻi ʻia me nā huapalapala nūnui no ke kōkua ʻana aku iā ʻoe. ʻOluʻolu e kāhea aku i ka helu kelepona kāki ʻole ma kou kāleka lālā.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते हैं, तो आपके लिए मुफ्त भाषा सहायता सेवाएँ और अन्य प्रारूपों में मुफ्त संचार, जैसे कि बड़े प्रिंट, उपलब्ध हैं। अपने सदस्य पहचान पत्र पर दिए गए टोल-फ्री नंबर पर कॉल करें।

LUS TSEEM CEEB: Yog tias koj hais **lus Hmoob (Hmong)**, cov kev pab cuam lus pub dawb thiab kev sib txuas lus dawb hauv lwm hom ntawv, xws li luam ntawv loj, muaj rau koj. Thov hu rau tus xov tooj hu dawb ntawm koj daim npav ID.

GEE NTỊ: Ọ bụrụ na ị na-asụ **asụsụ Igbo (Igbo)**, ọrụ enyemaka nkọwa asụsụ bụ n’efu yana inye nziritaozi n’ụdị ndị ọzọ dịịrị gị n’efu, dịka e ji nha mkpụrụedemede buru ibu dee ya. Kpọọ akara ekwenti nke a na-anaghị akwụ ụgwọ dị na kaadị njirimara onye òtù gị.

PANANGIKASO: No agsasaoka iti **Ilocano (Ilocano)**, magun-odmo dagiti libre a serbisio ti tulong iti pagsasao ken libre a komunikasion iti dadduma a pormat, kas iti dadakkel a letra. Tawagan ti awan-bayadna a numero a masarakan iti kard a pakabigbigam kas miembro.

PERHATIAN: Jika Anda berbicara **bahasa Indonesia (Indonesian)**, layanan bantuan bahasa gratis dan komunikasi gratis dalam format lain, seperti cetakan besar, tersedia untuk Anda. Hubungi nomor bebas pulsa yang tercantum pada kartu identifikasi keanggotaan Anda.

ATTENZIONE: Se parla **italiano (Italian)**, può usufruire di servizi di assistenza linguistica gratuiti e comunicazioni gratuite in altri formati, come ad esempio la stampa a caratteri grandi. Chiami il numero verde riportato sul Suo tesserino identificativo.

注意事項：日本語（Japanese）を話される場合、無料の言語支援サービスや、拡大文字など他の形式での無料コミュニケーションをご利用いただけます。[] にお電話ください。

ဟ်သူဉ်ဟ်သးတက့ၢ်-နမ့ၢ်စံးကတိၤ**ကညီကျိာ် (Karen)**
နှဉ်,နဒိးန့ၢ်တၢ်တိစၢၤမၤစၢၤဘဉ်ဃးဒီးကျိာ်တၢ်ကတိၤဒီးတၢ်ဆဲးကျၢဆဲးကျိးလၢကလီၤအဂၤ,အဒိဒ်သိးလံာ်မဲာ်ဖျၢဉ်အဒိဉ်တဖဉ်လၢအဘူးလဲကလီသ့နှဉ်လီၤ.ကိးဘဉ်လီကျိၤအကလီနီဉ်ဂံၢ်လၢအိဉ်ဖျါဖဲကရူၢ်ဖိအတၢ်အုဉ်ကီၤကးက့အပူၤနှဉ်တက့ၢ်.

ICITONDERWA: Nimba uyaga **Ikirundi (Kirundi)**, serevise y'ugufasha mu ndimi utariha n'itumanako mu bundi buryo, nk'ibicapo binini, wobironka. Tera akamo umuronko utariha ku bijanye n'ikarata yawe karanga y'umunyamuryango.

알림사항: 한국어(Korean)를 사용하시는 경우 무료 언어 지원 서비스와 대형 활자체 등 다른 형식으로 된 의사 소통 매체를 이용하실 수 있습니다. 회원 ID 카드에 나와 있는 무료 전화번호로 전화해 주십시오.

ئاگاداری: ئەگەر تۆ بە **زمانی کوردی سۆرانی (Kurdish Sorani)** قسە دەکەیت، ئەوە خزمەتگوزاری سەبارەت بە هاوکاری زمانی و پەیوەندیی بە فۆرماتەکانی تر، وەک چاپی گەورە، بە بێبەرامبەر لەبەردەست دادەبێت. پەیوەندی بە ژمارە تەلەفۆنی بێبەرامبەرەکەی سەر کارتی ئەندامێتی خۆت بکە

ໝາຍເຫດສຳຄັນ: ຖ້າທ່ານເວົ້າ**ພາສາລາວ (Lao)**, ພວກເຮົາມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາຟຣີ ແລະ ການສື່ສານຟຣີໃນຮູບແບບອື່ນໆໃຫ້ແກ່ທ່ານ, ເຊັ່ນ: ການພິມຂະໜາດໃຫຍ່. ໂທຫາເບີໂທຟຣີຢູ່ເທິງບັດປະຈຳຕົວສະມາຊິກຂອງທ່ານ.

लक्ष दया: जर तुम्ही **मराठी (Marathi)** बोलत असल्यास, तर मोफत भाषा सहाय्य सेवा आणि इतर फॉरमॅटमध्ये मोफत संप्रेषणे, जसे की मोठ्या प्रिंट, तुमच्यासाठी उपलब्ध आहेत. तुमच्या सदस्य ओळखपत्रावरील टोल फ्री क्रमांकावर कॉल करा.

Ñan: Ñe kwōj kenono **Kajin Majol (Marshallese)**, jibañ ko kōm maron im ejellok wonneir einwōt ukok im bōk melele ilo wāween ko jet, einwōt jeje ko relab, Kall ae nomba eo ejellok wonnen ebed itulikin kaat eo am.

BAA'ÁKONÍNÍZIN: Diné (Navajo) saad bee yáníłti'go, t'áá jíík'eh saad bee áka'e'eyeed bee áka'anída'wo'í dóó nááná łahgo át'éego bee hadadilyaa bee ahił hane'í, díí nitsaago bee ak'eda'ashchínígíí, náhóló. Bee atah nil'íní ninaaltsoos nitł'izí bee nééhoziní bąąh t'áá hiik'eh bee hane'í námboo bee hodíilnih.

ध्यान दनिुहोस्: यदि तपाईंले **नेपाली (Nepali)** बोल्नुहुन्छ भने, नि:शुल्क भाषा सहायता सेवाहरू र अन्य ढाँचाहरूमा नि:शुल्क संचारहरू, जस्तै ठूलो छाप, तपाईंका लागि उपलब्ध छन्।. आफ्नो सदस्य पहिचान कार्डमा रहेको टोल फ्री नम्बरमा कल गर्नुहोस्।

OBS: Hvis du snakker **norsk (Norwegian)**, er gratis språkhjelpstjenester og gratis kommunikasjon i andre formater, for eksempel stor skrift, tilgjengelig for deg. Ring gratisnummeret som du finner på medlemskortet ditt.

XIYYEEFFANNOO: Yoo **Afaan Oromoo (Oromo)** dubbattu ta'e, tajaajilootni deeggarsa afaanii bilisaa fi waliin dubbiin bilisaa kan akka maxxansa gurguddaa afaan keessaniin ni jiraatu. Lakkoofsa bilbila bilisaa kaardii miseensummaa keessan irra jiru irratti bilbilaa.

GEB ACHT: Wann du **Deitsch (Pennsylvania Dutch)** schwetzscht, Schprooch Helfe mitaus Koscht un Communications in annere Formats wie groosse Druck iss meeglich. Ruf die koschdelos Nummer uff dei Member Identification Kaart.

PAKAIR: Mah ke ese lokaian **Pohnpei (Pohnpeian)**, sahpis en sawas en lokaia oh mehn kapehse ni soangen mwohmw teikan kin sohte isepe, me duwehte inting lapala, kak kohda ohng kowe. Eker nempe ni sohte isepe me mih pohn noumw doaropwehn tohn pwihn ID.

UWAGA: Dla osób mówiących po **polsku (Polish)** dostępne są bezpłatne usługi pomocy językowej i bezpłatne komunikaty w innych formatach, takich jak duży druk. Prosimy zadzwonić pod bezpłatny numer podany na karcie identyfikacyjnej.

ATENÇÃO: se você fala **português (Portuguese)**, tem à sua disposição serviços gratuitos de assistência linguística e comunicações gratuitas em outros formatos, como caracteres grandes. Ligue para o número gratuito que se encontra no seu cartão de identificação de membro.

ਧਿਆਨ ਦਓਿ: ਜੇ ਤੁਸੀ **ਪੰਜਾਬੀ (Punjabi)** ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਅਤੇ ਹੋਰ ਫਾਰਮੈਟਾਂ, ਜਵਿੇਂ ਕਿ ਵੱਡੇ ਪ੍ਰਟਿੰ, ਵੱਿਚ ਮੁਫ਼ਤ ਸੰਚਾਰ ਉਪਲਬਧ ਹਨ। ਆਪਣੇ ਮੈਂਬਰ ਪਛਾਣ ਕਾਰਡ 'ਤੇ ਟੋਲ-ਫ੍ਰੀ ਨੰਬਰ 'ਤੇ ਕਾਲ ਕਰੋ।

ATENȚIE: Dacă vorbiți limba **română (Romanian)**, vă sunt disponibile servicii gratuite de asistență lingvistică și modalități gratuite de comunicare în alte formate, cum ar fi cu litere mărite. Apelați la numărul gratuit de pe legitimația dvs. de membru.

ВНИМАНИЕ: Если вы говорите на **русском** языке **(Russian)**, вам доступны бесплатные услуги языковой поддержки и бесплатные материалы в других форматах, например, напечатанные крупным шрифтом. Звоните по бесплатному номеру телефона, указанному на вашей идентификационной карте участника.

FA'AALIGA: Afai e te tautala i le **Faa-Samoa (Samoan),** o lo'o avanoa mo oe 'au'aunaga fesoasoani tau gagana e leai se totogi ma feso'ota'iga e leai se totogi i isi faiga, e pei o lomiga e lapopo'a mata'itusi. Valaau i le numera e leai se totogi i lau kata faailo o le sui auai (ID).

PAŽNJA: Ako govorite **srpski (Serbian)**, dostupne su vam besplatne usluge jezičke asistencije i besplatni načini komunikacije u drugim formatima, kao što je veliki format štampe. Pozovite besplatni broj koji se nalazi na vašoj članskoj identifikacionoj kartici.

FIIRO GAAR AH: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda bilaashka ah iyo isgaarsiino bilaash ah oo qaabab kale ah, sida far waaweyn, ayaa diyaar kuu ah. Ka wac lambarka wicitaanka bilaashka ah kaarkaaga aqoonsiga xubinta.

ZINGATIA: Ikiwa unazungumza **Kiswahili (Swahili)**, huduma za usaidizi wa lugha za bila malipo na mawasiliano ya bila malipo katika miundo mingine, kama vile maandishi makubwa, zinapatikana kwako. Piga nambari isiyolipishwa ya simu kwenye kadi yako ya kitambulisho cha mwanachama.

[illegible]
([illegible] **Syriac** [illegible])
[illegible]

PAUNAWA: Kung nagsasalita ka **ng Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika at libreng komunikasyon sa ibang mga format, tulad ng malalaking print. Tawagan ang walang bayad na numero na nasa iyong ID card ng miyembro.

శ్రద్ధ: మీరు **తెలుగు (Telugu)** మాట్లాడేవారైతే, మీకు ఉచిత భాష సహాయ సేవలు మరియు పెద్ద ముద్రణ వంటి ఇతర ఫార్మాట్‌లలో కమ్యూనికేషన్‌లు ఉచితంగా లభిస్తాయి. మీ మెంబరు ఐడెంటిఫికేషన్ కార్డులోని టోల్-ఫ్రీ నంబరుకి కాల్ చేయండి.

โปรดทราบ หากคุณพูดไทย **(Thai)** ได้ คุณสามารถใช้บริการช่วยเหลือด้านภาษาฟรีและการสื่อสารในรูปแบบอื่น ๆ ฟรี เช่น การพิมพ์ด้วยตัวอักษรขนาดใหญ่ โทรไปยังหมายเลขโทรฟรีสำหรับสมาชิกตามบัตรประจำตัวของคุณ

FAKATOKANGA: Kapau ‘oku´ke Lea **Faka-Tonga (Tongan),** ‘oku ‘i ‘ai ‘a e ngaahi tokoni ta‘etotongi ‘i he lea´ni pea mo e ngaahi founga kehe fakafetu‘utaki, hangē ko e ngaahi me‘a ‘oku paaki, ‘oku ‘ataa´ ma‘au. Fetu‘utaki ki he telefoni ta‘etotongi ‘oku hā ho kaati memipa.

DİKKAT: **Türkçe (Turkish)** konuşuyorsanız ücretsiz dil yardım hizmetlerinden ve büyük puntolu baskı gibi diğer formatlarda ücretsiz iletişimlerden yararlanabilirsiniz. Üye kimlik kartınızdaki ücretsiz hattı arayın.

УВАГА: Якщо ви розмовляєте **українською (Ukrainian)**, вам надаються безкоштовні мовні послуги та безкоштовні повідомлення в інших форматах, наприклад, крупним шрифтом. Зателефонуйте за безкоштовним номером телефону, позначеним на Вашій ідентифікаційній картці.

توجہ دیں: (Urdu) اگر آپ **اردو** زبان بولتے ہیں تو آپ کے لیے زبان کی معاون خدمات اور دیگر فارمیٹ میں مفت مواصلات، جیسے بڑے پرنٹ، آپ کے لیے دستیاب ہیں۔ اپنے ممبر شناختی کارڈ پر دیئے گئے ٹول فری نمبر پر کال کریں۔

LƯU Ý: Nếu quý vị nói Tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp các dịch vụ hỗ trợ ngôn ngữ miễn phí và các phương tiện trao đổi liên lạc miễn phí ở các định dạng khác, chẳng hạn như bản in chữ lớn. Gọi đến số điện thoại miễn phí có trên thẻ nhận dạng thành viên của quý vị.

ATENSYON: Kung ang imong sinultihan kay **Visayan (Visayan),** libre nga mga serbisyo sa tabang sa pinulongan ug libre nga komunikasyon sa ubang mga pormat, sama sa dagkong print, available kanimo. Tawage ang toll-free nga numero sa imong identipikasyon nga kard sa miyembro.

אכטונג: אויב איר רעדט אידיש (Yiddish), אומזיסטע שפראך הילף סערוויסעס און אומזיסטע קאמיוניקאציע אין אנדערע פארמאטן, ווי גרויסע אותיות זענען אוועילעבל פאר אייך. רופט די טאל פרייע נומער אויף אייער מעמבער אידענטיפיקאציע קארטל .

ÀKÍYÈSÍ: Tí o bá ń sọ **Yorùbá (Yoruba)**, àwọn ișẹ□ àtìlẹ□yìn èdè ọ□fẹ□ àti àwọn ìbánișọ□rọ□ nínú àwọn ìgúnrégé, bí àwọn àtẹ□jáde ńlá, wà fún ọ. Pe nọ□mbà tí kò nílò owó lórí káàdì ìdánimọ□ ọmọ ẹgbẹ□ rẹ.