



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: \$900 Individual / \$1,800 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> 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 deductible until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. Benefits available with no charge such as <u>Network Preventive care</u> services are covered before you meet your <u>deductible</u> . The <u>cost-sharing</u> below indicates whether the <u>deductible</u> applies for each benefit	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at healthcare.gov/coverage/preventive-care-benefits .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	Network: \$3,200 Individual / \$6,400 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 limit</u> has been met.
What is not included in the out-of-pocket limit?	Premiums, <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <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 <u>plan's 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 <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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

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	\$20 <u>copay</u> /visit, <u>deductible</u> does not apply	Not Covered	None
	<u>Specialist</u> visit	\$35 <u>copay</u> /visit, <u>deductible</u> does not apply	Not Covered	None
	<u>Preventive care/ screening/ immunization</u>	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Lab Testing: Free Standing/Office: \$5 <u>copay</u> /service, <u>deductible</u> does not apply Hospital: \$40 <u>copay</u> /service, <u>deductible</u> does not apply X-Ray/Diagnostics: Free Standing/Office: \$35 <u>copay</u> /service Hospital: \$60 <u>copay</u> /service	Not Covered	None
	Imaging (CT/PET scans, MRIs)	Free Standing/Office: \$50 <u>copay</u> /service Hospital: \$90 <u>copay</u> /service	Not Covered	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at uhc.com/xwidruglist2026	Tier 1 - \$0 Cost-share	No Charge	Not Covered	<u>Provider</u> 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. <u>Specialty drugs</u> limited to a 30-day supply at a <u>network</u> pharmacy. Certain drugs may have a <u>preauthorization</u> requirement. If you don't get <u>preauthorization</u> , 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 <u>plan</u> . Not all drugs are covered.
	Tier 2 – Preferred Generic	\$3 <u>copay</u> /prescription, <u>deductible</u> does not apply	Not Covered	
	Tier 3 - Preferred Brand	\$40 <u>copay</u> /prescription, <u>deductible</u> does not apply	Not Covered	
	Tier 4 – Non-Preferred Brand	40% <u>coinsurance</u>	Not Covered	
	Tier 5 - Specialty	50% <u>coinsurance</u>	Not Covered	

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)	
				Insulin products listed as Tier 1 on the <u>Prescription Drug List</u> are covered at No Charge at a <u>network</u> pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Free Standing/Office: \$200 <u>copay</u> /service Hospital: \$300 <u>copay</u> /service	Not Covered	None
	Physician/surgeon fees	Free Standing/Office: \$175 <u>copay</u> /date of service Hospital: \$250 <u>copay</u> /date of service	Not Covered	None
If you need immediate medical attention	<u>Emergency room care</u>	\$150 <u>copay</u> /visit	\$150 <u>copay</u> /visit	None
	<u>Emergency medical transportation</u>	\$150 <u>copay</u> /transport	\$150 <u>copay</u> /transport	None
	<u>Urgent care</u>	\$40 <u>copay</u> /visit, <u>deductible</u> does not apply	Not Covered	Virtual visits - No Charge by a Designated Virtual <u>Network Provider</u> .
If you have a hospital stay	Facility fee (e.g., hospital room)	25% <u>coinsurance</u>	Not Covered	None
	Physician/surgeon fees	25% <u>coinsurance</u>	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: \$20 <u>copay</u> /visit, <u>deductible</u> does not apply Intensive Outpatient: \$40 <u>copay</u> /visit Partial Hospitalization: \$55 <u>copay</u> /visit All Other Outpatient: \$20 <u>copay</u> /visit	Not Covered	None
	Inpatient services	25% <u>coinsurance</u>	Not Covered	None
If you are pregnant	Office visits	No Charge	Not Covered	<u>Cost-sharing</u> does not apply for <u>preventive services</u> . Depending on the type of service, a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound.)
	Childbirth/delivery professional services	25% <u>coinsurance</u>	Not Covered	
	Childbirth/delivery facility services	25% <u>coinsurance</u>	Not Covered	

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 need help recovering or have other special health needs	<u>Home health care</u>	25% <u>coinsurance</u>	Not Covered	Limited to 60 visits/year.
	<u>Rehabilitation services</u>	\$40 <u>copay</u> /visit	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.
	<u>Habilitative services</u>	\$40 <u>copay</u> /visit	Not Covered	Limits/year: Physical, Speech, Occupational: Unlimited visits each
	<u>Skilled nursing care</u>	25% <u>coinsurance</u>	Not Covered	Skilled Nursing is limited to 30 days/admission. Inpatient rehabilitation limited to 60 days/year.
	<u>Durable medical equipment</u>	25% <u>coinsurance</u>	Not Covered	None
	<u>Hospice services</u>	25% <u>coinsurance</u>	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	25% <u>coinsurance</u>	Not Covered	Limited to 1 pair/12 months.
	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) | • Dental care (Adult) | • Private-duty nursing |
| • Acupuncture | • Infertility treatment | • Routine eye care (Adult) |
| • Bariatric surgery | • Long-term care | • Routine foot care - except as covered for certain diseases |
| • Cosmetic surgery | • Non-emergency care when traveling outside the U.S. | • 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 |
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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): Dine'ehgo shika at'ohwol ninisingo, kwijigo 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	\$900
■ Specialist copayment	\$35
■ Hospital (facility) coinsurance	25%
■ Other coinsurance	25%

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:	
<i>Cost Sharing</i>	
Deductibles	\$900
Copayments	\$200
Coinsurance	\$2,100
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,260

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$900
■ Specialist copayment	\$35
■ Hospital (facility) coinsurance	25%
■ Other coinsurance	25%

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:	
<i>Cost Sharing</i>	
Deductibles	\$200
Copayments	\$200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$400

Mia's Simple Fracture

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

■ The plan's overall deductible	\$900
■ Specialist copayment	\$35
■ Hospital (facility) coinsurance	25%
■ Other coinsurance	25%

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:	
<i>Cost Sharing</i>	
Deductibles	\$900
Copayments	\$600
Coinsurance	\$10
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,510

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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](tel:1-800-368-1019), [1-800-537-7697](tel: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-notice>.

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AHVLLA: Hvsh asha **Chahta** anumpa (**Choctaw**), hochefo anumpa aiimpa kayvfi kiyo chi aiimpa, ilvppvt, haknip achuffa holisso kanahpesa holhtina kiyo, ilvmmito yvt chipisachi. Chipisachi hochefo kanahpesa holhtina i holisso illakmvt.

Asinei ngeni meininis: Ika pwe ka fos **Chuuk** (**Chuukese**), angangen anininis 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.

PID: Naye guel ë Thuonjäŋ (**Dinka**), akuɔɔny ke thok kāk abac ku jemjiem abac to̞dhēl kōk yic, cīmēnē kāci go̞t dīt nyiīn, atɔ̞tēlon yin. Yuɔ̞p rākāmā ë majan to̞ kændun akut kōū.

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)**, sarwisaaɗi ballondiral ɗemɗe ɗe njobetaake e jokkondiral ɗe njobetaake e nder mbaydiiji goɗɗi, ko wayi no binndi mawɗi, na ngoodi e juude maa. Noddu limoore nde njobataa e kartal tergal maa.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlose Sprachassistenzen 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 વનિ મૂલ્યે ભાષાકીય મદદરૂપ સેવાઓ અને અન્ય ફોર્મેટમાં વનિ મૂલ્યે સંચાર, જેમ કે મોટી પ્રિન્ટ, તમારા માટે ઉપલબ્ધ છે. તમારા સભ્ય ઓળખ કાર્ડ પરના ટોલ-ફ્રી નંબર પર કોલ કરો.

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

MALIU MAI! Inā ‘ōlelo ‘oe i ka ‘**ōlelo Hawai‘i (Hawaiian)**, loa‘a manuahi ke kōkua unuhi a me palapala i ho‘onohonoho ‘ia e like me i pa‘i ‘ia me nā huapalapala nūnui no ke kōkua ‘ana aku iā ‘oe. ‘Olu‘olu e kāhea aku i ka helu kelepona kāki ‘ole 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 कबिड़े 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 NTI: Ọ bụrụ na ị na-asụ **asụsụ Igbo (Igbo)**, ọrụ enyemaka nkọwa asụsụ bụ n'efu yana inye nziritaozi n'ụdị ndị ọzọ dịjiri gi n'efu, dika e ji nha mkpụrụedemede buru ibu dee ya. Kpọọ akara ekwenti nke a na-anaghi akwụ ụgwọ di na kaadi njirimara onye otu gi.

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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。
ဟ်သူၣ်ဟ်သးတၢ်န့ၣ်မ့ၢ်စံးကတိၤကညိၣ်ကိၣ် (Karen) န့ၣ်,နဒိးန့ၣ်တၢ်တိၤစၢၤမၤစၢၤဘၣ်သးဒီးကိၣ်တၢ်ကတိၤဒီးတၢ်ဆဲးကျဲၤဆဲးကျိးလၢက့ၢ်ဂီၤအဂၤ,အဒိဒ်သိးလံာ်မဲၢ်ဖျါၣ်အဒိၣ်တဖၣ်လၢအဘူးလဲကလီၤသ့န့ၣ်လီၤ.ကိးဘၣ်လီၤကျိၤအကလီၤနီၣ်ဂံၢ်လၢအိၣ်ဖျါဖဲကရူၢ်ဖိအတၢ်အုၣ်ကီၤကးက့အပူၤန့ၣ်တက့ၢ်.
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: ئمگەر تۆ به زمانی کوردی سۆرانی (Kurdish Sorani) قسه دهکهیت، ئهوه خزمهتگوزاری سیمبارهت به هاوکاری زمانی و پهیوهندیی به فۆرماتهکانی تر، وەک چاپی گموره، به بێبهرامبهر لهبهر دهست دادهبێت. پهیوهندی به ژماره تلهفونی بێبهرامبهرمهکهی سهر کارتێ ئهندهمانتی خۆت بکه
ໝາຍເຫດສຳຄັນ: ຖ້າທ່ານເວົ້າພາສາລາວ (Lao), ພວກເຮົາມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາພຣີແລະ ການສື່ສານພຣີໃນຮູບແບບອື່ນໆໃຫ້ແກ່ທ່ານ, ເຊັ່ນ: ການພິມຂະໜາດໃຫຍ່. ໂທຫາເບີໂທພຣີທຶບັດປະຈຳຕົວສະມາຊິກຂອງທ່ານ.
लक्ष दया: जर तुम्ही मराठी (Marathi) बोलत असल्यास, तर मोफत भाषा सहाय्य सेवा आणडितर फॉर्मॅटमध्ये मोफत संप्रेषणे, जसे की मोठ्या प्रटि, तुमच्यासाठी उपलब्ध आहेत. तुमच्या सदस्य ओळखपत्रावरील टोल फ्री क्रमांकावर कॉल करा.
Nan: 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 दनिहोस्: यदि तपाईंले नेपाली (Nepali) बोलनुहुन्छ भने, नःशिल्क भाषा सहायता सेवाहरू र अन्य ढाँचाहरूमा नःशिल्क 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.

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 founa 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.
اردو (Urdu) توجہ دیں: 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.
ÀKÌYÈSÍ: Tí o bá ń sọ Yorùbá (Yoruba) , àwọn iṣẹ̀ àtìlẹ̀yìn èdè ọ̀fẹ́ àti àwọn ìbáńsọ̀rọ̀ nínú àwọn ìgúnrégé, bí àwọn àtẹ̀lẹ́jádẹ̀ ńlá, wà fún ọ. Pe nọmbà tí kò nílò owó lórí kààdì ìdánimọ̀ ọmọ egbẹ̀ rẹ.