



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: \$0 Individual / \$0 Family	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes.	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: \$2,200 Individual / \$4,400 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/xwidoconfindoa2026 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	No Charge	Not Covered	None
	<u>Specialist</u> visit	\$10 copay /visit, deductible does not apply	Not Covered	None
	<u>Preventive care</u> / 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 <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	25% coinsurance, deductible does not apply	Not Covered	None
	Imaging (CT/PET scans, MRIs)	25% coinsurance, deductible does not apply	Not Covered	None
	Tier 1 - \$0 Cost-share	No Charge	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/xwidruglist 2026	Tier 2 – Preferred Generic	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.
	Tier 3 - Preferred Brand	\$15 copay /prescription, deductible does not apply	Not Covered	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 <u>network</u> pharmacy.
	Tier 4 – Non-Preferred Brand	\$50 copay /prescription, deductible does not apply	Not Covered	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.
	Tier 5 - Specialty	\$150 copay /prescription, deductible does not apply	Not Covered	See the website listed for information on drugs covered by your <u>plan</u> . Not all drugs are covered.
	Facility fee (e.g., ambulatory surgery center)	25% coinsurance, deductible does not apply	Not Covered	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	Physician/surgeon fees	25% coinsurance, deductible does not apply	Not Covered	None
If you need immediate medical attention	<u>Emergency room care</u>	25% coinsurance, deductible does not apply	25% coinsurance, deductible does not apply	None
	<u>Emergency medical transportation</u>	25% coinsurance, deductible does not apply	25% coinsurance, deductible does not apply	None

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)	
	<u>Urgent care</u>	\$5 <u>copay</u> /visit, <u>deductible</u> does not apply	Not Covered	Virtual visits - \$5 <u>copay</u> /visit by a Designated Virtual Network Provider, <u>deductible</u> does not apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	25% <u>coinsurance</u> , <u>deductible</u> does not apply	Not Covered	None
	Physician/surgeon fees	25% <u>coinsurance</u> , <u>deductible</u> does not apply	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: No Charge Intensive Outpatient: 25% <u>coinsurance</u> , <u>deductible</u> does not apply Partial Hospitalization: 25% <u>coinsurance</u> , <u>deductible</u> does not apply All Other Outpatient: 25% <u>coinsurance</u> , <u>deductible</u> does not apply	Not Covered	None
	Inpatient services	25% <u>coinsurance</u> , <u>deductible</u> does not apply	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 <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> , <u>deductible</u> does not apply	Not Covered	
	Childbirth/delivery facility services	25% <u>coinsurance</u> , <u>deductible</u> does not apply	Not Covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	25% <u>coinsurance</u> , <u>deductible</u> does not apply	Not Covered	Limited to 60 visits/year.
	<u>Rehabilitation services</u>	No Charge	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>	No Charge	Not Covered	Limits/year: Physical, Speech, Occupational: Unlimited visits each
	<u>Skilled nursing care</u>	25% <u>coinsurance</u> , <u>deductible</u> does not apply	Not Covered	Skilled Nursing is limited to 30 days/admission. Inpatient rehabilitation limited to 60 days/year.

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)	
	<u>Durable medical equipment</u>	25% <u>coinsurance</u> , <u>deductible</u> does not apply	Not Covered	None
	<u>Hospice services</u>	25% <u>coinsurance</u> , <u>deductible</u> does not apply	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> , <u>deductible</u> does not apply	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)
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S. diseases
- 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): Dinekehgo 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 \$0
- Specialist copayment \$10
- 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>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$2,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,260

Managing Joe's Type 2 Diabetes

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

- The plan's overall deductible \$0
- Specialist copayment \$10
- 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>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$20
<u>Coinsurance</u>	\$70
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$90

Mia's Simple Fracture

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

- The plan's overall deductible \$0
- Specialist copayment \$10
- 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>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$600
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$610

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

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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-notices>.

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 aiiimpa kayvfi kiyo chhi aiiimpa, ilvppvt, haknip achuffa holisso kanahpesa holhtina kiyo, ilvmmijto yvt chipisachi. Chipisachi hochefo kanahpesa 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 aiiitin katon chon non.	
PID: Naye guel ë Thuonjäñ (Dinka), akuwoñy ke thok kāk abac ku jemjiem abac to òhēl kōk yic, cīmēñē kăci gōt dīt nyiīn, atō òlōñ yin. Yuōp rākāmā ë majan tō kēndun 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 بہ 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 adfa haala Fulfulde (Fulani) , sarwisaaji ballondiral demde de njobetaake e jokkondiral de njobetaake e nder mbaydiiji godfɔ, 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.	
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ધયાન આપો: જો તમે ગુજરાતી (Gujarati) બોલતા હો તો વાંચી મૂલ્યે ભાષાકીય મદદરૂપ સેવાઓ અને અન્ય ફોર્મેટમાં વાંચી 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 la 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 ‘āna aku iā ‘oe. ‘Olu‘olu e kāhea aku i ka helu kelepona kāki ‘ole ma kou kāleka lāiā.	
ધયાન દે: 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: Ɔ burɔ na i na-asɔ asɔɔ Igbo (Igbo) , ɔrɔ enyemaka nkɔwa asɔɔ bu n'efu yana inyɛ nziritaozi n'ɔdi ndi ɔzɔ diiri gi n'efu, dika e ji nha mkpɔrɔ edemede buru ibu dee ya. Kpɔɔ akara ekwentii nke a na-anaghi akwɔ ɔgwɔ di na kaadi njirimara onye ɔtù gi.	

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、拡大文字などの無料フォーマット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。		ဟ်သျှုဟ်သးတက့ၢ်-န့ၢ်မ့ၢ်ခဲးကတိၤကညိၣ်က့ၢ် (Karen) န့ၢ်န့ၢ်ဒီးန့ၢ်တၢ်တိၤစၢၤမၤစၢၤတၢ်သးဒီးက့ၢ်တၢ်ကတိၤဒီးတၢ်ခဲးကျဲၤခဲးကျဲၤလၢက့ၢ်ဂီၤအဂၤ,အဒိဒ်သိးလံာ်မ့ၢ်ဖျၢၣ်အဒိဒ်တဖၣ်လၢအဘျးလဲကလိၤသ့န့ၢ်လီၤ.ကိးဘၢန့ၢ်လီၤကျိၤအကလိၤနီၣ်ဂီၢ်လၢအိၣ်ဖျါဖဲကရူၢ်ဖဲအတၢ်အုၣ်ကီၤကးက့ၢ်အပူၤန့ၢ်တက့ၢ်.		ICITONDERWA: Nimba uyaga kirundi (Kirundi), serevise y'ugufasha mu ndimi utariha n'itumanako mu bundi buryo, nk'ibicapo binini, wobironka. Tera akamo umuronko utariha ku bijanywe 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.		بە گەلگاداری: ئێگەر تۆ بە زمانی کوردی سورانی (Kurdish Sorani) قسە دەکەیت، ئێوه خزمەتگوزاری سەیارەت بە هاوکاری زمانی و پەیوەندییە فۆرماتەکانی تر، وەک چاپی گۆرە، بە ئێڤێر امبەر لەبەر دەست دادەنێت. پەیوەندی بە ژمارە تەلەفۆنی پێیڤەر امبەر مەکە سەر کارتی ئەندامانی خۆت بکە		ໝາຍເຫດສຳຄັນ: ຖ້າທ່ານເວົ້າພາສາລາວ (Lao), ພວກເຮົາມີການບໍ່ມີການຊ່ວຍເຫຼືອດ້ານພາສາພາສີ້ແລະ ການສື່ສານພາສີ້ໃຫ້ແກ່ທ່ານ, ເຊັ່ນ: ການພິມຂະໜານໃຫຍ່. ໃຫ້ຫາເບີໂທພາສີ້ເພື່ອບໍ່ຈຳຕົວສະມາຊິກຂອງທ່ານ.		लक्ष दया: जर तुम्ही मराठी (Marathi) बोलत असल्यास, तर मोफत भाषा सहाय्य सेवा आणि इतर फॉर्मेटमध्ये मोफत संप्रेषणे, जसे की मोठ्या प्रॉटि, तुमच्यासाठी उपलब्ध आहेत. तुमच्या सदस्य ओळखपत्रावरील टोल फ्री क्रमांकावर कॉल करा.		Nan: Ñe kwōj kenono Kajin Majol (Marshallese), jibaŋ 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'ÁKONÍNIZIN: Diné (Navajo) saad bee yáníłt'igo, t'áá jíík'eh saad bee áka'e'eyeed bee áka'anída'wo'í dóó nááná łahgo át'éego bee hadadilyaa bee ahíł hane'í, díí nitsaago bee ak'eda'ashchinígíí, náhółq. Bee atah nil'íní ninaaltsoos nítł'ízí bee nééhoziní baąh t'áá híik'eh bee hane'í námboo bee hodíłinih.		ध्यान दनिहोसः यदतिपाईले नेपाली (Nepali) बोलनुहुन्छ भने, निःशुल्क भाषा सहायता सेवाहरू र अन्य ढाँचाहरूमा निःशुल्क संचारहरू, जस्तै ठूलो छाप, तपाईँका 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.	
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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 Deutsch (Pennsylvania Dutch) schwetzscht, Schprooch Hilfe 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 duże 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 ਦਿਓ:	ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ (Punjabi) ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਅਤੇ ਹੋਰ ਟਾਰਗੈਟ, ਜੜ੍ਹਿ ਕੀਤੀਆਂ ਹਨ। ਆਪਣੇ ਮੈਂਬਰ ਪੱਛਾਣ ਨੰਬਰ 'ਤੇ ਟੈਲ-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 legătura 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'ĀALIGA:	Afai e te tautala i le Faa-Samoa (Samoan), o lo'o avanoa mo oe 'au'aunaga fesoasoani tau gagana e lei ai se totogi ma feso'ota'iga e lei ai se totogi i isi faiga, e pei o lomiga e lapopo'a mata'itusi. Valaau i le numera e lei ai 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 isiylipishwa ya simu kwenye kadi yako ya kitambulisho cha mwanachama.
සිංහල - සිංහලයාගේ සඳහා	අප්‍රකාශනයක් ලෙසින් පමණක් නොවන අතර ඔබගේ මවු වැඩ කරන රටේ කළ යුතු දේ සම්බන්ධයෙන් ඔබට තීරණ ගැනීමට හෝ විකල්ප සොයා බැලීමට ඉඩ ඇති බවට තීරණය කරයි.
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.
శిరద్ద:	మీరు తెలుగుగా (Telugu) మాట్లాడితే, మీకు ఉచిత భాష సహాయ నివలంబన మరియు వివిధ మార్గాలలో ఇతర టార్గెటెడ్ సర్వీసులు ఉచితంగా లభిస్తాయి. మీ సంఖ్యపై ప్రింట్ చేయించిన కారڈ్ నుండి ఫ్రీ కాల్ నంబర్‌ను వాడండి.
โปรดทราบ	หากคุณพูดไทย (Thai) ได้ คุณสามารถใช้บริการช่วยเหลือด้านภาษาฟรีและการสื่อสารในรูปแบบอื่น ๆ ฟรี เช่น การพิมพ์ด้วยตัวอักษรขนาดใหญ่ ไทโรปิ้งหมายเลขโทรฟรีสำหรับสมาชิกตามบัตรประจำตัวของคุณ

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.
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 (Urdu) توجہ دیں: اگر آپ اردو ممبر شناختی کارڈ پر دیئے گئے ٹول فری نمبر پر کال کریں۔
LU'U Ỗ: 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 sinulitihan 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), אומזיטע שפראך הילף סערווייטעס און אומזיטע קאמיוניקאציע קארטל, אומזיטע פאר אייך. רופט די טאל פרייע נומער אויף אייער מעמבער אידענטיפיקאציע קארטל.
ĀKIYÈSÍ: Tí o bá ń sọ Yorùbá (Yoruba) , àwọn işẹl àtẹlẹyin èdè oifẹl àti àwọn ibánişọlunín nínú àwọn ẹ̀gúnrégẹ́, bí àwọn àtẹlẹ́jádẹ́ nílá, wà fún ọ. Pe nọlmbà tí kò nílò owó lóri kààdì idánimọl ọmọ ẹgbẹl ẹ.