



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, <https://eoc.anthem.com/eocdps/8Y3FIND01012026>. 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/](http://www.healthcare.gov/sbc-glossary/) or call (855) 837-8540 to request a copy.

| Important Questions                                                       | Answers                                                                                                                                                                                                                                                             | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|---------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall <u>deductible</u>?</b>                             | \$5,000/person or \$10,000/family for In-Network Providers.                                                                                                                                                                                                         | 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 <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .                                                                                                                                                               |
| <b>Are there services covered before you meet your <u>deductible</u>?</b> | Yes. Primary Care. <u>Specialist Visit</u> . <u>Preventive Care</u> . Certain <u>Prescription Drugs</u> . Vision. For more information see below.                                                                                                                   | 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                            |
| <b>Are there other <u>deductibles</u> for specific services?</b>          | No.                                                                                                                                                                                                                                                                 | You don't have to meet <u>deductibles</u> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>       | \$9,750/person or \$19,500/family for In-Network Providers.                                                                                                                                                                                                         | 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.                                                                                                                                                                                                                                                                                     |
| <b>What is not included in the <u>out-of-pocket limit</u>?</b>            | <u>Premiums</u> , <u>balance-billing</u> charges (unless <u>balanced billing</u> is prohibited), 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> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Will you pay less if you use a <u>network provider</u>?</b>            | Yes. See <a href="http://www.anthem.com/find-care/?alphaprefix=EXG">www.anthem.com/find-care/?alphaprefix=EXG</a> or call (855) 837-8540 for a list of <u>network providers</u> . Benefits and costs may vary by site of service and how the <u>provider</u> bills. | 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 <u>referral</u> to see a <u>specialist</u> ? | 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                                                                                                                                             |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                      |                                                         | Level 1 Pharmacy- RX Only<br>(You will pay the least)                                                                                 | In-Network Provider<br>(You will pay more)                        | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                    |
| If you visit a health care <u>provider's</u> office or clinic                                                                                                                                                                        | Primary care visit to treat an injury or illness        | Not Applicable                                                                                                                        | \$10/visit, <u>deductible</u> does not apply                      | Not covered                                        | Virtual visits (Telehealth) benefits available.                                                                                                                                                    |
|                                                                                                                                                                                                                                      | <u>Specialist</u> visit                                 | Not Applicable                                                                                                                        | \$70/visit, <u>deductible</u> does not apply                      | Not covered                                        | Virtual visits (Telehealth) benefits available.                                                                                                                                                    |
|                                                                                                                                                                                                                                      | <u>Preventive care</u> / <u>screening</u> /immunization | Not Applicable                                                                                                                        | No charge, <u>deductible</u> does not apply                       | 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)              | Not Applicable                                                                                                                        | 25% <u>coinsurance</u>                                            | Not covered                                        | -----none-----                                                                                                                                                                                     |
|                                                                                                                                                                                                                                      | Imaging (CT/PET scans, MRIs)                            | Not Applicable                                                                                                                        | \$300/day, then 50% <u>coinsurance</u>                            | Not covered                                        | -----none-----                                                                                                                                                                                     |
| If you need drugs to treat your illness or condition<br>More information about <u>prescription drug coverage</u> is available at <a href="http://www.anthem.com/pharmacyinformation/">http://www.anthem.com/pharmacyinformation/</a> | Generic drugs (Tier 1)                                  | \$3/prescription, <u>deductible</u> does not apply (retail) and \$9/prescription, <u>deductible</u> does not apply (home delivery)    | \$15/prescription, <u>deductible</u> does not apply (retail only) | Not covered (retail and home delivery)             | For more information, refer to "Select Drug List" at <a href="http://www.anthem.com/pharmacyinformation/">http://www.anthem.com/pharmacyinformation/</a><br>*See <u>Prescription Drug</u> section. |
|                                                                                                                                                                                                                                      | Preferred brand drugs (Tier 2)                          | \$60/prescription, <u>deductible</u> does not apply (retail) and \$180/prescription, <u>deductible</u> does not apply (home delivery) | \$75/prescription, <u>deductible</u> does not apply (retail only) | Not covered (retail and home delivery)             |                                                                                                                                                                                                    |

\* For more information about limitations and exceptions, see the plan or policy document at <https://eoc.anthem.com/eocdps/8Y3FIND01012026>.

| Common Medical Event                                                             | Services You May Need                          | What You Will Pay                                  |                                                                                |                                                          | Limitations, Exceptions, & Other Important Information                                                                |
|----------------------------------------------------------------------------------|------------------------------------------------|----------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|
|                                                                                  |                                                | Level 1 Pharmacy- RX Only (You will pay the least) | In-Network Provider (You will pay more)                                        | Out-of-Network Provider (You will pay the most)          |                                                                                                                       |
|                                                                                  | Non-preferred brand drugs (Tier 3)             | 40% <u>coinsurance</u> (retail and home delivery)  | 55% <u>coinsurance</u> (retail only)                                           | Not covered (retail and home delivery)                   |                                                                                                                       |
|                                                                                  | <u>Specialty drugs</u> (Tier 4)                | 50% <u>coinsurance</u> (retail and home delivery)  | 60% <u>coinsurance</u> (retail only)                                           | Not covered (retail and home delivery)                   |                                                                                                                       |
| <b>If you have outpatient surgery</b>                                            | Facility fee (e.g., ambulatory surgery center) | Not Applicable                                     | 25% <u>coinsurance</u>                                                         | Not covered                                              | -----none-----                                                                                                        |
|                                                                                  | Physician/surgeon fees                         | Not Applicable                                     | 25% <u>coinsurance</u>                                                         | Not covered                                              | -----none-----                                                                                                        |
| <b>If you need immediate medical attention</b>                                   | <u>Emergency room care</u>                     | Not Applicable                                     | \$400/visit, then 25% <u>coinsurance</u>                                       | Covered as In-<br><u>Network</u>                         | -----none-----                                                                                                        |
|                                                                                  | <u>Emergency medical transportation</u>        | Not Applicable                                     | 25% <u>coinsurance</u>                                                         | Covered as In-<br><u>Network</u>                         | Non-emergency Out-of-Network Ambulance Services are limited to \$50,000 per trip, does not apply to air ambulance.    |
|                                                                                  | <u>Urgent care</u>                             | Not Applicable                                     | \$75/visit, <u>deductible</u> does not apply                                   | Covered as In-<br><u>Network</u>                         | -----none-----                                                                                                        |
| <b>If you have a hospital stay</b>                                               | Facility fee (e.g., hospital room)             | Not Applicable                                     | \$400/admission, then 25% <u>coinsurance</u>                                   | Not covered                                              | 60 days/year for Inpatient rehabilitation and skilled nursing services combined for In-<br><u>Network Providers</u> . |
|                                                                                  | Physician/surgeon fees                         | Not Applicable                                     | 25% <u>coinsurance</u>                                                         | Not covered                                              | -----none-----                                                                                                        |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                            | Not Applicable                                     | Office Visit 25% <u>coinsurance</u><br>Other Outpatient 25% <u>coinsurance</u> | Office Visit Not covered<br>Other Outpatient Not covered | Office Visit<br>Virtual visits (Telehealth) benefits available.<br>Other Outpatient<br>-----none-----                 |
|                                                                                  | Inpatient services                             | Not Applicable                                     | \$400/admission, then 25% <u>coinsurance</u>                                   | Not covered                                              | -----none-----                                                                                                        |
| <b>If you are pregnant</b>                                                       | Office visits                                  | Not Applicable                                     | 25% <u>coinsurance</u>                                                         | Not covered                                              | Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).                      |
|                                                                                  | Childbirth/delivery professional services      | Not Applicable                                     | 25% <u>coinsurance</u>                                                         | Not covered                                              |                                                                                                                       |

\* For more information about limitations and exceptions, see the plan or policy document at <https://eoc.anthem.com/eocdps/8Y3FIND01012026>.

| Common Medical Event                                           | Services You May Need                 | What You Will Pay                                  |                                              |                                                 | Limitations, Exceptions, & Other Important Information                                                             |
|----------------------------------------------------------------|---------------------------------------|----------------------------------------------------|----------------------------------------------|-------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|
|                                                                |                                       | Level 1 Pharmacy- RX Only (You will pay the least) | In-Network Provider (You will pay more)      | Out-of-Network Provider (You will pay the most) |                                                                                                                    |
|                                                                | Childbirth/delivery facility services | Not Applicable                                     | \$400/admission, then 25% <u>coinsurance</u> | Not covered                                     |                                                                                                                    |
| If you need help recovering or have other special health needs | <u>Home health care</u>               | Not Applicable                                     | 25% <u>coinsurance</u>                       | Not covered                                     | 120 visits/year for In- <u>Network Providers</u> .                                                                 |
|                                                                | <u>Rehabilitation services</u>        | Not Applicable                                     | 25% <u>coinsurance</u>                       | Not covered                                     | *See Therapy Services section.                                                                                     |
|                                                                | <u>Habilitation services</u>          | Not Applicable                                     | 25% <u>coinsurance</u>                       | Not covered                                     |                                                                                                                    |
|                                                                | <u>Skilled nursing care</u>           | Not Applicable                                     | 25% <u>coinsurance</u>                       | Not covered                                     | 60 days/year for Inpatient rehabilitation and skilled nursing services combined for In- <u>Network Providers</u> . |
|                                                                | <u>Durable medical equipment</u>      | Not Applicable                                     | 25% <u>coinsurance</u>                       | Not covered                                     | *See <u>Durable Medical Equipment</u> section.                                                                     |
|                                                                | <u>Hospice services</u>               | Not Applicable                                     | 25% <u>coinsurance</u>                       | Not covered                                     | -----none-----                                                                                                     |
| If your child needs dental or eye care                         | Children's eye exam                   | Not Applicable                                     | No charge, <u>deductible</u> does not apply  | Not covered                                     | *See Vision Services section.                                                                                      |
|                                                                | Children's glasses                    | Not Applicable                                     | No charge, <u>deductible</u> does not apply  | Not covered                                     |                                                                                                                    |
|                                                                | Children's dental check-up            | Not covered                                        | Not covered                                  | Not covered                                     | -----none-----                                                                                                     |

#### Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- |                                                                                                                                                                                                                                                                                     |                                                                                                                                                           |                                                                                                                                                                                                                                   |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Abortion (except in cases of rape, incest, or when the life of the mother is endangered)</li> <li>• Children's dental check-up</li> <li>• Infertility treatment</li> <li>• Private-duty nursing</li> <li>• Weight loss programs</li> </ul> | <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Cosmetic surgery</li> <li>• Long-term care</li> <li>• Routine eye care (Adult)</li> </ul> | <ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Dental care (Adult)</li> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Routine foot care unless <u>medically necessary</u></li> </ul> |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

\* For more information about limitations and exceptions, see the plan or policy document at <https://eoc.anthem.com/eocdps/8Y3FIND01012026>.

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Hearing aids 1 item(s)/ear every 48 months for children 18 years of age or under. \$3,000 maximum/hearing aid.
- Spinal Manipulation 20 visits/benefit period

**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: Georgia Office of Insurance and Safety Fire Commissioner, Consumer Services Division, 2 Martin Luther King, Jr. Drive, West Tower, Suite 716, Atlanta, Georgia 30334, (800) 656-2298, [www.oci.ga.gov/ConsumerService/Home.aspx](http://www.oci.ga.gov/ConsumerService/Home.aspx), or contact Anthem at the number on the back of your ID card. 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 [www.HealthCare.gov](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 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:

ATTN: Grievances and Appeals, P.O. Box 105449, Atlanta, GA 30548-5449

Georgia Office of Insurance and Safety Fire Commissioner, Consumer Services Division, 2 Martin Luther King, Jr. Drive, West Tower, Suite 716, Atlanta, Georgia 30334, (800) 656-2298, [www.oci.ga.gov/ConsumerService/Home.aspx](http://www.oci.ga.gov/ConsumerService/Home.aspx)

Additionally, a consumer assistance program can help you file your appeal. Contact Georgia Office of Insurance and Safety Fire Commissioner Customer Services Division, 2 Martin Luther King, Jr. Drive West Tower, Suite 702 Atlanta, GA 30334, (800) 656-2298, <https://oci.georgia.gov/insurance-resources/health>

**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.

*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<br>(9 months of in-network pre-natal care and a hospital delivery)                                                                                                                                                                                                                        |          | Managing Joe's Type 2 Diabetes<br>(a year of routine in-network care of a well-controlled condition)                                                                                                                                                                        |         | Mia's Simple Fracture<br>(in-network emergency room visit and follow up care)                                                                                                                                                                                                   |         |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|
| ■ The plan's overall <u>deductible</u>                                                                                                                                                                                                                                                                         | \$5,000  | ■ The plan's overall <u>deductible</u>                                                                                                                                                                                                                                      | \$5,000 | ■ The plan's overall <u>deductible</u>                                                                                                                                                                                                                                          | \$5,000 |
| ■ <u>Specialist copayment</u>                                                                                                                                                                                                                                                                                  | \$70     | ■ <u>Specialist copayment</u>                                                                                                                                                                                                                                               | \$70    | ■ <u>Specialist copayment</u>                                                                                                                                                                                                                                                   | \$70    |
| ■ Hospital (facility) <u>coinsurance</u>                                                                                                                                                                                                                                                                       | 25%      | ■ Hospital (facility) <u>coinsurance</u>                                                                                                                                                                                                                                    | 25%     | ■ Hospital (facility) <u>coinsurance</u>                                                                                                                                                                                                                                        | 25%     |
| ■ Other <u>coinsurance</u>                                                                                                                                                                                                                                                                                     | 25%      | ■ Other <u>coinsurance</u>                                                                                                                                                                                                                                                  | 25%     | ■ Other <u>coinsurance</u>                                                                                                                                                                                                                                                      | 25%     |
| This EXAMPLE event includes services like:<br><u>Specialist</u> office visits ( <i>prenatal care</i> )<br>Childbirth/Delivery Professional Services<br>Childbirth/Delivery Facility Services<br><u>Diagnostic tests</u> ( <i>ultrasounds and blood work</i> )<br><u>Specialist</u> visit ( <i>anesthesia</i> ) |          | This EXAMPLE event includes services like:<br><u>Primary care physician</u> office visits ( <i>including disease education</i> )<br><u>Diagnostic tests</u> ( <i>blood work</i> )<br><u>Prescription drugs</u><br><u>Durable medical equipment</u> ( <i>glucose meter</i> ) |         | This EXAMPLE event includes services like:<br><u>Emergency room care</u> ( <i>including medical supplies</i> )<br><u>Diagnostic test</u> ( <i>x-ray</i> )<br><u>Durable medical equipment</u> ( <i>crutches</i> )<br><u>Rehabilitation services</u> ( <i>physical therapy</i> ) |         |
| Total Example Cost                                                                                                                                                                                                                                                                                             | \$12,700 | Total Example Cost                                                                                                                                                                                                                                                          | \$5,600 | Total Example Cost                                                                                                                                                                                                                                                              | \$2,800 |
| In this example, Peg would pay:                                                                                                                                                                                                                                                                                |          | In this example, Joe would pay:                                                                                                                                                                                                                                             |         | In this example, Mia would pay:                                                                                                                                                                                                                                                 |         |
| <u>Cost Sharing</u>                                                                                                                                                                                                                                                                                            |          | <u>Cost Sharing</u>                                                                                                                                                                                                                                                         |         | <u>Cost Sharing</u>                                                                                                                                                                                                                                                             |         |
| <u>Deductibles</u>                                                                                                                                                                                                                                                                                             | \$5,000  | <u>Deductibles</u>                                                                                                                                                                                                                                                          | \$100   | <u>Deductibles</u>                                                                                                                                                                                                                                                              | \$2,500 |
| <u>Copayments</u>                                                                                                                                                                                                                                                                                              | \$10     | <u>Copayments</u>                                                                                                                                                                                                                                                           | \$1,700 | <u>Copayments</u>                                                                                                                                                                                                                                                               | \$200   |
| <u>Coinsurance</u>                                                                                                                                                                                                                                                                                             | \$1,900  | <u>Coinsurance</u>                                                                                                                                                                                                                                                          | \$0     | <u>Coinsurance</u>                                                                                                                                                                                                                                                              | \$0     |
| <u>What isn't covered</u>                                                                                                                                                                                                                                                                                      |          | <u>What isn't covered</u>                                                                                                                                                                                                                                                   |         | <u>What isn't covered</u>                                                                                                                                                                                                                                                       |         |
| Limits or exclusions                                                                                                                                                                                                                                                                                           | \$60     | Limits or exclusions                                                                                                                                                                                                                                                        | \$20    | Limits or exclusions                                                                                                                                                                                                                                                            | \$0     |
| The total Peg would pay is                                                                                                                                                                                                                                                                                     | \$6,970  | The total Joe would pay is                                                                                                                                                                                                                                                  | \$1,820 | The total Mia would pay is                                                                                                                                                                                                                                                      | \$2,700 |

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



## We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document.

### Spanish

Usted tiene derecho a obtener asistencia en su idioma sin cargo. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación ¿Tiene alguna deficiencia visual? También puede solicitar este documento en otros formatos.

### Chinese

您有權免費獲得使用您的語言提供的協助。只需撥打印於您的 ID 卡上的會員服務部電話號碼即可。視力障礙？您也可以索取本文件的其他格式。

### Vietnamese

Quý vị có quyền nhận trợ giúp bằng ngôn ngữ của mình, miễn phí. Quý vị chỉ cần gọi đến số điện thoại của Ban Dịch vụ Thành viên trên thẻ ID của quý vị. Quý vị bị khiếm thị? Quý vị cũng có thể yêu cầu các định dạng khác của tài liệu này.

### Korean

귀하는 귀하의 언어로 된 도움을 무료로 받을 권리가 있습니다. 귀하의 ID 카드에 있는 가입자 서비스 번호로 전화하십시오. 시각 장애인이신가요? 다른 형식으로 된 이 문서를 요청하실 수 있습니다.

### Tagalog

May karapatan kang makakuha ng tulong na nasa iyong wika nang libre. Tawagan lang ang numero ng Member Services na nasa iyong ID card. May kapansanan sa paningin? Maaari ka ring humingi ng iba pang mga format ng dokumentong ito.

### Russian

У вас есть право на бесплатное получение помощи на вашем родном языке. Просто позвоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. У вас проблемы со зрением? Вы также можете запросить этот документ в других форматах.

### French Creole

Ou gen dwa jwenn èd nan lang ou gratis. Jis rele nimewo Sèvis Manm ki sou Kat ID ou a gratis Gen pwoblèm vizyèl? Ou ka mande tou pou lòt fòm nan dokiman sa a.

### Arabic

لك الحق في الحصول على هذه المعلومات والحصول على المساعدة بلغتك مجاًاً. فقط اتصل برقم خدمات الأعضاء الموجود على بطاقة هويتك. هل تعاني من ضعف البصر؟ يمكنك أيضاً طلب تنسيقات أخرى لهذه الوثيقة.

### French

Vous avez le droit d'obtenir de l'aide dans votre langue gratuitement. Appelez simplement le numéro du Services membres figurant sur votre carte d'identité. Vous êtes une personne malvoyante ? Vous pouvez également demander à accéder à ce document dans d'autres formats.

### Persian

شما حق دارید به زبان خود به صورت رایگان کمک بگیرید. فقط با شماره خدمات اعضا مندرج در کارت عضویت خود تماس بگیرید. آیا دچار اختلال بینایی هستید؟ همچنین می‌توانید فرمت‌های دیگر این سند را درخواست کنید.

### Armenian

Դուք իրավունք ունեք անվճար օգնություն ստանալու ձեր լեզվով: Պարզապես զանգահարեք ձեր ID քարտի վրա գտնվող Անդամների սպասարկման համարին: Տեսողության խանգարում ունեցող եք: Կարող եք նաև խնդրել այս փաստաթղթի այլ ձևաչափեր:

### Japanese

あなたにはあなたの言語で無料で支援を受ける権利があります。ID カードに記載されている会員サービス番号にお電話ください。視覚障害をお持ちですか？他の形式でこの文書を要求することもできます。

### Italian

Hai il diritto di ricevere assistenza gratuita nella tua lingua. Basta chiamare il numero del Servizio Membri presente sulla tua tessera identificativa. Hai problemi di vista? È possibile richiedere anche altri formati di questo documento.

### German

Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Rufen Sie einfach die Nummer des Mitgliederservices auf Ihrer ID-Karte an. Sehbehindert? Sie können dieses Dokument auch in anderen Formaten anfordern.

### Polish

Masz prawo do bezpłatnej pomocy w swoim języku. Wystarczy zadzwonić pod numer Biura Obsługi Klienta podany na karcie identyfikacyjnej. Masz wadę wzroku? Możesz również poprosić o inne formaty tego dokumentu.

### Pennsylvania Dutch

Du hoscht's Recht fer Hilf griege in dei Schprooch fer nix. Duh yuscht die Member Services Number uffrufe uff dei ID Card. Hoscht Druwwel fer sehne? Du kannscht des do Schreiwes in en differnter Weg griege so as du's besser sehne kannscht.

### TTY/TTD:711

### It's important we treat you fairly

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