



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, visit engage.ameriben.com or call 1-844-511-1914. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-844-511-1914 to request a copy.

Important Questions	Answers				Why This Matters:
What is the overall <u>deductible</u> ?		Tier 1 – Emory Healthcare Network	Tier 2 – Anthem Network	Tier 3 – Non- Network	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> .
	Per participant:	\$850	\$1,000	\$2,000	
	Per family:	\$2,550	\$3,000	\$6,000	
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Network preventive care</u> , <u>network hospice care</u> , <u>prescription drugs</u> , and services which apply a <u>co-payment</u> .				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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.				You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?		Tier 1 – Emory Healthcare Network	Tier 2 – Anthem Network	Tier 3 – Non- Network	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.
	Per participant:	\$3,000	\$4,500	\$11,250	
	Per family:	\$6,000	\$9,000	\$22,500	
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billed</u> charges, health care this <u>Plan</u> doesn't cover, charges in excess of benefit maximums, charges in excess of maximum allowed amounts, pre-certification penalties, and non-medically necessary services.				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 <u>network provider</u>?	Yes, for medical: Emory Healthcare Network. See engage.ameriben.com or call 1-844-511-1914 for a list of network providers. Anthem. See www.anthem.com or call 1-844-511-1914 for a list of network providers. Yes, for prescription drugs: Prime Therapeutics. For a list of retail and mail pharmacies, call 1-877-427-9114 or visit www.PrimeOne.com/member.	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*
		Tier 1 – Emory Healthcare Network (You will pay the least)	Tier 2 – Anthem Network	Tier 3 – Non-Network (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	\$15 co-payment, deductible waived	Pediatrician and Pediatric Behavioral Health: \$25 co-payment, deductible waived Other Primary Care: \$35 co-payment, deductible waived	50% co-insurance after deductible	Office visit co-payments include the following services: • allergy testing • allergy injections • allergy serum • diagnostic testing • injections • laboratory work • non-surgical procedures • surgery, in office • X-rays Additional services performed during an office visit will apply a separate benefit.
	<u>Specialist</u> visit	\$25 co-payment, deductible waived	\$50 co-payment, deductible waived	50% co-insurance after deductible	

* For more information about limitations and exceptions, see the plan or policy document engage.ameriben.com.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information*
		Tier 1 – Emory Healthcare Network (You will pay the least)	Tier 2 – Anthem Network	Tier 3 – Non-Network (You will pay the most)	
	<u>Preventive care/screening/immunization</u>	No charge, deductible waived	No charge, deductible waived	50% co-insurance after deductible	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need 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)	Labs: 10% co-insurance, deductible waived X-Rays: 10% co-insurance after deductible	Labs: 25% co-insurance, deductible waived X-Rays: 25% co-insurance after deductible	Labs: 50% co-insurance, deductible waived X-Rays: 50% co-insurance after deductible	_____none_____
	Imaging (CT/PET scans, MRIs)	10% co-insurance after deductible	25% co-insurance after deductible	50% co-insurance after deductible	Pre-certification is required for certain non-network services. Failure to obtain pre-certification will reduce benefits by \$750 per occurrence for non-network services.

* For more information about limitations and exceptions, see the plan or policy document engage.ameriben.com.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information*
		Tier 1 – Emory Healthcare Network (You will pay the least)	Tier 2 – Anthem Network	Tier 3 – Non-Network (You will pay the most)	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.PrimeOne.com/member.	Preventive drugs	No charge, deductible waived		Reimbursement is based on the discounted network cost of the medication minus the applicable co-insurance	Not all <u>prescription drugs</u> are covered. To determine if a specific drug is covered under your <u>plan</u>, log into your account at www.PrimeOne.com/member. If you obtain <u>prescription drugs</u> from a non-network pharmacy, you will be required to pay the full cost of the prescription and then submit for reimbursement. Medications designated as specialty medications will follow applicable drug tier (i.e., preferred brand, non-preferred brand, etc.).
	Generic drugs	Retail 30-Day Supply: 10% co-insurance, deductible waived \$10 minimum \$25 maximum Retail or Mail Order 90-Day Supply: 10% co-insurance, deductible waived \$25 minimum \$62.50 maximum		Reimbursement is based on the discounted network cost of the medication minus the applicable co-insurance	
	Preferred brand drugs	Retail 30-Day Supply: 20% co-insurance, deductible waived \$30 minimum \$75 maximum Retail or Mail Order 90-Day Supply: 20% co-insurance, deductible waived \$75 minimum \$187.50 maximum		Reimbursement is based on the discounted network cost of the medication minus the applicable co-insurance	
	Non-preferred brand drugs	Retail 30-Day Supply: 30% co-insurance, deductible waived \$60 minimum \$120 maximum Retail or Mail Order 90-Day Supply: 30% co-insurance, deductible waived \$150 minimum \$300 maximum		Reimbursement is based on the discounted network cost of the medication minus the applicable co-insurance	
	Lifestyle drugs	Retail 30-Day Supply: 40% co-insurance, deductible waived		Reimbursement is based on the	

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information*
		Tier 1 – Emory Healthcare Network (You will pay the least)	Tier 2 – Anthem Network	Tier 3 – Non-Network (You will pay the most)	
		\$90 minimum \$150 maximum Retail or Mail Order 90-Day Supply: 40% co-insurance, deductible waived \$225 minimum \$375 maximum		discounted network cost of the medication minus the applicable co-insurance	
	Select medications	30-Day Supply: 40% co-insurance, deductible waived 90-Day Supply: Not covered		Reimbursement is based on the discounted network cost of the medication minus the applicable co-insurance	Includes select covered medications with specialized coverage or pharmacy access requirements and may change as therapies, clinical evidence, market conditions, and Plan benefits evolve. Certain medications, including GLP-1 or similar therapies prescribed for non-diabetes indications such as weight loss or weight management, may be assigned to this tier unless otherwise required by law or stated in Plan materials. The Plan may require use of CenterWell, HealthDyne, or another designated pharmacy/program; these fills remain under the prescription drug benefit when required by the Plan.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% co-insurance after deductible	25% co-insurance after deductible	50% co-insurance after deductible	Pre-certification is required. Failure to obtain pre-certification will reduce benefits by \$750 per occurrence for non-network services.
	Physician/surgeon fees	15% co-insurance after deductible	25% co-insurance after deductible	50% co-insurance after deductible	

* For more information about limitations and exceptions, see the [plan](#) or policy document [engage.ameriben.com](#).

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information*
		Tier 1 – Emory Healthcare Network (You will pay the least)	Tier 2 – Anthem Network	Tier 3 – Non-Network (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	\$250 co-payment, deductible waived			Emergency room co-payment includes facility and physician charges. Co-payment is waived if admitted.
	<u>Emergency medical transportation</u>	Ground Ambulance: 10% co-insurance, deductible waived Air Ambulance: 10% co-insurance after Tier 1 deductible			Pre-certification is required for transportation by fixed-wing aircraft (plane). Failure to obtain pre-certification will reduce benefits by \$750 per occurrence for non-network services.
	<u>Urgent care</u>	\$15 co-payment, deductible waived	\$35 co-payment, deductible waived	\$50 co-payment, deductible waived	—————none—————
If you have a hospital stay	Facility fee (e.g., hospital room)	15% co-insurance after deductible	25% co-insurance after deductible	50% co-insurance after deductible	Pre-certification is required. Failure to obtain pre-certification will reduce benefits by \$750 per occurrence for non-network services.
	Physician/surgeon fees	15% co-insurance after deductible	25% co-insurance after deductible	50% co-insurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visits and Physician Services: \$15 co-payment, deductible waived	Office Visits and Physician Services: \$25 co-payment, deductible waived	Office Visits and Physician Services: \$25 co-payment, deductible waived	Pre-certification is required for partial hospitalization and intensive outpatient treatment in excess of sixty (60) combined visits per calendar year. Failure to obtain pre-certification will reduce benefits by \$750 per occurrence for non-network services.
		Facility Services: 10% co-insurance after deductible	Facility Services: 25% co-insurance after deductible	Facility Services: 25% co-insurance after deductible	
	Inpatient services	15% co-insurance after deductible	25% co-insurance after deductible	50% co-insurance after deductible	Pre-certification is required. Failure to obtain pre-certification will reduce benefits by \$750 per occurrence for non-network services.
If you are pregnant	Office visits	\$25 co-payment, deductible waived	\$50 co-payment, deductible waived	50% co-insurance after deductible	

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information*
		Tier 1 – Emory Healthcare Network (You will pay the least)	Tier 2 – Anthem Network	Tier 3 – Non-Network (You will pay the most)	
	Childbirth/delivery professional services	15% co-insurance after deductible	25% co-insurance after deductible	50% co-insurance after deductible	<u>Cost sharing</u> does not apply for <u>preventive services</u>. Depending on the type of services, a <u>co-payment</u>, <u>co-insurance</u>, or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	15% co-insurance after deductible	25% co-insurance after deductible	50% co-insurance after deductible	
If you need help recovering or have other special needs	<u>Home health care</u>	10% co-insurance after deductible	25% co-insurance after deductible	50% co-insurance after deductible	Calendar Year Maximum: One hundred twenty (120) visits.
	<u>Rehabilitation services</u>	\$15 co-payment, deductible waived	\$25 co-payment, deductible waived	50% co-insurance after deductible	Combined Calendar Year Maximum: Ninety (90) visits for physical, occupational, and speech therapies. PT/OT/ST visit limits don't apply when there is a mental health/substance use disorder diagnosis. Pre-certification is required in excess of sixty (60) combined visits per calendar year for physical, occupational, and speech therapy. Failure to obtain pre-certification will reduce benefits by \$750 per occurrence for non-network services.
	<u>Habilitation services</u>	10% co-insurance after deductible	25% co-insurance after deductible	Behavioral Health: 25% co-insurance after Tier 2 deductible Other Habilitative: 50% co-insurance after deductible	_____none_____

* For more information about limitations and exceptions, see the plan or policy document engage.ameriben.com.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information*
		Tier 1 – Emory Healthcare Network (You will pay the least)	Tier 2 – Anthem Network	Tier 3 – Non-Network (You will pay the most)	
	<u>Skilled nursing care</u>	10% co-insurance after deductible	25% co-insurance after deductible	50% co-insurance after deductible	Calendar Year Maximum: One hundred twenty (120) days. Pre-certification is required. Failure to obtain pre-certification will reduce benefits by \$750 per occurrence for non-network services.
	<u>Durable medical equipment</u>	10% co-insurance, deductible waived	25% co-insurance, deductible waived	50% co-insurance after deductible	Pre-certification is required for DME in excess of \$3,000. Failure to obtain pre-certification will reduce benefits by \$750 per occurrence for non-network services.
	<u>Hospice services</u>	No charge, deductible waived	No charge, deductible waived	50% co-insurance after deductible	—————none—————
If your child needs dental or eye care	Children's eye exam	No charge, deductible waived	No charge, deductible waived	50% co-insurance after deductible	Calendar Year Maximum: One (1) exam every twelve (12) months.
	Children's glasses	Not Covered	Not Covered	Not Covered	—————none—————
	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 <u>excluded services</u> .)			
• Cosmetic surgery • Dental care (adult and child) • Glasses (adult and child)	• Long-term care • Private-duty nursing	• Routine foot care • Weight loss programs	

* For more information about limitations and exceptions, see the plan or policy document engage.ameriben.com.

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

- Acupuncture [limited to thirty (30) visits per calendar year combined with chiropractic]
- Bariatric surgery
- Chiropractic care [limited to thirty (30) visits per calendar year combined with acupuncture]
- Hearing aids [limited to one (1) hearing aid per ear every twenty-four (24) months for dependent children up to age twenty-six (26); limited to one (1) hearing aid per ear every three (3) years up to \$5,000 for employees and spouses]
- Non-emergency care when traveling outside the U.S. (Global Core providers only)
- Infertility treatment [limited to \$25,000 per lifetime combined with infertility prescription drugs]
- Routine eye care (adult and child)

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. You may also contact the Plan's COBRA Administrator at McGriff, 1-678-367-3107. 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 or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. You may also contact the third party administrator (TPA) to assist the plan administrator with claims adjudication. The TPA's name, address, and telephone number are:

AmeriBen
Attention: Appeals Coordination
P.O. Box 7186
Boise, ID 83707
1-844-511-1914

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? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-844-511-1914.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-511-1914.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-844-511-1914.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-844-511-1914.

* For more information about limitations and exceptions, see the [plan](#) or policy document engage.ameriben.com.

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

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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 <u>deductible</u>	\$850
■ <u>Specialist co-payment</u>	\$25
■ Hospital (facility) <u>cost sharing</u>	15%
■ Other <u>cost sharing</u>	10%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$850
Copayments	\$0
Coinsurance	\$1,200
What isn't covered	
Limits or exclusions	\$20
The total Peg would pay is	\$2,090

Coverage examples are calculated for individuals based on services performed by Tier 1 providers.

Managing Joe's type 2 Diabetes

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

■ The plan's overall <u>deductible</u>	\$850
■ <u>Specialist co-payment</u>	\$25
■ Hospital (facility) <u>cost sharing</u>	15%
■ Other <u>cost sharing</u>	10%

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$400
Copayments	\$90
Coinsurance	\$600
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$1,090

Mia's Simple Fracture

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

■ The plan's overall <u>deductible</u>	\$850
■ <u>Specialist co-payment</u>	\$25
■ Hospital (facility) <u>cost sharing</u>	15%
■ Other <u>cost sharing</u>	10%

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$850
Copayments	\$200
Coinsurance	\$100
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,150

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 مجاًئاً. 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 uffrue 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.

It's important we treat you fairly

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