

What is a benefit summary?

This is a summary of what the plan does and does not cover. This summary can also help you understand your share of the costs. It's always best to review your Certificate of Coverage (COC) and check your coverage before getting any health care services, when possible.

What are the benefits of the UnitedHealthcare Choice Direct Plan?

Get more protection with a national network and save with Tier 1 providers.

A network is a group of health care providers and facilities that have a contract with UnitedHealthcare. You can receive care from anyone in our network, but you can save more money when you use Tier 1 providers.

- > **Pay less by using certain freestanding centers.** Freestanding centers are health care facilities that do not bill for services as part of a hospital, such as MRI or surgery centers.
- > **Save money by staying in our network.** If you don't use the network, you'll have to pay for all of the costs.
- > **There's no need to choose a primary care provider (PCP) or get referrals to see a specialist.** Consider a PCP; they can be helpful in managing your care.
- > **Preventive care is covered 100% in our network.**

Are you a member?

Easily manage your benefits online at myuhc.com® and on the go with the **UnitedHealthcare Health4Me**® mobile app.

For questions, call the member phone number on your health plan ID card.

Not enrolled yet? Search for network doctors or hospitals at welcometouhc.com or call 1-866-873-3903, TTY 711, 8 a.m. to 8 p.m. local time, Monday through Friday.

Benefits At-A-Glance

What you may pay for network care

This chart is a simple summary of the costs you may have to pay when you receive care in the network. It doesn't include all of the deductibles and co-payments you may have to pay. You can find more benefit details beginning on page 2.

Co-payment	Individual Deductible	Co-insurance
(Your cost for an office visit)	(Your cost before the plan starts to pay)	(Your cost share after the deductible)
\$50	\$2,500	30%

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage for certain conditions. If this Benefit Summary conflicts with the Certificate of Coverage (COC), Schedule of Benefits, Riders, and/or Amendments, those documents are correct. Review your COC for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

Your Costs

In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

Your cost if you use Network Benefits

Annual Deductible

What is an annual deductible?

The annual deductible is the amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. It does not include any amount that exceeds Allowed Amounts. The deductible may not apply to all Covered Health Care Services. You may have more than one type of deductible.

- > Your co-pays don't count towards meeting the deductible unless otherwise described within the specific covered health care service.
- > All individual deductible amounts will count towards meeting the family deductible, but an individual will not have to pay more than the individual deductible amount.
- > This benefit plan includes a per occurrence deductible that applies to certain covered health care services. This per occurrence deductible must be met prior to and in addition to the medical deductible.

Medical Deductible - Individual	\$2,500 per year
Medical Deductible - Family	\$5,000 per year
Dental - Pediatric Services Deductible - Individual	Included in your medical deductible.
Dental - Pediatric Services Deductible - Family	Included in your medical deductible.

Out-of-Pocket Limit

What is an out-of-pocket limit?

The Out-of-Pocket Limit is the maximum you pay per year. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year.

- > All individual out-of-pocket limit amounts will count towards meeting the family out-of-pocket limit, but an individual will not have to pay more than the individual out-of-pocket limit amount.
- > Your co-pays, co-insurance, deductibles and per occurrence deductibles (including pharmacy) count towards meeting the out-of-pocket limit.

Out-of-Pocket Limit - Individual	\$7,900 per year
Out-of-Pocket Limit - Family	\$15,800 per year

Your Costs

What is co-insurance?

Co-insurance is the amount you pay each time you receive certain Covered Health Care Services calculated as a percentage of the Allowed Amount (for example, 20%). You pay co-insurance plus any deductibles you owe. Co-insurance is not the same as a co-payment (or co-pay).

What is a co-payment?

A Co-payment is the amount you pay each time you receive certain Covered Health Care Services calculated as a set dollar amount (for example, \$50). You are responsible for paying the lesser of the applicable Co-payment or the Allowed Amount. Please see the specific Covered Health Care Service to see if a co-payment applies and how much you have to pay.

What is Prior Authorization?

Prior Authorization is getting approval before you receive certain Covered Health Care Services. Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization.

Want more information?

Find additional definitions in the glossary at justplainclear.com.

Your Costs

Following is a list of services that your plan covers in alphabetical order. In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

Covered Health Care Services	Your cost if you use Network Benefits
Ambulance Services	
Emergency Ambulance:	30% co-insurance, after the medical deductible has been met.
Non-Emergency Ambulance:	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for Non-Emergency Ambulance.
Blood and Blood Products	
	30% co-insurance, after the medical deductible has been met.
Case Management Services	
	The amount you pay is based on where the covered health service is provided.
Cellular and Gene Therapy	
Cellular or Gene Therapy services must be received from a Designated Provider.	The amount you pay is based on where the covered health care service is provided. Prior Authorization is required.
Chiropractic Services	
Limited to 20 visits per condition per year.	\$50 co-pay per visit. A deductible does not apply.
Controlled Clinical Trials	
	The amount you pay is based on where the covered health care service is provided. Prior Authorization is required.
Dental - Pediatric Services (Benefits covered up to age 19)	
Benefits provided by the National Options PPO 20 Network (INO-MAC).	
Dental - Pediatric Preventive Services	
Dental Prophylaxis (Cleanings) Limited to two times every 12 months.	You pay nothing, after the medical deductible has been met.
Fluoride Treatments Limited to eight per 12 months.	You pay nothing, after the medical deductible has been met.
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	You pay nothing, after the medical deductible has been met.
Space Maintainers (Spacers)	You pay nothing, after the medical deductible has been met.

Your Costs

Covered Health Care Services

Your cost if you use Network Benefits

Dental - Pediatric Diagnostic Services

Evaluations (Check-up Exams) You pay nothing, after the medical deductible has been met.

Limited to 2 times per 12 months.
Covered as a separate Benefit only if no other service was done during the visit other than X-rays.

Intraoral Radiographs (X-ray) You pay nothing, after the medical deductible has been met.

Limited to 2 series of films per 12 months for Bitewings and 1 time per 36 months for Panoramic radiograph image.

Dental - Pediatric Basic Dental Services

Endodontics (Root Canal Therapy) 20% co-insurance, after the medical deductible has been met.

Adjunctive Services 20% co-insurance, after the medical deductible has been met.

Palliative (Emergency) Treatment:
Covered as a separate Benefit only if no other services (other than the exam and radiographs) were done on the tooth during the visit.

General Anesthesia: Covered only when clinically Necessary.

Occlusal Guard: Limited to one guard every 12 months.

Oral Surgery 20% co-insurance, after the medical deductible has been met.

Periodontics 20% co-insurance, after the medical deductible has been met.

Periodontal Surgery: Limited to one every 36 months per surgical area.

Scaling and Root Planing: Limited to one time per quadrant every 24 months.

Periodontal Maintenance: Limited to two times per 12 months.

Minor Restorative Services (Amalgam or Anterior Composite) 20% co-insurance, after the medical deductible has been met.

Simple Extractions (Simple tooth removal) 20% co-insurance, after the medical deductible has been met.

Limited to one time per tooth per lifetime.

Your Costs

Covered Health Care Services

Your cost if you use Network Benefits

Dental - Pediatric Major Restorative Services

Crowns/Inlays/Onlays 50% co-insurance, after the medical deductible has been met.

Limited to one time per tooth every 60 months.

Removable Dentures 50% co-insurance, after the medical deductible has been met.

(Full denture/partial denture)

Limited to a frequency of one every 60 months.

Bridges (Fixed partial dentures) 50% co-insurance, after the medical deductible has been met.

Limited to one time every 60 months.

Implant Procedures 50% co-insurance, after the medical deductible has been met.

Limited to one time every 60 months.

Dental - Pediatric Medically Necessary Orthodontics

Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies.

Prior Authorization is required for orthodontic treatment.

Dental Services - Accident Only

30% co-insurance, after the medical deductible has been met.

Prior Authorization is required.

Dental Services - Hospital and Ambulatory Facility Charges Related to Dental Care

Inpatient: 30% co-insurance, after the medical deductible has been met.

Outpatient: \$300 per occurrence deductible per date of service for services provided at an ambulatory surgical center or in a physician's office. An annual deductible does not apply.

30% co-insurance, after the medical deductible has been met for services provided at an outpatient hospital-based surgical center.

Detoxification Services

Inpatient: 30% co-insurance, after the medical deductible has been met.

Outpatient: \$100 co-pay per visit. A deductible does not apply.

Partial Hospitalization/Intensive Outpatient Treatment: 30% co-insurance, after the medical deductible has been met.

Your Costs

Covered Health Care Services

Your cost if you use Network Benefits

Diabetes Services

Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care:

The amount you pay is based on where the covered health care service is provided.

Diabetes Self-Management Items:

The amount you pay is based on where the covered health care service is provided under Durable Medical Equipment (DME), Orthotics and Supplies and Prescription Drug Products. Diabetes test strips are not subject to deductible, co-insurance or co-payment.

Durable Medical Equipment (DME), Orthotics and Supplies

30% co-insurance, after the medical deductible has been met.

Emergency Health Care Services - Outpatient

30% co-insurance, after the medical deductible has been met.

Notification is required if confined in an Out-of-Network Hospital.

Family Planning Services

\$50 co-pay per visit for a primary care physician office visit. A deductible does not apply.

\$100 co-pay per visit for a specialist office visit. A deductible does not apply.

See Prescription Drug Products for cost sharing for contraceptive Prescription Drug Products

Gender Dysphoria

The amount you pay is based on where the covered health care service is provided.

Prior Authorization is required for certain services.

Your Costs

Covered Health Care Services

Your cost if you use Network Benefits

Habilitative Services

Inpatient: The amount you pay is based on where the covered health care service is provided.

Outpatient: \$50 co-pay per visit. A deductible does not apply.

Outpatient therapies are limited per year as follows:

Unlimited for Covered Persons up to age 19 for the treatment of congenital anomaly or genetic birth defects, cleft lip and cleft palate, orthodontics, oral surgery, otologic and audiological therapy.

For Covered Persons age 19 or older, limited to:

30 visits of physical therapy per condition.

30 visits of occupational therapy per condition.

30 visits of speech therapy per condition.

Hearing Aids

Limited to one hearing aid per hearing impaired ear every 3 years. 30% co-insurance, after the medical deductible has been met.

Home Health Care

Note: Home Health Care visits that are provided according to the benefit described in Section 1, Pregnancy-Maternity Services in the Certificate of Coverage are not subject to cost share after the Annual Deductible has been met. 30% co-insurance, after the medical deductible has been met.

For the administration of intravenous infusion, you must receive services from a provider we identify.

Hospice Care

30% co-insurance, after the medical deductible has been met.

Hospital - Inpatient Stay

30% co-insurance, after the medical deductible has been met.

Your Costs

Covered Health Care Services

Your cost if you use Network Benefits

Infertility Services

30% co-insurance, after the medical deductible has been met.

Lab, X-Ray and Diagnostic - Outpatient

Lab Testing - Outpatient:

30% co-insurance, after the medical deductible has been met for services provided at a freestanding lab, freestanding diagnostic center or in a physician's office.

30% co-insurance, after the medical deductible has been met for services provided at a hospital-based lab or an outpatient hospital-based diagnostic center.

X-Ray and Other Diagnostic Testing - Outpatient:

30% co-insurance, after the medical deductible has been met for services provided at a freestanding lab, freestanding diagnostic center or in a physician's office.

30% co-insurance, after the medical deductible has been met for services provided at a hospital-based lab or an outpatient hospital-based diagnostic center.

Major Diagnostic and Imaging - Outpatient

\$300 per occurrence deductible per service for services provided at a freestanding diagnostic center or in a physician's office. An annual deductible does not apply.

30% co-insurance, after the medical deductible has been met for services provided at an outpatient hospital-based diagnostic center.

Medical Foods

30% co-insurance, after the medical deductible has been met.

Mental Health Care and Substance - Related and Addictive Disorders Services

Inpatient:

30% co-insurance, after the medical deductible has been met.

Outpatient:

\$100 co-pay per visit. A deductible does not apply.

Partial Hospitalization/Intensive Outpatient Treatment:

30% co-insurance, after the medical deductible has been met.

Nutritional Services and Medical Nutrition Therapy

30% co-insurance, after the medical deductible has been met.

Pharmaceutical Products - Outpatient

This includes medications given at a doctor's office, or in a Covered Person's home.

30% co-insurance, however you will never pay more than \$150 per 30 day supply for a Specialty Prescription Drug Product, after the medical deductible has been met.

Your Costs

Covered Health Care Services

Your cost if you use Network Benefits

Physician Fees for Surgical and Medical Services

You pay nothing, after the medical deductible has been met.

Physician's Office Services - Sickness and Injury

\$50 co-pay per visit for a primary care physician office visit. A deductible does not apply.

\$100 co-pay per visit for a specialist office visit. A deductible does not apply.

Additional co-pays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.

Pregnancy - Maternity Services

The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.

Prescription Drug Benefits

Prescription drug benefits are shown in the Prescription Drug benefit summary.

Preventive Care Services

Physician Office Services, Lab, X-Ray or other preventive tests. You pay nothing. A deductible does not apply.

Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a co-pay, co-insurance or deductible.

Prosthetic Devices

30% co-insurance, after the medical deductible has been met.

Reconstructive Procedures

The amount you pay is based on where the covered health care service is provided.

Your Costs

Covered Health Care Services

Your cost if you use Network Benefits

Rehabilitation Services - Outpatient Therapy

Limited to:	\$50 co-pay per visit. A deductible does not apply.
90 visits of cardiac rehabilitation per therapy (physical, speech, occupational).	
30 visits of physical therapy per condition.	
30 visits of occupational therapy per condition.	
30 visits of speech therapy per condition.	
One program per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy for pulmonary rehabilitation therapy.	

Scopic Procedures - Outpatient Diagnostic and Therapeutic

Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.	\$300 per occurrence deductible per date of service for services provided at a freestanding center or in a physician's office. An annual deductible does not apply. 30% co-insurance, after the medical deductible has been met for services provided at an outpatient hospital-based center.
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Skilled Nursing Facility / Inpatient Rehabilitation Facility Services

Limited to 100 days per year when admitted to a Skilled Nursing Facility.	30% co-insurance, after the medical deductible has been met.
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Surgery - Outpatient

\$300 per occurrence deductible per date of service for services provided at an ambulatory surgical center or in a physician's office. An annual deductible does not apply. 30% co-insurance, after the medical deductible has been met for services provided at an outpatient hospital-based surgical center.

Surgical Morbid Obesity Treatment

For Network Benefits, obesity - weight loss surgery must be received from a Designated Provider.	The amount you pay is based on where the covered health service is provided. Prior Authorization is required.
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Telehealth Services

The amount you pay is based on where the covered health care service is provided.

Your Costs

Covered Health Care Services

Your cost if you use Network Benefits

Therapeutic Treatments - Outpatient

Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.

\$300 co-pay per treatment. A deductible does not apply.

Transplantation Services

Network Benefits must be received from a Designated Provider.

The amount you pay is based on where the covered health care service is provided.

Prior Authorization is required.

Urgent Care Center Services

\$50 co-pay per visit. A deductible does not apply.

Additional co-pays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery and lab work.

Virtual Visits

Benefits are available only when services are delivered through a Designated Virtual Visit Network Provider. You can find a Designated Virtual Visit Network Provider by contacting us at myuhc.com[®] or the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.

\$10 co-pay per visit. A deductible does not apply.

Your Costs

Covered Health Care Services

Your cost if you use Network Benefits

Vision - Pediatric Services (Benefits covered up to age 19)

Find a listing of Spectera Eyecare Network Vision Care Providers at myuhcvision.com.

Routine Vision Exam \$30 co-pay per visit. A deductible does not apply.
Limited to once per year.

Eyeglass Lenses 50% co-insurance. A deductible does not apply.
Limited to once every 12 months.

Lens Extras You pay nothing. A deductible does not apply.
Limited to once every 12 months.
Coverage includes polycarbonate lenses and standard scratch-resistant coating.

Eyeglass Frames
Limited to once every 12 months.

Eyeglass frames with a retail cost up to \$130. 50% co-insurance. A deductible does not apply.

Eyeglass frames with a retail cost between \$130 - 160. 50% co-insurance. A deductible does not apply.

Eyeglass frames with a retail cost between \$160 - 200. 50% co-insurance. A deductible does not apply.

Eyeglass frames with a retail cost between \$200 - 250. 50% co-insurance. A deductible does not apply.

Eyeglass frames with a retail cost greater than \$250. 50% co-insurance. A deductible does not apply.

Contact Lenses/Necessary Contact Lenses 50% co-insurance. A deductible does not apply.

You are eligible to choose only one of either eyeglasses (Eyeglass Lenses and/or Eyeglass Frames) or Contact Lenses. If you choose more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

Fitting and evaluation limited to once every 12 months.

Limited to a 12 month supply.

Find a complete list of covered contacts at myuhcvision.com.

Low Vision Care Services You pay nothing for Low Vision Testing. A deductible does not apply.
25% co-insurance for Low Vision Therapy. A deductible does not apply.
Limited to comprehensive low vision exam once every 5 years, including 4 follow-up visits in any 5-year period and prescribed optical devices, such as high-powered spectacles, magnifiers and telescopes.

Services your plan generally does NOT cover. It is recommended that you review your COC, Amendments and Riders for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

- Cosmetic Surgery
- Dental Care (Adult)
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Private-Duty Nursing
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

For Internal Use only:

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MAMSI Life and Health Insurance Company does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to Civil Rights Coordinator.

Online: UHC_Civil_Rights@uhc.com

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

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

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

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

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

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

We provide free services to help you communicate with us. Such as, letters in others languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATENÇÃO: Se você fala português (Portuguese), contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'italiano (Italian), sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie Deutsch (German) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

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をご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما فارسی (Farsi) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप हिंदी (Hindi) बोलते है, आपको भाषा सहायता सेवाएं, नि:शुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus Hmoob (Hmong), muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ (Khmer) ស្រវឹងនិយាយភាសាដើមឥតគិតថ្លៃ គឺមានស្តាប់អ្នក។ សមនូវសព្វទៅលើខតតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

PAKDAAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍI BAA'ÁKONÍNÍZIN: Diné (Navajo) bizaad bee yániti'go, saad bee áka'anida'awo'igíí, t'áá jíik'eh, bee ná'ahóot'i'. T'áá shqoqí ninaaltsoos nit'i'izi bee nééhozinígíí bine'déé' t'áá jíik'ehgo béesh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho Soomaali (Somali), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call the toll-free phone number listed on your identification card.

ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LUU Ý: Nếu quý vị nói tiếng Việt (Vietnamese), quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: 한국어(Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng Tagalog (Tagalog), may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является русском (Russian). Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث العربية (Arabic)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرف العضوية.

ATANSYON: Si w pale Kreyòl ayisyen (Haitian Creole), ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez français (French), des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po polsku (Polish), udostępniłmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

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