



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, www.myhighmark.com or call 1-888-601-2242. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.HealthCare.gov/sbc-glossary/ or call 1-888-601-2242 to request a copy.

| Important Questions | Answers | Why This Matters: |
|--|---|--|
| What is the overall deductible? | \$0 at Indian Health Care Provider (IHCP) or with IHCP referral at non-IHCP; or \$2,000 individual/\$4,000 family network. \$4,000 individual/\$8,000 family out-of-network. | Generally, you must pay all of the costs from providers up to the deductible 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> . |
| Are there services covered before you meet your deductible? | Yes. Office visits, <u>preventive care services</u> , outpatient mental health, outpatient substance abuse, <u>rehabilitation services</u> , <u>habilitation services</u> , pediatric eye exam, and <u>prescription drug</u> benefits are covered before you meet your <u>deductible</u> . <u>Copayments</u> and <u>coinsurance</u> amounts don't count toward the <u>network deductible</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 out-of-pocket limit for this <u>plan</u>? | \$8,300 individual/\$16,600 family network. \$16,600 individual/\$33,200 family out-of-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. |
| What is not included in the out-of-pocket limit? | <u>Premiums</u> , balance-billed charges, and health care this <u>plan</u> doesn't cover. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . |

| | | |
|--|---|--|
| Will you pay less if you use a <u>network provider</u> ? | Yes. See www.myhighmark.com or call 1-888-601-2242 for a list of <u>network providers</u> . | <p>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 charge</u> 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.</p> <p>Non-emergency and non-urgent care received from out-of-network providers will only be covered within the state of Delaware. Non-emergency and non-urgent care received from out-of-network providers outside of Delaware will not be covered. Out-of-state non-emergency and non-urgent care received from providers outside of Delaware who are in the nationwide BlueCard PPO network, as well as all emergency and urgent care services, will remain covered at the in-network benefit level. Please consult your plans documents for specific details.</p> |
| Do I 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 overall deductible has been met, if a deductible applies.

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|--|--|---|--|--|---|
| | | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP In-Network Provider (You will pay more) | Non-IHCP Out-of-Network Provider (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | No charge | \$30 <u>copay/visit</u> <u>Deductible</u> does not apply. | 50% <u>coinsurance</u> | You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. |
| | <u>Specialist</u> visit | No charge | \$60 <u>copay/visit</u> <u>Deductible</u> does not apply. | 50% <u>coinsurance</u> | |
| | <u>Preventive care/screening/immunization</u> | No charge | No charge <u>Deductible</u> does not apply. | Not covered | Please refer to your <u>preventive</u> schedule for additional information. See Below* |

*Cost sharing waived at non- IHCP with IHCP referral. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|--|--|--|--|--|--|
| | | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP In-Network Provider (You will pay more) | Non-IHCP Out-of-Network Provider (You will pay the most) | |
| If you have a test | Diagnostic test (x-ray, blood work) | No charge | 25% coinsurance | 50% coinsurance | Copayments, if any, do not apply to diagnostic services prescribed for the treatment of mental illness or substance abuse. Precertification may be required. See Below* |
| | Imaging (CT/PET scans, MRIs) | No charge | 25% coinsurance | 50% coinsurance | |
| If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at https://www.myhighmark.com/find-a-doctor/#/drug | Tier 1 | No charge per prescription (retail) No charge per prescription (mail order) | \$15 copay per prescription (retail) \$15 copay per prescription (mail order) | Not covered | Up to 34/90-day supply retail pharmacy. Up to 34/90-day supply maintenance <u>prescription drugs</u> through mail order. This <u>plan</u> uses an Essential <u>Formulary</u> . <u>Cost-sharing</u> for Prescription Insulin Drugs will not exceed \$100 per month. <u>Deductible</u> does not apply to <u>prescription drugs</u> . See Below* |
| | Tier 2 | No charge per prescription (retail) No charge per prescription (mail order) | \$30 copay per prescription (retail) \$30 copay per prescription (mail order) | Not covered | |
| | Tier 3 | No charge per prescription (retail) No charge per prescription (mail order) | \$60 copay per prescription (retail) \$60 copay per prescription (mail order) | Not covered | |
| | Tier 4 | No charge per prescription (retail) No charge per prescription (mail order) | \$100 copay per prescription (retail) \$100 copay per prescription (mail order) | Not covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No charge | 25% coinsurance | 50% coinsurance | Precertification may be required. See Below* |

*Cost sharing waived at non- IHCP with IHCP referral. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|--|--|--|
| | | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP In-Network Provider (You will pay more) | Non-IHCP Out-of-Network Provider (You will pay the most) | |
| | Physician/surgeon fees | No charge | 25% coinsurance | 50% coinsurance | Precertification may be required. See Below* |
| If you need immediate medical attention | <u>Emergency room care</u> | No charge | 25% coinsurance | 25% coinsurance | Out-of-network: Subject to non IHCP network deductible. See Below* |
| | <u>Emergency medical transportation</u> | No charge | 25% coinsurance | 25% coinsurance | Out-of-network: Subject to non IHCP network deductible. See Below* |
| | <u>Urgent care</u> | No charge | \$45 copay/visit Deductible does not apply. | \$45 copay/visit Deductible does not apply. | The copayment, if any, does not apply to urgent care services prescribed for the treatment of mental illness or substance abuse. See Below* |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No charge | 25% coinsurance | 50% coinsurance | Precertification may be required. See Below* |
| | Physician/surgeon fees | No charge | 25% coinsurance | 50% coinsurance | Precertification may be required. See Below* |
| If you have mental health, behavioral health, or substance abuse services | Outpatient services | No charge | \$30 copay/visit Deductible does not apply. | 50% coinsurance | Precertification may be required. See Below* |
| | Inpatient services | No charge | 25% coinsurance | 50% coinsurance | Precertification may be required. See Below* |
| If you are pregnant | Office visits | No charge | 25% coinsurance | 50% coinsurance | <u>Cost sharing</u> does not apply to certain preventive services. Depending on the type of services, <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | No charge | 25% coinsurance | 50% coinsurance | <u>Cost sharing</u> waived at non-IHCP with IHCP referral. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing). |
| | Childbirth/delivery facility services | No charge | 25% coinsurance | 50% coinsurance | |

*Cost sharing waived at non- IHCP with IHCP referral. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|--|--------------------------------|---|---|--|---|
| | | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP In-Network Provider (You will pay more) | Non-IHCP Out-of-Network Provider (You will pay the most) | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | No charge | 25% <u>coinsurance</u> | 50% <u>coinsurance</u> | Combined <u>network</u> and <u>out-of-network</u> : 100 visits per benefit period, aggregate with visiting nurse. Precertification may be required. See Below* |
| | <u>Rehabilitation services</u> | No charge | \$23 <u>copay</u> /visit for physical medicine and occupational therapy \$30 <u>copay</u> /visit for speech therapy <u>Deductible</u> does not apply. | 25% <u>coinsurance</u> for physical medicine and occupational therapy 50% <u>coinsurance</u> for speech therapy | Combined <u>network</u> and <u>out-of-network</u> : 30 combined physical medicine and occupational therapy visits and 30 speech therapy visits per benefit period. <u>Copayment</u> , if any, does not apply to therapy services prescribed for the treatment of mental health or substance abuse. The limit, if any, does not apply to therapy services prescribed for the treatment of mental health or substance abuse. Precertification may be required. See Below* |
| | <u>Habilitation services</u> | No charge | \$23 <u>copay</u> /visit for physical medicine and occupational therapy \$30 <u>copay</u> /visit for speech therapy <u>Deductible</u> does not apply. | 25% <u>coinsurance</u> for physical medicine and occupational therapy 50% <u>coinsurance</u> for speech therapy | Combined <u>network</u> and <u>out-of-network</u> : 30 combined physical medicine and occupational therapy visits and 30 speech therapy visits per benefit period. <u>Copayment</u> , if any, does not apply to therapy services prescribed for the treatment of mental health or substance abuse. The limit, if any, does not apply to therapy services prescribed for the treatment of mental health or substance abuse. Precertification may be required. See Below* |
| | <u>Skilled nursing care</u> | No charge | 25% <u>coinsurance</u> | 50% <u>coinsurance</u> | Combined <u>network</u> and <u>out-of-network</u> : 120 days per confinement. Benefits renew after 180 days without care. Precertification may be required. See Below* |

*Cost sharing waived at non- IHCP with IHCP referral. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|--|----------------------------------|---|--|--|---|
| | | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP In-Network Provider (You will pay more) | Non-IHCP Out-of-Network Provider (You will pay the most) | |
| | <u>Durable medical equipment</u> | No charge | 25% coinsurance | 50% coinsurance | Precertification may be required. See Below* |
| | <u>Hospice service</u> | No charge | 25% coinsurance | 50% coinsurance | Precertification may be required. See Below* |
| If your child needs dental or eye care | Children's Eye exam | No charge | No charge <u>Deductible</u> does not apply. | Not covered | Combined IHCP and non-IHCP <u>network</u> : One eye exam per 12 month period up to age 19. See Below* |
| | Children's Glasses | No charge | No charge <u>Deductible</u> does not apply. | Not covered | Combined IHCP and non-IHCP <u>network</u> : One pair of frames/lenses or contacts every 12 months for members under the age of 19. See Below* |
| | Children's Dental check-up | Not covered | Not covered | Not covered | -----none----- |

*Cost sharing waived at non- IHCP with IHCP referral. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).

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.)

| | | |
|-----------------------|----------------------------|------------------------|
| • Acupuncture | • Long-term care | • Routine foot care |
| • Cosmetic surgery | • Pediatric dental care | • Weight loss programs |
| • Dental care (Adult) | • Routine eye care (Adult) | |

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

| | | |
|--|---------------------|--|
| • Abortion, elective and non-elective. Non-elective abortions are abortions performed where a pregnancy is the result of rape or incest, or for a pregnancy which, as certified by a physician, places the life of the woman in danger unless an abortion is performed (i.e., abortions for which Federal funding is allowed). | • Bariatric surgery | • Infertility treatment |
| | • Chiropractic care | • Non-emergency care when traveling outside the U.S. |
| | • Hearing aids | • Private-duty nursing |

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or at <https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa>, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other options to continue coverage are available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit <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 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:

- Highmark BCBS Inc. at 1-888-601-2242.
- The Delaware Department of Insurance/Consumer Assistance Program: 1351 West North St., Suite 101, Dover, DE 19904, or 302-674-7300.
- Additionally, the Delaware Department of Insurance/Consumer Assistance Program can help you file your appeal.

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.

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

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|-----|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$0 |
| ■ <u>Specialist</u> <u>coinsurance</u> | 0% |
| ■ <u>Hospital (facility)</u> <u>coinsurance</u> | 0% |
| ■ <u>Other</u> <u>coinsurance</u> | 0% |

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 |
|---------------------------|-----------------|

In this example, Peg would pay:

| <u>Cost Sharing</u> | |
|---------------------|-----|
| Deductibles | \$0 |
| Copayments | \$0 |
| Coinsurance | \$0 |

What isn't covered

| | |
|-----------------------------------|-------------|
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$60 |

Managing Joe's type 2 Diabetes

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

| | |
|---|-----|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$0 |
| ■ <u>Specialist</u> <u>coinsurance</u> | 0% |
| ■ <u>Hospital (facility)</u> <u>coinsurance</u> | 0% |
| ■ <u>Other</u> <u>coinsurance</u> | 0% |

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay:

| <u>Cost Sharing</u> | |
|---------------------|-----|
| Deductibles | \$0 |
| Copayments | \$0 |
| Coinsurance | \$0 |

What isn't covered

| | |
|-----------------------------------|-------------|
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$20 |

Mia's Simple Fracture

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

| | |
|---|-----|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$0 |
| ■ <u>Specialist</u> <u>coinsurance</u> | 0% |
| ■ <u>Hospital (facility)</u> <u>coinsurance</u> | 0% |
| ■ <u>Other</u> <u>coinsurance</u> | 0% |

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$2,800 |
|---------------------------|----------------|

In this example, Mia would pay:

| <u>Cost Sharing</u> | |
|---------------------|-----|
| Deductibles | \$0 |
| Copayments | \$0 |
| Coinsurance | \$0 |

What isn't covered

| | |
|-----------------------------------|------------|
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$0 |

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

To find more information about Highmark's benefits and operating procedures, such as accessing the drug formulary or using network providers, please go to DiscoverHighmark.com; or for a paper copy, call 1-855-873-4109.

Discrimination is Against the Law

The Claims Administrator/Insurer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Claims Administrator/Insurer will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Claims Administrator/Insurer will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Claims Administrator/Insurer:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Claims Administrator/Insurer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with:

Civil Rights Coordinator
P.O. Box 22492
Pittsburgh, PA 15222
Phone: 1-866-286-8295 (TTY: 711), Fax: 412-544-2475
Email: CivilRightsCoordinator@highmarkhealth.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
Phone: 1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at
hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak English, free language translation and interpretation services are available to you. Appropriate auxiliary aids and services (such as large print, audio, and Braille) to provide information in accessible formats are also available free of charge. Call the number on the back of your ID card (TTY: 711) for help.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de traducción e interpretación de idiomas. También hay disponibles ayudas y servicios auxiliares adecuados (como letra grande, audio y Braille) para proporcionar información en formatos accesibles sin cargo. Llame al número que figura al dorso de su tarjeta de identificación (TTY: 711) si necesita ayuda.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Übersetzungs- und Dolmetscherdienste zur Verfügung. Außerdem sind kostenlos entsprechende Hilfsmittel und Dienstleistungen (wie Großdruck, Audio und Blindenschrift) zur Bereitstellung von Informationen in barrierefreien Formaten erhältlich. Wählen Sie hierfür bitte die Nummer auf der Rückseite Ihrer Ausweiskarte (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis tradiksyon ak entèpretasyon aladispozisyon w gratis nan lang ou pale a. Èd ak sèvis siplémentè apwopriye (tèlke gwo lèt, odyo, Braille) pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele nimewo ki sou do Kat ID w lan (TTY: 711) pou jwenn èd.

ВНИМАНИЕ: Если Вы говорите на русском языке, Вам доступны бесплатные услуги перевода на другой язык. Также предоставляется дополнительная бесплатная помощь и услуги отображения информации в доступных форматах (например, крупным шрифтом, шрифтом Брайля или в виде аудиозаписи). Для получения помощи позвоните по номеру, указанному на обратной стороне вашей идентификационной карты (TTY: 711).

ATTENZIONE: se parla italiano, sono disponibili servizi gratuiti di traduzione e interpretariato. Sono inoltre disponibili gratuitamente adeguati supporti e servizi ausiliari (ad esempio caratteri grandi, audio e Braille) per fornire informazioni in formati accessibili. Per assistenza, chiami il numero riportato sul retro della Sua tessera di identificazione (TTY: 711).

ATTENTION : si vous parlez français, des services de traduction et d'interprétation gratuits sont à votre disposition. Vous pouvez aussi bénéficier gratuitement de l'accès à des outils et services auxiliaires appropriés (affichage en gros caractères, audio et le braille) dans des formats accessibles. Veuillez appeler le numéro qui se trouve au verso de votre carte d'identification (TTY : 711) pour obtenir de l'aide.

ÀKÍYÈSÍ: Tí o bá nsø èdè Yorùbá, áwọn isé itumó ati ògbufo èdè wà ní àròwojó lófèé fún o. Awọn isé itójú ati irànlowó tó yé (bii titéwé nla, gbigbó ohùn, ati iwé afójú) lati pèsè iwifúnni ni awọn ọna ìrááyè si wà pèlu lófèé. Pe nòmba tó wà lehin kaádi idánímò rẹ (TTY: 711) fún irànlowó.

אכטונג: אובי איר רעדט איז'יש, קענט איר באקז'ווען שפראך איבערעצעונג און דאלמעטונג סערויסען פֿרִי פֿון אַפְּצָאַל. געהעריגע הילפֿסְטִילען אַוְן סערויסען (אַזְּוִיְׁוִי גְּרוּסְעַדְרָאָן, אָזְּיִא אַוְן בְּרָעֵי) צְוּשְׁטָעָן אַיְפְּאָרָאַצְּעָן זָעָנָן אַוְן דָּא צְוָן באַקְזָוּן פֿרִי פֿון אַפְּצָאַל. רופּט דָעַם נְמָעַר אַוְן דִּי אַכְדָּעָר זִיְּטִי פֿון אַיְיר אַיְדָעָנִיְּטָעָט קָאָרְטִיל (TTY: 711) פֿאָר הַלְּפִיד.

تَبَيَّبَ: إِذَا كَنْتَ تَتَحَدَّثُ لِلْغُلَّةِ الْعَرَبِيَّةِ، فَسَتَتَوَفَّرُ لَكَ خَدْمَاتُ التَّرْجِيمَةِ التَّحْرِيرِيَّةِ وَالْتَّرْجِيمَةِ الْفُورِيَّةِ مُجَانًا. تَوَفُّرُ أَصْنَاعُ الْوَسَائِلِ وَالْخَدْمَاتُ الْمُسَاعِدَةُ الْمُنْسَبَّةُ (مُثَلُ الْطَّبَاعَةُ الْكَبِيرَةُ، وَالْوَسَائِلُ الصَّوْتِيَّةُ، وَطَرِيقَةُ بَرَائِيلِ) لِتَقْدِيمِ الْمُعْلَمَاتِ بِتَسْبِيَّاتٍ يُمْكِنُ الْوَصُولُ إِلَيْهَا مِنْ دُونِ أَيِّ تَكْلِيفٍ. اتَّصِلُ عَلَى الرَّقْمِ الْمُذَوَّنِ عَلَى ظَهِيرَ بَطَاقَةِ هُويَّتِكَ (TTY: 711) لِلْحُصُولِ عَلَى الْمُسَاعَدَةِ.

注意：如果您说中文，我们将为您提供免费的语言翻译和口译服务。此外，我们还免费提供相应的辅助工具和服务（如大字体、音频和盲文），以便您获取无障碍格式的信息。如需帮助，请拨打您的 ID 卡背面的号码（听障人士专用号码：711）。

ધ્યાન આપશો: જો તમે ગુજરાતી બોલતા હોવ, તો તમારા માટે નિઃશુલ્ક ભાષા અનુવાદ અને ઇન્ટરપ્રિટેશન સેવાઓ ઉપલબ્ધ છે. સુલભ શ્રોમેટમાં માહિતી પૂરી પાડવા માટે યોગ્ય સહાયક સાધનસામગ્રી અને સેવાઓ (જેમ કે મોટી પ્રિન્ટ, ઓડિયો અને બેઇલ) પણ નિઃશુલ્ક ઉપલબ્ધ છે. મદદ માટે તમારા આઇડી કાર્ડની પાછળ આપેલા નંબર (TTY: 711) પર કોલ કરો.

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi có dịch vụ biên dịch và phiên dịch ngôn ngữ miễn phí dành cho quý vị. Chúng tôi cũng cung cấp miễn phí các dịch vụ và hỗ trợ bổ sung thích hợp (như chữ in lớn, tệp âm thanh và chữ nón) để cung cấp thông tin ở các định dạng dễ tiếp cận. Vui lòng gọi số điện thoại trên mặt sau của thẻ nhận dạng của quý vị (TTY: 711) để được trợ giúp.

ધ્યાન દિનુહોસ: યदि તપાઈ નેપાલી બોલ્નુહન્દ ભને, તપાઈલાઈ નિઃશુલ્ક ભાષા અનુવાદ ર દોભાસે સેવાહરુ ઉપલબ્ધ છન્હાં. પદ્ધુંચ્યોગ્ય ઢાંચાહરુમા જાનકારી પ્રદાન ગર્ન ઉપયુક્ત સહાયક પ્રવિધિ ર સેવાહરુ (જસ્તે ટૂલો પ્રિન્ટ, અડિયો ર બ્રેલ) પણ નિઃશુલ્ક ઉપલબ્ધ છન્હાં। મદદતકો લાગિ તપાઈકો ID કાર્ડકો પછાડિકો નમ્બરમા કલ ગર્નુહોસ (TTY: 711)।

કृपया ध्यान दें: यदि आप हिंदी भाषा बोलते हैं, तो आपके लिए मुफ्त भाषा अनुवाद और व्याख्या संबंधी सेवाएं उपलब्ध हैं। एक्सेस करने योग्य फ़ार्मेट में सूचना उपलब्ध कराने के लिए उपयुक्त सहायक सामग्री और सेवाएं (जैसे बड़े प्रिंट, ऑडियो और ब्रेल) भी निःशुल्क उपलब्ध हैं। सहायता के लिए अपने पहचान कार्ड के पीछे लिखे नंबर (TTY: 711) पर कॉल करें।

주의: 한국어를 사용하는 경우 무료 언어 번역 및 통역 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공받을 수 있는 적절한 보조 수단 및 서비스(예: 큰 활자, 오디오, 점자)도 무료로 이용할 수 있습니다. 도움이 필요하시면 ID 카드 뒷면에 있는 번호로 전화하십시오(TTY: 711).