



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 1-877-986-4571. 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 1-877-986-4571 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$0 individual/\$0 family enhanced value <u>network</u> , \$0 individual/\$0 family standard value <u>network</u> . \$5,000 individual/\$10,000 family out-of- <u>network</u> . All in- <u>network</u> services are credited to both the enhanced and standard value deductibles.	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> .
Are there services covered before you meet your deductible?	Yes. <u>Emergency room care</u> and <u>urgent care</u> are covered before you meet your out-of- <u>network deductible</u> . <u>Copayments</u> and <u>coinsurance</u> amounts don't count toward your out-of- <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 deductibles 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 plan?	\$9,700 individual/\$19,400 family enhanced value <u>network</u> , \$9,700 individual/\$19,400 family standard value <u>network</u> . All in- <u>network</u> services credited to both the enhanced and standard value <u>out-of-pocket limits</u> . \$19,400 individual/\$38,800 family out-of- <u>network</u> .	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 1-877-986-4571 for a list of <u>network providers</u> .	You pay the least if you use a <u>provider</u> in <u>Enhanced Network</u> . You pay more if you use a <u>provider</u> in <u>Standard 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. Out-of-Network benefits consist of two levels of benefits. In-state out-of-network providers, and out-of-state out-of-network providers. Costs will vary depending on whether services are received from an in-state out-of-network provider or an out-of-state out-of-network provider. Covered services received from a provider located outside of Pennsylvania participating in the local PPO network, as well as all emergency and urgent care services, will remain covered at the in-network benefit level. Please consult your plan documents for specific details.
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
		<u>Enhanced Network Provider</u> (You will pay the least)	<u>Standard Network Provider</u>	<u>Out-of-Network Provider</u> (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	\$45 <u>copay</u> /visit	\$55 <u>copay</u> /visit	60% <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. Please refer to your <u>preventive</u> schedule for additional information.
	<u>Specialist</u> visit	\$45 <u>copay</u> /visit	\$55 <u>copay</u> /visit	60% <u>coinsurance</u>	
	<u>Preventive care/screening</u> /immunization	No charge	No charge	Not covered	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$60 <u>copay</u> /visit (blood work/lab) \$175 <u>copay</u> /visit (x-ray)	\$75 <u>copay</u> /visit (blood work/lab) \$225 <u>copay</u> /visit (x-ray)	60% <u>coinsurance</u>	<u>Copayments</u> , if any, do not apply to diagnostic services prescribed for the treatment of mental illness or substance abuse. Precertification may be required.
	Imaging (CT/PET scans, MRIs)	\$800 <u>copay</u> /visit	\$900 <u>copay</u> /visit	60% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Enhanced <u>Network Provider</u> (You will pay the least)	Standard <u>Network Provider</u>	<u>Out-of-Network Provider</u> (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.myhighmark.com	Tier 1	\$5/\$10/\$15 <u>copay</u> per prescription (retail) \$10 <u>copay</u> per prescription (mail order)	\$5/\$10/\$15 <u>copay</u> per prescription (retail) \$10 <u>copay</u> per prescription (mail order)	Not covered	Up to 31/60/90-day supply retail pharmacy. Up to 90-day supply maintenance <u>prescription drugs</u> through mail order.
	Tier 2	\$30/\$60/\$90 <u>copay</u> per prescription (retail) \$60 <u>copay</u> per prescription (mail order)	\$30/\$60/\$90 <u>copay</u> per prescription (retail) \$60 <u>copay</u> per prescription (mail order)	Not covered	This <u>plan</u> has an Essential <u>Formulary</u> .
	Tier 3	\$250/\$500/\$750 <u>copay</u> per prescription (retail) \$500 <u>copay</u> per prescription (mail order)	\$250/\$500/\$750 <u>copay</u> per prescription (retail) \$500 <u>copay</u> per prescription (mail order)	Not covered	
	Tier 4	50% <u>coinsurance</u> \$250/\$500/\$750 min \$1,000/\$2,000/\$3,000 max per prescription (retail) 50% <u>coinsurance</u> \$500 min/\$2,000 max per prescription (mail order)	50% <u>coinsurance</u> \$250/\$500/\$750 min \$1,000/\$2,000/\$3,000 max per prescription (retail) 50% <u>coinsurance</u> \$500 min/\$2,000 max per prescription (mail order)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$1,000 <u>copay</u> /visit	\$1,250 <u>copay</u> /visit	60% <u>coinsurance</u>	Precertification may be required.
	Physician/surgeon fees	\$1,000 <u>copay</u> /visit	\$1,250 <u>copay</u> /visit	60% <u>coinsurance</u>	Precertification may be required.
If you need immediate medical	<u>Emergency room care</u>	\$1,250 <u>copay</u> /visit	\$1,250 <u>copay</u> /visit	\$1,250 <u>copay</u> /visit <u>Deductible</u> does not apply.	Copayment waived if admitted as an inpatient.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Enhanced <u>Network Provider</u> (You will pay the least)	Standard <u>Network Provider</u>	<u>Out-of-Network Provider</u> (You will pay the most)	
attention	<u>Emergency medical transportation</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u> <u>Deductible</u> does not apply.	-----None-----
	<u>Urgent care</u>	\$90 <u>copay</u> /visit	\$90 <u>copay</u> /visit	\$90 <u>copay</u> /visit <u>Deductible</u> does not apply.	The <u>copayment</u> , if any, does not apply to <u>urgent care</u> services prescribed for the treatment of mental illness or substance abuse.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$2,500 <u>copay</u> /visit	\$3,000 <u>copay</u> /visit	60% <u>coinsurance</u>	Precertification may be required.
	Physician/surgeon fees	No charge	No charge	60% <u>coinsurance</u>	Precertification may be required.
If you have mental health, behavioral health, or substance abuse services	Outpatient services	\$45 <u>copay</u> /visit	\$45 <u>copay</u> /visit	60% <u>coinsurance</u>	Standard value network benefit is subject to enhanced value network deductible. Precertification may be required.
	Inpatient services	\$2,500 <u>copay</u> /visit	\$2,500 <u>copay</u> /visit	60% <u>coinsurance</u>	Standard value network benefit is subject to enhanced value network deductible. Precertification may be required.
If you are pregnant	Office visits	30% <u>coinsurance</u>	50% <u>coinsurance</u>	60% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) <u>Network</u> : The first visit to determine pregnancy is covered at no charge. Please refer to the Women's Health <u>Preventive Schedule</u> for additional information. Precertification may be required.
	Childbirth/delivery professional services	No charge	No charge	60% <u>coinsurance</u>	
	Childbirth/delivery facility services	\$2,500 <u>copay</u> /visit	\$3,000 <u>copay</u> /visit	60% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Enhanced <u>Network Provider</u> (You will pay the least)	Standard <u>Network Provider</u>	<u>Out-of-Network Provider</u> (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	60% <u>coinsurance</u>	Combined <u>network</u> and out-of- <u>network</u> : 60 visits per benefit period, aggregate with visiting nurse. Precertification may be required.
	<u>Rehabilitation services</u>	\$45 <u>copay</u> /visit	\$55 <u>copay</u> /visit	60% <u>coinsurance</u>	Combined <u>network</u> and out-of- <u>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.
	<u>Habilitation services</u>	\$45 <u>copay</u> /visit	\$55 <u>copay</u> /visit	60% <u>coinsurance</u>	Combined <u>network</u> and out-of- <u>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.
	<u>Skilled nursing care</u>	\$2,500 <u>copay</u> /visit	\$3,000 <u>copay</u> /visit	60% <u>coinsurance</u>	Combined <u>network</u> and out-of- <u>network</u> : 120 days per benefit period. Precertification may be required.
	<u>Durable medical equipment</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	60% <u>coinsurance</u>	Precertification may be required.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Enhanced <u>Network Provider</u> (You will pay the least)	Standard <u>Network Provider</u>	<u>Out-of-Network Provider</u> (You will pay the most)	
	<u>Hospice services</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	60% <u>coinsurance</u>	Combined <u>network</u> and out-of- <u>network</u> : Respite care limit of 7 days every 6 months. Precertification may be required.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Not covered	Combined enhanced and standard value <u>network</u> : One eye exam per 12 month period up to age 19.
	Children's glasses	No charge	No charge	Not covered	Combined enhanced and standard value <u>network</u> : One pair of frames/lenses every 12 months for members under the age of 19.
	Children's dental check-up	No charge	No charge	Not covered	Combined enhanced and standard value <u>network</u> : One exam every 6 months.

Excluded Services & Other Covered Services:

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

- Abortion, except 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.
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

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

- Chiropractic care
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Routine eye care (Adult)

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, Inc. at 1-877-986-4571.
- Additionally, a consumer assistance program can help you file your appeal. Contact the Pennsylvania Department of Consumer Services at 1-877-881-6388.

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 plan's overall deductible	\$0
■ Specialist copayment	\$45
■ Hospital (facility) copayment	\$2,500
■ Other coinsurance	30%

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:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$3,400
<u>Coinsurance</u>	\$0

What isn't covered

Limits or exclusions	\$60
The total Peg would pay is	\$3,460

Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$0
■ Specialist copayment	\$45
■ Hospital (facility) copayment	\$2,500
■ Other coinsurance	30%

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:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$1,100
<u>Coinsurance</u>	\$200

What isn't covered

Limits or exclusions	\$20
The total Joe would pay is	\$1,320

Mia's Simple Fracture (in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$0
■ Specialist copayment	\$45
■ Hospital (facility) copayment	\$2,500
■ Other coinsurance	30%

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:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$800
<u>Coinsurance</u>	\$400

What isn't covered

Limits or exclusions	\$0
The total Mia would pay is	\$1,200

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

Insurance or benefit administration may be provided by Highmark Blue Cross Blue Shield, First Priority Life Insurance Company or First Priority Health, all of which are independent licensees of the Blue Cross and Blue Shield Association.

To find more information about Highmark's benefits and operating procedures, such as accessing the drug formulary or using network providers, please go to <http://www.highmark.com/transparency-in-coverage>; or for a paper copy, call 1-855-873-4106.

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 siplemantè apwopriye (tèlke gwo lèt, odyo, Braille) pou bay enfòmasyon nan fòm 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 nsọ èdè Yorùbá, àwọn iṣẹ ìtumọ ati ògbuṣọ èdè wà ní àrọwọtọ lófẹ́ẹ́ fún ọ. Àwọn iṣẹ ìtọ́jú ati ìrànጓwọ́ tó yẹ (bíi titẹwé nla, gbígbo ohùn, ati iwé afọ́jú) lati pèsè iwífúnni ní àwọn ọ̀na ìrádáyè sì wà pẹ̀lu lófẹ́ẹ́. Pẹ nọmba tó wà lẹhin kaádi ìdánimọ rẹ (TTY: 711) fún ìrànጓwọ́.

אכטונג: אויב איר רעדט אידיש, קענט איר באקומען שפראך איבערזעצונג און דאלמעטשונג סערוויסעס פריי פון אפצאל. געהעריגע הילפסמיטלען און סערוויסעס (אזוי ווי גרויסע דרוק, אודיא און ברעיל) צו צושטעלן אינפארמאציע אין צוגענגליכע פארמאטן זענען אויך דא צו באקומען פריי פון אפצאל. רופט דעם נומער אויף די אנדערע זייט פון אייער אידענטיטעט קארטל (TTY: 711) פאר הילף.

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات الترجمة التحريرية والترجمة الفورية مجانًا. تتوفر أيضًا الوسائل والخدمات المساعدة المناسبة (مثل الطباعة الكبيرة، والوسائل الصوتية، وطريقة برايل) لتقديم المعلومات بتنسيقات يمكن الوصول إليها من دون أي تكلفة. اتصل على الرقم المدون على ظهر بطاقة هويتك (TTY: 711) للحصول على المساعدة.

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、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 નિ:શુલ્ક ભાષા અનુવાદ અને ઇન્ટરપ્રિટેશન સેવાઓ ઉપલબ્ધ છે. સુલભ ફોર્મેટમાં માહિતી પૂરી પાડવા માટે યોગ્ય સહાયક સાધનસામગ્રી અને સેવાઓ (જેમ કે મોટી પ્રિન્ટ, ઓડિયો અને બ્રેલ) પણ નિ:શુલ્ક ઉપલબ્ધ છે. મદદ માટે તમારા આઈડી 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 nổi) 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 દિનુહોસ્: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंलाई नि:शुल्क भाषा अनुवाद र दोभासे सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायक प्रविधि र सेवाहरू (जस्तै ठूलो प्रिन्ट, अडियो र ब्रेल) पनि नि:शुल्क उपलब्ध छन्। मददतको लागि तपाईंको ID कार्डको पछाडिको नम्बरमा कल गर्नुहोस् (TTY: 711)।

कृपया ध्यान दें: यदि आप हिंदी भाषा बोलते हैं, तो आपके लिए मुफ्त भाषा अनुवाद और व्याख्या संबंधी सेवाएं उपलब्ध हैं। एक्सेस करने योग्य फॉर्मेट में सूचना उपलब्ध कराने के लिए उपयुक्त सहायक सामग्री और सेवाएं (जैसे बड़े प्रिंट, ऑडियो और ब्रेल) भी नि:शुल्क 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).