Coverage Period: 01/01/2020 – 12/31/2020 Coverage for: Family | Plan Type: PPO

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, call us at 1-855-521-9351 or visit https://cdn1.brighthealthplan.com/docs/2020_COCs/COC_40463OK0010022_01_20200101.pdf. 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 1-855-521-9351 to request a copy.

Important Questions	Answers	Why This Matters
What is the overall deductible?	For Network Providers: \$4,700 Individual or \$9,400 Family For Non-Network Providers: \$14,100 Individual or \$28,200 Family	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. Primary Care, some Prescription Drugs, Urgent Care, and Pediatric Dental and Vision are covered before the deductible.	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</u> <u>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 <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	For Network Providers: \$8,150 Individual or \$16,300 Family For Non-Network Providers: None	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 <u>out-of-pocket limit?</u>	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a <u>network provider</u> ?	Yes. See https://member. brighthealthplan.com/providers or call 1-855-521-9351 for a list of network providers .	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 specialist you choose without a referral.

BHOK0003-0619; 40463OK0010022_01

^{*} For more information about limitations and exceptions, see the <u>plan</u> or policy document at https://cdn1.brighthealthplan.com/docs/2020 COCs/COC 40463OK0010022 01 20200101.pdf

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical		What You Will Pay		Limitations Européises 9 Other	
Event	Services You May Need	Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information	
	Primary care visit to treat an injury or illness	\$40 copay/visit. Deductible does not apply.	50% coinsurance	None	
If you visit a health	Specialist visit	40% coinsurance	50% coinsurance	None	
care <u>provider's</u> office or clinic	Preventive care/screening/ immunization	No charge	No charge	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.	
If you have a test	Diagnostic test (x-ray, blood work)	40% coinsurance	50% coinsurance	None	
ii you nave a test	Imaging (CT/PET scans, MRIs)	40% coinsurance	50% coinsurance	Services require <u>pre-authorization</u> .	
If you need drugs to treat your illness or condition. More	Generic drugs	Retail: \$15/prescription Mail Order: \$37.50/prescription. Deductible does not apply.	50% coinsurance	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).	
information about prescription drug	Preferred brand drugs	Retail: 40% coinsurance Mail Order: 40% coinsurance	50% coinsurance	Copay shown is per retail prescription.	
<u>coverage</u> is available at https://cdn1.brighthealthp	Non-preferred brand drugs	Retail and Mail Order: 40% coinsurance	50% coinsurance	Mail Order cost is 2.5 times the Retail	
lan.com/docs/formulary/2 020-ok-ifp-formulary- en.pdf	Specialty drugs	Retail and Mail Order: \$680/prescription. Deductible does not apply.	50% coinsurance	cost. Some prescription drugs may require authorization.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance	50% coinsurance	Services require <u>pre-authorization</u> .	
Surgery	Physician/surgeon fees	40% coinsurance	50% coinsurance	Services require <u>pre-authorization</u> .	
	Emergency room care	40% coinsurance	40% coinsurance	None	
If you need immediate	Emergency medical transportation	40% coinsurance	40% coinsurance	None	
medical attention	<u>Urgent care</u>	\$75 copay/visit. Deductible does not apply.	50% coinsurance	None	
If you have a hospital	Facility fee (e.g., hospital room)	40% coinsurance	50% coinsurance	Services require pre-authorization.	
stay	Physician/surgeon fees	40% coinsurance	50% coinsurance	Services require pre-authorization.	

Common	Caminas Vau May	What You Will Pay		Limitations Evantions 9 Other	
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	40% coinsurance All other Outpatient Items and Services: 40% coinsurance	50% coinsurance	All other Outpatient Items and Services are subject to the plan deductible and coinsurance.	
abuse services	Inpatient services	40% coinsurance	50% coinsurance	Services require <u>pre-authorization</u> .	
	Office visits	40% coinsurance	50% coinsurance	Cost sharing does not apply for preventive services.	
If you are pregnant	Childbirth/delivery professional services	40% coinsurance	50% coinsurance	Delivery stays exceeding 48 hours for vaginal delivery or 96	
	Childbirth/delivery facility services	40% coinsurance	50% coinsurance	hours for a cesarean delivery require <u>pre-authorization</u> .	
	Home health care	40% coinsurance	50% coinsurance	Services require <u>pre-authorization</u> . Limited to 30 visits per calendar year.	
	Rehabilitation services	40% coinsurance	50% coinsurance	Limited to 25 visits combined between speech, occupational, and physical therapy. Services require pre-authorization.	
If you need help recovering or have	Habilitation services	40% coinsurance	50% coinsurance	Limited to 25 visits combined between speech, occupational, and physical therapy. Services require pre-authorization.	
other special health needs	Skilled nursing care	40% coinsurance	50% coinsurance	Services require <u>pre-authorization</u> . Limited to 30 days per calendar year.	
	Durable medical equipment	40% coinsurance	50% coinsurance	Services require <u>pre-authorization</u> .	
	Hospice services	40% coinsurance	50% coinsurance	Services require <u>pre-authorization</u> .	
	Children's eye exam	No charge	50% coinsurance	Limited to 1 exam per year for members up to the end of the month in which they turn 19.	
If your child needs dental or eye care	Children's glasses	No charge up to the Provider's contracted amount.	50% coinsurance	Limited to 1 pair of glasses, including standard frames and standard lenses or contact lenses, every year for members up to the end of the month in which they turn 19.	
·	Children's dental check- up	No charge	No charge	Includes diagnostic and <u>preventive services</u> for members up to the end of the month in which the member turns 19. Refer to the Certificate of Coverage for covered services and limitations.	

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 in cases of rape, incest, or when the life of the mother is endangered)
- Acupuncture
- Bariatric Surgery

- Cosmetic Surgery
- Dental Care (Adults)
- Infertility Treatment
- Long Term Care

- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adults)
- 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
- Hearing Aids (Limited to one hearing aid impaired ear every 4 years.)
- Private-duty Nursing (Limited to 85 visits per calendar year)

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: Bright Health at 1-855-521-9351; the Oklahoma Insurance Department, Consumer Assistance at 1-800-522-0071; the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272), or https://www.dol.gov/ebsa/contactEBSA/consumerassistance.html; and Healthcare.gov at https://www.HealthCare.gov, or call 1-800-318-2596. 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 https://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 <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact: the Oklahoma Insurance Department, Consumer Assistance at 1-800-522-0071.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your <u>plan</u> doesn't meet the <u>Minimum Value Standards</u>, you may be eligible for a <u>premium tax credit</u> to help you pay for a <u>plan</u> through the <u>Marketplace</u>. **Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-521-9351.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-521-9351.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-521-9351.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-521-9351.

-To see examples of how this <u>plan</u> 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>	\$4,700
■ Specialist copayment	40%
■ Hospital (facility) coinsurance	40%
■ Other <u>coinsurance</u>	40%

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

In this example, Peg would pay:		
Cost Sharing		
Deductibles	\$3,190	
Copayments	\$0	
Coinsurance	\$4,960	
What isn't covered		
Limits or exclusions	\$60	
The total Peg would pay is	\$8,210	

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>	\$4,700
■ Specialist copayment	40%
■ Hospital (facility) coinsurance	40%
■ Other coinsurance	40%

This EXAMPLE event includes services like:

Primary care physician office visits (including disease education)

Diagnostic tests (blood work)

Prescription drugs

Total Example Cost

Durable medical equipment (glucose meter)

In this example, Joe would pay:		
Cost Sharing		
Deductibles	\$3,430	
Copayments	\$790	
Coinsurance	\$2,290	
What isn't covered		
Limits or exclusions	\$60	
The total Joe would pay is	\$6,570	

\$7,400

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$4,700
■ Specialist copayment	40%
■ Hospital (facility) coinsurance	40%
■ Other <u>coinsurance</u>	40%

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)
Diagnostic test (x-ray)

Durable medical equipment (arutabae)

Durable medical equipment (crutches) Rehabilitation services (physical therapy)

Total Example Cost

In this example, Mia would pay:		
Cost Sharing		
Deductibles	\$1,160	
<u>Copayments</u>	\$0	
Coinsurance	\$765	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$1,925	

\$12.800

\$1,925



Nondiscrimination Notice and Assistance with Communication

Bright Health does not exclude, deny benefits to, or otherwise discriminate against any individual on the basis of sex, age, race, color, national origin, or disability. "Bright Health" means Bright Health plans and their affiliates, which are listed below.

Language assistance and alternate formats:

Assistance is available at no cost to help you communicate with us. Services include, but are not limited to:

- Interpreters for languages other than English;
- Written information in alternative formats such as large print; and
- Assistance with reading Bright Health websites.

To ask for help with these services, please call the Member Services number on your member ID card.

If you think that we failed to provide language assistance or alternate formats, or you were discriminated against because of your sex, age, race, color, national origin, or disability, you can send a complaint to:

Bright Health Civil Rights Coordinator
Bright Health
P.O. Box 16275
Reading, PA 19612-6275
Phone: (844) 202-2154
Email: OAG@brighthealthplan.com

You can also file a complaint with the U.S Dept. of Health and Human Services, the Office of Civil Rights:

- 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

If you need help with your complaint, please call the Member Services number on your member ID card. You must send the complaint within 60 days of discovering the issue.

Language Assistance and Alternate Formats

This information is available in other formats like large print. To ask for another format, please call the Member Services number on your member ID card.



Language Assistance and Alternate Formats

This information is available in other formats like large print. To ask for another format, please call the Member Services number on your member ID card.

English ATTENTION: If you speak a language other than English, language assistance services, free

of charge, are available to you. Call the Member Services number on your ID card.

Arabic

انتباه: إذا كنت تتحدث لغة غير الإنجليزية، فخدمات المساعدة اللغوية متاحة من أجلك، دون تكلفة. اتصل برقم خدمات الأعضاء الموجود على بطاقة تعريف الهوية الخاصة بك.

Chinese (S) 注意:如果您使用的语言并非英语,则可获得免费的语言协助服务。请拨打身份证上

的会员服务号码。

French ATTENTION: Si vous parlez une autre langue que l'anglais, des services d'assistance

linguistique sont mis gratuitement à votre disposition. Appelez le numéro des services aux

membres figurant sur votre carte d'identification.

German ACHTUNG: Falls Sie eine andere Sprache als Englisch sprechen, steht Ihnen eine kostenfreie

fremdsprachliche Unterstützung zur Verfügung. Wählen Sie die Mitgliederservice-Nummer auf

Ihrer ID-Karte.

Greek ΠΡΟΣΟΧΗ: Αν μιλάτε κάποια γλώσσα διαφορετική από τα Αγγλικά, παρέχονται δωρεάν

υπηρεσίες γλωσσικής βοήθειας. Καλέστε τον αριθμό του Τμήματος Υπηρεσιών Μέλους

(Member Services) που αναγράφεται στην ταυτότητά σας (ID card).

Italian ATTENZIONE: se parla una lingua diversa dall'inglese, sono disponibili servizi di

assistenza linguistica gratuiti. Chiami il numero Member Services che trova sulla Sua tessera

identificativa.

Japanese ご注意:英語以外の言語を話される場合は、無料の言語支援サービスをご利用いただ

けます。IDカードに記載されているメンバーサービスの番号までお電話ください。

Korean 주의: 영어가 아닌 다른 언어를 사용할 경우 무료 언어 지원 서비스를 이용하실 수

있습니다. 신분증에 기재된 회원 서비스 번호로 연락하십시오.

Polish UWAGA: Jeśli nie mówisz po angielsku, możesz skorzystać z darmowych usług

tłumaczeniowych. Zadzwoń na numer obsługi podany na twojej karcie identyfikacyjnej.

Portuguese ATENÇÃO: Se falar um idioma que não o inglês, estão disponíveis serviços gratuitos de

assistência de idioma para si. Contacte o número de serviços para membros no seu cartão de

identificação.

Russian ВНИМАНИЕ: если вы не говорите на английском языке, вы можете воспользоваться

бесплатными услугами языковой поддержки. Позвоните в Отдел обслуживания участников программы по телефону, указанному на вашей идентификационной

карточке.

Spanish (US) ATENCIÓN: Si no habla inglés, tiene a su disposición servicios gratuitos de asistencia

lingüística. Comuníquese al número de Servicios para miembros que figura en su tajeta de ID.

Tagalog PAALALA: Kung nagsasalita ka ng isang wika bukod sa Ingles, magagamit mo ang mga

serbisyong tulong sa wika nang walang bayad. Tumawag sa numero ng Member Services na

nasa iyong ID card.



Urdu

توجہ دیں: اگر آپ انگریزی کے علاوہ کوئی اور زبان بولتے ہیں تو آپ کیلئے زبان کی معاونت کی خدمات مفت دستیاب ہیں۔ اینے ID کارڈیر موجود اراکین کی خدمات کے نمبر پر کال کریں۔

Vietnamese CHÚ Ý: Nếu bạn nói một thứ tiếng nào khác ngoài tiếng Anh, bạn sẽ được cấp các dịch vụ

hỗ trợ ngôn ngữ miễn phí. Gọi số Dịch vụ Hội viên trên Thẻ ID của bạn.

Navajo Shooh: Bilagáanaa bizaad doo doohts'a'góó, ata'hane', t'áá níík'eh, níká'adoojahígíí hóló.

Naaltsoos bee éédahózin bikáá' béésh bee hane' biká'ígíí bich'i' hodíílnih.

Amharic ማሳሰብያ: ከእንባሊዝኛ ውጪ የሆነ ቋንቋ የሚናንት ከሆነ ከክፍያ ነጻ የሆኑ የቋንቋ ድጋፍ አንልባሎቶችን ማባኘት

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Burmese သင္သသည္ အဂၤလိပ္စစ္ကကားမဟုတ္ေသာ အျခားဘာသာစကားတစ္ခုအား မျပာဆိုသူျဖစ္ပါက

ဘာသာစကားအခမဲ့ပံ့ပိုးသည္ ဝန္ေဆာင္မမႈအား သင္ရရရွိဳင္ပပါသည္။ သင္ ID (သက္ေသခံ)

ကတ္ပုပားပေၚရွိ အဖြဲြာင္မမ်ားဝန္ေဆာင္မမႈဌာနအား ဖုန္းခေၚဆိုပါ။

Cherokee of 04001: FT SOHODY JOHOF BZ YPB, SOHAOJ DPODSPODY TALOTAT, L

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 $J4\phi J$ O'OT GVP AC $\phi \Lambda J$ TO $h\phi J$.

Cushite-Oromo XIYYEEFFANNOO: Afaan Ingiliziin ala afaan kan biraa kan dubbattu yoo ta'e.

tajaajilliwwan gargaarsa afaanii, kan tolaa, siif ni jiru. Kaardii Waraqaa-eenyummeessaa

keerra kan jiru lakkoofsa Tajaajilawwan Miseensaatti bilbili.

French Creole ATANSYON: Si w pale you lot lang ke Angle, gen sevis ed lengwistik ki disponib pou w

gratis. Rele nimewo Sèvis pou manm yo nan kat idantite w la.

Gujarti ધ્યાન આપો: જો તમે અંગ્રેજી સિવાયની અન્ય કોઈ ભાષા બોલો છો, તો તમારા માટે ભાષા

સહાય સેવાઓ નિઃશુલ્ક ઉપલબ્ધ છે. તમારા આઈડી કાર્ડ પર રહેલાં સદસ્થની સેવાઓનાં નંબર

પર કૉલ કરો.

Hindi ध्यान दें: यदि आप अंग्रेजी के अलावा कोई अन्य भाषा बोलते हैं, तो आपके लिए मफ़्त में

भाषा सहायता सेवाएं उपलब्ध हैं। आपके आईडी कार्ड पर दिए गए सदस्य सेवा नंबर पर

कॉल करें।

Hmong UA ZOO SAIB: Yog tias koj hais ib hom lus dhau ntawm lus As Kiv, muaj cov kev pab cuam

txhais lus uas tsis xam nqi dab tsi rau koj tau siv. Hu rau Lub Chaw Pab Cuam Tswv Cuab tus

nab npawb xov tooj nyob ntawm koj daim npav ID.

Karen တိါနီဉ် – နမ္။ကတီးကျိဉ်လ၊တမ္၊အဲ့ကလံးကျိဉ်ဘဉ်နှဉ်, ကျိဉ်တါတိစားမးစားတါမးစားတဖဉ်, လ၊တလိဉ်ဟ္ဉ်အပူးတဖဉ်အိဉ်လ၊နဂီါနှဉ်

လီး. ကိုးကရာဖိတာ်မာစားတဖဉ် (ခုနှာ်ဘနမှနမလငစနျ) အနိုဉ်င်္ဂျစ်နှ တာ်အုဉ်သးနိုဉ်င်္ဂျစ်းကုအဖိုမိဉ်နှဉ်တကုန်.

Kru / Bassa YI LE: I balè u mpot hop umpè èbes Ngissi, bot ba nhola ni kobol mahop bayé ha i nyuu yoñ,

ngui nsaa wogui wo. Sebel Ndap Mahola i nyuu Mbon i nsinga i yé ntilgaga munu i Kat yon i

Mbon.

Kurdish

ئاگادارى: ئەگەر بە زمانلېكى ترى جگە لە ئېنگلېزى قسە دەكەيت، خزمەتگوزاريە زمانەوانيەكان بەخۆرايى بۆ تۆ بەدەستن. يەپوەندى بە زمارەي خزمەنگوزارى ئەندامانى سەر ناسنامەكەت بىكە.



ໍໂປດຊາບ: ຖ້າທ່ານເວົາພາສາອື່ນນອກຈາກພາສາອັງກິດ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາທີ່ບໍ Laotian

ເສຍຄ່າແມ່ນມີພ້ອມໃຫ້ທ່ານ. ກະລຸນາໂທຫາ ໝາຍເລກການບໍລິການສະມາຊິກທີ່ຢູ່ເທິງ ບັດ ID

ຂອງທ່ານ.

ចាប់អារម្មណ៍៖ ប្រសិនបើលោកអ្នកនិយាយភាសាផ្សេង ក្រៅពីភាសាអង់គ្លេស នោះសេវា Mon-Khmer

ជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសម្រាប់លោកអ្នក។ សូមទូរស័ព្ទទៅលេខសេវាបម្រើ

សមាជិកដែលមាននៅលើកាតសម្គាល់របស់លោកអ្នក។

ध्यान दिनुहोस्: यदि तपाइँ अङ्ग्रेजी बाहेक अन्य भाषा बोल्नुहुन्छ भने तपाइँको लागि नि:शुल्क रूपमा भाषा सहायता सेवा उपलब्ध छ। तपाइँको आइडी कार्डमा भएको सदस्य सेवा नम्बरमा कल गर्नुहोस्। Nepali

Persian Farsi

توجه: در صورتی که به زبانی غیر از انگلیسی صحبت می کنید خدمات کمکی زبانی به طور رایگان برای شما وجود دارد. برای این منظور با شماره خدمات اعضای موجود روی کارت شناسایی خود تماس بگیرید

Serbo-Croatian PAŻNJA: Ako govorite neki drugi jezik osim engleskog, dostupne su vam besplatne usluge

za jezičnu pomoć. Pozovite broj službe za članove na vašoj ličnoj karti.

Syriac

أَرْوَهُوْ: أَى هُو وَقَدِيْ اللَّهُ لَكُمُنَا السِّنَا صَهُمْ فَعَ كَمُنَا أَنْكُمُ مُنَا: هُو الْكُفُو مُنْكُونُ وَمُوَمَنَا وَوَقِعُونَا وَوَقِعُونَا وَهُوَمُونَا وَهُوَمُونَا وَهُونُونَا وَهُونَا لِمُعْلِقُونَا وَهُونُونَا وَهُونُونَا وَهُونُونَا وَهُونُونَا وَهُونُونَا وَهُونُونَا وَهُونُونَا وَهُونُونَا وَهُونَا لِمُؤْمِنَا وَهُونُونَا وَهُونُونَا وَهُونُونَا وَهُونُونَا وَهُونَا لَائِمُونَا وَهُونُونَا وَهُونُونَا وَهُونُونَا وَهُونَا لِمُؤْمِنَا وَهُونُونَا وَهُونُونَا وَهُونُونَا وَهُونُونَا وَهُونُونَا وَهُونُونَا وَهُونُونَا وَهُونَا لِمُؤْمِنَا وَهُونُونَا وَهُونَا وَهُونَا وَهُونَا لِمُؤْمِنَا لِمُؤْمِنَا وَهُونُونَا وَهُمُونَا لِمُعُمُونَا وَمُؤْمِنَا وَنُونَا وَهُونَا وَاللَّهُ وَمُعُونَا لِمُعُلِّمُ وَمُونَا لِمُؤْمِنَا لِمُعُونَا لِمُؤْمِنَا وَلَالِهُ مُنْ لِمُونَا لِمُونَا لِمُؤْمِنَا وَلَالِمُونَا لِمُؤْمِنَا لِمُؤْمِنَا لِمُؤْمِنَا لِمُونَا لِمُؤْمِنَا ل

ข้อควรทราบ: หากคุณใช้ภาษาอื่นที่ไม่ใช่ภาษาอังกฤษ เรามีบริการความช่วยเหลือทางภาษา Thai

จัดให้แก่คุณโดยไม่คิดค่าใช้จ่ายใด ๆ ติดต่อหมายเลขให้บริการสมาชิกที่บัตรประจำตัวของคุณ

Turkish DİKKAT: İngilizce haricinde bir dil konuşuyorsanız, dil yardım hizmetlerinden ücretsiz

olarak faydalanabilirsiniz. Kimlik kartınızın üzerindeki numaradan Üye Hizmetlerini arayın.

Ukrainian УВАГА: якщо ви не розмовляєте англійською, то можете скористатися безкоштовними

послугами мовної підтримки. Зателефонуйте до Відділу обслуговування учасників

програми за телефоном, вказаним на вашій ідентифікаційній картці.