Bright Health: Silver 10 Plan

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

The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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 1-855-521-9347. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms see the Glossary. You can view the Glossary at http://www.brighthealthplan.com or call 1-855-521-9347 to request a copy.

| Important Questions | Answers | Why This Matters |
|--|--|--|
| What is the overall deductible? | \$4,000 Individual or \$8,000 Family | Generally, you must pay all of the costs from <u>providers</u> 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. 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 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 deductibles for specific services. |
| What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ? | \$8,150 Individual or \$16,300 Family | 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</u> limit has been met. |
| What is not included in the out-of-pocket limit? | 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 www.brighthealthplan.com or call 1-855-521-9347 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 plan's <u>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 provider's 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. |



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

| | | What You Will Pay | | Limitations Evacutions 9 |
|--|--|--|---|---|
| Common Medical Event | Services You May Need | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
| | Primary care visit to treat an injury or illness | \$35 copay/visit | Not Covered | None |
| If you visit a health care provider's office or clinic | Specialist visit | 40% coinsurance | Not Covered | None |
| | Preventive care/screening/ immunization | No charge | Not Covered | None |
| If you have a test | Diagnostic test (x-ray, blood work) | 40% coinsurance | Not Covered | None |
| | Imaging (CT/PET scans, MRIs) | 40% coinsurance | Not Covered | Services require pre-authorization. |
| If you need drugs to treat | Generic drugs | \$15 copay/prescription | Not Covered | Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). Copay shown is per retail prescription. Mail Order cost is 2.5 times the Retail cost. |
| your illness or condition. | Preferred brand drugs | 40% coinsurance | Not Covered | |
| More information about prescription drug | Non-preferred brand drugs | 40% coinsurance | Not Covered | |
| coverage is eveilable of | Specialty drugs | \$680 copay/prescription | Not Covered | |
| If you have outpatient | Facility fee (e.g., ambulatory surgery center) | 40% coinsurance | Not Covered | Services require pre-authorization. |
| surgery | Physician/surgeon fees | 40% coinsurance | Not Covered | Services require pre-authorization. |
| | Emergency room care | 40% coinsurance | 40% coinsurance | None |
| If you need immediate medical attention | Emergency medical transportation | 40% coinsurance | 40% coinsurance | None |
| | <u>Urgent care</u> | \$75 copay/visit | \$75 copay/visit | None |
| If you have a hospital | Facility fee (e.g., hospital room) | 40% coinsurance | Not Covered | Services require pre-authorization. |
| stay | Physician/surgeon fees | 40% coinsurance | Not Covered | Services require pre-authorization. |

^{*} For more information about limitations and exceptions, see the plan or policy document at www.brighthealthplan.com

| | | What You Will Pay | | Limitations, Exceptions, & | |
|--|---|---|---|--|--|
| Common Medical Event | Services You May Need | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | Other Important Information | |
| If you need mental | Outpatient services | 40% coinsurance | Not Covered | None | |
| health, behavioral health, or substance abuse services | Inpatient services | 40% coinsurance | Not Covered | Services require pre-authorization. | |
| | Office visits | 40% coinsurance | Not Covered | None | |
| If you are pregnant | Childbirth/delivery professional services | 40% coinsurance | Not Covered | Delivery stays exceeding 48 hours for vaginal delivery or 96 hours for a cesarean delivery require pre- | |
| | Childbirth/delivery facility services | 40% coinsurance | Not Covered | authorization. | |
| | Home health care | 40% coinsurance | Not Covered | Limited to 60 days per calendar year. Services require pre-authorization. | |
| | Rehabilitation services | 40% coinsurance | Not Covered | Limited to 45 combined visits per year for | |
| recovering or mave officer | Habilitation services | 40% coinsurance | Not Covered | Occupational Therapy, Physical Therapy, Speech Therapy and Chiropractic Manipulations. Services require pre-authorization. | |
| special health needs | Skilled nursing care | 40% coinsurance | Not Covered | Limited to 60 days per calendar year. Services require pre-authorization. | |
| | Durable medical equipment | 40% coinsurance | Not Covered | Services require pre-authorization. | |
| | Hospice services | 40% coinsurance | Not Covered | Services require pre-authorization. | |
| | Children's eye exam | No charge | Not Covered | Limited to 1 exam per year. | |
| If your child needs dental or eye care | Children's glasses | No charge | Not Covered | Limited to 1 pair of glasses, including standard frames and standard lenses every year. Contact lenses are limited to a one-year supply. | |
| | Children's dental check-up | No charge | No charge | Refer to the Schedule of Benefits for covered services and limitations. | |

 $[\]hbox{* For more information about limitations and exceptions, see the plan or policy document at $\underline{www.brighthealthplan.com}$ }$

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)
- Hearing Aids
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. You may contact the Nebraska Department of Insurance at P.O. Box 82089, Lincoln, NE 68501-2089, 402-471-2201 or 877-564-7323. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your <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 Nebraska Department of Insurance at P.O. Box 82089, Lincoln, NE 68501-2089, 402-471-2201 or 877-564-7323.

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 plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-521-9347.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-521-9347.

Chinese (中文): 如果需要中文的帮助,请拨打这个号码 1-855-521-9347.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-521-9347.

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

^{*} For more information about limitations and exceptions, see the plan or policy document at www.brighthealthplan.com

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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> | \$4,000 |
|---|---------|
| ■ Specialist [cost sharing] | 40% |
| Hospital (facility) [cost sharing] | 40% |
| Other [cost sharing] | 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 | \$12,800 |
|--------------------|----------|
|--------------------|----------|

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 plan's overall deductible | \$4,000 |
|--------------------------------------|---------|
| ■ Specialist [cost sharing] | 40% |
| ■ Hospital (facility) [cost sharing] | 40% |
| Other [cost sharing] | 40% |

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)

In this example, Joe would pay:

| Cost Sharing | | |
|----------------------------|---------|--|
| Deductibles | \$3,430 | |
| Copayments | \$750 | |
| Coinsurance | \$2,290 | |
| What isn't covered | | |
| Limits or exclusions | \$60 | |
| The total Joe would pay is | \$6,530 | |

Mia's Simple Fracture

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

| ■ The <u>plan's</u> overall <u>deductible</u> | \$4,000 |
|---|---------|
| ■ Specialist [cost sharing] | 40% |
| ■ Hospital (facility) [cost sharing] | 40% |
| Other [cost sharing] | 40% |

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 \$1,9 | 25 |
|--------------------------|----|
|--------------------------|----|

In this example, Mia would pay:

| Cost Sharing | | |
|----------------------------|---------|--|
| Deductibles | \$1,160 | |
| Copayments | \$0 | |
| Coinsurance | \$765 | |
| What isn't covered | | |
| Limits or exclusions | \$0 | |
| The total Mia would pay is | \$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.



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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 ہوائے ہیں تو آپ کیائے 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'į' hodíílnih.

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

ይችላሉ:: በመታወቂያ ላይ በሚገኝ የአባላት አገልባሎት ቁጥር ላይ ይደውሉ::

Burmese သင္သသည္ အဂၤလိပ္စစကားမဟုတ္ေသာ အျခားဘာသာစကားတစ္ခုအား မျပာဆိုသူျဖစ္ပါက

ဘာသာစကားအခမဲ့ပံ့ပိုးသည့္ ဝန္ေဆာင္မမႈအား သင္ရရရွိဳင္ပပါသည္။ သင့္ ID (သက္ေသခံ)

ကတ္ျပားပေၚရွိ အဖဲြာင္မမ်ားဝန္ေဆာင္မမႈဌာနအား ဖုန္းခေၚဆိုပါ။

Cherokee of 04001: FT SOHOY AOHOF BZ YPB, SOHAGA DPGSPGY TALCATT, C

ALGA GECCY PARTY DAMAL HAS BELLEVILLE SERVING ALCOHOL WAS ALCOHOLD WAS ALCOHOL WAS ALCOHOLD WAS ALCOHOL WAS ALCOHOLD WAS ALCO

 $J4\phi J$ O'OT GVP AC $\phi \Lambda J$ T $\theta f\phi J$.

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 yon lòt lang ke Angle, gen sèvis èd 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 નિઃશલ્ક 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 တိၢိနီဉ် – နမ္။်ကတီးကျိဉ်လ၊တမ္၊အဲ့ကလံးကျိဉ်ဘဉ်နှဉ်, ကျိဉ်တ၊်တိစားမးစားတ၊်မးစားတဖဉ်, လ၊တလိဉ်ဟ္ဉ်အပူးတဖဉ်အိဉ်လ၊နဂီါနှဉ်

လီး. ကိုးကရာဖိတာ်မာစားတဖဉ် (နူနာ်ဘန္ဒမုနမလငစနျ) အနိုဉ်င်္ဂျစ်န္ တင်္ကြာည်းနိုဉ်င်္ဂျစ်းကူအဖိုမိဉ်နှဉ်တက္နှင့်

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. بەيوەندى بە زمارەي خزمەنگوزارى ئەندامانى سەر ناسنامەكەت بىكە.



ໍໄປດຊາບ: 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 لِمُعُونُونَا وَمُؤْمِنَا وَنُونَا وَهُونَا وَمُؤْمِنَا لِمُؤْمِنَا وَاللَّهُ وَالْمُؤْمِنَا وَاللَّهُ وَلَالِمُونَا لِمُؤْمِنَا وَلَا مُعُلِمُونَا لِمُؤْمِنَا لِمُؤْمِنَا وَلَائِمُ وَلَائِمُ لِمُؤْمِنَا وَلَائِمُ لِمُؤْمِنَا لِ

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.