




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.** Benefits may change upon renewal. For more information about your coverage, or to get a copy of the complete terms of coverage, visit Member Online Services at www.horizonblue.com/members or by calling 1-800-355-BLUE(2583). If you do not currently have coverage with Horizon BCBSNJ you can view a sample policy here, www.state.nj.us/dobi/division_insurance/ihcseh/sehforms.html. 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.cciio.cms.gov or call 1-800-355-BLUE (2583) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$1,350.00 Individual/\$2,700.00 Family for OMNIA Tier 1 providers . \$2,500.00/Individual or \$5,000.00/Family for Tier 2 providers . OMNIA Tier 1 accumulates to Tier 2.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible?	Yes. Preventive care is covered before you meet your deductible .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes. For prescription drugs \$250.00/Individual or \$500.00/Family for Tier 1 Pharmacies. All Tiers apply to Tier 1. There are no other specific deductibles .	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For Health/Pharmacy OMNIA Tier 1 providers \$8,550.00 Individual/\$17,100.00 Family and for Tier 2 providers \$9,000.00 Individual/\$18,000.00 Family. Aggregate family. OMNIA Tier 1 accumulates to Tier 2.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket 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 network provider?	Yes. See www.horizonblue.com or call 1-800-355-BLUE (2583) for a list of in-network providers .	You pay the least if you use a provider in OMNIA Tier 1. You pay more if you use a provider in Tier 2. You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Do you need a [referral](#) to see a [specialist](#)? No. You can see the [specialist](#) you choose without a [referral](#).

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		OMNIA Tier 1 Provider (You will pay the least)	Tier 2 Network Provider	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	\$20.00 Copayment per visit. \$10.00 Copayment per visit for Telemedicine services. Deductible does not apply.	\$30.00 Copayment per visit. \$15.00 Copayment per visit for Telemedicine services.	Not Covered.	Horizon CareOnline telemedicine services is an additional telemedicine feature provided through Horizon BCBSNJ's telemedicine vendor.
	Specialist visit	\$40.00 Copayment per visit. \$10.00 Copayment per visit for Telemedicine services. Deductible does not apply.	\$50.00 Copayment per visit. \$15.00 Copayment per visit for Telemedicine services.	Not Covered.	
	Preventive care/ screening/ immunization	No Charge. Deductible does not apply.	No Charge. Deductible does not apply.	Not Covered.	
If you have a test	Diagnostic test (x-ray, blood work)	No Charge for Home, Office, Independent Laboratory. Deductible does not apply. \$50.00 Copayment for Outpatient Hospital.	No Charge for Home, Office, Independent Laboratory. Deductible does not apply. 30% Coinsurance for Outpatient Hospital.	Not Covered.	Molecular and genomic testing are subject to pre-service and post-service medical necessity review.
	Imaging (CT/PET scans, MRIs)	\$75.00 Copayment for Outpatient Facility.	30% Coinsurance for Outpatient Facility.	Not Covered.	Requires pre-approval .

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.horizonblue.com/members.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		OMNIA Tier 1 Provider (You will pay the least)	Tier 2 Network Provider	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at Prime Therapeutics LLC (Prime) Service Center www.MyPrime.com or 1-800-370-5088. View the formulary at www.myprime.com/content/dam/prime/membersportal/WebDocs/2026/NJ_3T_HealthInsuranceMarketplace.pdf	Generic drugs	\$10.00 Copayment /Retail. \$20.00 Copayment Mail order.	\$10.00 Copayment /Retail. \$20.00 Copayment Mail order.	\$10.00 Copayment /Retail. \$20.00 Copayment Mail order.	Prior authorization may be required. Covers up to a 30 day supply per copayment , up to a 90 day supply applying separate copayments (retail) and a 90 day supply (mail order). Deductible for all Tiers apply to Tier 1 Deductible . Additional charges apply when using an out-of-network pharmacy. Cost sharing limits apply for Asthma Inhalers and Insulin, and for certain Epinephrine autoinjector devices.
	Preferred brand drugs	\$40.00 Copayment /Retail. \$80.00 Copayment Mail order.	\$40.00 Copayment /Retail. \$80.00 Copayment Mail order.	\$40.00 Copayment /Retail. \$80.00 Copayment Mail order.	
	Non-preferred brand drugs	\$75.00 Copayment /Retail. \$150.00 Copayment Mail order.	\$75.00 Copayment /Retail. \$150.00 Copayment Mail order.	\$75.00 Copayment /Retail. \$150.00 Copayment Mail order.	
	Specialty drugs	Covered at retail benefit in above applicable categories.	Covered at retail benefit in above applicable categories.	Not Covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$200.00 Copayment for Ambulatory Surgical Center. \$250.00 Copayment for Outpatient Facility.	30% Coinsurance for Ambulatory Surgical Center, Outpatient Facility.	Not Covered.	Procedures related to spine surgery are subject to pre-service and post-service utilization management review.
	Physician/surgeon fees	Deductible applies for Ambulatory Surgical Center, Outpatient Facility.	30% Coinsurance for Ambulatory Surgical Center, Outpatient Facility.	Not Covered.	Procedures related to spine surgery are subject to pre-service and post-service utilization management review. Deductible applies for OMNIA Tier 1 anesthesia in an ASC, Outpatient Facility. 30% Coinsurance for Tier 2 anesthesia in an ASC, Outpatient Facility.
If you need immediate medical attention	Emergency room care	\$100.00 Copayment then 10% Coinsurance .	\$100.00 Copayment then 10% Coinsurance .	\$100.00 Copayment then 10% Coinsurance .	Copayment waived if admitted within 24 hours. Out-of-network payment at the in-network level of benefits applies only to true medical emergencies and accidental injuries.

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.horizonblue.com/members.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		OMNIA Tier 1 Provider (You will pay the least)	Tier 2 Network Provider	Out-of-Network Provider (You will pay the most)	
	Emergency medical transportation	Deductible applies.	Deductible applies.	Deductible applies.	Out-of-network payment at the in-network level of benefits applies only to true medical emergencies and accidental injuries.
	Urgent care	\$75.00 Copayment . Deductible does not apply.	\$75.00 Copayment .	\$75.00 Copayment .	Out-of-network payment at the Tier 2 in-network level only for urgent care .
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500.00 Copayment per day for Inpatient Hospital.	30% Coinsurance for Inpatient Hospital.	Not Covered.	Requires pre-approval . OMNIA Tier 1 In-network separation period is limited to 90 days. \$2,500.00 OMNIA Tier 1 copayment maximum per admission.
	Physician/surgeon fees	Deductible applies for Inpatient Hospital.	30% Coinsurance for Inpatient Hospital.	Not Covered.	Deductible applies for OMNIA Tier 1 anesthesia. 30% Coinsurance for Tier 2 anesthesia.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20.00 Copayment per visit for Office. Deductible does not apply. \$20.00 Copayment per visit for Outpatient Services.	\$30.00 Copayment per visit for Office. 30% Coinsurance for Outpatient Services.	Not Covered.	The Integrated System of Care (ISC) is available for members with serious mental illness or substance use disorder. Reimbursement for ISC services requires a contracted ISC provider. Locate an ISC provider at www.HorizonBlue.com/member-ISC
	Inpatient services	\$500.00 Copayment per day for Inpatient Hospital.	30% Coinsurance for Inpatient Hospital.	Not Covered.	Requires pre-approval . OMNIA Tier 1 in-network separation period is limited to 90 days. \$2,500.00 OMNIA Tier 1 copayment maximum per admission.
If you are pregnant	Office visits	\$20.00 Copayment per visit for Office. \$40.00 Copayment per visit for Specialist. Deductible does not apply.	\$30.00 Copayment per visit for Office. \$50.00 Copayment per visit for Specialist.	Not Covered.	Cost sharing does not apply for preventive services . Maternity care may include tests and services described elsewhere in the SBC (i.e. Ultrasound.)
	Childbirth/delivery professional services	Deductible applies for Inpatient Hospital.	30% Coinsurance for Inpatient Hospital.	Not Covered.	_____none_____

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		OMNIA Tier 1 Provider (You will pay the least)	Tier 2 Network Provider	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	\$500.00 Copayment per day for Inpatient Hospital.	30% Coinsurance for Inpatient Hospital.	Not Covered.	OMNIA Tier 1 in-network separation period is limited to 90 days. \$2,500.00 OMNIA Tier 1 copayment maximum per admission.
If you need help recovering or have other special health needs	Home health care	\$10.00 Copayment per visit for Outpatient Facility. Deductible does not apply.	\$15.00 Copayment per visit for Outpatient Facility.	Not Covered.	Requires pre-approval . Private-duty nursing is only covered under the Home health care benefit when required by a Home health care plan . Coverage is limited to 60 visits per calendar year.
	Rehabilitation services	\$500.00 Copayment per day for Inpatient Hospital.	30% Coinsurance for Inpatient Hospital.	Not Covered.	Requires pre-approval . OMNIA Tier 1 in-network separation period is limited to 90 days. \$2,500.00 OMNIA Tier 1 copayment maximum per admission.
	Habilitation services	\$500.00 Copayment per day for Inpatient Hospital.	30% Coinsurance for Inpatient Hospital.	Not Covered.	
	Skilled nursing care	\$500.00 Copayment per day for Inpatient Facility.	30% Coinsurance for Inpatient Facility.	Not Covered.	
	Durable medical equipment	50% Coinsurance .	50% Coinsurance .	Not Covered.	Requires pre-approval . Tier 2 Deductible accumulates to Tier 1. Tier 2 MOOP accumulates to Tier 1.
	Hospice services	\$500.00 Copayment per day for Inpatient Facility.	30% Coinsurance for Inpatient Facility.	Not Covered.	Requires pre-approval . OMNIA Tier 1 in-network separation period is limited to 90 days. \$2,500.00 OMNIA Tier 1 copayment maximum per admission.
If your child needs dental or eye care	Children's eye exam	No Charge. Deductible does not apply.	No Charge. Deductible does not apply.	Not Covered.	This benefit is administered by Davis Vision. In-network routine vision exam child visit limit is 1 visit.
	Children's glasses	Amounts greater than \$150.00 for non-collection frames. Deductible does not apply.	Amounts greater than \$150.00 for non-collection frames. Deductible does not apply.	Not Covered.	This benefit is administered by Davis Vision. Lenses and Hardware are covered once every 12 months. Limit includes 1 pair of frames from the select Davis Vision collection or \$150.00 allowance for non-collection frames.

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.horizonblue.com/members.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		OMNIA Tier 1 Provider (You will pay the least)	Tier 2 Network Provider	Out-of-Network Provider (You will pay the most)	
	Children's dental check-up	Not Covered.	Not Covered.	Not Covered.	_____none_____

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 .)		
<ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult) • Long-term care • Most coverage provided outside the United States. • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • Private-duty nursing (only covered through the Home Health Care benefit when the Home Health Care plan is provided) • Routine eye care (Adult, Optometrist/Ophthalmologist office. For verification of coverage on routine vision services, please see your policy or plan document.) 	<ul style="list-style-type: none"> • Routine foot care (excludes services or supplies related to Routine Foot Care, except: a) an open cutting operation to treat weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions; b) the removal of nail roots; and c) treatment or removal of corns, calluses or toenails in conjunction with the treatment of metabolic or peripheral vascular disease) • Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> • Abortion services • Acupuncture when used as a substitute for other forms of anesthesia 	<ul style="list-style-type: none"> • Bariatric surgery • Chiropractic care (limited to 30 visits per calendar year) 	<ul style="list-style-type: none"> • Hearing aids, including coverage for cochlear implants (limited to one hearing aid per hearing impaired ear per 24-month period) • Infertility treatment (limited to artificial insemination; requires pre-approval)

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.horizonblue.com/members.

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. To contact the [plan](#) call 1-800-355-BLUE (2583). 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 www.getcovered.nj.gov or call 1-833-677-1010.

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: 1-800-355-BLUE (2583) or visit www.Horizonblue.com. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. You may also contact the NJ Department of Banking and Insurance Consumer Protection Services at 1-888-393-1062 ext 50998.

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)	Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	Mia's Simple Fracture (in-network emergency room visit and follow up care)																																										
<ul style="list-style-type: none"> ■ The plan's overall deductible \$1,350.00 ■ Specialist Copayment \$40.00 ■ Hospital (facility) Copayment \$500.00 ■ Other Coinsurance 0% 	<ul style="list-style-type: none"> ■ The plan's overall deductible \$1,350.00 ■ Specialist Copayment \$40.00 ■ Hospital (facility) Copayment \$500.00 ■ Other Coinsurance 50% 	<ul style="list-style-type: none"> ■ The plan's overall deductible \$1,350.00 ■ Specialist Copayment \$40.00 ■ Hospital (facility) Copayment \$500.00 ■ Other Coinsurance 50% 																																										
<p>This EXAMPLE event includes services like: Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)</p>	<p>This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)</p>	<p>This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic test (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>)</p>																																										
<p>Total Example Cost \$12,700.00</p>	<p>Total Example Cost \$5,600.00</p>	<p>Total Example Cost \$2,800.00</p>																																										
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This [plan](#) has other [deductibles](#) for specific services included in this coverage example. See "Are there other [deductibles](#) for specific services?" row above.

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.



Notice of Nondiscrimination

Horizon Blue Cross Blue Shield of New Jersey complies with applicable Federal civil rights laws and does not discriminate against nor does it exclude people or treat them differently on the basis of race, color, gender, national origin (including limited English proficiency and primary language), age, disability, pregnancy, gender identity, sex, sexual orientation, sex characteristics or health status in the administration of the plan, including enrollment and benefit determinations.

Horizon provides language assistance services and appropriate auxiliary aids and services at no cost to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information written in other languages.

Contacting Member Services

Please call Member Services at **1-800-355-BLUE (2583) (TTY 711)** or the phone number on the back of your member ID card, if you need the free aids and services noted above and for **all other Member Services issues, including:**

- **Claim, benefits or enrollment inquiries**
- **Lost/stolen ID cards**
- **Address changes**
- **Any other inquiry related to your benefits or health plan**

Filing a Section 1557 Grievance

If you believe that Horizon has failed to provide the free communication aids and services or discriminated on the basis of race, color, gender, national origin (including limited English proficiency and primary language), age or disability you can file a discrimination complaint also known as a Section 1557 Grievance. Horizon BCBSNJ's Civil Rights Coordinator can be reached by calling the Member Services number on the back of your member ID card or by writing to the following address:

**Horizon BCBSNJ – Civil Rights Coordinator
PO Box 820
Newark, NJ 07101**

If you are not a Horizon member, you may contact Section 1557 Coordinator by calling **1-866-660-6528 (TTY 711)** or by writing to Horizon BCBSNJ's Civil Rights Coordinator at the above-referenced address. 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 <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf><https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> opens a dialog window, or by mail or phone at:

**Office for Civil Rights Headquarters
U.S. Department of Health and Human Services 200 Independence Avenue, SW
Room 509F, HHH Building Washington, D.C. 20201
1-800-368-1019 or 1-800-537-7697 (TDD)**

OCR Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.



Notice of Availability

If you speak English, free language assistance services and auxiliary aids are available to provide information in accessible formats. Call the number on the back of your member ID card for help.

Si habla español, hay servicios gratuitos de asistencia lingüística y ayudas auxiliares disponibles para proporcionar información en formatos accesibles. Llame al número que figura en el reverso de su tarjeta de identificación de miembro para obtener ayuda.

如果您說中文，我們提供免費的語言協助服務和輔助工具，以無障礙格式提供資訊。請撥打您的會員 ID 卡背面的電話號碼尋求協助。

한국어를 사용하시는 경우, 무료 언어 지원 서비스 및 보조 기구를 통해 접근 가능한 형식으로 정보를 제공받을 수 있습니다. 도움이 필요하시면 가입자 ID 카드 뒷면에 있는 번호로 전화하시기 바랍니다.

Se fala português, estão disponíveis serviços de assistência linguística e auxiliares gratuitos para fornecer informações em formatos acessíveis. Telefone para o número no verso do seu cartão de identificação de associado para obter ajuda.

જો તમે ગુજરાતી બોલતા હોવ, તો સુલભ ફોર્મેટમાં માહિતી પૂરી પાડવા માટે નિ:શુલ્ક ભાષા સહાય સેવાઓ અને પૂરક સહાયો ઉપલબ્ધ છે. મદદ માટે તમારા સભ્ય આઈડી કાર્ડની પાછળના નંબર પર કોલ કરો.

Jeśli posługujesz się językiem polski, dostępne są bezpłatne usługi wsparcia językowego i materiały pomocnicze w celu przekazania informacji w przystępnym formacie. Aby uzyskać pomoc, zadzwoń pod numer podany na odwrocie identyfikacyjnej karty członkowskiej.

Se parlate italiano, sono disponibili servizi gratuiti di assistenza linguistica e ausili aggiuntivi per fornire informazioni in formati accessibili. Chiamate il numero sul retro della Vostra tessera identificativa per ricevere assistenza.

إذا كنت تتحدث العربية، تتوفر خدمات المساعدة اللغوية المجانية والمساعدات الإضافية لتوفير المعلومات بصيغ يسهل الوصول إليها. اتصل بالرقم الموجود على ظهر بطاقة هوية العضو للحصول على المساعدة.

Kung nagsasalita ka ng Tagalog, handang magamit ang mga libheng tulong na serbisyo sa wika at mga auxiliary na tulong para magbigay ng impormasyon sa mga naa-access na format. Tawagan ang numero sa likod ng iyong kard ng pagkakakilanlan bilang miyembro para sa tulong.

Если вы говорите на Русский язык, мы готовы бесплатно предоставить услуги переводчика и вспомогательные средства для получения информации в доступных форматах. Для получения помощи позвоните по номеру, указанному на обратной стороне вашей карточки участника.

Si w pale Kreyòl Ayisyen, sèvis asistans lang gratis ak èd oksilyè disponib pou bay enfòmasyon nan fòm ki aksesib. Rele nimewo ki sou do kat manm ou a pou èd.

यदि आप हिंदी बोलते हैं, तो सुलभ प्रारूपों में जानकारी प्रदान करने के लिए नि:शुल्क भाषा सहायता सेवाएं और सहायक साधन उपलब्ध हैं। मदद के लिए अपने सदस्य आईडी कार्ड के पीछे दिए गए नंबर पर कॉल करें।

Nếu bạn nói tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí và công cụ hỗ trợ để cung cấp thông tin ở các định dạng có thể truy cập. Hãy gọi số điện thoại ở mặt sau thẻ nhận dạng thành viên của bạn để được trợ giúp.

Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition, ainsi que des outils auxiliaires fournissant des informations dans des formats accessibles. Pour recevoir de l'aide, appelez le numéro indiqué au dos de votre carte de membre.

اگر آپ اردو بولتے ہیں، تو مفت زبان کی خدمات اور معاون امداد ایک قابل رسائی شکل میں معلومات کی فراہمی کے لیے دستیاب ہیں۔ مدد کے لیے اپنے ممبر آئی ڈی کارڈ کی پشت پر موجود نمبر پر کال کریں۔

আপনি যদি বাংলায় ভাষায় কথা বলেন, তাহলে সহজলভ্য ফরম্যাটে তথ্য প্রদানের জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবা ও সহায়ক উপকরণ উপলব্ধ রয়েছে। সাহায্যের জন্য আপনার সদস্য আইডি কার্ডের পিছনে দেওয়া নম্বরে কল করুন।

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