

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered ServicesBlueCross BlueShield of Texas : G9EE5ADT Blue Advantage Gold HMOSM 923Coverage Period: 12/01/2022-11/30/2023
Coverage for: Individual + Family | Plan Type: HMO

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, visit www.bcbstx.com/member/policy-forms/2022 or by calling 1-877-299-2377. 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 1-855-756-4448 to request a copy.

| Important Questions | Answers | Why This Matters: |
|--|--|--|
| What is the overall deductible? | \$1,250 Individual/\$3,750 Family | 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. In-Network Preventive Health Care services, services with a copayment, and some prescription drugs are 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? | No. | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan? | \$5,000 Individual/\$10,000 Family | 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-billed 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.bcbstx.com/go/bahmo or call 1-877-299-2377 for a list of Participating providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. 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? | Yes. | This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist. |



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 | Participating Providers (You will pay the least) | What You Will Pay | Non-Participating Providers (You will pay the most) | Limitations, Exceptions, & Other Important Information |
|---|---|--|-------------------|---|--|
| Primary care visit to treat an injury or illness | \$40/visit; <u>deductible</u> does not apply | | Not Covered | | Virtual Visits are available. See your benefit booklet* for details. |
| <u>Specialist</u> visit | \$80/visit; <u>deductible</u> does not apply | | Not Covered | | <u>Referral</u> required. |
| <u>Preventive care/screening/immunization</u> | No Charge; <u>deductible</u> does not apply | | Not Covered | | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your <u>plan</u> will pay for. <u>Preadmission</u> may be required; see your benefit booklet* for details. |
| If you visit a health care provider's office or clinic | | | | | |
| <u>Diagnostic test</u> (x-ray, blood work) | Lab: 20% <u>coinsurance</u> X-Rays: \$150/test plus 20% <u>coinsurance</u> | | Not Covered | | <u>Referral</u> may be required. <u>Preadmission</u> may also be required; see your benefit booklet* for details. |
| <u>Imaging</u> (CT/PET scans, MRIs) | \$200/test plus 20% <u>coinsurance</u> | | Not Covered | | <u>Referral</u> may be required. <u>Preadmission</u> may also be required; see your benefit booklet* for details. |
| If you have a test | | | | | |

*For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com/member/policy-forms/2022.

| Common Medical Event | Services You May Need | What You Will Pay Participating Providers (You will pay the least) | Non-Participating Providers (You will pay the most) | Limitations, Exceptions, & Other Important Information |
|--|--|--|--|---|
| Preferred generic drugs | Retail - Preferred Participating - No Charge Participating - \$10/prescription Mail - No Charge; <u>deductible does not apply</u> | Not Covered | | |
| Non-preferred generic drugs | Retail - Preferred Participating - \$10/prescription Participating - \$20/prescription Mail - \$30/prescription; <u>deductible does not apply</u> | Not Covered | | Limited to a 30-day supply at retail (or a 90-day supply at a <u>network</u> of select retail pharmacies). Up to a 90-day supply at mail order. <u>Specialty drugs</u> limited to a 30-day supply. Payment of the difference between the cost of a brand name drug and a generic may also be required if a generic drug is available. Certain drugs require approval before they will be covered. |
| Preferred brand drugs | Retail - Preferred Participating - \$50/prescription Participating - \$70/prescription Mail - \$150/prescription; <u>deductible does not apply</u> | Not Covered | | <u>Cost-sharing</u> for insulin included in the drug list will not exceed \$25 per prescription for a 30-day supply, regardless of the amount or type of insulin needed to fill the prescription. |
| Non-preferred brand drugs | Retail - Preferred Participating - \$100/prescription Participating - \$120/prescription Mail - \$300/prescription; <u>deductible does not apply</u> | Not Covered | | |
| Preferred <u>specialty drugs</u> | \$150/prescription; <u>deductible does not apply</u> | Not Covered | | |
| Non-preferred <u>specialty drugs</u> | \$250/prescription; <u>deductible does not apply</u> | Not Covered | | |
| Facility fee (e.g., ambulatory surgery center) | \$250/visit plus 20% <u>coinsurance</u> | Not Covered | | Referral required. Preauthorization may also be required. For Outpatient Infusion Therapy, see your benefit booklet* for details. |
| Physician/surgeon fees | 20% <u>coinsurance</u> | Not Covered | | |
| <u>Emergency room care</u> | \$600/visit plus 20% <u>coinsurance</u> | \$600/visit plus 20% <u>coinsurance</u> | <u>Copayment</u> waived if admitted. | |
| <u>Emergency medical transportation</u> | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | <u>Preauthorization</u> may be required for non-emergency transportation; see your benefit booklet* for details. | |
| <u>Urgent care</u> | \$75/visit; <u>deductible does not apply</u> | Not Covered | None | |

If you need drugs to treat your illness or condition
More information about prescription drug coverage is available at www.bcbstx.com/rx22

*For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com/member/policy-forms/2022.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|------------------------------------|---|---|--|
| | | Participating Providers (You will pay the least) | Non-Participating Providers (You will pay the most) | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$300/visit plus 20% <u>coinsurance</u> | Not Covered | Referral required. Preauthorization may also be required; see your benefit booklet* for details. |
| | Physician/surgeon fees | 20% <u>coinsurance</u> | Not Covered | Referral required. Preauthorization may also be required; see your benefit booklet* for details. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$40 /office visit; deductible does not apply, 20% <u>coinsurance</u> for other outpatient services | Not Covered | Referral required. Preauthorization may also be required; see your benefit booklet* for details. |
| | Inpatient services | \$300/visit plus 20% <u>coinsurance</u> | Not Covered | Referral required. Preauthorization may also be required; see your benefit booklet* for details. |

*For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com/member/policy-forms/2022.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|--|---|---|
| | | Participating Providers (You will pay the least) | Non-Participating Providers (You will pay the most) | |
| If you are pregnant | Office visits | Primary Care: \$40/initial visit Specialist: \$80/initial visit; <u>deductible</u> does not apply | Not Covered | <u>Copayment</u> applies to first prenatal visit (per pregnancy). <u>Cost sharing</u> does not apply for preventive services. Depending on the type of services, <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). |
| | Childbirth/delivery professional services | 20% <u>coinsurance</u> | Not Covered | |
| | Childbirth/delivery facility services | \$300/visit plus 20% <u>coinsurance</u> | Not Covered | |
| | Home health care | 20% <u>coinsurance</u> | Not Covered | 60 visits/year. <u>Referral</u> required. <u>Preauthorization</u> may also be required; see your benefit booklet* for details. |
| | Rehabilitation services | 20% <u>coinsurance</u> | Not Covered | Separate 35 visit maximum per benefit period for <u>Habilitation</u> and <u>Rehabilitation services</u> , including chiropractic care. <u>Referral</u> required. <u>Preauthorization</u> may also be required; see your benefit booklet* for details. |
| | Habilitation services | 20% <u>coinsurance</u> | Not Covered | 25 days/year. <u>Referral</u> required. <u>Preauthorization</u> may also be required; see your benefit booklet* for details. |
| If you need help recovering or have other special health needs | Skilled nursing care | 20% <u>coinsurance</u> | Not Covered | <u>Referral</u> required. <u>Preauthorization</u> may also be required; see your benefit booklet* for details. |
| | Durable medical equipment | 20% <u>coinsurance</u> | Not Covered | <u>Referral</u> required. <u>Preauthorization</u> may also be required; see your benefit booklet* for details. |
| | Hospice services | 20% <u>coinsurance</u> | Not Covered | <u>Referral</u> required. <u>Preauthorization</u> may also be required; see your benefit booklet* for details. |
| | Children's eye exam | No Charge; <u>deductible</u> does not apply | Up to a \$30 reimbursement is available; <u>deductible</u> does not apply | One visit per year. Out-of-Network reimbursement will not exceed the retail cost. See your benefit booklet* (Pediatric Vision Care Benefits) for details. |
| | If your child needs dental or eye care | | | |

*For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com/member/policy-forms/2022.

| Common Medical Event | Services You May Need | What You Will Pay Participating Providers (You will pay the least) | Non-Participating Providers (You will pay the most) | Limitations, Exceptions, & Other Important Information |
|----------------------|---|--|--|---|
| Children's glasses | No Charge; <u>deductible</u> does not apply | Reimbursement is available; <u>deductible</u> does not apply | One pair of glasses every 12 months. Reimbursement for frames, lenses, and lens options purchased Out-of-Network is available (not to exceed the retail cost). See your benefit booklet* (Pediatric Vision Care Benefits) for details. | |
| | Children's dental check-up | 30% <u>coinsurance</u> | 30% <u>coinsurance</u> | Oral exams are limited to two every benefit period. Benefits for periodic and comprehensive oral evaluations are limited to a combined maximum of two every 12 months. See your benefit booklet* (Pediatric Dental Benefits Rider) for details. |

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 for a pregnancy that, as certified by a physician, places the woman in danger of death or a serious risk of substantial impairment of a major bodily function unless an abortion is performed)
- Acupuncture
- Bariatric surgery
- Cosmetic surgery (except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors, or diseases when medically necessary)
- Dental care (Adult)
- Infertility treatment (diagnosis and treatment covered; in vitro not covered)
 - Long-term care
 - Non-emergency care when traveling outside the U.S.
 - Private-duty nursing (unless medically necessary)
 - Weight loss programs
- Routine eye care (Adult)
 - Routine foot care (except in connection with diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency)

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

- Chiropractic care (35 visits/year combined with habilitation and rehabilitation services)
 - Hearing aids (limited to one hearing aid per ear every 36 months)

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: the plan at Blue Cross and Blue Shield of Texas at 1-888-697-0683 or visit www.bcbstx.com. For group health coverage subject to ERISA, contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For non-federal governmental group health plans, contact Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cms.gov. Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law. 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.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 on how 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: For group health coverage subject to ERISA: Blue Cross and Blue Shield of Texas at or visit www.bcbstx.com, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, and the Texas Department of Insurance, Consumer Protection at 1-800-252-3439 or www.tdi.texas.gov. For non-federal governmental group health plans and church plans that are group health plans, Blue Cross and Blue Shield of Texas at 1-877-299-2377 or www.bcbstx.com or contact the Texas Department of Insurance, Consumer Protection at 1-800-252-3439 or www.tdi.texas.gov. Additionally, a consumer assistance program can help you file your appeal. Contact the Texas Department of Insurance's Consumer Health Assistance Program at 1-800-252-3439 or visit www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/tx.html.

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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-299-2377.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-299-2377.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-299-2377.

Navajo (Dine): Dinek'ehgo shika atohwol ninisingo, kwijjigo hohé' 1-877-299-2377.

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 | \$1,250 |
| Specialist copayment | \$80 |
| Hospital (facility) copay/coins | \$300+20% 20% |
| Other coinsurance | |

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

| | |
|--|------------------|
| The plan's overall deductible | \$1,250 |
| Specialist copayment | \$80 |
| Hospital (facility) copay/coins | \$300+20% 20% |
| Other coinsurance | |

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

| | |
|--|------------------|
| The plan's overall deductible | \$1,250 |
| Specialist copayment | \$80 |
| Hospital (facility) copay/coins | \$300+20% 20% |
| Other coinsurance | |

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)

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 | \$12,700 |
|---------------------------|-----------------|

In this example, Peg would pay:

| | Cost Sharing |
|--------------------|--------------|
| Deductibles | \$1,250 |
| Copayments | \$700 |
| Coinsurance | \$2,100 |

In this example, Joe would pay:

| | Cost Sharing |
|--------------------|--------------|
| Deductibles | \$900 |
| Copayments | \$800 |
| Coinsurance | \$0 |

In this example, Mia would pay:

| | Cost Sharing |
|--------------------|--------------|
| Deductibles | \$1,250 |
| Copayments | \$700 |
| Coinsurance | \$100 |

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 | \$5,600 |
|---------------------------|----------------|

In this example, Mia would pay:

| | Cost Sharing |
|--------------------|--------------|
| Deductibles | \$1,250 |
| Copayments | \$700 |
| Coinsurance | \$0 |

In this example, Joe would pay:

| | Cost Sharing |
|--------------------|--------------|
| Deductibles | \$900 |
| Copayments | \$800 |
| Coinsurance | \$0 |

In this example, Peg would pay:

| | Cost Sharing |
|--------------------|--------------|
| Deductibles | \$1,250 |
| Copayments | \$700 |
| Coinsurance | \$100 |

In this example, Mia would pay:

| | Cost Sharing |
|--------------------|--------------|
| Deductibles | \$1,250 |
| Copayments | \$700 |
| Coinsurance | \$100 |

In this example, Joe would pay:

| | Cost Sharing |
|--------------------|--------------|
| Deductibles | \$900 |
| Copayments | \$800 |
| Coinsurance | \$0 |

In this example, Peg would pay:

| | Cost Sharing |
|--------------------|--------------|
| Deductibles | \$1,250 |
| Copayments | \$700 |
| Coinsurance | \$100 |

In this example, Mia would pay:

| | Cost Sharing |
|--------------------|--------------|
| Deductibles | \$1,250 |
| Copayments | \$700 |
| Coinsurance | \$100 |

In this example, Joe would pay:

| | Cost Sharing |
|--------------------|--------------|
| Deductibles | \$900 |
| Copayments | \$800 |
| Coinsurance | \$0 |

In this example, Peg would pay:

| | Cost Sharing |
|--------------------|--------------|
| Deductibles | \$1,250 |
| Copayments | \$700 |
| Coinsurance | \$100 |

In this example, Mia would pay:

| | Cost Sharing |
|--------------------|--------------|
| Deductibles | \$1,250 |
| Copayments | \$700 |
| Coinsurance | \$100 |

In this example, Joe would pay:

| | Cost Sharing |
|--------------------|--------------|
| Deductibles | \$900 |
| Copayments | \$800 |
| Coinsurance | \$0 |

In this example, Peg would pay:

| | Cost Sharing |
|--------------------|--------------|
| Deductibles | \$1,250 |
| Copayments | \$700 |
| Coinsurance | \$100 |

In this example, Mia would pay:

| | Cost Sharing |
|--------------------|--------------|
| Deductibles | \$1,250 |
| Copayments | \$700 |
| Coinsurance | \$100 |

In this example, Joe would pay:

| | Cost Sharing |
|--------------------|--------------|
| Deductibles | \$900 |
| Copayments | \$800 |
| Coinsurance | \$0 |

In this example, Peg would pay:

| | Cost Sharing |
|--------------------|--------------|
| Deductibles | \$1,250 |
| Copayments | \$700 |
| Coinsurance | \$100 |

In this example, Mia would pay:

| | Cost Sharing |
|--------------------|--------------|
| Deductibles | \$1,250 |
| Copayments | \$700 |
| Coinsurance | \$100 |

In this example, Joe would pay:

| | Cost Sharing |
|--------------------|--------------|
| Deductibles | \$900 |
| Copayments | \$800 |
| Coinsurance | \$0 |

In this example, Peg would pay:

| | Cost Sharing |
|--------------------|--------------|
| Deductibles | \$1,250 |
| Copayments | \$700 |
| Coinsurance | \$100 |

In this example, Mia would pay:

| | Cost Sharing |
|--------------------|--------------|
| Deductibles | \$1,250 |
| Copayments | \$700 |
| Coinsurance | \$100 |

In this example, Joe would pay:

| | Cost Sharing |
|--------------------|--------------|
| Deductibles | \$900 |
| Copayments | \$800 |
| Coinsurance | \$0 |

In this example, Peg would pay:

| | Cost Sharing |
|--------------------|--------------|
| Deductibles | \$1,250 |
| Copayments | \$700 |
| Coinsurance | \$100 |

In this example, Mia would pay:

| | Cost Sharing |
|--------------------|--------------|
| Deductibles | \$1,250 |
| Copayments | \$700 |
| Coinsurance | \$100 |

In this example, Joe would pay:

| | Cost Sharing |
|--------------------|--------------|
| Deductibles | \$900 |
| Copayments | \$800 |
| Coinsurance | \$0 |

In this example, Peg would pay:

| | Cost Sharing |
|--------------------|--------------|
| Deductibles | \$1,250 |
| Copayments | \$700 |
| Coinsurance | \$100 |

In this example, Mia would pay:

| | Cost Sharing |
|--------------------|--------------|
| Deductibles | \$1,250 |
| Copayments | \$700 |
| Coinsurance | \$100 |

In this example, Joe would pay:

| | Cost Sharing |
| --- | --- |

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Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance. We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960
Email: CivilRightsCoordinator@hcsc.net

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>
Complaint Forms: <http://www.hhs.gov/ocr/office/file/index.html>



If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost.

To talk to an interpreter, call 855-710-6984.

| | | | |
|------------------------|--|--|--|
| Español Spanish | Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984. | إنْ كَانْ لَدِيْكَ أَوْ لَدِيْ شَخْصَ تَسَاعِدُهُ أَسْنَدَهُ، فَلَدِيْكَ الْحَقُّ فِي الْحُصُولِ عَلَى الْمَسَاعِدَةَ وَالْمَعْلُومَاتَ الْشَّرُورِيَّةَ بِلِفَاتَقٍ مِنْ دُونِ يَدِيْكَ تَكَيْفَهُ. لِتَحْدُثَ مَعَ مُتَرَجِّمَ قُوْرِيْ، اتَّصِلْ مَعَ الْرَّمْمَ 855-710-6984. | |
| العَربِيَّةُ Arabic | 855-710-6984 | أَنْ كَانْ لَدِيْكَ أَوْ لَدِيْ شَخْصَ تَسَاعِدُهُ أَسْنَدَهُ، فَلَدِيْكَ الْحَقُّ فِي الْحُصُولِ عَلَى الْمَسَاعِدَةَ وَالْمَعْلُومَاتَ الْشَّرُورِيَّةَ بِلِفَاتَقٍ مِنْ دُونِ يَدِيْكَ تَكَيْفَهُ. لِتَحْدُثَ مَعَ مُتَرَجِّمَ قُوْرِيْ، اتَّصِلْ مَعَ الْرَّمْمَ 855-710-6984. | |
| 繁體中文 Chinese | 如果您，或您正在協助的對象，對此有疑問，您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員，請撥電話號碼 855-710-6984。 | જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ્ટ બી. એમ. કાલેક્ટર્સ બાયટે પ્રશ્ન હોય, તો તમને [લેના ખ ચેર્ચ] તમારી ભાષામાં મદદ અને માહિતી મેળવવાની હક્ક છે. ડુસ્ટિન્યુ સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કોલ કરો. | |
| Français French | Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète,appelez 855-710-6984. | હિંದી Hindi | ચિદ આપને, ચા આપ જિસકી સહાયતા કર રહે હોય તેમસે, પ્રશ્ન હોય, તો આપને આણ મ નિઃશુલ્ક સહાયતા ઔર જાનકારી પ્રાપ્ત કરન કા અધિકાર હૈ। કિસ્મિ અનવાદક સ બાત કરન ક લિએ 855-710-6984 પર કાલ કરો! |
| Deutsch German | Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an. | Italiano Italian | Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenerne aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984. |
| 한국어 Korean | 만약 구하 또는 구하는 사람의 질문이 있다면 구하는 무료로 그려한 도움과 정보를 구하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984로 전화하십시오. | Diné Navajo | T'áá ni, éí doodago la' da bílk anánilwo'ígíí, na 'ídílkidgo, ts' idá bee ná ahóóti'i' t'áá niik' e niká'a doolwol dóó bina'ídílkidgií bee níl h odoonih. Ata'dahalne'ígíí bichí'i' hodilníih kwe'é 855-710-6984. |
| فارسی Persian | اگر شما، یا کسی که شما به او ھکک می کنید، سؤالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان ھکک و اطلاعات مربوط فراخوازید. جوھت گفتگو با یک مترجم شهافی، با شماره 855-710-6984 تماسا حاصل ننمایید. | Polski Polish | Jesli Ty lub osoba, której pomagasz, macie jakiekolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwój pod numer 855-710-6984. |
| Русский Russian | Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984. | Tagalog Tagalog | Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuhang tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984. |
| اردو Urdu | اگر آپ کو، پاکسی اپسے فرد کو جس کی آپ جد کر رہے ہیں کوئی سوال درپیش می تو، آپ کو اپنی زبان میں مختتمدد اور معلومات حاصل کرنے کا حق ہے۔ مشرح میں بات کرنے کے لئے، آپ کو اپنی زبان میں مختتمدد اور معلومات حاصل کرنے کا حق ہے۔ مشرح میں بات کرنے کے لئے، آپ کو اپنی زبان میں مختتمدد اور معلومات حاصل کرنے کا حق ہے۔ | Tiếng Việt Vietnamese | Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với mặt thông dịch viên, gọi 855-710-6984. |