Summary of Bronze 8000EX *Benefits*

Benefit	In-Network	Out-of-Network
General Provisions		
Benefit Period	Plan Year	
Provider Network	WNY HMO/POS 200 Network Primary Care Physician required, access to our national PPO network	
Deductible Individual Family	 $7,000 $14,000	 N/A N/A
Coinsurance	100% after deductible	N/A
Out-of-Pocket Maximum Individual Family	 $7,000 $14,000	 N/A N/A
Domestic Partner and Children	Includes coverage for Domestic Partner and Children	
Office Visits		
Primary Care Provider Office & Telehealth Visits	Covered in full after deductible	N/A
Specialist Office & Telehealth Visits	Covered in full after deductible	N/A
Telemedicine (Am-Well)	Covered in full after deductible	Not Covered
Allergy Testing & Injections	Covered in full after deductible / Covered in full after deductible	N/A
Prenatal and Postnatal Care Cost-share applies to initial visit only	Covered in full after deductible	N/A
Preventive Care		
Immunizations	Covered in full	N/A
Colorectal cancer screening	Covered in full	N/A
Mammograms	Covered in full	N/A
Routine Physical exams	Covered in full	Not Covered
Routine Gynecological exams	Covered in full	N/A
Routine Diagnostic services	Covered in full	N/A
Well Child Visits	Covered in full	Not Covered
Hospital Services		
Inpatient Hospital	Covered in full after deductible	N/A
Inpatient Maternity	Covered in full after deductible	N/A
Outpatient Surgery Facility	Covered in full after deductible	N/A
Skilled Nursing Facility	Covered in full after deductible Limit: None	N/A
Emergency & Urgent Care Services		
Emergency Room Waived if admitted	Covered in full after deductible	Covered as In-Network
Ambulance	Covered in full after deductible	Covered as In-Network
Urgent Care Center	Covered in full after deductible	Covered as In-Network
Therapy, Rehabilitative and Habilitative Services		
Chiropractic Care	Covered in full after deductible	N/A
Physical, Occupational, & Speech Therapies (Rehabilitative and Habilitative)	Covered in full after deductible	N/A
Therapy Benefit Maximum	60 combined PT/OT/ST Visits per condition per plan year	
Respiratory Therapy	Covered in full after deductible	N/A
Mental Health/Substance Abuse		
Inpatient Mental Health	Covered in full after deductible	N/A
Inpatient Substance Abuse Detoxification & Rehabilitation	Covered in full after deductible	N/A
Outpatient Mental Health	Covered in full after deductible	N/A
Outpatient Substance Abuse Detoxification & Rehabilitation	Covered in full after deductible	N/A
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET scan, etc.)	Covered in full after deductible	N/A
Radiology (X-ray, Diagnostic testing)	Covered in full after deductible	N/A

Benefit	In-Network	Out-of-Network
Laboratory Testing & Pathology	Covered in full after deductible	N/A
Other Services		
Diabetic Insulin, Equipment, & Supplies Includes Test strips, Syringes, etc	Covered in full after deductible	N/A
Diabetes Care Management Program	100%	Not Covered
	Continuous glucose monitor sprints are limited to three (3) per benefit period	
Dialysis	Covered in full after deductible / Covered in full after deductible	N/A
Outpatient Chemotherapy	Covered in full after deductible / Covered in full after deductible	N/A
Durable Medical Equipment	Covered in full after deductible	N/A
Orthotics & Prosthetics	Covered in full after deductible	N/A
Home Health Care	Covered in full after deductible / Covered in full after deductible	N/A
	Limit: 40 aggregate visits per year; Home Infusion counts toward home health care visit limit.	
Hospice	Covered in full after deductible	N/A
	Limit: None	
Wellness Card	$250 per contract	
	Benefit allowance accessible through the use of a debit card, at participating providers for exercise centers, fitness clubs, & gyms	
Prescription Drugs		
Prescription Drug	**Retail Drugs (30-day Supply)** Covered in full after deductible Covered in full after deductible Covered in full after deductible **Mail Order Drugs (90-day Supply)** Covered in full after deductible Covered in full after deductible Covered in full after deductible	
Pediatric Vision Services - Davis Vision National Network		
Exam	Covered in full after deductible	Not Covered
Pediatric frame selection	Covered in full after deductible	Not Covered
Standard eyeglass lenses (per pair)	Covered in full after deductible	Not Covered
Pediatric Dental Services - United Concordia Elite Prime Network		
Preventive Services	$25 copay	$25 copay
Basic Services	100% after deductible	100% after deductible
Major Services	100% after deductible	100% after deductible
Medically Necessary Orthodontics	100% after deductible	100% after deductible

Discrimination is Against the Law

The Claims Administrator/Insurer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Claims Administrator/Insurer will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Claims Administrator/Insurer will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Claims Administrator/Insurer:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters

- Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Claims Administrator/Insurer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

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

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

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。请拨打您的身份证背面的号码（TTY：711）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

Kominike : Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan nimewo ki nan do kat idantite w la (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

注： 日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。
ID カードの裏に明記されている番号に電話をおかけください（TTY: 711）。

توجه: اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.

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AHRENS

BAR ASSOCIATION MARKETPLACE

See Next Insert for Summary of Benefits and Coverage

What this Plan Covers & What You Pay For Covered Services

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.bcbswny.com or call 1-844-639-2441. 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 1-844-639-2441 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$7,000 individual/$14,000 family in-network.	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 services and pediatric dental exam are covered before you meet your in-network deductible. Copayments and coinsurance amounts don't count toward the in-network 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 https://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?	$7,000 individual/$14,000 family in-network.	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 in-network provider?	Yes. See www.bcbswny.com/find-a-doctor/ or call 1-844-639-2441 for a list of in-network providers.	This plan uses a provider in-network. You will pay less if you use a provider in the plan's in-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 in-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 I 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 overall **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-In-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	Covered in full	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 plan will pay for. Please refer to your preventive schedule for additional information.
	Specialist visit	Covered in full	Not covered	
	Preventive care/screening/Immunization	Covered in full Deductible does not apply.	Not covered	
If you have a test	Diagnostic test (x-ray, blood work)	Covered in full	Not covered	Precertification may be required.
	Imaging (CT/PET scans, MRIs)	Covered in full	Not covered	Precertification may be required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.bcbswny.com/find-a-doctor/#/drug	Generic drugs	Covered in full (retail)	Not covered	Some generic drugs may be subject to non-preferred brand cost share. In-network: Specialty drugs could be generic, preferred brand or non-preferred brand. Please visit our website for a copy of our medication guide.
	Formulary Brand drugs	Covered in full (retail)	Not covered	
	Non-Formulary Brand drugs	Covered in full (retail)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Covered in full	Not covered	Precertification may be required.
	Physician/surgeon fees	Covered in full	Not covered	Precertification may be required.
If you need immediate medical attention	Emergency room care	Covered in full	Covered in full	Out-of-network: Subject to in-network deductible.
	Emergency medical transportation	Covered in full	Covered in full	Out-of-network: Subject to in-network deductible.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-In-network Provider (You will pay the most)	
	Urgent care	Covered in full	Covered in full	Out-of-network: Subject to in-network deductible.
If you have a hospital stay	Facility fee (e.g., hospital room)	Covered in full	Not covered	Precertification may be required.
	Physician/surgeon fees	Covered in full	Not covered	Precertification may be required.
If you have mental health, behavioral health, or substance abuse services	Outpatient services	Covered in full	Not covered	Precertification may be required.
	Inpatient services	Covered in full	Not covered	Precertification may be required.
If you are pregnant	Office visits	Covered in full	Not covered	Cost sharing does not apply for preventive services. Professional services: For participating providers, cost share applies only to initial visit to determine pregnancy.
	Childbirth/delivery professional services	Covered in full	Not covered	Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	Covered in full	Not covered	In-network: The first visit to determine pregnancy is covered at no charge. Please refer to the Women's Health Preventive Schedule for additional information. Precertification may be required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-In-network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	Covered in full	Not covered	Combined in-network and out-of-network: 40 visits per benefit period, aggregate with visiting nurse. Home Infusion counts toward visit limit. Precertification may be required.
	Rehabilitation services	Covered in full	Not covered	Combined in-network and out-of-network: combined habilitation and rehabilitation services. Combined in-network and out-of-network: 60 physical medicine, 60 occupational therapy visits and 60 speech therapy visits per benefit period. Precertification may be required.
	Habilitation services	Covered in full	Not covered	
	Skilled nursing care	Covered in full	Not covered	Precertification may be required.
	Durable medical equipment	Covered in full	Not covered	Precertification may be required.
	Hospice services	Covered in full	Not covered	Precertification may be required.
If your child needs dental or eye care	Children's eye exam	Covered in full	Not covered	In-network: One eye exam per 12-month period up to age 19.
	Children's glasses	Covered in full	Not covered	In-network: One pair frames/lenses every 12 months.
	Children's dental check-up	$25 copay/visit Deductible does not apply.	$25 copay/visit Deductible does not apply.	Combined in-network and out-of-network: One exam every 6 months.

Excluded Services & Other Covered Services:

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

- Acupuncture
- Cosmetic surgery
- Custodial care
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs

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

- Chiropractic care
- Bariatric surgery
- Dental care (Adult)
- Elective abortion
- Hearing aids
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or at https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other options to continue coverage are available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Highmark, Inc. at 1-844-639-2441.
- The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- Additionally, a consumer assistance program can help you file your appeal. Contact the Pennsylvania Department of Consumer Services at 1-877-881-6388.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

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

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$7,000
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$7,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$7,060**

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

The plan's overall deductible	$7,000
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$5,400
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$5,420**

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

The plan's overall deductible	$7,000
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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

Notice of Nondiscrimination

The plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please call the customer service number on the back of your member ID card or contact the Civil Rights Coordinator.

If you believe that the plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295 (TTY 711), Fax: 1-412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org

You can file a grievance in person or by mail, fax, or email. You can also file a civil rights complaint with the US 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 or by mail or phone at US Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

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

For assistance in English, call the customer service number listed on your member ID card.

Para obtener asistencia en español, llame al servicio de atención al cliente al número que aparece en su tarjeta de identificación.

請撥打您 ID 卡上的客服號碼以尋求中文協助。

Обратитесь по номеру телефона обслуживания клиентов, указанному на Вашей идентификационной карточке, для помощи на русском языке.

פאר הילף אין אידיש, רופט די קאסטומער סערוויס אויפן נומער וואס שטייט אויף אייער ID קארטל.

বাংলায় সহায়তার জন্য, আপনার আইডি কার্ডে তালিকাভুক্ত নম্বরে ক্রেতা পরিষেবায় ফোন করুন।

한국어로 도움을 받고 싶으시면 ID 카드에 있는 고객 서비스 전화번호로 문의해 주십시오.

Aby uzyskać pomoc w języku polskim, należy zadzwonić do działu obsługi klienta pod numer podany na identyfikatorze.

اردو میں مدد کے لیے، کسٹمر سروس اپ کے شناختی کارڈ پر درج کردہ نمبر پر کال کریں

Pour une assistance en français, composez le numéro de téléphone du service à la clientèle figurant sur votre carte d'identification.

اردو زبان میں مدد کے لئے، کسٹمر سروس کو اپنے آئی ڈی کارڈ پر درج نمبر پر کال کریں۔

Para sa tulong sa Tagalog, tumawag sa numero ng serbisyo sa customer na nasa inyong ID card.

Για βοήθεια στα ελληνικά, καλέστε το τμήμα εξυπηρέτησης πελατών στον αριθμό που αναφέρεται στην ταυτότητά σας.

Për ndihmë në gjuhën shqipe, merrni në telefon shërbimin klientor në numrin e renditur në kartën tuaj të identitetit.

Rele nimewo sèvis kliyantèl ki nan kat ID ou pou jwenn èd nan Kreyòl Ayisyen.

Per assistenza in italiano chiamate il numero del servizio clienti riportato nella vostra scheda identificativa.

Diné k´ehjí yá´áti´bee shíká adoowot nohsingo naaltsoos nihaa halne´go nidaahtinígíí bine´déé´ Customer Service bibéésh bee hane´é biká'ígíí bich´j´dahodootnih.