

1 - NENY LG EPO 5000 \$15/\$15 Copay with Rx

On the chart below, you'll see what you pay for specific services. You are responsible for paying for non-emergency services received from an out-of-network provider. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	In-Network
General Provisions	
Effective Date	01/01/2025
Benefit Period (1)	Contract Year
Deductible (per benefit period)	
Individual	\$0
Family	\$0
Deductible Accumulation (2)	N/A
Coinsurance – payment based on the plan allowance	0% coinsurance
Out-of-Pocket Maximum (Includes deductible, coinsurance, copayments, prescription drug cost sharing and other qualified medical expenses). Once met, the plan pays 100% of covered services for the rest of the benefit period.	
Individual	\$6,600
Family	\$13,200
Out-of-Pocket Accumulation (2)	Embedded
Office/Urgent Care Visits	
Primary Care Provider (PCP) Office Visits & Virtual Visits	\$15 copayment
Specialist Office Visits & Virtual Visits	\$15 copayment
Virtual Visit Provider Originating Site Fee	Covered in full
Urgent Care Center Visits	\$15 copayment
Telemedicine Services (3)	\$15 copayment
Preventive Care (4)	
Routine Adult	
Physical exams	Covered in full
Adult immunizations	Covered in full
Routine gynecological exams, including a Pap Test	Covered in full
Mammograms, annual routine	Covered in full
Diagnostic services and procedures	Covered in full
Routine Pediatric	
Physical exams	Covered in full
Pediatric immunizations	Covered in full
Diagnostic services and procedures	Covered in full
Emergency Services	
Emergency Room Services (5)	\$50 copayment (Emergency Room copayment waived if admitted)
Ambulance	\$0 copayment
Hospital and Medical/Surgical Expenses (5)	
Hospital Inpatient	\$0 copayment per admission
Outpatient Surgery	\$0 copayment
Medical Care (including inpatient visits and consultations)	Covered in full
Therapy and Rehabilitation Services	
Physical Therapy, Speech Therapy & Occupational Therapy	\$15 copayment for PCP; \$15 copayment for Specialist Benefit Limit: Unlimited visits/benefit period, combined for PT/ST/OT
Respiratory Therapy	\$15 copayment for PCP; \$15 copayment for Specialist
Spinal Manipulations	\$15 copayment for PCP; \$15 copayment for Specialist
Cardiac Rehabilitation Therapy	\$15 copayment for PCP; \$15 copayment for Specialist
Infusion Therapy	\$15 copayment for PCP; \$15 copayment for Specialist; Covered in full for Home Infusion
Chemotherapy and Radiation Therapy	\$15 copayment for PCP; \$15 copayment for Specialist
Dialysis	\$15 copayment for PCP; \$15 copayment for Specialist; Covered in full for Home Dialysis
Mental Health/Substance Abuse	
Inpatient Mental Health Services	\$0 copayment per admission
Inpatient Detoxification/Rehabilitation	\$0 copayment per admission
Outpatient Mental Health Services - Includes Virtual Behavioral Health Visits	\$0 copayment
Outpatient Substance Abuse	\$0 copayment
Other Services	

Benefit	In-Network
Acupuncture	\$15 copayment for PCP; \$15 copayment for Specialist Benefit Limit: 12 visits/benefit period
Allergy Extracts	Covered in full
Allergy Injections	\$15 copayment for PCP; \$15 copayment for Specialist
Applied Behavior Analysis for Autism Spectrum Disorder	\$0 copayment
Assisted Fertilization Procedures (GIFT & ZIFT excluded)	See Service Category (i.e. lab, surgery, imaging) Benefit Limit: 3 Cycles per Lifetime for In Vitro Fertilization
Dental Services Related to Accidental Injury	See Service Category (i.e. lab, surgery, imaging)
Diagnostic Services	
Advanced Imaging (MRI, CAT, PET scan, etc.)	Covered in full
Standard Imaging	Covered in full
Diagnostic Medical	\$15 copayment for PCP; \$15 copayment for Specialist
Pathology/Laboratory	Covered in full
Allergy Testing	\$15 copayment for PCP; \$15 copayment for Specialist
Mammograms, medically necessary	Covered in full
Durable Medical Equipment	20%; \$15 copayment per item for Diabetic Equipment and Supplies
Prosthetics	20% for External Devices; Covered in full for Internal Devices
Orthotics	20%
Home Health Care	\$15 copayment for PCP; \$15 copayment for Specialist Benefit Limit: Unlimited visits/benefit period
Hospice	\$0 copayment per admission for Inpatient; \$15 copayment for Outpatient
Maternity (non-preventive professional services) including dependent daughter	\$15 copayment for PCP; \$15 copayment for Specialist (one copayment on global professional bill)
Infertility Counseling, Testing and Treatment	See Service Category (i.e. lab, surgery, imaging)
Skilled Nursing Facility Care	\$0 copayment per admission Benefit Limit: 100 days/benefit period
Transplant Services	\$0 copayment per admission
Wellness Card	\$400
Prescription Drugs	
Prescription Drug Deductible	
Individual	None
Family	None
Prescription Drug Program ⁽⁶⁾ Defined by the National Plus NY Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the Comprehensive Formulary with Incentive Benefit Design.	<p style="text-align: center;">Retail Drugs (30/60/90-day supply)</p> <p style="text-align: center;">Generic Formulary Drugs: \$5 / \$10 / \$15 copayment Brand Formulary Drugs: \$20 / \$40 / \$60 copayment Generic & Brand Non-Formulary Drugs: \$35/ \$70 / \$105 copayment Cost-sharing for Prescription Insulin Drugs will be \$0</p> <p style="text-align: center;">Specialty Drugs – Retail or Mail Order (31-day Supply)</p> <p style="text-align: center;">Generic Formulary Drugs: \$5 copayment Brand Formulary Drugs: \$20 copayment Generic & Brand Non-Formulary Drugs: \$35 copayment</p> <p style="text-align: center;">Maintenance Drugs through Mail Order (30/60/90-day Supply)</p> <p style="text-align: center;">Generic Formulary Drugs: \$5 / \$10 / \$12.50 copayment Brand Formulary Drugs: \$20 / \$40 / \$50 copayment Generic & Brand Non-Formulary Drugs: \$35 / \$70 / \$87.50 copayment Cost-sharing for Prescription Insulin Drugs will be \$0</p>


This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy / plan documents, as limitations and exclusions apply. The policy / plan documents control in the event of a conflict with this benefit summary.

- 1) Your group's benefit period is based on a Contract Year. The Contract Year is a consecutive 12-month period beginning on your employer's effective date. Contact your employer to determine the effective date applicable to your program.
- 2) If you are enrolled in a "Family" plan, with your non-embedded deductible, the entire family deductible must be satisfied before claims reimbursement begins. With your embedded out-of-pocket maximum, once any eligible family member satisfies his/her individual out-of-pocket maximum, claims will pay at 100% of the plan allowance for covered expenses, for the rest of the plan year. Claims for the remaining family members will pay at 100% once the family out-of-pocket maximum amount is met.
- 3) Telemedicine Services must be performed by the Highmark Blue Shield Designated Telemedicine Vendor.
- 4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).
- 5) Benefits for Emergency Care Services rendered by an Out-of-Network Provider will be paid at the Network services level. Benefits for Hospital Services or Medical Care Services rendered by an Out-of-Network Provider to a member requiring an inpatient admission or

observation immediately following receipt of Emergency Care Services will be paid at the Network services level. The member will not be responsible for any amounts billed by the Out-of-Network Provider that are in excess of the plan allowance for such services.

- 6) The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved drugs selected for their quality, safety, and effectiveness. The formulary was developed by Highmark Pharmacy Services and approved by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. All plan formularies include products in every major therapeutic category. Plan formularies vary by the number of different drugs they cover and in the cost-sharing requirements. Your program includes coverage for both formulary and non-formulary drugs at the copayment or coinsurance amounts listed above. Your plan requires that you use a specific specialty pharmacy for hemophilia medications. Please contact member services for more details. Your plan offers the Free Market Health program for select specialty medications. You will be contacted by one of the specialty network pharmacies who will provide quality service, care, and coordination of your specialty prescription fill and delivery. No enrollment necessary.

Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield is an independent licensee of the Blue Cross Blue Shield Association.

 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.myhighmark.com or call 1-844-639-2440. 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 1-844-639-2440 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$0	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your deductible?	No.	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 deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	\$6,600 individual/\$13,200 family in-network out-of-pocket limit.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	In-network: <u>Premiums</u> , balance-billed charges, and health care this <u>plan</u> doesn't cover do not apply to your total maximum out-of-pocket.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use an in-network provider?	Yes. See www.myhighmark.com or call 1-844-639-2440 for a list of in-network providers.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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-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	\$15 <u>copay</u> /visit	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. Please refer to your <u>preventive</u> schedule for additional information.
	<u>Specialist</u> visit	\$15 <u>copay</u> /visit	Not covered	
	<u>Preventive care/screening/immunization</u>	No charge	No covered	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	Not covered	Precertification may be required.
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	Precertification may be required.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.myhighmark.com .	Formulary Generic drugs	\$5/\$10/\$15 <u>copay</u> per prescription (retail) \$5/\$10/\$12.50 <u>copay</u> per prescription (mail order)	Not covered	Up to 30/60/90-day supply retail pharmacy. Up to 30/60/90-day supply maintenance <u>prescription drugs</u> through mail order. <u>Cost-sharing</u> for Prescription Insulin Drugs will not exceed \$0.
	Formulary Brand drugs	\$20/\$40/\$60 <u>copay</u> per prescription (retail) \$20/\$40/\$50 <u>copay</u> per prescription (mail order)	Not covered	
	Non-Formulary Brand drugs	\$35/\$70/\$105 <u>copay</u> per prescription (retail) \$35/\$70/\$87.50 <u>copay</u> per prescription (mail order)	Not covered	

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-Network Provider (You will pay the most)	
	<u>Specialty drugs</u>	\$5 <u>copay</u> per prescription (formulary generic) \$20 <u>copay</u> per prescription (formulary brand) \$35 <u>copay</u> per prescription (non-formulary generic & non-formulary brand) (retail & mail order)	Not covered	<u>Specialty drugs</u> are limited to a 31-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	Precertification may be required.
	Physician/surgeon fees	No charge	Not covered	Precertification may be required.
If you need immediate medical attention	<u>Emergency room care</u>	\$50 <u>copay</u> /visit	\$50 <u>copay</u> /visit	<u>Copay</u> waived if admitted as an inpatient.
	<u>Emergency medical transportation</u>	No charge	No charge	-----none-----
	<u>Urgent care</u>	\$15 <u>copay</u> /visit	\$15 <u>copay</u> /visit	-----none-----
If you have a hospital stay	Facility fees (e.g., hospital room)	No charge	Not covered	Precertification may be required.
	Physician/surgeon fees	No charge	Not covered	Precertification may be required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>In-Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	Not covered	Precertification may be required.
	Inpatient services	No charge	Not covered	Precertification may be required.
If you are pregnant	Office visits	No charge after first \$15 <u>copay</u>	Not covered	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply.
	Childbirth/delivery professional services	No charge	Not covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	No charge	Not covered	<u>In-network</u> : The first visit to determine pregnancy is covered at no charge. Please refer to the Women's Health <u>Preventive Schedule</u> 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-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	\$15 <u>copay</u> /visit	Not covered	Precertification may be required.
	<u>Rehabilitation services</u>	\$15 <u>copay</u> /visit	Not covered	Precertification may be required.
	<u>Habilitation services</u>	Not covered	Not covered	-----none-----
	<u>Skilled nursing care</u>	No charge	Not covered	In- <u>network</u> : 100 days per benefit period. Precertification may be required.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u> (DME) \$15 <u>copay</u> (diabetic equipment & diabetic supplies)	Not covered	Precertification may be required.
	<u>Hospice services</u>	\$15 <u>copay</u> /visit	Not covered	Precertification may be required.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	-----none-----
	Children's glasses	Not covered	Not covered	-----none-----
	Children's dental check-up	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.)

- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- 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.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids (internal)
- Infertility treatment

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, or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 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 <http://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 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 1-844-639-2440.
- The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- Additionally, an independent consumer assistance program can help you file your appeal. Contact the consumer assistant services at 1-888-614-5400.

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 \$0
- Specialist copayment \$15
- 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
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$60
The total Peg would pay is	\$70

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

- The plan's overall deductible \$0
- Specialist copayment \$15
- 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
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$200
<u>What isn't covered</u>	
Limits or exclusions	\$20
The total Joe would pay is	\$720

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

- The plan's overall deductible \$0
- Specialist copayment \$15
- 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
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$50
<u>What isn't covered</u>	
Limits or exclusions	\$0
The total Mia would pay is	\$250

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-844-639-2440.

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

Insurance or benefit administration may be provided by Highmark Blue Shield of Northeastern New York which are independent licensees of the Blue Cross and Blue Shield Association. Health care plans are subject to terms of the benefit agreement.

To find more information about Highmark's benefits and operating procedures, such as accessing the drug formulary or using network providers, please go to [DiscoverHighmark.com](https://www.discoverhighmark.com); or for a paper copy, call 1-844-639-2440.

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 libheng 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 المساعدة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

ATTENTION: Si c'est créole que vous connaissez, il y a un certain service de langues qui est gratis et disponible pour vous-même. Composez le numéro qui est au dos de votre carte d'identité. (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.