HIGHMARK

2 - NENY LG EPO 6300 HDHP Copay with Rx

This program is a qualified high deductible plan as defined by the Internal Revenue Service. It is designed for use with a Health Savings Account (HSA). 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	$3,300
Family	$6,600
Deductible Accumulation (2)	Embedded
Coinsurance – payment based on the plan allowance	0% after deductible
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	$8,300
Family	$16,600
Out-of-Pocket Accumulation (2)	Embedded
Office/Urgent Care Visits	
Primary Care Provider (PCP) Office Visits & Virtual Visits	$25 copayment after deductible
Specialist Office Visits & Virtual Visits	$40 copayment after deductible
Virtual Visit Provider Originating Site Fee	$0 copayment after deductible
Urgent Care Center Visits	$35 copayment after deductible
Telemedicine Services (3)	$25 copayment after deductible
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)	$100 copayment after deductible (Emergency Room copayment waived if admitted)
Ambulance	$100 copayment after deductible
Hospital and Medical/Surgical Expenses (5)	
Hospital Inpatient	$250 copayment after deductible per admission
Outpatient Surgery	$150 copayment after deductible
Medical Care (including inpatient visits and consultations)	$0 copayment after deductible
Therapy and Rehabilitation Services	
Physical Therapy, Speech Therapy & Occupational Therapy	$25 copayment after deductible for PCP; $40 copayment after deductible for Specialist **Benefit Limit:** 60 visits/benefit period, PT/ST/OT combined
Respiratory Therapy	$25 copayment after deductible for PCP; $40 copayment after deductible for Specialist
Spinal Manipulations	$25 copayment after deductible for PCP; $40 copayment after deductible for Specialist
Cardiac Rehabilitation Therapy	$25 copayment after deductible for PCP; $40 copayment after deductible for Specialist
Infusion Therapy	$25 copayment after deductible for PCP; $40 copayment after deductible for Specialist; $0 copayment after deductible for Home Infusion
Chemotherapy and Radiation Therapy	$25 copayment after deductible for PCP; $40 copayment after deductible for Specialist

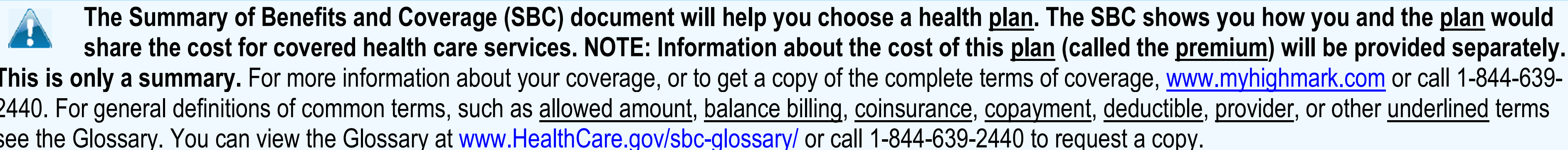
Benefit	In-Network
Dialysis	$25 copayment after deductible for PCP; $40 copayment after deductible for Specialist; $0 copayment after deductible for Home Dialysis
Mental Health/Substance Abuse	
Inpatient Mental Health Services	$250 copayment after deductible per admission
Inpatient Detoxification/Rehabilitation	$250 copayment after deductible per admission
Outpatient Mental Health Services - Includes Virtual Behavioral Health Visits	$25 copayment after deductible
Outpatient Substance Abuse	$25 copayment after deductible
Other Services	
Acupuncture	$25 copayment after deductible for PCP; $40 copayment after deductible for Specialist
	Benefit Limit: 12 visits/benefit period
Allergy Extracts	$0 copayment after deductible
Allergy Injections	$25 copayment after deductible for PCP; $40 copayment after deductible for Specialist
Applied Behavior Analysis for Autism Spectrum Disorder	$25 copayment after deductible
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.)	$25 copayment after deductible
Standard Imaging	$25 copayment after deductible
Diagnostic Medical	$25 copayment after deductible for PCP; $40 copayment after deductible for Specialist
Pathology/Laboratory	$25 copayment after deductible
Allergy Testing	$25 copayment after deductible for PCP; $40 copayment after deductible for Specialist
Mammograms, medically necessary	$25 copayment after deductible
Durable Medical Equipment	20% after deductible; $25 copayment after deductible per item for Diabetic Equipment and Supplies
Prosthetics	20% after deductible for External Devices; $0 copayment after deductible for Internal Devices
Orthotics	20% after deductible
Home Health Care	$25 copayment after deductible for PCP; $40 copayment after deductible for Specialist
	Benefit Limit: 100 visits/benefit period
Hospice	$250 copayment per admission for Inpatient; $40 copayment after deductible for Outpatient
Maternity (non-preventive professional services) including dependent daughter	$25 copayment after deductible for PCP; $40 copayment after deductible 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	$250 copayment after deductible per admission
	Benefit Limit: 100 days/benefit period
Transplant Services	$250 copayment after deductible per admission
Wellness Card	$400
Prescription Drugs	
Prescription Drug Deductible	
Individual	Integrated with medical deductible
Family	Integrated with medical deductible

Benefit	In-Network
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. **Preventive Prescription Drugs – Preventive NY1 Commercial Drug List**	**Retail Drugs (30/60/90-day supply)** Generic Formulary Drugs: $5 / $10 / $15 copayment after deductible Brand Formulary Drugs: $20 / $40 / $60 copayment after deductible Generic & Brand Non-Formulary Drugs: $35/ $70 / $105 copayment after deductible Cost-sharing for Prescription Insulin Drugs will be $0 **Specialty Drugs – Retail or Mail Order (31-day Supply)** Generic Formulary Drugs: $5 copayment after deductible Brand Formulary Drugs: $20 copayment after deductible Generic & Brand Non-Formulary Drugs: $35 copayment after deductible **Maintenance Drugs through Mail Order (30/60/90-day Supply)** Generic Formulary Drugs: $5 / $10 / $12.50 copayment after deductible Brand Formulary Drugs: $20 / $40 / $50 copayment after deductible Generic & Brand Non-Formulary Drugs: $35 / $70 / $87.50 copayment after deductible Cost-sharing for Prescription Insulin Drugs will be $0

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 embedded deductible, only one eligible family member must satisfy his/her individual deductible 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) At a retail or mail order pharmacy, if your deductible has not been met, you pay the entire cost for your prescription drug at the discounted rate Highmark has negotiated. The amount you pay for your prescription will be applied to your deductible. If your deductible has been met, you will only pay any member responsibility based on the benefit level indicated above. You will pay this amount at the pharmacy when you have your prescription filled. 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?	$3,300 individual/$6,600 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 are covered before you meet your in-network deductible. Copayments and coinsurance amounts don't count toward the network deductible.	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?	$8,300 individual/$16,600 family in-network out-of-pocket limit.	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?	In-network: Premiums, balance-billed charges, and health care this plan 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 out-of-pocket limit.
Will you pay less if you use a in-network provider?	Yes. See www.myhighmark.com or call 1-844-639-2440 for a list of in-network 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?	No.	You can see the specialist you choose without a referral.

An example of a benefit book can be found at https://shop.highmark.com/sales/#!/sbc-agreements.

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	$25 copay/visit	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	$40 copay/visit	Not covered	
	Preventive care/screening/immunization	No charge Deductible does not apply.	No covered	
If you have a test	Diagnostic test (x-ray, blood work)	$25 copay/visit	Not covered	Precertification may be required.
	Imaging (CT/PET scans, MRIs)	$25 copay/visit	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 www.myhighmark.com.	Formulary Generic drugs	$5/$10/$15 copay per prescription (retail) $5/$10/$12.50 copay per prescription (mail order)	Not covered	Up to 30/60/90-day supply retail pharmacy. Up to 30/60/90-day supply maintenance prescription drugs through mail order. Cost-sharing for Prescription Insulin Drugs will not exceed $0.
	Formulary Brand drugs	$20/$40/$60 copay per prescription (retail) $20/$40/$50 copay per prescription (mail order)	Not covered	
	Non-Formulary Brand drugs	$35/$70/$105 copay per prescription (retail) $35/$70/$87.50 copay 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)	
	Specialty drugs	$5 copay per prescription (formulary generic) $20 copay per prescription (formulary brand) $35 copay per prescription (non-formulary generic & non-formulary brand) (retail & mail order)	Not covered	Specialty drugs are limited to a 31-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 copay/visit	Not covered	Precertification may be required.
	Physician/surgeon fees	No charge	Not covered	Precertification may be required.
If you need immediate medical attention	Emergency room care	$100 copay/visit	$100 copay/visit	Out-of-network: Subject to in-network deductible. Copay waived if admitted as an inpatient.
	Emergency medical transportation	$100 copay	$100 copay	Out-of-network: Subject to in-network deductible.
	Urgent care	$35 copay/visit	$35 copay/visit	Out-of-network: Subject to in-network deductible.
If you have a hospital stay	Facility fees (e.g., hospital room)	$250 copay per admission	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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/visit	Not covered	Precertification may be required.
	Inpatient services	$250 copay per admission	Not covered	Precertification may be required.
If you are pregnant	Office visits	No charge after first $40 copay	Not covered	Cost sharing does not apply for preventive services. 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.) 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.
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	$250 copay per admission	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)	
If you need help recovering or have other special health needs	Home health care	$40 copay/visit	Not covered	In-network: 100 visits per benefit period, combined with visiting nurse. Precertification may be required.
	Rehabilitation services	$40 copay/visit	Not covered	In-network: 60 combined physical medicine, occupational therapy, and speech therapy visits per benefit period. Precertification may be required.
	Habilitation services	Not covered	Not covered	-----------none-----------
	Skilled nursing care	$250 copay per admission	Not covered	In-network: 100 visits per benefit period, combined with visiting nurse. Precertification may be required.
	Durable medical equipment	20% coinsurance (DME) $25 copay (diabetic equipment & diabetic supplies)	Not covered	Precertification may be required.
	Hospice services	$40 copay/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 $3,300
- Specialist copayment $40
- 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	$3,300
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,660**

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

- The plan's overall deductible $3,300
- Specialist copayment $40
- 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	$3,300
Copayments	$300
Coinsurance	$80
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,700**

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

- The plan's overall deductible $3,300
- Specialist copayment $40
- 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**

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.

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

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; 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 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).

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.