**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 1-888-510-1084. 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 1-888-510-1084 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $1,800 individual/$3,600 family network.<br>$3,600 individual/$7,200 family out-of-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 policy, the overall family deductible must be met before the plan begins to pay. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care services and pediatric vision exams are covered before you meet your network deductible.<br><br>Copayments and coinsurance amounts don't count toward the 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?** | $7,500 individual/$15,000 family network out-of-pocket.<br>$15,000 individual/$30,000 family out-of-network.<br><br>$1,000,000 individual/$2,000,000 family out-of-state out-of-network (non-participating). | 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.myhighmark.com or call 1-888-510-1084 for a list of 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).<br>Out-of-Network benefits consist of two levels of benefits. In-state out-of-network providers, and out-of-state out-of-network providers. Costs will vary depending on whether services are received from an in-state out-of-network provider or an out-of-state out-of-network provider. Covered services received from a provider located outside of Pennsylvania participating in the local PPO network, as well |

| | | |
|---|---|---|
| | | as all emergency and urgent care services, will remain covered at the in-network benefit level. Please consult your plan documents for specific details. 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 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 |
|---|---|---|---|---|
| | | 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 copay/visit | 50% coinsurance | 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.<br><br>Please refer to your preventive schedule for additional information. |
| | Specialist visit | $15 copay/visit | 50% coinsurance | |
| | Preventive care/screening/Immunization | No charge<br>Deductible does not apply. | No coverage | |
| **If you have a test** | Diagnostic test (x-ray, blood work) | $15 copay/visit | 50% coinsurance | Copayments, if any, do not apply to diagnostic services prescribed for the treatment of mental illness or substance abuse.<br>Precertification may be required. |
| | Imaging (CT/PET scans, MRIs) | $175 copay/visit | 50% coinsurance | |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.myhighmark.com | Tier 1 | No charge per prescription (retail)<br>No charge per prescription (mail order) | Not covered | Up to 31/60/90-day supply retail pharmacy.<br><br>Up to 90-day supply maintenance prescription drugs through mail order.<br><br>This plan uses an Essential Formulary. |
| | Tier 2 | $30/$60/$90 copay/prescription (retail)<br>$60 copay/prescription (mail order) | Not covered | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Tier 3 | $150/$300/$450 copay/prescription (retail)<br>$300 copay/prescription (mail order) | Not covered | |
| | Tier 4 | 50% coinsurance<br>$250/$500/$750 min<br>$1,000/$2,000/$3,000 max per prescription (retail)<br>50% coinsurance<br>$500 min/$2,000 max per prescription (mail order) | Not covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $130 copay/visit | 50% coinsurance | Precertification may be required. |
| | Physician/surgeon fees | $130 copay/visit | 50% coinsurance | Precertification may be required. |
| **If you need immediate medical attention** | Emergency room care | $250 copay/visit | $250 copay/visit | Copay waived if admitted as an inpatient.<br>Out-of-network: Subject to network deductible. |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | Out-of-network: Subject to network deductible. |
| | Urgent care | $30 copay/visit | $30 copay/visit | Out-of-network: Subject to network deductible.<br>The copayment, if any, does not apply to urgent care services prescribed for the treatment of mental illness or substance abuse. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $450 copay/visit | 50% coinsurance | Precertification may be required. |
| | Physician/surgeon fees | No charge | 50% coinsurance | Precertification may be required. |
| **If you have mental health, behavioral health, or substance abuse services** | Outpatient services | $15 copay/visit | 50% coinsurance | Precertification may be required. |
| | Inpatient services | $450 copay/visit | 50% coinsurance | Precertification may be required. |
| **If you are pregnant** | Office visits | 20% coinsurance | 50% coinsurance | Cost sharing does not apply for preventive services. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Childbirth/delivery professional services | No charge | 50% coinsurance | Depending on the type of services, a copayment, coinsurance, or deductible may apply.<br>Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)<br><br>Network: The first visit to determine pregnancy is covered at no charge. Please refer to the Women's Health Preventive Schedule for additional information.<br>Precertification may be required. |
| | Childbirth/delivery facility services | $450 copay/visit | 50% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 50% coinsurance | Combined network and out-of-network: 60 visits per benefit period, aggregate with visiting nurse.<br>Precertification may be required. |
| | Rehabilitation services | $15 copay/visit | 50% coinsurance | Combined network and out-of-network: 30 combined physical medicine and occupational therapy visits and 30 speech therapy visits per benefit period.<br>Copayment, if any, does not apply to therapy services prescribed for the treatment of mental health or substance abuse.<br>The limit, if any, does not apply to therapy services prescribed for the treatment of mental health or substance abuse.<br>Precertification may be required. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Habilitation services | $15 copay/visit | 50% coinsurance | Combined network and out-of-network: 30 combined physical medicine and occupational therapy visits and 30 speech therapy visits per benefit period.<br>Copayment, if any, does not apply to therapy services prescribed for the treatment of mental health or substance abuse.<br>The limit, if any, does not apply to therapy services prescribed for the treatment of mental health or substance abuse.<br>Precertification may be required. |
| | Skilled nursing care | $450 copay/visit | 50% coinsurance | Combined network and out-of-network: 120 days per benefit period.<br>Precertification may be required. |
| | Durable medical equipment | 20% coinsurance | 50% coinsurance | Precertification may be required. |
| | Hospice services | 20% coinsurance | 50% coinsurance | Combined network and out-of-network: Respite care limit of 7 days every six months.<br>Precertification may be required. |
| **If your child needs dental or eye care** | Children's eye exam | No charge<br>Deductible does not apply. | Not covered | Network: One eye exam per 12 month period up to age 19. |
| | Children's glasses | No charge | Not covered | Network: One pair of frames/lenses every 12 months for members under the age of 19. |
| | 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.)**

- Abortion, except where a pregnancy is the result of rape or incest, or for a pregnancy which, as certified by a physician, places the life of the woman in danger unless an abortion is performed.
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Pediatric dental exams
- 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.)**

- Chiropractic care
- Infertility treatment
- Non-emergency care when traveling outside the U.S.

**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 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 1-888-510-1084.
- 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 | $1,800 |
| Specialist copay | $15 |
| Hospital (facility) copay | $450 |
| Other coinsurance | 20% |

**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 | $1,800 |
| Copayments | $700 |
| Coinsurance | $0 |
| ***What isn't covered*** | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$2,560** |

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

| | |
|---|---|
| The plan's overall deductible | $1,800 |
| Specialist copay | $15 |
| Hospital (facility) copay | $450 |
| Other coinsurance | 20% |

**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 | $1,800 |
| Copayments | $400 |
| Coinsurance | $100 |
| ***What isn't covered*** | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$2,320** |

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

| | |
|---|---|
| The plan's overall deductible | $1,800 |
| Specialist copay | $15 |
| Hospital (facility) copay | $450 |
| Other coinsurance | 20% |

**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 | $1,800 |
| Copayments | $100 |
| Coinsurance | $40 |
| ***What isn't covered*** | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,940** |

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

Highmark Benefits Group Inc. is an independent licensee of the Blue Cross Blue Shield Association.

Insurance or benefit administration may be provided by Highmark Blue Shield, Highmark Benefits Group, Highmark Select Resources, or Highmark Health Insurance Company, all of which are independent licensees of the Blue Cross and Blue Shield Association.

To find more information about Highmark's benefits and operating procedures, such as accessing the drug formulary or using network providers, please go to http://www.highmark.com/transparency-in-coverage; or for a paper copy, call 1-855-873-4106.

**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 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
Phone: 1-800-368-1019, 800-537-7697 (TDD)

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

---

ATTENTION: If you speak English, free language translation and interpretation services are available to you. Appropriate auxiliary aids and services (such as large print, audio, and Braille) to provide information in accessible formats are also available free of charge. Call the number on the back of your ID card (TTY: 711) for help.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de traducción e interpretación de idiomas. También hay disponibles ayudas y servicios auxiliares adecuados (como letra grande, audio y Braille) para proporcionar información en formatos accesibles sin cargo. Llame al número que figura al dorso de su tarjeta de identificación (TTY: 711) si necesita ayuda.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Übersetzungs- und Dolmetscherdienste zur Verfügung. Außerdem sind kostenlos entsprechende Hilfsmittel und Dienstleistungen (wie Großdruck, Audio und Blindenschrift) zur Bereitstellung von Informationen in barrierefreien Formaten erhältlich. Wählen Sie hierfür bitte die Nummer auf der Rückseite Ihrer Ausweiskarte (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis tradiksyon ak entèpretasyon aladispozisyon w gratis nan lang ou pale a. Èd ak sèvis siplemantè apwopriye (tèlke gwo lèt, odyo, Braille) pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele nimewo ki sou do Kat ID w lan (TTY: 711) pou jwenn èd.

ВНИМАНИЕ: Если Вы говорите на русском языке, Вам доступны бесплатные услуги перевода на другой язык. Также предоставляется дополнительная бесплатная помощь и услуги отображения информации в доступных форматах (например, крупным шрифтом, шрифтом Брайля или в виде аудиозаписи). Для получения помощи позвоните по номеру, указанному на обратной стороне вашей идентификационной карты (TTY: 711).

ATTENZIONE: se parla italiano, sono disponibili servizi gratuiti di traduzione e interpretariato. Sono inoltre disponibili gratuitamente adeguati supporti e servizi ausiliari (ad esempio caratteri grandi, audio e Braille) per fornire informazioni in formati accessibili. Per assistenza, chiami il numero riportato sul retro della Sua tessera di identificazione (TTY: 711).

ATTENTION : si vous parlez français, des services de traduction et d'interprétation gratuits sont à votre disposition. Vous pouvez aussi bénéficier gratuitement de l'accès à des outils et services auxiliaires appropriés (affichage en gros caractères, audio et le braille) dans des formats accessibles. Veuillez appeler le numéro qui se trouve au verso de votre carte d'identification (TTY : 711) pour obtenir de l'aide.

ÀKÍYÈSÍ: Tí o bá nsọ èdè Yorùbá, àwọn iṣẹ ìtumọ ati òǵbufọ èdè wà ní àrọwọtó lọ́fẹ̀ẹ́ fún ọ. Awọn iṣẹ ìtọ́jú ati ìrànlọ́wọ́ tó yẹ (bíi titẹwé nla, gbigbọ ohùn, ati ìwé afọ́jú) lati pèsè iwifúnni ni awọn ọna ìrááyè si wà pẹlu lọ́fẹ̀ẹ́. Pe nọmba tó wà lẹhin kaádì ìdánimọ rẹ (TTY: 711) fún iranlọwọ.

אכטונג: אויב איר רעדט אידיש, קענט איר באקומען שפּראך איבערזעצונג און דאלמעטשונג סערוויסעס פריי פון אפצאל. געהעריגע הילפסמיטלען און סערוויסעס (אזויווי גרויסע דרוק, אודיא און ברעיל) צו צושטעלן אינפארמאציע אין צוגענגליכע פארמאטן זענען אויך דא צו באקומען פריי פון אפצאל. רופט דעם נומער אויף די אנדערע זייט פון אייער אידענטיטעט קארטל (TTY: 711) פאר הילף.

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات الترجمة التحريرية والترجمة الفورية مجانًا. تتوفر أيضًا الوسائل والخدمات المساعدة المناسبة (مثل الطباعة الكبيرة، والوسائل الصوتية، وطريقة برايل) لتقديم المعلومات بتنسيقاتٍ يمكن الوصول إليها من دون أي تكلفة. اتصل على الرقم المدوّن على ظهر بطاقة هويتك (TTY: 711) للحصول على المساعدة.

注意：如果您说中文，我们将为您提供免费的语言翻译和口译服务。此外，我们还免费提供相应的辅助工具和服务（如大字体、音频和盲文），以便您获取无障碍格式的信息。如需帮助，请拨打您的 ID 卡背面的号码（听障人士专用号码： 711）。

ધ્યાન આપશો: જો તમે ગુજરાતી બોલતા હોવ, તો તમારા માટે નિઃશુલ્ક ભાષા અનુવાદ અને ઇન્ટરપ્રિટેશન સેવાઓ ઉપલબ્ધ છે. સુલભ ફોર્મેટમાં માહિતી પૂરી પાડવા માટે યોગ્ય સહાયક સાધનસામગ્રી અને સેવાઓ (જેમ કે મોટી પ્રિન્ટ, ઓડિયો અને બ્રેઇલ) પણ નિઃશુલ્ક ઉપલબ્ધ છે. મદદ માટે તમારા આઇડી કાર્ડની પાછળ આપેલા નંબર (TTY: 711) પર કૉલ કરો.

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi có dịch vụ biên dịch và phiên dịch ngôn ngữ miễn phí dành cho quý vị. Chúng tôi cũng cung cấp miễn phí các dịch vụ và hỗ trợ bổ sung thích hợp (như chữ in lớn, tệp âm thanh và chữ nổi) để cung cấp thông tin ở các định dạng dễ tiếp cận. Vui lòng gọi số điện thoại trên mặt sau của thẻ nhận dạng của quý vị (TTY: 711) để được trợ giúp.

ध्यान दिनुहोस्: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंलाई निःशुल्क भाषा अनुवाद र दोभासे सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायक प्रविधि र सेवाहरू (जस्तै ठूलो प्रिन्ट, अडियो र ब्रेल) पनि निःशुल्क उपलब्ध छन्। मद्दतको लागि तपाईंको ID कार्डको पछाडिको नम्बरमा कल गर्नुहोस् (TTY: 711)।

कृपया ध्यान दें: यदि आप हिंदी भाषा बोलते हैं, तो आपके लिए मुफ़्त भाषा अनुवाद और व्याख्या संबंधी सेवाएं उपलब्ध हैं। एक्सेस करने योग्य फ़ॉर्मेट में सूचना उपलब्ध कराने के लिए उपयुक्त सहायक सामग्री और सेवाएं (जैसे बड़े प्रिंट, ऑडियो और ब्रेल) भी निःशुल्क उपलब्ध हैं। सहायता के लिए अपने पहचान कार्ड के पीछे लिखे नंबर (TTY: 711) पर कॉल करें।

주의: 한국어를 사용하는 경우 무료 언어 번역 및 통역 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공받을 수 있는 적절한 보조 수단 및 서비스(예: 큰 활자, 오디오, 점자)도 무료로 이용할 수 있습니다. 도움이 필요하시면 ID 카드 뒷면에 있는 번호로 전화하십시오(TTY: 711).