


**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.\[insert\].com](http://www.[insert].com). 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.ircgov.com](http://www.ircgov.com) or call 1-800-664-5295 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	In-Network: <b>\$600</b> Per Person/ <b>\$1,200</b> Family. <u>Out-of-Network</u> : <b>\$1,200</b> Per Person/ <b>\$2,400</b> Family.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. <u>Preventive care</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. 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 <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	Yes. <b>\$200</b> In-Network/ <b>\$400</b> Out-of-Network Per Admission <u>Deductible</u> . There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	Yes. In-Network: <b>\$3,000</b> Per Person/ <b>\$6,000</b> Family. <u>Out-Of-Network</u> : <b>\$4,000</b> Per Person/ <b>\$8,000</b> Family.	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.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<u>Premium</u> , <u>balance-billed</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="https://providersearch.floridablue.com/providersearch/pub/index.htm">https://providersearch.floridablue.com/providersearch/pub/index.htm</a> or call 1-800-664-5295 for a list of <u>network providers</u> .	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 charge</u> 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.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	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 deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	Primary Care Visits: \$30 <u>Copay</u> per Visit/ Virtual Visits (Telemedicine): \$10 <u>Copay</u> per Visit General Medicine/ \$20 Specialist	Primary Care Visits: <u>Deductible</u> + 30% <u>Coinsurance</u> / Virtual Visits (Telemedicine): Not Covered	Physician administered drugs may have higher cost shares.
	<u>Specialist</u> visit	\$50 <u>Copay</u> per Visit	<u>Deductible</u> + 30% <u>Coinsurance</u>	Physician administered drugs may have higher cost shares.
	<u>Preventive care/screening/immunization</u>	No Charge	30% <u>Coinsurance</u>	Physician administered drugs may have higher cost shares. 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.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	Independent Clinical Lab: No Charge/ Independent Diagnostic Testing Center: \$15 <u>Copay</u> per Visit	<u>Deductible</u> + 30% <u>Coinsurance</u>	Tests performed in hospitals may have higher cost-share.
	Imaging (CT/PET scans, MRIs)	\$200 <u>Copay</u> per Visit	<u>Deductible</u> + 30% <u>Coinsurance</u>	Tests performed in hospitals may have higher cost-share. Prior Authorization may be required. Your benefits/services may be denied.
<b>If you need drugs to treat your illness or condition</b>  More information about <u>prescription drug coverage</u> is available at <a href="http://www.Express-Scripts.com">www.Express-Scripts.com</a>	Generic drugs	\$10 30 DS Retail Copay \$20 90 DS Retail or Mail Order Copay	n/a	<b>Generic Policy:</b> If your doctor writes a prescription stating that a Generic may be dispensed, we will only pay for the Generic drug. If you choose to buy the Brand name drug in this situation, you will be required to pay the Brand co-pay plus the difference in cost between the Generic and Brand name drug. The Generic Policy does not apply if your doctor requires a brand name medication. <b>Step Therapy:</b> Step therapy promotes the use of
	Preferred brand drugs	\$50 30 DS Retail Copay \$100 90 DS Retail or Mail Order Copay	n/a	
	Non-preferred brand drugs	\$75 30 DS Retail Copay \$150 90 DS Retail or Mail Order Copay	n/a	

For more information about limitations and exceptions, see the plan or policy document at [www.ircgov.com](http://www.ircgov.com).

				generic medications first before non-preferred brand medications. If you choose to use certain non-preferred brand-name drugs before trying a generic medication or a preferred brand medication, your prescription may not be covered, and you may need to pay the full cost.
	<u>Specialty drugs</u>	Subject to cost share based on applicable drug tier	n/a	<p><b>Specialty Medications:</b> Specialty medications are limited to 30-day supply and must be ordered from Express Scripts at 1-800-803-2523. Specialty medications require prior authorization and quantity limits may apply. Some specialty medications may qualify for third party copayment assistance programs which could lower your out of pocket costs for those products. For any such specialty medication where third party copayment assistance is used, the member shall not receive credit toward their Maximum Out-Of-Pocket or deductible for any copayment or coinsurance amounts that are applied to a manufacturer coupon or rebate.</p> <p>Please see “Important Questions” regarding the plan’s out-of-pocket limit.</p>
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	<u>Deductible + 20% Coinsurance</u>	<u>Deductible + 30% Coinsurance</u>	—————none—————
	Physician/surgeon fees	<u>Deductible + 20% Coinsurance</u>	Ambulatory Surgical Center: <u>Deductible + 30% Coinsurance</u> / Hospital: <u>In-Network Deductible + 20% Coinsurance</u>	—————none—————

For more information about limitations and exceptions, see the [plan](#) or policy document at [www.ircgov.com](http://www.ircgov.com).

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 need immediate medical attention	<u>Emergency room care</u>	<u>Deductible + \$250 Copay per Visit + 20% Coinsurance</u>	<u>In-Network Deductible + \$250 Copay per Visit + 20% Coinsurance</u>	—————none—————
	<u>Emergency medical transportation</u>	<u>Deductible + 20% Coinsurance</u>	<u>In-Network Deductible + 20% Coinsurance</u>	—————none—————
	<u>Urgent care</u>	Urgent Care Visits: \$30 <u>Copay per Visit</u>	Urgent Care Visits: \$30 <u>Copay per Visit</u>	—————none—————
If you have a hospital stay	Facility fee (e.g., hospital room)	<u>Hospital Option 1: Deductible + \$200 Copay per Admission + 20% Coinsurance</u>	<u>Deductible + \$400 Copay per Admission + 30% Coinsurance</u>	Inpatient Rehab Services limited to 30 days. Option 2 hospitals may have a higher cost-share.
	Physician/surgeon fees	<u>Deductible + 20% Coinsurance</u>	<u>In-Network Deductible + 20% Coinsurance</u>	—————none—————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Physician Office: \$45 <u>Copay per Visit / Hospital Opt 1: Deductible + 20% Coinsurance</u>	<u>Deductible + 30% Coinsurance</u>	Option 2 hospitals may have a higher cost-share.
	Inpatient services	<u>Physician Services: Deductible + 20% Coinsurance / Deductible + \$200 Copay per Admission + 20% Coinsurance</u>	<u>Physician Services: In-Network Deductible + 20% Coinsurance/ Hospital: Deductible + \$400 Copay per Admission + 30% Coinsurance</u>	Prior Authorization may be required. Your benefits/services may be denied. Option 2 hospitals may have a higher cost-share.
If you are pregnant	Office visits	\$50 <u>Copay</u> on initial Visit	<u>Deductible + 30% Coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	<u>Deductible + 20% Coinsurance</u>	<u>In-Network Deductible + 20% Coinsurance</u>	—————none—————

For more information about limitations and exceptions, see the [plan](#) or policy document at [www.ircgov.com](http://www.ircgov.com).

	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 facility services	Hospital Option 1: <u>Deductible</u> + \$200 Copay per Admission + + 20% <u>Coinsurance</u>	<u>Deductible</u> + \$400 Copay per Admission + 30% <u>Coinsurance</u>	Option 2 hospitals may have a higher cost-share.
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 30% <u>Coinsurance</u>	Coverage limited to 20 visits.
	<u>Rehabilitation services</u>	Physician Office: \$45 <u>Copay</u> per Visit/ Outpatient Rehab Center: <u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 30% <u>Coinsurance</u>	Coverage limited to 35 visits, including 26 manipulations. Services performed in hospital may have higher cost-share. Prior Authorization may be required. Your benefits/services may be denied.
	<u>Habilitation services</u>	Not Covered	Not Covered	Not Covered
	<u>Skilled nursing care</u>	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 30% <u>Coinsurance</u>	Coverage limited to 60 days.
	<u>Durable medical equipment</u>	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 30% <u>Coinsurance</u>	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of <u>DME</u> due to use/age.
	<u>Hospice services</u>	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 30% <u>Coinsurance</u>	—————none—————
<b>If your child needs dental or eye care</b>	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

**Excluded Services & Other Covered Services:**

<b>Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u>.)</b>		
• Bariatric surgery	• Infertility treatment	• Preferred brand drugs
• Cosmetic surgery	• Long-term care	• Private-duty nursing
• Dental care (Adult)	• Non-preferred brand drugs	• Routine eye care (Adult)
• Generic drugs	• Pediatric dental check-up	• Routine foot care unless for treatment of diabetes
• Habilitation services	• Pediatric eye exam	• Specialty drugs
	• Pediatric glasses	• Weight loss programs

For more information about limitations and exceptions, see the plan or policy document at [www.ircgov.com](http://www.ircgov.com).

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

- Acupuncture
- Chiropractic care - Limited to 35 visits
- Most coverage provided outside the United States. See [www.floridablue.com](http://www.floridablue.com).
- 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: State Department of Insurance at 1-877-693-5236, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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](http://www.cciio.cms.gov). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](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 the insurer at 1-800-664-5295. You may also contact your State Department of Insurance at 1-877-693-5236 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). For group health coverage subject to ERISA contact your employee services department. For non-federal governmental group health plans and church plans that are group health plans contact your employee services department. You may also contact the state insurance department at 1-877-693-5236. Additionally, a consumer assistance program can help you file your appeal. Contact U.S. Department of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or [www.dol.gov/ebsa/consumer\\_info\\_health.html](http://www.dol.gov/ebsa/consumer_info_health.html).

**Does this plan provide Minimum Essential Coverage? Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet Minimum Value Standards? [ Yes / No ]**

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)

■ <b>The plan's overall deductible</b>	\$600
■ <b>Specialist Copayment</b>	\$50
■ <b>Hospital (facility) Coinsurance</b>	20%
■ <b>Other Copayment (Hospital)</b>	\$200
■ <b>OOP Maximum</b>	\$3,000

**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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$600
<u>Copayments</u>	\$250
<u>Coinsurance</u>	\$2,150
<u>What isn't covered</u>	
Limits or exclusions	\$100
<b>The total Peg would pay is</b>	<b>\$3,100</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ <b>The plan's overall deductible</b>	\$600
■ <b>Specialist Copayment</b>	\$50
■ <b>Hospital (facility) Coinsurance</b>	20%
■ <b>Other Copayment</b>	N/A
■ <b>OOP Maximum</b>	\$3,000

**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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$6,000
<b>The total Joe would pay is</b>	<b>\$6,400</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ <b>The plan's overall deductible</b>	\$600
■ <b>Specialist Copayment</b>	\$50
■ <b>Hospital (facility) Coinsurance</b>	20%
■ <b>Other Copayment (ER)</b>	\$250
■ <b>OOP Maximum</b>	\$3,000

**This EXAMPLE event includes services like:**

Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$600
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$200
<u>What isn't covered</u>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,100</b>

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: [www.floridablue.com](http://www.floridablue.com).

## Section 1557 Notification: Discrimination is Against the Law

Florida Blue, Florida Blue HMO, Florida Blue Preferred HMO (collectively, "Florida Blue"), Florida Combined Life and the Blue Cross and Blue Shield Federal Employee Program® (FEP) comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Florida Blue, Florida Blue HMO, Florida Blue Preferred HMO, Florida Combined Life and FEP:

- Provide 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)
- Provide 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:

- Florida Blue (health and vision coverage): 1-800-352-2583
- Florida Combined Life (dental, life, and disability coverage): 1-888-223-4892
- Federal Employee Program: 1-800-333-2227

If you believe that we have 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:

**Florida Blue (including FEP members):**

Section 1557 Coordinator  
4800 Deerwood Campus Parkway, DCC 1-7  
Jacksonville, FL 32246  
1-800-477-3736 x29070  
1-800-955-8770 (TTY)  
Fax: 1-904-301-1580  
section1557coordinator@floridablue.com

**Florida Combined Life:**

Civil Rights Coordinator  
17500 Chenal Parkway  
Little Rock, AR 72223  
1-800-260-0331  
1-800-955-8770 (TTY)  
civilrightscordinator@fclife.com

Health insurance is offered by Florida Blue. HMO coverage is offered by Florida Blue HMO, an affiliate of Florida Blue. Dental insurance is offered by Florida Combined Life Insurance Company, Inc., an affiliate of Blue Cross and Blue Shield of Florida, Inc. These companies are Independent Licensees of the Blue Cross and Blue Shield Association.



You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 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>, 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

1-800-537-7697 (TDD)

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

**ATENCIÓN:** Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-352-2583 (TTY: 1-877-955-8773). FEP: Llame al 1-800-333-2227

**ATANSYON:** Si w pale Kreyòl ayisyen, ou ka resevwa yon èd gratis nan lang pa w. Rele 1-800-352-2583 (pou moun ki pa tande byen: 1-800-955-8770). FEP: Rele 1-800-333-2227

**CHÚ Ý:** Nếu bạn nói Tiếng Việt, có dịch vụ trợ giúp ngôn ngữ miễn phí dành cho bạn. Hãy gọi số 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Gọi số 1-800-333-2227

**ATENÇÃO:** Se você fala português, utilize os serviços linguísticos gratuitos disponíveis. Ligue para 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Ligue para 1-800-333-2227

**注意:** 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-352-2583 (TTY: 1-800-955-8770)。FEP: 請致電1-800-333-2227

**ATTENTION:** Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-352-2583 (ATS : 1-800-955-8770). FEP : Appelez le 1-800-333-2227

**PAUNAWA:** Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Tumawag sa 1-800-333-2227

Health insurance is offered by Florida Blue. HMO coverage is offered by Florida Blue HMO, an affiliate of Florida Blue. Dental insurance is offered by Florida Combined Life Insurance Company, Inc., an affiliate of Blue Cross and Blue Shield of Florida, Inc. These companies are Independent Licensees of the Blue Cross and Blue Shield Association.

**ВНИМАНИЕ:** Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-352-2583 (телетайп: 1-800-955-8770). FEP: Звоните 1-800-333-2227

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-352-2583 (رقم هاتف الصم والبكم: 1-800-955-8770). اتصل برقم 1-800-333-2227.

**ATTENZIONE:** Qualora fosse l'italiano la lingua parlata, sono disponibili dei servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-352-2583 (TTY: 1-800-955-8770). FEP: chiamare il numero 1-800-333-2227

**ACHTUNG:** Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: +1-800-352-2583 (TTY: +1-800-955-8770). FEP: Rufnummer +1-800-333-2227

주의: 한국어 사용을 원하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-352-2583 (TTY: 1-800-955-8770) 로 전화하십시오. FEP: 1-800-333-2227 로 연락하십시오.

**UWAGA:** Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Zadzwoń pod numer 1-800-333-2227.

**सुचना:** જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવા તમારા માટે ઉપલબ્ધ છે.

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**توجه:** اگر یہ زبان فارسی صحبت می کنید، تسهیلات زبانی رایگان در دسترس شما خواهد بود.  
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**Baa ákonínzin:** Diné bizaad bee yáníiti'go, saad bee áká anáwo', t'áá jíik'eh, ná hóló. Kojj' hodiílnih 1-800-352-2583 (TTY: 1-800-955-8770). FEP igii éi kojj' hodiílnih 1-800-333-2227.

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