**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay for Covered Services
This health plan is offered by Quartz Health Benefit Plans Corporation

Quartz

9032793 - QUARTZ ONE ACHIEVE W/UW HEALTH SILVER STANDARD EASY PRICING CSR 87

Coverage Period: 1/1/2027 - 12/31/2027
**Coverage for:** Individual/Family | **Plan Type:** HMO

**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, visit **www.QuartzBenefits.com/certlookup**. 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 **https://www.healthcare.gov/sbc-glossary** or call Customer Success: 1-800-362-3310 to request a copy.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | Individual: **$800** per Benefit Year<br>Family: **$800**/individual or **$1,600**/family per Benefit Year | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.<br><br>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 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?** | Individual: **$3,600** per Benefit Year<br>Family: **$3,600**/individual or **$7,200**/family per Benefit Year | The out-of-pocket limit is the most you could pay in a year for covered services.<br><br>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 billing charges, dental coinsurance, cost-sharing assistance for certain brand drugs, 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.<br><br>See www.QuartzBenefits.com/FindADoctor | 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 |

| | | |
|---|---|---|
| | or call 1-800-362-3310 for a list of network providers. | 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?** | In-Network providers: No.<br>Out-of-Network providers: Yes, written referral is required. | In-Network: You can see the specialist you choose without a referral.<br>Out-of-Network: This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist. |



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 |
|---|---|---|---|---|
| | | In Network (You will pay the least) | Out-of-Network (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 | $20 copay/visit; deductible does not apply | Not covered | Virtual Visits are covered with a $20 copay; deductible does not apply. A covered Telehealth visit applies the same cost-sharing as an in-person visit. Deductible and/or coinsurance may apply for additional services performed at your visit. |
| | Specialist visit | $40 copay/visit; deductible does not apply | Not covered | A covered Telehealth visit applies the same cost-sharing as an in-person visit. Deductible and/or coinsurance may apply for additional services performed at your visit. |
| | Other practitioner office visit | Chiro/Non-Routine Adult Vision: $20 copay/visit; deductible does not apply | Not covered | Benefits are not available for care that is Maintenance and Supportive Care. Routine Adult Vision exams are not covered. Deductible and/or coinsurance may apply for additional services performed at your visit. |
| | Preventive care/screening/ immunization | No charge; deductible does not apply | 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. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 30% coinsurance | Not covered | Prior authorization may be required. See www.QuartzBenefits.com/WIPAList or call (800) 362-3310 for additional information. |
| | Imaging (CT/PET scans, MRIs) | 30% coinsurance | Not covered | ----------none---------- |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In Network (You will pay the least) | Out-of-Network (You will pay the most) | |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.QuartzBenefits.com/formulary | Low Cost Generic | $10 copay/prescription; deductible does not apply | Not covered | Preventive medications are covered without member cost sharing as specified on the formulary.<br>Multiple copays will apply for claims of greater than 30 day supply when covered; for claims of 31 to 60 days supply, two copays will apply, and for claims of 61 to 90 days supply, three copays will apply.<br>Coverage restrictions may apply to some medications. See the Quartz Formulary for details; the formulary is subject to change following quarterly Pharmacy & Therapeutics Committee meetings, or following updates to drug availability (e.g., new generic drugs).<br>Manufacturer-funded cost-sharing assistance for your prescriptions will be credited to your Annual Deductible or Annual Maximum Out-of-Pocket Limit. |
| | Generic \| Tier 1 | $10 copay/prescription; deductible does not apply | Not covered | |
| | Preferred Brand \| Tier 2 | $20 copay/prescription; deductible does not apply | Not covered | |
| | Non-Preferred Brand & Generic \| Tier 3 | $60 copay/prescription | Not covered | |
| | Specialty \| Tier 4 | $250 copay/prescription | Not covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 30% coinsurance | Not covered | Prior authorization may be required. See www.QuartzBenefits.com/WIPAList or call (800) 362-3310 for additional information.<br>Oral Surgery: Not covered |
| | Physician/surgeon fees | 30% coinsurance | Not covered | |
| **If you need immediate medical attention** | Emergency room care | 30% coinsurance | 30% coinsurance | Foreign claims for emergency care are subject to a $20,000 limit per Benefit Year. |
| | Emergency medical transportation | 30% coinsurance | 30% coinsurance | Foreign claims for emergency care are subject to a $20,000 limit per Benefit Year. |
| | Urgent care | $30 copay/visit; deductible does not apply | $30 copay/visit; deductible does not apply | Deductible and/or coinsurance may apply for additional services performed at your visit. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 30% coinsurance | Not covered | Prior authorization is required. See www.QuartzBenefits.com/WIPAList or call (800) 362-3310 for additional information. |
| | Physician/surgeon fees | 30% coinsurance | Not covered | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In Network (You will pay the least) | Out-of-Network (You will pay the most) | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $20 copay/visit; deductible does not apply | Not covered | Benefits are not available for care that is Maintenance and Supportive Care. A covered Telehealth visit applies the same cost-sharing as an in-person visit. However, reduced cost-sharing may apply for visits through the mental well-being program. Deductible and/or coinsurance may apply for additional services performed at your visit. |
| | Inpatient services | 30% coinsurance | Not covered | Prior authorization is required. See www.QuartzBenefits.com/WIPAList or call (800) 362-3310 for additional information. |
| **If you are pregnant** | Office visits | PCP: $20 copay/visit; deductible does not apply<br><br>Specialist: $40 copay/visit; deductible does not apply | Not covered | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Prior authorization is required for inpatient services. See www.QuartzBenefits.com/WIPAList or call (800) 362-3310 for additional information. Deductible and/or coinsurance may apply for additional services performed at your visit. |
| | Childbirth/delivery professional services | 30% coinsurance | Not covered | |
| | Childbirth/delivery facility services | 30% coinsurance | Not covered | |
| **If you need help recovering or have other special health needs** | Home health care | 30% coinsurance | Not covered | Coverage is limited to 60 visits per Benefit Year. Prior authorization is required. See www.QuartzBenefits.com/WIPAList or call (800) 362-3310 for additional information. |
| | Rehabilitation services | $20 copay/visit; deductible does not apply | Not covered | Coverage is limited to 20 visits each for Physical, Speech and Occupational therapy and Pulmonary Rehab per Benefit Year. Cardiac Rehab is limited to 36 visits per Benefit Year. Inpatient Rehab is limited to 60 days per Benefit Year. Post Cochlear Implant Aural Therapy is limited to 30 visits per Benefit Year. A covered Telehealth visit applies the same cost-sharing as an in-person visit. Deductible and/or coinsurance may apply for additional services performed at your visit. |
| | Habilitation services | $20 copay/visit; deductible does not | Not covered | Coverage is limited to 20 visits each for Physical, Speech and Occupational therapy per Benefit Year. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In Network (You will pay the least) | Out-of-Network (You will pay the most) | |
| | | apply | | Prior authorization may be required. See www.QuartzBenefits.com/WIPAList or call (800) 362-3310 for additional information.<br>A covered Telehealth visit applies the same cost-sharing as an in-person visit.<br>Deductible and/or coinsurance may apply for additional services performed at your visit. |
| | Skilled nursing care | 30% coinsurance | Not covered | Coverage limited to 30 days per confinement. This benefit is combined with the Swing Bed Care benefit.<br>Prior authorization is required. See www.QuartzBenefits.com/WIPAList or call (800) 362-3310 for additional information. |
| | Durable medical equipment | 30% coinsurance; deductible does not apply | Not covered | Purchase or rental of DME items may require Prior Authorization. See www.QuartzBenefits.com/WIPAList or call (800) 362-3310 for additional information.<br>Glasses/contacts for Adult Routine Vision are not covered.<br>Coverage for --<br>Hearing Aids: Limited to one per ear every 36 months.<br>To obtain the list of covered hearing aid models log onto www.QuartzBenefits.com/hearingaids or contact Customer Success. |
| | Hospice services | 30% coinsurance | Not covered | Prior authorization is required. See www.QuartzBenefits.com/WIPAList or call (800) 362-3310 for additional information.<br>Hospice coverage excludes room and board charges in a Skilled Nursing Facility. |
| **If your child needs dental or eye care** | Children's eye exam | $20 copay/visit; deductible does not apply | Not covered | ----------none---------- |
| | Children's glasses | 30% coinsurance; deductible does not apply | Not covered | Limited to one pair of glasses or set of contacts per Benefit Year. |
| | Children's dental check-up | Not covered | Not covered | ----------none---------- |

**Excluded Services & Other Covered Services:**

| Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.) | | |
|---|---|---|
| • Acupuncture | • Dental care (Adult) | • Non-formulary drugs without an approved exception |
| • Allergy testing | • Infertility treatment | • Private-duty nursing |
| • Bariatric surgery | • Long-term care | • Routine eye care (Adult) |
| • Cosmetic surgery | • Non-emergency care when traveling outside the U.S. | • Weight loss programs |

| Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.) | | |
|---|---|---|
| • Chiropractic care | • Hearing aids | • Routine foot care |

**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: Office of the Commissioner of Insurance, Complaints Department, PO Box 7873, Madison, WI 53707-7873, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa, or visit www.HealthCare.gov or call 1-800-318-2596. 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 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 on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or for assistance, contact: Office of the Commissioner of Insurance, Complaints Department, PO Box 7873, Madison, WI 53707-7873, or if coverage is under a group health plan the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

**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 Coverage Meet the Minimum Value Standard? Not Applicable**
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.

**Language Access Services:**
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-362-3310 or 1-800-877-8973 (TTY).
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-362-3310 or 1-800-877-8973 (TTY)
Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-362-3310 or 1-800-877-8973 (TTY)
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-362-3310 or 1-800-877-8973 (TTY)

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

## 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** | **$800** |
| ■ **Specialist copayment** | **$40** |
| ■ Hospital (facility) coinsurance | **30%** |
| ■ Other coinsurance | **30%** |
| **This EXAMPLE event includes services like:**<br>Specialist office visits (*prenatal care*)<br>Childbirth/Delivery Professional Services<br>Childbirth/Delivery Facility Services<br>Diagnostic tests (*ultrasounds and blood work*)<br>Specialist visit (*anesthesia*) | |
| **Total Example Cost** | **$12,700** |
| **In this example, Peg would pay:** | |
| *Cost Sharing* | |
| Deductibles | $800 |
| Copayments | $60 |
| Coinsurance | $2,700 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$3,560** |

| **Managing Joe's type 2 Diabetes** (a year of routine in-network care of a well-controlled condition) | |
|---|---|
| ■ **The plan's overall deductible** | **$800** |
| ■ **Specialist copayment** | **$40** |
| ■ Hospital (facility) coinsurance | **30%** |
| ■ Other coinsurance | **30%** |
| **This EXAMPLE event includes services like:**<br>Primary care physician office visits (*including disease education*)<br>Diagnostic tests (*blood work*)<br>Prescription drugs<br>Durable medical equipment (*glucose meter*) | |
| **Total Example Cost** | **$5,600** |
| **In this example, Joe would pay:** | |
| *Cost Sharing* | |
| Deductibles | $100 |
| Copayments | $900 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$1,000** |

| **Mia's Simple Fracture** (in-network emergency room visit and follow up care) | |
|---|---|
| ■ **The plan's overall deductible** | **$800** |
| ■ **Specialist copayment** | **$40** |
| ■ Hospital (facility) coinsurance | **30%** |
| ■ Other coinsurance | **30%** |
| **This EXAMPLE event includes services like:**<br>Emergency room care (*including medical supplies*)<br>Diagnostic test (*x-ray*)<br>Durable medical equipment (*crutches*)<br>Rehabilitation services (*physical therapy*) | |
| **Total Example Cost** | **$2,800** |
| **In this example, Mia would pay:** | |
| *Cost Sharing* | |
| Deductibles | $800 |
| Copayments | $100 |
| Coinsurance | $400 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,300** |

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

# Notice of Non-Discrimination and Availability of Language Assistance Services and Auxiliary Aids and Services

Quartz is the brand name for a group of companies committed to your health: Quartz Health Benefit Plans Corporation, Quartz Health Insurance Corporation, Quartz Health Plan Corporation, and Quartz Health Plan MN Corporation. These companies are separate legal entities. In this notice, "we" refers to all Quartz companies.

For assistance understanding these materials in a language other than English, call (800) 362-3310, and a Customer Success representative will assist you. TTY users should call 711 or (800) 877-8973.

We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex (includes sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes). Quartz does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

We provide reasonable modifications and free appropriate auxiliary aids and services to people with disabilities to communicate effectively with us and to participate in health programs or activities, such as -

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

We 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 Customer Success at (800) 362-3310.

If you believe we 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-

Chief Compliance Officer
2650 Novation Parkway
Fitchburg, WI 53713
Phone: (800) 362-3310
TTY: 711 or toll-free (800) 877-8973
Fax: (608) 644-3500
Email: AppealsSpecialists@QuartzBenefits.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Chief Compliance Officer 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
(800) 368-1019; (800) 537-7697 (TDD)

Complaint forms are available at hhs.gov/ocr/office/file/index.html. Quartz is a Qualified Health Plan issuer in the Health Insurance Marketplace® in certain states. To learn more, visit the Health Insurance Marketplace® at HealthCare.gov.

ATTENTION: Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call (800) 362-3310, TTY: 711 / (800) 877-8973.

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|---|
| Spanish - ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al (800) 362-3310. TTY: 711 / (800) 877-8973 o hable con su proveedor. |
| Chinese -**注意**：**如果您**说[**中文**]，**我**们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 (800) 362-3310. TTY: 711 / (800) 877-8973 **或咨**询您的服务提供商。 |
| Hmong - LUS CEEV TSHWJ XEEB: Yog hais tias koj hais Lus Hmoob muaj cov kev pab cuam txhais lus pub dawb rau koj. Cov kev pab thiab cov kev pab cuam ntxiv uas tsim nyog txhawm rau muab lus qhia paub ua cov hom ntaub ntawv uas tuaj yeem nkag cuag tau rau los kuj yeej tseem muaj pab dawb tsis xam tus nqi dab tsi ib yam nkaus. Hu rau (800) 362-3310. TTY: 711 / (800) 877-8973 los sis sib tham nrog koj tus kws muab kev saib xyuas kho mob. |
| Russian - ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону (800) 362-3310. TTY: 711 / (800) 877-8973 или обратитесь к своему поставщику услуг. |
| Vietnamese - LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số (800) 362-3310. TTY: 711 / (800) 877-8973 hoặc trao đổi với người cung cấp dịch vụ của bạn. |
| Laotian - ຊຸ[illegible]ຈ: ຖ້າທ່ານ[illegible] ລາວ, ຈະ[illegible]ການ[illegible]ຄ່າ[illegible]ທ່ານ. [illegible]ການ[illegible]ຄ່າ[illegible]ຂ[illegible]ໃ[illegible]ທ່ານ. ໂ[illegible](800) 362-3310. TTY: 711 / (800) 877-8973 [illegible] |

German - ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie (800) 362-3310. TTY: 711 / (800) 877-8973 an oder sprechen Sie mit Ihrem Provider.

Pennsylvania Dutch - LET OP: als je Nederlands spreekt, zijn er gratis taalhulpdiensten voor je beschikbaar. Passende hulpmiddelen en diensten om informatie in toegankelijke formaten te verstrekken, zijn ook gratis beschikbaar. Bel (800) 362-3310. TTY: 711 / (800) 877-8973 of spreek met je provider."

Arabic - تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1(800) 362-3310. TTY: 711 / (800) 877-8973 أو تحدث إلى مقدم الخدمة".

Polish - UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer (800) 362-3310. TTY: 711 / (800) 877-8973 lub porozmawiaj ze swoim dostawcą.

French - ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le (800) 362-3310. TTY: 711 / (800) 877-8973 ou parlez à votre fournisseur.

Hindi - ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निशुल्क उपलब्ध हैं। । (800) 362-3310. TTY / TDD: 711 / (800) 877-8973 पर कॉल करें या अपने प्रदाता से बात करें।

Korean -주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. (800) 362-3310. TTY: 711 / (800) 877-8973 번으로 전화하거나 서비스 제공업체에 문의하십시오.

Albanian - VINI RE: Nëse flisni [shqip], shërbime falas të ndihmës së gjuhës janë në dispozicion për ju. Ndihma të përshtatshme dhe shërbime shtesë për të siguruar informacion në formate të përdorshme janë gjithashtu në dispozicion falas. Telefononi (800) 362-3310. TTY: 711 / (800) 877-8973 ose bisedoni me ofruesin tuaj të shërbimit.

Tagalog - PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa (800) 362-3310. TTY: 711 / (800) 877-8973 o makipag-usap sa iyong provider.

Somali - FIIRO GAAR AH: Haddaad ku hadasho Soomaali, adeegyo kaalmada luuqadda ah oo bilaash ah ayaad heli kartaa. Qalab caawinaad iyo adeegyo oo habboon si loogu bixiyo macluumaadka qaabab la adeegsan karo ayaa sidoo kale bilaa lacag heli karaa. Wac (800) 362-3310. TTY: 711 / (800) 877-8973 ama la hadal bixiyahaaga. Gargaarsi gargaaraa fi tajaajilli sirrii ta'ee fi odeeffannoo bifa dhaqqabamaa ta'een kennuunis bilisaan ni argama.

Cushite (Oromo) - XIYYEEFFANNOO: Afaan Kushii yoo dubbattan tajaajilli gargaarsa afaanii bilisaan isiniif ni kennama. Gargaarsi gargaaraa fi tajaajilli sirrii ta'ee fi odeeffannoo bifa dhaqqabamaa ta'een kennuunis bilisaan ni argama. (800) 362-3310 bilbili. TTY: 711 / (800) 877-8973 ykn dhiyeessaa keessan waliin haasa'aa.

Amharic - ማሳሰቢያ፦ አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎት በነፃ ይቀርብልዎታል። መረጃን በተደራሽ ቅርጸት ለማቅረብ ተገቢ የሆኑ ተጨማሪ እገዛዎች እና አገልግሎቶች እንዲሁ በነፃ ይገኛሉ። በስልክ ቁጥር (800) 362-3310. TTY: 711 / (800) 877-8973 ይደውሉ ወይም አገልግሎት አቅራቢዎን ያናግሩ።

Karen - ဆူ– နမ့်ကတိၤ ထၢနှာ်လီၤဖဲအံၤ အဃိ, တၢ်အိဉ်ဒီး ကျိာ်တၢ်ဆိဉ်ထွဲမၤစၢၤ လၢတလၢာ် ဘူဉ်လၢာ်စုၤလၢနဂီၢ်လီၤ. တၢ်အိဉ်ဒီး တၢ်မၤစၢၤတၢ်နှာ်ဟူပီးလီဒီး တၢ်မၤစၢၤတၢ်မၤ လၢအ ကပြၫ်အဘဉ် လၢကဟ့ဉ်တၢ်ဂ့ၢ်တၢ်ကျိၤ လၢတၢ်မၤနှာ်အီၤသ့တဖဉ် လၢတလၢာ်ဘူဉ်လၢာ်စုၤ လၢနဂီၢ်လီၤ. ကိး (800) 362-3310. TTY: 711 / (800) 877-8973 မ့တမ့ၢ် ကတိၤတၢ်ဒီး နပှၤလၢဟ့ဉ် နၤတၢ်ကွၢ်ထွဲမၤစၢၤတက့ၢ်.

Mon-Khmer, Cambodian (Khmer) - សូមយកចិត្តទុកដាក់៖ បុរសិនបើអ្នកនិយាយ ភាសាខុមរ៉ែ សវោកមុមជំនួយភាសាឥតគិតថ្លៃគឺមានសម្រាប់អ្នក។ ជំនួយ និងសវោកមុមឌលែជាការជួយដ៏សមរមុយ កុនុងការផ្តល់ព័ត៌មានតាមទមរង់ឌលែអាចចូលបុរើបុរាស់បាន កំអាចរកបានដោយឥតគិតថ្លៃដែរ។ ហៅទូរសព្ទទៅ (800) 362-3310. TTY: 711 / (800) 877-8973 ឬនិយាយទៅកាន់អ្នកផ្តល់សវោរបស់អ្នក។

Serbo-croatian (Serbian) - ПАЖЊА: Ако говорите српскохрватски, доступне су вам бесплатне језичке услуге. Бесплатна су и одговарајућа помоћна помагала и услуге за пружање информација у приступачним форматима. Позовите (800) 362-3 ТТИ: 711 / (800) 877-8973 или разговарајте са својим провајдером.

Thai - หมายเหตุ: หากคุณใช้ภาษา ไทย เรามีบริการความช่วยเหลือด้านภาษาฟรี นอกจากนี้ ยังมีเครื่องมือและบริการช่วยเหลือเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่าย โปรดโทรติดต่อ (800) 362-3310. TTY: 711 / (800) 877-8973 หรือปรึกษาผู้ให้บริการของคุณ"

Gujarati - ધ્યાન આપો: જો તમે ગુજરાતી બોલો છો, તો તમારા માટે મફત ભાષા સહાય સેવાઓ ઉપલબ્ધ છે. સુલભ ફોર્મેટમાં માહિતી પ્રદાન કરવા માટે યોગ્ય સહાયક સહાય અને સેવાઓ પણ મફતમાં ઉપલબ્ધ છે. કૉલ કરો (800) 362-3310. TTY: / (800) 877-8973 અથવા તમારા પ્રદાતા સાથે વાત કરો.

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| Urdu - ( یا اپنے فراہم کنندہ سے بات کریں۔ TTY: 711 / (800) 877-8973 پر کال کریں۔ 362-3310 (800توجہ: اگر آپ اردو بولتے ہیں، تو آپ کے لیے مفت زبان کی مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ |
| Italian - ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'(800) 362-3310. TTY: 711 / (800) 877-8973 o parla con il tuo fornitore. |
| Greek - ΠΡΟΣΟΧΗ: Εάν μιλάτε ελληνικά, υπάρχουν διαθέσιμες δωρεάν υπηρεσίες υποστήριξης στη συγκεκριμένη γλώσσα. Διατίθενται δωρεάν κατάλληλα βοηθήματα και υπηρεσίες για παροχή πληροφοριών σε προσβάσιμες μορφές. Καλέστε το (800) 362-3310. TTY: 711 / (800) 877-8973 ή απευθυνθείτε στον πάροχό σας. |
| Nepali - ध्यान दनिुहोस्: यदि तपाइँ नेपाली बोल्नुहुन्छ भने, तपाइँलाई नशिुल्क भाषा सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायक सहायताहरू र सेवाहरू पनि नशिुल्क उपलब्ध छन्। कल (800) 362-3310। TTY: 711 / (800) 877-8973 वा आफ्नो प्रदायक सँग कुरा गर्नुहोस्। |
| Ukrainian - УВАГА: Якщо ви розмовляєте українська мова, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби та послуги для надання інформації у доступних форматах також доступні безкоштовно. Зателефонуйте за номером (800) 362-3310. TTY: 711 / (800) 877-8973 або зверніться до свого постачальника. |
| Tibetan - ངོས་འཁལ་དུ་ཞུ་དགོས་པ་ཡིན་ན་སྐད་ཡིག་རོགས་སྐྱོར་གྱི་ཞབས་ཏོག་ཚུ་ཨེ་ཅིས་ཀྱང་ཐོབ་ཆོག་པ་ཨིན། འོན་ཀང་ཚོགས་གྱི་རིགས་གཅིག་ལུ་ཡོད་པའི་རྒྱབ་རྟེན་ཞུན་དག་ཚུ་དང་ཞབས་ཏོག་ཚུ་ཡང་ཐོབ་ཆོག་པ་ཨིན། ཁ་པར་(८००)३७२-३३१० TTY: 711 / (800) 877-8973 ཡང་ན་ཁྱེད་ཀྱི་མཁོ་སྐྱོན་ཁྱེད་མཁན་པ་སྐད་ཅ་བཤད་རོགས། |
| Wolof - FÀTTAL: Sooy wax Wolof, ay serwiis yu lay jàppale ci làkk wi doo fay. Ay ndimbal ak ay serwiis yu war ngir joxe leeral ci formaa yu yomb am nañu ci te doo fay. Woowal (800) 362-3310. TTY: 711 / (800) 877-8973 wala nga waxtaan ak sa joxekat. |