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



9030739 - QUARTZ ONE GOLD I405-01 VALUE TIER RX W/DENTAL & VISION-SA1

Coverage Period: 1/1/2023 - 12/31/2023

Coverage for: Single/Family | Plan Type: HMO



The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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 1-800-362-3310 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Single: \$2,000 per Benefit Year Family: \$2,000 /individual or \$4,000 /family per Benefit Year	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> .
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> services and <u>prescription drugs</u> are covered before you meet your <u>deductible</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 preventive services without cost-sharing and before you meet your <u>deductible</u> . 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 <u>deductibles</u> for specific services.
What is the <u>out-of-</u> <u>pocket limit</u> for this <u>plan</u> ?	Single: \$6,000 per Benefit Year Family: \$6,000 /individual or \$12,000 /family per Benefit Year	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges, adult dental coinsurance, cost-sharing assistance for your prescriptions, and health care this	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

	plan doesn't cover.	
Will you pay less if you use a network provider?	Yes. See <u>www.QuartzBenefits.com/FindADoct</u> <u>or</u> or call 1-800-362-3310 for a list of network providers.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan</u> 's <u>network</u> . You will pay the most if you use an out-of- <u>network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider</u> 's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an out-of- <u>network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	In- <u>Network providers</u> : No. Out-of- <u>Network providers</u> : Yes, written <u>referral</u> is required.	In-Network: You can see the <u>specialist</u> you choose without a <u>referral</u> . Out-of-Network: This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

		What You Will Pay		
Common Medical Event	Services You May Need	In Network (You will pay the least)	Out-of-Network (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	\$25 <u>copay</u> /visit; <u>deductible</u> does not apply	Not covered	Virtual Visits and Telehealth Visits are covered at no charge. Deductible and/or coinsurance may apply for additional services performed at your visit.
If you visit a health care	Specialist visit	\$50 <u>copay</u> /visit; <u>deductible</u> 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.
provider's office or clinic	Other practitioner office visit	Chiro/Adult Vision: \$25 copay/visit; deductible does not apply	Not covered	Benefits are not available for care that is Maintenance and Supportive Care. 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	Coverage is limited to preventive services as defined by the Affordable Care Act. 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.

		What You Will Pay			
Common Medical Event	Services You May Need	In Network (You will pay the least)	Out-of-Network (You will pay the most)	Limitations, Exceptions, & Other Important Information	
If you have a test	Diagnostic test (x-ray, blood work)	Lab: \$25 copay/visit; deductible does not apply X-Ray: \$50 copay/visit; deductible does not apply	Not covered	none	
	Imaging (CT/PET scans, MRIs)	40% coinsurance	Not covered	none	
If you need drugs to treat your illness or condition	Preferred Generics Tier 1	Value Tier: \$10 copay/prescription All others: \$35 copay/prescription	Not covered	Multiple <u>copays</u> will apply for <u>claims</u> of greater than 30 day supply when covered; for <u>claims</u> of 31 to 60 days supply, two <u>copays</u> will apply, and for <u>claims</u> of 61 to 90 days supply, three <u>copays</u>	
More information about prescription drug coverage is available at	Preferred Brands Tier 2	Value Tier: \$10 copay/prescription All others: \$150 copay/prescription	Not covered	will apply. Coverage restrictions may apply to some medications. See the Quartz Formulary for details Manufacturer-funded cost-sharing assistance for	
www.QuartzBenefi ts.com/formulary	Non-Preferred Brands & Generics Tier 3	50% coinsurance	Not covered	your prescriptions will not be credited to your Annual Maximum Out-of-Pocket Limit.	
If you have	Tier 4 Facility fee (e.g., ambulatory surgery center)	40% coinsurance	Not covered Not covered	Prior authorization may be required. See www.QuartzBenefits.com/WIPAList or call (800) 362-3310 for additional information.	
outpatient surgery	Physician/surgeon fees	40% coinsurance	Not covered	Oral Surgery benefits are administered by Momentum Insurance <u>Plans</u> . For Customer Service, call 1-855-333-3511.	
	Emergency room care	40% coinsurance	40% coinsurance	none	
If you need immediate	Emergency medical transportation	40% coinsurance	40% coinsurance	none	
medical attention	<u>Urgent care</u>	\$50 <u>copay</u> /visit; <u>deductible</u> does not apply	\$50 <u>copay</u> /visit; <u>deductible</u> does not apply	Deductible and/or coinsurance may apply for additional services performed at your visit.	

		What You	ı Will Pay		
Common Medical Event	Services You May Need	In Network (You will pay the least)	Out-of-Network (You will pay the most)	Limitations, Exceptions, & Other Important Information	
If you have a	Facility fee (e.g., hospital room)	40% coinsurance	Not covered	Prior authorization is required. See www.QuartzBenefits.com/WIPAList or call (800)	
hospital stay	Physician/surgeon fees	40% coinsurance	Not covered	362-3310 for additional information.	
If you need mental health, behavioral health, or substance abuse	Outpatient services	\$25 <u>copay</u> /visit; <u>deductible</u> does not apply	Not covered	Benefits are not available for care that is Maintenance and Supportive Care. Virtual Visits and Telehealth Visits are covered at no charge. Deductible and/or coinsurance may apply for additional services performed at your visit.	
services	Inpatient services	40% 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: \$25 copay/visit Specialist: \$50 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/WIPALisorcal (800) 362-3310 for additional information.	
	Childbirth/delivery professional services	40% coinsurance	Not covered	Deductible and/or coinsurance may apply for additional services performed at your visit.	
	Childbirth/delivery facility services	40% coinsurance	Not covered		
If you need help	Home health care	40% 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.	
recovering or have other special health needs	Rehabilitation services	40% coinsurance	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	

		What You	u Will Pay	
Common Medical Event	Services You May Need	In Network (You will pay the least)	Out-of-Network (You will pay the most)	Limitations, Exceptions, & Other Important Information
				Year. Post Cochlear Implant Aural Therapy is limited to 30 visits per Benefit Year. A covered Telehealth visit applies the same costsharing as an in-person visit.
	Habilitation services	40% coinsurance	Not covered	Coverage is limited to 20 visits each for Physical, Speech and Occupational therapy per Benefit Year. Prior authorization may be required. See www.QuartzBenefits.com/WIPAList or call (800) 362-3310 for additional information. A covered Telehealth visit applies the same cost-sharing as an in-person visit.
	Skilled nursing care	40% <u>coinsurance</u>	Not covered	Coverage limited to 30 days per confinement. This benefit is combined with the Swing Bed Care benefit. Prior authorization is required. See www.QuartzBenefits.com/WIPAList or call (800) 362-3310 for additional information.
	Durable medical equipment	40% coinsurance	Not covered	Purchase of DME with a per unit cost of \$500 or more (except for hearing aids and glasses/contacts) and all DME rentals must be Prior Authorized. Glasses/contacts for Adult Routine Vision are limited to one pair of glasses or set of contacts per Benefit Year. Quartz's contribution to adult vision hardware is limited to \$100, after DME cost-sharing. Coverage for Hearing Aids: Limited to one per ear every 36 months. To obtain the list of covered hearing aid models log onto www.QuartzBenefits.com/hearingaids or contact Customer Service.

		What You Will Pay			
Common Medical Event	Services You May Need	In Network (You will pay the least)	Out-of-Network (You will pay the most)	Limitations, Exceptions, & Other Important Information	
	Hospice services	40% coinsurance	Not covered	Prior authorization is required. See www.QuartzBenefits.com/WIPAList or call (800) 362-3310 for additional information. Hospice coverage excludes room and board charges in a Skilled Nursing Facility.	
lfahilal	Children's eye exam	\$25 <u>copay</u> /visit; <u>deductible</u> does not apply	Not covered	none	
If your child needs dental or		Not covered	Limited to one pair of glasses or set of contacts per Benefit Year.		
eye care	Children's dental check-up	No charge; deductible does not apply	Not covered	Dental benefits are administered by Momentum Insurance Plans. For Customer Service, call 1-855-333-3511.	

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.)

- Abortions (except in cases of rape, incest)
 Infertility treatment or when the life of the mother is endangered)
- Bariatric surgery
- Cosmetic surgery

- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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.)
- Acupuncture (Limited) Chiropractic care

- Dental care (Adult)
- Hearing aids

- Routine eye care (Adult)
- Routine foot care (Limited)

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/aboutebsa/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 <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. 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 <u>plan</u> 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

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 <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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 <u>plan's</u> overall <u>deductible</u> \$2,000		
■ Specialist copayment \$50		
■ Hospital (facility) coinsurance 40%		
■ Other coinsurance 40%		
This FXAMPI F event includes services		

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	\$2,000		
Copayments	\$200		
Coinsurance	\$2,600		
What isn't covered			
Limits or exclusions	\$0		
The total Peg would pay is \$4,80			

Managing Joe's type 2 D (a year of routine in-network can controlled condition)	re of a well-			
■ The <u>plan's</u> overall <u>deductible</u>	\$2,000			
■ Specialist copayment	\$50			
■ Hospital (facility) coinsurance	40%			
Other coinsurance	40%			
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	\$0			
Copayments	\$800			
Coinsurance	\$0			
What isn't covered				
Limits or exclusions	\$0			
The total Joe would pay is	\$800			

Mia's Simple Fracti			
follow up care) The plan's overall	#0.000		
deductible	\$2,000		
■ Specialist copayment	\$50		
■ Hospital (facility)	40%		
<u>coinsurance</u>	40 /0		
Other <u>coinsurance</u> This EXAMPLE event include	40%		
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	\$2,000		
Copayments	\$200		
Coinsurance \$1			
What isn't covered			

The total Mia would pay is

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

\$2,300



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.

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 - ເຊີນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍເສຍຄ່າໃຫ້ທ່ານ. ມີເຄືອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍເສຍຄ່າທີເໝາະສົມເພືອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ (800) 362-3310. TTY: 711 / (800) 877-8973 ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

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.

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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."

."أو تحدث إلى مقدم الخدمة 897-877 (800) / 711 . (300) تتبيه: إذا كنت تتحدث اللغة العربية، فستترفر لك خدمات المساعدة اللغوية المجانية. كما نتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجائل. اتصل على الرقم - Arabic

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 निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। । (800) 362-3310. TTY / TDD: 711 / (800) 877-8973 पर कॉल करें या अपने परदाता 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 전화하 거나 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.

Karen - ဆူ– နမ့်ာကတိုး ထာနာ်လီးဖဲအံး အဃိ, တာ်အိဉ်ဒီး ကြိာ်တာ်ဆီဉ်ထွဲမးစုး၊ လ၊တလာ် ဘူဉ်လာ်စူးလ၊နဂ်ီလီး. တာ်အိဉ်ဒီး တာ်မးစုးတာ်နာ်ဟူပီးလီဒီး တာ်မးစုးးတာ်မေး လ၊အ ကြးအဘဉ် လ၊ကဟုဉ်တါကို၊ လ၊တာ်မာနာ်အီးသံ့တဖဉ် လ၊တလာာ်ဘူဉ်လာာ်စူး လ၊နဂ်ီလီး. ကိုး (800) 362-3310. TTY: 711 / (800) 877-8973 မှတမ့်၊ ကတိုးတာ်ဒီး နပုးလ၊ဟုဉ် နူးတာ်ကွာ်ထွဲမှုးစု၊းတက္ခ်ု.

Mon-Khmer, Cambodian (Khmer) - សូមយកចិត្តតទុកដាក់៖ បុរសិនប**៍អុនកនិយាយ ភាសាខុម**រែ សរោកមុមជំនួយភាសាឥតគិតថលគើមានសម្**រាប់អុនក**។ ជំនួយ និងសរោកមុមដលែជាការជួយដ៍សមរមុយ កុន្ទងការផុកល់ព័ត៌មានតាមទម្សង់ដលែអាចចូលបុរ**ី**បុរាស់បាន ក៍អាចរកបានដ**ោយឥតគិតថ្**លផៃងដរែ។ ហ**ៅទូរសពុទទ**ៅ (800) 362-3310. TTY: 711 / (800) 877-8973 ឬនិយាយទ**ៅកាន់អុនក**ផុកល់សវោរបស់អុនក។

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 ยังมีเครื่องมือและบริการช่วยเหลือเพื่อให้ข้อมูลในรูปแบบทีเข้าถึงได้โดยไม่เสียค่าใช้จ่าย โปรดโหรติดต่อ (800) 362-3310. TTY: 711 / (800) 877-8973 หรือปรีกษาผู้ให้บริการของคุณ"

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.

یا اپنے فراہم کنندہ سے بات کریں۔ 897-877 (800) / 711 : TTY بر کال کریں۔ 310-350 (800 توجہ: اگر آپ ار دو بولئے 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۔) - Urdu

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 दिनुहोस्: यदि तपाइँ नेपाली बोल्नुहुन्छ भने, तपाइँलाई निःशुल्क भाषा सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायक सहायताहरू र सेवाहरू पनि निःशुल्क उपलब्ध छन्। कल (800) 362-3310। TTY: 711 / (800) 877-8973 वा आफ्नो प्रदायकसँग 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. ТТҮ: 711 / (800) 877-8973 або зверніться до свого постачальника.

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.