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



9031716 - QUARTZ ONE SILVER I320 VALUE TIER RX DIRECT Coverage Period: 1/1/2024 - 12/31/2024 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 Customer Success: 1-800-362-3310 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	Single: \$2,500 per Benefit Year Family: \$2,500 /individual or \$5,000 /family per Benefit Year	 Generally, you must pay all of the costs from providers 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 <u>deductible</u> ?	Yes. <u>Preventive care</u> services 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 <u>https://www.healthcare.gov/coverage/preventive-care-benefits</u> .
Are there other deductibles for specific services?	Yes. \$2,500 /individual or \$5,000 /family per Benefit Year for prescription expenses. 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. 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> .
What is the <u>out-of-</u> <u>pocket limit</u> for this <u>plan</u> ?	Single: \$9,400 per Benefit Year Family: \$9,400 /individual or \$18,800 /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 <u>out-of-pocket</u>	Premiums, balance billing charges, dental coinsurance, cost-sharing	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

limit?	assistance for your prescriptions, and health care this <u>plan</u> doesn't cover.	
Will you pay less if you use a <u>network</u> <u>provider</u> ?	Yes. See <u>www.QuartzBenefits.com/FindADoct</u> or or call 1-800-362-3310 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</u> 's <u>network</u> . You will pay the most if you use an out-of- <u>network</u> <u>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 <u>referral</u> to see a <u>specialist</u> ?	In- <u>Network providers</u> : No. Out-of- <u>Network providers</u> : Yes, written <u>referral</u> is required.	In- <u>Network</u> : You can see the <u>specialist</u> you choose without a <u>referral</u> . Out-of- <u>Network</u> : 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 <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.

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	Services You May Need	What You Will Pay		
Common Medical Event		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	\$20 <u>copay</u> /visit; <u>deductible</u> does not apply	Not covered	Virtual Visits and Telehealth Visits are covered at no charge. <u>Deductible</u> and/or <u>coinsurance</u> may apply for additional services performed at your visit.
If you visit a health care <u>provider's</u> office or clinic	<u>Specialist</u> visit	\$100 <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. <u>Deductible</u> and/or <u>coinsurance</u> may apply for additional services performed at your visit.
	Other practitioner office visit	Chiro/Non-Routine Adult Vision: \$20 <u>copay</u> /visit; <u>deductible</u> does not apply	Not covered	Benefits are not available for care that is Maintenance and Supportive Care. Routine Adult Vision exams are not covered. <u>Deductible</u> and/or <u>coinsurance</u> may apply for additional services performed at your visit.

		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
	Preventive care/screening/ immunization	No charge; <u>deductible</u> 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 <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
lf you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Lab: \$40 <u>copay</u> /day; <u>deductible</u> does not apply X-Ray: \$100 <u>copay</u> /day; <u>deductible</u> does not apply	Not covered	Prior authorization may be required. See <u>www.QuartzBenefits.com/WIPAList</u> or call (800) 362-3310 for additional information.
	Imaging (CT/PET scans, MRIs)	50% coinsurance	Not covered	Prior authorization may be required. See <u>www.QuartzBenefits.com/WIPAList</u> or call (800) 362-3310 for additional information.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.QuartzBenefi ts.com/formulary	Preferred Generics Tier 1	Value Tier: No charge; <u>deductible</u> does not apply All others: \$35 <u>copay</u> /prescription; <u>deductible</u> does not apply	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> will apply.
	Preferred Brands Tier 2	Value Tier: No charge; <u>deductible</u> does not apply All others: \$150 <u>copay</u> /prescription; <u>deductible</u> does not apply	Not covered	Coverage restrictions may apply to some medications. See the Quartz <u>Formulary</u> for details Manufacturer-funded cost-sharing assistance for your prescriptions will not be credited to your Annual <u>Deductible</u> or Annual Maximum Out-of- Pocket Limit.
	Non-Preferred Brands & Generics Tier 3	50% coinsurance	Not covered	

		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	
	Tier 4	60% coinsurance	Not covered		
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	50% <u>coinsurance</u>	Not covered	Prior authorization may be required. See <u>www.QuartzBenefits.com/WIPAList</u> or call (800) 362-3310 for additional information.	
surgery	Physician/surgeon fees	50% <u>coinsurance</u>	Not covered	Oral Surgery: Not covered	
lf you need	Emergency room care	\$1,250 <u>copay</u> /visit; <u>deductible</u> does not apply	\$1,250 <u>copay</u> /visit; <u>deductible</u> does not apply	Emergency room <u>copay</u> waived if admitted. <u>Deductible/coinsurance</u> does not apply to additional services performed at your visit.	
immediate medical attention	Emergency medical transportation	50% coinsurance	50% coinsurance	none	
	<u>Urgent care</u>	\$100 <u>copay</u> /visit; <u>deductible</u> does not apply	\$100 <u>copay</u> /visit; <u>deductible</u> does not apply	Deductible and/or coinsurance may apply for additional services performed at your visit.	
lf you have a	Facility fee (e.g., hospital room)	50% coinsurance	Not covered	Prior authorization is required. See www.QuartzBenefits.com/WIPAList or call (800)	
hospital stay	Physician/surgeon fees	50% coinsurance	Not covered	362-3310 for additional information.	
If you need mental health, behavioral health, or substance abuse	Outpatient services	\$20 <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. <u>Deductible</u> and/or <u>coinsurance</u> may apply for additional services performed at your visit.	
services	Inpatient services	50% <u>coinsurance</u>	Not covered	Prior authorization is required. See <u>www.QuartzBenefits.com/WIPAList</u> or call (800) 362-3310 for additional information.	
lf you are pregnant	Office visits	PCP: \$20 <u>copay</u> /visit; <u>deductible</u> does not apply <u>Specialist</u> : \$100	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 <u>www.QuartzBenefits.com/WIPAList</u> or call (800) 362-3310 for additional information. <u>Deductible</u> and/or <u>coinsurance</u> may apply 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
		<u>copay</u> /visit; <u>deductible</u> does not apply		additional services performed at your visit.
	Childbirth/delivery professional services	50% coinsurance	Not covered	
	Childbirth/delivery facility services	50% coinsurance	Not covered	
	Home health care	50% <u>coinsurance</u>	Not covered	Coverage is limited to 60 visits per Benefit Year. Prior authorization is required. See <u>www.QuartzBenefits.com/WIPAList</u> or call (800) 362-3310 for additional information.
If you need help recovering or have other special health needs	Rehabilitation services	\$100 <u>copay</u> /visit; <u>deductible</u> does not apply	Not covered	Coverage is limited to 21 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	\$100 <u>copay</u> /visit; <u>deductible</u> does not apply	Not covered	Coverage is limited to 21 visits each for Physical, Speech and Occupational therapy per Benefit Year. Prior authorization may be required. See <u>www.QuartzBenefits.com/WIPAList</u> or call (800) 362-3310 for additional information. A covered Telehealth visit applies the same cost- sharing as an in-person visit. <u>Deductible</u> and/or <u>coinsurance</u> may apply for additional services performed at your visit.

		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
	Skilled nursing care	50% <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 <u>www.QuartzBenefits.com/WIPAList</u> or call (800) 362-3310 for additional information.
	<u>Durable medical</u> equipment	50% <u>coinsurance;</u> <u>deductible</u> does not apply	Not covered	Purchase or rental of DME items may require Prior Authorization. See <u>www.QuartzBenefits.com/WIPAList</u> or call (800) 362-3310 for additional information. Glasses/contacts for Adult Routine Vision are not covered. Coverage for Hearing Aids: Limited to one per ear every 36 months. To obtain the list of covered hearing aid models log onto <u>www.QuartzBenefits.com/hearingaids</u> or contact Customer Success.
	Hospice services	50% <u>coinsurance</u>	Not covered	Prior authorization is required. See <u>www.QuartzBenefits.com/WIPAList</u> or call (800) 362-3310 for additional information. Hospice coverage excludes room and board charges in a Skilled Nursing Facility.
lf your child needs dental or eye care	Children's eye exam	\$20 <u>copay</u> /visit; <u>deductible</u> does not apply	Not covered	none
	Children's glasses	50% <u>coinsurance;</u> <u>deductible</u> 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.)				
Abortions (except in cases of rape, incest	 Dental care (Adult) 	 Private-duty nursing 		
or when the life of the mother is	 Infertility treatment 	 Routine eye care (Adult) 		
endangered)	Long-term care	 Weight loss programs 		
Acupuncture	 Non-emergency care when traveling outside 	de		
Bariatric surgery	the U.S.			
Cosmetic surgery				
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/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.

<u>Minimum Essential Coverage</u> generally includes <u>plans</u>, <u>health insurance</u> available through the <u>Marketplace</u> or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of <u>Minimum Essential Coverage</u>, you may not be eligible for the <u>premium</u> tax credit.

Does this Coverage Meet the Minimum Value Standard? Not Applicable

Language Access Services:

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>	\$2,500			
Specialist copayment	\$100	Ľ		
Hospital (facility) <u>coinsurance</u>	50%			
Other <u>coinsurance</u>	50%			
This EXAMPLE event includes services like: Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood</i> <i>work</i>)				
Specialist visit (anesthesia) Total Example Cost	\$12,700	-		
In this example, Peg would pay:				
Cost Sharing				
Deductibles	\$2,500			
Copayments \$300				
Coinsurance \$3,000				
What isn't covered				
Limits or exclusions \$0				
The total Peg would pay is	\$5,800	-		

Managing Joe's type 2 Diabetes (a year of routine in-network care of a well- controlled condition)				
The <u>plan's</u> overall <u>deductible</u>	\$2,500			
Specialist copayment	\$100			
Hospital (facility) <u>coinsurance</u>	50%			
Other <u>coinsurance</u>	50%			
This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (glucose meter)				
Total Example Cost \$5,600				
In this example, Joe would pay:				
Cost Sharing				
Deductibles \$0				
Copayments \$500				
Coinsurance \$				
What isn't covered				
Limits or exclusions \$0				
The total Joe would pay is \$500				

Mia's Simple Fracture

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

The <u>plan's</u> overall <u>deductible</u>	\$2,500			
Specialist copayment	\$100			
Hospital (facility)	50%			
<u>coinsurance</u>	0070			
Other <u>coinsurance</u>	50%			
This EXAMPLE event include	s			
services like:				
Emergency room care (includin	ng 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	\$1,000			
Copayments \$1,300				
Coinsurance \$10				
What isn't covered				
Limits or exclusions \$				
The total Mia would pay is	\$2,400			

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.

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. ТТҮ: 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 - ເຊັນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມັບລິການຊ່ວຍດ້ານພາສາແບບບໍເສຍຄ່າໃຫ້ທ່ານ. ມໂຄ້ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍເສຍຄ່າທີເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ (800) 362-3310. TTY: 711 / (800) 877-8973 ຫຼື ລົມກັບຜູໃຫ້ບໍລິການຂອງທ່ານ.

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.

QA00172 (0924)

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 مقم الخدمة 877-8978 (800) / 171: TTY: 711 (800) 312-3310. TTY: 71 (المعادة العربية، فستتوفر لك خدمات المعاعدة اللغوية المجانية. كما نتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجائا. 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: यद आप हर्दिी बोलते हैं, तो आपके लए नन्धिलक भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लएि उपयुक्त सहायक साधन और सेवाएँ भी नन्धिलक 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 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.

Amharic - ማሳሰቢያ፦ አማርኛ የሚናንሩ ከሆነ፤ የቋንቋ ድጋፍ አንልማሎት በነፃ ይቀርብልዎታል። መረጃን በተደራሽ ቅርጸት ለማቅረብ ተንቢ የሆኑ ተጨማሪ እንዛዎች እና አንልማሎቶች እንዲሁ በነፃ ይንኛሉ። በስልክ ቁጥር (800) 362-3310. TTY: 711 / (800) 877-8973 ይደውሉ ወይም አንልማሎት አቅራቢዎን ያናማሩ።

Karen - ဆူ– နမ့်၊ကတိၤ ထ၊နာ်လီ၊ဖဲအံၤ အဃိ, တာ်အိဉ်ဒီး ကိုာ်တာ်ဆီဉ်ထွဲမၤစၢၤ လ၊တလာ် ဘူဉ်လာာ်စ္ၤလာနဂ်ီ၊လီၤ. တာ်အိဉ်ဒီး တာ်မၤစၢၤတာ်နာ်ဟူပီးလီဒီး တာ်မၤစၢၤတာ်မၤ လ၊အ ကျ်းအဘဉ် လ၊ကဟ့ဉ်တာ်ဂွာ်တာ်ကိုၤ လ၊တာ်မၤနာ်အီၤသ့တဖဉ် လ၊တလာ်ဘူဉ်လာ်စ္ၤ လ၊နဂ်ီ၊လီၤ. ကိး (800) 362-3310. TTY: 711 / (800) 877-8973 မှတမ္ခ်၊ ကတိၤတာ်ဒီး နပုၤလ၊ဟွဉ် နၤတာက္ခ်ာထွဲမၤစၢၤတက္ခ်၊

Mon-Khmer, Cambodian (Khmer) - សូមយកចិតុតទុកដាក់៖ បុរសិនបា៏អុនកនិយាយ កាសាខុមរ៉េ សវោកមុមងំនួយកាសាឥតគិតផលកើមមានសមុរាប់អុនក។ ងំនួយ និងសវោកមុមដលែងាការជួយដ៍សមរមុយ ក្នុនុងការផុតលំព័ត៌មានតាមទម្សង់ដលែអាចចូលបុរាប៊ីបុរាស់បាន ក៍អាចរកបានដ**ោយឥតគិតផលផែងដរែ។ ហ**ៅទូរសពុទទ**ៅ (800) 362-3310. TTY: 711 / (800) 877-8973** ឬនិយាយទ**ៅកាន់អ**ុនកផុតល់សវោរបស់អុនក។

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 ยังมีเครืองมือและบริการช่วยเหลือเพื่อให้ข้อมูลในรูปแบบทีเข้าถึงได้โดยไม่เสียค่าใช้จ่าย โปรดโหรติดต่อ (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 માહતીિ 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۔ 1718-8973 (800) / 1717 پر کال کریں۔ 360-361 (8000 توجہ: اگر آپ اردو بولٹے ہیں، تو آپ کے لیے مفت زبان کی مدد کی خدمات دستیاب ہیں۔ قابل رسانی 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 दनिहोस्: यद तिपाइँ नेपाली बोल्नुहुन्छ भने, तपाइँलाई नन्धिुल्क भाषा सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायक सहायताहरू र सेवाहरू पन निन्धिुल्क 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.

Tibetan - 式家町間町傍安木之間を放気数で海中省近天の考え数で数で通りたのの通り、前のるあの創業ののスホイに向かったに向かったに向かったすのでのなくますのないなまかでのないますのなくなり、大手のかったものなくないの TTY: 711 / (800) 877-8973 weat のようながないないの ないない ないのういろう しんしょう ひょうしん しゅう しょうしん しゅう しょうしん しゅう しょうしょう しゅう しょうしょう

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.