## Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

This health plan is offered by Quartz Health Plan MN Corporation



9829430 - QUARTZ SELECT BRONZE (VISION) \$8,200 HSA DIRECT

**Coverage Period:** 1/1/2026 - 12/31/2026

Coverage for: Individual/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 <a href="https://www.healthcare.gov/sbc-glossary">www.QuartzBenefits.com/certlookup</a> or call 1-800-362-3310. For general definitions of common terms, such as <a href="mailto:allowed amount">allowed amount</a>, <a href="mailto:belling">belling</a>, <a href="mailto:coinsurance">coinsurance</a>, <a href="mailto:coinsurance">copayment</a>, <a href="mailto:deductible">deductible</a>, <a href="mailto:provider">provider</a>, or other <a href="mailto:underlined">underlined</a> terms see the Glossary. You can view the Glossary at <a href="https://www.healthcare.gov/sbc-glossary">https://www.healthcare.gov/sbc-glossary</a> or call Customer Success: 1-800-362-3310 to request a copy.

| Important Questions   | Answers  | Why this Matters:   |
|---|--|---|
| What is the overall deductible?   | Individual: <b>\$8,200</b> per Benefit Year<br>Family: <b>\$8,200</b> /individual or<br><b>\$16,400</b> /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. Preventive care services are covered before you meet your deductible.   | 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits">https://www.healthcare.gov/coverage/preventive-care-benefits</a> . |
| 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><br><u>pocket limit</u> for this<br><u>plan</u> ? | Individual: <b>\$8,200</b> per Benefit Year Family: <b>\$8,200</b> /individual or <b>\$16,400</b> /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 (unless balance billing is prohibited), and health care this plan doesn't cover.               | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .  |

| Will you pay less if you use a network provider? | Yes.  See <a href="http://quartzbenefits.com/select">http://quartzbenefits.com/select</a> or call 1-800-362-3310 for a list of <a href="network">network</a> 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-Network providers: No. Out-of-Network providers: Yes, written referral 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<br>Medical Event                     | Services You May<br>Need                            | In Network<br>(You will pay the<br>least)  | Out-of-Network<br>(You will pay the<br>most)  | Limitations, Exceptions, & Other Important Information  |  |
| <b>1</b>                                    | Primary care visit to treat an injury or illness    | 0% coinsurance                             | Not covered   | Charges for Virtual Visits will apply to your deductible/coinsurance. A covered Telehealth visit applies the same cost-sharing as an in-person visit.                             |  |
| If you visit a health care                  | th care Specialist visit 0% coinsurance Not covered | Not covered                                | A covered Telehealth visit applies the same cost-<br>sharing as an in-person visit. |   |  |
| offic offic Previous                        | Other practitioner office visit                     | Chiro/Adult Vision: 0% coinsurance         | Not covered   | Benefits are not available for care that is Maintenance and Supportive Care.  |  |
|   | Preventive care/screening/immunization              | No charge;<br>deductible does not<br>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)                 | 0% coinsurance                             | Not covered   | Prior authorization may be required. See <a href="https://www.QuartzBenefits.com/MNPAList">www.QuartzBenefits.com/MNPAList</a> or call (800) 362-3310 for additional information. |  |
| Imaging (CT/PET scans, MRIs) 0% coinsurance |   | Not covered                                | none  |   |  |

| What You Will Pay  |  | u Will Pay                                |  |  |
|--|--|---|--|--|
| Common<br>Medical Event  | Services You May<br>Need                       | In Network<br>(You will pay the<br>least) | Out-of-Network<br>(You will pay the<br>most) | Limitations, Exceptions, & Other Important Information   |
| If you need drugs to treat your  | Generic   Tier 1                               | 0% coinsurance                            | Not covered                                  | Preventive medications are covered without member cost sharing as specified on the formulary.  |
| illness or condition   | Preferred Brand   Tier<br>2                    | 0% coinsurance                            | Not covered                                  | Coverage restrictions may apply to some medications. See the Quartz Formulary for details;   |
| More information about   | Non-Preferred Brand<br>& Generic   Tier 3      | 0% coinsurance                            | Not covered                                  | the <u>formulary</u> is subject to change following quarterly Pharmacy & Therapeutics Committee  |
| prescription drug<br>coverage is<br>available at<br>www.QuartzBenefi<br>ts.com/formulary | Specialty   Tier 4                             | 0% coinsurance                            | Not covered                                  | meetings, or following updates to drug availability (e.g., new generic drugs).  Manufacturer-funded cost-sharing assistance will be credited to your Annual Deductible or Annual Maximum Out-of-Pocket Limit |
| If you have outpatient   | Facility fee (e.g., ambulatory surgery center) | 0% coinsurance                            | Not covered                                  | Prior authorization may be required. See <a href="https://www.QuartzBenefits.com/MNPAList">www.QuartzBenefits.com/MNPAList</a> or call (800) 362-3310 for additional information.                            |
| surgery  | Physician/surgeon fees                         | 0% coinsurance                            | Not covered                                  | Oral Surgery: 0% coinsurance Coverage is limited to procedures listed in your Certificate of Coverage  |
| If you need  | Emergency room care                            | 0% coinsurance                            | 0% coinsurance                               | Foreign <u>claims</u> for emergency care are subject to a \$20,000 limit per Benefit Year.   |
| immediate<br>medical attention   | Emergency medical transportation               | 0% coinsurance                            | 0% coinsurance                               | Foreign <u>claims</u> for emergency care are subject to a \$20,000 limit per Benefit Year.   |
|  | <u>Urgent care</u>                             | 0% coinsurance                            | 0% coinsurance                               | none   |
| If you have a  | Facility fee (e.g., hospital room)             | 0% coinsurance                            | Not covered                                  | Prior authorization is required. See <a href="https://www.QuartzBenefits.com/MNPAList">www.QuartzBenefits.com/MNPAList</a> or call (800)   |
| hospital stay  | Physician/surgeon fees                         | 0% coinsurance                            | Not covered                                  | 362-3310 for additional information.   |
| If you need<br>mental health,<br>behavioral<br>health, or                                | Outpatient services                            | 0% coinsurance                            | Not covered                                  | A covered Telehealth visit applies the same cost-<br>sharing as an in-person visit. However, reduced<br>cost-sharing may apply for visits through the mental<br>well-being program.                          |
| substance abuse services   | Inpatient services                             | 0% coinsurance                            | Not covered                                  | Prior authorization is required. See <a href="https://www.QuartzBenefits.com/MNPAList">www.QuartzBenefits.com/MNPAList</a> or call (800) 362-3310 for additional information.                                |

|  |   | What You Will Pay                          |  |   |
|--|---|--|--|---|
| Common<br>Medical Event  | Services You May<br>Need                  | In Network<br>(You will pay the<br>least)  | Out-of-Network<br>(You will pay the<br>most) | Limitations, Exceptions, & Other Important Information  |
|  | Office visits                             | No charge;<br>deductible does not<br>apply | Not covered                                  | Prenatal care services include education, routine evaluation of the growth & development of the fetus, routine prenatal screenings, and routine   |
| If you are   | Childbirth/delivery professional services | 0% coinsurance                             | Not covered                                  | prenatal care visits. You may be responsible for cost-sharing for other services that are not   |
| pregnant   | Childbirth/delivery facility services     | 0% coinsurance                             | Not covered                                  | considered prenatal care. Prior authorization is required. See <a href="https://www.QuartzBenefits.com/MNPAList">www.QuartzBenefits.com/MNPAList</a> or call (800) 362-3310 for additional information.   |
|  | Home health care                          | 0% coinsurance                             | Not covered                                  | Coverage is limited to 120 visits per Benefit Year. Prior authorization is required. See <a href="https://www.QuartzBenefits.com/MNPAList">www.QuartzBenefits.com/MNPAList</a> or call (800) 362-3310 for additional information.   |
| If you need help<br>recovering or<br>have other<br>special health<br>needs | Rehabilitation<br>services                | 0% coinsurance                             | Not covered                                  | Prior authorization is required after 20 visits per therapy discipline (Physical, Speech, and Occupational therapy and Pulmonary Rehab) per Benefit Year. Cardiac Rehab – Prior authorization is required after 36 visits per Benefit Year. Inpatient Rehab is limited to 60 days per Benefit Year. Post Cochlear Implant Aural Therapy - Prior authorization is required after 30 visits per Benefit Year. A covered Telehealth visit applies the same cost-sharing as an in-person visit. |
|  | Habilitation services                     | 0% coinsurance                             | Not covered                                  | Prior authorization is required after 20 visits per therapy discipline (Physical, Speech, and Occupational therapy and Pulmonary Rehab) per Benefit Year. A covered Telehealth visit applies the same cost-sharing as an in-person visit.   |

|                               | What You Will Pay          |   |  |  |
|-------------------------------|----------------------------|---|--|--|
| Common<br>Medical Event       | Services You May<br>Need   | In Network<br>(You will pay the<br>least) | Out-of-Network<br>(You will pay the<br>most) | Limitations, Exceptions, & Other Important Information   |
|                               | Skilled nursing care       | 0% coinsurance                            | Not covered                                  | Coverage limited to 120 days per confinement. This benefit is combined with the Swing Bed Care benefit. Prior authorization is required. See <a href="https://www.QuartzBenefits.com/MNPAList">www.QuartzBenefits.com/MNPAList</a> or call (800) 362-3310 for additional information.  |
|                               | Durable medical equipment  | 0% 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 <a href="https://www.QuartzBenefits.com/hearingaids">www.QuartzBenefits.com/hearingaids</a> or contact Customer Success. |
|                               | Hospice services           | 0% coinsurance                            | Not covered                                  | Prior authorization is required. See  www.QuartzBenefits.com/MNPAList or call (800)  362-3310 for additional information.  |
|                               | Children's eye exam        | 0% coinsurance                            | Not covered                                  | none   |
| If your child needs dental or | Children's glasses         | 0% coinsurance                            | Not covered                                  | Limited to one pair of glasses or set of contacts per Benefit Year.  |
| eye care                      | 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.)

- Bariatric surgery
- Cosmetic surgery
- · Infertility treatment

Acupuncture (Limited)

- Long-term care
- Non-emergency care when traveling
- outside the U.S.
- Non-<u>formulary</u> drugs without an approved exception
- 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.)

Abortion

- · Chiropractic care
- · Hearing aids

- Routine eye care (Adult)
- · 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: Minnesota Department of Health at 1-800-657-3916 or 651-201-5100, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <a href="www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa">www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa</a>, or contact Quartz at 1-800-362-3310. Other coverage options may be available to you too, including buying individual insurance coverage through the <a href="health Insurance Marketplace">Health Insurance Marketplace</a>. For more information about the <a href="Marketplace">Marketplace</a>, visit <a href="www.mnsure.org">www.mnsure.org</a> or call 1-855-366-7873.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your <a href="plan">plan</a> for a denial of a <a href="claim">claim</a>. This complaint is called a <a href="grievance">grievance</a> or <a href="mappeal">appeal</a>. For more information about your rights, look at the explanation of benefits you will receive for that medical claim</a>. Your plan documents also provide complete information on how to submit a <a href="mailto:claim">claim</a>, <a href="mailto:appeal">appeal</a>, or a <a href="mailto:grievance">grievance</a> for any reason to your

<u>plan</u>. For more information about your rights, this notice, or for assistance, contact: Minnesota Department of Health, Managed Care Section, P.O. Box 64882, St. Paul, Minnesota 55164-0882, 1-800-657-3916 or 651-201-5100. If coverage is under a group health plan, contact the

### Does this Plan Provide Minimum Essential Coverage? Yes.

Employee Benefits Security Administration at 1-866-444-EBSA (3272).

Minimum Essential Coverage 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**

If your <u>plan</u> doesn't meet the <u>Minimum Value Standards</u>, you may be eligible for a <u>premium</u> tax credit to help you pay for a <u>plan</u> through the <u>Marketplace</u>.

#### **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<br>(9 months of in-network pre-natal care and a<br>hospital delivery) |         |  |
|--|---------|--|
| ■ The <u>plan's</u> overall <u>deductible</u>  | \$8,200 |  |
| ■ Specialist coinsurance   | 0%      |  |
| ■ Hospital (facility) coinsurance  | 0%      |  |
| Other coinsurance  | 0%      |  |

## 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                     | \$8,200  |  |
| Copayments                      | \$0      |  |
| Coinsurance                     | \$0      |  |
| What isn't covered              |          |  |
| Limits or exclusions            |          |  |
| The total Peg would pay is      | \$8,200  |  |

| coverage.   |         |  |  |
|---|---------|--|--|
|   |         |  |  |
| 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>   | \$8,200 |  |  |
| ■ Specialist coinsurance  | 0%      |  |  |
| <ul><li>Hospital (facility)<br/>coinsurance</li></ul>   | 0%      |  |  |
| ■ Other <u>coinsurance</u>  | 0%      |  |  |
| This EXAMPLE event includes services like: Primary care physician office visits (including disease education) Diagnostic tests (blood work) |         |  |  |

| \$5,600                         |  |  |
|---------------------------------|--|--|
| In this example, Joe would pay: |  |  |
| Cost Sharing                    |  |  |
| \$5,400                         |  |  |
| \$0                             |  |  |
| \$0                             |  |  |
| What isn't covered              |  |  |
| \$0                             |  |  |
| \$5,400                         |  |  |
|                                 |  |  |

Durable medical equipment (glucose

Prescription drugs

meter)

| <b>Mia's Simple Fracture</b><br>(in-network emergency room visit and<br>follow up care) |    |  |
|---|----|--|
| ■ The <u>plan's</u> overall<br>deductible \$8,200                                       |    |  |
| ■ Specialist coinsurance 0  |    |  |
| <ul><li>Hospital (facility)</li><li>coinsurance</li></ul>                               | 0% |  |
| ■ Other <u>coinsurance</u>  | 0% |  |

# This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

Diagnostic test (x-ray)

Durable medical equipment (crutches)

Rehabilitation services (physical therapy)

| Total Example Cost              | \$2,800 |  |
|---------------------------------|---------|--|
| In this example, Mia would pay: |         |  |
| Cost Sharing                    |         |  |
| Deductibles                     | \$2,800 |  |
| Copayments                      |         |  |
| Coinsurance                     | \$0     |  |
| What isn't covered              |         |  |
| Limits or exclusions \$         |         |  |
| The total Mia would pay is      | \$2,800 |  |

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. TTY: 711 / (800) 877-8973 или обратитесь к своему поставщику услуг.

Vietnamese - LƯU Ý: Neếu bạn nói tieếng Việt, chúng tôi cung caếp mieễn phí các dịch vụ hoễ trợ ngôn ngữ. Các hoễ trợ dịch vụ phù hợp đeể cung caếp thông tin theo các định dạng deễ tieếp cận cũng được cung caếp mieễn phí. Vui lòng gọi theo soế (800) 362-3310. TTY: 711 / (800) 877-8973 hoặc trao đoể i với người cung caếp dịch vụ của bạn.

Laotian – ເຊີນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສິມເພືອໃຫ້ຂຶ້ມນໃນຮູບແບບທີສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ (800) 362–3310. TTY: 711 / (800) 877–8973 ຫຼື ລົມກັບຜູ້ໃຫບໍລິການຂອງທ່ານ.

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 aratis beschikbaar. Bel (800) 362-3310. TTY: 711 / (800) 877-8973 of spreek met je provider."

"أو تحدث إلى مقدم الخدمة 787-8973 (800) 711 : TTY: 711 أيتيبه: إذا كنت تتحدث اللغة العربية، فستتوفى لك خدمات المساحدة اللغوية المجانية. كما تتوفى وسائل مساحدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم (800)

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 - �ान द�: य�द आप �ह� दी बोलते ह�, तो आपके �लए �न:शु� भाषा सहायता सेवाएं उपल� होती ह�। सुलभ प्रारुप� म� जानकारी प्रदान करने के �लए उपयु� सहायक साधन और सेवाएँ भी �न:शु� उपल� ह�।। (800) 362-3310. ▼/ TDD: 711 /

(८००) ८७७-८९७७ पर कॉल कर� या अपने प्रदाता से बात कर�।

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.

Karen – ဆူ– နမ့ာ်ကတိၤ ထာ�ုာ်လီၤဖဲအံၤ အဃိ, တာ်အိဉ်ဒီး ကိျာ်တာ်ဆီဉ်ထွဲမၤစၢၤ လၢတလာ် ဘူဉ်လာာ်စ္၊းလာနဂ်ီးလီၤ. တာ်အိဉ်ဒီး တာ်မ ၤစာၤတာ်န ာ်ဟ ူပီးလီဒီး တာ်မၤစာၤလာမၤ လာအ �ကားအဘဉ် လၢကဟ္ဉ်တာ်ဂ္ ာ်တ ာ်က ျိ်ၤ လာတာမ် ၤန္ရာ်အီၤသဲ့တဖဉ် လာတလာ်ဘူဉ်လာစ္၊ လာနဂ်ီးလီၤ. ကိႏ (800) 362–3310. TTY: 711 / (800) 877–8973 မှတမှာ် ကတိၤတာဒီ် း နပုၤလာဟ္ခဉ် နၤတာ်ကွာ်ထွဲမးစာၤတက္ခာ်.

Mon-Khmer, Cambodian (Khmer) - សូមយកថិតុទុកដក់៖ ្របសិនេៈបរ៉េរួសនិយយភាសាែខុម េសវកម្មង់នួយភាសាឥតគិត់ៃថុស៊ីមានស<sub>្រ</sub>មាប់អុស។ ជំនួយ ន**ិងសេវកម្**មនែលដការជួយដ៍សមរម្យ ស្តេសការជុសព័ត៌មានតាមទ**្រមង់**ែដលអចចូលេ្របីចូបាស់បាន ក៍អចរកបានេះ ដយឥតគិត់ៃថុលង់ែដរ។ េ�ទូរសព្ទេ � (800) 362-3310. TTY: 711 / (800) 877-8973 ឬនិយ ឃេ�កាន**់ អុសផុស េសវ របស់អុស។** 

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 ไหย เรามีบริการความช่วยเหลือด้านภาษาฟรี นอกจากนี้ ยังมีเครื่องมือและบริการช่วยเหลือเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่าย 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 ફોમ�ટમાં માિહતી 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 اینٹر فراہم کنندہ سے بات کریں۔ 873-8773 (800) / TTY: 711 ٹوجہ: اگر آپ ار دو بولٹے ہیں، تو آپ کے لیے مفت زبان کی مدد کی خدمات دستیاب ہیں۔ قابل رسائی فار میٹس معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ 3310-362 پر کال کریں۔ 1878-873

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: Εαάν μιλαάτε ελληνικαά, υπαάρχουν διαθεάσιμες δωρεαάν υπηρεσιάες υποστηάριξης στη συγκεκριμεάνη γλωά σσα. Διατιάθενται δωρεαάν καταάλληλα βοηθηάματα και υπηρεσιάες για παροχηά πληροφοριωά ν σε προσβαάσιμες μορφεάς. Καλεάστε το (800) 362-3310. TTY: 711 / (800) 877-8973 ηά απευθυνθειάτε στον παάροχοά σας.

Nepali - �ान �दनुहोस्: य�द तपाइँ नेपाली बोल्नुहु� भने, तपाइँलाई �नःशु� भाषा सहायता सेवाहरू उपल� छन्। पहुँचयो� ढाँचाहरूमा जानकारी प्रदान गनर् उपयु� सहायक सहायताहरू र सेवाहरू प�न �नःशु� उपल� छन्। क्800) 362-

33101 TTY: ७११ / (८००) ८७७-८९७७ वा आ**क**ो प्रदायकसँग करा गनहींस।

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 - Languis & Caralles & Ca

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.

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