Sentara Health Administration, Inc.

Sentara POS 750/25/15%

City of Chesapeake

Plan Effective Date: 01/01/2027

Large Group Benefit Summary

This document is not a contract or health plan policy from Sentara. If there are any differences between this Benefit Summary and the Plan coverage documents issued when You are enrolled, the provisions of the coverage documents will prevail for all benefits, conditions, cost sharing, and limitations and exclusions.

This document is an overview of Your Covered Services and Your out-of-pocket cost sharing amounts including any Deductibles, Copayment and Coinsurance. There are two benefit columns. One column lists cost sharing amounts You will pay for In-Network benefits from Plan Providers. The other column lists cost sharing amounts You will pay for Out-of-Network benefits from Non-Plan Providers. You or Your means the Subscriber and each family member who is a Covered Person under the Plan.

Details about Covered Services are in the section “What is Covered." Details about services and treatments that are not Covered are in the section “What is Not Covered."

Some benefits require Pre-Authorization before You receive them. These services are marked with an * in this document.

Some Covered Services may have visit limits. Once a visit limit is reached, no additional services are Covered under the benefit. If a service is shown as Covered under Out-of-Network benefits, visit limits are combined with In-Network and Out-of-Network benefits unless otherwise stated.

Services or treatment You receive Out-of-Network or from Non-Plan Providers will be Covered under Your Plan’s Out-of-Network benefits unless:

1. The Covered Service is an Emergency Service or an air ambulance service;
2. During treatment at an In-Network Hospital or other In-Network Facility, You receive Covered Services from a Non-Plan Provider; or
3. We have approved Your Covered Service in advance as an Authorized Out-of-Network Service.

For the services above, Members are only responsible for applicable In-Network Copayments, Coinsurance and Deductibles which will be applied to In-Network Maximum Out-of-Pocket Amounts. Members are protected from balance billing for these services.

If Your Plan has a Deductible, that is the dollar amount that must be paid out-of-pocket by a Member for Covered Services each year before the Plan begins to pay for benefits. Your Plan’s Maximum Out-of-Pocket Amount means the total dollar amount Members pay out-of-pocket for most Covered Services during a year. Deductibles, Copayments and Coinsurance for most Covered Services count toward the Maximum amount. Your Plan may have separate Deductibles for In-Network and Out-of-Network benefits.

Copayments and Coinsurances listed in this document are amounts You pay directly to a Provider for a Covered Service. Copayments are shown as flat dollar amounts. Coinsurance is shown as a percentage of the Plan’s Allowable Charge for Your Covered Service. You will pay a Copayment or Coinsurance, but not both, for a Covered Service. For some benefits You may see the statement, “Cost sharing determined by the type and place of service.” For these services Your cost sharing will be based on where You receive a service, for example in a Physician office

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or inpatient setting, and/or the type of service. You may also have to pay for balance billing amounts that are more than the Plan's Allowable Charge for a Covered Service from Non-Plan Providers.

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Deductible and Maximum Out-of-Pocket Amount (MOOP)		
	In-Network	**Out-of-Network**
Deductible Plan Year	$750/Individual; $1,500/Family	$1,000/Individual; $2,000/Family

The In-Network and Out-of-Network Deductibles are separate. Most amounts You pay for In-Network Covered Services will count toward meeting the In-Network Deductible. Most amounts You pay for Out-of-Network Covered Services will count toward meeting the Out-of-Network Deductible.

The Deductible applies to all Covered Services except for:

- In-Network Preventive Care Services required by law;
- Other services in this document shown as Covered without a Deductible.

If You are the Subscriber, and the only Member Covered under Your Plan, the Individual Deductible amount applies. If You have other family members on Your Plan, the Family Deductible amount applies. The Plan has an embedded Individual Deductible within the Family Deductible. If one family member meets the Individual Deductible, his or her benefits will begin. Once the total family Coverage Deductible is met benefits are available for all family members. No one Member can contribute more than their Individual Deductible amount to the Family Deductible. Copayment or Coinsurance amounts a Member pays for services shown as Covered without a Deductible will not count toward meeting the Individual or Family Deductible.

Any amounts applied to the Plan Deductible(s) during the last three months of the Plan year can be carried forward to the next year.

	In-Network	**Out-of-Network**
Maximum Out-of-Pocket Plan Year	$4,000/Individual; $8,000/Family	$6,500/Individual; $13,000/Family

The In-Network and the Out-of-Network Maximum Out-of-Pocket Amounts are separate. Most amounts You pay, for In-Network Covered Services will count toward meeting the In-Network Maximum. Most amounts You pay, for Covered Services Out-of-Network will count toward meeting the Out-of-Network Maximum.

The following will not count toward any Plan Maximum Amount(s):

- Amounts You pay for services not Covered under Your Plan;
- Amounts You pay for any services after a benefit limit has been reached;
- Balance billing amounts that are more than the Plan's Allowable Charge for a Covered Service from Non-Plan Providers;
- Premium amounts;
- Except for Emergency Services, amounts You pay for Out-of-Network Services
- Copayments, Coinsurance, or Deductibles for Covered Services that are not Essential Health Benefits;
- Other services in this document that are shown as excluded from the Maximum Amount.

If You are the Subscriber, and the only Member Covered under Your Plan, the Individual Maximum applies. If You have other family members on Your Plan, the Family Maximum applies. Under family Coverage, the Individual Maximum applies separately to each Covered family member. Once the total family Coverage Maximum is met, the Family Maximum Amount is satisfied. No one Member can contribute more than their Individual Maximum Amount to the family limit.

Some benefits require Pre-Authorization before You receive them. These services are marked with ***** in the chart.

Benefit	In-Network	Out-of-Network
Physician Office Visits Your Copayment or Coinsurance applies to Covered Services done during an office visit. You will pay an additional Copayment or Coinsurance for outpatient therapies and services, injectable and infused medications, allergy care, testing and serum, outpatient advanced imaging procedures, and sleep studies done during an office visit. Virtual Consults must be provided by approved Plan providers. For mental health or substance use disorders You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Outpatient Office Visits. ***Pre-Authorization is required for in-office surgery.**		
Primary Care Visit	You Pay $25	After Deductible You Pay 40%
Virtual Consult	No Charge	Not Covered
Specialist Visit	You Pay $50	After Deductible You Pay 40%
Vaccines and Immunotherapeutic Agents You are responsible for Coinsurance amount up to a maximum of $250 per dose. This does not include routine immunizations Covered under Preventive Care.	After Deductible You Pay 50%	After Deductible You Pay 50%
Preventive Care Recommended preventive care services are Covered at no cost sharing when received from In-Network Plan Providers. You may still have to pay an office visit Copayment or Coinsurance when You receive preventive care. . Cost sharing, including Deductibles, Copayments or Coinsurances do not apply to Prostate Cancer Screenings received from In-Network or Out-of-Network Providers. Cost sharing including Deductibles, Copayments or Coinsurances does not apply to Diagnostic and Supplemental Breast Examinations to evaluate, detect, or screen for breast cancer when received from In-Network Providers. Some services may be provided under Your prescription drug benefit. Please use the following link for a complete list of Covered preventive care services: healthcare.gov/what-are-my-preventive-care-benefits.		
Recommended exams, screenings, tests, immunizations, and other services	No Charge	After Deductible You Pay 40%
Prostate Cancer Screenings	No Charge	After Deductible You Pay 40%
Diagnostic and Supplemental Breast Examinations*	No Charge	After Deductible You Pay 40%
Outpatient Therapies and Services You pay a Copayment or Coinsurance amount for each visit at a Physician's office, a free-standing outpatient Facility, a Hospital outpatient Facility, or at home. Visit limits do not apply to outpatient habilitative or rehabilitative therapy services if You get that care as part of the Hospice or Early Intervention benefit, or as part of a treatment plan for Autism Spectrum Disorder. Visit limits do not apply to outpatient or home health habilitative or rehabilitative therapy services for mental health conditions or substance use disorders. For Mental Health conditions or Substance Use Disorders You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Other Outpatient Services.		
Occupational and Physical Therapy* Services limited to 30 combined visits per Plan year.	After Deductible You Pay 15%	After Deductible You Pay 40%

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

Benefit	In-Network	Out-of-Network
Speech Therapy* Services limited to 30 visits per Plan year.	After Deductible You Pay 15%	After Deductible You Pay 40%
Cardiac Rehabilitation* Services limited to 30 visits per Plan year.	After Deductible You Pay 15%	After Deductible You Pay 40%
Pulmonary Rehabilitation* Services limited to 30 visits per Plan year.	After Deductible You Pay 15%	After Deductible You Pay 40%
Vascular Rehabilitation* Services limited to 30 visits per Plan year.	After Deductible You Pay 15%	After Deductible You Pay 40%
Vestibular Rehabilitation* Services limited to 30 visits per Plan year.	After Deductible You Pay 15%	After Deductible You Pay 40%
IV Infusion Therapy	**PCP Office Visit** You Pay $25 **Specialist Office Visit** You Pay $50 **Outpatient Facility** After Deductible You Pay 15%	After Deductible You Pay 40%
Respiratory/Inhalation Therapy	**PCP Office Visit** You Pay $25 **Specialist Office Visit** You Pay $50 **Outpatient Facility** After Deductible You Pay 15%	After Deductible You Pay 40%
Chemotherapy and Chemotherapy Drugs*	**PCP Office Visit** You Pay $25 **Specialist Office Visit** You Pay $50 **Outpatient Facility** After Deductible You Pay 15%	After Deductible You Pay 40%
Wigs Reimbursement for wigs in conjunction with chemotherapy	After Deductible Coverage is limited to a maximum benefit of $250 once every 12 months	After Deductible Coverage is limited to a maximum benefit of $250 once every 12 months

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

Benefit	In-Network	Out-of-Network
Radiation Therapy*	**PCP Office Visit** You Pay $25 **Specialist Office Visit** You Pay $50 **Outpatient Facility** After Deductible You Pay 15%	After Deductible You Pay 40%
Pre-Authorized Injectable and Infused Medications* Includes injectable and infused medications, biologics, and IV therapy medications that require Pre-Authorization. Office visit, outpatient Facility, or home health Copayment or Coinsurance will also apply. Does not apply to Chemotherapy Drugs.	After Deductible You Pay 15%	After Deductible You Pay 40%
Outpatient Dialysis You Pay a Copayment or Coinsurance for each visit at any place of service. Coverage also includes home dialysis equipment and supplies.		
Dialysis Services	After Deductible You Pay 15%	After Deductible You Pay 40%
Outpatient Surgery You pay a Copayment or Coinsurance for services provided in a free-standing ambulatory surgery center or Hospital outpatient surgical Facility.		
Surgery Services*	After Deductible You Pay 15%	After Deductible You Pay 40%
Outpatient Lab, Diagnostic, Imaging and Testing You pay a Copayment or Coinsurance for services done in a free-standing outpatient Facility or lab or a Hospital outpatient Facility or lab. For mental health conditions or substance use disorders You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Other Outpatient Services.		
Diagnostic Procedures	After Deductible You Pay 15%	After Deductible You Pay 40%
X-Ray **Ultrasound** **Doppler Studies**	After Deductible You Pay 15%	After Deductible You Pay 40%
Lab Work	After Deductible You Pay 15%	After Deductible You Pay 40%

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

Benefit	In-Network	Out-of-Network
Outpatient Advanced Imaging, Testing and Scans You pay a Copayment or Coinsurance for services done in a Physician's office, a freestanding outpatient Facility or a Hospital outpatient Facility or lab. For mental health conditions or substance use disorders You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Other Outpatient Services.		
Magnetic Resonance Imaging (MRI)* **Magnetic Resonance Angiography (MRA)*** **Positron Emission Tomography (PET)*** **Computerized Axial Tomography (CT)*** **Computerized Axial Tomography Angiogram (CTA)*** **Magnetic Resonance Spectroscopy (MRS)** **Single Photon Emission Computed Tomography (SPECT)** **Nuclear Cardiology** **Sleep Studies**	After Deductible You Pay 15%	After Deductible You Pay 40%
Maternity Care Includes prenatal care, delivery, and postpartum care and services, and home health visits. You must also pay Your Inpatient Hospital Copayment or Coinsurance. Recommended preventive care services and screenings are Covered under preventive benefits.		
Maternity Care	You Pay $350 Global Copayment for delivering Obstetrician prenatal, delivery, and postpartum services	After Deductible You Pay 40%
Inpatient Services		
Inpatient Hospital Services*	After Deductible You Pay 15%	After Deductible You Pay 40%
Transplants*	After Deductible You Pay 15%	After Deductible You Pay 40%
Skilled Nursing Facility Services* Limited to a maximum of 90 days per Plan year.	After Deductible You Pay 15%	After Deductible You Pay 40%
Non-Emergent Ambulance Services Includes non-Emergency transportation that is Medically Necessary and Pre-Authorized. You pay a Copayment or Coinsurance per transport each way. For mental health conditions or substance use disorders You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services.		
Water and Ground Services Non-Emergent Transportation*	After Deductible You Pay $100	After Deductible You Pay 40%
Air Ambulance Services Non-Emergent Transportation*	After Deductible You Pay $100	After Deductible You Pay $100

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

Benefit	In-Network	Out-of-Network
Emergency Services Includes medical Emergency Services, Physician services, Advanced Diagnostic Imaging, such as MRIs and CT scans, other Facility charges, such as diagnostic x-ray and lab services and medical supplies provided in an Emergency Department, including an independent freestanding Emergency Department, In-Network or Out-of-Network.		
Emergency Services	After Deductible You Pay 15%	After Deductible You Pay $15%
Emergency Ambulance	After Deductible You Pay $100	After Deductible You Pay $100
Urgent Care Services Includes Urgent Care Services, Physician services, and other ancillary services received at an Urgent Care Facility. If You are transferred to an Emergency Department from an Urgent Care Center, You will pay the Emergency Services Copayment or Coinsurance. For mental health conditions or substance use disorders You will pay the Copayment or Coinsurance listed under Mental Health and Substance Use Disorder Services Other Outpatient Services.		
Urgent Care Services	You Pay $50	After Deductible You Pay 40%
Mental Health and Substance Use Disorder Services Includes inpatient and outpatient services for the treatment of mental health and substance use disorders. Virtual Consults must be furnished by approved Plan providers. ***Pre-Authorization is required for Inpatient Hospital Services, partial hospitalization services, intensive outpatient program (IOP) services, Transcranial Magnetic Stimulation (TMS), and electro-convulsive therapy.**		
Emergency Ambulance	After Deductible You Pay 15%	After Deductible You Pay 15%
Emergency Services	After Deductible You Pay 15%	After Deductible You Pay 15%
Inpatient Hospital Services*	After Deductible You Pay 15%	After Deductible You Pay 40%
Residential Treatment Services*	After Deductible You Pay 15%	After Deductible You Pay 40%
Outpatient Office Visits (PCP and Specialist)	You Pay $25	After Deductible You Pay 40%
Outpatient Office Visits (Virtual Consult)	You Pay $25	Not Covered
Partial Hospitalization/Intensive Outpatient Program Facility Services*	After Deductible You Pay 15%	After Deductible You Pay 40%
Other Outpatient Services*	After Deductible You Pay 15%	After Deductible You Pay 40%
Autism Spectrum Disorder*	Cost sharing determined by the type and place of service.	Cost sharing determined by the type and place of service.
Mental Health and Substance Use Disorder Services Non-Emergent Ambulance Services Includes non-Emergency transportation that is Medically Necessary and Pre-Authorized. You pay a Copayment or Coinsurance per transport each way.		
Water and Ground Services Non-Emergent Transportation*	After Deductible You Pay $100	After Deductible You Pay 40%
Air Ambulance Services Non-Emergent Transportation*	After Deductible You Pay $100	After Deductible You Pay $100

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Benefit	In-Network	Out-of-Network
Diabetes Treatment Includes supplies, equipment, and education. An annual diabetic eye exam is Covered from an In-Network Plan Provider or a participating Vision Services Plan (VSP) provider at the office visit Copayment or Coinsurance amount.		
Insulin Pumps, Pump Infusion Sets and Supplies*	No Charge	After Deductible You Pay 40%
Equipment and Supplies Includes test strips, lancets, lancet devices, Home Blood Glucose Meters/Monitors and control solution, and Continuous Blood Glucose Monitors, sensors, and supplies. ***Pre-Authorization is required for Continuous Blood Glucose Monitors, sensors, and supplies**	No Charge	After Deductible You Pay 40%
Insulin, and Needles and Syringes for Injection	Covered under the Plan's Prescription Drug Benefit	Covered under the Plan's Prescription Drug Benefit
Outpatient Self-Management Training, Education, Nutritional Therapy	No Charge	After Deductible You Pay 40%
Prosthetic Limb Replacement		
Prosthetic Devices and Components, repair, fitting, replacement, adjustment*	After Deductible You Pay 30%	After Deductible You Pay 40%
Durable Medical Equipment (DME) and Supplies		
DME, Orthopedic Devices, Prosthetic Appliances, Devices*	After Deductible You Pay 30%	After Deductible You Pay 40%
Early Intervention Services For Dependent children from birth to age three.		
Speech and language therapy, Occupational therapy, Physical therapy, Assistive technology services and devices*	Cost sharing determined by the type and place of service.	Cost sharing determined by the type and place of service.
Home Health Care Includes skilled home health care services. You will also pay a separate Copayment or Coinsurance for therapies and infused medications received at home. Visit limits do not apply to outpatient habilitative or rehabilitative therapy services for mental health conditions and substance use disorders.		
Home Health Care* Limited to a maximum of 100 visits per Plan year.	You Pay $25	After Deductible You Pay 40%
Hospice Care		
Hospice Care*	After Deductible No Charge	After Deductible You Pay 40%

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

Benefit	In-Network	Out-of-Network
Vision Care The Plan contracts with Vision Services Plan (VSP) to administer this benefit. Services must be received from VSP providers.		
Vision Exams Limited to one routine eye exam every 12 months from a participating VSP provider.	No Charge	Members will be reimbursed up to $30 for one routine eye exam only
Chiropractic Care The Plan Contracts with American Specialty Health Group (ASH) to administer this benefit. Services include therapy to treat problems of the bones, joints, and back. Services must be received from ASH providers.		
Chiropractic Care Maximum number of visits 20 per Plan year. This benefit also includes Coverage of Chiropractic appliances up to a maximum benefit of 1 appliance per Person per Plan year when medically necessary.	After Deductible You Pay $20	After Deductible You Pay 40%
Reconstructive Breast Surgery Includes Covered Services for Members who have had a mastectomy.		
Surgery and Reconstruction* **Prostheses*** **Physical Complications*** **Lymphedema***	Cost sharing determined by the type and place of service.	Cost sharing determined by the type and place of service.
Clinical Trials Includes “routine patient costs” for a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition.		
Clinical Trial Services*	Cost sharing determined by the type and place of service.	Cost sharing determined by the type and place of service.
Allergy Care		
Allergy Care, Testing, and Serum	Cost sharing determined by the type and place of service.	Cost sharing determined by the type and place of service.
Telemedicine Services Includes the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment. Your out-of-pocket Deductible, Copayment, or Coinsurance amounts will not exceed the Deductible, Copayment or Coinsurance amount You would have paid if the same services were provided through face-to-face diagnosis, consultation, or treatment.		
Telemedicine Services	Cost sharing determined by the type and place of service.	Cost sharing determined by the type and place of service.
Hearing Aid Rider		

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

Benefit	In-Network	Out-of-Network
Hearing Aid Services* Covered Services include the following up to the annual maximum benefit of $2,500 per ear: • the hearing aid(s); • audiometric specialist office visits for fitting, including molds and dispensing; • repair, replacement or refurbishment of the hearing aid(s) Replacement is covered only every 36 months from date of acquisition. Batteries and supplies are not covered.	After Deductible You Pay $50	After Deductible You Pay 40%

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

Notice/Notes/Terms & Conditions:

Dependent Children enrolled in the Plan are Covered until the end of month they turn 26.

This Plan does not have pre-existing condition exclusions.

This Plan does not have annual or lifetime dollar limits on Essential Health Benefits.

This is a group plan sponsored by Your employer. Your employer will pay the premium to us on Your behalf. Your employer will tell You how much You must contribute, if any, to the premium.

Availability of Language Assistance Services and Auxiliary Aids and Services

Amharic:
ትኩረት፡- አማርኛ የሚናገሩ ከሆነ፣ የነጻ ቋንቋ ድጋፍ አገልግሎቶች ይኖሩዎታል። መረጃን በተደራሽ ቅረጸዎች ለማቅረብ አግባብ የሆኑ ተስማሚ ረዳት እና አገልግሎቶች በነጻ ይገኛሉ። በ 1-855-687-6260 (TTY: 711) ይደውሉ ወይም አቅራቢዎን ያነጋግሩ።

Arabic:

تنبيه: إذا كنت تتحدث اللغة العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر خدمات ومساعدات إضافية مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على 1-855-687-6260 (الهاتف النصي: 711) أو تحدث إلى مقدم الخدمة الخاص بك."

Bengali/Bangla:

বিঃদ্রঃ আপনি যদি বাংলা ভাষায় কথা বলেন, তবে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবা উপলব্ধ। তথ্য সহজে বোঝার উপযোগী ফরম্যাটে দেওয়ার জন্য প্রয়োজনীয় সহায়ক উপকরণ এবং পরিষেবাও বিনামূল্যে প্রদান করা হয়। কল করুন 1-855-687-6260 (TTY: 711)-তে অথবা আপনার পরিষেবা প্রদানকারীর সঙ্গে কথা বলুন।"

Chinese (Mandarin):

注意：如果您说普通话，我们可为您提供免费的语言协助服务。我们还免费提供适当的辅助工具和服务，确保您可以无障碍获取信息。请拨打 1-855-687-6260（文本电话服务：711），或与您的服务提供商联系。

French:

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ATTENTION : Si vous parlez français, des services d'assistance linguistique gratuits sont mis à votre disposition. Des aides et des services auxiliaires appropriés destinés à fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-855-687-6260 (TTY : 711) ou adressez-vous à votre prestataire. »

French Creole/Haitian Creole:

ATANSYON: Si w pale kreyòl Ayisyen, ou gen sèvis asistans lengwistik gratis ki disponib pou ou. Gen èd ak sèvis oksilyè apwopriye pou bay enfòmasyon nan fòma aksesib ki disponib gratis egalman. Rele 1-855-687-6260 (TTY: 711) oubyen pale ak founisè swen sante w la.

German:

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Unterstützungsdienste in Ihrer Sprache zur Verfügung. Entsprechende zusätzliche Hilfsmittel und Dienste, um Informationen in zugänglichen Formaten bereitzustellen, sind ebenfalls kostenlos verfügbar. Rufen Sie uns an unter 1-855-687-6260 (TTY: 711) oder sprechen Sie mit Ihrem Anbieter."

Gujarati:

ધ્યાન આપો: જો તમે ગુજરાતી બોલો છો, તો તમને મફત ભાષા સહાય સેવાઓ ઉપલબ્ધ કરાવવામાં છે. સુલભ ફોર્મેટમાં માહિતી પૂરી પાડવા માટે યોગ્ય સહાયક સહાય અને સેવાઓ પણ મફતમાં ઉપલબ્ધ કરાવવામાં આવે છે. 1-855-687-6260 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો."

Hindi:

ध्यान दें: यदि आप हिन्दी बोलते हैं तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध हैं। सुलभ प्रारूप में सूचना उपलब्ध कराने के लिए उपयुक्त सहायक साधन और सेवाएं भी निःशुल्क उपलब्ध हैं। 1-855-687-6260 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।"

Hmong:

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LUS TSEEM CEEB: Yog koj hais lus Hmoob, yuav muaj cov kev pab los muab kev pab txhais lus dawb rau koj. Tsis tas li ntawd, kuj tseem muaj cov kev pab thiab cov kev pab cuam uas tsim nyog los muab cov ntaub ntawv ua cov qauv nkag siv tau pub dawb thiab. Hu rau 1-855-687-6260 (TTY: 711) los sis tham nrog koj tus kws kho mob.

Igbo:

GEE NTỊ: Ọ bụrụ na ị na-asụ asụsụ Igbo, e nwere ọrụ enyemaka asụsụ n'efu dị maka gị. Ngwaọrụ na ọrụ enyemaka kwekọrọ ekwekọ iji nye ozi n'ụdị ndị mmadụ nwere ike iji rụọ ọrụ dịkwa n'efu. Kpọọ 1-855-687-6260 (TTY:711) ma ọ bụ kwuoro onye na-enye gị ọrụ."

Italian:

ATTENZIONE: Se parla italiano, sono per Lei disponibili servizi di assistenza linguistica gratuiti. Sono, inoltre, disponibili gratuitamente strumenti e servizi ausiliari appropriati per fornire informazioni in formati accessibili. Chiami il numero 1-855-687-6260 (TTY: 711) o consulti il Suo fornitore".

Japanese:

ご注意：日本語を話される場合、無料の言語支援サービスをご利用いただけます。接近可能な形式の情報を提供するための適切な補助器具やサービスも無料でご利用いただけます。1-855-687-6260（テキスト電話（TTY）: 711）番までお電話いただくか、ご担当のプロバイダーにお問い合わせください。

Korean:

중요 안내: 한국어를 구사할 시 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하기 위한 적절한 보조 수단 및 서비스도 무료로 제공됩니다. 1-855-687-6260번(중계 통화: 711)으로 전화하거나 제공자에게 알리십시오."

Kru/Bassa:

DYÉĐÉ-GBO-DÈ-ĐÈ: Ɔ jǔ ké m̀ dyi B̌ásɔ́ɔ̀-wùɖù po-nyɔ̀ jǔìn, wuɖu-xwíníín-mú-zà-zà ɓě se wíɖí péè-péè ɖò kɔ̃ɛ nì ɓó m̀ bìì. Hwòɖǒ-fɔ́nɔ́-nyɔ́ kè nyɔ-bɔ̃ǔn-po-kà ɓě ɓé nyuɛɛ se wíɖí péè-péè ɖò kɔ̃. 1-855-687-6260 (TTY: 711) Ɔ ɖà mɔ̀ɔ̀ wùɖù gbo nyɔ-kpò nyí."

Laotian:
ຄວນເອົາໃຈໃສ່: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ມີບໍລິການຊ່ວຍເຫຼືອທາງດ້ານພາສາຟຣີໃຫ້ກັບທ່ານ.
ນອກຈາກນີ້ຍັງມີບໍລິການຊ່ວຍເຫຼືອເພີ່ມຕື່ມທີ່ເໝາະສົມໃນການໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ເຂົ້າເຖິງໄດ້ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ.
ໂທ 1-855-687-6260 (TTY: 711) ຫຼື ເວົ້າກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

Mon-Khmer, Cambodian:

ការយកចិត្តទុកដាក់៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ
សេវាកម្មជំនួយភាសាគឺមានសម្រាប់អ្នកដោយឥតគិតថ្លៃ។ ជំនួយ
និងសេវាកម្មជំនួយសមស្របដើម្បីផ្តល់ព័ត៌មានក្នុងទម្រង់ដែលអាចចូលប្រើបានក៏មានដោយឥតគិត
ថ្លៃផងដែរ។ សូមទូរស័ព្ទទៅលេខ 1-855-687-6260 (ទូរលេខ: 711)
ឬទាក់ទងទៅកាន់អ្នកផ្តល់សេវាកម្មរបស់អ្នក។

Pennsylvania Dutch:
Uffbassa: Wann du Pennsylvaanisch Deitsch schwetzscht, sinn Hilf mit die Schprooch fer nix zu hawe. Aagmässiche Hilfsmittel un Hilfsdienscht fer Auskunft in e leichter verstaendlicher Gstalt sinn aach fer nix zu hawe. Ruf 1-855-687-6260 (TTY: 711) odder schwetz mit dei Versorger

Navajo:

NÁÁNÍZIN: Diné bizaad yiníł't'éego, t'áá jíík'eh saad bee áká anilyeedígíí t'áá hadoohkáát nihá. T'áá jíík'ehgo bee áká anídaaltsoozígíí át'égo bee haz'ání dóó áká aná'álwo'ígíí t'áá jíík'ehgo doo biniiyé łahgo ájíltsooz doo. Jooba' 1-855-687-6260 (TTY: 711) doo nihá bee áłchíní nínízingo bína'nitinígíí bich'į' ákót'é.

Persian/Farsi:

توجه: اگر فارسی صحبت می‌کنید، خدمات کمک زبانی رایگان برای شما موجود است. کمک‌ها و خدمات کمکی مناسب برای ارائه اطلاعات در قالب‌های قابل‌دسترس نیز به صورت رایگان موجود است. با شماره 1-855-687-6260 (TTY: 711) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید."

Polish:

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.

UWAGA: Jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Odpowiednie pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-855-687-6260 (TTY: 711) lub porozmawiaj ze swoim dostawcą."

Portuguese:
ATENÇÃO: Se você fala português, estão disponíveis serviços gratuitos de assistência linguística. Auxílios e serviços apropriados para fornecer informações em formatos acessíveis também são oferecidos sem custo. Ligue para 1-855-687-6260 (TTY: 711) ou fale com seu prestador."

Russian:

ВНИМАНИЕ! Если вы говорите по-русски, вам доступны бесплатные услуги языковой поддержки. Также бесплатно предоставляются необходимые вспомогательные средства и услуги для получения информации в доступных форматах. Позвоните по номеру 1-855-687-6260 (TTY: 711) или обратитесь к своему поставщику услуг.

Spanish:

ATENCIÓN: Si habla en español, se encuentran disponibles servicios gratuitos de asistencia lingüística para usted. También hay disponibles servicios y ayudas auxiliares adecuados para brindar información en formatos accesibles sin cargo. Llame al 1-855-687-6260 (TTY: 711) o hable con su proveedor.

Tagalog:

PAUNAWA: Kung nagsasalita ka ng Tagalog, may available na libreng serbisyo ng tulong sa wika para sa iyo. Available din nang libre ang mga angkop na pantulong na kagamitan at serbisyo para magbigay ng impormasyon sa mga accessible na format. Tumawag sa 1-855-687-6260 (TTY: 711) o kausapin ang iyong provider."

Thai:

หมายเหตุ: หากคุณพูดภาษาไทย เรามีบริการช่วยเหลือด้านภาษาให้กับคุณฟรี
มีความช่วยเหลือและบริการที่เหมาะสมเพื่อให้ได้รับข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่มีค่าใช้จ่าย โทร 1-855-687-6260 (TTY: 711) หรือสอบถามเพิ่มเติมกับผู้ให้บริการของคุณ”

Urdu:

توجه فرمایئے: اگر آپ اردو بولتے ہیں تو آپ کے لیے مفت زبان میں مدد فراہم کی جا سکتی ہے۔ معلومات کو قابلِ رسائی شکل میں فراہم کرنے کے لیے موزوں معاون سہولیات اور خدمات بھی بلا معاوضہ دستیاب ہیں۔ 1-855-687-6260 پر کال کریں (TTY: 711) یا اپنے فراہم کنندہ سے بات کریں۔"

Vietnamese:

CHÚ Ý: Nếu quý vị nói Tiếng Việt, dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn dành cho quý vị. Chúng tôi cũng cung cấp miễn phí các phương tiện và dịch vụ hỗ trợ phù hợp nhằm cung cấp thông tin bằng các định dạng dễ tiếp cận. Hãy gọi 1-855-687-6260 (TTY: 711) hoặc trò chuyện với nhà cung cấp dịch vụ của quý vị.

Yoruba:

ÀKÍYÈSÍ: Ti o bá ń sọ èdè Yorùbá, iṣẹ́ ìrànlọ́wọ́ èdè wà fún ọ lọ́fẹ̀ẹ́. Àwọn irin iṣẹ́ àti iṣẹ́ ìrànlọ́wọ́ tí ó yẹ láti pèsè àlàyé ní àwọn ọ̀nà tí ọwọ́ ká wà ní àrọ́wọ́tó lọ́fẹ̀ẹ́ bákan náà. Pe 1-855-687-6260 (TTY: 711) tàbí kí o bá olùpèsè rẹ sọ̀rọ̀."

Some benefits require Pre-Authorization before You receive them. These services are marked with * in the chart.