2026 Summary of Benefits

Medicare Advantage PPO Plans

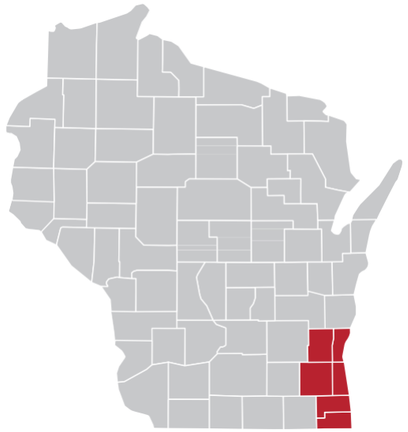
Southeast Wisconsin

2026 NETWORK HEALTH SOUTHEAST WISCONSIN (PPO)

SERVICE AREA AND ELIGIBILITY

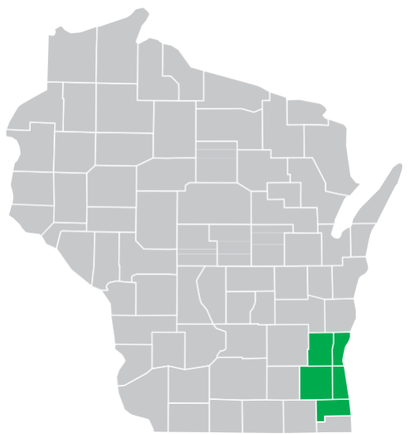
To be eligible to join the Network Health Southeast Wisconsin PPO plans described in this booklet, you must be enrolled in Medicare Part A and Part B and live in the service area.

This Summary of Benefits applies to the Network Health PPO plans and Southeast Wisconsin counties that are listed within each of the two map keys below.



Network Health Anywhere
Network Health Bravo

Kenosha, Milwaukee, Ozaukee, Racine, Washington, Waukesha



Network Health Go

Milwaukee, Ozaukee, Racine, Washington, Waukesha

SUMMARY OF BENEFITS

WHAT IS A SUMMARY OF BENEFITS?

This booklet gives you a summary of what we cover and what you pay on Network Health's Southeast Wisconsin PPO plans. It doesn't list every service we cover or every limitation or exclusion. A complete list of services can be found in the plan-specific *Evidence of Coverage* at **networkhealth.com/medicare/plan-materials**. Contact the member experience team for a printed copy.

WHAT IS A PREFERRED PROVIDER (PPO) PLAN?

A PPO plan allows you to **choose any doctor who accepts Medicare beneficiaries.** Doctors and other providers are divided into in-network or out-of-network based on if they have a contract with Network Health. With a PPO plan you can use both in- and out-of-network doctors.

CONTACT NETWORK HEALTH

By Phone	Sales Team – **800-983-7587** Member Experience Team – **800-378-5234** TTY/TDD Users – **711**
Online	**networkhealth.com**
By Mail or In Person	**Network Health** **1570 Midway Pl.** **Menasha, WI 54952** **Network Health** **16960 W. Greenfield Ave., Suite 5** **Brookfield, WI 53005**
Hours of Operation	• Normal office hours are Monday–Friday, 8 a.m. to 5 p.m. • Network Health is closed on New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, the day after Thanksgiving, Christmas Eve Day and Christmas Day. • From October 1–March 31, you can call the sales team and the member experience team seven days a week from 8 a.m. to 8 p.m., Central Time. From April 1–September 30, we are available Monday–Friday, from 8 a.m. to 8 p.m., Central Time.
Additional Resources	**Medicare – Available 24 hours a day, seven days a week** For coverage and costs of Original Medicare, look in your current *"Medicare & You"* handbook. View it online at medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227) (TTY 1-877-486-2048), 24 hours a day, seven days a week.

2026 NETWORK HEALTH SOUTHEAST WISCONSIN (PPO)

Your Costs	Network Health Go (Includes pharmacy) Please see county listing for service area.	
	In-Network	Out-of-Network
Monthly Premium	$0	
Monthly Part B Premium Giveback[2] You must meet all eligibility requirements to receive the Medicare Part B Premium Giveback	Not included	
Annual Medical Deductible	$0	
Annual Medical Maximum Out-of-Pocket	$4,500	$7,400 combined in- and out-of-network
Hospital Services		
Inpatient Hospital Services[1] Per admission	$295 per day, days 1 - 6 $0 days 7 and beyond	$800 per day, days 1 - 7 $0 days 8 and beyond
Outpatient Hospital Services[1]	$275	$550
Ambulatory Surgical Center[1]	$225	$450
General Services		
Primary Care Provider Visit	$0	$30
Specialist Visit	$50	$100
Preventive Care		
Preventive Care Visits*	$0	$15
Annual Medicare Wellness Visit	$0	$15
Annual Routine Physical	$0	$15
Physician Telehealth Services	Virtual primary care and urgent care services cost the same as an in-person visit.	
Medicare-Covered Vaccines Flu, pneumonia, COVID-19	$0	$0
Medicare-Covered Vaccines Hepatitis B[1], all other Part B	$0	$15
Emergency Care		
Emergency Room Visit Copayment is waived if admitted to a U.S. hospital within 24 hours	$130	$130
Urgent Care		
Urgent Care Visit Free-standing facility	$50	$50
Diagnostic Services		
Diagnostic Tests[1] Such as ultrasound, EKG, stress test	$35	$70

*Includes abdominal aortic aneurysm screening, alcohol misuse screening and counseling, annual wellness visit, bone mass measurement, breast cancer screening, cardiovascular disease screening, cardiovascular disease risk reduction visit, cervical and vaginal cancer screening, colorectal cancer screening (screening colonoscopy, fecal occult blood test, flexible sigmoidoscopy), depression screening, diabetes screening, glaucoma screening, HIV screening, lung cancer screening, medical nutrition therapy services, Medicare Diabetes Prevention Program, obesity screening and therapy, prostate cancer screening, screening for sexually transmitted infections and counseling, smoking and tobacco use cessation counseling, one time Welcome to Medicare preventive visit.

SUMMARY OF BENEFITS

Network Health Anywhere (Includes pharmacy) Please see county listing for service area.	Network Health Bravo (Excludes pharmacy) Please see county listing for service area.	
YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS	In-Network	Out-of-Network
$0	$0	
$21 per month	$15 per month	
$0	$0	
$4,500 combined in- and out-of-network	$4,500	$8,000 combined in- and out-of-network
Hospital Services		
$275 per day, days 1 - 6 $0 days 7 and beyond	$295 per day, days 1 - 6 $0 days 7 and beyond	$550 per day, days 1 - 6 $0 days 7 and beyond
$260	$275	$450
$185	$225	$450
General Services		
$0	$0	$30
$45	$40	$75
Preventive Care		
$0	$0	$15
$0	$0	$15
$0	$0	$15
Virtual primary care and urgent care services cost the same as an in-person visit.	Virtual primary care and urgent care services cost the same as an in-person visit.	
$0	$0	$0
$0	$0	$15
Emergency Care		
$130	$130	$130
Urgent Care		
$45	$45	$45
Diagnostic Services		
$90	$20	$50

[1]Service may require prior authorization.
[2]Visit **networkhealth.com/medicare/extra-benefits** for more information, this is not a medical benefit.

2026 NETWORK HEALTH SOUTHEAST WISCONSIN (PPO)

Your Costs	Network Health Go (Includes pharmacy) Please see county listing for service area.	
	In-Network	**Out-of-Network**
Labs What you pay may be based on the service received and/or where you are treated	$0 or $20	$40
Diagnostic Radiology Services[1] Advanced Imaging (PET, CAT, MRI, MRA, NUC Scans)	$275	$550
X-rays	$35	$70
Hearing Services		
Routine Hearing Exam[2]	$0	$40
Diagnostic Hearing Exam Exam to diagnose and treat hearing issues	$50	$100
Hearing Aids[2] Maximum of two hearing aids per year Required hearing aid evaluation with TruHearing, fitting included	$495 to $1,695 per device, must be purchased through TruHearing	No coverage out-of-network
Dental Services		
Dental Services[2] When receiving out-of-network care for eligible services, you must pay the difference between the Say Cheese Dental Network in-network payment and the amount charged by the out-of-network dentist	Up to $1,155 reimbursed through Pick Your Perks	
Medicare-Covered Dental Services Does not include services in connection with care, treatment, filling, removal or replacement of teeth	$50	$100
Optional Comprehensive Dental Coverage[2]	$49 monthly premium $1,000 combined in- and out-of-network annual maximum	
Vision Services		
Annual Routine Vision Exam[2]	$10	$40 reimbursement
Diagnostic Eye Exam To diagnose and treat diseases and conditions of the eye	$50	$100
Post-Cataract Eyewear One pair of eyeglasses or contact lenses after each cataract surgery	$0	$100
Additional Eyewear[2]	Up to $1,155 reimbursed through Pick Your Perks	
Mental Health/Substance Abuse		
Outpatient Mental Health Individual or group therapy	$50	$100
Inpatient Mental Health[1] Per admission	$395 per day, days 1 - 4 $0 days 5 and beyond	$800 per day, days 1 - 7 $0 days 8 and beyond

[1]Service may require prior authorization.
[2]Visit **networkhealth.com/medicare/extra-benefits** for more information, this is not a medical benefit.

SUMMARY OF BENEFITS

Network Health Anywhere (Includes pharmacy) Please see county listing for service area.		Network Health Bravo (Excludes pharmacy) Please see county listing for service area.	
YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS		**In-Network**	**Out-of-Network**
$0 or $40		$0 or $20	$30
$310		$200	$250
$90		$35	$40
Hearing Services			
$0	$40	$0	$40
$45		$40	$75
$495 to $1,695 per device, must be purchased through TruHearing	No coverage out-of-network	$495 to $1,695 per device, must be purchased through TruHearing	No coverage out-of-network
Dental Services			
100% preventive, 50% of the cost comprehensive coverage in-network, includes one implant and resin	Member pays 80% out-of-network	100% coverage in-network, includes one implant and resin	Member pays 50% out-of-network
$2,000 combined in- and out-of-network annual maximum		$5,000 combined in- and out-of-network annual maximum	
$45		$40	$75
Not available		Not available	Not available
Vision Services			
$0	$40 reimbursement out-of-network	$0	$40 reimbursement
$45		$40	$75
$0		$0	$75
$350 allowance at EyeMed providers		$400 allowance at EyeMed providers	Not covered
Mental Health/Substance Abuse			
$45		$20	$20
$295 per day, days 1 - 4 $0 days 5 and beyond		$395 per day, days 1 - 4 $0 days 5 and beyond	$395 per day, days 1 - 4 $0 days 5 and beyond

[1]Service may require prior authorization.
[2]Visit **networkhealth.com/medicare/extra-benefits** for more information, this is not a medical benefit.

2026 NETWORK HEALTH SOUTHEAST WISCONSIN (PPO)

Your Costs	Network Health Go (Includes pharmacy) Please see county listing for service area.	
	In-Network	**Out-of-Network**
Opioid Treatment Services	$50	$100
Substance Abuse Services Outpatient individual or group therapy	$50	$100
Continued Care Services		
Skilled Nursing Facility[1] Per admission	$0 per day, days 1 - 20 $218 per day, days 21 – 45 $0 days 46 - 100	$0 per day, days 1 - 20 $218 per day, days 21 – 45 $0 days 46 - 100
Outpatient Physical[1]**, Occupational**[1]**, Speech Therapy**	$50	$100
Transportation Services		
Air and Ground Ambulance Services	$275	$275
Non-Emergency Transportation[3] 24 one-way trips, to get to and from dialysis for members diagnosed with ESRD	In addition to 24 trips, up to $1,155 reimbursed through Pick Your Perks for rides to medical appointments and pharmacies	
Drug Coverage		
Medicare Part B Drugs[1] Plan will apply the CMS published adjusted beneficiary coinsurance as required under the Inflation Reduction Act	20% of the total cost	50% of the total cost
Medicare Part D Drugs[1] See Your Drug Costs table for specific drug tier costs	Covered	Not covered
Additional Benefits		
Pick Your Perks[2] Reimbursement for the following extra benefits: dental services, vision hardware, healthy home-delivered meals, non-emergency transportation, eligible over-the-counter items, acupuncture, massage therapy, personal training (4 visits or $225 allowance), nutritional/dietary counseling	$1,155	
Over-the-Counter Catalog[2]	Up to $1,155 reimbursed through Pick Your Perks	
Fitness with One Pass™[2]	Included	
MDLIVE® Virtual Visit[2] For medical services	$0	Not covered
Travel Coverage		
Travel within the United States	Receive in-network coverage when you venture outside Wisconsin and within the United States territories. You can see any provider who accepts Medicare beneficiaries.	

[1]Service may require prior authorization.
[2]Visit **networkhealth.com/medicare/extra-benefits** for more information, this is not a medical benefit.
[3]This is a Special Supplemental Benefit for the Chronically Ill (SSBCI) benefit. In addition to an eligible chronic condition, members must also meet additional eligibility requirements to receive the SSBCI benefit.

SUMMARY OF BENEFITS

Network Health Anywhere (Includes pharmacy) Please see county listing for service area.	Network Health Bravo (Excludes pharmacy)	
YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS	**In-Network**	**Out-of-Network**
$45	$20	$20
$45	$20	$20
Continued Care Services		
$0 per day, days 1 - 20 $218 per day, days 21 – 45 $0 days 46 - 100	$0 per day, days 1 - 20 $218 per day, days 21 – 45 $0 days 46 - 100	$218 per day, days 1 - 45 $0 per day, days 46 – 100
$45	$30	$75
Transportation Services		
$250	$300	$300
Covered	Covered	Covered
Drug Coverage		
20% of the total cost	20% of the total cost	50% of the total cost
Covered	Not covered	Not covered
Additional Benefits		
Not available	Not available	
$25 per quarter Two orders per quarter No rollover on quarterly allowance	$100 per quarter Two orders per quarter No rollover on quarterly allowance	Not covered
Included	Included	
$0	$0	Not covered
Travel Coverage		
Receive in-network coverage when you venture outside Wisconsin and within the United States territories. You can see any provider who accepts Medicare beneficiaries.	Receive in-network coverage when you venture outside Wisconsin and within the United States territories. You can see any provider who accepts Medicare beneficiaries.	

[1]Service may require prior authorization.
[2]Visit **networkhealth.com/medicare/extra-benefits** for more information, this is not a medical benefit.
[3]This is a Special Supplemental Benefit for the Chronically Ill (SSBCI) benefit. In addition to an eligible chronic condition, members must also meet additional eligibility requirements to receive the SSBCI benefit.

2026 NETWORK HEALTH SOUTHEAST WISCONSIN (PPO)

Your Costs	Network Health Go (Includes pharmacy) Please see county listing for service area.	
	In-Network	Out-of-Network
International Emergency Coverage View the Evidence of Coverage at networkhealth.com/medicare/plan-materials for details	$130 per incident $100,000 maximum benefit	$130 per incident $100,000 maximum benefit
Recovery and Rehabilitation Services		
Durable Medical Equipment Such as traditional insulin pumps[1], CPAP machines, prosthetic devices[1], etc.	20% of the allowed amount	25% of the allowed amount
Durable Medical Equipment for Home Infusion	0% of the allowed amount	25% of the allowed amount
Medicare-Covered Chiropractic Services Manipulation of the spine to correct misalignment of one or more of the bones of your spine	$15	$30
Medicare-Covered Acupuncture For chronic low back pain only, up to 12 visits in 90 days and no more than 20 visits per year	$50	$100
Medicare-Covered Home Health Care Visits[1]	$0	$15
Cancer Services		
Chemotherapy[1]	20% of the allowed amount	50% of the allowed amount
Radiation Therapy[1] Per service	20% of the allowed amount	40% of the allowed amount
Acupuncture[3] Up to 12 visits per year are covered for members who are undergoing chemotherapy and have severe nausea and/or vomiting	$0	$0
Diabetic Services		
Diabetes Monitoring Supplies and Test Strips Preferred test strips Preferred continuous glucose monitoring devices and supplies[1] obtained through your pharmacy Must have a diabetic diagnosis with insulin use All other brands are not covered	$0 for up to a 90-day supply	$0 for up to a 90-day supply
Diabetic Shoe Inserts Copayment per pair	$10	$30
Diabetes Management Diabetes self-management training teaches you to cope with and manage your diabetes	$0	$0
Part B Insulin[1] One-month supply	20% of the total cost, up to $35	50% of the total cost
Renal Services		
Dialysis Per treatment	20% of the allowed amount	25% of the allowed amount

[1]Service may require prior authorization.
[2]Visit **networkhealth.com/medicare/extra-benefits** for more information, this is not a medical benefit.
[3]This is a Special Supplemental Benefit for the Chronically Ill (SSBCI) benefit. In addition to an eligible chronic condition, members must also meet additional eligibility requirements to receive the SSBCI benefit.

SUMMARY OF BENEFITS

Network Health Anywhere (Includes pharmacy)	Network Health Bravo (Excludes pharmacy) Please see county listing for service area.	
YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS	In-Network	Out-of-Network
$130 per incident $100,000 maximum benefit	$130 per incident $100,000 maximum benefit	$130 per incident $100,000 maximum benefit
Recovery and Rehabilitation Services		
20% of the allowed amount	20% of the allowed amount	25% of the allowed amount
0% of the allowed amount	0% of the allowed amount	25% of the allowed amount
$15	$15	$40
$45	$40	$75
$0	$0	$15
Cancer Services		
20% of the allowed amount	20% of the allowed amount	50% of the allowed amount
20% of the allowed amount	20% of the allowed amount	25% of the allowed amount
$0	$0	$0
Diabetic Services		
$0 for up to a 90-day supply	$0 for up to a 90-day supply	$0 for up to a 90-day supply
$10	$10	$30
$0	$0	$0
20% of the total cost, up to $35	20% of the total cost, up to $35	50% of the total cost
Renal Services		
20% of the allowed amount	20% of the allowed amount	25% of the allowed amount

[1]Service may require prior authorization.
[2]Visit **networkhealth.com/medicare/extra-benefits** for more information, this is not a medical benefit.
[3]This is a Special Supplemental Benefit for the Chronically Ill (SSBCI) benefit. In addition to an eligible chronic condition, members must also meet additional eligibility requirements to receive the SSBCI benefit.

2026 NETWORK HEALTH SOUTHEAST WISCONSIN (PPO)

Your Drug Costs		Network Health Go (Includes pharmacy)	Network Health Anywhere (Includes pharmacy)
		Please see county listing for service area.	
Yearly Drug Deductible You pay the full amount of your covered Part D drugs until the deductible is met		$340 Applies to Tiers 2 - 5	$320 Applies to Tiers 2 - 5
INITIAL COVERAGE – Amount shown is the maximum you will pay. You may pay less.			
PREFERRED	**30-Day Supply** **Preferred Pharmacy or Preferred Mail Order Pharmacy**	$0 for Tier 1 $8 for Tier 2 23% for Tier 3 25% for Tier 4 29% for Tier 5	$1 for Tier 1 $8 for Tier 2 22% for Tier 3 28% for Tier 4 29% for Tier 5
PREFERRED	**3-Month Supply** **Preferred Pharmacy** **100-Day Supply for Tier 1** **90-Day Supply for Tiers 2-4**	$0 for Tier 1 $20 for Tier 2 23% for Tier 3 25% for Tier 4 Tier 5 is not available	$2 for Tier 1 $20 for Tier 2 22% for Tier 3 28% for Tier 4 Tier 5 is not available
PREFERRED	**3-Month Supply** **Preferred Mail Order Pharmacy** **100-Day Supply for Tier 1** **90-Day Supply for Tiers 2-4**	$0 for Tier 1 $0 for Tier 2 after deductible 23% for Tier 3 25% for Tier 4 Tier 5 is not available	$0 for Tier 1 $0 for Tier 2 after deductible 22% for Tier 3 28% for Tier 4 Tier 5 is not available
STANDARD	**30-Day Supply** **Standard Pharmacy or Standard Mail Order Pharmacy**	$8 for Tier 1 $17 for Tier 2 25% for Tier 3 25% for Tier 4 29% for Tier 5	$8 for Tier 1 $17 for Tier 2 25% for Tier 3 28% for Tier 4 29% for Tier 5
STANDARD	**3-Month Supply** **Standard Pharmacy or Standard Mail Order Pharmacy** **100-Day Supply for Tier 1** **90-Day Supply for Tiers 2-4**	$20 for Tier 1 $42 for Tier 2 25% for Tier 3 25% for Tier 4 Tier 5 is not available	$20 for Tier 1 $42 for Tier 2 25% for Tier 3 28% for Tier 4 Tier 5 is not available
Part D Insulin and Vaccines			
Part D Insulin[1] One-month supply		The lesser of 25% or $35	The lesser of 25% or $35
Part D Vaccines Shingrix, RSV, all other adult ACIP recommended vaccines		$0	$0
CATASTROPHIC COVERAGE			
You enter catastrophic coverage when your total out-of-pocket costs reach $2,100. You pay $0.			

[1]Service may require prior authorization.

PRE-ENROLLMENT CHECKLIST

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a member of the member experience team at **800-378-5234** (TTY 711), Monday–Friday from 8 a.m. to 8 p.m. From October 1–March 31, we're available every day, 8 a.m. to 8 p.m.

Understanding the Benefits

- ☐ The *Evidence of Coverage* (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs and benefits before you enroll. Visit **networkhealth.com/medicare/plan-materials** or call **800-378-5234** (TTY 711) to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.
- ☐ Review how enrolling into a Network Health Medicare Advantage plan will impact your current healthcare coverage.

Understanding Important Rules

- ☐ You must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/coinsurance may change on January 1, 2027.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you may pay a higher copayment for services received by non-contracted providers.

Discrimination is Against the Law

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

Network Health:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - o Qualified sign language interpreters
  - o Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - o Qualified interpreters
  - o Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact Network Health's Compliance Officer.

If you believe that Network Health has 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:

Network Health
Attn: Compliance Officer
1570 Midway Place
Menasha, WI 54952
Phone: 800-378-5234
(TTY users should call 711)
Email: compliance@networkhealth.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Network Health's 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 https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, for 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
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

This notice is available at Network Health's website: networkhealth.com

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

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 800-378-5234 (TTY: 711) or speak to your provider.

Albanian: 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 800-378-5234 (TTY: 711) ose bisedoni me ofruesin tuaj të shërbimit.

Arabic: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات تنبيه كما تتوفر وسائل مساعدة وخدمات المساعدة اللغوية المجانية. مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. أو اتصل على الرقم 5234-378-800 (711) تحدث إلى مقدم الخدمة.

Chinese: **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 800-378-5234（**文本**电话：711）**或咨**询您的服务提供商。

French: 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 800-378-5234 (TTY : 711) ou parlez à votre fournisseur.

German: 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 800-378-5234 (TTY : 711) an oder sprechen Sie mit Ihrem Provider.

Hindi: यदि आप हिंदी बोलतेहैं, तो आपकेलिए निः शु भाषा सहायता सेवाएं उपल होती हैं। सुलभप्रारूपोंमेंजानकारी प्रदान करनेकेलिए उपयुसहायक साधन और सेवाएँभी निः श उपल 800-378-5234 (TTY : 711) पर कॉल करेंयाअपनेप्रदाता सेबात करें ।

Hmong: 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 800-378-5234 (TTY : 711) los sis sib tham nrog koj tus kws muab kev saib xyuas kho mob.

Korean:한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조기구 및 서비스도 무료로 제공됩니다. 800-378-5234 (TTY : 711) 번으로 전화하거나서비스 제공업체에 문의하십시오.

Laotian: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີ ບໍ ລິ ການຊ່ວຍດ້ານພາສາແບບບ ເສຍຄ່າໃຫ້ທ່ານ. ມີ ເຄື ອງຊ່ວຍ ແລະ ການບ ລິ ການແບບບ ເສຍຄ່າທີ ເໝາະສົ ມເພື ອໃຫ້ຂໍ ມູນໃນຮູ ບແບບທີ ສາມາດເຂົ ້າເຖິ ງໄດ້. ໂທຫາເບີ 800-378-5234(TTY : 711) ຫຼື ລ ມກັ ບພໍ ໃຫ້ ບ ລິ ການຂອງທ່ານ.

Pennsylvania Dutch: Wann du Druwwel hoscht fer Englisch verschtehe, kenne mer epper beigriege fer dich helfe unni as es dich ennich eppes koschte zeelt. Mir kenne dich helfe aa wann du Druwwel hoscht fer heere odder sehne. Mir kenne Schtofft lauder mache odder iesier fer lese un sell koscht dich aa nix. Ruf 800-378-5234 (TTY: 711) uff odder schwetz mit dei Provider.

Polish: 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 800-378-5234 (TTY : 711) lub porozmawiaj ze swoim dostawcą.

Russian: 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 800-378-5234 (TTY : 711) или обратитесь к своему поставщику услуг.

Spanish: 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 800-378-5234 (TTY : 711) o hable con su proveedor.

Tagalog: 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 800-378-5234 (TTY : 711) o makipag-usap sa iyong provider.

Vietnamese: 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 800-378-5234 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn. .

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