

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

Wausau School District - AHP Signature Network HDHP - \$1,600 Deductible



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) 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 <https://www.aspirushealthplan.com/group-individual/files/COCs/>. For definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 1-866-631-5404 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	For participating providers: \$1,600/Covered Person or \$3,200/Family; For non-participating providers: \$1,600/Covered Person or \$3,200/Family.	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the policy, the overall family <a href="#">deductible</a> must be met before the <a href="#">plan</a> begins to pay. Non-participating <a href="#">provider deductible</a> amounts credit toward participating <a href="#">provider deductible</a> amounts.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> services, office visits and <a href="#">prescription drugs</a> purchased from a pharmacy are covered before you meet your deductible.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain preventive services without <a href="#">cost-sharing</a> and before you meet your deductible. See a list of covered preventive services at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For participating providers: \$3,000/Covered Person or \$6,000/Family (excluding <a href="#">copayments</a> ), up to a maximum out-of-pocket (including <a href="#">copayments</a> ) of \$7,150 Person/\$14,300 Family for participating providers; For nonparticipating providers: \$4,500/Covered Person or \$9,000 Family (excluding <a href="#">copayments</a> ), up to a maximum of \$7,150 Person/\$14,300 Family for nonparticipating providers.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , the overall family <a href="#">out-of-pocket limit</a> must be met. Non-participating <a href="#">provider</a> out-of-pocket amounts credit toward participating <a href="#">provider</a> out-of-pocket amounts.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Premiums, balance-billing charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="https://p1.aspirushealthplan.com/find-a-doctor">https://p1.aspirushealthplan.com/find-a-doctor</a> or call 1-866-631-5404 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the in-network <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Signature Network Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening</a> /immunization	No charge ( <a href="#">deductible</a> does not apply)	40% <a href="#">coinsurance</a>	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Certain genetic tests and high-technology imaging require prior authorization. Benefits may not be payable if you do not obtain prior authorization.
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Certain genetic tests and high-technology imaging require prior authorization. Benefits may not be payable if you do not obtain prior authorization.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at <a href="https://aspirushealthplan.com/group-individual/resources/pharmacy/">https://aspirushealthplan.com/group-individual/resources/pharmacy/</a>	Generic drugs	Tier 1: \$10 <a href="#">copayment</a> /prescription (retail) & \$10 <a href="#">copayment</a> /home delivery). Tier 2: \$30 <a href="#">copayment</a> /prescription (retail) & \$30 <a href="#">copayment</a> / (home delivery). Tier 3: \$50 <a href="#">copayment</a> / prescription (retail) & \$50 <a href="#">copayment</a> / (home delivery)	Not Applicable	Provider means pharmacy for purposes of this section. Covers up to a 90-day supply retail/90-day supply home delivery. If brand is dispensed when a generic is available, you are responsible for the cost difference between the brand and generic which, unless your physician specifically instructs to dispense the brand drug 'as written'. The difference does not count toward your out-of-pocket limit. Drugs provided by an entity other than a pharmacy require prior authorization. Benefits may not be payable if you do not obtain prior authorization. Certain preventive medication are covered at 100%.
	Preferred brand drugs	Tier 1: \$10 <a href="#">copayment</a> /prescription (retail) & \$10 <a href="#">copayment</a> /home delivery). Tier 2: \$30 <a href="#">copayment</a> /prescription (retail) & \$30 <a href="#">copayment</a> / (home delivery). Tier 3: \$50 <a href="#">copayment</a> / prescription (retail) & \$50 <a href="#">copayment</a> / (home delivery)	Not Applicable	Provider means pharmacy for purposes of this section. Covers up to a 90-day supply retail/90-day supply home delivery. If brand is dispensed when a generic is available, you are responsible for the cost difference between the brand and generic which, unless your physician specifically instructs to dispense the brand drug 'as written'. The difference does not count toward your out-of-pocket limit. Drugs provided by an entity other than a pharmacy require prior authorization. Benefits may not be payable if you do not obtain prior authorization. Certain preventive medication are covered at 100%.
	Non-preferred drugs	Tier 1: \$10 <a href="#">copayment</a> /prescription (retail) & \$10 <a href="#">copayment</a> /home delivery). Tier 2: \$30 <a href="#">copayment</a> /prescription (retail) & \$30 <a href="#">copayment</a> / (home delivery). Tier 3: \$50 <a href="#">copayment</a> / prescription (retail) & \$50 <a href="#">copayment</a> / (home delivery)	Not Applicable	Provider means pharmacy for purposes of this section. Covers up to a 90-day supply retail/90-day supply home delivery. If brand is dispensed when a generic is available, you are responsible for the cost difference between the brand and generic which, unless your physician specifically instructs to dispense the brand drug 'as written'. The difference does not count toward your out-of-pocket limit. Drugs provided by an entity other than a pharmacy require prior authorization. Benefits may not be payable if you do not obtain prior authorization. Certain preventive medication are covered at 100%.
	<a href="#">Specialty drugs</a>	25% of the drug up to a \$200	Not Applicable	<a href="#">Specialty drugs</a> are limited to a 30-day supply. <a href="#">Specialty drugs</a>

		What You Will Pay		
Common Medical Event	Services You May Need	Signature Network Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
		<a href="#">copayment</a> per prescription - both retail & home delivery (limited to 30-day supply)		require prior authorization. Benefits may not be payable if you do not obtain prior authorization.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Signature Network Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
If you need immediate medical attention	<a href="#">Emergency room services</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	<a href="#">Urgent care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	All non-emergent inpatient hospital stays require prior authorization. Benefits may not be payable if you do not obtain prior authorization.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	All non-emergent inpatient hospital stays require prior authorization. Benefits may not be payable if you do not obtain prior authorization.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	All non-emergent inpatient hospital stays require prior authorization. Benefits may not be payable if you do not obtain prior authorization.
	Inpatient services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	All non-emergent inpatient hospital stays require prior authorization. Benefits may not be payable if you do not obtain prior authorization.
If you are pregnant	Office visits	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Cost sharing does not apply for preventive services. Depending on the type of services, copayment, <a href="#">coinsurance</a> , <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). All non-emergent inpatient hospital stays require prior authorization. Benefits may not be payable if you do not obtain prior authorization.
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Cost sharing does not apply for preventive services. Depending on the type of services, copayment, <a href="#">coinsurance</a> , <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). All non-emergent inpatient hospital stays require prior authorization. Benefits may not be payable if you do not obtain prior authorization.
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Cost sharing does not apply for preventive services. Depending on the type of services, copayment, <a href="#">coinsurance</a> , <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). All non-emergent inpatient hospital stays require prior authorization. Benefits may not be payable if you do not obtain prior authorization.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Signature Network Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Coverage limited to 40 visit per covered person per year.
	<b>Rehabilitation services</b>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Coverage is limited to 30 days per calendar year. All non-emergent inpatient hospital stays require prior authorization. Benefits may not be payable if you do not obtain prior authorization.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Prior authorization required for: -All CPAP/BIPAP purchases and rentals -Purchases over \$1,000 -All other rentals as states on our website ( <a href="http://www.aspirushealthplan.com">www.aspirushealthplan.com</a> ) Benefits may not be payable if you do not obtain prior authorization.
	<a href="#">Hospice service</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Hospice service</a> s require prior authorization. Benefits may not be payable if you do not obtain prior authorization.
If your child needs dental or eye care	<b>Children's eye exam</b>	No charge ( <a href="#">deductible</a> does not apply)	40% <a href="#">coinsurance</a>	None
	<b>Children's glasses</b>	Not covered	Not covered	None
	<b>Children's dental check-up</b>	Not covered	Not covered	None

### Excluded Services & Other Covered Services:

Services your <a href="#">plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
• Acupuncture	• Bariatric surgery	• Cosmetic surgery
• Dental care (Adults)	• Infertility treatment	• Long-term care
• Private-duty nursing	• Routine foot care (except certain conditions)	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
• Chiropractic care	• Hearing aids (every 3 years, up to age 19)	• Non-emergency care when traveling outside the U.S.
• Routine eye care (Adult)		

### 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 the agency is the Department of Labor's Employee Benefits Security Administration at 1.866.444.EBSA (3272) /[www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1.800.318.2596.

### Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Aspirus Health Plan at 1-866-631-5404. You may also contact your state insurance department at 1-800-236-8517 or the Department of Labor's Employee Benefits Security Administration at 1.866.444.EBSA (3272) /[www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

### Does this plan provide Minimum Essential Coverage? Yes

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

### Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#) you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

### Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 866-631-5404.

Hmong (Hmoob): Kev pab nyob rau hauv Hmoob hu 866-631-5404.

Traditional Chinese (傳統中文): 有關中文協助,請致電 866-631-5404.


German (Deutsch): Für Hilfe in deutscher Sprache rufen 866-631-5404.

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.



About these Coverage Examples:

 **This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductibles](#), [copayments](#), and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby  
(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$1,600
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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	
<a href="#">Deductibles</a>	\$1600
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1400
What isn't covered	
Limits or Exclusions	\$60
The total Peg would pay is	\$3,060

Managing Joe's Type 2 Diabetes  
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$1,600
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (including disease education)  
[Diagnostic tests](#) (blood work)  
[Prescription drugs](#)  
[Durable Medical Equipment \(glucose meter\)](#)

Total Example Cost	\$5,600
In this example, Joe would pay:	
Cost Sharing	
<a href="#">Deductibles</a>	\$1600
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$70
What isn't covered	
Limits or Exclusions	\$20
The total Joe would pay is	\$1,990

Mia's Simple Fracture  
(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$1,600
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

This EXAMPLE event includes services like:

[Emergency room care](#) (including medical supplies)  
[Diagnostic tests](#) (x-ray)  
[Durable medical equipment](#) (crutches)  
[Rehabilitation services](#) (physical therapy)

Total Example Cost	\$2,800
In this example, Mia would pay:	
Cost Sharing	
<a href="#">Deductibles</a>	\$1600
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$200
What isn't covered	
Limits or Exclusions	\$0
The total Mia would pay is	\$1,810

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.



## Nondiscrimination & Language Access Policy

Aspirus Health Plan, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. We do not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

We will:

Provide free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

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 us at the phone number shown on the inside cover of this *certificate of coverage*, your id card, or [aspirushealthplan.com](http://aspirushealthplan.com).

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a *grievance* with:

Nondiscrimination Grievance Coordinator  
Aspirus Health Plan, Inc.  
PO Box 1062  
Minneapolis, MN 55440  
Phone: 1.866.631.5404 (TTY: 711)  
Fax: 763.847.4010  
Email: [customerservice@aspirushealthplan.com](mailto:customerservice@aspirushealthplan.com)

You can file a *grievance* in person or by mail, fax, or email. If you need help filing a *grievance*, the Nondiscrimination Grievance Coordinator 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>, 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  
1.800.368.1019, 800.537.7697 (TDD)

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

## Language Assistance Services

**Albanian:** KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1.866.631.5404 (TTY: 711).

**Arabic:** تنبيه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك مجاناً. اتصل بن أعلى رقم الهاتف 1.866.631.5404 (رقم هاتف الصم والبك : 711)

**French:** ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelezle 1.866.631.5404 (ATS : 711).

**German:** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.866.631.5404 (TTY: 711).

**Hindi:** \_यान द\_ : य\_द आप िहंदी बोलते ह\_ तो आपके िलए मु\_त म\_ भाषा सहायता सेवाएं उपल\_ध ह\_। 1.866.631.5404 (TTY: 711) पर कॉल कर\_।

**Hmong:** LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1.866.631.5404 (TTY: 711).

**Korean:** 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.866.631.5404 (TTY: 711)번으로 전화해 주십시오.

**Polish:** UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1.866.631.5404 (TTY: 711).

**Russian:** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1.866.631.5404 (телетайп: 711).

**Spanish:** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.866.631.5404 (TTY: 711).

**Tagalog:** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nangwalang bayad. Tumawag sa 1.866.631.5404 (TTY: 711)

**Traditional Chinese:** 注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 1.866.631.5404 (TTY: 711)。

**Vietnamese:** CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1.866.631.5404 (TTY: 711).

**Pennsylvania Dutch:** Wann du Deitsch (Pennsylvania German / Dutch) schwetzscht, kannscht du mitaus Koschte ebbergricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1.866.631.5404 (TTY: 711).

**Lao:** ໄປດຊາຍ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1.866.631.5404 (TTY: 711).