



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 our website at [MolinaMarketplace.com](https://MolinaMarketplace.com) or call 1-888-858-3973. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, Deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at [healthcare.gov/sbc-glossary/](https://healthcare.gov/sbc-glossary/) or call 1-800-318-2596 to request a copy.

| Important Questions                                                       | Answers                                                                                                                                                                 | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall <u>Deductible</u>?</b>                             | \$850 / individual or \$1700 / family                                                                                                                                   | 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> .                                                                                                                                                               |
| <b>Are there services covered before you meet your <u>Deductible</u>?</b> | Yes. <u>Preventive care</u> and services indicated in the chart starting on page 2.                                                                                     | 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 <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>Deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                            |
| <b>Are there other <u>Deductibles</u> for specific services?</b>          | No.                                                                                                                                                                     | You don't have to meet <u>Deductible</u> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>       | For network <u>providers</u> \$3050 individual / \$6100 family; for <u>out-of-network</u> providers, there is no coverage unless Prior Authorized by Molina Healthcare. | 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.                                                                                                                                                                                                                                                                                     |
| <b>What is not included in the <u>out-of-pocket limit</u>?</b>            | <u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.                                                                       | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Will you pay less if you use a <u>network provider</u>?</b>            | Yes. See <a href="https://Molinamarketplace.com">Molinamarketplace.com</a> or call 1-888-858-3973 for a list of <u>network providers</u> .                              | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| <b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>          | No.                                                                                                                                                                     | You can see the <u>Specialist</u> you choose without a <u>referral</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |

 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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                          |                                                           | Participating Provider<br>(You will pay the least)                                                                                 | Non-Participating Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>If you visit a health care provider's office or clinic</b>                                                                                                                                                                            | Primary care visit to treat an injury or illness          | \$8 <u>copay</u> /visit; <u>Deductible</u> does not apply                                                                          | Not covered                                           | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                                                                                                                                                                                          | <u>Specialist</u> visit                                   | \$30 <u>copay</u> /visit; <u>Deductible</u> does not apply                                                                         | Not covered                                           | <u>Preauthorization</u> may be required, or services not covered.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|                                                                                                                                                                                                                                          | <u>Preventive care/screening/immunization</u>             | No charge                                                                                                                          | Not covered                                           | You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>If you have a test</b>                                                                                                                                                                                                                | <u>Diagnostic test</u> (x-ray, blood work)                | \$80 <u>copay</u> for x-rays; <u>Deductible</u> does not apply; \$40 <u>copay</u> for blood work; <u>Deductible</u> does not apply | Not covered                                           | <u>Preauthorization</u> may be required, or services not covered.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|                                                                                                                                                                                                                                          | Imaging (CT/PET scans, MRIs)                              | 35% <u>coinsurance</u>                                                                                                             | Not covered                                           | <u>Preauthorization</u> is required or Imaging services are not covered                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <u>prescription drug coverage</u> is available at <a href="http://MolinaMarketplace.com/UTFormulary2026">MolinaMarketplace.com/UTFormulary2026</a> | Generic drugs - preferred                                 | \$5 <u>copay</u> /prescription (retail); <u>Deductible</u> does not apply                                                          | Not covered                                           | <u>Preauthorization</u> may be required, or services may not be covered. Certain <u>prescription drugs</u> are available for up to a 90-day extended supply at network retail pharmacies or a mail order option. Cost sharing for an extended supply is three times (3x) the 30-day retail <u>cost sharing</u> . Mail order not available for <u>Specialty drugs</u> . For brand drugs with a generic equivalent, coupons or any other form of third-party prescription drug <u>cost-sharing</u> assistance will not apply toward any <u>Deductibles</u> or annual <u>out-of-pocket limit</u> . |
|                                                                                                                                                                                                                                          | Preferred brand drugs                                     | \$65 <u>copay</u> /prescription (retail); <u>Deductible</u> does not apply                                                         | Not covered                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                                                                                                                                                                                          | Non-preferred brand drugs and non-preferred generic drugs | 40% <u>coinsurance</u> (retail)                                                                                                    | Not covered                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                                                                                                                                                                                          | <u>Specialty drugs</u>                                    | 50% <u>coinsurance</u>                                                                                                             | Not covered                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>If you have outpatient surgery</b>                                                                                                                                                                                                    | Facility fee (e.g., ambulatory surgery center)            | 35% <u>coinsurance</u>                                                                                                             | Not covered                                           | <u>Preauthorization</u> may be required, or services not covered.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|                                                                                                                                                                                                                                          | Physician/surgeon fees                                    | 35% <u>coinsurance</u>                                                                                                             | Not covered                                           | <u>Preauthorization</u> may be required, or services not covered.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |

| Common Medical Event                                                      | Services You May Need                     | What You Will Pay                                            |                                                       | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                  |
|---------------------------------------------------------------------------|-------------------------------------------|--------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                           | Participating Provider<br>(You will pay the least)           | Non-Participating Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                         |
| If you need immediate medical attention                                   | <u>Emergency room care</u>                | 35% <u>coinsurance</u>                                       | 35% <u>coinsurance</u>                                | <u>Cost-sharing</u> for <u>emergency room care</u> does not apply if admitted to the hospital.                                                                                                                                                                                                                                                                          |
|                                                                           | <u>Emergency medical transportation</u>   | 35% <u>coinsurance</u>                                       | 35% <u>coinsurance</u>                                |                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                           | <u>Urgent care</u>                        | \$25 <u>copay</u> /visit<br><u>Deductible</u> does not apply | Not covered                                           | <u>Preauthorization</u> is required for out-of-area <u>Urgent care</u> services, or services not covered.                                                                                                                                                                                                                                                               |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)        | 35% <u>coinsurance</u>                                       | Not covered                                           | <u>Preauthorization</u> is required or services not covered.                                                                                                                                                                                                                                                                                                            |
|                                                                           | Physician/surgeon fees                    | 35% <u>coinsurance</u>                                       | Not covered                                           |                                                                                                                                                                                                                                                                                                                                                                         |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | \$8 <u>copay</u> /visit;<br><u>Deductible</u> does not apply | Not covered                                           | None.                                                                                                                                                                                                                                                                                                                                                                   |
|                                                                           | Inpatient services                        | 35% <u>coinsurance</u>                                       | Not covered                                           | <u>Preauthorization</u> is required for inpatient care or services not covered.                                                                                                                                                                                                                                                                                         |
| If you are pregnant                                                       | Office visits                             | No charge                                                    | Not covered                                           | <u>Cost sharing</u> does not apply to routine prenatal care and first post-natal visit and certain <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Pregnancy termination services, subject to restrictions and state law. |
|                                                                           | Childbirth/delivery professional services | 35% <u>coinsurance</u>                                       | Not covered                                           |                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                           | Childbirth/delivery facility services     | 35% <u>coinsurance</u>                                       | Not covered                                           |                                                                                                                                                                                                                                                                                                                                                                         |
| If you need help recovering or have other special health needs            | <u>Home health care</u>                   | 35% <u>coinsurance</u>                                       | Not covered                                           | Limited to:<br><ul style="list-style-type: none"> <li>• Up to 2 hours nursing per visit</li> <li>• Up to 4 hours home health aide per visit</li> <li>• 30 visits per calendar year</li> </ul> <u>Preauthorization</u> is required after 7 visits for home settings, or services may not be covered.                                                                     |
|                                                                           | <u>Rehabilitation services</u>            | \$35 <u>copay</u> /visit<br><u>Deductible</u> does not apply | Not covered                                           | 20 visits/year - Speech, Physical, Occupational Therapy combined                                                                                                                                                                                                                                                                                                        |

\* For more information about limitations and exceptions, see the plan or policy document at [www.MolinaMarketplace.com](http://www.MolinaMarketplace.com).

| Common Medical Event                   | Services You May Need            | What You Will Pay                                            |                                                       | Limitations, Exceptions, & Other Important Information                                                         |
|----------------------------------------|----------------------------------|--------------------------------------------------------------|-------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|
|                                        |                                  | Participating Provider<br>(You will pay the least)           | Non-Participating Provider<br>(You will pay the most) |                                                                                                                |
|                                        | <u>Habilitation services</u>     | \$35 <u>copay</u> /visit<br><u>Deductible</u> does not apply | Not covered                                           | 20 visits/year - Speech, Physical, Occupational Therapy combined                                               |
|                                        | <u>Skilled nursing care</u>      | 35% <u>coinsurance</u>                                       | Not covered                                           | Limited to 30 days per calendar year. <u>Preauthorization</u> may be required, or services may not be covered. |
|                                        | <u>Durable medical equipment</u> | 35% <u>coinsurance</u>                                       | Not covered                                           | Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.                          |
|                                        | <u>Hospice services</u>          | No charge                                                    | Not covered                                           | Limited to 6 months in a 3-year period. Notification only, <u>Preauthorization</u> is not required.            |
| If your child needs dental or eye care | Children's eye exam              | No charge                                                    | Not covered                                           | One screening/exam per calendar year                                                                           |
|                                        | Children's glasses               | No charge                                                    | Not covered                                           | Coverage limited to one pair of glasses/year.                                                                  |
|                                        | Children's dental check-up       | Not covered                                                  | Not covered                                           | Not Applicable. Coverage can be purchased as a standalone product; it is not covered by this policy.           |

#### Excluded Services & Other Covered Services:

| Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)                                                |                                                                                                                                                                              |                                                                                                                                                                                                 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>Abortion (except in cases of rape, incest, or when the life of the mother is endangered)</li> <li>Acupuncture</li> <li>Bariatric surgery</li> <li>Routine Foot Care</li> </ul> | <ul style="list-style-type: none"> <li>Cosmetic Surgery</li> <li>Dental care (Adult)</li> <li>Hearing aids</li> <li>Infertility treatment</li> <li>Long-term care</li> </ul> | <ul style="list-style-type: none"> <li>Non-emergency care when traveling outside the U.S.</li> <li>Private-duty nursing</li> <li>Chiropractic care</li> <li>Routine eye care (Adult)</li> </ul> |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)                                                                                   |                                                                                                                                                                              |                                                                                                                                                                                                 |
| None                                                                                                                                                                                                                  |                                                                                                                                                                              |                                                                                                                                                                                                 |

**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: Utah Insurance Department 1-801-538-3077. 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 on how 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: Utah Insurance Department 1-801-538-3077.

**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.

*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

## 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 <u>plan's</u> overall <u>Deductible</u> | \$850 |
| ■ <u>Specialist copayment</u>                 | \$30  |
| ■ Hospital (facility) <u>coinsurance</u>      | 35%   |
| ■ Other <u>coinsurance</u>                    | 35%   |

**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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

**In this example, Peg would pay:**

| <i>Cost Sharing</i> |        |
|---------------------|--------|
| <u>Deductibles</u>  | \$850  |
| <u>Copayments</u>   | \$700  |
| <u>Coinsurance</u>  | \$1500 |

| <i>What isn't covered</i> |     |
|---------------------------|-----|
| Limits or exclusions      | \$0 |

|                                   |               |
|-----------------------------------|---------------|
| <b>The total Peg would pay is</b> | <b>\$3050</b> |
|-----------------------------------|---------------|

### 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> | \$850 |
| ■ <u>Specialist copayment</u>                 | \$30  |
| ■ Hospital (facility) <u>coinsurance</u>      | 35%   |
| ■ Other <u>coinsurance</u>                    | 35%   |

**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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

**In this example, Joe would pay:**

| <i>Cost Sharing</i> |        |
|---------------------|--------|
| <u>Deductibles</u>  | \$800  |
| <u>Copayments</u>   | \$1200 |
| <u>Coinsurance</u>  | \$0    |

| <i>What isn't covered</i> |     |
|---------------------------|-----|
| Limits or exclusions      | \$0 |

|                                   |               |
|-----------------------------------|---------------|
| <b>The total Joe would pay is</b> | <b>\$2000</b> |
|-----------------------------------|---------------|

### Mia's Simple Fracture

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

|                                               |       |
|-----------------------------------------------|-------|
| ■ The <u>plan's</u> overall <u>Deductible</u> | \$850 |
| ■ <u>Specialist copayment</u>                 | \$30  |
| ■ Hospital (facility) <u>coinsurance</u>      | 35%   |
| ■ Other <u>coinsurance</u>                    | 35%   |

**This EXAMPLE event includes services like:**

Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

**In this example, Mia would pay:**

| <i>Cost Sharing</i> |       |
|---------------------|-------|
| <u>Deductibles</u>  | \$850 |
| <u>Copayments</u>   | \$300 |
| <u>Coinsurance</u>  | \$300 |

| <i>What isn't covered</i> |     |
|---------------------------|-----|
| Limits or exclusions      | \$0 |

|                                   |               |
|-----------------------------------|---------------|
| <b>The total Mia would pay is</b> | <b>\$1450</b> |
|-----------------------------------|---------------|

The plan would be responsible for the other costs of these EXAMPLE covered services.



## Non-Discrimination Notice – Section 1557 Molina Healthcare of Utah - Marketplace

Molina Healthcare complies with applicable Federal civil rights laws and does not discriminate on the basis of age, color, disability, national origin, race, or sex.

To help you effectively communicate with us, Molina Healthcare provides services free of charge and in a timely manner:

- Molina Healthcare provides reasonable modifications and appropriate aids and services to people with disabilities. This includes:(1) Qualified interpreters. (2) Information in other formats, such as large print, audio, accessible electronic formats, Braille.
- Molina Healthcare provides language services to people who speak another language or have limited English skills. This includes:(1) Qualified oral interpreters. (2) Information translated in your language.

If you need these services, contact Molina Member Services at 1-888-858-3973 or TTY/TDD: 711, Monday to Friday, 8 a.m. to 6 p.m., local time.

If you believe we have discriminated on the basis of age, color, disability, national origin, race, or sex, you can file a grievance. You can file a grievance by phone, mail, email, or online. If you need help writing your grievance, we will help you. You may obtain our grievance procedure by visiting our website at [MolinaHealthcare.com/members/common/en-US/Notice-of-Nondiscrimination.aspx](https://MolinaHealthcare.com/members/common/en-US/Notice-of-Nondiscrimination.aspx)

Call our Civil Rights Coordinator at 1-866-606-3889, TTY/TDD: 711 or submit your grievance to:

Civil Rights Unit  
200 Oceangate, Suite 100  
Long Beach, CA 90802  
Email: [Civil.Rights@MolinaHealthcare.com](mailto:Civil.Rights@MolinaHealthcare.com)  
Website: [MolinaHealthcare.Alertline.com](https://MolinaHealthcare.Alertline.com)

You can also file a civil rights complaint (grievance) with the U.S. Department of Health and Human Services, Office for Civil Rights, online through the Office for Civil Rights Complaint Portal 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  
Phone: 1-800-368-1019



**Non-Discrimination Notice – Section 1557  
Molina Healthcare of Utah - Marketplace**

TTY/TDD: 800-537-7697

Complaint forms are available here: <https://www.hhs.gov/sites/default/files/ocr-cr-complaint-form-package.pdf>



|                                    |                                                                                                                                                                        |
|------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| English                            | For free language assistance services, and auxiliary aids and services, call 1-888-858-3973 (TTY: 711).                                                                |
| Spanish<br>Español                 | Para obtener servicios gratuitos de asistencia lingüística, así como ayudas y servicios auxiliares, llame al 1-888-858-3973 (TTY: 711).                                |
| Chinese (Traditional)<br>中文 (台灣繁體) | 如需免費的語言協助服務以及輔助裝置和服務，請致電 1-888-858-3973（聽障專線：711）。                                                                                                                     |
| Vietnamese<br>Tiếng Việt           | Để sử dụng dịch vụ hỗ trợ ngôn ngữ miễn phí cũng như các dịch vụ và tính năng hỗ trợ thêm, hãy gọi 1-888-858-3973 (TTY: 711).                                          |
| Korean<br>한국인                      | 무료 언어 지원 서비스와 보조 지원 및 서비스를 원하시면 1-888-858-3973 (TTY: 711)로 연락 주시기 바랍니다.                                                                                                |
| Navajo<br>Diné                     | T'áá jiik'eh saad bee áka'aná'awo' bee áka'anída'awo'í, dóó bee ahxít hane'í ádaat'éhígíí dóó bee áka'nída'awo'í biniyégo, kohji' hodíilnih 1-888-858-3973 (TTY: 711). |
| Nepali<br>नेपाली                   | भाषासम्बन्धी निःशुल्क सहायता सेवा र अतिरिक्त सहायता तथा सेवाहरूका लागि 1-888-858-3973 (TTY: 711) मा कल गर्नुहोस्।                                                      |
| Tongan<br>Tonga                    | Ke ma'u 'a e tokoni ki he lea fakafonua ta'etotongi, mo e ngaahi tokoni mo e ngaahi tokoni 'a e houalotu, telefoni ki he 1-888-858-3973 (TTY: 711).                    |
| Serbo-Croatian<br>Srpski           | За бесплатну помоћ у вези са језиком и помагала и услуге, позовите 1-888-858-3973 (TTY: 711).                                                                          |
| Tagalog                            | Para sa libreng serbisyo sa tulong sa wika, at mga auxiliary aid at serbisyo, tumawag sa 1-888-858-3973 (TTY: 711).                                                    |
| German<br>Deutsch                  | Kostenlose Sprachassistentendienste, Hilfsmittel und Dienstleistungen erhalten Sie unter 1-888-858-3973 (TTY: 711).                                                    |
| Russian<br>Русский                 | Для получения бесплатных услуг языковой помощи, а также вспомогательных средств и услуг, позвоните: 1-888-858-3973 (телетайп: 711).                                    |
| Arabic<br>العربية                  | اتصل على الرقم 1-888-858-3973 (الهاتف النص 711 (TTY)) لتلقي خدمات المساعدة اللغوية المجانية والخدمات والمساعدات الإضافية.                                              |



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Mon-Khmer Cambodian  
ខ្មែរ

សម្រាប់សេវាកម្មជំនួយភាសា និងជំនួយផ្នែកស្តាប់ដោយឥតគិតថ្លៃ សូមទូរសព្ទទៅ 1-888-858-3973 (TTY: 711)។

French  
Français

Pour bénéficier de services d'assistance linguistique gratuits, ainsi que de services et aides complémentaires, appelez le 1-888-858-3973 (ATS : 711).

Japanese  
日本語

無料の言語サポートや補助器具・サービスをご希望の方は、1-888-858-3973 ( TTY: 711 ) までお電話ください。