group health Cooperative™ of eau claire

2025

Cooperative Advantage (HMO D-SNP)

Summary of Benefits

To Enroll in Cooperative Advantage (HMO D-SNP) you

- ☐ Are entitled to Medicare Part A.
- ☐ Enrolled in Medicare Part B.
- ☐ Reside in the service area of Cooperative Advantage.
- ☐ Are a U.S. citizen or lawfully present in the United States.
- ☐ Eligible and enrolled in Wisconsin Medicaid.

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 customer service representative at 1-800-460-4641. (TTY users call 711).

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 group-health.com/Cooperative-Advantage or call 1-800-460-4641 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.

Understanding Important Rules

- ☐ As a member of our plan, you do not pay a separate monthly plan premium for Cooperative Advantage. For most Cooperative Advantage members, Medicaid pays for your Part A premium, and for your Part B premium.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2026
- ☐ Except in emergency or urgent situations, we do not cover services by out-of- network providers (doctors who are not listed in the provider directory). Cooperative Advantage's network of doctors, hospitals, other providers, and pharmacies can be found in the provider or pharmacy directory on our website at group-health.com/cooperative-advantage.
- ☐ This plan is a dual eligible special needs plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare Part A and B, and medical assistance from a state plan under Medicaid. D-SNPs may provide additional information if they impose restrictions to specific Medicaid eligibility category(ies).
- ☐ This is a summary of health and prescription drug services covered by Cooperative Advantage (HMO D-SNP) January 1, 2025 - December 31, 2025.
- ☐ Cooperative Advantage (HMO D-SNP) is a Medicare Advantage Health Maintenance Organization (HMO) Plan with a Medicare contract. Enrollment in the plan depends on contract renewal.
- ☐ The benefit information provided is a summary of what the plan covers and what you pay. It does not list every service that we cover or list every limitation or exclusion. This information is not a complete description of benefits. The complete list of services we cover is found in the Evidence of Coverage. You can review the Evidence of Coverage at group-health.com/cooperative-advantage. If you would like a printed copy of the Evidence of Coverage mailed to you, please call our Member Services Department at 1-800-460-4641, TTY users can call 711.

Your eligibility to enroll in this plan depends on your type of Medicaid. You can enroll in this plan if you are in one of these Medicaid categories:

- ☐ Qualified Medicare Beneficiary Plus (QMB+): You get Medicaid coverage of Medicare cost-share and are also eligible for full Medicaid benefits. Medicaid pays your Part A and Part B premiums, deductibles, coinsurance, and copayment amounts for Medicare covered services. You pay nothing, except for Part D prescription drug copays (if applicable).
- ☐ Qualified Medicare Beneficiary (QMB): You get Medicaid coverage of Medicare cost-share but are not eligible for full Medicaid benefits. Medicaid pays your Part A and Part B premiums, deductibles, coinsurance, and copayment amounts only for Medicare covered services. You pay nothing, except for Part D prescription drug copays (if applicable).
- ☐ Full Benefits Dual Eligible (FBDE): Medicaid may provide limited assistance with Medicare cost-sharing. Medicaid also provides full Medicaid benefits. You are eligible for full Medicaid benefits. At times you may also be eligible for limited assistance from the State Medicaid Office in paying your Medicare cost share amounts. Generally, your cost share is 0% when the service is covered by both Medicare and Medicaid. There may be cases where you must pay cost sharing when a service or benefit is not covered by Medicaid.

If your category of Medicaid eligibility changes, your cost share may also increase or decrease, or you may become ineligible for our Plan. We will notify you if become ineligible you must recertify your Medicaid enrollment to continue to receive your Medicare coverage.

If you have questions about your Medicaid eligibility, please contact Member Services.

Contact Us

- ☐ Toll free 1-800-460-4641, TTY users can call 711
- ☐ Hours of operation from April 1 - September 30 are Monday through Friday,

  8:00 A.M. to 8:00 P.M. From October 1 - March 31, hours of operation are 8:00 A.M. to 8:00 P.M., seven days a week.

Service Area Counties

Adams	Crawford	Jackson	Pepin	Shawano
Ashland	Douglas	Juneau	Pierce	St. Croix
Barron	Dunn	La Crosse	Polk	Taylor
Bayfield	Eau Claire	Lafayette	Portage	Trempealeau
Buffalo	Forest	Langlade	Price	Vernon
Burnett	Grant	Lincoln	Richland	Vilas
Chippewa	Green	Marathon	Rusk	Washburn
Clark	Iowa	Monroe	Sauk	Wood
Columbia	Iron	Oneida	Sawyer	

Out-of-network/non-contracted providers are under no obligation to treat Cooperative Advantage's members, except in emergency situations. Please call our Member Services at 1-800-460-4641, TTY users can call 711 or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Benefits, premiums, deductibles, and/or copayments/coinsurance may change at any time. You will receive notice when necessary.

To know more about your coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

This information is not a complete description of benefits. Call Member Services at 1-800-460-4641, TTY users can call 711 for more information.

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

Your Part B premium is covered by your state's Medicaid agency for D-SNP enrollees

Premium and benefits	Cooperative Advantage (HMO D-SNP)
Monthly Plan Premium and Deductible	$0
Premium – Part B If you pay a Medicare Part B Premium, you must continue to do so.	$0
Maximum Out-of-Pocket Responsibility	$9,350 annually

Benefits

		In-Network
Inpatient Hospital Care[1]		$0 copayment Review your Evidence of Coverage for more detailed information.
Outpatient Hospital Coverage[1]	Ambulatory Surgery Center (ASC)	$0 copayment
	Outpatient services	$0 copayment
	Outpatient Blood Services	$0 copayment

	Outpatient Observation	$0 copayment
Doctor's Office Visits	Primary Care Physician (PCP) visit	$0 copayment
	Specialist visit	$0 copayment
	Virtual Medical Visits	$0 copayment to talk with a network telehealth provider online through live audio and video
Preventive Services		$0 copayment
Emergency Care		$0 copayment
Urgently Needed Services		$0 copayment
Outpatient Diagnostic Services/ Labs/Imaging[1]	Diagnostic tests and procedures	$0 copayment
	Labs	$0 copayment
	Diagnostic radiology, therapeutic radiology, X-rays	$0 copayment Prior authorization required for genetic testing and CT, MRI, and PET scans.

Hearing Services	Medicare-covered hearing exam	$0 copayment
	Routine Hearing Exam	$0 copayment, one (1) per year
	Hearing Aids	Maximum plan benefit of $2,000 every three (3) years. Plan covers up to two (2) covered hearing aids (one (1) hearing aid for $0 copayment out of pocket per ear)
Dental Services	Medicare-covered	$0 copayment
	Preventive	$0 copayment for exams, cleanings, X-rays and fluoride treatments every year for up to 2 visits.
	Comprehensive	Maximum benefit of $1,000 per year. Plan covers non-routine diagnostic, and restorative services, endodontics, periodontics, and extractions.
Vision Services	Medicare-covered exams	$0 copayment
	Routine eye exams	$0 copayment, one (1) routine eye exam, including refraction, every calendar year.

	Eyeglasses (Lens and Frames) Contact Lenses	Plan pays up to $500 for eyeglasses or contact lenses every year.
	Medicare-covered Eyeglasses (Lens and Frames) after Cataract surgery Contact Lenses after Cataract surgery	$0 copayment
Mental Health Services[1]	Outpatient Mental Health Services	$0 copayment
	Psychological and neuropsychological testing	$0 copayment
	Intensive outpatient services.	$0 copayment
Medicare-covered Chiro	Medicare covered chiropractic care (manual manipulation of the spine to correct subluxation when one or more of the bones of your spine move out of position)	$0 copayment
Skilled Nursing Facility[1]	Requires member to need daily skilled nursing and/or skilled rehabilitation services.	$0 copayment

Outpatient Rehabilitation Services[1]	Physical Therapy	$0 copayment
	Occupational Therapy	$0 copayment
	Speech Therapy	$0 copayment
Ambulance[1]	Ground	$0 copayment
	Air	$0 copayment
Transportation		$0.00 copayment This plan offers coverage for 40, one-way trips to plan-approved location every year.Trips limited to 60 miles.
Durable Medical Equipment and supplies[1]	Prosthetics/Medical Supplies	$0 copayment
	Durable Medical Equipment	$0 copayment
	Diabetic Supplies and Services, Therapeutic Shoes or Inserts	$0 copayment
Medicare Part B Drugs	Insulin Drugs	$0 copayment
	All Part B Drugs and Chemotherapy Drugs[1]	$0 copayment
Part D Prescription Drugs	Retail Pharmacy and Mail-Order Pharmacy	$0 copayment

[1] Prior authorization rules apply for services featuring a superscript 1.

PART D PRESCRIPTION DRUGS

Because you are a member of Cooperative Advantage and have both Medicare and Medicaid coverage, you will not have cost-share for your Part D prescription drugs.

All part D vaccines including but not limited to the shingles vaccine, tetanus vaccine and tetanus-diphtheria-pertussis (Tdap) vaccine given as routine vaccinations, are covered for members with Part D coverage.

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you. Call Member Services for more information.

Important Message About What You Pay for Insulin - You won't pay more than $35 for a one-month supply of each insulin product covered by our plan.

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your Part D deductible. Call Customer Service for more information.

*Costs may differ based on pharmacy type or status (e.g., preferred/non-preferred, mail order, long-term care (LTC), and 30- or 90-day supply).

Additional Benefits

Fitness Program	$0.00 copayment The plan covers 32 monthly credits available to use towards a nationwide network of gyms, local fitness studio or community center.
Over-the-Counter Drugs	$0.00 copayment The plan covers up to $70.00 each month for specific Over-the-Counter (OTC) drugs or health-related items that are listed in the Over-the-Counter Item Catalog.
Meals – Post-discharge	$0.00 copayment The plan covers 28 home-delivered meals after qualifying discharge from hospital.

Special Supplemental Benefits for Chronically Ill Food Program	$125.00 allowance for food each month. Members with one or more of the chronic conditions as listed in the Evidence of Coverage qualify for the food allowance each month. Unused allowances each month DO NOT rollover to following months.

Medicaid Benefits

For members who are entitled to full benefits under Medicaid, these are benefits that you may be entitled to. These are additional Medicaid benefits that may not be covered by Cooperative Advantage.

The benefits described below are covered by Medicaid. You can see what Wisconsin Department of Health Services covers. Coverage of the benefits depends on your level of Medicaid eligibility. If Medicare doesn't cover a service or a benefit has run out, Medicaid may help, but you may have to pay a cost share. In some situations, Medicaid may pay your Medicare cost sharing amount. See your Medicaid Member Handbook for more details. If you have questions about your Medicaid eligibility and what benefits you are entitled to, call ForwardHealth Member Services at 1-800-362- 3002.

Benefit	Medicaid	Cooperative Advantage Medicare
Acupuncture	Not Covered	$0 copayment Review your Evidence of Coverage for more detailed information.
Ambulance Services (Must be medically necessary)	Covered	$0 copayment

Ambulatory Surgical Services	Covered	$0 copayment
Cardiac and Pulmonary Rehabilitation Services	Covered	$0 copayment
Chiropractic Services	Covered Copay apply per service	$0 copayment
Dental Services	Covered Copay apply per service	Covered Preventive and Comprehensive $0 copay. $1,000 max comprehensive allowance
Diabetes Programs and Supplies	Covered Copay apply per service	$0 copayment
Diagnostic Tests, X- rays, Lab Services, and Radiology Services	Covered Copay apply per service	$0 copayment for diagnostic procedures and test/X-rays lab
Dialysis Services	Covered	$0 copayment
Durable Medical Equipment	Covered Copay apply per service	$0 copayment
Emergency Care	Covered	$0 copayment
Hearing Services	Covered Copay per services. No copay for hearing and batteries.	$0 copayment
Home Health Services	Covered: Skilled nursing, OT, PT, ST, personal care worker, and private duty nursing	$0 copayment Covered: Skilled nursing, Physical, Occupational, and Speech Therapy Not covered: Personal care worker and private duty nursing

Outpatient Mental Health Care: This includes psychosocial rehabilitative services, including case management services, provided by staff of a certified community support program	Covered. Not including room and board. Copay per service.	$0 copayment. Not covered: Residential Treatment
Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	Covered Copay per service.	$0 copayment
Outpatient Hospital Services	Covered. Copay per service.	$0 copayment
Outpatient Substance Abuse Care	Covered, includes residential treatment. Not including room and board.	$0 copayment. Not covered: Residential Treatment
Over-the-Counter Items	Some over-the-counter drugs are covered. Copay apply.	Covered. $0 copayment $70.00 allowance each month.
Podiatry Services	Covered	$0 copayment

Physician Specialist Services	Covered Copay per service.	$0 copayment
Psychiatric Services	Covered Copay per service.	Covered. $0 copayment
Transportation Services (Routine)	Covered	Covered. $0 copayment 40 one-way transportation trips to plan approved location.
Worldwide Emergency/Urgent Coverage (out of service area)	Not Covered	Not Covered
Urgently Needed Services	Covered	Covered. $0 copayment
Vision Services	Covered	No copay for one routine eye exam, include refraction, every calendar year. $500.00 for eyeglasses or contact lenses every year

Inpatient Care		
	Medicaid	Cooperative Advantage Medicare
Inpatient Hospital Care (includes substance abuse and rehabilitative services)	Covered	Covered. $0 copayment
Inpatient Mental Health Services	Covered	Covered. $0 copayment
Skilled Nursing Facility	Covered	Covered. $0 copayment
Hospice		
Hospice Services	Covered	Covered by Original Medicare
Other Services		
Kidney Disease Education	Covered	Covered. $0 copayment
Prescription Drug Benefits		
Outpatient Prescription Drugs: Part D	Covered Coverage of generic and brand name prescription drugs and some over the counter (OTC) drugs	Covered. Coverage of generic and brand name prescription drugs. Additional Over-the-Counter (OTC) items available as a supplemental benefit

Additional Medicaid Benefits

Benefit	Medicaid
Non-emergency medical transportation	Covered
Dental, except in Milwaukee, Waukesha, Racine, Kenosha, Ozaukee, and Washington counties	Covered
Prenatal care coordination	Covered
Targeted case management	Covered
School-based services	Covered
Childcare coordination	Covered
Certain Tuberculosis-related services, including directly observed therapy (DOT), patient education and anticipatory guidance, symptom and treatment monitoring.	Covered
Crisis intervention benefit	Covered
Community Support Program services	Covered
Comprehensive Community services	Covered
Community Recovery services	Covered
Chiropractic services	Covered

Lead investigations, as defined in Wis. Stat. §254.11(8s), of persons having lead poisoning or lead exposure, as defined in Wis. Stat. §254.11(9).	Covered
Medication therapy management	Covered
Prescription, over-the-counter drugs, and diabetic and other drug related supplies	Covered
Provider administered drugs	Covered
Behavioral Treatment Services (Autism Services)	Covered
Residential Substance Use Disorder Treatment	Covered
Hub and Spoke Integrated Recovery Support Services Health Home for SUD Treatment Pilot Program	Covered

Notice of Non-Discrimination and Availability of Language Assistance Services and Auxiliary Aids and Services

Discrimination is Against the Law

Group Health Cooperative of Eau Claire complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people less favorably on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes).

Group Health Cooperative of Eau Claire provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:

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

Group Health Cooperative of Eau Claire provides free language assistance services to people whose primary language is not English, which may include:

- Qualified interpreters
- Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our Civil Rights Coordinator: 1-800-460-4641 (TTY: 711). If you believe that Group Health Cooperative of Eau Claire has failed to provide these services or discriminated in another way on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes), you can file a grievance with our Civil Rights Coordinator. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights 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.

Civil Rights Coordinator P.O. Box 3217 Eau Claire, WI 54702-3217 Phone: 1-800-460-4641 (TTY: 711) Fax: 715-852-5739 Email: humanresources@group-health.com	**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 (TDD: 800-537-7697) Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html

This notice is available at Group Health Cooperative of Eau Claire's website: www.group-health.com.

group health Cooperative of eau claire

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services (§ 92.11)

English: ATTENTION: If you speak English, 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 1-800-460-4641 (TTY: 711) or speak to your provider.	**Vietnamese:** Việt – LƯU Ý: 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 1-800-460-4641 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.
Spanish: Español – ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. llame al 1-800-460-4641 (TTY: 711) o hable con su proveedor.	**Arabic:** اللغة الإنجليزية: تنبيه: إذا كنت تتحدث الإنجليزية ، فإن خدمات المساعدة اللغوية المجانية متاحة لك. كما تتوفر مجانا مساعدات وخدمات مساعدة مناسبة لتوفير المعلومات بأشكال يسهل الوصول إليها. اتصل بالرقم 1-800-460-4641 (الهاتف النصي: 711) أو تحدث إلى مزودك .
Hmong: Lus Hmoob – LUS CEEV TSHWJ XEEB: Yog hais tias koj hais Lus Hmoob muaj cov kev pab cuam txhais lus pub dawb rau koj. Cov kev pab thiab cov kev pab cuam ntxiv uas tsim nyog txhawm rau muab lus qhia paub ua cov hom ntaub ntawv uas tuaj yeem nkag cuag tau rau los kuj yeej tseem muaj pab dawb tsis xam tus nqi dab tsi ib yam nkaus. Hu rau 1-800-460-4641 (TTY: 711) los sis sib tham nrog koj tus kws muab kev saib xyuas kho mob.	**French:** Français – ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement Appelez le 1-800-460-4641 (TTY: 711) ou parlez à votre fournisseur.
Somali: Soomaali – FIIRO GAAR AH: Haddaad ku hadasho Soomaali, adeegyo kaalmada luuqadda ah oo bilaash ah ayaad heli kartaa. Qalab caawinaad iyo adeegyo oo habboon si loogu bixiyo macluumaadka qaabab la adeegsan karo ayaa sidoo kale bilaa lacag heli karaa. Wac 1-800-460-4641 (TTY: 711) ama la hadal bixiyahaag.	**Tagalog:** Tagalog – PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-460-4641 (TTY: 711) o makipag-usap sa iyong provider.
Laotian: ລາວ – ຊົນລະນາບ : ຖ້າ ທ່ານເວົ້າພາສາ ລາວ , ຈະມີບໍລິການຊ່ ວຍດ້ ານພາສາແບບບ່ ເສຍຄ່ າໃຫ້ ທ່ານ .ນອກ ນັ້ ນຍັ ງມີ ການບໍລິການແບບບ່ ເສຍຄ່ າທີ່ ເໝາະສົ ມເພື ່ ອໃຫ້ ຂ້ ມູ ນໃນ ຮູ ບແບບທ່ ີ ສາມາດ ເຂ ົ ້ າ ເ ຖ ິ ງ ໄ ດ ້ . ໂທຫາ ເ ບ 1-800-460-4641 (TTY: 711) ກ ັ ບ ຜ ູ ້ ໃ ຫ ້ ບ ໍ ລ ິ ການຂອງທ ່ ານ .	**German:** Deutsch – ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-800-460-4641 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.
Burmese: မြန်မာ - သတိပြု ရန်- သင်က မြန်မာဘာသာစကား ပြောဆိုပါက၊ အခမဲ့ ဘာသာစကားအကူအညီ ဝန်ဆောင်မများကို ရရှိပါသည်။ အသုံးပြုိင်သော ဖော်မတ်များဖြင့် အချက်အလက်များ ဖော်ပြပေးရန် သင့်လျော်သော အရန်အကူအညီများ ့ င့် ဝန်ဆောင်မ များကိုလည်း အခမဲ့ ရ ုိင်ပါသည်။ 1-800-460-4641 (TTY: 711) သို့ဖုန်းခေါ်ဆိုပါ သင်၏ ဆောင်ရွက်ပေးသူ ့ င့် စကားပြောပါ။".	**Pennsylvanian Dutch:** Pennsylvanisches Niederländisch: ACHTUNG: Wenn Sie Englisch sprechen, stehen Ihnen kostenlose Sprachunterstützungsdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-800-460-4641 (TTY: 711) an oder sprechen Sie mit Ihrem Anbieter.
Russian: РУССКИЙ – ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-460-4641 (TTY: 711) или обратитесь к своему поставщику услуг.	**Hindi:** हंद : ध्यान दें: य द आप अंग्रेज़ी बोलते हैं, तो आपके लए नशु ल्क भाषा सहायता सेवाएँ उपलब्ध हैं। सुलभ प्रारूपों में जानकार प्रदान करने के लए उपयु क्त सहायक उपकरण और सेवाएँ भी नशु ल्क उपलब्ध हैं। 1-800-460-4641 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।
Chinese Mandarin: 中文 – 注意：如果您說[中文]，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電1-800-460-4641 (TTY: 711) 或與您的提供者討論。」.	**Polish:** POLSKI: UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-800-460-4641 (TTY: 711) lub porozmawiaj ze swoim dostawcą".
Korean: 한국어– 주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-460-4641 (TTY: 711) 번으로 전화하거나 서비스 제공업체에 문의하십시오.	**Albanian:** SHQIP – VINI RE: Nëse flisni [shqip], shërbime falas të ndihmës së gjuhës janë në dispozicion për ju. Ndihma të përshtatshme dhe shërbime shtesë për të siguruar informacion në formate të përdorshme janë gjithashtu në dispozicion falas. Telefononi 1-800-460-4641 (TTY: 711) ose bisedoni me ofruesin tuaj të shërbimit.

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