

Your Benefit Summary

Connect 1500 Gold

Tribal Zero



| Providence Connect Network | |
|--|----------------|
| Individual Calendar Year Deductible | Not Applicable |
| Individual Out-of-Pocket Maximum This amount includes the Deductible. | Not Applicable |

Important information about your plan

This summary provides only highlights of your benefits. To view your plan details, register and login at myProvidence.com.

- Once you have registered, you can select your Medical Home online or by calling Customer Service.
- This plan provides benefits only for Medically Necessary Services when provided by physicians or providers in your Medical Home. The only exception is Emergency Care and Urgent Care Services.
- Some Services and penalties do not apply to the Out-of-Pocket Maximum.
- Prior Authorization is required for some Services.
- View a list of In-Network Providers and pharmacies at ProvidenceHealthPlan.com/findaprovider.
- Limitations and exclusions apply. See your contract for details.
- Medicare Part D creditable.
- Find important information about how to use your plan at ProvidenceHealthPlan.com/usingyourplan.
- Learn more about PHP's covered preventive services rated "A" or "B" by the U.S. Preventive Services Task Force at ProvidenceHealthPlan.com/PreventiveCare.

Below is the amount you pay after you have met your calendar year Deductible

| ✓ Deductible does not apply | In-Network Only |
|---|-----------------|
| On-Demand Visits | |
| Providence ExpressCare Virtual | Covered in full |
| Providence ExpressCare Retail Health Clinic visits | Covered in full |
| Preventive Care | |
| Periodic health exams and well-baby care | Covered in full |
| Routine immunizations and shots | Covered in full |
| Colonoscopy (preventive, age 45+) | Covered in full |
| Gynecological exams (1 per calendar year), breast exams and Pap tests | Covered in full |
| Mammograms | Covered in full |
| Nutritional Counseling | Covered in full |
| Tobacco cessation, counseling/classes and deterrent medications | Covered in full |
| Diabetes Self-Management Education | Covered in full |

Your Benefit Summary

Below is the amount you pay after you have met your calendar year Deductible

✓ Deductible does not apply

In-Network Only

Physician/Professional Services

| | |
|---|-----------------|
| Office visits to a Primary Care Provider or Naturopath (In-Person or Virtually) | Covered in full |
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| Office visits to an Alternative Care Provider (In-Person or Virtually) (Chiropractic manipulation and acupuncture services are covered separately from the office visit at the levels listed for those benefits.) | Covered in full |
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| Office visits to specialists (In-Person or Virtually) | Covered in full |
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| Inpatient Hospital visits | Covered in full |
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| Allergy shots and allergy serums, injectable and infused medications | Covered in full |
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| Surgery and anesthesia in an office or facility | Covered in full |
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Diagnostic Services

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| X-ray, lab and testing services (includes ultrasound) | Covered in full |
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| High-tech imaging Services (such as PET, CT or MRI) | Covered in full |
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|---------------|-----------------|
| Sleep studies | Covered in full |
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| Diagnostic and Supplemental Breast Exams | Covered in full |
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Emergency Care and Urgent Care Services

Emergency Services (Deductible applies)
(For Emergency Medical Conditions only. If admitted to the Hospital, all Services subject to inpatient benefits.)

| | |
|------------|-----------------|
| In-Network | Covered in full |
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|----------------|-----------------|
| Out-of-Network | Covered in full |
|----------------|-----------------|

Emergency medical transportation (air and/or ground)
(Emergency transportation is covered regardless of whether or not the provider is an In-Network Provider.)

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| In-Network | Covered in full |
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|----------------|-----------------|
| Out-of-Network | Covered in full |
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Urgent Care visits (for non-life threatening illness/minor injury)

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|------------|-----------------|
| In-Network | Covered in full |
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| Out-of-Network | Covered in full |
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Hospital Services

| | |
|----------------------------|-----------------|
| Inpatient/Observation care | Covered in full |
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|---|-----------------|
| Skilled Nursing Facility (limited to 60 days per calendar year) | Covered in full |
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|--|-----------------|
| Inpatient rehabilitative care (Limited to 30 days per calendar year; 60 days for head/spinal injuries. Limits do not apply to Mental Health and Substance Use Disorder Services.) | Covered in full |
|--|-----------------|

Your Benefit Summary

Below is the amount you pay after you have met your calendar year Deductible

✓ **Deductible does not apply**

In-Network Only

Hospital Services

| | |
|--|-----------------|
| Inpatient habilitative care (Limited to 30 days per calendar year; 60 days for head/spinal injuries. Limits do not apply to Mental Health and Substance Use Disorder Services.) | Covered in full |
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Outpatient Services

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| Outpatient surgery at an Ambulatory Surgery Center | Covered in full |
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| Outpatient surgery at a Hospital-based facility | Covered in full |
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| Colonoscopy (non-preventive) at an Ambulatory Surgery Center | Covered in full |
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|---|-----------------|
| Colonoscopy (non-preventive) at a Hospital-based facility | Covered in full |
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| Outpatient dialysis, infusion, chemotherapy and radiation therapy | Covered in full |
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|---|-----------------|
| Outpatient rehabilitative services: physical, occupational or speech therapy (Limited to 30 visits per calendar year; up to 30 additional visits per specified condition. Limits do not apply to Mental Health and Substance Use Disorder Services.) | Covered in full |
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|---|-----------------|
| Outpatient habilitative services: physical, occupational or speech therapy (Limited to 30 visits per calendar year; up to 30 additional visits per specified condition. Limits do not apply to Mental Health and Substance Use Disorder Services.) | Covered in full |
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|---|-----------------|
| Vision Therapy (convergence insufficiency) (Limited to 12 visits per lifetime) | Covered in full |
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Maternity Services

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| Prenatal visits | Covered in full |
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Delivery and postnatal physician/provider visits

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| Certified nurse midwife | Covered in full |
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| Primary Care Provider | Covered in full |
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| OB/GYN Physician/Provider | Covered in full |
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| All other licensed maternity providers | Covered in full |
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| Inpatient Hospital/facility services | Covered in full |
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|------------------------------|-----------------|
| Routine newborn nursery care | Covered in full |
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Medical Equipment, Supplies and Devices

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|---|-----------------|
| Medical equipment, appliances, prosthetics/orthotics and supplies | Covered in full |
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| Diabetes supplies (such as lancets, test strips, needles and glucose monitors) | Covered in full |
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|--|-----------------|
| Hearing aids (Limited to one aid per ear every 3 calendar years) | Covered in full |
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Your Benefit Summary

Below is the amount you pay after you have met your calendar year Deductible

✓ Deductible does not apply

In-Network Only

Medical Equipment, Supplies and Devices

| | |
|---|-----------------|
| Removable custom shoe orthotics (Limited to \$200 per calendar year) | Covered in full |
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| Oral Sleep Apnea Appliance | Covered in full |
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Mental Health and Substance Use Disorder (Services, except outpatient provider office visits, may require prior authorization.)

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| Inpatient and residential services | Covered in full |
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| Day treatment, intensive outpatient, and partial hospitalization services | Covered in full |
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| Outpatient provider visits (In-Person or Virtually) | Covered in full |
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| Applied Behavior Analysis | Covered in full |
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Home Health and Hospice

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| Home health care | Covered in full |
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|--------------|-----------------|
| Hospice care | Covered in full |
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| Respite care (limited to Members receiving Hospice care; limited to 5 consecutive days, up to 30 days per lifetime) | Covered in full |
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Biofeedback

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| Biofeedback for specified diagnosis (limited to 10 visits per lifetime) | Covered in full |
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Chiropractic Manipulation and Acupuncture (Massage therapy not covered) (Acupuncture and Chiropractic Manipulation Copayments and Coinsurance do not apply to your Out-of-Pocket Maximums)

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| Chiropractic manipulations (limited to 20 visits per calendar year) | Covered in full |
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| Acupuncture (limited to 12 visits per calendar year) | Covered in full |
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Prescription Drugs

Formulary N

Below is the amount you pay after you have met your calendar year Deductible

✓ Deductible does not apply

Up to a 30-Day Supply

(From a participating retail, preferred or specialty pharmacy)

| | |
|--------|-----------------|
| Tier 1 | Covered in full |
| Tier 2 | Covered in full |
| Tier 3 | Covered in full |
| Tier 4 | Covered in full |
| Tier 5 | Covered in full |
| Tier 6 | Covered in full |

90-Day Supply

(From a participating mail order or preferred retail pharmacy)

| | |
|--------|-----------------|
| Tier 1 | Covered in full |
| Tier 2 | Covered in full |
| Tier 3 | Covered in full |
| Tier 4 | Covered in full |

Pharmacies

Your prescription drug benefit requires that you fill your prescriptions at a Participating Pharmacy. There are four types of participating pharmacies:

- Retail: a Participating Pharmacy that allows up to a 30-day supply as outlined in your handbook of short-term and maintenance prescriptions.
- Preferred Retail: a Participating Pharmacy that allows up to a 90-day supply of maintenance prescriptions and access to up to a 30-day supply of short-term prescriptions.
- Specialty: a Participating Pharmacy that allows up to a 30-day supply of specialty and self-administered chemotherapy prescriptions. These prescriptions require special delivery, handling, administration and monitoring by your pharmacist.
- Mail Order: a Participating Pharmacy that allows up to a 90-day supply of maintenance prescriptions and specializes in direct delivery to your home. To order prescriptions by mail, your provider may call in the prescription or you can mail your prescription along with your Member identification number to one of our participating mail-order pharmacies.
- View a list of our participating pharmacies ProvidenceHealthPlan.com/planpharmacies.

Using your prescription drug benefit

- To find if a drug is covered under your plan check online at ProvidenceHealthPlan.com/pharmacy. Note that your plan's formulary includes ACA Preventive drugs which are medications that are covered at no cost when received from participating pharmacies as required by the Patient Protection and Affordable Care Act.
- FDA-approved women's contraceptives, as listed on your formulary, are covered at no cost for up to a 12-month supply, after a 3-month initial fill, at any Participating Pharmacy.

Prescription Drugs

Formulary N

- You may purchase up to a 90-day supply of maintenance drugs using a participating mail-service or preferred retail pharmacy. Not all drugs are considered maintenance prescriptions, including compounded drugs and drugs obtained from specialty pharmacies.
- If you or your provider request or prescribe a brand-name drug when a generic is available, regardless of reason, you will be responsible for the cost difference between the brand-name and generic drug in addition to the Tier 4 or Tier 6 copayment or coinsurance indicated on the benefit summary. Your total cost, however, will never exceed the actual cost of the drug.
- Approved non-formulary non-specialty drugs will be covered at the Tier 4 cost sharing tier. Approved non-formulary specialty drugs will be covered at the Tier 6 cost sharing tier.
- Compounded medications are prescriptions that are custom prepared by your pharmacist. They must contain at least one FDA-approved drug to be eligible for coverage under your plan. Compounded medications are covered for up to a 30-day supply at a 0% coinsurance after the deductible. Claims are subject to clinical review for medical necessity and are not guaranteed for payment.
- Specialty drugs, which can be found in Tier 5 and Tier 6, are prescriptions that require special delivery, handling, administration and monitoring by your pharmacist.
- Most specialty and chemotherapy drugs are only available at our designated specialty pharmacies.
- Diabetes supplies may be obtained at your participating pharmacy, and are covered under your prescription benefit. Refer to your formulary and Member Contract for details.
- Certain drugs, devices, and supplies obtained from your pharmacy may apply towards your medical benefit.
- Insulin cost share capped at \$85 for a 30-day supply, \$255 for a 90-day supply. Deductible does not apply.
- Some prescription drugs require Prior Authorization for medical necessity, place of therapy, length of therapy, step therapy, or number of doses. If a drug to treat your covered medical condition is not in the formulary, please contact us.
- Self-administered chemotherapy is covered under the Prescription Drug Benefit unless the Outpatient Chemotherapy coverage results in a lower out-of-pocket expense to you. Please refer to your Contract for more information.
- Self-injectable medications are only covered when they are being self-administered and labeled by the FDA for self-administration; in some cases, a Prior Authorization may be required for the drug. Documentation of self-administration may also be required. Drugs labeled for self-administration that are being administered by a provider will fall to the Member's medical benefit.
- If you take an eligible specialty medication, the Specialty Pharmacy Variable Copay Program helps lower your out-of-pocket costs to \$0. The list of medications eligible for this program is available at [ProvidenceHealthPlan.com/smartrxassist](https://www.providencehealthplan.com/smartrxassist). Refer to your contract for more information.
- Be sure you present your current Providence Health Plan Member identification card.

Routine Vision Services

Provided by VSP

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|-------------------------------------|----------------|
| Individual Calendar Year Deductible | Not Applicable |
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|----------------------------------|----------------|
| Individual Out-of-Pocket Maximum | Not Applicable |
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This amount includes the deductible.

VSP Advantage Network (For Customer Service call 800-877-7195)

Below is the amount you pay after you have met your calendar year Deductible

✓ Deductible does not apply

In-Network Only

Pediatric Vision Services (under age 19)

| | |
|--|-----------------|
| Routine eye exam (limited to 1 exam per calendar year) | Covered in full |
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Lenses (limited to 1 pair per calendar year)

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|---------------|-----------------|
| Single vision | Covered in full |
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| Lined bifocal | Covered in full |
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| Lined trifocal | Covered in full |
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| Lenticular lenses | Covered in full |
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| Frames (limited to 1 pair per calendar year; select from VSP's Otis & Piper™ Eyewear Collection) | Covered in full |
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| Contact lens services and materials in place of glasses | Covered in full |
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Standard: 1 pair per calendar year (1 contact lens per eye)

Monthly: 6 month supply per calendar year (6 lenses per eye)

Bi-weekly: 3 month supply per calendar year (6 lenses per eye)

Dailies: 3 month supply per calendar year (90 lenses per eye)

Adult Vision Services

(Copayments do not apply to your Out-of-Pocket Maximum)

| | |
|--|-----------------|
| Routine eye exam (limited to 1 exam per calendar year) | Covered in full |
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Pediatric Dental Service (under age 19)

Delta Dental PPO™ Network

For customer service, including dental prior authorizations and claims, call 833-212-5035

Below is the amount you pay after you have met your calendar year deductible

✓ **Deductible does not apply**

In-Network Only

| Preventive | |
|---|-------------------|
| Routine Exams One per 6 months | Covered in full ✓ |
| Bitewing X-rays One set per 12 months | Covered in full ✓ |
| Cleanings One per 6 months | Covered in full ✓ |
| Topical Fluoride One per 6 months | Covered in full ✓ |
| Fissure sealants 1 service per tooth (molar) every 5 years (Limited to the unrestored occlusal surfaces of permanent molars) | Covered in full ✓ |
| Basic | |
| Restorative fillings | Covered in full |
| Space Maintainers Once per space | Covered in full |
| Major | |
| Oral surgery (extractions and other minor surgical procedures) | Covered in full |
| Endodontics and Periodontics | Covered in full |
| Stainless Steel Crowns Once per lifetime for primary teeth; once per 24 months for permanent teeth | Covered in full |
| Porcelain Crowns One service per tooth in a 7-year period | Covered in full |
| Denture and bridge work (construction or repair of fixed bridges, partials and complete dentures) Limited to once every 7 years. Dentures not covered for members under age 16. Partial dentures if placed within 2 months of the extraction of an anterior tooth or for missing anterior teeth for members age 16 and under. | Covered in full |
| Occlusal guard (nightguard) covered up to \$200 every five years | Covered in full |
| Athletic mouthguards Limited to once every 12 months for under age 16 and once every 24 months for ages 16 and over | Covered in full |
| Orthodontia is covered to treat cleft palate with or without cleft lip | Covered in full |

Explanation of terms and phrases

ACA Preventive Drugs - ACA Preventive drugs are medications, including contraceptives, which are listed in our formulary, and are covered at no cost when received from Participating Pharmacies as required by the Patient Protection and Affordable Care Act (ACA). Over the counter preventive drugs received from Participating Pharmacies cannot be covered in full without a written prescription from your Qualified Practitioner.

Brand-name drugs - Brand-name drugs are protected by U.S. patent laws and only a single manufacturer has the rights to produce and sell them.

Coinsurance - The percentage of the cost that you may need to pay for Covered Service.

Copay - The fixed dollar amount you pay to a healthcare provider for a Covered Service at the time care is provided.

Deductible - The dollar amount that an individual or family pays for Covered Service before the plan pays any benefits within a Calendar Year. The following expenses do not apply to the individual or family deductible: Services not covered by the plan; fees that exceed Usual, Customary and Reasonable (UCR) charges as established by the plan; penalties incurred if you do not follow the plan's Prior Authorization requirements; copays and Coinsurance for Services that do not apply to the deductible.

NOTE: No Member will ever pay more than an Individual Deductible before the Plan begins paying for covered services for that Member.

Formulary - A formulary is a list of FDA-approved prescription drugs developed by physicians and pharmacists, designed to offer effective drug treatment choices for covered medical conditions. The Providence Health Plan formulary includes both brand-name and generic medications.

Generic drugs - Generic drugs have the same active-ingredient formula as the brand-name drug. Generic drugs are usually available after the brand-name patent expires.

Medical Home - A full Service healthcare clinic which has been designated as a Medical Home providing and coordinating Members' medical care.

Medicare Part D creditable

Medicare Part D creditable - Coverage is creditable when the plan payout for prescription drugs is, on average for all plan participants, as much as the average payout under the standard Medicare Part D benefit.

Not Medicare Part D creditable - Coverage is non-creditable when the plan payout for prescription drugs is, on average for all plan participants, less than what standard Medicare Part D prescription drug coverage would be expected to pay.

Non-Formulary Medication - An FDA-approved drug, generic or brand-name, that is not included in the list of approved formulary medications. These prescriptions require a Prior Authorization by the health plan and, if approved, will pay at either the highest non-specialty or specialty cost sharing tier.

Office Visits Virtually - Scheduled visits with the member's PCP or Specialist using a teleconferencing application such as Zoom.

Out-of-Pocket Maximum - The limit on the dollar amount that an individual or family pays for specified Covered Services in a Calendar Year. Some Services and expenses do not apply to the individual or family Out-of-Pocket Maximum. See your Member handbook or contract for details.

NOTE: Once any Member meets the Individual Out-of-Pocket Maximum, the Plan will begin to pay 100% for Covered Services for that Member.

Primary Care Provider - A qualified physician or practitioner that can provide most of your care and, when necessary, will coordinate care with other providers in a convenient and cost-effective manner.

Explanation of terms and phrases

In-Network - Refers to Services received from an extensive network of highly qualified physicians, health care providers and facilities contracted by Providence Health Plan for your specific plan. Generally, your Out-of-Pocket costs will be less when you receive Covered Service from In-Network Providers.

Limitations and Exclusions - All Covered Services are subject to the limitations and exclusions specified for your plan. Refer to your Member handbook or contract for a complete list.

Maintenance Prescriptions - Medications that are typically prescribed to treat long-term or chronic conditions, such as diabetes, high blood pressure and high cholesterol. Maintenance drugs are those that you have received under our plan for at least 30 days and that you anticipate continuing to use in the future. Compounded and specialty medications are excluded from this definition; and are limited to a 30 day supply.

Prescription drug Prior Authorization - The process used to request an exception to the Providence Health Plan drug formulary. A Prior Authorization can be requested by the prescriber, member or pharmacy. Some drugs require Prior Authorization for Medical Necessity, place of therapy, length of therapy, step therapy or number of doses. Visit us online for additional information at ProvidenceHealthPlan.com.

Prescription drug Tier - The prescription drug tier number correlates to a drug's placement on the formulary. Tier 1 and Tier 2 consists of mainly generic drugs while Tier 3 and Tier 4 contains both generic and brand-name drugs. Specialty drugs are listed in Tier 5 and Tier 6.

Prior Authorization - Some Services must be pre-approved. In-Network, your provider will request Prior Authorization. Out-of-Network, you are responsible for obtaining Prior Authorization.

Explanation of terms and phrases

Providence ExpressCare Virtual - Services for common conditions (such as sore throat, cough, or fever, etc.) using Providence's web-based platform through a tablet, smartphone, or computer for same day appointments.

Providence ExpressCare Retail Health Clinic - A walk-in health clinic, other than an office, Urgent Care facility, pharmacy or independent clinic that is located within a retail operation. A Retail Health Clinic provides same-day visits for basic illness and injuries or preventive services.

Specialty Drugs - Specialty drugs are injectable, infused, oral, topical, or inhaled therapies that often require specialized delivery, handling, monitoring and administration and are generally high cost. These drugs must be purchased through our designated specialty pharmacy. Due to the nature of these medications, specialty drugs are limited to a 30-day supply. Your benefits include specialty drugs listed on our formulary in Tier 5 and Tier 6. Generally your out-of-pocket costs will be less for Tier 5 drugs.

Contact us

Portland Metro Area: 503-574-7500
All other areas: 800-878-4445
TTY:711

[ProvidenceHealthPlan.com/contactus](https://www.providencehealthplan.com/contactus)

Non-Discrimination Statement

Providence Health Plan and Providence Health Assurance comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, sexual orientation, religion, gender identity, marital status or sex. Providence Health Plan and Providence Health Assurance do not exclude people or treat them differently because of race, color, national origin, age, disability, sexual orientation, religion, gender identity, marital status or sex.

Providence Health Plan and Providence Health Assurance:

- 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, you can call us at 503-574-7500 or 1-800-878-4445 (TTY: 711).

If you believe that Providence Health Plan or Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sexual orientation, religion, gender identity, marital status or sex, you can file a grievance with our Non-discrimination Coordinator by mail:

Providence Health Plan and Providence Health Assurance
Attn: Non-discrimination Coordinator
PO Box 4158
Portland, OR 97208-4158
E-mail: PHPAppealsandGrievances@providence.org

If you need help filing a grievance, call us at 503-574-7500 or 1-800-878-4445 (TTY: 711) for assistance.

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, DC 20201
1-800-368-1019, 1-800-537-7697 (TTY)

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

Members of Oregon Plans may file a complaint with the Division of Financial Regulation at 1-888-877-4894 or visit <https://dfr.oregon.gov/Pages/index.aspx>.

Language Access Services

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call [1-800-898-8174] (TTY: [711]).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-898-8174 (TTY: 711).

Russian: ВНИМАНИЕ: Если Вы говорите по-русски, то Вам доступны услуги бесплатной языковой поддержки. Звоните 1-800-898-8174 (телетайп: 711).

Vietnamese: CHÚ Ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Xin gọi số 1-800-898-8174 (TTY: 711).

Traditional Chinese: 注意：如果您說中文，您可以免費獲得語言支援服務。請致電 1-800-898-8174 (TTY: 711)。

Kushite: XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-898-8174 (TTY: 711).

Farsi:

توجه: اگر به زبان فارسی صحبت میکنید، تسهیلات زبانی ن به صورت رایگان به شما ارائه میشود. با 1-800-898-8174 (TTY: 711) تماس بگیرید.

Ukrainian: УВАГА! Якщо Ви розмовляєте українською мовою, для Вас доступні безкоштовні послуги мовної підтримки. Телефонуйте за номером 1-800-898-8174 (телетайп: 711).

Japanese:

お知らせ: 日本語での通話をご希望の場合、言語支援サービスを無料でご利用いただけます。1-800-898-8174 (TTY: 711) まで、お電話ください。

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-898-8174(TTY: 711) 번으로 전화해 주십시오

Nepali: ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंले दनम्र भाषा सहायता सेवाहरू दनःशुल्क रूपमा उपलब्ध छन् । 1-800-898-8174 (TTY: 711) मा फोन गर्नुहोस् ।

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii gratuite de asistență lingvistică. Sunați 1-800-898-8174 (TTY: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzen zur Verfügung. Rufnummer: 1-800-898-8174 (TTY: 711).

Hmong: LUS CEEB TOOM: Yog tias koj hais lus Hmoob, cov kev pab txhais lus, muaj kev pab dawb rau koj. Hu rau 1-800-898-8174 (TTY: 711).

Cambodian: កំណត់សម្គាល់៖ បើសិនជាអ្នកនិយាយភាសាខ្មែរ អាចម្តងបសវនករជំនួយខ្លួនភាសាបោយមិនគិតថ្លៃពីបោកអ្នក។

សូមបោកទូរស័ព្ទបលម 1-800-898-8174 (TTY: 711)។

Laotian: ເລືອນຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ຈະມີການຊ່ວຍເຫຼືອ ວ່າ ດ້ານພາສາ ໃດຍບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ໂທ 1-800-898-8174 (TTY: 711)