

# 2022 Summary of Benefits

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## **Providence Medicare Dual Plus (HMO D-SNP)**

January 1, 2022 – December 31, 2022

This plan is available in Clackamas, Multnomah and Washington counties in Oregon.

## When you join Providence

You're part of something bigger than an insurance policy. You're part of a community of care, focused on your health and well-being. To help you make the right health care decisions, we're providing this summary of benefits, a succinct guide that breaks down what we would cover and what you would pay if you joined our Providence Medicare Dual Plus (HMO D-SNP) plan. To be clear, this summary of benefits is just that, a summary. It doesn't list every service that we cover nor every limitation or exclusion. Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

For a complete list of services that we cover, please refer to the Evidence of Coverage (EOC). You can request a printed copy by visiting [ProvidenceHealthAssurance.com/EOC](https://www.providencehealthassurance.com/EOC) or by calling our Customer Service department at one of the numbers listed in the "Get in touch" section below.

## Plan overview

Providence Medicare Advantage Plans is an HMO, HMO-POS and HMO SNP with Medicare and Oregon Health Plan contracts. Enrollment in Providence Medicare Advantage Plans depends on contract renewal.

Our plan members get all of the benefits covered by Original Medicare as well as some extra benefits outlined in this summary.

## Who can join?

To join our plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, be eligible for full Oregon Health Plan (Medicaid) benefits and live in our service area. Our service area includes Clackamas, Multnomah and Washington counties in Oregon.

## Get in touch

Questions? We're here to help seven days a week from 8 a.m. to 8 p.m. (Pacific Time).

- + If you're a member of this plan, call us toll-free at 1-800-603-2340 (TTY: 711)
- + If you're not a member of this plan, call us toll-free at 1-800-457-6064 (TTY: 711)
- + You can also visit us online at [ProvidenceHealthAssurance.com](https://www.providencehealthassurance.com)

## Helpful resources

- + Visit [ProvidenceHealthAssurance.com/findaprovider](https://www.providencehealthassurance.com/findaprovider) to see our plan's Provider and Pharmacy Directory or to request a printed copy. You can also call us to have a printed copy mailed to you.
- + Want to see our plan's formulary (list of Part D prescription drugs), including any restrictions? Visit [ProvidenceHealthAssurance.com/Formulary](https://www.providencehealthassurance.com/Formulary), or give us a call for a printed copy.
- + To learn more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook, view it online at [www.Medicare.gov](https://www.Medicare.gov) or request a printed copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

## Providence Medicare Dual Plus (HMO D-SNP)

|  |   |
|--|---|
| Monthly Plan Premium   | \$0<br>You must continue to pay your Medicare Part B premium.   |
| Annual Medical Deductible  | \$0 or \$233 per year<br>\$0 per year for Part D prescription drugs   |
| Maximum Out-of-Pocket Responsibility (does not include prescription drugs) | In this plan, you might pay nothing for Medicare-covered services, depending on your level of Oregon Health Plan (Medicaid) eligibility.<br><br>Your yearly limit(s) in this plan in-network: \$3,400 |

| Benefits                                  | In-network  |
|---|---|
| Inpatient Hospital Coverage <sup>1</sup>  | <p><b><u>Providence Medicare Dual Plus (HMO D-SNP):</u></b><br/>These are 2022 cost-sharing amounts.</p> <p>\$0 or \$1,556 deductible for each benefit period<br/>\$0 copayment for days 1-60;<br/>\$389 copayment each day for days 61-90;<br/>\$778 copayment each day for days 91-150<br/>\$0 copayment each day for days 151 and beyond</p> <p><b><u>Oregon Health Plan (Medicaid):</u></b><br/>\$0 copayment for Medicaid-covered services</p> |
| Outpatient Hospital Coverage <sup>1</sup> | <p><b><u>Providence Medicare Dual Plus (HMO D-SNP):</u></b><br/>0% or 20% of the total cost for outpatient surgery at a hospital facility</p> <p><b><u>Oregon Health Plan (Medicaid):</u></b><br/>\$0 copayment for Medicaid-covered services</p>   |
| Ambulatory Surgery Center <sup>1</sup>    | <p><b><u>Providence Medicare Dual Plus (HMO D-SNP):</u></b><br/>0% or 20% of the total cost for outpatient surgery at an Ambulatory Surgery Center</p> <p><b><u>Oregon Health Plan (Medicaid):</u></b><br/>\$0 copayment for Medicaid-covered services</p>  |

<sup>1</sup> Services may require prior authorization.

<sup>2</sup> Services may require a referral from your doctor.

## Providence Medicare Dual Plus (HMO D-SNP)

| Benefits                 |                               | In-network  |
|--------------------------|-------------------------------|---|
| Doctor Visits            | Primary Care Provider Visit   | <p><b>Providence Medicare Dual Plus (HMO D-SNP):</b><br/>0% or 20% of the total cost</p> <p><b>Oregon Health Plan (Medicaid):</b><br/>\$0 copayment for Medicaid-covered services</p>   |
|                          | Specialist Visit <sup>2</sup> | <p><b>Providence Medicare Dual Plus (HMO D-SNP):</b><br/>0% or 20% of the total cost</p> <p><b>Oregon Health Plan (Medicaid):</b><br/>\$0 copayment for Medicaid-covered services</p>   |
| Preventive Care          |                               | <p><b>Providence Medicare Dual Plus (HMO D-SNP):</b><br/>You pay nothing for all preventive services covered under Original Medicare</p> <p><b>Oregon Health Plan (Medicaid):</b><br/>\$0 copayment for Medicaid-covered services</p>   |
| Emergency Care           |                               | <p><b>Providence Medicare Dual Plus (HMO D-SNP):</b><br/>0% or 20% of the total cost, up to \$120<br/>If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care.</p> <p><b>Oregon Health Plan (Medicaid):</b><br/>\$0 copayment for Medicaid-covered services</p> |
| Urgently Needed Services |                               | <p><b>Providence Medicare Dual Plus (HMO D-SNP):</b><br/>0% or 20% of the total cost, up to \$65<br/>If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgent care.</p> <p><b>Oregon Health Plan (Medicaid):</b><br/>\$0 copayment for Medicaid-covered services</p>     |

<sup>1</sup> Services may require prior authorization.

<sup>2</sup> Services may require a referral from your doctor.

# Providence Medicare Dual Plus (HMO D-SNP)

| Benefits  |  | In-network   |
|---|--|--|
| Diagnostic Services/<br>Labs/Imaging <sup>1</sup> | Diagnostic Radiology Services (e.g. MRI, ultrasounds, CT scans) <sup>1</sup> | <b>Providence Medicare Dual Plus (HMO D-SNP):</b><br>0% or 20% of the total cost<br><b>Oregon Health Plan (Medicaid):</b><br>\$0 copayment for Medicaid-covered services                                       |
|   | Therapeutic Radiology Services   | <b>Providence Medicare Dual Plus (HMO D-SNP):</b><br>0% or 20% of the total cost<br><b>Oregon Health Plan (Medicaid):</b><br>\$0 copayment for Medicaid-covered services                                       |
|   | Outpatient X-rays  | <b>Providence Medicare Dual Plus (HMO D-SNP):</b><br>0% or 20% of the total cost<br><b>Oregon Health Plan (Medicaid):</b><br>\$0 copayment for Medicaid-covered services                                       |
|   | Diagnostic Tests and Procedures <sup>1</sup>                                 | <b>Providence Medicare Dual Plus (HMO D-SNP):</b><br>0% or 20% of the total cost<br><b>Oregon Health Plan (Medicaid):</b><br>\$0 copayment for Medicaid-covered services                                       |
|   | Lab Services   | <b>Providence Medicare Dual Plus (HMO D-SNP):</b><br>\$0 copayment<br><b>Oregon Health Plan (Medicaid):</b><br>\$0 copayment for Medicaid-covered services   |
| Hearing Services                                  | Medicare-Covered <sup>2</sup>  | <b>Providence Medicare Dual Plus (HMO D-SNP):</b><br>0% or 20% of the total cost<br><b>Oregon Health Plan (Medicaid):</b><br>\$0 copayment for Medicaid-covered services                                       |
| Dental Services                                   | Medicare-Covered <sup>2</sup>  | <b>Providence Medicare Dual Plus (HMO D-SNP):</b><br>0% or 20% of the total cost<br><b>Oregon Health Plan (Medicaid):</b><br>\$0 copayment for Medicaid-covered services                                       |
|   | Embedded Preventive  | <b>Providence Medicare Dual Plus (HMO D-SNP):</b><br>\$0 copayment<br>Includes exams, cleanings, X-rays; limits apply.<br><b>Oregon Health Plan (Medicaid):</b><br>\$0 copayment for Medicaid-covered services |

<sup>1</sup> Services may require prior authorization.

<sup>2</sup> Services may require a referral from your doctor.

# Providence Medicare Dual Plus (HMO D-SNP)

| Benefits                            |  | In-network  |
|-------------------------------------|--|---|
| Vision Services                     | Medicare-Covered Exams <sup>2</sup> /Screening | <p><b><u>Providence Medicare Dual Plus (HMO D-SNP):</u></b><br/>0% or 20% of the total cost per exam<br/>0% or 20% of the total cost for glaucoma screening</p> <p><b><u>Oregon Health Plan (Medicaid):</u></b><br/>Not covered</p>   |
|                                     | Routine Exam                                   | <p><b><u>Providence Medicare Dual Plus (HMO D-SNP):</u></b><br/>Allowance of up to \$75 per calendar year for a routine vision exam (including refraction)</p> <p><b><u>Oregon Health Plan (Medicaid):</u></b><br/>Not covered</p>  |
|                                     | Medicare-Covered Eyewear                       | <p><b><u>Providence Medicare Dual Plus (HMO D-SNP):</u></b><br/>0% or 20% of the total cost for one pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery</p> <p><b><u>Oregon Health Plan (Medicaid):</u></b><br/>Not covered</p>   |
|                                     | Routine Eyeglasses or Contact Lenses           | <p><b><u>Providence Medicare Dual Plus (HMO D-SNP):</u></b><br/>Allowance of up to \$210 per calendar year for any combination of routine prescription eyewear</p> <p><b><u>Oregon Health Plan (Medicaid):</u></b><br/>Not covered</p>  |
| Mental Health Services <sup>1</sup> | Inpatient Visit                                | <p><b><u>Providence Medicare Dual Plus (HMO D-SNP):</u></b><br/>These are 2022 cost-sharing amounts.</p> <p>\$0 or \$1,556 deductible for each benefit period<br/>\$0 copayment for days 1-60;<br/>\$389 copayment each day for days 61-90;<br/>\$778 copayment per each “lifetime reserve day” after day 90 (up to 60 days over your lifetime)<br/>\$0 copayment for all costs beyond lifetime reserve days.</p> <p><b><u>Oregon Health Plan (Medicaid):</u></b><br/>\$0 copayment for Medicaid-covered services</p> |
|                                     | Outpatient Individual and Group Therapy Visit  | <p><b><u>Providence Medicare Dual Plus (HMO D-SNP):</u></b><br/>0% or 20% of the total cost</p> <p><b><u>Oregon Health Plan (Medicaid):</u></b><br/>\$0 copayment for Medicaid-covered services</p>   |

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<sup>2</sup> Services may require a referral from your doctor.

# Providence Medicare Dual Plus (HMO D-SNP)

| Benefits                                    | In-network  |
|---|---|
| Skilled Nursing Facility (SNF) <sup>1</sup> | <p><b><u>Providence Medicare Dual Plus (HMO D-SNP):</u></b><br/>These are 2022 cost-sharing amounts.</p> <p>\$0 copayment for days 1-20 of a benefit period;<br/>\$194.50 copayment each day for days 21-100</p> <p><b><u>Oregon Health Plan (Medicaid):</u></b><br/>\$0 copayment for Medicaid-covered services. Medicaid covers up to 20 days in a SNF.</p> |
| Physical Therapy <sup>1</sup>               | <p><b><u>Providence Medicare Dual Plus (HMO D-SNP):</u></b><br/>0% or 20% of the total cost</p> <p><b><u>Oregon Health Plan (Medicaid):</u></b><br/>\$0 copayment for Medicaid-covered services</p>   |
| Ambulance <sup>1</sup>                      | <p><b><u>Providence Medicare Dual Plus (HMO D-SNP):</u></b><br/>0% or 20% of the total cost</p> <p><b><u>Oregon Health Plan (Medicaid):</u></b><br/>\$0 copayment for Medicaid-covered services</p>   |
| Transportation                              | <p><b><u>Providence Medicare Dual Plus (HMO D-SNP):</u></b><br/>\$0 copayment for 36 one-way trips (max of 25 miles each way)</p> <p><b><u>Oregon Health Plan (Medicaid):</u></b><br/>\$0 copayment for Medicaid-covered services</p>   |
| Medicare Part B Drugs <sup>1</sup>          | <p><b><u>Providence Medicare Dual Plus (HMO D-SNP):</u></b><br/>0% or 20% of the total cost</p> <p><b><u>Oregon Health Plan (Medicaid):</u></b><br/>\$0 copayment for Medicaid-covered services</p>   |
| Meal Delivery Program (post-discharge only) | <p><b><u>Providence Medicare Dual Plus (HMO D-SNP):</u></b><br/>\$0 copayment for 2 meals per day for 14 days, following a qualifying inpatient hospitalization</p> <p><b><u>Oregon Health Plan (Medicaid):</u></b><br/>Not covered</p>   |
| Over-the-Counter Items                      | <p><b><u>Providence Medicare Dual Plus (HMO D-SNP):</u></b><br/>\$204 allowance per quarter (retail card, catalog, online, mail, and telephonic ordering)</p> <p><b><u>Oregon Health Plan (Medicaid):</u></b><br/>Not covered</p>   |

# Providence Medicare Dual Plus (HMO D-SNP)

|   |  |
|---|--|
| Personal Emergency Response System (PERS) | <b><u>Providence Medicare Dual Plus (HMO D-SNP):</u></b><br>\$0 copayment<br><b><u>Oregon Health Plan (Medicaid):</u></b><br>Not covered |
| Wellness Program                          | \$0 copayment for monthly gym membership with participating fitness clubs<br><b><u>Oregon Health Plan (Medicaid):</u></b><br>Not covered |

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<sup>2</sup> Services may require a referral from your doctor.



# Prescription Drug Benefits

## Providence Medicare Dual Plus (HMO D-SNP)

| Prescription Drug Deductible                                 |   |                  |                  |
|--|---|------------------|------------------|
| Yearly Deductible  | If you receive “Extra Help” to pay your prescription drugs, this payment stage does not apply to you. |                  |                  |
| Initial Coverage   | You pay the following until your total yearly out-of-pocket costs reach \$4,430.                      |                  |                  |
| For Generic Drugs (including brand drugs treated as generic) |   |                  |                  |
| You Pay Either:  | \$0 copayment   | \$1.35 copayment | \$3.95 copayment |
| For All Other Drugs  |   |                  |                  |
| You Pay Either:  | \$0 copayment   | \$4.00 copayment | \$9.85 copayment |
|  | You may get your drugs at network retail pharmacies and mail order pharmacies.                        |                  |                  |

If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy. You may get drugs from a standard in-network pharmacy, but may pay more than you pay at a preferred in-network pharmacy.

|                       |  |  |  |
|-----------------------|--|--|--|
| Coverage Gap          | Because there is no coverage gap for the plan, this payment stage does not apply to you.   |  |  |
| Catastrophic Coverage | After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$7,050, you pay nothing for all drugs. |  |  |

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

# Summary of Benefits

## Providence Medicare Dual Plus (HMO D-SNP)

### Summary of Oregon Health Plan (Medicaid) Covered Services

The benefits described in the Premium and Benefit section of the Summary of Benefits are covered by Providence Medicare Dual Plus (HMO D-SNP). For certain members, the Oregon Health Plan (Medicaid) may only pay cost-sharing amounts for services that the Oregon Health Plan (Medicaid) would normally cover. Please contact the Oregon Health Plan (Medicaid) or your Coordinated Care Organization for more information. Providence Medicare Dual Plus (HMO D-SNP) members who are enrolled with Providence through Health Share of Oregon for the Oregon Health Plan (Medicaid) will not have out-of-pocket costs for any Medicare-covered medical service. Prescription drug cost-sharing amounts still apply.

Detailed information regarding your Oregon Health Plan (Medicaid) benefits can be found at the following link: [www.oregon.gov/oha/HSD/OHP/Pages/Benefits.aspx](http://www.oregon.gov/oha/HSD/OHP/Pages/Benefits.aspx) or by calling your Coordinated Care Organization's Customer Service.

| <b>The following is a list of Oregon Health Plan (Medicaid) Covered Services</b> |  |
|--|--|
| <b>Benefits</b>  | <b>Additional information</b>  |
| Chemical dependency care   |  |
| Dental   | Basic services including cleaning, fluoride varnish, fillings and extractions<br>Urgent or immediate treatment<br>Dentures<br>Stainless steel crowns for molars (back teeth)<br>Other crowns for pregnant women and children under age 21<br>Sealants, root canals on back teeth for children under age 21 |
| Hearing  | Hearing aids and hearing aid exams   |
| Home health  | Private duty nursing   |
| Hospice care   | End-of-life care   |
| Hospital care  | Emergency treatment<br>Inpatient and outpatient care   |
| Immunizations and vaccines   | Such as the flu shot or measles-mumps-rubella (MMR) vaccine  |
| Labor, delivery, and post-partum care  |  |
| Laboratory tests and X-rays  |  |
| Medical care from a physician, nurse practitioner or physician assistant         | Such as a routine check-up or a general appointment  |
| Medical equipment and supplies   | Such as diabetes testing strips or crutches  |
| Medical transportation   | Such as an ambulance or non-emergency transportation to an appointment   |
| Mental health care   | Such as therapy or medical treatment   |
| Physical, occupational and speech therapy  |  |
| Prescription drugs   | OHP with Limited Drug only includes drugs that are not covered by Medicare Part D  |
| Vision   | Medical services<br>Services to correct vision for pregnant women and children under age 21<br>Glasses are covered for pregnant adults and adults who have a qualifying medical condition such as aphakia or keratoconus, or after cataract surgery.   |

# Summary of Benefits

## Providence Medicare Dual Plus (HMO D-SNP)

### Services that are not covered by the Oregon Health Plan Medicaid (Exclusions):

Not all medical treatments are covered. When you need medical treatment, please contact your Primary Care Provider. These are some of the exclusions (does not include every exclusion):

- + Medicare Part D covered prescription drugs
- + Conditions where a “home” treatment is effective, such as applying ointment, resting a painful joint, drinking plenty of fluids, or a soft diet. Such conditions include:
  - + Canker sores
  - + Diaper rash
  - + Corns/calluses
  - + Sunburn
  - + Food poisoning
  - + Sprains
- + Personal comfort or convenience items (radios, telephones, hot tubs, treadmills, etc.)
- + Services that are primarily cosmetic, such as:
  - + Benign skin tumors
  - + Cosmetic surgery
- + Removal of scars
- + Conditions where treatment is not normally effective such as:
  - + Some back surgery
  - + TMJ surgery
  - + Some transplants
- + Services performed by an immediate relative or member of your household
- + Any services received outside the United States
- + Non-emergency care if you go to a provider who is not a network provider
- + Other non-covered services include, but are not limited to, the following:
  - + Infertility service

If you have any questions about covered or non-covered services, contact your Coordinated Care Organization’s Customer Service.

This information is not a complete description of benefits. Call **1-800-603-2340**, TTY users call 711 for more information. The Part B premium is covered for full-dual enrollees who are eligible for Providence Medicare Dual Plus (HMO D-SNP). Premium, copays, coinsurance, and deductibles may vary based on the level of Extra Help you receive. Please contact the plan for further details.

## 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 are a Medicare member who needs these services, call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. Hearing impaired members may call our TTY line at 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

If you need help filing a grievance, and you are a Medicare member call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445 (TTY line at 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>.

## Language Access Information

**ATTENTION:** If you speak English, language assistance services, free of charge, are available to you. Call 1-800-603-2340 (TTY: 711).

**Spanish:** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-603-2340 (TTY: 711).

**Chinese:** 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-603-2340 (TTY: 711)

**Vietnamese:** CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-603-2340 (TTY: 711).

**Korean:** 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-603-2340 (TTY: 711) 번으로 전화해 주십시오.

**Russian:** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-603-2340 (телетайп: 711).

**Tagalog:** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-603-2340 (TTY: 711).

**Ukrainian:** УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-603-2340 (телетайп: 711).

**Mon-Khmer, Cambodian:** ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃគឺអាចមានសំរាប់អ្នក។ ចូរទូរស័ព្ទ 1-800-603-2340 (TTY: 711)។

**Japanese:** 注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。1-800-603-2340 (TTY:711)まで、お電話にてご連絡ください。

**Amharic:** ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገዝዎት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 1-800-603-2340 (መስማት ለተሳናቸው: 711)።

**Cushite (Oromo):** XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-603-2340 (TTY: 711).

### Arabic:

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-603-2340 (رقم هاتف الصم والبكم: (TTY: 711).

**Punjabi:** ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-603-2340 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

**German:** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-603-2340 (TTY: 711).

**Laotian:** ໂປດຊາບ: ຖ້າ ວ່າ ທ່ານ ອ້າ າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອ ອັດຕາ າພາສາ, ໂດຍບໍ່ເສັຽ ງຄ່າ າ, ແມ່ນ ນມພັດ ອມໃຫ້ ທ່ານ. ໂທຣ 1-800-603-2340 (TTY: 711).

**Romanian:** ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-603-2340 (TTY: 711).

**French:** ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-603-2340 (ATS: 711).

**Thai:** เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-603-2340 (TTY: 711)

**Persian:**

**توجه:** اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما تماس بگیرید.  
فراهم می باشد. با 1-800-603-2340 (TTY: 711)