Providence
Medicare Advantage Plans

2026 Summary of Benefits

Providence Medicare Dual Plus (HMO D-SNP)

January 1, 2026 – December 31, 2026

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

H9047_2026PD_PHA1550_M MDC-906K

When You Join Providence

You are not just part of an insurance policy but part of a community of care, focused on your health and well-being. This Summary of Benefits is provided to help you make the right health care decisions. It is a short guide of what we would cover and what you would pay if you joined our Providence Medicare Dual Plus (HMO D-SNP). To be clear, this is not a complete breakdown of benefits, and will not list every service that we cover, nor every limitation or exclusion. Plans may offer supplemental benefits in addition to Part C 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** or by calling our Customer Service department at one of the numbers listed in the "Get in touch" section below.

Plan Overview

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

Not only do our plan members get all of the benefits covered by Original Medicare, they also get 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, Washington counties in Oregon.

Get In Touch

Questions? We're here to help: From April 1st to September 30th, the hours are Monday through Friday from 8 a.m. to 8 p.m. From October 1st to March 31st, the hours are Sunday through Saturday (7 days a week) from 8 a.m. to 8 p.m.

- 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 / 1-800-855-7100)
- You can also visit us online at **ProvidenceHealthAssurance.com**

Helpful Resources

- Visit **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**, 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** 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
Annual Medical Deductible	$0
Maximum Out-of-Pocket (does not include prescription drugs)	You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. Your yearly limit(s) in this plan in-network: $9,250

Benefits	In-Network
Inpatient Hospital Coverage[1]	Providence Medicare Dual Plus (HMO D-SNP): $0 copayment for inpatient hospital Oregon Health Plan (Medicaid): $0 copayment for Medicaid-covered services
Outpatient Hospital Coverage[1]	Providence Medicare Dual Plus (HMO D-SNP): $0 copayment for outpatient surgery at a hospital facility Oregon Health Plan (Medicaid): $0 copayment for Medicaid-covered services
Ambulatory Surgical Center (ASC) Services[1]	Providence Medicare Dual Plus (HMO D-SNP): $0 copayment for outpatient surgery at an Ambulatory Surgical Center Oregon Health Plan (Medicaid): $0 copayment for Medicaid-covered services

[1] Services may require prior authorization. See the Evidence of Coverage for more information.

Providence Medicare Dual Plus (HMO D-SNP)

Benefits		In-Network
Doctor Visits	Primary Care Provider Visit	Providence Medicare Dual Plus (HMO D-SNP): $0 copayment for primary care visits Oregon Health Plan (Medicaid): $0 copayment for Medicaid-covered services
	Specialist Visit	Providence Medicare Dual Plus (HMO D-SNP): $0 copayment for specialist visits Oregon Health Plan (Medicaid): $0 copayment for Medicaid-covered services
Preventive Care (e.g., annual check-ups, immunizations, flu shots)		Providence Medicare Dual Plus (HMO D-SNP): You pay nothing for all preventive services covered under Original Medicare Oregon Health Plan (Medicaid): $0 copayment for Medicaid-covered services
Emergency Care		Providence Medicare Dual Plus (HMO D-SNP): $0 copayment for emergency care Oregon Health Plan (Medicaid): $0 copayment for Medicaid-covered services
Urgently Needed Services		Providence Medicare Dual Plus (HMO D-SNP): $0 copayment for urgently needed services Oregon Health Plan (Medicaid): $0 copayment for Medicaid-covered services

[1] Services may require prior authorization. See the Evidence of Coverage for more information.

Providence Medicare Dual Plus (HMO D-SNP)

Benefits		In-Network
Diagnostic Services/ Labs/Imaging	Diagnostic Radiology Services (e.g., MRI, ultrasounds, CT scans) [1]	Providence Medicare Dual Plus (HMO D-SNP): $0 copayment for diagnostic radiology services Oregon Health Plan (Medicaid): $0 copayment for Medicaid-covered services
	Therapeutic Radiology Services[1]	Providence Medicare Dual Plus (HMO D-SNP): $0 copayment for therapeutic radiology services Oregon Health Plan (Medicaid): $0 copayment for Medicaid-covered services
	Outpatient X-rays	Providence Medicare Dual Plus (HMO D-SNP): $0 copayment for outpatient x-rays Oregon Health Plan (Medicaid): $0 copayment for Medicaid-covered services
	Diagnostic Tests and Procedures[1]	Providence Medicare Dual Plus (HMO D-SNP): $0 copayment for diagnostic tests and procedures Oregon Health Plan (Medicaid): $0 copayment for Medicaid-covered services
	Lab Services[1]	Providence Medicare Dual Plus (HMO D-SNP): $0 copayment Oregon Health Plan (Medicaid): $0 copayment for Medicaid-covered services
Hearing Services	Medicare-Covered	Providence Medicare Dual Plus (HMO D-SNP): $0 copayment Oregon Health Plan (Medicaid): $0 copayment for Medicaid-covered services
Dental Services	Medicare-Covered[1]	Providence Medicare Dual Plus (HMO D-SNP): $0 copayment Oregon Health Plan (Medicaid): $0 copayment for Medicaid-covered services
	Other/Non-Medicare-Covered	Providence Medicare Dual Plus (HMO D-SNP): $450 allowance every six months for any dental services of your choosing; unspent dollars will expire if not used during the year the allowance is issued Oregon Health Plan (Medicaid): $0 copayment for Medicaid-covered services

[1] Services may require prior authorization. See the Evidence of Coverage for more information.

Providence Medicare Dual Plus (HMO D-SNP)

Benefits		In-Network
Vision Services	Medicare-Covered Exams/Screening	Providence Medicare Dual Plus (HMO D-SNP): $0 copayment per exam $0 copayment for glaucoma screening Oregon Health Plan (Medicaid): $0 copayment for Medicaid-covered services; once every 24 months for adults age 21 or older
	Routine Exam	Providence Medicare Dual Plus (HMO D-SNP): One routine vision exam per calendar year at $0 copayment (including refraction) Oregon Health Plan (Medicaid): $0 copayment for Medicaid-covered services; once every 24 months for adults age 21 or older
	Medicare-Covered Eyewear	Providence Medicare Dual Plus (HMO D-SNP): $0 copayment for the total cost for one pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery Oregon Health Plan (Medicaid): $0 copayment for Medicaid-covered services; only for specific medical conditions
	Routine Eyeglasses or Contact Lenses	Providence Medicare Dual Plus (HMO D-SNP): Allowance of up to $150 per calendar year for any combination of routine prescription eyewear Oregon Health Plan (Medicaid): $0 copayment for Medicaid-covered services; only for specific medical conditions
Mental Health Services	Inpatient Visit[1]	Providence Medicare Dual Plus (HMO D-SNP): $0 copayment for inpatient visits Oregon Health Plan (Medicaid): $0 copayment for Medicaid-covered services
	Outpatient Individual[1] and Group Therapy Visit[1]	Providence Medicare Dual Plus (HMO D-SNP): $0 copayment for outpatient therapy visits Oregon Health Plan (Medicaid): $0 copayment for Medicaid-covered services

Providence Medicare Dual Plus (HMO D-SNP)

Benefits		In-Network
Skilled Nursing Facility (SNF) [1]		Providence Medicare Dual Plus (HMO D-SNP): $0 copayment for days 1-20 $0 copayment each day for days 21-100 Oregon Health Plan (Medicaid): $0 copayment for Medicaid-covered services. Medicaid covers up to 20 days in a SNF.
Physical Therapy[1]		Providence Medicare Dual Plus (HMO D-SNP): $0 copayment for physical therapy Oregon Health Plan (Medicaid): $0 copayment for Medicaid-covered services
Ambulance[1]		Providence Medicare Dual Plus (HMO D-SNP): $0 copayment for ambulance services Oregon Health Plan (Medicaid): $0 copayment for Medicaid-covered services
Transportation (This plan includes non-medical transportation)[2]		Providence Medicare Dual Plus (HMO D-SNP): $0 copayment for 24 one-way trips (max of 25 miles each) if you qualify for Special Supplementary Benefits for the Chronically Ill (SSBCI) Oregon Health Plan (Medicaid): $0 copayment for Medicaid-covered services; non-emergency medical transportation to covered appointments
Medicare Part B Drugs[1]		Providence Medicare Dual Plus (HMO D-SNP): $0 copayment for Part B Drugs Oregon Health Plan (Medicaid): $0 copayment for Medicaid-covered services
Meal Delivery Program (post-discharge only)		Providence Medicare Dual Plus (HMO D-SNP): $0 copayment for 2 meals per day for 28 days, following a qualifying inpatient hospitalization Oregon Health Plan (Medicaid): Not covered
Pre-loaded Debit Card	Over-the-Counter Items	Providence Medicare Dual Plus (HMO D-SNP): $40 allowance every three months (retail card, catalog, online, mail, and telephonic ordering).
	Food and Produce[2]	$200 allowance every three months if you qualify for SSBCI (retail card, catalog, online, mail, and telephonic ordering). You can also use

		your card to buy eligible healthy food items like produce, dairy products, meats, and more. Unspent dollars will rollover from quarter to quarter, then expire at the end of the 2026 calendar year. **Oregon Health Plan (Medicaid):** Not covered
Personal Emergency Response System (PERS)		**Providence Medicare Dual Plus (HMO D-SNP):** $0 copayment **Oregon Health Plan (Medicaid):** Not covered
Wellness Program		**Providence Medicare Dual Plus (HMO D-SNP):** $0 copayment for monthly gym membership with participating fitness clubs **Oregon Health Plan (Medicaid):** Not covered

[1] Services may require prior authorization. See the Evidence of Coverage for more information.
[2] This benefit is part of a special supplemental program for the chronically ill. Members with diabetes mellitus, chronic and disabling mental health conditions, cardiovascular disorders, chronic lung disorders, neurologic disorders, and other eligible conditions not listed may qualify to receive this benefit. Eligibility for this benefit cannot be guaranteed based solely on your condition. All applicable eligibility requirements must be met before the benefit is provided. For more details, please contact Customer Service at 503-574-8000 or 1-800-603-2340. (TTY users call 711.) From April 1st to September 30th, the hours are Monday through Friday from 8 a.m. to 8 p.m. (Pacific Time). From October 1st to March 31st, the hours are Sunday through Saturday (7 days a week) from 8 a.m. to 8 p.m. (Pacific Time). This call is free.

Prescription Drug Benefits

Providence Medicare Dual Plus (HMO D-SNP)

Prescription Drug Deductible	
Yearly Deductible	You do not have a deductible.

Initial Coverage	You pay the following until your total yearly out-of-pocket costs reach $2,100.
For Generic Drugs (including brand drugs treated as generic)	
You Pay:	You pay $0, $1.60 or $5.10 copayment
For All Other Drugs	
You Pay:	You pay $0, $4.90 or $12.65 copayment
	You may get your drugs at network retail pharmacies and mail order pharmacies.

Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $2,100, you pay nothing for all drugs.

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

Important message about what you pay for vaccines: Our plan covers most Part D vaccines at no cost to you. Call Customer Service for more information.

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 or by calling your Coordinated Care Organization's Customer Service.

The following is a list of Oregon Health Plan (Medicaid) Covered Services	
Benefits	**Additional information**
Dental	Basic services including cleaning, fluoride varnish, fillings, and extractions Urgent or immediate treatment Dentures Stainless steel crowns for molars (back teeth)
Health Related Social Needs (HRSN) Services	Assistance with housing and nutrition. Available to eligible members based on a needs assessment.
Hearing	Hearing aids and hearing aid exams
Home health	Care provided by a registered nurse or home health aide
Hospice care	End-of-life care
Hospital care	Emergency treatment Inpatient and outpatient care
Immunizations and vaccines	Such as the flu shot or COVID-19 vaccine
Pregnancy care	Labor, delivery, and post-partum care
Laboratory tests and X-rays	Such as blood screening and mammograms
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 residential treatment
Physical, occupational and speech therapy	Therapy to improve skills or function for daily living
Prescription drugs	OHP with Limited Drug only includes drugs that are not covered by Medicare Part D
Substance use disorder treatment	Such as counseling, medication assisted treatment, acupuncture, residential treatment, and peer delivered services
Vision	Medical eye exams for any eye condition Glasses are covered for adults who have a qualifying medical condition such as aphakia or keratoconus.

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 detail.

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Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

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 1-800-603-2340 (TTY: 711) or speak to your provider."

Español (Spanish)
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 1-800-603-2340 (TTY: 711) o hable con su proveedor.

Việt (Vietnamese)
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 1-800-603-2340 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn."

中文 (Chinese-Simplified)
注意：如果您说 中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-800-603-2340（文本电话：711）或咨询您的服务提供商。"

中文 (Chinese- Traditional)
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 1-800-603-2340（TTY：711）或與您的提供者討論。」

РУССКИЙ (Russian)
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 1-800-603-2340 (TTY: 711) или обратитесь к своему поставщику услуг.

한국어 (Korean)
주의: 한국어 를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-603-2340 (TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오."

українська мова (Ukrainian)
УВАГА: Якщо ви розмовляєте українська мова, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби та послуги для надання інформації у доступних форматах також доступні безкоштовно. Зателефонуйте за номером 1-800-603-2340 (TTY: 711) або зверніться до свого постачальника».

日本語 (Japanese)
注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-800-603-2340（TTY：711）までお電話ください。または、ご利用の事業者にご相談ください。

العربية (Arabic)
تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1- 800-603-2340 (711) أو تحدث إلى مقدم الخدمة".

ភាសាខ្មែរ (Khmer)
សូមយកចិត្តទុកដាក់៖ ប្រសិនបើអ្នកនិយាយ *ភាសាខ្មែរ* សេវាកម្មជំនួយភាសាឥតគិតថ្លៃគឺមានសម្រាប់អ្នក។ ជំនួយ និងសេវាកម្មដែលជាការជួយដ៏សមរម្យក្នុងការផ្តល់ព័ត៌មានតាមទម្រង់ដែលអាចចូលប្រើប្រាស់បាន ក៏អាចរកបានដោយឥតគិតថ្លៃផងដែរ។ ហៅទូរសព្ទទៅ 1-800-603-2340 (TTY: 711) ឬនិយាយទៅកាន់អ្នកផ្តល់សេវារបស់អ្នក។”

Deutsch (German)
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 1-800-603-2340 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.“

فارسي (Farsi)
توجه: اگر فارسي صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. با شماره 1-800-603-2340 (تله‌تایپ: 711) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید.

Français (French)
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 1-800-603-2340 (TTY : 711) ou parlez à votre fournisseur. »

ไทย (Thai)
หมายเหตุ: หากคุณใช้ภาษา ไทย เรามีบริการความช่วยเหลือด้านภาษาฟรี นอกจากนี้ ยังมีเครื่องมือและบริการช่วยเหลือเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่าย โปรดโทรติดต่อ 1-800-603-2340 (TTY: 711) หรือปรึกษาผู้ให้บริการของคุณ”

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 1-800-603-2340 (TTY: 711) o makipag-usap sa iyong provider.”

አማርኛ (Amharic)
ማሳሰቢያ፦ አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎት በነፃ ይቀርብልዎታል። መረጃን በተደራሽ ቅርጸት ለማቅረብ ተገቢ የሆኑ ተጨማሪ እገዛዎች እና አገልግሎቶች እንዲሁ በነፃ ይገኛሉ። በስልክ ቁጥር 1-800-603-2340 (TTY: 711) ይደውሉ ወይም አገልግሎት አቅራቢዎን ያናግሩ።”

ਪੰਜਾਬੀ (Punjabi)
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹੁੰਦੀਆਂ ਹਨ। ਪਹੁੰਚਯੋਗ ਫਾਰਮੈਟਾਂ ਵਿੱਚ ਜਾਣਕਾਰੀ ਪ੍ਰਦਾਨ ਕਰਨ ਲਈ ਢੁਕਵੇਂ ਪੂਰਕ ਸਹਾਇਕ ਸਾਧਨ ਅਤੇ ਸੇਵਾਵਾਂ ਵੀ ਮੁਫ਼ਤ ਵਿੱਚ ਉਪਲਬਧ ਹੁੰਦੀਆਂ ਹਨ। 1-800-603-2340 (TTY: 711) ‘ਤੇ ਕਾਲ ਕਰੋ ਜਾਂ ਆਪਣੇ ਪ੍ਰਦਾਤਾ ਨਾਲ ਗੱਲ ਕਰੋ।”

ລາວ (Laos)
ເຊີນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ
ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 1-800-603-2340 (TTY: 711) ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.”

ՀԱՅԵՐԵՆ (Armenian)
ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Եթե խոսում եք հայերեն, Դուք կարող եք օգտվել լեզվական աջակցության անվճար ծառայություններից: Մատչելի ձևաչափերով տեղեկատվություն տրամադրելու համապատասխան օժանդակ միջոցներն ու ծառայությունները նույնպես տրամադրվում են անվճար: Զանգահարեք 1-800-603-2340 հեռախոսահամարով (TTY՝ 711) կամ խոսեք Ձեր մատակարարի հետ:

Lus Hmoob (Hmong)
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 1-800-603-2340 (TTY: 711) los sis sib tham nrog koj tus kws muab kev saib xyuas kho mob.”

हिंदी (Hindi)
ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-800-603-2340 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।”