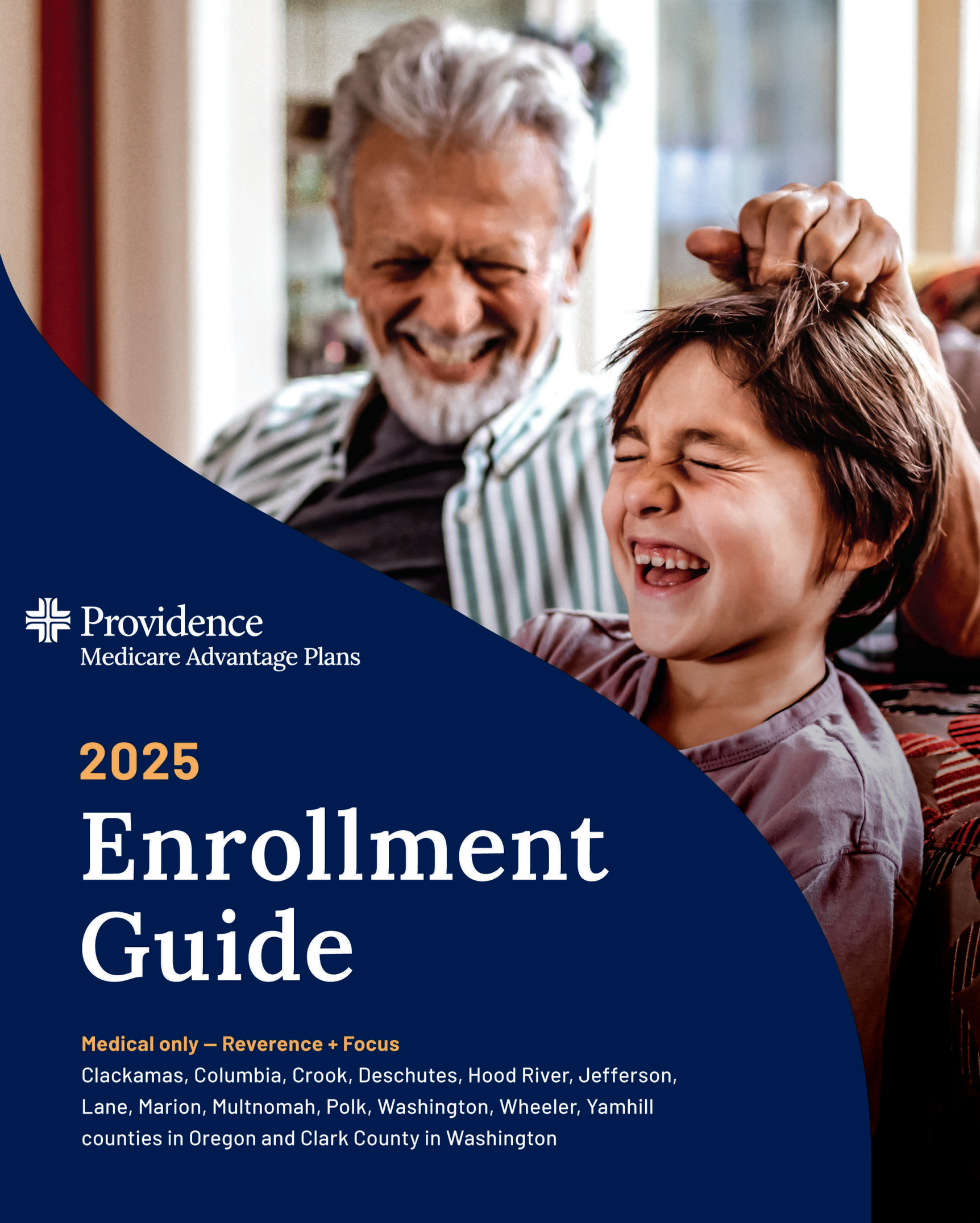


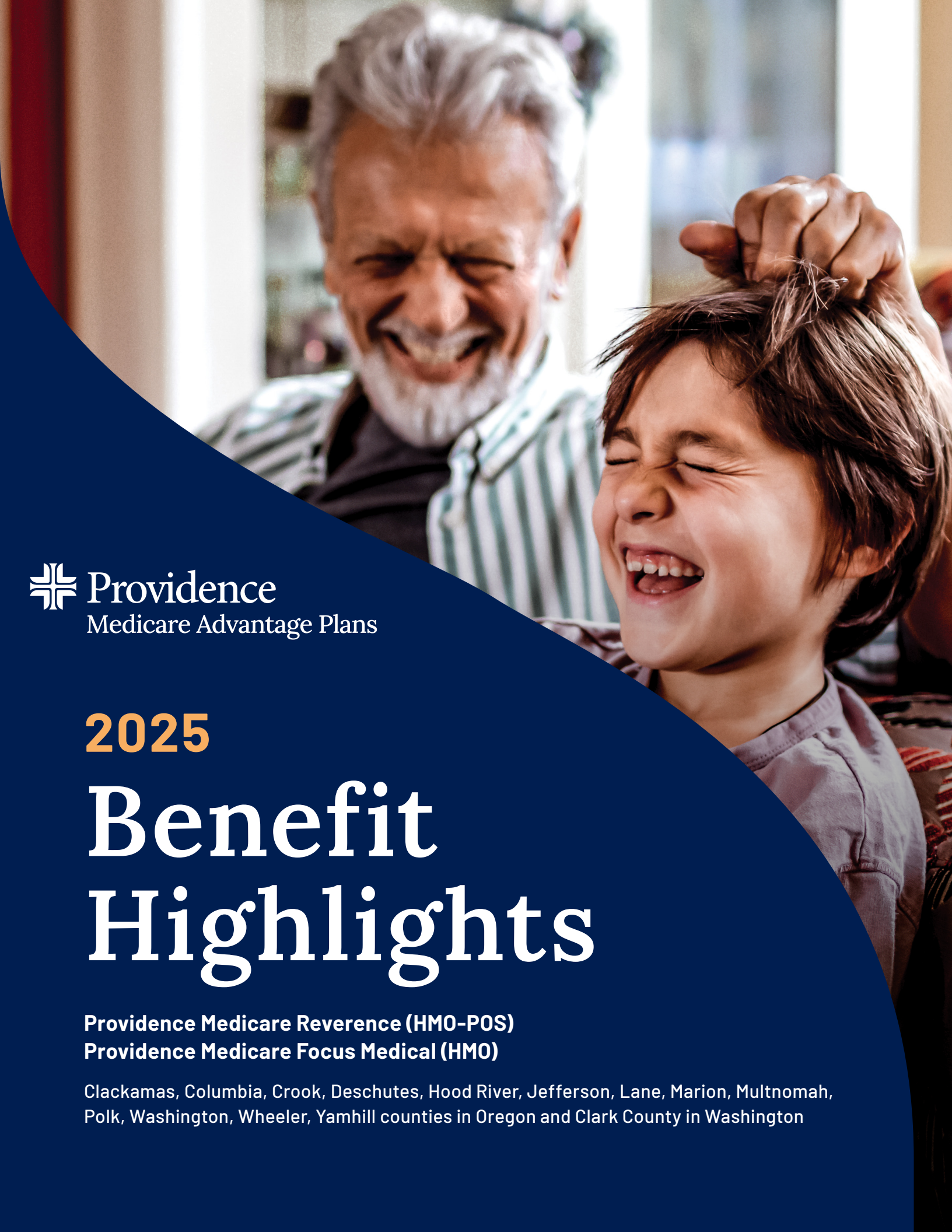
Providence
Medicare Advantage Plans

2025

Enrollment Guide

Medical only — Reverence + Focus

Clackamas, Columbia, Crook, Deschutes, Hood River, Jefferson, Lane, Marion, Multnomah, Polk, Washington, Wheeler, Yamhill counties in Oregon and Clark County in Washington



Providence
Medicare Advantage Plans

2025

Benefit Highlights

Providence Medicare Reverence (HMO-POS)
Providence Medicare Focus Medical (HMO)

Clackamas, Columbia, Crook, Deschutes, Hood River, Jefferson, Lane, Marion, Multnomah, Polk, Washington, Wheeler, Yamhill counties in Oregon and Clark County in Washington

Providence Medicare Advantage Plans

– Part C

	Providence Medicare Reverence (HMO-POS)		Providence Medicare Focus Medical (HMO)
Monthly premium	$25		$140
	In-network	**Out-of-network**	**In-network**
Medical deductible	$0	$0	$0
Out-of-pocket Maximum	$5,000	No maximum	$3,800
Benefits	**You pay**		**You pay**
Doctor office visit (PCP)	$15	$25	$0
Specialist visit	$30	$50	$20
Preventive care	$0	30%	$0
Inpatient hospital	1-6 days: $300 7-90 days: $0	30%	1-5 days: $250 6-90 days: $0
Skilled nursing facility	1-20 days: $0 21-100 days: $214	30%	1-20 days: $0 21-100 days: $214
Outpatient surgery - Ambulatory	$250	30%	$200
Outpatient surgery - Hospital	$250	30%	$250
Diabetic supplies	$0	30%	$0
Lab	$0	30%	$0
X-ray	$15	30%	$0
Diagnostic radiology	20%	30%	15%
Outpatient diagnostic tests & procedures	20%	30%	20%
Chiropractic	$20/18 visits	Not Covered	$20/18 visits
Acupuncture	$20/18 visits	Not Covered	$20/18 visits
Naturopathy	$20/6 visits	Not Covered	$20/6 visits
Therapy: PT, OT, ST	$30	30%	$20
Durable medical equipment	20%	30%	20%
Home health	$0	30%	$0
Telehealth - Primary**	$0	N/A	$0
Telehealth - Specialist**	$30	N/A	$20
Worldwide Coverage	**In-network**	**Out-of-network**	**In-network**
Urgent care	$25	N/A	$25
Emergency room*	$125	N/A	$125
Ambulance - Ground no transport	$50	$50	$50
Ambulance - Ground emergency transport	$275	$275	$275
Ambulance - Air	$275	$275	$275

*Copay waived if you are admitted to the hospital within 24 hours for the same condition.

**You will pay the cost sharing that applies to the services.

Other charges and limits may apply. Please refer to Evidence of Coverage for more information. Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost sharing that applies to out-of-network services.

2025 Optional Supplemental Dental Benefits

	In-network	Out-of-network*	In-network	Out-of-network*
Benefits include: Preventive (See EOC Chapter 4) and Comprehensive Dental	**Basic**		**Enhanced**	
Monthly premium	$37.50		$53.50	
Annual deductible[1]	$50	$150	$50	$150
Annual maximum	$1,000/Every year		$1,500/Every year	
Waiting periods	None		None	
Provider network	Delta Dental Medicare Advantage		Delta Dental Medicare Advantage	
Out-of-network reimbursement	None		None	
	In-network	**Out-of-network**	**In-network**	**Out-of-network**
Bitewing X-rays[2]	$0	20%	$0	20%
Panoramic & other diagnostic X-rays[3]	$0	20%	$0	20%
Simple extractions	50%	60%	50%	60%
Basic fillings	30%	60%	30%	60%
Dentures	50%	60%	50%	60%
Crowns and bridges	50%	60%	50%	60%
Oral surgery	Not Covered	Not Covered	50%	60%
Endodontics (root canals)	Not Covered	Not Covered	50%	60%
Periodontics (deep cleaning)	Not Covered	Not Covered	50%	60%

***Important notes:** Limitations and exclusions apply. Please refer to your Evidence of Coverage for a complete list of covered dental services. Members are encouraged to use an in-network Dental provider. Out-of-network dentists may charge more than the amount allowed by Providence Medicare Advantage Plans.

[1] Deductibles are waived for diagnostic and preventive services
[2] Bitewing or Periapical X-rays – one bitewing series or one bitewing series plus periapical as needed (up to 10) per calendar year
[3] Full mouth and Panoramic X-ray – limited to once every 5 years

Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Dental, hearing, vision, and more

	Providence Medicare Reverence (HMO-POS)	Providence Medicare Focus Medical (HMO)
Flexible Benefit Card Over-the-counter items	$75/Every three months	$75/Every three months
Preventive dental	$0 In-network, 20% Out-of-network	$0
Routine eye exam (one per year)	$0	$0
Prescription eyeglasses or contact lenses*	$250/Every year	$250/Every year
Routine hearing exam (one per year)**	$0	$0
Hearing aids (two per year)**	$399-$699	$399-$699
Meal delivery after inpatient hospital stay	14 days/28 meals	14 days/28 meals
Personal Emergency Response System	$0	$0
Fitness center membership	$0	$0
Wigs for hair loss related to chemotherapy	$0	$0

*You are responsible for any cost above the allowance for prescription eyeglasses or contact lenses.

**You must see a TruHearing provider. Other charges and limits may apply.

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.

Want to learn more?

Here's how to connect with us.

Call us for information, to enroll, or to make a personal appointment at

1-888-804-5927 (TTY: 711)

8 a.m. to 5 p.m. (Pacific Time) Monday – Friday

Check us out online for more information or to enroll at

TheProvidenceAdvantage.com/EnrollGuide25

Providence
Medicare Advantage Plans

Pre-Enrollment Checklist

Providence Medicare Advantage Plans

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 **503-574-8000** or **1-800-603-2340 (TTY: 711)**, 8 a.m. to 8 p.m. (Pacific Time), seven days a week.

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 **ProvidenceHealthAssurance.com/EOC** or call **503-574-8000** or **1-800-603-2340 (TTY: 711)** 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

- In addition to your monthly plan premium (including $0 premium plans), you must continue to pay your Medicare Part B premium. This premium is normally taken out of your social security check each month. The Part B premium is covered for full-dual enrollees who are eligible for Providence Medicare Dual Plus (HMO D-SNP). The Providence Medicare Pine + Rx (HMO) plan includes a Part B Buydown. The Medicare Part B Buydown, also known as Part B premium reduction, will reduce your monthly Part B premium by $16. Providence Medicare Advantage Plans will pay the Social Security Administration (SSA) directly. If you pay your Part B medical premium through your Social Security benefit, your monthly Social Security check will increase by $16. If you pay your Part B premium directly to Medicare, your monthly premium payment will be reduced by $16.
- Benefits, premiums, and/or copayments/co-insurance may change every year.
- When selecting an HMO product, remember that 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).
- Our HMO-POS plans allow you to see providers outside of our network (non-contracted providers). However, while we will pay for certain covered services, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay a higher copay for services received by non-contracted providers.
- Providence Medicare Dual Plus (HMO D-SNP) 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 and medical assistance from a state plan under Medicaid.
- Effect on current coverage. If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.

OMB No. 0938-1378
Expires: 07/31/2024

Providence
Medicare Advantage Plans

2025 Medicare Advantage Enrollment Request Form

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit **Medicare.gov** to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional — you can't be denied coverage because you don't fill them out.

What happens next?

Submit your completed and signed form using one of the three options below. Once they process your request to join, they'll contact you.

01 By mail:
Providence Medicare Advantage Plans
P.O. Box 5548
Portland, OR 97228-5548

02 Scan and fax pages to:
503-574-8653

03 Scan and email pages to:
provMedicare@providence.org

How do I get help with this form?

- Call Providence Medicare Advantage Plans at **503-574-6508** or **1-855-234-2495 (TTY: 711)**.
- Or, call Medicare at **1-800-MEDICARE** (**1-800-633-4227**). TTY: **1-877-486-2048**.
- **En español:** Llame a Providence Medicare Advantage Plans al **503-574-6508** or **1-855-234-2495/TTY: 711** o a Medicare gratis al **1-800-633-4227** y oprima el 8 para asistencia en español y un representante estará disponible para asistirle.

Individuals experiencing homelessness

If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

Section 1 – All fields on this page are required (unless marked optional)

Select the plan you want to join:

- ☐ Providence Medicare Focus Medical (HMO) - $140 per month
- ☐ Providence Medicare Reverence (HMO-POS) - $25 per month

To enroll in an Optional Supplemental Dental Plan*, please select the plan you want to join:

☐ **Basic:** $37.50 per month
☐ **Enhanced:** $53.50 per month
☐ Do not want Optional Supplemental Dental Plan

*I understand enrollment in the plan listed above is optional. I also understand that I must maintain my coverage in Providence Medicare Advantage Plans in order to be enrolled in the optional supplemental dental plan selected. Additionally, I understand that I must pay the optional supplemental dental plan premium in order to maintain my coverage. I will read the optional benefit plan information when I receive it and learn my responsibilities as a member and what services are covered by the plan.

Requested Effective Date of Coverage (Optional): ___ ___ /___ ___/___ ___
(must be first of the month)

First Name _____ Last Name _____ Middle Initial (Optional) _____

__ __/__ __/__ __ __ __
Birth Date (MM/DD/YYYY)

SEX: ☐ Male ☐ Female

( ) -
Phone Number

Permanent Residence Street Address (Don't enter a PO Box)

City _____ County (Optional) _____ State _____ ZIP Code _____

Mailing Address, if different from your permanent address (PO Box allowed):

Street Address

City _____ State _____ ZIP Code _____

Your Medicare information:

__ __ __ __-__ __ __-__ __ __ __ Medicare Number

__ __/__ __/__ __ __ __ Hospital (Part A) Effective Date (Optional)

__ __/__ __/__ __ __ __ Medical (Part B) Effective Date (Optional)

Answer these important questions:

Will you have other coverage in addition to Providence Medicare Advantage Plans? ☐ Yes ☐ No

Some individuals may have other coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

If "yes," please list your other coverage and your identification (ID) number for this coverage.

_____

Name of other coverage

_____ _____

ID number for this coverage Group number for this coverage

Check all that apply: ☐ Medical ☐ Vision ☐ Dental ☐ Prescription

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Providence Medicare Advantage Plans.
- By joining this Medicare Advantage Plan I acknowledge that Providence Medicare Advantage Plans will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my Providence Medicare Advantage Plans coverage begins, I must get all of my medical and prescription drug benefits from Providence Medicare Advantage Plans. Benefits and services provided by Providence Medicare Advantage Plans and contained in my Providence Medicare Advantage Plans "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Providence Medicare Advantage Plans will pay for benefits or services that are not covered.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
  1. This person is authorized under State law to complete this enrollment, and
  2. Documentation of this authority is available upon request by Medicare.

_____ ___ ___/___ ___/___ ___

Signature **Today's Date**

If you are the authorized representative, sign above and fill out these fields:

_____ _____

Name Address

( ) - _____

Phone Number Relationship to enrollee

Section 2 – All fields on this page are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ **I choose not to answer.**

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Black or African American
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian or Chamorro
- ☐ Japanese
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ Vietnamese
- ☐ White
- ☐ **I choose not to answer.**

List your Primary Care Provider (PCP), clinic, or health center:

_____

If you do not provide a PCP, one will be assigned.

Select one if you want us to send you information in an accessible format.

☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Please contact Providence Medicare Advantage Plans at **1-800-603-2340** or **503-574-8000** if you need information in an accessible format other than what's listed above. Our office hours are seven days a week, 8 a.m. to 8 p.m. (Pacific Time). TTY users can call 711.

Do you work?

☐ Yes ☐ No

Does your spouse work?

☐ Yes ☐ No

_____

Email Address

Paying your plan premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail each month. **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.**

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay Providence Medicare Advantage Plans the Part D-IRMAA.

Please select a premium payment option:

☐ Get a monthly bill – Once you receive your first bill, you can choose a different payment option:

- **You can pay by credit/debit card or checking/savings account:** One-time or recurring payments can be made via your myProvidence account at **myProvidence.com** or through the Providence website at **Providence.org/PremiumPay**.
- **You can pay by phone:** Self Service is available 24 hours a day, 7 days a week, at **1-844-791-1468, TTY: 711**.

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.

I get monthly benefits from: ☐ Social Security ☐ RRB

(The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. You may receive an invoice for the first few months before the withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a letter and paper bill for your monthly premiums.)

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name

Relationship to enrollee

Signature

National Producer Number (Agents/Brokers only)

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Advantage plan only during the Annual Enrollment Period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- ☐ I am new to Medicare.
- ☐ I am leaving employer or union coverage on (insert date): ___ ___ /___ ___/___ ___
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date): ___ ___ /___ ___/___ ___
- ☐ I am enrolling during the Annual Enrollment Period (October 15-December 7)
- ☐ I am enrolling during a Special Enrollment Period (insert special enrollment being used) _____
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP) (January 1-March 31 or I recently enrolled in an MA plan during my Initial Coverage Election Period).
- ☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date): ___ ___ /___ ___/___ ___
- ☐ I recently was released from incarceration. I was released on (insert date): ___ ___ /___ ___/___ ___
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date): ___ ___ /___ ___/___ ___
- ☐ I recently obtained lawful presence status in the United States. I got this status on (insert date): ___ ___ /___ ___/___ ___
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date): ___ ___ /___ ___/___ ___
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ I recently left a PACE program on (insert date): ___ ___ /___ ___/___ ___
- ☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into the facility on (insert date): ___ ___ /___ ___/___ ___ I moved/will move out of the facility on (insert date): ___ ___ /___ ___/___ ___
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date): ___ ___ /___ ___/___ ___
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan (insert date): ___ ___ /___ ___/___ ___

☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date): ___ ___ /___ ___/___ ___

☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date): ___ ___ /___ ___/___ ___

☐ I recently received notice of a Medicare entitlement determination for a retroactive effective date. (Please attach a copy of your entitlement notice.) I was notified on (insert date): ___ ___ /___ ___/___ ___

> If none of these statements applies to you or you're not sure, please contact Providence Medicare Advantage Plans at **1-800-603-2340** or **503-574-8000** (TTY users should call 711) to see if you are eligible to enroll. We are open seven days a week, 8 a.m. to 8 p.m. (Pacific Time).

Providence
Medicare Advantage Plans

Providence
Medicare Advantage Plans

2025 Summary of Benefits

Providence Medicare Reverence (HMO-POS)

January 1, 2025 – December 31, 2025

This plan is available in **Clackamas, Columbia, Crook, Deschutes, Hood River, Jefferson, Lane, Marion, Multnomah, Polk, Washington, Wheeler, and Yamhill counties in Oregon and Benton, Clark, Franklin, Snohomish, Spokane, and Walla Walla counties in Washington.**

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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 Reverence (HMO-POS). 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, and live in our service area. Our service area includes Clackamas, Columbia, Crook, Deschutes, Hood River, Jefferson, Lane, Marion, Multnomah, Polk, Washington, Wheeler, and Yamhill counties in Oregon and Benton, Clark, Franklin, Snohomish, Spokane, and Walla Walla counties in Washington.

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 /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 Directory or to request a printed copy. You can also call us to have a printed copy mailed to you.
- 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 Reverence (HMO-POS)

Monthly Plan Premium	$25 In addition, you must continue to pay your Medicare Part B premium.	
Annual Medical Deductible	$0 There is no medical deductible for in- or out-of-network services.	
Maximum Out-of-Pocket Responsibility	Your yearly limit(s) for this plan:	
	In-network: $5,000	Out-of-network: No Maximum

Benefits		In-Network	Out-Of-Network
Inpatient Hospital Coverage[1]		$300 copayment each day for days 1-6 and $0 copayment each day for day 7 and beyond	30% of the total cost per admission
Outpatient Hospital Coverage[1]		$250 copayment for outpatient surgery at a hospital facility	30% of the total cost
Ambulatory Surgical Center (ASC) Services[1]		$250 copayment for outpatient surgery at an Ambulatory Surgical Center	30% of the total cost
Doctor Visits	Primary Care Provider Visit	$15 copayment	$25 copayment
	Specialist Visit	$30 copayment	$50 copayment
Preventive Care (e.g., annual check-ups, immunizations, flu shots)		You pay nothing	30% of the total cost
Emergency Care		$125 copayment If you are admitted to the hospital within 24 hours, the emergency care copayment will be waived.	
Urgently Needed Services		$25 copayment If you are admitted to the hospital within 24 hours, the urgent care copayment will be waived.	

Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our Customer Service number or see your Evidence of Coverage for more information, including the cost sharing that applies to out-of-network services. For 2025, referrals are not required for in-network specialists visits and Medicare-covered services.

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

Providence Medicare Reverence (HMO-POS)

Benefits		In-Network	Out-Of-Network
Diagnostic Services/ Labs/Imaging	Diagnostic Radiology Services (e.g., MRI, ultrasounds, CT scans) [1]	20% of the total cost up to $250 per day	30% of the total cost
	Therapeutic Radiology Services[1]	20% of the total cost	30% of the total cost
	Outpatient X-rays	$15 copayment per day	30% of the total cost
	Diagnostic Tests and Procedures[1]	20% of the total cost	30% of the total cost
	Lab Services[1]	$0 copayment	30% of the total cost
Hearing Services	Medicare-Covered	$30 copayment	30% of the total cost
	Routine Exam	$0 copayment	Not covered
	Hearing Aids	$399 copayment per Advanced hearing aid or $699 copayment per Premium hearing aid	Not covered
Dental Services	Medicare-Covered[1]	$30 copayment	30% of the total cost
	Embedded Preventive	$0 copayment Includes exams, fluoride treatment, cleanings, X-rays; limits apply	20% of the total cost Includes exams, fluoride treatment, cleanings, X-rays; limits apply
	Optional	Covered for additional premium; see last page of this summary	
Vision Services	Medicare-Covered Exams/Screening	$30 copayment per exam $0 copayment for glaucoma screening	30% of the total cost per exam 30% of the total cost for glaucoma screening
	Routine Exam	There is no coinsurance, or copayment for one routine vision exam (including refraction) per calendar year.	
	Medicare-Covered Eyewear	$0 copayment for one pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery	30% of the total cost for one pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery
	Routine Eyeglasses or Contact Lenses	Allowance of up to $250 per calendar year for any combination of routine prescription eyewear	

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

Providence Medicare Reverence (HMO-POS)

Benefits		In-Network	Out-Of-Network
Mental Health Services	Inpatient Visit[1]	$275 copayment each day for days 1-6 and $0 copayment each day for days 7-90	30% of the total cost per admission
	Outpatient Individual[1] and Group Therapy Visit[1]	$30 copayment	30% of the total cost
Skilled Nursing Facility (SNF)[1]		$0 copayment each day for days 1-20 and $214 copayment each day for days 21-100	30% of the total cost for each benefit period (days 1-100)
Physical Therapy[1]		$30 copayment	30% of the total cost
Ambulance[1]		$275 copayment	
Transportation		Not covered	
Medicare Part B Drugs[1]		0% - 20% of the total cost (Insulin cost share up to $35 per month)	30% of the total cost (Insulin cost share up to $35 per month)
Alternative Care (visit limits)		Chiropractic: $20 copayment; 18 visits every calendar year Acupuncture: $20 copayment; 18 visits every calendar year Naturopath: $20 copayment; 6 visits every calendar year	Not covered
Meal Delivery Program (post-discharge only)		$0 copayment for 2 meals per day for 14 days, following a qualifying inpatient hospitalization	Not covered
Over-the-Counter Items		$75 allowance every three months (retail card, catalog, online, mail, and telephonic ordering)	
Personal Emergency Response System (PERS)		$0 copayment	Not covered
Wellness Program		$0 copayment for monthly gym membership with participating fitness clubs	
Wig		There is no coinsurance, or copayment for one synthetic wig due to hair loss from chemotherapy	

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

Optional Supplemental Dental

Providence Medicare Reverence (HMO-POS)

Please Note:

Optional Benefits: You must pay an extra premium each month for these benefits.
Cost Sharing: While you can see any dentist, our in-network providers have agreed to accept a contracted rate for the services they provide. This means cost sharing will be lower if you see an in-network provider.

Option 1: Providence Dental Basic Benefits include: Preventive (See Page 4) and Comprehensive Dental		
Monthly Premium	Additional $37.50 per month. You must keep paying your Medicare Part B and monthly plan premium.	
Benefits	**In-Network**	**Out-Of-Network**
Deductible	$50	$150
Annual Benefit Maximum	$1,000 every calendar year	
Diagnostic and Preventive Care*	You pay 0%	You pay 20%
Basic Care*	You pay 30% for fillings You pay 50% for all other services	You pay 60%
Major Restorative Care* (e.g., crowns, bridges)	You pay 50%	You pay 60%

Optional Supplemental Dental

Providence Medicare Reverence (HMO-POS)

Option 2: Providence Dental Enhanced Benefits include: Preventive (See Page 4) and Comprehensive Dental		
Monthly Premium	Additional $53.50 per month. You must keep paying your Medicare Part B and monthly plan premium.	
Benefits	**In-Network**	**Out-Of-Network**
Deductible	$50	$150
Annual Benefit Maximum	$1,500 every calendar year	
Diagnostic and Preventive Care*	You pay 0%	You pay 20%
Basic Care*	You pay 30% for fillings You pay 50% for all other services	You pay 60%
Major Restorative Care* (e.g., crowns, bridges)	You pay 50%	You pay 60%

*Limitations and exclusions apply. Please refer to your Evidence of Coverage for a complete list of covered dental services. Members must use a Medicare-contracted provider. Out-of-network dentists may charge more than the amount allowed by Providence Medicare Advantage Plans.

Providence
Medicare Advantage Plans

2025 Summary of Benefits

Providence Medicare Focus Medical (HMO)

January 1, 2025 – December 31, 2025

This plan is available in **Clackamas, Columbia, Crook, Deschutes, Hood River, Jefferson, Lane, Marion, Multnomah, Polk, Washington, Wheeler, and Yamhill counties in Oregon and Clark County in Washington.**

H9047_2025PD_PHA827_M MDC-901D

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 Focus Medical (HMO). 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, and live in our service area. Our service area includes Clackamas, Columbia, Crook, Deschutes, Hood River, Jefferson, Lane, Marion, Multnomah, Polk, Washington, Wheeler, and Yamhill counties in Oregon and Clark County in Washington.

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 /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 Directory or to request a printed copy. You can also call us to have a printed copy mailed to you.
- 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 Focus Medical (HMO)

Monthly Plan Premium	$140 In addition, you must continue to pay your Medicare Part B premium.
Annual Medical Deductible	$0 There is no medical deductible.
Maximum Out-of-Pocket Responsibility	Your yearly limit(s) for this plan:
	In-network: $3,800

Benefits		In-Network
Inpatient Hospital Coverage[1]		$250 copayment each day for days 1-5 and $0 copayment each day for day 6 and beyond
Outpatient Hospital Coverage[1]		$250 copayment for outpatient surgery at a hospital facility
Ambulatory Surgical Center (ASC) Services[1]		$200 copayment for outpatient surgery at an Ambulatory Surgical Center
Doctor Visits	Primary Care Provider Visit	$0 copayment
	Specialist Visit	$20 copayment
Preventive Care (e.g., annual check-ups, immunizations, flu shots)		You pay nothing
Emergency Care		$125 copayment If you are admitted to the hospital within 24 hours, the emergency care copayment will be waived.
Urgently Needed Services		$25 copayment If you are admitted to the hospital within 24 hours, the urgent care copayment will be waived.

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

Providence Medicare Focus Medical (HMO)

Benefits		In-Network
Diagnostic Services/ Labs/Imaging	Diagnostic Radiology Services (e.g., MRI, ultrasounds, CT scans)[1]	15% of the total cost up to $250 per day
	Therapeutic Radiology Services[1]	15% of the total cost
	Outpatient X-rays	$0 copayment
	Diagnostic Tests and Procedures[1]	20% of the total cost
	Lab Services[1]	$0 copayment
Hearing Services	Medicare-Covered	$20 copayment
	Routine Exam	$0 copayment
	Hearing Aids	$399 copayment per Advanced hearing aid or $699 copayment per Premium hearing aid
Dental Services	Medicare-Covered[1]	$20 copayment
	Embedded Preventive	$0 copayment Includes exams, fluoride treatment, cleanings, X-rays; limits apply
	Optional	Covered for additional premium; see last page of this summary
Vision Services	Medicare-Covered Exams/Screening	$20 copayment per exam $0 copayment for glaucoma screening
	Routine Exam	There is no coinsurance, or copayment for one routine vision exam (including refraction) per calendar year.
	Medicare-Covered Eyewear	$0 copayment for one pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery
	Routine Eyeglasses or Contact Lenses	Allowance of up to $250 per calendar year for any combination of routine prescription eyewear
Mental Health Services	Inpatient Visit[1]	$200 copayment each day for days 1-7 and $0 copayment each day for days 8-90
	Outpatient Individual[1] and Group Therapy Visit[1]	$20 copayment

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

Providence Medicare Focus Medical (HMO)

Benefits	In-Network
Skilled Nursing Facility (SNF) [1]	$0 copayment each day for days 1-20 and $214 copayment each day for days 21-100
Physical Therapy[1]	$20 copayment
Ambulance[1]	$275 copayment
Transportation	Not covered
Medicare Part B Drugs[1]	0% - 20% of the total cost (Insulin cost share up to $35 per month)
Alternative Care (visit limits)	Chiropractic: $20 copayment; 18 visits every calendar year Acupuncture: $20 copayment; 18 visits every calendar year Naturopath: $20 copayment; 6 visits every calendar year
Meal Delivery Program (post-discharge only)	$0 copayment for 2 meals per day for 14 days, following a qualifying inpatient hospitalization
Over-the-Counter Items	$75 allowance every three months (retail card, catalog, online, mail, and telephonic ordering)
Personal Emergency Response System (PERS)	$0 copayment
Wellness Program	$0 copayment for monthly gym membership with participating fitness clubs
Wig	There is no coinsurance, or copayment for one synthetic wig due to hair loss from chemotherapy

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

Optional Supplemental Dental

Providence Medicare Focus Medical (HMO)

Please Note:

Optional Benefits: You must pay an extra premium each month for these benefits.
Cost Sharing: While you can see any dentist, our in-network providers have agreed to accept a contracted rate for the services they provide. This means cost sharing will be lower if you see an in-network provider.

Option 1: Providence Dental Basic Benefits include: Preventive (See Page 4) and Comprehensive Dental		
Monthly Premium	Additional $37.50 per month. You must keep paying your Medicare Part B and monthly plan premium.	
Benefits	**In-Network**	**Out-Of-Network**
Deductible	$50	$150
Annual Benefit Maximum	$1,000 every calendar year	
Diagnostic and Preventive Care*	You pay 0%	You pay 20%
Basic Care*	You pay 30% for fillings You pay 50% for all other services	You pay 60%
Major Restorative Care* (e.g., crowns, bridges)	You pay 50%	You pay 60%

Optional Supplemental Dental

Providence Medicare Focus Medical (HMO)

Option 2: Providence Dental Enhanced Benefits include: Preventive (See Page 4) and Comprehensive Dental		
Monthly Premium	Additional $53.50 per month. You must keep paying your Medicare Part B and monthly plan premium.	
Benefits	**In-Network**	**Out-Of-Network**
Deductible	$50	$150
Annual Benefit Maximum	$1,500 every calendar year	
Diagnostic and Preventive Care*	You pay 0%	You pay 20%
Basic Care*	You pay 30% for fillings You pay 50% for all other services	You pay 60%
Major Restorative Care* (e.g., crowns, bridges)	You pay 50%	You pay 60%

*Limitations and exclusions apply. Please refer to your Evidence of Coverage for a complete list of covered dental services. Members must use a Medicare-contracted provider. Out-of-network dentists may charge more than the amount allowed by Providence Medicare Advantage Plans.

Providence
Medicare Advantage Plans

ProvidenceMedicareAdvantagePlans.com

Scope of Appointment

The Centers for Medicare and Medicaid Services requires agents to document the scope of a marketing appointment* prior to any individual sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or their authorized representative.

Please initial below beside the type of product(s) you want the agent to discuss.
(Refer to page 2 for product type descriptions)

_____ Stand-alone Medicare Prescription Drug Plans (Part D)

_____ Medicare Advantage Plans (Part C) and Cost Plans

_____ Dental/Vision/Hearing Products

_____ Hospital Indemnity Products

_____ Medicare Supplement (Medigap) Products

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above. Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the federal government. This individual may also be paid based on your enrollment in a plan. Signing this form does NOT obligate you to enroll in a plan, affect your current or future Medicare enrollment, or automatically enroll you in the plan(s) discussed.

Beneficiary or Authorized Representative Signature and Signature Date

_____ ___/___/___

SIGNATURE SIGNATURE DATE

If you are the authorized representative, please sign above and print below

_____ _____

REPRESENTATIVE'S NAME YOUR RELATIONSHIP TO THE BENEFICIARY

To be completed by Agent

AGENT NAME

AGENT PHONE NUMBER

BENEFICIARY NAME

BENEFICIARY PHONE NUMBER

BENEFICIARY ADDRESS

INITIAL METHOD OF CONTACT

AGENT'S SIGNATURE

PLAN(S) THE AGENT REPRESENTED DURING THIS MEETING

__/__/__
DATE APPOINTMENT COMPLETED

Agent, if the form was not signed by beneficiary at least 48 hours prior, provide explanation why SOA was not documented prior to the meeting:

*Scope of Appointment documentation is subject to CMS record retention requirements.

Stand-alone Medicare Prescription Drug Plans (Part D)

Medicare Prescription Drug Plan (PDP): A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans.

Medicare Advantage Plans (Part C) and Cost Plans

Medicare Health Maintenance Organization (HMO): A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).

Medicare Preferred Provider Organization (PPO) Plan: A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors and hospitals but you can also use out-of-network providers, usually at a higher cost.

Medicare Private Fee-For-Service (PFFS) Plan: A Medicare Advantage Plan in which you may go to any Medicare-approved doctor, hospital and provider that accepts the plan's payment, terms and conditions and agrees to treat you — not all providers will. If you join a PFFS Plan that has a network, you can see any of the network providers who have agreed to always treat plan members. You will usually pay more to see out-of-network providers.

Medicare Point of Service (POS) Plan: A type of Medicare Advantage Plan available in a local or regional area which combines the best feature of an HMO with an out-of-network benefit. Like the HMO, members are required to designate an in-network physician to be the primary health care provider. You can use doctors, hospitals, and providers outside of the network for an additional cost.

Medicare Special Needs Plan (SNP): A Medicare Advantage Plan that has a benefit package designed for people with special health care needs. Examples of the specific groups served include people who have both Medicare and Medicaid, people who reside in nursing homes, and people who have certain chronic medical conditions.

Medicare Medical Savings Account (MSA) Plan: MSA Plans combine a high deductible health plan with a bank account. The plan deposits money from Medicare into the account. You can use it to pay your medical expenses until your deductible is met.

Medicare Cost Plan: In a Medicare Cost Plan, you can go to providers both in and out of network. If you get services outside of the plan's network, your Medicare-covered services will be paid for under Original Medicare but you will be responsible for Medicare coinsurance and deductibles.

Medicare Medicaid Plan (MMP): An MMP is a private health plan designed to provide integrated and coordinated Medicare and Medicaid benefits for dual eligible Medicare beneficiaries.

Dental/Vision/Hearing Products

Plans offering additional benefits for consumers who are looking to cover needs for dental, vision, or hearing. These plans are not affiliated or connected to Medicare.

Hospital Indemnity Products

Plans offering additional benefits; payable to consumers based upon their medical utilization; sometimes used to defray copays/coinsurance. These plans are not affiliated or connected to Medicare.

Medicare Supplement (Medigap) Products

Plans offering a supplemental policy to fill "gaps" in Original Medicare coverage. A Medigap policy typically pays some or all of the deductible and coinsurance amounts applicable to Medicare-covered services, and sometimes covers items and services that are not covered by Medicare, such as care outside of the country. These plans are not affiliated or connected to Medicare.

IMPORTANT INFORMATION:

2025 Medicare Star Ratings

Official U.S. Government Medicare Information

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Providence Medicare Advantage Plans - H9047

For 2025, Providence Medicare Advantage Plans - H9047 received the following Star Ratings from Medicare:

Overall Star Rating:	★★★★☆
Health Services Rating:	★★★★☆
Drug Services Rating:	★★★½☆

Providence Medicare Advantage Plans

Every year, Medicare evaluates plans based on a 5-star rating system.

Why Star Ratings Are Important

Medicare rates plans on their health and drug services.

This lets you easily compare plans based on quality and performance.

Star Ratings are based on factors that include:

- Feedback from members about the plan's service and care
- The number of members who left or stayed with the plan
- The number of complaints Medicare got about the plan
- Data from doctors and hospitals that work with the plan

More stars mean a better plan – for example, members may get better care and better, faster customer service.

The number of stars show how well a plan performs.

★★★★★ EXCELLENT
★★★★☆ ABOVE AVERAGE
★★★☆☆ AVERAGE
★★☆☆☆ BELOW AVERAGE
★☆☆☆☆ POOR

Get More Information on Star Ratings Online

Compare Star Ratings for this and other plans online at Medicare.gov/plan-compare.

Questions about this plan?

Contact Providence Medicare Advantage Plans 7 days a week from 8:00 a.m. to 8:00 p.m. Pacific time at 800-457-6064 (toll-free) or 800-735-2900 (TTY). Current members please call 800-603-2340 (toll-free) or 711 (TTY).

Providence
Medicare Advantage Plans

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।”

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