Provider Partners Health Plans

Summary of Benefits 2027

Provider Partners Illinois Advantage Plan (HMO I-SNP) (H3800-001)
Provider Partners Indiana Advantage Plan (HMO I-SNP) (H4444-001)
Provider Partners Missouri Advantage Plan (HMO I-SNP) (H9191-001)
Provider Partners North Carolina Advantage Plan (HMO I-SNP) (H4439-001)
Provider Partners Pennsylvania Advantage Plan (HMO I-SNP) (H4093-001)
Provider Partners Texas Advantage Plan (HMO I-SNP) (H4054-001)

This is a summary of drug and health services covered by Provider Partners Health Plans (HMO I-SNP) for the plan year: January 1, 2027 - December 31, 2027. This plan, Provider Partners Illinois Advantage Plan, Provider Partners Indiana Advantage Plan, Provider Partners Missouri Advantage Plan, Provider Partners North Carolina Advantage Plan, Provider Partners Pennsylvania Advantage Plan, Provider Partners Texas Advantage Plan, is offered by Provider Partners Health Plans. When this Summary of Benefits says "we", "us", or "our" it means Provider Partners Health Plans. When it says "plan" or "our plan", it means Provider Partners Illinois Advantage Plan, Provider Partners Indiana Advantage Plan, Provider Partners Missouri Advantage Plan, Provider Partners North Carolina Advantage Plan, Provider Partners Pennsylvania Advantage Plan, Provider Partners Texas Advantage Plan.

Provider Partners Health Plans (HMO I-SNP) is a Health Maintenance Organization (HMO) Special Needs plan (SNP) with a Medicare contract. Enrollment in Provider Partners Health Plans depends on contract renewal.

Benefits, premiums and/or copayments/ co-insurance may change on January 1 of each year. Limitations, copayment, and restrictions may apply. This information is not a complete description of benefits.

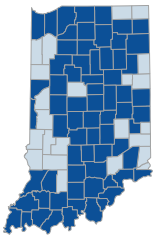
A complete list of benefits is available in the Evidence of Coverage. Call Member Services at 1-800-405-9681/TTY 711 for more information or visit our website at **www.pphealthplan.com.**

To join Provider Partners Health Plans (HMO I-SNP), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. This plan is available to anyone with Medicare who lives (or is expected to live) for at least 90 days in a row in a facility like a nursing facility. You must continue to pay your Medicare Part B Premium.

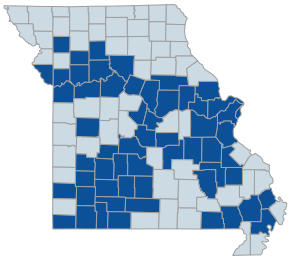
Our service area includes the following counties in **Illinois (IL):** Cook, DuPage, Kane, Lake, McHenry, Ogle, Will, and Winnebago.



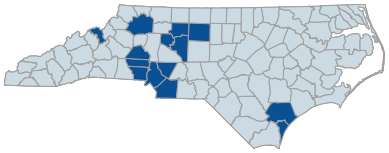
Our service area includes the following counties in **Indiana (IN):** Allen, Bartholomew, Boone, Brown, Carroll, Cass, Clark, Crawford, Daviess, DeKalb, Decatur, Delaware, Dubois, Elkhart, Fayette, Floyd, Fulton, Gibson, Grant, Hamilton, Hancock, Harrison, Hendricks, Henry, Howard, Huntington, Jackson, Jefferson, Johnson, Knox, Kosciusko, La Porte, Lake, Lawrence, Madison, Marion, Marshall, Miami, Monroe, Montgomery, Morgan, Noble, Orange, Perry, Pike, Porter, Posey, Pulaski, Putnam, Randolph, Ripley, Scott, Shelby, Spencer, St. Joseph, Starke, Switzerland, Tippecanoe, Tipton, Vanderburgh, Vermillion, Wabash, Warren, Warrick, Washington, Wayne, Wells, White, and Whitley.



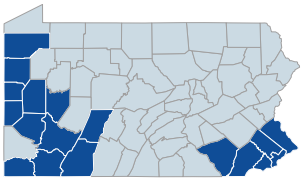
Our service area includes the following counties in **Missouri (MO):** Audrain, Barry, Boone, Butler, Caldwell, Callaway, Camden, Carroll, Cedar, Chariton, Christian, Clay, Cole, Crawford, Dade, Dallas, DeKalb, Douglas, Franklin, Greene, Henry, Hickory, Howard, Iron, Jackson, Jasper, Jefferson, Laclede, Lafayette, Lawrence, Lincoln, Livingston, Madison, Maries, McDonald, Miller, Moniteau, Montgomery, New Madrid, Phelps, Platte, Polk, Ray, Reynolds, Ripley, Saline, Scott, St. Charles, St. Francois, St. Louis, St. Louis City, Stoddard, Stone, Taney, Warren, Washington, Webster, and Wright.



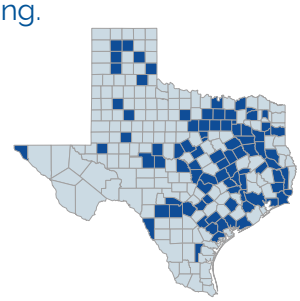
Our service area includes the following counties in **North Carolina (NC):** Cabarrus, Catawba, Davidson, Davie, Forsyth, Gaston, Guilford, Lincoln, Mecklenburg, Mitchell, New Hanover, Pender, Union, and Wilkes.



Our service area includes the following counties in **Pennsylvania (PA):** Allegheny, Armstrong, Beaver, Bucks, Butler, Cambria, Chester, Crawford, Delaware, Fayette, Greene, Lancaster, Lawrence, Mercer, Montgomery, Philadelphia, Somerset, and Westmoreland.



Our service area includes the following counties in **Texas (TX):** Anderson, Angelina, Bandera, Bexar, Brazos, Brown, Burleson, Burnet, Caldwell, Chambers, Cherokee, Collin, Collingsworth, Colorado, Comanche, Concho, Cooke, Dallas, DeWitt, Delta, Denton, Ector, El Paso, Falls, Fannin, Fort Bend, Freestone, Garza, Goliad, Gray, Gregg, Grimes, Guadalupe, Hall, Hardin, Harris, Harrison, Henderson, Hood, Hopkins, Howard, Hutchinson, Jackson, Jasper, Jefferson, Jim Wells, Karnes, Kaufman, Lampasas, Limestone, Lubbock, Madison, Matagorda, Maverick, McLennan, Medina, Milam, Moore, Nacogdoches, Navarro, Orange, Palo Pinto, Parker, Potter, Randall, Refugio, Robertson, Rockwall, Runnels, San Saba, Smith, Somervell, Tarrant, Titus, Tom Green, Travis, Trinity, Tyler, Upshur, Uvalde, Van Zandt, Victoria, Washington, Williamson, Wise, and Young.



Except in emergency situations, if you use the providers that are not in our network, we may not pay for these services.

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

This document is available in other formats such as Braille or large print.

This material is available for free in Spanish.

800-405-9681 | TTY 711

Hours of Operation:

October 1 – March 31
8 AM – 8 PM Daily

April 1 – September 30
8 AM – 8 PM M–F

Benefits	Provider Partners Health Plans HMO I-SNP
Monthly Plan Premium *(includes both medical and drugs)*	You pay: **IL:** $7.60 **IN:** $17.00 **MO:** $18.40 **NC:** $13.30 **PA:** $12.80 **TX:** $6.30 You must continue to pay your Medicare Part B premium.
Deductible	You pay $283 except for insulin furnished through an item of durable medical equipment. These are 2026 cost-sharing amounts and can change for 2027. Provider Partners Health Plans will provide updated rates at www.pphealthplan.com as soon as they're released. See outpatient prescription drugs section for Part D deductible.
Maximum Out-of-Pocket Responsibility *(does not include Part D prescription drugs)*	You pay no more than $9,850 annually. This is the most you pay per year for copays, coinsurance and other costs for medical services.
Inpatient Hospital	$1,736 deductible for each benefit period. Days 1–60: $0 after you pay your Part A deductible. Days 61–90: $434 copayment each day. Days 91-150: $868 copayment each day while using your 60 lifetime reserve days. After day 150: You pay all costs. Beyond lifetime reserve days. You pay all costs. These are 2026 cost-sharing amounts and can change for 2027. Provider Partners Health Plans will provide updated rates at www.pphealthplan.com as soon as they're released. Prior authorization may apply.
Outpatient Hospital	You pay 20% of the total cost for Medicare-covered services. Prior authorization may apply.
Ambulatory Surgery Center (ASC)	You pay 20% of the total cost for Medicare-covered services. Prior authorization may apply.
Doctor Visits • Primary care	You pay 20% of the total cost for Medicare-covered services.
• Primary care - Telehealth	You pay 20% of the total cost for Medicare-covered services.
• Specialists	You pay 20% of the total cost for Medicare-covered services.
Preventive Care (e.g., flu vaccine, diabetic screenings)	You pay nothing. Other preventive services are available. There are some covered services that have a cost.

Benefits	Provider Partners Health Plans HMO I-SNP
Emergency Care	You pay 20% of the total cost (up to $100 maximum) per visit. Coinsurance is waived if you are admitted to the same hospital within 24 hours for the same condition.
Urgently Needed Services	You pay 20% of the total cost (up to $40 maximum) per visit.
Diagnostic Services/Labs/ Imaging	
• Diagnostic tests and procedures	You pay 20% of the total cost for Medicare-covered services. Prior authorization may apply.
• Lab services	You pay 20% of the total cost for Medicare-covered services. Prior authorization may apply.
• MRI, PET, Nuclear Medicine	You pay 20% of the total cost for Medicare-covered services.
• X-Rays	You pay 20% of the total cost for Medicare-covered services.
Hearing Services	
• Routine hearing exam	You pay $0 of the total cost for one routine hearing exam per year.
• Supplemental hearing aid	**IL:** You pay $0 for a $2,000 hearing aid allowance that applies to both ears combined every 2 years. **IN:** You pay $0 for a $2,000 hearing aid allowance that applies to both ears combined every 2 years. **MO:** You pay $0 for a $2,000 hearing aid allowance that applies to both ears combined every 2 years. **NC:** You pay $0 for a $2,000 hearing aid allowance that applies to both ears combined every 2 years. **PA:** You pay $0 for a $2,000 hearing aid allowance that applies to both ears combined every 2 years. **TX:** You pay $0 for a $2,000 hearing aid allowance that applies to both ears combined every 2 years.
• Medicare-covered hearing services	You pay 20% of the total cost for Medicare-covered services. Call Member Services or refer to the Evidence of Coverage, Chapter 4, for more information on the hearing benefit.
Dental Services	
• Preventive and Comprehensive Supplemental Dental Services	**IL:** You pay $0 for a $3,000 preventive and comprehensive dental allowance per year. Once the allowance has been exhausted, you are responsible for the remaining charges. **IN:** You pay $0 for a $5,000 preventive and comprehensive dental allowance per year. Once the allowance has been exhausted, you are responsible for the remaining charges.

Benefits	Provider Partners Health Plans HMO I-SNP
Dental Services Continued	**MO:** You pay $0 for a $5,000 preventive and comprehensive dental allowance per year. Once the allowance has been exhausted, you are responsible for the remaining charges. **NC:** You pay $0 for a $5,000 preventive and comprehensive dental allowance per year. Once the allowance has been exhausted, you are responsible for the remaining charges. **PA:** You pay $0 for a $3,000 preventive and comprehensive dental allowance per year. Once the allowance has been exhausted, you are responsible for the remaining charges. **TX:** You pay $0 for a $4,600 preventive and comprehensive dental allowance per year. Once the allowance has been exhausted, you are responsible for the remaining charges.
• Medicare-covered dental services	You pay 20% of the total cost for Medicare-covered services. Prior authorization may apply. Call Member Services or refer to the Evidence of Coverage, Chapter 4, for more information on the dental benefit.
Vision Services	
• Routine vision exam	You pay $0 of the total cost for one routine vision exam per year.
• Supplemental eyewear	**IL:** You pay $0 for a $300 eyewear allowance per year. **IN:** You pay $0 for a $500 eyewear allowance per year. **MO:** You pay $0 for a $500 eyewear allowance per year. **NC:** You pay $0 for a $300 eyewear allowance per year. **PA:** You pay $0 for a $300 eyewear allowance per year. **TX:** You pay $0 for a $150 eyewear allowance per year.
• Medicare-covered eye exams	You pay 20% of the total cost of Medicare-covered services.
• Medicare-covered eyewear	You pay 20% of the total cost of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery. Call Member Services or refer to the Evidence of Coverage, Chapter 4 for more information on the vision benefit.
Mental Health Services	$1,736 deductible for each benefit period.
• Inpatient Hospital - Psychiatric	Days 1–60: $0 after you pay your Part A deductible. Days 61–90: $434 copayment each day. Days 91-150: $868 copayment each day while using your 60 lifetime reserve days. After day 150: You pay all costs. Beyond lifetime reserve days: You pay all costs. These are 2026 cost-sharing amounts and can change for 2027. Provider Partners Health Plans will provide updated rates at www.pphealthplan.com as soon as they're released. Prior authorization may apply.
• Outpatient group therapy/ individual therapy visit	You pay 20% of the total cost of Medicare-covered services

Benefits	Provider Partners Health Plans HMO I-SNP
Skilled Nursing Facility	You pay: Days 1-100: $0 copayment. Days 101 and beyond: You pay all costs. Prior authorization may apply.
Physical Therapy	You pay 0% of the total cost of Medicare-covered services. Prior authorization may apply.
Ambulance	You pay 20% of the total cost for each one-way Medicare-covered ambulance trip.
Transportation (Non-Emergency, Routine)	**IL:** You pay $0 for up to 66 one-way trips per year to health-related locations via taxi, rideshare services, van, or medical transport. **IN:** You pay $0 for up to 74 one-way trips per year to health-related locations via taxi, rideshare services, van, or medical transport. **MO:** You pay $0 for up to 38 one-way trips per year to health-related locations via taxi, rideshare services, van, or medical transport. This benefit allows members to be accompanied by a health aide, if the member chooses so. **NC:** You pay $0 for up to 70 one-way trips per year to health-related locations via taxi, rideshare services, van, or medical transport. **PA:** You pay $0 for up to 38 one-way trips per year to health-related locations via taxi, rideshare services, van, or medical transport. **TX:** Transportation not covered. Call Member Services or refer to the Evidence of Coverage, Chapter 4, for more information on this transportation benefit.
Medicare Part B Drugs	You can pay from 0% to 20% for Medicare Part B Chemotherapy/ Radiation Drugs and other Medicare Part B Drugs. Prior authorization may apply for billed charges in excess of $1,500. You can pay from 0% to 20% (with a $35 maximum) for insulin per month.

Benefits	Provider Partners Health Plans HMO I-SNP
Annual Physical Exam	You pay 20% of the total cost of services.
Foot Care (podiatry services) • Routine foot care	**IL:** You pay $0 for up to 5 routine podiatry visits per year. **IN:** You pay $0 for up to 12 routine podiatry visits per year. **MO:** You pay $0 for up to 6 routine podiatry visits per year. **NC:** You pay $0 for up to 6 routine podiatry visits per year. **PA:** You pay $0 for up to 4 routine podiatry visits per year. **TX:** You pay $0 for up to 6 routine podiatry visits per year.
• Medicare-covered foot care	You pay 20% of the total cost for Medicare-covered services. Call Member Services or refer to the Evidence of Coverage, Chapter 4, for more information on the podiatry benefit.
Over-the-Counter (OTC) Benefit	Limited to allowance every quarter for specific over-the-counter drugs and other health-related products, as listed in the OTC catalog. **IL:** You pay $0 for a $255 catalog allowance per quarter. **IN:** You pay $0 for a $155 catalog allowance per quarter. **MO:** You pay $0 for a $175 catalog allowance per quarter. **NC:** You pay $0 for a $301 catalog allowance per quarter. **PA:** You pay $0 for a $151 catalog allowance per quarter. **TX:** You pay $0 for a $70 catalog allowance per quarter. OTC items may be purchased only for the member and are limited to one order every quarter. Any unused benefit expires at the end of each quarter and cannot be carried over to the next quarter. Call Member Services or refer to the Evidence of Coverage, Chapter 4, for more information on the over-the-counter benefit.

Other Benefits

Special Supplemental Benefits for the Chronically Ill*	**IL:** You pay $0 for a $200 essential clothing allowance per year. **IN:** You pay $0 for a $175 essential clothing allowance per year and a $400 healthy food and produce allowance per quarter. **MO:** You pay $0 for a $360 essential clothing allowance per year. **NC:** You pay $0 for a $300 essential clothing allowance per year. **PA:** You pay $0 for a $300 essential clothing allowance per year. **TX:** You pay $0 for a $200 essential clothing allowance per year and a $150 digital communication allowance per quarter. *These are special supplemental benefits available only to eligible members. Not all members will qualify. Members diagnosed with certain chronic conditions and who meet additional eligibility requirements may be eligible for these benefits. Eligible conditions may include cardiovascular disorders, chronic heart failure, dementia, diabetes, and chronic and disabling mental health conditions. Other qualifying conditions not listed here may also make you eligible. Please contact the plan for more information about eligibility. Funds are loaded onto a restricted spend debit card** for use at participating retail locations. Food and produce funds are made available quarterly for the purchase of healthy options through a variety of participating retail locations. The benefit resets every quarter; any unused funds do not rollover. This can take up to three months. Eligible members will receive an annual allowance for essential clothing items, such as sweatshirts, sweatpants, undergarments, and socks. The benefit resets every year; any unused funds do not rollover. This can take up to three months. The quarterly digital communication benefit helps eligible members with the cost of a wireless service provider bill. The benefit resets every quarter, any unused funds do not rollover. This can take up to three months. **The Benefits Mastercard® Prepaid Card is issued by The Bancorp Bank N.A., pursuant to license by Mastercard International Incorporated and card can be used for eligible expenses wherever Mastercard is accepted. Mastercard and the circles design is a trademark of Mastercard International Incorporated. Valid only in the U.S. No cash access. This is not a gift card or gift certificate. You have received this card as a gratuity without the payment of any monetary value or consideration. Call Member Services or refer to the Evidence of Coverage, Chapter 4 for more information on the Special Supplemental Benefits for the Chronically Ill.

Pharmacy Prescription Drug Benefits

Deductible	You pay $700	
	Standard Retail Rx 30-day supply	Mail-Order 30-day supply
Initial Coverage Tier 1: All Part D Covered Drugs	You pay 25% of the total cost of the drug. You pay $35 per month supply of each covered insulin product on this tier.	You pay 25% of the total cost of the drug. You pay $35 per month supply of each covered insulin product on this tier.
Vaccine Tier	You pay $0 for pneumonia, influenza, Hepatitis B, and COVID-19 vaccines. For further information about vaccines, please reference the Evidence of Coverage.	
Catastrophic Coverage *(after you or others on your behalf pay $2,400)* • Generic Drugs • Brand-Name Drugs	 You pay nothing. You pay nothing.	

DISCRIMINATION IS AGAINST THE LAW

Provider Partners Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2). Provider Partners Health Plans does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Provider Partners Health Plans:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact the Provider Partners Health Plans Compliance Officer.

If you believe that Provider Partners Health Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Provider Partners Health Plans Compliance Officer
Mailing Address: 8820 Columbia 100 Parkway, Suite #430
Columbia, MD 21045
Phone: 1-833-213-0636
Fax: 1-844-570-7811
Email: compliance@pphealthplan.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Provider Partners Health Plans Compliance Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

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

This notice is available at Provider Partners Health Plans website: www.pphealthplan.com

NOTICE OF AVAILABILITY OF LANGUAGE ASSISTANCE SERVICES AND AUXILIARY AIDS AND SERVICES

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 1-800-405-9681(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 1-800-405-9681(TTY: 711) o hable con su proveedor.

中文 (Simplified Chinese)

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 1-800-405-9681 (文本电话：711) 或咨询您的服务提供商。

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 1-800-405-9681(Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

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. 1-800-405-9681 (TTY: 711) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

POLSKI (Polish)

UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-800-405-9681(TTY: 711) lub porozmawiaj ze swoim dostawcą.

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 1-800-405-9681(711) أو تحدث إلى مقدم الخدمة

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 1-800-405-9681 (TTY: 711) или обратитесь к своему поставщику услуг.

Tagalog (Tagalog)

PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-405-9681(TTY: 711) o makipag-usap sa iyong provider.

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 1-800-405-9681(TTY : 711) ou parlez à votre fournisseur.

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 1-800-405-9681(TTY: 711) an oder sprechen Sie mit Ihrem Provider.

ગુજરાતી (Gujarati)

ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-800-405-9681(TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.

اردو (Urdu)

توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں1-800-405-9681(TTY:711)۔ "پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔

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। 1-800-405-9681(TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

NOTICE OF AVAILABILITY OF LANGUAGE ASSISTANCE SERVICES AND AUXILIARY AIDS AND SERVICES

Pennsylvanisch Deitsch (Pennsylvanian Dutch)

ACHTUNG: Wann du Pennsylvanisch Deitsch schwetzscht, sin Hilfsdienst fer die Sprooch fer dich gratis verfügbar. Passende Hilfsmittel un Dienscht, fer Informatione in zugängliche Formate ze gebbe, sin aa gratis verfügbar. Ruf 1-800-405-9681 (TTY: 711) oder schwetz mit dein Anbieter.

Italiano (Italian)

ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'1-800-405-9681(tty: 711) o parla con il tuo fornitore.

فارس (Persian)

توجه: اگري]واردیکردنیزبان[یصحبتي یمکنید، یخدماتیپشتیبانیزبانیرایگانیدریدستسي شمایقراریداردي. همچنییکمیکهایویخدماتیپشتیبانیمناسبیبراییارائهیاطالعاتیدریقال یبهاییقابلیدستسي، یبهطوریرایگاني موجودي یمباشندي. بایشمارهي-1-800-405-9681-ي) تلهتایپ:ي 711-)یتماسیبگتیدییایارائهدهنده خودیصحبتیکنیدي

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。1-800-405-9681（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。

Kreyòl Ayisyen (French Creole)

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd aladispozisyon w gratis pou lang ou pale a. Èd ak sèvis siplemantè apwopriye pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele nan 1-800-405-9681(TTY: 711) oswa pale avèk founisè w la.

Português do Brasil (Portuguese)

ATENÇÃO: Se você fala Português do Brasil, serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-800-405-9681(TTY : 711) ou fale com seu provedor.

ភាសាខ្មែរ / (Mon-Khmer, Cambodian)

ការយកចិត្តទុកដាក់: ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ សេវាកម្មជំនួយភាសាឥតគិតថ្លៃមានសម្រាប់អ្នក។ ជំនួយ និងសេវាកម្មជំនួយសមស្របដើម្បីផ្តល់ព័ត៌មានជាទម្រង់ដែលអាចចូលប្រើបានក៏មានដោយឥតគិតថ្លៃផងដែរ។ សូមទូរស័ព្ទទៅលេខ 1-800-405-9681(TTY: 711) ឬនិយាយជាមួយអ្នកផ្តល់សេវារបស់អ្នក។

Српски (Serbian)

ПАЖЊА: Ако говорите Српски, обезбеђена вам је преводилачка услуга. Додатна одговарајућа помоћ и услуге за пружање информација у доступним форматима такође су доступни без надокнаде. Назовите 1-800-405-9681(TTY: 7-1-1) или разговарајте са вашим пружаоцем услуга.

Ελληνικά (Greek)

ΠΡΟΣΟΧΗ: Εάν μιλάτε ελληνικά, υπάρχουν διαθέσιμες δωρεάν υπηρεσίες υποστήριξης στη συγκεκριμένη γλώσσα. Διατίθενται δωρεάν κατάλληλα βοηθήματα και υπηρεσίες για παροχή πληροφοριών σε προσβάσιμες μορφές. Καλέστε το 1-800-405-9681(TTY: 711) ή απευθυνθείτε στον πάροχό σας».

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 1-800-405-9681(TTY: 711) ይደውሉ ወይም አገልግሎት አቅራቢዎን ያናግሩ።

ลาว (Laotian)

ເຊີນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 1-800-405-9681(TTY: 711) ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

Yorùbá (Yoruba)

ÀKÍYÈSÍ: Tí o bá ń ṣọ Yorùbá (Yoruba), àwọn iṣẹ́àtìlẹyìn ´èdè ọ̀f̀ àti àwọn ìbánisọ̀rọ̀nínú àwọn ìgúnrégé, bí a àwọn àt ̀jáde ńlá, wà fún ọ. Pe 1-800-405-9681 (TTY: 711)

NOTICE OF AVAILABILITY OF LANGUAGE ASSISTANCE SERVICES AND AUXILIARY AIDS AND SERVICES

Kru- Bassa (Kru)

DYÉ-GBO-DÈ-yi po-nyvùu (Bassa) po-nyí, wu xwíníín-mú-zà-zà kè b céèdyèè kò-kò , hwn-kà céè-dyèè se wíí kè nìà k1-800-405-9681. (TTY: 711)

Ibo (Ilbo)

GEE NTỊ: Ọ bụrụ na ị na-asụ asụsụ Igbo (Igbo), ọrụ enyemaka nkọwa asụsụ bụ n'efu yana inye nziritaozi n'ụdị ndị ọzọ dịịrị gị n'efu, dịka e ji nha mkpụrụedemede buru ibu dee ya. Kpọọ 1-800-405-9681. (TTY: 711)

မြန်မာ (Burmese)

သတိပြုရန်- သင်က မြန်မာဘာသာစကား ပြောဆိုပါက၊ အခမဲ့ ဘာသာစကားအကူအညီ ဝန်ဆောင်မှုများကို ရနိုင်ပါသည်။ အသုံးပြုနိုင်သော ဖော်မတ်များဖြင့် အချက်အလက်များ ဖော်ပြ ပေးရန် သင့်လျော်သော အရန်အကူအညီများနှင့် ဝန်ဆောင်မှု များကိုလည်း အခမဲ့ ရရှိနိုင်ပါသည်။ 1-800-405-9681(TTY: 711) သို့ဖုန်းခေါပါ သို့မဟုတ် သင်၏ ဆောင်ရွက်ပေးသူနှင့် စကားပြောပါ။

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 1-800-405-9681(TTY: 711) los sis sib tham nrog koj tus kws muab kev saib xyuas kho mob.

Nederlands (Dutch)

LET OP: als je Nederlands spreekt, zijn er gratis taalhulpdiensten voor je beschikbaar. Passende hulpmiddelen en diensten om informatie in toegankelijke formaten te verstrekken, zijn ook gratis beschikbaar. Bel 1-800-405-9681(tty: 711) of spreek met je provider.

Cushite- Oromo (Cushite)

XIYYEEFFANNOO: Yoo Afaan Oromoo (Oromo) kan dubbattan ta'e, tajaajilootni deeggarsa afaanii bilisaa fi waliin dubbiin bilisaa kan akka maxxansa gurguddaa afaan keessaniin ni jiraatu. 1-800-405-9681 (TTY 711) irratti bilbilaa.

ਪੰਜਾਬੀ (Panjabi)

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। 1-800-405-9681(TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ ਜਾਂ ਆਪਣੇ ਪ੍ਰਦਾਤਾ ਨਾਲ ਗੱਲ ਕਰੋ।

नेपाली (Nepali)

सावधान: यदि तपाईं नेपाली भाषा बोल्नुहुन्छ भने तपाईंका लागि निःशुल्क भाषिक सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायता र सेवाहरू पनि निःशुल्क उपलब्ध छन्। 1-800-405-9681(TTY: 711) मा फोन गर्नुहोस् वा आफ्नो प्रदायकसँग कुरा गर्नुहोस्।

Bantu-Kirundi (Bantu)

ICITONDERWA: Nimba uvuga Ikirundi (Kirundi), seruvise zo kugufasha mu bijanye n'indimi n'uguhanahana amakuru mu bundi buryo, na canecane mu gukoresha indome nini, zirahari ku buntu. Hamagara kuri 1-800-405-9681 (TTY 711)