Provider Partners Health Plans

Summary of Benefits 2026

Provider Partners Indiana Community Plan (HMO I-SNP) (H4444-002)
Provider Partners Maryland Community Plan (HMO I-SNP) (H8067-003)
Provider Partners Missouri Community Plan (HMO I-SNP) (H9191-004)
Provider Partners North Carolina Community Plan (HMO I-SNP) (H4439-002)
Provider Partners Pennsylvania Community Plan (HMO I-SNP) (H4093-004)

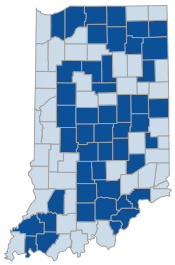
This is a summary of drug and health services covered by Provider Partners Health Plans (HMO I-SNP) for the plan year: January 1, 2026 - December 31, 2026. This plan, Provider Partners Indiana Community Plan, Provider Partners Maryland Community Plan, Provider Partners Missouri Community Plan, Provider Partners North Carolina Community Plan, Provider Partners Pennsylvania Community 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 Indiana Community Plan, Provider Partners Maryland Community Plan, Provider Partners Missouri Community Plan, Provider Partners North Carolina Community Plan, Provider Partners Pennsylvania Community 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.

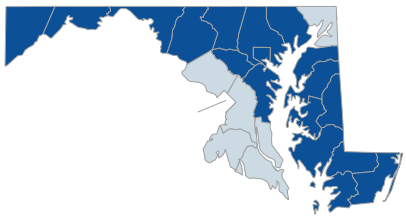
Benefits, premiums and/or copayments/co-insurance may change on January 1 of each year. Limitations, copayment, and restrictions may apply. This information is not a complete description of benefits. A complete list of benefits is available in the Evidence of Coverage. Call Member Services at 1-800-405-9681/TTY 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, live at home and your state of residence has certified that you need the type of care that is usually provided in a nursing home. You must continue to pay your Medicare Part B Premium.

Our service area includes the following counties in **Indiana (IN):** Allen, Boone, Brown, Cass, Clark, Daviess, Decatur, DeKalb, Delaware, Dubois, Elkhart, Fayette, Floyd, Gibson, Hamilton, Hancock, Hendricks, Henry, Howard, Jackson, Jefferson, Johnson, Kosciusko, LaPorte, Lawrence, Madison, Marion, Marshall, Miami, Monroe, Montgomery, Morgan, Noble, Orange, Pike, Porter, Putnam, Randolph, Scott, Shelby, St. Joseph, Tippecanoe, Vanderburgh, Wabash, Warrick, Washington, Wells, White, and Whitley.

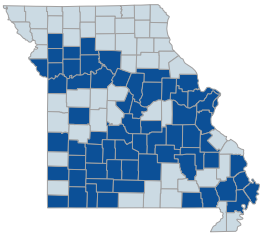


Our service area includes the following counties in **Maryland (MD)**: Allegany, Anne Arundel, Baltimore, Baltimore City, Caroline, Carroll, Dorchester, Frederick, Garrett, Harford, Howard, Kent, Queen Anne's, Somerset, Talbot, Washington, Wicomico, and Worcester.

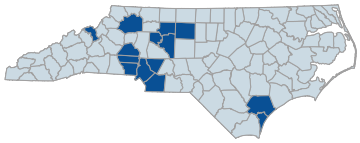


Our service area includes the following counties in **Missouri (MO)**: Audrain, Barry, Boone, Butler, Caldwell, Callaway, Camden, Cape Girardeau, Carroll, Cedar, Chariton, Christian, Clay, Clinton, Cole, Crawford, Dade, Dallas, DeKalb, Dent, Douglas, Franklin,

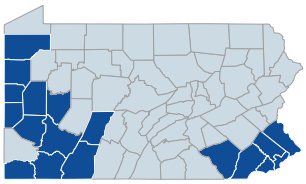
Greene, Henry, Hickory, Howard, Iron, Jackson, Jasper, Jefferson, Laclede, Lafayette, Lawrence, Lincoln, Livingston, Madison, Maries, McDonald, Miller, Mississippi, Moniteau, Montgomery, New Madrid, Phelps, Platte, Polk, Pulaski, Ray, Reynolds, Ripley, Saline, Scott, St. Charles, St. Francois, St. Louis, St. Louis City, Stoddard, Stone, Taney, Texas, Vernon, 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.



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.

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 $0 You must continue to pay your Medicare Part B premium.
Deductible	You pay $0 See outpatient prescription drugs section for Part D deductible.
Maximum Out-of-Pocket Responsibility *(does not include Part D prescription drugs)*	**IN:** You pay no more than $3,750 annually **MD:** You pay no more than $3,750 annually **MO:** You pay no more than $3,750 annually **NC:** You pay no more than $3,750 annually **PA:** You pay no more than $2,600 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 each day. Days 91-150: $868 each day while using your 60 lifetime reserve days. After day 150: You pay all costs. Beyond lifetime reserve days. You pay all costs. Prior authorization may apply.

Benefits	Provider Partners Health Plans HMO I-SNP
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 a $10 copayment for each visit.
• 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.
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 $45 maximum combined) per visit.
Diagnostic Services/Labs/ Imaging	
• Diagnostic tests & 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 a year.
• Supplemental hearing aid	**IN:** You pay $0 for a $2,000 hearing aid allowance that applies to both ears combined every 2 years. **MD:** 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.
• Medicare-covered hearing exams	You pay 20% of the total cost for Medicare-covered hearing services. Call Member Services or refer to the Evidence of Coverage, Chapter 4, for more information on the hearing benefit.

Benefits	Provider Partners Health Plans HMO I-SNP
Dental Services • Preventative & Comprehensive Supplemental dental services	**IN:** You pay $0 for a combined annual allowance of $3,000. Once the allowance has been exhausted, you are responsible for any remaining charges. **MD:** You pay $0 for a combined annual allowance of $3,000. Once the allowance has been exhausted, you are responsible for any remaining charges. **MO:** You pay $0 for a combined annual allowance of $3,000. Once the allowance has been exhausted, you are responsible for any remaining charges. **NC:** You pay $0 for a combined annual allowance of $3,000. Once the allowance has been exhausted, you are responsible for any remaining charges. **PA:** You pay $0 for a combined annual allowance of $3,000. Once the allowance has been exhausted, you are responsible for any remaining charges.
• Medicare-covered dental 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 dental benefit.
Vision Services • Routine vision exam • Supplemental eyewear	You pay 0% of the total cost for one routine vision exam a year. **IN:** You pay $0 for a $300 annual allowance for routine eye wear **MD:** You pay $0 for a $300 annual allowance for routine eye wear **MO:** You pay $0 for a $300 annual allowance for routine eye wear **NC:** You pay $0 for a $300 annual allowance for routine eye wear **PA:** You pay $0 for a $300 annual allowance for routine eye wear
• 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 • Inpatient Hospital - Psychiatric	$1,736 deductible for each benefit period. Days 1–60: $0 after you pay your Part A deductible. Days 61–90: $434 each day. Days 91-150: $868 each day while using your 60 lifetime reserve days. After day 150: You pay all costs. Beyond lifetime reserve days: You pay all costs. Prior authorization may apply.
• Outpatient group therapy/ individual therapy visit	You pay 20% of the total cost for Medicare-covered services
Skilled Nursing Facility	**IN:** You pay $0 for Skilled Nursing Facility services Prior authorization may apply.

Benefits	Provider Partners Health Plans HMO I-SNP
Skilled Nursing Facility (continued)	**MD:** You pay: Days 1-20: $0 copayment Days 21-100: $217 copayment each day Days 101 and beyond: You pay all costs Prior authorization may apply. **MO:** You pay: Days 1-20: $0 copayment Days 21-100: $217 copayment each day Days 101 and beyond: You pay all costs Prior authorization may apply. **NC:** You pay: Days 1-20: $0 copayment Days 21-100: $217 copayment each day Days 101 and beyond: You pay all costs. Prior authorization may apply. **PA:** You pay: Days 1-20: $0 copayment Days 21-100: $217 copayment each day Days 101 and beyond: You pay all costs. Prior authorization may apply.
Physical Therapy	You pay a $10 copayment for each Medicare-covered physical therapy visit. Prior authorization may apply.
Ambulance	You pay 20% of the total cost for each one-way Medicare-covered ambulance trip
Transportation	**IN:** You pay $0 for up to 46 one-way trips every year to health-related locations via taxi, rideshare services, van, or medical transport. **MD:** You pay $0 for up to 30 one-way trips every year to health-related locations via taxi, rideshare services, van, or medical transport. **MO:** You pay $0 for up to 28 one-way trips every year to health-related locations via taxi, rideshare services, van, or medical transport. **NC:** You pay $0 for up to 28 one-way trips every year to health-related locations via taxi, rideshare services, van, or medical transport. **PA:** You pay $0 for up to 28 one-way trips every year to health-related locations via taxi, rideshare services, van, or medical transport. 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.

Value-Added Benefits

Annual Physical Exam	You pay 20% of the total cost of services.
Foot Care (podiatry services) • Routine foot care	**IN:** You pay $0 for up to 12 routine visits every year **MD:** You pay $0 for up to 4 routine visits every year **MO:** You pay $0 for up to 5 routine visits every year **NC:** You pay $0 for up to 6 routine visits every year **PA:** You pay $0 for up to 4 routine visits every 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. **IN:** You pay $0 for a $100 quarterly allowance every year **MD:** You pay $0 for a $100 quarterly allowance every year **MO:** You pay $0 for a $100 quarterly allowance every year **NC:** You pay $0 for a $150 quarterly allowance every year **PA:** You pay $0 for a $150 quarterly allowance every year 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 the 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.
Special Supplemental Benefits for the Chronically Ill - Food and Produce*	**IN:** You pay $0 for a $150 quarterly allowance for healthy food, produce, and digital communications. The quarterly allowance under the food, produce, and digital communications benefit can be used towards the cost of a wireless service provider bill. **MD:** You pay $0 for a $60 quarterly allowance for healthy food and produce. **MO:** You pay $0 for a $100 quarterly allowance for healthy food and produce. **NC:** You pay $0 for a $100 quarterly allowance for healthy food and produce. **PA:** You pay $0 for a $100 quarterly allowance for healthy food and produce. *These are special supplemental benefits, not all members will qualify. Members that have been diagnosed with one or more of the following chronic conditions AND meet certain criteria may be eligible for these benefits: cardiovascular disorders, chronic heart failure, dementia, diabetes and chronic and disabling mental health conditions. Other conditions may also make you eligible for these benefits. Funds are made available to you via a restricted spend prepaid debit card** for use at participating retail locations. Members can purchase healthy foods and prepared meals. Any unused funds do not rollover to the next period. This can take up to three months. &more Benefits Prepaid Mastercard® is issued by Avidia Bank, pursuant to a license from Mastercard Incorporated. Use of this card is subject to the terms and conditions of the Cardholder Agreement. Call Member Services or refer to the Evidence of Coverage, Chapter 3 for more information on the SSBCI Benefit.

Pharmacy	Prescription Drug Benefits	
Deductible	You pay $615	
	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 $2,100)* • 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 Heath 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. همچنییکمیکهایویخدماتیپشتیبانیمناسبیبرایایارائهیاطالعاتیدریقال یبهاییقابلیدستسي، یبهطوریرایگاني موجودي یمباشندي. بایشمارهي-1-800-405-9681-ي) تلهتایپ:ي 711-)یتماسیبگتیدییایایارائهدهنده 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 [inserir idioma], 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)

DYÉĐÉ-GBO-DÈ-ĐĐMĐyi po-nyĐĐĐwùĐ (Bassa) po-nyĐĐní, wuĐ xwíníín-mú-zà-zà kè b ĐĐĐ céèdyèĐ kò-kò Đ, hwĐn-kà céè-dyèĐ vĐĐĐĐĐĐĐ se wíĐpĐĐpĐĐ kĐĐnì Đ mĐìì. Đ nĐĐ nìà kĐ1-800-405-9681. (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 ဖော်ပြပေးရန် သင့်လျော်သော အရန်အကူအညီများနှင့် ဝန်ဆောင်မှုများကိုလည်း အခမဲ့ ရရှိနိုင်ပါသည်။ 1-800-405-9681(TTY: 711) သို့ဖုန်းခေါ်ပါ 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 नि:शुल्क भाषिक सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायता र सेवाहरू पनि नि:शुल्क 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)

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

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