2025 SUMMARY OF BENEFITS

January 1, 2025 – December 31, 2025

The Health Plan SecureChoice - Option II (PPO)

H8604-011

A Medicare Advantage Plan with Prescription Drugs

Our service area includes the following counties in **Ohio**:

Adams, Allen, Ashland, Ashtabula, Athens, Auglaize, Belmont, Brown, Butler, Carroll, Champaign, Clark, Clermont, Clinton, Columbiana, Coshocton, Crawford, Cuyahoga, Darke, Delaware, Fairfield, Fayette, Franklin, Fulton, Gallia, Geauga, Greene, Guernsey, Hamilton, Hardin, Harrison, Henry, Highland, Hocking, Holmes, Jackson, Jefferson, Knox, Lake, Lawrence, Licking, Logan, Lorain, Madison, Mahoning, Medina, Meigs, Mercer, Miami, Monroe, Montgomery, Morgan, Morrow, Muskingum, Noble, Ottawa, Paulding, Perry, Pickaway, Pike, Portage, Preble, Putnam, Richland, Ross, Scioto, Seneca, Shelby, Stark, Summit, Trumbull, Tuscarawas, Van Wert, Vinton, Warren, Washington, Wayne, Wyandot.

Our service area includes the following counties in **West Virginia**:

Barbour, Berkeley, Boone, Braxton, Brooke, Cabell, Calhoun, Clay, Doddridge, Fayette, Gilmer, Grant, Greenbrier, Hampshire, Hancock, Hardy, Harrison, Jackson, Jefferson, Kanawha, Lewis, Lincoln, Logan, Marion, Marshall, Mason, McDowell, Mercer, Mineral, Mingo, Monongalia, Monroe, Morgan, Nicholas, Ohio, Pendleton, Pleasants, Pocahontas, Preston, Putnam, Raleigh, Randolph, Ritchie, Roane, Summers, Taylor, Tucker, Tyler, Upshur, Wayne, Webster, Wetzel, Wirt, Wood, Wyoming.

This document is available in other formats such as braille, large print and audio CD. For additional information on available formats, call us at **1.877.847.7915 (TTY: 711)**.

INTRODUCTION

The benefit information provided in this booklet is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, access our Evidence of Coverage online at healthplan.org/medicare. Or call us to request a copy.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at medicare.gov or get a copy by calling 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048.

The Health Plan SecureChoice - Option II (PPO) is a PPO plan with a Medicare contract. Enrollment in The Health Plan SecureChoice - Option II (PPO) depends on contract renewal.

ELIGIBILITY

To join The Health Plan SecureChoice – Option II (PPO) you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

WHICH DOCTORS, HOSPITALS AND PHARMACIES CAN I USE?

This is a Preferred Provider Organization (PPO) plan. This means that even though we have a network of doctors, hospitals, pharmacies and other providers, you may use providers that are not in our network. However, if you use providers outside of our network, your costs may be higher. No referral is needed, but some services do require prior authorization from the plan.

Out-of-network/non-contracted providers are under no obligation to treat SecureChoice (PPO) 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.

You can see current provider lists on our website at healthplan.org/medicare. Or call us and we will send you a copy.

HOW TO REACH US

If you are a member, call toll-free: 1.877.847.7907 (TTY: 711)

If you are not a member, call toll-free: 1.877.847.7915 (TTY: 711)

Hours of operation:

- October 1 to March 31, 8:00 a.m. to 8:00 p.m. Eastern, 7 days a week.
- April 1 to September 30, 8:00 a.m. to 8:00 p.m. Eastern, Monday through Friday.

Or visit our website: healthplan.org/medicare.

Pre-Enrollment Checklist

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 **1.877.847.7915. (TTY: 711)**.

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 healthplan.org/medicare or call **1.877.847.7915 (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 medicines 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

- ☐ **Effect on Current Coverage**. Your current health care coverage will end once your new Medicare coverage starts. For example, if you are in Tricare or a Medicare plan, you will no longer receive benefits from that plan once your new coverage starts.
- ☐ In addition to your monthly plan premium (if applicable), you must continue to pay your Medicare Part B premium if not otherwise paid by a third party like the state. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2026.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, 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 co-pay for services received by non-contracted providers.

PREMIUMS & BENEFITS	THE HEALTH PLAN SECURECHOICE-OPTION II (PPO) H8604-011	
Monthly Plan Premium	**$109.00** You must continue to pay your Medicare Part B premium	
Annual Medical Deductible	$1,500 Applies to all out-of-network Medicare Part A and Part B covered services except for emergency care, urgently needed services, and emergency ambulance transport	
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	$6,700 for Medicare-covered services you receive from providers in our plan. $10,000 for Medicare-covered services you receive from providers both in and out of our plan. This is the most that you will pay out-of-pocket for covered Medicare Part A and Part B services in 2025. The amounts you pay for copayments and co-insurance for these covered services count towards the maximum out-of-pocket amount(s).	
Inpatient Hospital Coverage* **(Per admission or stay)**	In-Network: Days 1-6: $295 copay per day Days 7-90: $0 copay Days 91 and beyond: $0 copay	Out-of-Network: 30% co-insurance per stay
	Our plan covers an unlimited number of days for an inpatient hospital stay	
Outpatient Hospital Coverage*	In-Network: $295 copay for outpatient surgeries. $0 copay for diagnostic colonoscopies. $150 copay for observation visits	Out-of-Network: 30% co-insurance
Ambulatory Surgical Center*	In-Network: $295 copay	Out-of-Network: 30% co-insurance
Doctor Visit: Primary Care Provider	In-Network: $10 copay	Out-of-Network: $25 copay
Doctor Visit: Specialist*	In-Network: $45 copay No referral needed. However, organizational authorization may be required for tertiary specialists	Out-of-Network: $60 copay

PREMIUMS & BENEFITS	THE HEALTH PLAN SECURECHOICE-OPTION II (PPO) H8604-011	

Preventive Care (Medicare-covered zero cost sharing preventive services)	Medicare–covered zero cost sharing preventive services $0 copay for the following*:
	• Abdominal aortic aneurysm screenings
	• Alcohol misuse screenings & counseling
	• Blood-based biomarker tests
	• Cardiovascular disease screenings
	• Cardiovascular disease (behavioral therapy)
	• Cervical & vaginal cancer screenings
	• Colorectal cancer screenings
	  o Multi-target stool DNA tests
	  o Screening barium enemas
	  o Screening colonoscopies
	  o Screening fecal occult blood tests
	  o Screening flexible sigmoidoscopies
	• Depression screenings
	• Diabetes screenings
	• Diabetes self-management training
	• Flu shots
	• Glaucoma tests
	• Hepatitis B shots
	• Hepatitis B Virus (HBV) infection screenings
	• Hepatitis C screening tests
	• HIV screenings
	• Lung cancer screenings
	• Mammograms (screening)
	• Medicare Diabetes Prevention Program
	• Nutrition therapy services
	• Obesity screenings & counseling
	• One-time "Welcome to Medicare" preventive visit
	• Pneumococcal shots
	• Prostate cancer screenings
	• Sexually transmitted infections screenings & counseling
	• Shots:
	  o COVID-19 vaccines
	  o Flu shots
	  o Hepatitis B shots
	  o Pneumococcal shots
	• Tobacco use cessation counseling
	• Yearly "Wellness" visit
	Any other preventive services approved by Medicare during the contract year will be covered
		Out-of-Network:
		30% co-insurance

	Annual Physical Exam $0 copay/1 per year	Out-of-Network: $25 copay

PREMIUMS & BENEFITS	THE HEALTH PLAN SECURECHOICE-OPTION II (PPO) H8604-011	
Emergency Care (Worldwide)	In-Network: $125 copay	Out-of-Network: $125 copay
	If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care Covered emergency services outside of the U.S. have a $25,000 annual plan max	
Urgently Needed Services	In-Network: $45 copay	Out-of-Network: $45 copay
	If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgently needed services	
Diagnostic Radiological Service* (such as MRIs, CT scans)	In-Network: $0 or $150 copay $150 for CT scans, MRI, MRA, PET and SPECT scans $0 copay for all diagnostic mammograms and diagnostic bone density exams	Out-of-Network: 30% co-insurance
Therapeutic Radiological Services* (such as radiation treatment for cancer)	In-Network: 20% co-insurance	Out-of-Network: 30% co-insurance
Lab Services	In-Network: $0 copay	Out-of-Network: 30% co-insurance
Diagnostic Tests and Procedures	In-Network: $50 copay	Out-of-Network: 30% co-insurance
Outpatient X-rays*	In-Network: $50 copay	Out-of-Network: 30% co-insurance

PREMIUMS & BENEFITS	THE HEALTH PLAN SECURECHOICE-OPTION II (PPO) H8604-011	
Hearing Services: Medicare-covered Exam	In-Network: $45 copay	Out-of-Network: $60 copay
	Exam to diagnose and treat hearing and balance issues	
Medicare-covered Dental Services*	In-Network: $45 copay	Out-of-Network: $60 copay
	This does not include services in connection with care, treatment, filling, removal, or replacement of teeth	
Routine Dental Services	In-Network using Liberty Dental Providers: $0 copay for preventive: 2 exams 2 cleanings 1 set of bitewing X-rays every year One full mouth X-ray every 3 years Liberty Dental providers are considered in-network for this plan. You can find the dental directory on our website at healthplan.org/medicare, or by calling us at 1.877.847.7915 (TTY: 711).	Out-of-Network using non-Liberty Dental providers: 0%-30% depending on the service 30% co-insurance for preventive: 2 exams, 2 cleanings, 1 set of bitewing X-rays every year. One full mouth X-ray every 3 years
Optional Supplemental Dental	Comprehensive dental benefits are available with a separate monthly premium. See the "Optional Supplemental Benefits" section in the back of this book	
Vision Services: Medicare-covered exam to diagnose and treat conditions of the eye	In-Network: $0-$45 copay	Out-of-Network: $25-$60 copay
Vision Services: Medicare-covered eyewear	In-Network: $0 copay Limited coverage of eyewear related to cataract surgery.	Out-of-Network: 30% co-insurance

PREMIUMS & BENEFITS	THE HEALTH PLAN SECURECHOICE-OPTION II (PPO) H8604-011	
Vision Services: Routine eye exam	In-Network: $0 copay for one exam every year	Out-of-Network: $60 copay for one exam every year
	Routine vision services are provided through plan participating providers. Contact the plan for more details	
Vision Services: Routine eyewear	In-Network: $0 copay	Out-of-Network: $15 copay
	This plan has a coverage limit for routine eyewear. We will cover up to $150 toward glasses (lens and frames) or contacts (including fitting exam) every year if purchased at a participating provider	
Inpatient Mental Health Services* **(Per admission or stay)**	In-Network: Days 1-5: $250 copay per day Days 6-90: $0 copay	Out-of-Network: 30% co-insurance
Outpatient Individual or Group Mental Health Therapy Visit*	In-Network: $40 copay	Out-of-Network: $60 copay
Skilled Nursing Facility* **(Per benefit period, as defined by Original Medicare)**	In-Network: Days 1-20: $0 copay Days 21-100 $214 copay per day	Out-of-Network: 20% co-insurance
	This plan covers up to 100 days in a skilled nursing facility during each benefit period.	
Physical Therapy*	In-Network: $40 copay	Out-of-Network: $60 copay

PREMIUMS & BENEFITS	THE HEALTH PLAN SECURECHOICE-OPTION II (PPO) H8604-011	
Ambulance Authorization required for non-emergency Medicare services.	In-Network: $200 copay for all other ambulance services $500 copay for air ambulance services	Out-of-Network: $200 copay for all other ambulance services $500 copay for air ambulance services
	The above cost shares are for Medicare-covered ambulance services only Emergency transportation is covered worldwide. Covered emergency transportation services outside of the U.S. have a $25,000 annual plan maximum	
Transportation (Routine)	Not covered	Not covered

PREMIUMS & BENEFITS	THE HEALTH PLAN SECURECHOICE-OPTION II (PPO) H8604-011	
Medicare Part B Drugs* Part B drugs may be subject to step therapy. See Evidence of Coverage for details	In-Network: Most Part B drugs and biologicals will have a 20% coinsurance. However, Medicare publishes a list of certain Part B drugs and biologicals with prices that have increased faster than the rate of inflation. For these drugs and biologicals, the coinsurance will be 20% of the inflation-adjusted payment amount, which will be less than what they would pay in coinsurance otherwise. The amount could change throughout the year depending on the rate of inflation.	Out-of-Network: Most Part B drugs and biologicals will have a 30% coinsurance. However, Medicare publishes a list of certain Part B drugs and biologicals with prices that have increased faster than the rate of inflation. For these drugs and biologicals, the coinsurance will be 30% of the inflation-adjusted payment amount, which will be less than what they would pay in coinsurance otherwise. The amount could change throughout the year depending on the rate of inflation.
ADDITIONAL BENEFITS		
Medicare-covered Foot Exams and Treatment* (Podiatry)	In-Network: $45 copay	Out-of-Network: $60 copay
Routine Foot Care* (Podiatry)	In-Network: $45 copay	Out-of-Network: $60 copay
	Routine foot care covered for up to 2 visits every year	

PREMIUMS & BENEFITS	THE HEALTH PLAN SECURECHOICE-OPTION II (PPO) H8604-011	
Durable Medical Equipment* (like wheelchairs and oxygen) and Prosthetics* (like braces and artificial limbs)	In-Network: 20% co-insurance	Out-of-Network: 40% co-insurance
	Must meet certain criteria to be covered. Contact the plan for more details	
Diabetic Monitoring Supplies*	In-Network: 0-20% coinsurance for each Medicare-covered supply to monitor blood glucose. • 0% coinsurance for OneTouch/LifeScan or Abbot supplies including test strips, glucose monitors, solutions, lancets, and lancing devices at a network pharmacy. • 20% coinsurance for non-OneTouch/LifeScan or Abbot supplies including test strips, glucose monitors, solutions, lancets, and lancing devices, with a medical exception, at a network pharmacy. • 20% coinsurance for supplies including test strips, glucose monitors, solutions, lancets, and lancing devices when obtained through a contracted DME Provider. Coverage is limited to 100 strips for a 30-day supply. Additional quantities require coverage review.	Out-of-Network: 40% co-insurance
Diabetic Therapeutic Shoes or Inserts*	In-Network: 20% co-insurance	Out-of-Network: 40% co-insurance
Health/Wellness Programs (e.g., fitness, tobacco cessation, etc.)	In-Network: $0 copay	Out-of-Network: 30% co-insurance
	SilverSneakers is the fitness program covered by this plan.	
Home Health Services*	In-Network: $0 copay	Out-of-Network: 30% co-insurance
Cardiac/Pulmonary Rehabilitation Services*	In-Network: $0 copay	Out-of-Network: 30% co-insurance

PREMIUMS & BENEFITS	THE HEALTH PLAN SECURECHOICE-OPTION II (PPO) H8604-011	
Chiropractic Services*	In-Network: $15 copay	Out-of-Network: $60 copay
	Medicare-covered chiropractic services only	
Over-the-Counter Items (OTC)	$45 allowance per calendar quarter The unused quarterly allowance amount will not carry over to the next quarter. Unused amounts will not carry over to the next calendar year. Members can shop in-store or online through our contracted vendor.	
Telehealth Services	$0 copay This applies to: • Primary Care Physician Services • Physician Specialist Services • Individual Sessions for Mental Health Specialty Services • Individual Sessions for Psychiatric Services • Individual Sessions for Outpatient Substance Abuse Services must be accessed through our contracted vendor.	
Wellness Incentive Program	Earn $25 on your InComm card after receiving any of these services: • Breast Cancer Screening • Colorectal Cancer Screening • Annual Wellness Visit Limit one incentive reward per service per year.	

Services with an ***** may require your provider to obtain prior authorization from the plan.

Prescription Coverage

Costs may differ based on pharmacy type and status. For example, preferred/standard retail, mail order, long term care or home infusion pharmacies. For more information, please call us or access our Evidence of Coverage online at healthplan.org/medicare.

THE HEALTH PLAN SECURECHOICE - OPTION II (PPO) H8604-011				
Outpatient Prescription Drugs				
Stage 1: **Annual Prescription (Part D) Deductible**	$0 per year for Tier 1 and Tier 2 Part D prescription drugs $100 per year for Tier 3, Tier 4, and Tier 5 Part D prescription drugs			
Stage 2: **Initial Coverage**	After you pay your yearly deductible, you pay the amount listed in the table(s) until your total yearly drug costs reach **$2,000** There are preferred and standard retail pharmacies in our network. You will generally pay a lower copay at a preferred pharmacy.			
	Preferred Retail Pharmacy 30-day supply	**Standard Retail Pharmacy 30-day supply**	**Preferred Mail Order Pharmacy 30-day supply**	**Standard Mail Order Pharmacy 30-day supply**
Tier 1: Preferred Generic	$3	$13	$3	$13
Tier 2: Generic	$10	$20	$10	$20
Tier 3: Preferred Brand	$47	$47	$47	$47
Tier 4: Non-Preferred Drug	$100	$100	$100	$100
Tier 5: Specialty Tier (Extended day supply not available in this Tier)	31%	31%	31%	31%
	Preferred Retail Pharmacy 90-day supply	**Standard Retail Pharmacy 90-day supply**	**Preferred Mail Order Pharmacy 90-day supply**	**Standard Mail Order Pharmacy 90-day supply**
Tier 1: Preferred Generic	$9	$39	$0	$39
Tier 2: Generic	$30	$60	$0	$60
Tier 3: Preferred Brand	$141	$141	$125	$141
Tier 4: Non-Preferred Drug	$300	$300	$275	$300
Tier 5: Specialty Tier (Extended day supply not available in this Tier)	N/A	N/A	N/A	N/A

THE HEALTH PLAN SECURECHOICE - OPTION II (PPO) H8604-011	
Stage 3: **Catastrophic Coverage**	You pay nothing for covered Part D drugs if you reach the Catastrophic Coverage Stage.

IMPORTANT MESSAGE ABOUT WHAT YOU PAY FOR INSULIN AND VACCINES

You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.

Our plan covers most Part D vaccines at no cost to you. Call member services for more information.

Medicare Prescription Payment Plan- Part D Rx

The Medicare Prescription Payment Plan is a new payment option in the prescription drug law that works with your current drug coverage to help you manage your out-of-pocket Medicare Part D drug costs by spreading them across the calendar year (January-December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage Plan with drug coverage) can use this payment option. **All plans offer this payment option and participation is voluntary**.

If you select this payment option, each month you'll continue to pay your plan premium (if you have one), and you'll get a bill from your health or drug plan to pay for your prescription drugs (instead of paying the pharmacy). There's no cost to participate in the Medicare Prescription Payment Plan. Please contact the plan for details.

Optional Supplemental Benefits - Dental

This coverage is available to you for an additional monthly cost of **$35.40**. This will be in addition to your The Health Plan SecureChoice PPO monthly premium.

Our plan will cover up to $1,500 for dental services per plan year. You will be responsible for a portion of the cost for services, as indicated below. The benefit is administered through Liberty Dental providers.

This is not a complete description of benefits. There are covered services that are not listed here. In addition, some of the following services have limitations, exclusions, and maximums. Please contact the plan for complete details.

Monthly Premium	**$35.40**
Maximum Benefit – Plan Coverage Limit	**$1,500 per year**

Covered Dental Benefits	In-Network You Pay	Out-of-Network You Pay
Basic Benefits		
Fillings	20%	50%
Resin-based Composite	20%	50%
Endodontics	50%	75%
Scaling and Root Planing	50%	75%
Periodontal Maintenance	50%	75%
General Anesthesia/Intravenous Sedation	50%	75%
Major Benefits		
Crown	50%	75%
Extractions	50%	75%
Complete and Partial Dentures	50%	75%
Denture Adjustment	50%	75%
Denture Repair	50%	75%
Denture Reline/Rebase	50%	75%

How to add this additional Optional Supplemental dental coverage to your plan: Mark the appropriate section on your initial Medicare Advantage plan enrollment form. You can also add this coverage: Up to 60 days after your effective date or during the Annual Enrollment Period (AEP). This coverage will have an additional monthly cost. Your options are listed on the enrollment form. Please contact the plan for complete details.

Discrimination is Against the Law

The Health Plan of West Virginia (The Health Plan) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, creed, ancestry, religion, national origin, age, disability, marital status, health status, income level, or sex (consistent with the scope of sex discrimination as described by applicable law).
The Health Plan does not exclude people or treat them less favorably because of race, color, creed, ancestry, religion, national origin, age, disability, marital status, health status, income level, or sex.

The Health Plan:

- 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 Director, Health Equity & Wellness.

If you believe that The Health Plan of West Virginia has failed to provide these services or discriminated in another way on the basis of race, color, creed, ancestry, religion, national origin, age, disability, marital status, health status, income level, or sex, you can file a grievance with: Director, Health Equity & Wellness, 1110 Main Street, Wheeling, West Virginia 26003, Phone: 740.699.6142, TTY: 711, Fax: 740.699.6163, civilrightscoordinator@healthplan.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Director, Health Equity & Wellness 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, 1.800.537.7697 (TDD)

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

This notice is available at The Health Plan's website: healthplan.org.

TheHealthPlan
1110 Main Street, Wheeling, WV 26003-2704 | healthplan.org

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 1.877.847.7907 (TTY: 711) or speak to your provider.

Spanish

Español
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 1.877.847.7907 (TTY: 711) o hable con su proveedor.

Chinese (Simplified)

中文 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 1.877.847.7907 (TTY: 711) 或咨询您的服务提供商。

Chinese (Traditional)

中文
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 1.877.847.7907 (TTY: 711) 或與您的提供者討論。

German

Deutsch
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 1.877.847.7907 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

Arabic

العربية
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 1.877.847.7907 (TTY: 711) أو تحدث إلى مقدم الخدمة.

Pennsylvania Dutch
Hinweis: Wenn du Pennsylvaniä Deitsch redst, kannscht du kostenlose Sprachhilfe-Dienste nutze. Auwersichtliche Hilfsmittel und Dienste, um Information in zugängliche Formate zu gebbe, sin au kostenlos verfügbar. Ruf 1.877.847.7907 (TTY: 711) an oder red mit deinem Anbieter für Hilfe.

Russian
РУССКИЙ
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 1.877.847.7907 (TTY: 711) или обратитесь к своему поставщику услуг.

French
Français
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 1.877.847.7907 (TTY: 711) ou parlez à votre fournisseur.

Vietnamese
Việt
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 1.877.847.7907 (TTY: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

Korean
한국어
주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1.877.847.7907 (TTY: 711) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

Cushite (Oromo)
HUBACHIISA: Afaan Oromoo dubbattu yoo ta'eef, tajaajilli gargaarsa Afaan Hiikuu (Turjumaanaa) bilisaan kan isiniif dhiyaatu ta'a. Gargaarsi walqabataa fi tajaajilli sirrii ta'ee fi odeeffannoo bifa unkaalee dhaqqabamoo ta'aniin kennuunis bilisaan ni argama. 1.877.847.7907 (TTY: 711) irratti bilbilaa ykn dhiyeessaa keessan waliin haasa'aa.

Japanese
日本語
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。1.877.847.7907 (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。

Italian
Italiano
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 1.877.847.7907 (TTY: 711) o parla con il tuo fornitore.

Dutch
Nederlands
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 1.877.847.7907 (TTY: 711) of spreek met je provider.

Ukrainian
українська мова
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 1.877.847.7907 (TTY: 711) або зверніться до свого постачальника.

Romanian
ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii gratuite de asistență lingvistică. De asemenea, sunt disponibile gratuit ajutoare și servicii auxiliare adecvate pentru a furniza informații în formate accesibile. Sunați la 1.877.847.7907 (TTY: 711) sau vorbiți cu furnizorul dvs.

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 1.877.847.7907 (TTY: 711) o makipag-usap sa iyong provider.

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