2026 Summary of Benefits for Saint Alphonsus Health Plan Choice (PPO)

Saint Alphonsus Health Plan

A Member of Trinity Health

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2026 Summary of Benefits

Saint Alphonsus Health Plan Choice (PPO)

This is a summary of Medicare health care and prescription drug coverage for Saint Alphonsus Health Plan Choice (PPO).

January 1 – December 31, 2026

Saint Alphonsus Health Plan Choice (PPO) is a Medicare Advantage Local PPO plan with a Medicare contract. Enrollment in the Plan depends on contract renewal.

The benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please call 1-800-240-3851 (TTY 711) and request the "Evidence of Coverage" or access it online at www.thpmedicare.org/saint-alphonsus/.

To join **Saint Alphonsus Health Plan Choice (PPO),** you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes these counties in Idaho: Ada, Adams, Boise, Canyon, Elmore, Gem, Owyhee, Payette, Valley and Washington.

Find a provider at this link www.thpmedicare.org/saint-alphonsus/find-a-provider.

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), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)

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

For more information, please call us at 1-800-240-3851 (TTY users should call 711), 8 a.m. to 8 p.m., 7 days a week, or visit us at www.thpmedicare.org/saint-alphonsus/.

Premiums and Benefits

This is a short list of benefits and cost sharing for our plan. For a complete list, see the *Evidence of Coverage* on our website at www.thpmedicare.org/saint-alphonsus/.

Premiums and Benefits	Saint Alphonsus Health Plan Choice (PPO)
Monthly Plan Premium (includes both medical and drugs)	You pay $0 each month. You must continue to pay your Medicare Part B premium.
Part B Premium Buy-down	Our plan will reduce your monthly Medicare Part B premium by $7.
Deductible	You pay $0 for in- and out-of-network medical benefits. You pay $250 for Part D prescription drugs on Tiers 3, 4, and 5.
Maximum Out-of-Pocket Responsibility (does not include Part D prescription drugs)	You pay no more than $6,100 for in- and out-of-network combined annually. Includes copays and other costs for in-and out-of-network medical services for the year.
Inpatient Hospital	For in-network inpatient hospital stays, you pay: $350 copay per day for days 1-5; $0 copay per day for days 6-90. For out-of-network stays, you pay: 30% of the total cost per stay. May require prior authorization.
Outpatient Hospital	For services at an in-network outpatient hospital, you pay $350 copay. For services at an out-of-network outpatient hospital, you pay 30% of the total cost.
Ambulatory Surgical Center (ASC)	You pay $350 copay in-network. You pay 30% of the total cost out-of-network.

Premiums and Benefits	Saint Alphonsus Health Plan Choice (PPO)
Doctor Visits	
• Primary care provider	You pay $0 copay in-network. You pay $30 copay out-of-network.
• Specialists	You pay $35 copay in-network. You pay $60 copay out-of-network.
Preventive Care (e.g., flu vaccine, diabetic screenings)	You pay $0 copay in- and out-of-network.
Emergency Care	You pay $130 copay per visit. ER cost sharing is waived if you are admitted to the hospital within 48 hours for the same condition. $130 copay for each emergency care visit outside of the United States and its territories. Worldwide ER services cost sharing is waived if you are admitted to the hospital within 48 hours for the same condition.
Urgently Needed Services	You pay $50 copay per visit. $130 copay for each urgently needed care visit outside of the United States and its territories. $250 to $300 copay for each emergency/urgently needed care transportation service outside of the United States and its territories.
Diagnostic Services /Labs /Imaging /Radiology	
• Diagnostic tests and procedures	You pay $30 copay in-network. You pay 30% of the total cost out-of-network.
• Lab services	You pay $5 copay in-network. You pay $15 copay out-of-network.
• MRIs, CAT scans	You pay $200 to $225 copay in-network. You pay 30% of the total cost out-of-network.

Premiums and Benefits	Saint Alphonsus Health Plan Choice (PPO)
• X-rays	You pay $20 copay in-network. You pay 30% of the total cost out-of-network.
• Therapeutic radiology services	You pay 20% of the total cost in-network. You pay 30% of the total cost out-of-network. May require prior authorization.
Hearing Services	
• Medicare-covered hearing exam	You pay $35 copay in-network. You pay $60 copay out-of-network.
• Routine hearing exam	You pay $0 copay in-network (1 exam every year). You pay $60 copay out-of-network.
• Fitting and evaluation for hearing aids	You pay $0 copay in-network (unlimited visits every year). You pay $60 copay out-of-network.
• Hearing aids	You pay $599 to $899 copay in-network for prescription hearing aids – all types (2 hearing aids every year). No out-of-network coverage. Must use TruHearing® provider to access this benefit.
Dental Services	
• Medicare-covered dental services	You pay $35 copay in-network. You pay 30% of the total cost out-of-network.

Premiums and Benefits	Saint Alphonsus Health Plan Choice (PPO)

• Preventive dental services
  ○ 2 oral exams every year
  ○ 2 cleanings every year
  ○ 2 fluoride treatments every year
  ○ 1 X-ray; x-ray benefit is for bitewing x-rays two to eight per calendar year, vertical bitewing x-rays one per consecutive 36 months, or one full mouth x-ray every 36 consecutive months.
  ○ 1 visit for other diagnostic dental services; intraoral tomosynthesis benefit is for two to eight x-rays per calendar year for bitewing and periapical, or 1 per consecutive 36 months for comprehensive series.
  ○ 1 visit for other preventive dental services; space maintainer benefit is for 1 per consecutive 60 months, re-cement or re-bond of space maintainer is for 1 per consecutive 6 months, or removal of fixed space maintainer is unlimited.
	$1,000 maximum plan coverage amount every year for combined in- and out-of-network diagnostic and preventive dental services. This amount is combined with the non-Medicare-covered comprehensive dental services benefit.
	You pay $0 copay in-network for an office visit. Services include exams, X-rays, other diagnostic dental services, cleanings, fluoride treatments, other preventive dental services.
	You must use the Dental Benefit Providers, Inc. provider network to access this benefit.

Premiums and Benefits	Saint Alphonsus Health Plan Choice (PPO)
• Comprehensive dental services: • Restorative Services: 1 visit; frequencies include unlimited, one per consecutive 6 months, one per consecutive 12 months, or one per consecutive 60 months depending on service code. • Endodontics: 1 visit; frequencies include one per tooth per lifetime, two per tooth per lifetime, or unlimited depending on service code. • Periodontics: 1 visit; frequencies include unlimited, two per calendar year, two per consecutive 12 months, one per consecutive 36 months, or one per quadrant per consecutive 24 or 36 months depending on service code. • Oral and Maxillofacial Surgery: 1 visit; frequency includes unlimited, 1 per site per visit, consecutive 36 months, or lifetime, 1 per tooth per lifetime, 1 per consecutive 36 months, or 1 biopsy per site per visit depending on service code. • Adjunctive General Services: 1 visit; frequency is unlimited, 1 per consecutive 6 months, or 2 per calendar	$1,000 maximum plan coverage amount every year for combined in- and out-of-network non-Medicare-covered comprehensive dental services. This amount is combined with the diagnostic and preventive dental services benefit. You pay 50% of the total cost in- and out-of-network for restorative services. You pay 70% of the total cost in and out-of-network for endodontics services. You pay 70% of the total cost in and out-of-network for periodontics services. You pay 50% of the total cost in and out-of-network for oral and maxillofacial surgery services. You pay $0 copay in and out-of-network for adjunctive general services. You must use the Dental Benefit Providers, Inc. provider network to access this benefit.

Premiums and Benefits	Saint Alphonsus Health Plan Choice (PPO)
year depending on the service code.	
Vision Services	
• Medicare-covered benefits	You pay $35 copay in-network for an eye exam to diagnose and treat diseases and conditions of the eye. You pay $50 copay out-of-network. You pay $0 copay in-network for one pair of eyeglasses or contact lenses after cataract surgery. You pay 30% of the total cost out-of-network.
• Routine eye exams	You pay $0 copay in-network (1 exam every year). You pay $50 copay out-of-network.
• Routine eyewear	$125 maximum plan coverage amount every year for all in- and out-of-network non-Medicare-covered eyewear. No out-of-network coverage. Must use Spectera, Inc. provider to access this benefit.
Mental Health Services	
• Outpatient therapy with a psychiatrist	You pay $35 copay in-network for individual sessions. You pay $60 copay out-of-network. You pay $35 copay in-network for group sessions. You pay $60 copay out-of-network.
• Outpatient therapy with a mental health care professional (non-psychiatrist)	You pay $35 copay in-network for individual sessions. You pay $60 copay out-of-network. You pay $35 copay in-network for group sessions. You pay $60 copay out-of-network.
Skilled Nursing Facility (SNF)	For in-network SNF stays, you pay: $0 copay per day for days 1-20; $218 copay per day for days 21-60; $0 copay per day for days 61-100. For out-of-network stays, you pay: 30% of the total cost per stay.

Premiums and Benefits	Saint Alphonsus Health Plan Choice (PPO)
Physical Therapy	You pay $35 copay in-network. You pay $60 copay out-of-network.
Ambulance	You pay $250 copay in- and out-of-network for ground ambulance services. You pay $300 copay in- and out-of-network for air ambulance services. May require prior authorization.
Transportation	Not covered.
Medicare Part B Drugs	You pay $35 copay in- and out-of-network for Medicare Part B insulin drugs. You pay 20% of the total cost in-network for Medicare Part B chemotherapy and radiation drugs.* You pay 30% of the total cost out-of-network.* You pay 20% of the total cost in-network for other Medicare Part B drugs.* You pay 30% of the total cost out-of-network.* May require prior authorization or step therapy. *You may pay less for certain Part B rebatable drugs. If the drug price has increased at a rate faster than the rate of inflation, the amount you pay will be based on a lower, inflation-adjusted price.
Podiatry Services	You pay $35 copay in-network for Medicare podiatry services. You pay $60 copay out-of-network for Medicare podiatry services.
Durable Medical Equipment	You pay 20% of the total cost in-network durable medical equipment. You pay 30% of the total cost out-of-network durable medical equipment. May require prior authorization.

Premiums and Benefits	Saint Alphonsus Health Plan Choice (PPO)
Prosthetic Devices (braces, artificial limbs, etc.)	Prosthetic devices: You pay 20% of the total cost for in-network devices. You pay 30% of the total cost for out-of-network devices. Related medical supplies: You pay 20% of the total cost for in-network supplies. You pay 30% of the total cost for out-of-network supplies. May require prior authorization.
Diabetic Supplies and Services	Diabetic supplies: You pay $0 copay for in-network supplies. You pay 30% of the total cost for out-of-network supplies. Diabetes self-management training: You pay $0 copay in- and out-of-network. Therapeutic shoes or inserts: You pay 20% of the total cost for in-network shoes. You pay 30% of the total cost for out-of-network shoes. May require prior authorization.
Fitness Benefit	You pay $0 copay for the fitness benefit. One Pass® must be used for this benefit.
Meal Benefit	You pay $0 copay for the meal benefit. The benefit consists of 2 meals per day for 7 days, immediately following a qualifying discharge. There is no annual limit on occurrences. Benefit is combined in and out-of-network. GA Foods must be used for in-and out-of-network meals benefit.

Part D Prescription Drugs

This is a summary of Part D prescription drug coverage and cost sharing for our plan. For more information, see the *Evidence of Coverage* on our website at www.thpmedicare.org/saint-alphonsus/.

Part D Prescription Drugs	
Part D Insulin Coverage	You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.
ED Drug Coverage	Included! Call for details.
Deductible	You will pay a yearly deductible of $250 on Tier 3, Tier 4, and Tier 5 drugs. **You must pay the full cost of your Tier 3, Tier 4, Tier 5 drugs** until you reach this amount. For all other drugs, including insulin, you will not have to pay any deductible.

Initial Coverage	You pay the following until your total yearly drug costs reach $2,100. Total yearly drug costs are the drug costs paid by both you and our Part D plan.		
30-Day Supply	**Standard Retail Rx** 30-day supply	**Preferred Retail Rx** 30-day supply	**Mail Order Rx** 30-day supply
Tier 1: Preferred Generic	$10	$0	$0
Tier 2: Generic	$20	$6	$0
Tier 3: Preferred Brand	25% of the total cost	25% of the total cost	25% of the total cost
Tier 4: Non-Preferred Drug	30% of the total cost	30% of the total cost	30% of the total cost
Tier 5: Specialty Tier	30% of the total cost	30% of the total cost	30% of the total cost
90-Day Supply	**Standard Retail Rx** 90-day supply	**Preferred Retail Rx** 90-day supply	**Mail Order Rx** 90-day supply
Tier 1: Preferred Generic	$30	$0	$0
Tier 2: Generic	$60	$18	$0
Tier 3: Preferred Brand	25% of the total cost	25% of the total cost	25% of the total cost
Tier 4: Non-Preferred Drug	30% of the total cost	30% of the total cost	30% of the total cost
Tier 5: Specialty Tier	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.
Catastrophic Coverage	You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $2,100 limit for the calendar year. During this payment stage, you pay nothing for your covered Part D drugs. ED drugs will have the Tier 2 copay in the catastrophic stage for 2026.		

Your cost-sharing may be different if you use a Long-Term Care pharmacy, or an out-of-network pharmacy or if you purchase a long-term supply (up to 90 days) of a drug. Please call us or see the plan's Evidence of Coverage on our website www.thpmedicare.org/saint-alphonsus/ for complete information about your costs or covered drugs.

Additional Benefits

This plan provides additional benefits. For more information, see the *Evidence of Coverage* on our website at www.thpmedicare.org/saint-alphonsus/.

Additional Benefits	
Flexible Benefit Card- Including Member Rewards/Incentive and Supplemental Vision/Hearing Allowance	Included! You receive a $250 annual allowance on your card you can use towards plan-covered vision and hearing services. This benefit does not carry over to the next plan year. You can receive $50 annually added to your Flexible Benefit Card in your Member Rewards wallet when you complete an Annual Wellness Visit and fill out the necessary attestation.
Over the Counter (OTC) Allowance	$0 copay. $50 maximum plan coverage amount every 3 months for OTC items. No out-of-network coverage. Must utilize Over the Counter Health Solutions (OTCHS) to access this benefit. This benefit does not carry over to the next plan year. Unused portion does not carry over to the next period.
24 Hour Nurse Advice Line + Virtual Care Visits	$0 copay. No out-of-network coverage. You must call 1-855-638-5842 to access this benefit.
Visitor Travel Allowance	$1,500 Travel allowance does not carry over to the next plan year. May require prior authorization.
Acupuncture	$20 copay, 6 visits every year, for in-network services. $60 copay, for out-of-network services. May require prior authorization.

Optional Supplemental Benefits

This plan offers some extra benefits that are not covered by Original Medicare and not included in its benefits package. These extra benefits are called **Optional Supplemental Benefits**. If you want these optional supplemental benefits, you must sign up for them. For more information, see the *Evidence of Coverage* on our website at www.thpmedicare.org/saint-alphonsus/.

Optional Supplemental Benefits	
Optional Dental Silver	The premium for the Dental Silver benefit is $20 per month. You pay this monthly premium in addition to your Medicare Part B premium and plan premium (if applicable). • There is an annual maximum benefit limit of $1,500. • $0 copay for diagnostic and preventive services, emergency palliative treatment and X-rays. • 50% coinsurance for extractions, endodontic services, periodontic services and other oral surgery. • 0% - 50% coinsurance for restorative services.
Optional Dental Gold	The premium for the Dental Gold benefit is $49 per month. You pay this monthly premium in addition to your Medicare Part B premium and plan premium (if applicable). • There is an annual maximum benefit limit of $2,000. • $0 copay for diagnostic and preventive services, emergency palliative treatment and X-rays. • 50% coinsurance for extractions, endodontic services, periodontic services and other oral surgery. • 0% - 50% coinsurance for restorative services. • 50% coinsurance for crowns, bridges and dentures.

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 800-964-4525 (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 www.thpmedicare.org/saint-alphonsus/for-members/plan-documents or call 800-964-4525 (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 new doctors.

- ❑ 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, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.

- ❑ Benefits, premiums and/or copayments/coinsurance may change on January 1, 2027.

- ❑ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for 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.

- ❑ **Effect on Current Coverage:** Your current health care coverage will end once your new Medicare coverage starts. For example, if you have a different Medicare plan, you will no longer receive benefits from that plan once your new coverage starts.

We're Here for You

If you have any questions about your Saint Alphonsus Health Plan benefits, we are a phone call or click away. You can reach us at 800-240-3851 (TTY: 711), 8 a.m. – 8 p.m., 7 days a week. On certain holidays, your call will be handled by our automated phone system. You may also visit our website, www.thpmedicare.org/saint-alphonsus/ Medicare is also available at 1-800-MEDICARE, 24 hours a day, 7 days a week. We look forward to serving you!

Saint Alphonsus Health Plan (HMO/PPO) is a Medicare Advantage organization with a Medicare contract. Enrollment in Saint Alphonsus Health Plan depends on contract renewal. Benefits vary by county.

This document is available in other alternate formats.

ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call 1-800-240-3851 (TTY: 711).

ATENCIÓN: Si habla español, hay servicios de traducción, libre de cargos, disponibles para usted. Llame al 1-800-964- 4525 (TTY: 711).

Saint Alphonsus Health Plan Choice (PPO) is a local PPO plan with a Medicare contract. Enrollment depends on contract renewal. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year. You must continue to pay your Medicare Part B premium. The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary. Please call our Member Services number or see your "Evidence of Coverage" for more information, including the cost-sharing that applies to out-of-network services. Health coverage is offered by Mount Carmel Health Plan Of Idaho, Inc.

NOTICE INFORMING INDIVIDUALS ABOUT NONDISCRIMINATION, AVAILABILITY OF LANGUAGE ASSISTANCE, AUXILIARY AIDS, AND ACCESSIBILITY SERVICES

Trinity Health understands that we all have different lived experiences, needs, identities, customs, and abilities. We are committed to providing quality, accessible, equitable care and services that are responsive to the needs of the diverse communities served.

Saint Alphonsus Health Plan Choice (PPO) welcomes all individuals who come to us for care, treatment, and services. We comply with all Federal civil right laws and do not exclude anyone or treat them differently because of their age, race, color, ethnicity (including limited English proficiency and primary language), national origin, religion, culture, language, physical or mental disability, socioeconomic status (including ability to pay or participation in Medicaid, Medicare or Children's Health Insurance Program), sex (including sex at birth or legal sex), sex characteristics (including intersex traits), pregnancy or related conditions, sex stereotypes, sexual orientation, gender identity or expression, veteran status, or any other category protected by law.

As a sponsored ministry of the Catholic Church, we provide healthcare services guided by the moral principles described in the Ethical and Religious Directives for Catholic Healthcare Services published by the U.S. Conference of Catholic Bishops.

Saint Alphonsus Health Plan Choice (PPO) provides free auxiliary aids and communication services, so that people can communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language assistance services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages.

If you need these services, contact

Language Assistance Services at **1-800-240-3851**
Telecommunications Relay Service (TRS): 7-1-1

Saint Alphonsus Health Plan Choice (PPO) allows service animals that are trained to do work or perform tasks for the benefit of individuals with a disability.

If you need another type of reasonable modification or accessibility services, please discuss it with your provider or the Section 1557/Americans with Disabilities Act Coordinator:
ATTN: Member Services Manager
3100 Easton Square Place, Suite 300
Columbus, OH 43219
Phone:
1-800-240-3851 (TTY 711)

Fax:
1-833-802-2200

Email:
medigoldappeals@mchs.com

If you believe that Saint Alphonsus Health Plan Choice (PPO) has failed to provide these services or discriminated in another way, you can file a grievance with:

Member Services
3100 Easton Square Place Suite 300
Columbus, OH 43219
1-800-240-3851
medigoldappeals@mchs.com

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, DC 20201
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 the Saint Alphonsus Health Plan Choice (PPO) website:
www.thpmedicare.org/saint-alphonsus/

Notice of Accessibility

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 1-800-240-3851 (TTY: 711) or speak to your provider.

Spanish: Español
ATENCIÓN: Si habla español, dispone de servicios gratuitos de asistencia lingüística. También dispone de recursos y servicios auxiliares gratuitos para proporcionar información en formatos accesibles. Llame al 1-800-240-3851 (TTY: 711) o hable con su proveedor.

Simplified Chinese: 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 1-800-240-3851（文本电话：711）或咨询您的服务提供商。”

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 1-800-240-3851 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.”

Albanian: SHQIP
VINI RE: Nëse flisni shqip, shërbime falas të ndihmës së gjuhës janë në dispozicion për ju. Ndihma të përshtatshme dhe shërbime shtesë për të siguruar informacion në formate të përdorshme janë gjithashtu në dispozicion falas. Telefononi 1-800-240-3851 (TTY: 711) ose bisedoni me ofruesin tuaj të shërbimit.”

Korean: 한국어
주의: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-240-3851 (TTY: 711) 번으로 전화하거나 서비스 제공업체에 문의하십시오."

Bengali: বাংলা
মনোযোগ দিন: যদি আপনি বাংলা বলেন তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবাদি উপলব্ধ রয়েছে। অ্যাক্সেসযোগ্য ফরম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সহযোগিতা এবং পরিষেবাদিও বিনামূল্যে উপলব্ধ রয়েছে। 1-800-240-3851 (TTY: 711) নম্বরে কল করুন অথবা আপনার প্রদানকারীর সাথে কথা বলুন।”

Polish: POLSKI
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 1-800-240-3851 (TTY: 711) lub porozmawiaj ze swoim dostawcą”.

German: Deutsch
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Geeignete Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten sind ebenfalls kostenlos verfügbar. Rufen Sie 1-800-240-3851 (TTY: 711) an oder wenden Sie sich an Ihren Anbieter.

Italian: Italiano
ATTENZIONE: Se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi adeguati per fornire informazioni in formati accessibili. Chiama il numero 1-800-240-3851 (TTY: 711) o parla con il tuo fornitore.

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。1-800-240-3851（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。

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 1-800-240-3851 (TTY: 711) или обратитесь к своему поставщику услуг.

Croatian: hrvatski
PAŽNJA: Ako govorite hrvatski, dostupne su vam besplatne usluge jezične pomoći. Odgovarajuća pomoćna sredstva i usluge za pružanje informacija u pristupačnim formatima također su dostupne besplatno. Nazovite 1-800-240-3851 (TTY: 711) ili razgovarajte sa svojim davateljem usluga.

Serbian: Српски
ПАЖЊА: Ако говорите Српски, доступне су вам бесплатне услуге језичке помоћи. Одговарајућа помоћна средства и услуге за пружање информација у приступачним форматима такође су доступни бесплатно. Позовите 1-800-240-3851 (TTY: 711) или разговарајте са својим оператером.

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 1-800-240-3851 (TTY: 711) o makipag-usap sa iyong provider.

Haitian: Kreyòl Ayisyen
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 1-800-240-3851 (TTY: 711) oswa pale avèk founisè w la.

Yiddish: ייִדי

אבטונג: אויב איר רעדט אריינשטעלן שפראך, זענען פרייע שפראך הילף סערוויסעס פאראן פאר אייך. פאסיגע הילפסמיטלען און סערוויסעס צו צושטעלן אינפארמאציע אין צוגענגליכע פארמאטן זענען אויך פאראן פריי פון אפצאל. רופט אדער רעדט מיט אייער פראווייידער (TTY: 711) 1-800-240-3851

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 1-800-240-3851 (TTY: 711) أو تحدث إلى مقدم الخدمة".

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 1-800-240-3851 (ATS : 711) ou contactez votre fournisseur.

Urdu: ardo
دھیان دیں: اگر آپ بولتے ہیں انسرٹ لینگوئج، آپ کے لیے مفت زبان کی مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں پر کال (TTY: 711) معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ 1-800-240-3851 کریں یا اپنے فراہم کنندہ سے بات کریں۔

Greek: Ελληνικά
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 1-800-240-3851 (TTY: 711) ή απευθυνθείτε στον πάροχό σας».

Swahili/Bantu: Kiswahili
MAKINIKA: Ikiwa wewe huzungumza Kiswahili, msaada na huduma za lugha bila malipo unapatikana kwako. Vifaa vya usaidizi vinavyofaa na huduma bila malipo ili kutoa taarifa katika mifumo inayofikiwa pia inapatikana bila malipo. Piga simu 1-800-240-3851 (TTY: 711) au zungumza na mtoa huduma wako."

Farsi/Persian:

فارسي

توجه: اگر وارد کردن زبان 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 1-800-240-3851(تله‌تایپ:711) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید.

Dutch: Nederlands
LET OP: Als u Nederlands, spreekt, kunt u gratis gebruikmaken van taalondersteuning. Ook zijn er gratis hulpmiddelen en diensten beschikbaar om informatie in toegankelijke formaten te verstrekken. Bel 1-800-240-3851 (TTY: 711) of neem contact op met uw provider.

Ukranian: 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 1-800-240-3851 (TTY: 711) або зверніться до свого постачальника».

Romanian: România
ATENȚIE: Dacă vorbiți România, aveți la dispoziție servicii gratuite de asistență lingvistică. De asemenea, sunt disponibile gratuit materiale auxiliare și servicii adecvate pentru furnizarea de informații în formate accesibile. Sunați la 1-800-240-3851 (TTY: 711) sau discutați cu furnizorul dumneavoastră.

Laotian: ລາວ
ເຊີນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 1-800-240-3851 (TTY: 711) ຫຼື ຕິດຕໍ່ກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ."

Hindi: हिंदी
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। 1-800-240-3851 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।"

Thai: ไทย
หมายเหตุ: หากคุณใช้ภาษา ไทย เรามีบริการความช่วยเหลือด้านภาษาฟรี นอกจากนี้ ยังมีเครื่องมือและบริการช่วยเหลือเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่าย โปรดโทรติดต่อ 1-800-240-3851 (TTY: 711) หรือปรึกษาผู้ให้บริการของคุณ"

Karen: ထၢနှဉ်လီၤဖဲအံၤ
ဆူ– နမ့ါကတိၤ ထၢနှဉ်လီၤဖဲအံၤ အဃိ, တၢ်အိဉ်ဒီး ကျိာ်တၢ်ဆိဉ်ထွဲမၤစၢၤ လၢတလၢာ် ဘူဉ်လာ်စ့ၤလၢနဂီၢ်လီၤ. တၢ်အိဉ်ဒီး တၢ်မၤစၢၤတၢ်နှၢ်ဟူပီးလီဒီး တၢ်မၤစၢၤတၢ်မၤ လၢအ ကျၢးအဘဉ် လၢကဟ့ဉ်တၢ်ဂ့ၢ်တၢ်ကျိၤ လၢတၢ်မၤနှၢ်အီၤသ့တဖဉ် လၢတလာ်ဘူဉ်လာ်စ့ၤ လၢနဂီၢ်လီၤ. ကိး 1-800-240-3851 (TTY: 711) မ့တမ့ၢ် ကတိၤတၢ်ဒီး နပှၤလၢဟ့ဉ် နၤတၢ်ကွၢ်ထွဲမၤစၢၤတက့ၢ်."

Somali: Soomaali
FIIRO GAAR AH: Haddii aad ku hadasho Soomaali, adeegyada kaalmada luqadda bilaashka ah ayaa diyaar kuu ah. Kaalmooyinka iyo adeegyada ku habboon ee lagu bixiyo macluumaadka qaabab la heli karo ayaa sidoo kale lagu heli karaa lacag la'aan. Wac 1-800-240-3851 (TTY: 711) ama la hadal adeeg bixiyahaaga.

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