2017 Health Net Medicare Advantage Plan Information

Thank you for your interest in applying for the HealthNet Medicare Advantage plan. Below are links to the items which are part of the Enrollment Packet you would receive if we were to mail it to you. Please take note and make sure to review the information. Health Net will send out an outbound enrollment verification letter by mail within 15 calendar days from receipt of the enrollment request.

Enrollment Packet – click links below to view the information

Star Rating: HMO / PPO
Download Application
Benefits: Aqua (N) / Aqua (S) / Ruby (pdx) / Ruby (other) / Jade (pdx) / Jade (other) / Violet 1 (North) / Violet 1 (South) / Violet 2 (clmw) / Violet 2 (mp) / Violet 2 (bly) / Violet 2 (dj) / Violet 2 (j) / Violet 3
Providers
Formulary
Multi-language Support

Initial Enrollment Period (IEP)

If you are new to Medicare, you can enroll during your Initial Enrollment Period (IEP); the three months before, the month of, and the three months after your Part B effective date. Once you have been enrolled in a Medicare Plan, you can only make changes during the Annual Enrollment Period (AEP). Please be aware of the AEP dates are now October 15th to December 7th. This will give you a January 1st effective date for your new plan.

Annual Enrollment Period (AEP)

Applications must be signed and dated on, or between October 15th and December 7th. ***If they are signed prior to October 15th they will be returned to you with a new application.*** If they are received after December 7th, you will not be able to change plans until the next AEP for January of the following year.

Special Enrollment Period (SEP)

There are a number of reasons for Special Enrollments; Loss of a job that provides benefits, death of a spouse who's plan provided benefits, moving to an area where your old plan is not available, etc…

Once you submit your application to us, we will review your application for completeness and accuracy before we submit it to the company. You may fax, upload, email or mail your application in to CDA Insurance:

CDA Insurance LLC
PO Box 26540
Eugene, Oregon 97402

Fax: 1.541.284.2994 or 888.632.5470
Secure File Upload: Click here
Email: cs@cda-insurance.com

If you should have any questions on the application, please call a licensed insurance agent at 1.800.884.2343 or 1.541.434.9613. Our website: http://www.orhi.us

Y0062_MULTIPLAN_CDA INSURANCE Oregon Accepted effective 7/31/2016

Health Net
MEDICARE PROGRAMS

Health Net 2017 Individual Enrollment Form

Please contact Health Net if you need information in another language or format.

To enroll in Health Net, please provide the following information:

Please check which plan you want to enroll in:

Health Net Ruby (HMO)
(includes prescription drug coverage)

- ☐ Clackamas, Lane, Multnomah, and Washington counties, OR — $0 per month
- ☐ Benton, Linn, Marion, Polk, and Yamhill counties, OR — $0 per month

Health Net Jade (HMO SNP)[1]
(Cardiovascular Disorders, Chronic Heart Failure(CHF), Diabetes)
(includes prescription drug coverage)

- ☐ Clackamas, Lane, Multnomah, and Washington counties, OR — $0 per month
- ☐ Benton, Linn, and Yamhill counties, OR — $0 per month

Health Net Violet Option 1 (PPO)
(includes prescription drug coverage)

- ☐ Benton, Clackamas, Lane, Linn, Marion, Multnomah, Polk, Washington, and Yamhill counties, OR; Clark County, WA — $116 per month
- ☐ Douglas, Jackson, and Josephine counties, OR — $105 per month

Health Net Violet Option 2 (PPO)
(includes prescription drug coverage)

- ☐ Clackamas, Lane, Multnomah, and Washington counties, OR — $19 per month
- ☐ Benton, Linn, and Yamhill counties, OR — $24 per month
- ☐ Marion and Polk counties, OR — $32 per month
- ☐ Douglas and Josephine counties, OR — $25 per month
- ☐ Jackson County, OR — $25 per month
- ☐ Clark County, WA — $0 per month

Health Net Violet Option 3 (PPO)
(includes prescription drug coverage)

- ☐ Douglas and Josephine counties, OR — $0 per month

Health Net Aqua (PPO)
(without prescription drug coverage)

- ☐ Benton, Clackamas, Lane, Linn, Marion, Multnomah, Polk, Washington, and Yamhill counties, OR; Clark County, WA — $45 per month
- ☐ Douglas, Jackson, and Josephine counties, OR — $49 per month

[1]You must meet specific enrollment criteria to enroll in this plan.

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Optional Supplemental Benefit Packages

Health Net Ruby (HMO)

Choose one:

☐ Preventive Dental and Hearing $16 per month

☐ Comprehensive Dental and Hearing $40 per month

Health Net Jade (HMO SNP)

☐ DPPO Extended Comprehensive Dental $24 per month

Health Net Violet Option 1 (PPO) & Aqua (PPO)

Choose one:

☐ Preventive Dental $15 per month

☐ Comprehensive Dental $39 per month

Health Net Violet Option 2 (PPO)

Benton, Clackamas, Lane, Linn, Marion, Multnomah, Polk, Washington, and Yamhill counties, OR; Clark County, WA

Choose one:

☐ Preventive Dental $15 per month

☐ Comprehensive Dental $39 per month

and/or:

☐ Routine Vision $6 per month

Health Net Violet Option 2 (PPO)

Douglas, Jackson, and Josephine counties, OR

Choose one:

☐ Preventive Dental $15 per month

☐ Comprehensive Dental $39 per month

Health Net Violet Option 3 (PPO)

Choose one:

☐ Preventive Dental $15 per month

☐ Comprehensive Dental $39 per month

and/or:

☐ Routine Vision $6 per month

Monthly Plan Premium Amount (including optional supplemental package premium amount)

$________ Requested Effective Date: ______/______/__________

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Last name | First name | Middle initial | ☐ Mr. ☐ Mrs. ☐ Ms.

Birth date (M M D D Y Y Y Y) | Sex: ☐ M ☐ F | Home phone number

Alternate phone number

Permanent residence street address
(PO Box is not allowed)

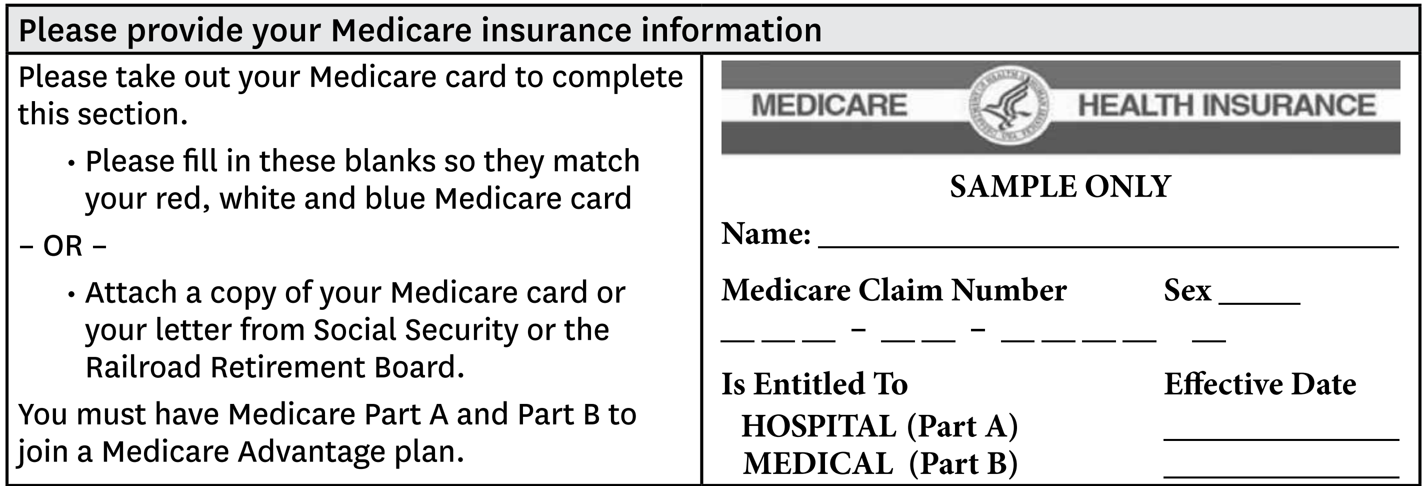
City | County | State | ZIP code

Mailing address (only if different from your permanent residence address)
Street address

City | State | ZIP code

Emergency contact | **Phone number**

Relationship to you | **Email address**



Please provide your Medicare insurance information

Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card

– OR –

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

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Paying your plan premium

For Medicare Advantage Prescription Drug plans with no premiums: If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay by mail or "Electronic Funds Transfer (EFT)" each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you are assessed a Part D-Income related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. DO NOT pay Health Net the Part D-IRMAA.

For all plans with premiums: You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or "Electronic Funds Transfer (EFT)" each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or RRB. DO NOT pay Health Net the Part D-IRMAA.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

If you don't select a payment option, you will get a bill each month.

Please select a premium payment option:

☐ Get a bill

☐ Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:

Account holder name

Bank routing number	Bank account number

Account type: ☐ Checking ☐ Saving

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☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. (The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

Please read and answer these important questions:

1. Do you have End Stage Renal Disease (ESRD)? ☐ Yes ☐ No

   If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you had a successful kidney transplant or you don't need dialysis; otherwise, we may need to contact you to obtain additional information.

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

   Will you have other prescription drug coverage in addition to Health Net? ☐ Yes ☐ No

   If "Yes," please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage	ID # for this coverage	Group # for this coverage

3. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No

   If "Yes," please provide the following information:

   Name of institution ______

   Phone number of institution ___ - ___ - ___

   Address of institution (number and street) ______

4. Are you enrolled in your State Medicaid program? ☐ Yes ☐ No

   If "Yes," please provide your Medicaid number: ______

5. Do you or your spouse work? ☐ Yes ☐ No

6. Do you have Cardiovascular Disorders, Chronic Heart Failure (CHF) and/or Diabetes? ☐ Yes ☐ No

Please choose the name of a Primary Care Physician (PCP), clinic or health center:

______

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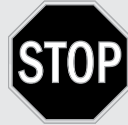
Please check one of the boxes below if you would prefer that we send you information in a language other than English or in another format:

☐ Spanish

☐ Large print

Please contact Health Net at 1-800-949-6192 if you need information in another format or language than what is listed above. From October 1 through February 14, our office hours are 8:00 a.m. to 8:00 p.m., 7 days a week, excluding certain holidays. However, after February 14, our office hours are 8:00 a.m. to 8:00 p.m., Monday through Friday. On weekends and certain holidays, your call will be handled by our automated phone system. TTY users should call 711.



Please read this important information

If you currently have health coverage from an employer or union, joining Health Net could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Health Net. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please read and sign below

By completing this enrollment application, I agree to the following:

Health Net is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. For plans without prescription drugs, I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15–December 7 of every year), or under certain special circumstances.

Health Net serves a specific service area. If I move out of the area that Health Net serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Health Net, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Health Net when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

For HMO plans, I understand that beginning on the date Health Net coverage begins, I must get all of my health care from Health Net, except for emergency or urgently needed services or out-of-area dialysis services. For PPO plans, I understand that beginning on the date Health Net coverage begins, using services in-network can cost less than using services out-of-network,except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, Health Net provides refunds for all covered benefits, even if I get services out of network. Services authorized by Health Net and other services contained in my Health Net *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR HEALTH NET WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Health Net, he/she may be paid based on my enrollment in Health Net.

Release of Information: By joining this Medicare health plan, I acknowledge that Health Net will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Health Net will release my information including my prescription drug event data (if applicable) to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

Signature ______________________ **Today's date** ___ ___ ______
M M D D Y Y Y Y

If you are the authorized representative, you must sign above and provide the following information:

Name ______________________

Address ______________________

Phone number ____ – ____ – ____ **Relationship to enrollee** ______________________

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OFFICE USE ONLY:

Name of staff member/agent/broker (if assisted in enrollment): ____

Plan ID #: ____

Effective date of coverage: __ __ / __ __ / __ __ __ __ (M M D D Y Y Y Y)

☐ ICEP/IEP ☐ AEP SEP (type): ____ ☐ Not eligible

Health Net sales representative / Authorized agent

(Individual sales representative/agent who completed the application)

Agent type (select one): ☐ Authorized agent ☐ Health Net employee

Complete section or place printed label here:

Sales rep / Agent name: Tiffany Jackson Health Net ID #: AJ246

Sales rep / Agent NPN #: ____

Agency / FMO affiliation: CDA Insurance LLC Health Net ID #: AA490

(if applicable)

This information must match your approved Health Net licensing records.

Agency phone #: 800 – 884 – 2343

Email: client.services@cda-insurance.com

Agency FMO phone # (if applicable): ____ – ____ – ____

Sales representative/Authorized agent application receipt date: __ __ / __ __ / __ __ __ __ (M M D D Y Y Y Y)

(Applications must be received at Health Net within 1 calendar day of this date)

Application receipt location: ☐ Appointment ☐ Sales event ☐ Walk-in

☐ Other (specify): ____

Provider information for HMO plans:

PCP name: ____ PCP ID: ____

PPG name: ____ PPG ID: ____

Is PCP/PPG selected accepted for the plan chosen? ☐ Yes ☐ No

Current patient? ☐ Yes ☐ No

Physician of choice information for PPO plans:

POC name: ____ POC PCP ID: ____

POC address: ____

Effective date: __ __ / __ __ / __ __ __ __ (M M D D Y Y Y Y)

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

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

- ☐ I am new to Medicare.
- ☐ I recently moved outside of the service area for my current plan, or I recently moved and this plan is a new option for me. I moved on (insert date). M M D D Y Y Y Y
- ☐ I recently was released from incarceration. I was released on (insert date). M M D D Y Y Y Y
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date). M M D D Y Y Y Y
- ☐ I recently obtained lawful presence status in the United States. I got this status on (insert date). M M D D Y Y Y Y
- ☐ I have both Medicare and Medicaid, or my state helps pay for my Medicare premiums.
- ☐ I get extra help paying for Medicare prescription drug coverage.
- ☐ I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date). M M D D Y Y Y Y
- ☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date). M M D D Y Y Y Y
- ☐ I recently left a PACE program on (insert date). M M D D Y Y Y Y
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date). M M D D Y Y Y Y
- ☐ I am leaving employer or union coverage on (insert date). M M D D Y Y Y Y
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ I was enrolled in a Special Needs Plan (SNP), but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date). M M D D Y Y Y Y

If none of these statements applies to you or you're not sure, please contact Health Net at 1-800-949-6192 (TTY users should call 711) to see if you are eligible to enroll. From October 1 through February 14, our office hours are 8:00 a.m. to 8:00 p.m., 7 days a week, excluding certain holidays. However, after February 14, our office hours are 8:00 a.m. to 8:00 p.m., Monday through Friday. On weekends and certain holidays, your call will be handled by our automated phone system.

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Health Net complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Health Net does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Health Net:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Health Net's Customer Contact Center at 1-888-445-8913 (TTY: 711), 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.

If you believe that Health Net 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 by calling the number above and telling them you need help filing a grievance; Health Net's Customer Contact Center 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, DC 20201, 1-800-368-1019 (TDD: 1-800-537-7697).

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

Health Net has a contract with Medicare to offer HMO, PPO and HMO SNP coordinated care plans. Enrollment in a Health Net Medicare Advantage plan depends on contract renewal.

You must continue to pay your Medicare Part B premium. However, for full-dual beneficiaries, the State will cover your Part B premium as long as you retain your Medicaid eligibility.

This information is available for free in other languages. Please call our member services number at 1-800-949-6192 (TTY: 711). From October 1 through February 14, our office hours are 8:00 a.m. to 8:00 p.m., 7 days a week, excluding certain holidays. However, after February 14, our office hours are 8:00 a.m. to 8:00 p.m., Monday through Friday. On weekends and certain holidays, your call will be handled by our automated phone system.

Esta información está disponible en forma gratuita en otros idiomas. Llame al número de nuestro Departamento de Servicios al Afiliado en 1-800-949-6192. Desde el 1 de octubre hasta el 14 de febrero, nuestro horario de atención es de 8:00 a.m. a 8:00 p.m., los 7 días de la semana, excepto ciertos días feriados. Sin embargo, después del 14 de febrero, nuestro horario de atención será de 8:00 a.m. a 8:00 p.m., de lunes a viernes. Los fines de semana y ciertos días feriados su llamada será atendida por nuestro sistema automático de teléfono. Los usuarios de TTY deben llamar al 711.

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Multi-Language Insert

Multi-language Interpreter Services

English:
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Spanish:
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Chinese:
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711)。

Tagalog:
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

French:
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (ATS :711).

Vietnamese:
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

German:
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Korean:
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711) 번으로 전화해 주십시오.

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Russian:
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (телетайп: 711).

Arabic:
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (رقم هاتف الصم والبكم: 711).

Hindi:
ध्यान दें: यदि आप हदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711) पर कॉल करें।

Italian:
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Portuguese:
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

French Creole:
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Polish:
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Japanese:
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711)まで、お電話にてご連絡ください。

Farsi:

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (TTY: 711) 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) تماس بگیرید.

Armenian:

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY (հեռատիպ)՝ 711):

Cambodian:

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711)។

Punjabi:

ਧਿਆਨ ਦਓਿ1 ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। ,ਜੇ ਤੁਸੀ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ : 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711)ਤੇ ਕਾਲ ' ਕਰੋ।

Thai:

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Laotian:

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Serbo-Croatian:

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

Ukranian:

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (телетайп: 711).

Syriac:
ܙܘܗܪܐ: ܐܢ ܐܢܬܘܢ ܟܐ ܡܡܠܠܝܬܘܢ ܠܫܢܐ ܐܬܘܪܝܐ، ܬܡܨܝܬܘܢ ܕܡܫܬܡܫܝܬܘܢ ܒܚܠܡܬܐ ܕܗܝܪܬܐ
ܒܠܫܢܐ ܡܓܢܢܐܝܬ. ܩܪܘܢ ܥܠ ܡܢܝܢܐ
1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711)

Hmong:
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Romanian:
ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Amharic:
ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (መስማት ለተሳናቸው: 711).

Navajo:
Díí baa akó nínízin: Díí saad bee yáníłti’go **Diné Bizaad**, saad bee áká’ánída’áwo’dę́ę́’, t’áá jiik’eh, éí ná hóló, kojį’ hódíílnih 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Cushite:
XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711.)

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