Health Net®
MEDICARE PROGRAMS

Health Net Violet 3 (PPO) offered by HEALTH NET LIFE INSURANCE COMPANY

Annual Notice of Changes for 2021

You are currently enrolled as a member of Health Net Violet 3 (PPO). Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

What to do now

1. ASK: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 1.5 and 1.6 for information about benefit and cost changes for our plan.

☐ Check the changes in the booklet to our prescription drug coverage to see if they affect you.

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2021 Drug List and look in Section 1.6 for information about changes to our drug coverage.
- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit go.medicare.gov/drugprices. These dashboards highlight which manufacturers have been

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increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

☐ Check to see if your doctors and other providers will be in our network next year.

- Are your doctors, including specialists you see regularly, in our network?
- What about the hospitals or other providers you use?
- Look in Section 1.3 for information about our Provider & Pharmacy Directory.

☐ Think about your overall health care costs.

- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
- How much will you spend on your premium and deductibles?
- How do your total plan costs compare to other Medicare coverage options?

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

☐ Check coverage and costs of plans in your area.

- Use the personalized search feature on the Medicare Plan Finder at www.medicare.gov/plan-compare website.
- Review the list in the back of your Medicare & You handbook.
- Look in Section 3.2 to learn more about your choices.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. CHOOSE: Decide whether you want to change your plan

- If you don't join another plan by December 7, 2020, you will be enrolled in Health Net Violet 3 (PPO).
- To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

4. ENROLL: To change plans, join a plan between **October 15** and **December 7, 2020**

- If you don't join another plan by **December 7, 2020**, you will be enrolled in Health Net Violet 3 (PPO).
- If you join another plan by **December 7, 2020**, your new coverage will start on **January 1, 2021**. You will be automatically disenrolled from your current plan.

Additional Resources

- Please contact our Member Services number at 1-888-445-8913 for additional information. (TTY users should call 711). Hours are from October 1 to March 31, you can call us 7 days a week from 8 a.m. to 8 p.m. From April 1 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. A messaging system is used after hours, weekends, and on federal holidays.
- We must provide information in a way that works for you (in languages other than English, in audio, in large print, or other alternate formats, etc.).
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Health Net Violet 3 (PPO)

- HEALTH NET LIFE INSURANCE COMPANY is contracted with Medicare for PPO plans. Enrollment in HEALTH NET LIFE INSURANCE COMPANY depends on contract renewal.
- When this booklet says "we," "us," or "our," it means HEALTH NET LIFE INSURANCE COMPANY. When it says "plan" or "our plan," it means Health Net Violet 3 (PPO).

Summary of Important Costs for 2021

The table below compares the 2020 costs and 2021 costs for Health Net Violet 3 (PPO) in several important areas. **Please note this is only a summary of changes**. A copy of the *Evidence of Coverage* is located on our website at or.healthnetadvantage.com. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Cost	2020 (this year)	2021 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$0	$0
Deductible	$165	$200
Maximum out-of-pocket amounts This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	From network providers: $5,900 From network and out-of-network providers combined: $8,700	From network providers: $7,550 From network and out-of-network providers combined: $7,550
Doctor office visits	**In-network** Primary care visits: You pay a $20 copay per visit. (Deductible waived) Specialist visits: You pay a $40 copay per visit. (Deductible waived)	**In-network** Primary care visits: You pay a $20 copay per visit. (Deductible waived) Specialist visits: You pay a $50 copay per visit. (Deductible waived)

Cost	2020 (this year)	2021 (next year)
Doctor office visits (continued)	**Out-of-network** Primary care visits: You pay a $30 copay per visit. (Deductible applies) Specialist visits: You pay a $50 copay per visit. (Deductible applies)	**Out-of-network** Primary care visits: You pay a $30 copay per visit. (Deductible applies) Specialist visits: You pay a $60 copay per visit. (Deductible applies)
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	**In-network** For Medicare-covered admissions, per admission: **Days 1 - 4:** You pay a $295 copay per day. **Days 5 and beyond:** You pay a $0 copay per day. (Deductible applies) **Out-of-network** **Days 1 - 10:** You pay a $475 copay per day. **Days 11 and beyond:** You pay a $0 copay per day. (Deductible applies)	**In-network** For Medicare-covered admissions, per admission: **Days 1- 4:** You pay a $450 copay per day. **Days 5 and beyond:** You pay a $0 copay per day. (Deductible applies) **Out-of-network** **Days 1 - 10:** You pay a $500 copay per day. **Days 11 and beyond:** You pay a $0 copay per day. (Deductible applies)
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $200 (applies to tiers 3, 4 and 5) Copayment/Coinsurance as applicable during the Initial Coverage Stage:	Deductible: $200 (applies to tiers 3, 4 and 5) Copayment/Coinsurance as applicable during the Initial Coverage Stage:

Cost	2020 (this year)	2021 (next year)
Part D prescription drug coverage (continued)	• **Drug Tier 1 - Preferred Generic Drugs:** Standard cost-sharing: You pay a $10 copay for a one-month (30-day) supply. Preferred cost-sharing: You pay a $5 copay for a one-month (30-day) supply. • **Drug Tier 2 - Generic Drugs:** Standard cost-sharing: You pay a $20 copay for a one-month (30-day) supply. Preferred cost-sharing: You pay a $15 copay for a one-month (30-day) supply. • **Drug Tier 3 - Preferred Brand Drugs:** Standard cost-sharing: You pay a $47 copay for a one-month (30-day) supply. Preferred cost-sharing: You pay a $37 copay for a one-month (30-day) supply. • **Drug Tier 4 - Non-Preferred Drugs:** Standard cost-sharing: You pay a $100 copay for a one-month (30-day) supply.	• **Drug Tier 1 - Preferred Generic Drugs:** Standard cost-sharing: You pay a $10 copay for a one-month (30-day) supply. Preferred cost-sharing: You pay a $5 copay for a one-month (30-day) supply. • **Drug Tier 2 - Generic Drugs:** Standard cost-sharing: You pay a $20 copay for a one-month (30-day) supply. Preferred cost-sharing: You pay a $15 copay for a one-month (30-day) supply. • **Drug Tier 3 - Preferred Brand Drugs:** Standard cost-sharing: You pay a $47 copay for a one-month (30-day) supply Preferred cost-sharing: You pay a $37 copay for a one-month (30-day) supply. • **Drug Tier 4 - Non-Preferred Drugs:** Standard cost-sharing: You pay a $100 copay for a one-month (30-day) supply.

Cost	2020 (this year)	2021 (next year)
Part D prescription drug coverage (continued)	Preferred cost-sharing: You pay a $90 copay for a one-month (30-day) supply. • **Drug Tier 5 - Specialty Tier:** Standard cost-sharing: You pay 29% of the total cost for a one-month (30-day) supply. Preferred cost-sharing: You pay 29% of the total cost for a one-month (30-day) supply. • **Drug Tier 6 - Select Care Drugs:** Standard cost-sharing: You pay a $0 copay for a one-month (30-day) supply. Preferred cost-sharing: You pay a $0 copay for a one-month (30-day) supply.	Preferred cost-sharing: You pay a $90 copay for a one-month (30-day) supply. • **Drug Tier 5 - Specialty Tier:** Standard cost-sharing: You pay 29% of the total cost for a one-month (30-day) supply. Preferred cost-sharing: You pay 29% of the total cost for a one-month (30-day) supply. • **Drug Tier 6 - Select Care Drugs:** Standard cost-sharing: You pay a $0 copay for a one-month (30-day) supply. Preferred cost-sharing: You pay a $0 copay for a one-month (30-day) supply.

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2020 (this year)	2021 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium, however our plan covers some of the cost of your Medicare Part B Premium.)	$0	$0 **Part B buy down** $29
Optional supplemental benefits monthly premium	Health Net complete Dental $39 Health Net Basic Dental $19	Not available Not available

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be *less* if you are receiving "Extra Help" with your prescription drug costs. Please see Section 6 regarding "Extra Help" from Medicare.

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amounts

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during the year. These limits are called the "maximum out-of-pocket amounts." Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2020 (this year)	2021 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays and deductibles) from network providers count toward your in-network maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$5,900	$7,550 Once you have paid $7,550 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from in- network providers for the rest of the calendar year.
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays and deductibles) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount	$8,700	$7,550 Once you have paid $7,550 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from in- network or out-of-network providers for the rest of the calendar year.

Section 1.3 – Changes to the Provider Network

Our network has changed more than usual for 2021. An updated Provider & Pharmacy Directory is located on our website at or.healthnetadvantage.com. You may also call Member Services for updated provider information or to ask us to mail you a Provider & Pharmacy Directory. **We strongly suggest that you review our current Provider & Pharmacy Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are still in our network.**

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, we must furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.

- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.

Section 1.4 – Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies. Our network includes pharmacies with preferred cost-sharing, which may offer you lower cost-sharing than the standard cost-sharing offered by other network pharmacies for some drugs.

Our network has changed more than usual for 2021. An updated Provider & Pharmacy Directory is located on our website at or.healthnetadvantage.com. You may also call Member Services for updated provider information or to ask us to mail you a Provider & Pharmacy Directory. **We strongly suggest that you review our current Provider & Pharmacy Directory to see if your pharmacy is still in our network.**

Section 1.5 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*, in your *2021 Evidence of Coverage.*

Cost	2020 (this year)	2021 (next year)
Additional medical nutritional therapy	Additional medical nutritional therapy is not covered.	**In and Out-of-network** You pay a $0 copay for additional medical nutrition therapy services. Please refer to the Evidence of Coverage for benefit details.

Additional telehealth services	Additional telehealth services are not covered.	Certain additional telehealth services, including those for: primary care, specialist and other health care professional services, and outpatient mental health specialty services, including psychiatric care are covered. Cost-shares for covered additional telehealth services are the same as the standard cost-sharing for those services in an office setting. See Chapter 4 of your Evidence of Coverage for more details.
Dental services	**Additional services** Additional dental services are offered as part of an optional supplemental benefit package. See Chapter 4, Section 2.2 of your Evidence of Coverage for more details.	**Additional services** The additional dental benefit is not covered.
Diabetes self-management training, diabetic services and supplies	**In-network** You pay a $0 copay for Medicare-covered diabetic supplies. Diabetic supplies are limited to Accu-Chek™ and OneTouch™. Other brands are not covered unless medically necessary and pre-authorized. You pay 19% of the total cost for Medicare-covered therapeutic shoes for people with diabetes who have severe diabetic foot disease.	**In-network** You pay a $0 copay of the total cost for Medicare-covered diabetic glucometer and supplies. Diabetic glucometer and supplies are limited to Accu-Chek™ and OneTouch™. Other brands are not covered unless medically necessary and pre-authorized. You pay 20% of the total cost for Medicare-covered therapeutic shoes for people with diabetes who have severe diabetic foot disease.

Diabetes self-management training, diabetic services and supplies (continued)	**Out-of-network** You pay a $0 copay for Medicare-covered diabetic supplies. Diabetic supplies are limited to Accu-Chek™ and OneTouch™. Other brands are not covered unless medically necessary and pre-authorized. You pay 20% of the total cost for Medicare-covered therapeutic shoes for people with diabetes who have severe diabetic foot disease.	**Out-of-network** You pay a $0 copay for Medicare-covered diabetic glucometer and supplies. Diabetic glucometer and supplies are limited to Accu-Chek™ and OneTouch™. Other brands are not covered unless medically necessary and pre-authorized. You pay 20% of the total cost for Medicare-covered therapeutic shoes for people with diabetes who have severe diabetic foot disease.
Durable medical equipment (DME) and related supplies	**In-network** You pay 19% of the total cost for Medicare-covered DME and related supplies. **Out-of-network** You pay 20% of the total cost for Medicare-covered DME and related supplies.	**In-network** You pay 20% of the total cost for Medicare-covered DME and related supplies. **Out-of-network** You pay 20% of the total cost for Medicare-covered DME and related supplies.
Health and wellness education programs	**Fitness benefit** **In-network** Fitness benefit is offered as part of your plan. You pay a $0 copay for the fitness benefit. You have the following choices available at no cost to you: • Fitness Center Membership: You can visit a participating fitness center near you that takes part in the program; or • Home Fitness Kits: You can choose from a variety of home fitness kits. You can receive 1 kit each benefit year.	**Fitness benefit** Fitness benefit is offered as part of your plan. You pay a $0 copay for the fitness benefit. You have the following choices available at no cost to you: • Fitness Center Membership: You can visit a participating fitness center near you that takes part in the program; and • Home Fitness Kits: You can choose from a variety of home fitness kits. You can receive up to 2 kits each benefit year.

Health and wellness education programs (continued)	Please refer to the Evidence of Coverage for benefit details.	Please refer to the Evidence of Coverage for benefit details.
Hearing services	**Additional services** **In- and out-of-network** Routine hearing test is not covered. Hearing aids fitting and evaluation are not covered.	**Additional services** **In-and out-of-network** You pay a $0 copay for each routine hearing test. You pay a $0 copay for a hearing aid fitting exam, up to one fitting exam every calendar. You pay a $0 - $1,580 copay per hearing aid. Copay amount depends on technology level of hearing aid you purchase. Limited to 2 hearing aids total, 1 per ear, per calendar year. Please refer to the Evidence of Coverage for benefit details.
Home health services	**In-network** You pay a $0 copay for each Medicare-covered home health visit. **Out-of-network** You pay 30% of the total cost for each Medicare-covered home health visit.	**In-network** You pay a $0 copay for each Medicare-covered home health visit. **Out-of-network** You pay 20% of the total cost for each Medicare-covered home health visit.
Inpatient hospital care	**In-network** For Medicare-covered admissions, per admission: **Days 1 - 4:** You pay a $295 copay per day. **Days 5 and beyond:** You pay a $0 copay per day.	**In-network** For Medicare-covered admissions, per admission: **Days 1 - 4:** You pay a $450 copay per day. **Days 5 and beyond:** You pay a $0 copay per day.

Inpatient hospital care (continued)	**Out-of-network** For Medicare-covered admissions, per admission: **Days 1 - 10:** You pay a $475 copay per day. **Days 11 and beyond:** You pay a $0 copay per day.	**Out-of-network** For Medicare-covered admissions, per admission: **Days 1 -10:** You pay a $500 copay per day. **Days 11 and beyond:** You pay a $0 copay per day.
Medicare Part B prescription drugs	**In-network** You pay 17% of the total cost for Medicare-covered Part B chemotherapy drugs. You pay 17% of the total cost for all other Medicare-covered Part B drugs. **Out-of-network** You pay 20% of the total cost for Medicare-covered Part B chemotherapy drugs. You pay 20% of the total cost for all other Medicare-covered Part B drugs.	**In-network** You pay 20% of the total cost for Medicare-covered Part B chemotherapy drugs. You pay 20% of the total cost for all other Medicare-covered Part B drugs. **Out-of-network** You pay 20% of the total cost for Medicare-covered Part B chemotherapy drugs. You pay 20% of the total cost for all other Medicare-covered Part B drugs.
Nutritional/Dietary counseling benefit	Nutritional/dietary counseling benefit is <u>not</u> covered.	**In and Out-of-network** You pay a $0 copay for each nutritional/dietary counseling visit. Please refer to the Evidence of Coverage for benefit details.
Outpatient Diagnostic tests and therapeutic services and supplies **Diagnostic procedures and tests**	**<u>COVID-19 coverage</u>** Services for COVID-19 testing were covered under your diagnostic procedures and tests benefits.	**<u>COVID-19 coverage</u>** **In-network** You pay a $0 copay for laboratory and diagnostic procedures and tests related to COVID-19 insert for plans

Outpatient Diagnostic tests and therapeutic services and supplies **Diagnostic procedures and tests (continued)**		with location based services: at any location. **Out-of-network** You pay the out-of-network cost-share listed below for these services.
	Diagnostic procedures and tests **In-network** You pay 19% of the total cost for Medicare-covered diagnostic procedures and tests. You pay 0% of the total cost for Medicare-covered EKG tests. **Out-of-network** You pay 20% of the total cost for Medicare-covered diagnostic procedures and tests. You pay 0% of the total cost for Medicare-covered EKG tests. **Lab services** **In-network** You pay a $15 copay for Medicare-covered laboratory services. **Out-of-network** You pay a $20 copay for Medicare-covered laboratory services.	**Diagnostic procedures and tests** **In-network** You pay 20% of the total cost for Medicare-covered diagnostic procedures and tests. You pay 0% of the total cost for Medicare-covered EKG tests. **Out-of-network** You pay 20% of the total cost for Medicare-covered diagnostic procedures and tests. You pay 0% of the total cost for Medicare-covered EKG tests. **Lab services** **In-network** You pay a $0 copay for Medicare-covered laboratory services performed in a hospital or a facility associated with a hospital/ at a physician's office or an independent lab location. You pay a $15 copay for Medicare-covered laboratory services at all other locations.

Outpatient Diagnostic tests and therapeutic services and supplies **Diagnostic procedures and tests (continued)**		**Out-of-network** You pay a $20 copay for Medicare-covered laboratory services.
Outpatient Diagnostic tests and therapeutic services and supplies **Diagnostic radiological services *(including CTs, PET Scans, MRIs, and other complex radiological services.)***	**In-network** You pay 19% of the total cost for Medicare-covered diagnostic radiological services. **Out-of-network** You pay 20% of the total cost for Medicare-covered diagnostic radiological services.	**In-network** You pay 20% of the total cost for Medicare-covered diagnostic radiological services. **Out-of-network** You pay 20% of the total cost for Medicare-covered diagnostic radiological services.
Outpatient Diagnostic tests and therapeutic services and supplies **Therapeutic radiology**	**In-network** You pay 19% of the total cost for Medicare-covered therapeutic radiological services, including technician materials and supplies. **Out-of-network** You pay 20% of the total cost for Medicare-covered therapeutic radiological services, including technician materials and supplies.	**In-network** You pay a 20% of the total cost for Medicare-covered therapeutic radiological services, including technician materials and supplies. **Out-of-network** You pay 20% of the total cost for Medicare-covered therapeutic radiological services, including technician materials and supplies.
Outpatient hospital observation	**In-network** You pay a $300 copay for each Medicare-covered observation service visit. **Out-of-network** You pay a $335 copay for each Medicare-covered observation service visit.	**In-network** You pay a $450 copay for each Medicare-covered observation service visit. **Out-of-network** You pay a $500 copay for each Medicare-covered observation service visit.

Outpatient mental health care	**Additional counseling services** Additional counseling services are not covered.	**Additional counseling services** **In Network:** You pay a $0 copay for each counseling visit with a Teladoc™ provider. You pay a $40 copay for each counseling visit with a Medicare-qualified mental health provider. **Out-of-network** You pay a $50 copay for each counseling visit with a Medicare-qualified mental health provider.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers (ASC)	**In-network** You pay a $300 copay for each Medicare-covered visit to an outpatient hospital facility. You pay a $250 copay for each Medicare-covered visit to an ASC. **Out-of-network** You pay a $335 copay for each Medicare-covered visit to an outpatient hospital facility You pay a $285 copay for each Medicare-covered visit to an ASC.	**In-network** You pay 20% of the total cost, up to $450 for each Medicare-covered visit to an outpatient hospital facility. You pay 20% of the total cost, up to $400 for each Medicare-covered visit to an ASC. **Out-of-network** You pay a $500 copay for each Medicare-covered visit to an outpatient hospital facility You pay a $450 copay for each Medicare-covered visit to an ASC.
Physician/Practitioner services, including doctor's office visits	**In-network** You pay a $40 copay for each Medicare-covered specialist visit.	**In-network** You pay a $50 copay for each Medicare-covered specialist visit.

Physician/Practitioner services, including doctor's office visits (continued)	**Out-of-network** You pay a $50 copay for each Medicare-covered specialist visit.	**Out-of-network** You pay a $60 copay for each Medicare-covered specialist visit. Cost-shares for covered additional telehealth services are the same as the standard cost-sharing for those services in an office setting.
Skilled nursing facility (SNF) care	For Medicare-covered admissions, per benefit period: **In-network** **Days 1 – 20**: You pay a $0 copay per day. **Days 21 – 100**: You pay a $170 copay per day. You pay all costs for each day after day 100. **Out-of-network** **Days 1 – 20**: You pay a $0 copay per day. **Days 21 – 100**: You pay a $220 copay per day. You pay all costs for each day after day 100.	For Medicare-covered admissions, per benefit period: **In-network** **Days 1 – 20**: You pay a $0 copay per day. **Days 21 – 100**: You pay a $160 copay per day. You pay all costs for each day after day 100. **Out-of-network** **Days 1 – 20**: You pay a $0 copay per day. **Days 21 – 100**: You pay a $195 copay per day. You pay all costs for each day after day 100.
Optional supplemental package #1 – You may purchase this optional supplemental benefits package for an additional premium.	Health Net Complete Dental includes: **<u>Dental services</u>** There is an in- and out-of-network $1,000 combined benefit maximum for preventive and comprehensive	An optional supplemental benefit package is not offered.

Optional supplemental package #1 (continued)	dental services each calendar year. **In-network and out-of-network** Preventive dental services- Includes 2 exams, 2 cleanings, 1 fluoride treatment and 1 set of dental x-rays. You pay a $0 copay per visit. Comprehensive dental services include: Non-Routine Services - You pay 50% of the total cost Diagnostic services - You pay a $0 copay per service Restorative service - You pay 20% of the total cost Endodontics - You pay 50% of the total cost Periodontics - You pay 50% of the total cost Extractions - You pay 50% - 50% of the total cost Prosthodontics, including dentures, other oral/maxillofacial surgery, and other services - You pay 50% of the total cost Additional information can be found in your 2020 Evidence of Coverage.

Optional supplemental package #2- – You may purchase this optional supplemental benefits package for an additional premium.	Health Net Basic Dental includes: **<u>Dental services</u>** You pay a $35 annual deductible for preventive dental services. There is an in- and out-of-network $500 benefit maximum for preventive dental services each calendar year. **In-network** Preventive dental services- Includes 2 exams, 2 cleanings, 1 fluoride treatment and 1 set of dental x-rays. You pay a $0 copay per visit. **Out-of-network** Preventive dental services- Includes 2 exams, 2 cleanings, 1 fluoride treatment and 1 set of dental x-rays. You pay 20% of the total cost per visit. Additional information can be found in your 2020 Evidence of Coverage.	A second optional supplemental benefit package is not offered.
Prior Authorization	The following in-network benefits required prior authorization: • Ambulatory surgical center (ASC) services • Ambulance services for fixed wing aircraft and non-emergency services • Durable medical equipment • Home health services • Inpatient hospital care	The following in-network benefits will require prior authorization: • Ambulatory surgical center (ASC) services • Ambulance services for fixed wing aircraft and non-emergency services • Diabetic services and supplies • Durable medical equipment

Prior Authorization (continued)	• Inpatient mental health care • Medicare Part B prescription drugs • Outpatient diagnostic and therapeutic radiological services • Outpatient diagnostic tests and lab services • Outpatient hospital observation • Outpatient hospital services, including surgery • Outpatient rehabilitation services – physical and speech therapy • Outpatient rehabilitation service – occupational therapy • Outpatient substance abuse • Partial hospitalization services • Prosthetic devices and related supplies • Skilled Nursing Facility (SNF) care	• Home health services • Inpatient hospital care • Inpatient mental health care • Medicare Part B prescription drugs • Outpatient diagnostic and therapeutic radiological services • Outpatient diagnostic tests and lab services • Outpatient hospital observation • Outpatient hospital services, including surgery • Outpatient rehabilitation services – physical and speech therapy • Outpatient rehabilitation service – occupational therapy • Outpatient substance abuse • Partial hospitalization services • Prosthetic devices and related supplies • Skilled Nursing Facility (SNF) care

Section 1.6 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or "Drug List." A copy of our Drug List is provided electronically.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug. **We encourage current members** to ask for an exception before next year.
    - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage (What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* or call Member Services.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Member Services to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of Coverage.*) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

Your current formulary exception will continue to be covered through the date included in the approval letter you previously received. You do not need to submit a new exception request until your current approval ends.

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules.

When we make these changes to the Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to reflect drug changes. (To learn more about changes we may make to the Drug List, see Chapter 5, Section 6 of the Evidence of Coverage.)

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. If you receive "Extra Help" and haven't received this insert by September 30, 2020, please call Member Services and ask for the "LIS Rider." Phone numbers for Member Services are in Section 7.1 of this booklet.

There are four "drug payment stages." How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your *Evidence of Coverage* for more information about the stages.)

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage*, which is located on our website at or.healthnetadvantage.com. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2020 (this year)	2021 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Tier 3 – Preferred Brand, Tier 4 – Non-Preferred Drug, and Tier 5 – Specialty Tier drugs until you have reached the yearly deductible.	The deductible is $200 During this stage, you pay $10 cost-sharing ($5 cost-sharing through a preferred retail network) for drugs on Tier 1 – Preferred Generic, $20 cost-sharing ($15 cost-sharing through a preferred retail network) for drugs on Tier 2 - Generic, and $0 cost-sharing for Tier 6 – Select Care Drugs and the full cost of drugs on Tier 3 – Preferred Brand, Tier 4 – Non-Preferred Drugs and Tier 5 – Specialty Tier until you have reached the yearly deductible.	The deductible is $200 During this stage, you pay $10 cost-sharing ($5 cost-sharing through a preferred retail network) for drugs on Tier 1 – Preferred Generic, $20 cost-sharing ($15 cost-sharing through a preferred retail network) for drugs on Tier 2 - Generic, and $0 cost-sharing for Tier 6 – Select Care Drugs and the full cost of drugs on Tier 3 – Preferred Brand, Tier 4 – Non-Preferred Drugs and Tier 5 – Specialty Tier until you have reached the yearly deductible.

Changes to Your Cost Sharing in the Initial Coverage Stage

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs* in your *Evidence of Coverage*.

Stage	2020 (this year)	2021 (next year)
Stage 2: Initial Coverage Stage	Your cost for a one-month supply at a network pharmacy:	Your cost for a one-month supply at a network pharmacy:

Stage	2020 (this year)	2021 (next year)
Stage 2: Initial Coverage Stage (continued) Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.**	**Drug Tier 1 – Preferred Generic Drugs:** *Standard cost-sharing:* You pay a $10 copay per prescription. *Preferred cost-sharing:* You pay a $5 copay per prescription. Excluded drugs are not covered in this or any tier for 2020.	**Drug Tier 1 – Preferred Generic Drugs:** *Standard cost-sharing:* You pay a $10 copay per prescription. *Preferred cost-sharing:* You pay a $5 copay per prescription. You have additional coverage for some excluded drugs used for sexual or erectile dysfunction on Drug Tier 1 (Preferred Generic Drugs Tier). The amount you pay when you fill prescriptions for these drugs does not count toward your total drug costs. Quantity limits may apply.
	Drug Tier 2 – Generic Drugs: *Standard cost-sharing:* You pay a $20 copay per prescription. *Preferred cost-sharing:* You pay a $15 copay per prescription.	**Drug Tier 2 – Generic Drugs:** *Standard cost-sharing:* You pay a $20 copay per prescription. *Preferred cost-sharing:* You pay a $15 copay per prescription.
	Drug Tier 3 – Preferred Brand Drugs: *Standard cost-sharing:* You pay a $47 copay per prescription. *Preferred cost-sharing:* You pay a $37 copay per prescription.	**Drug Tier 3 – Preferred Brand Drugs:** *Standard cost-sharing:* You pay a $47 copay per prescription. *Preferred cost-sharing:* You pay a $37 copay per prescription.

Stage	2020 (this year)	2021 (next year)
Stage 2: Initial Coverage Stage (continued)	**Drug Tier 4 – Non-Preferred Drugs:** *Standard cost-sharing:* You pay a $100 copay per prescription. *Preferred cost-sharing:* You pay a $90 copay per prescription. **Drug Tier 5 – Specialty Tier:** *Standard cost-sharing:* You pay 29% of the total cost. *Preferred cost-sharing:* You pay 29% of the total cost. **Drug Tier 6 – Select Care Drugs:** *Standard cost-sharing:* You pay a $0 copay per prescription. *Preferred cost-sharing:* You pay a $0 copay per prescription.	**Drug Tier 4 – Non-Preferred Drugs:** *Standard cost-sharing:* You pay a $100 copay per prescription. *Preferred cost-sharing:* You pay a $90 copay per prescription. **Drug Tier 5 – Specialty Tier:** *Standard cost-sharing:* You pay 29% of the total cost. *Preferred cost-sharing:* You pay 29% of the total cost. **Drug Tier 6 – Select Care Drugs:** *Standard cost-sharing:* You pay a $0 copay per prescription *Preferred cost-sharing:* You pay a $0 copay per prescription.
Stage 2: Initial Coverage Stage (continued) The costs in this row are for a one-month 30-day) supply when you fill your prescription at a network pharmacy. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter	Once your total drug costs have reached $4,020, you will move to the next stage (the Coverage Gap Stage).	Once your total drug costs have reached $4,130, you will move to the next stage (the Coverage Gap Stage).

Stage	2020 (this year)	2021 (next year)
6, Section 5 of your *Evidence of Coverage*. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.		

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage**. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 2 Administrative Changes

Description	2020 (this year)	2021 (next year)
Mail Order Pharmacy	There are two mail order pharmacies: • CVS Caremark Mail Service Pharmacy • Homescripts Mail Order Pharmacy	There is one mail order pharmacy: • CVS Caremark Mail Service Pharmacy
Maximum out-of-pocket amount changes (MOOP)	The following in-network benefits and services apply to your in-network and combined maximum out-of-pocket: • All Medicare-covered benefits.	The following in-network benefits and services apply to your in-network and combined maximum out-of-pocket: • All Medicare-covered benefits. The following out-of-network benefits and

Description	2020 (this year)	2021 (next year)
Maximum out-of-pocket amount changes (MOOP) (continued)	• All non-Medicare covered services covered by your plan The following out-of-network benefits and services apply to your combined out-of-pocket maximum • All Medicare-covered benefits. • All non-Medicare-covered services covered by your plan.	services apply to your combined out-of-pocket maximum • All Medicare-covered benefits.
Service area changes	Our service area includes: • Douglas (OR) • Josephine (OR)	Our service area includes: • Benton (OR) • Clackamas (OR) • Clark (WA) • Douglas (OR) • Jackson (OR) • Josephine (OR) • Lane (OR) • Linn (OR) • Marion (OR) • Multnomah (OR) • Polk (OR) • Washington (OR) • Yamhill (OR)

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Health Net Violet 3 (PPO)

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our Health Net Violet 3 (PPO).

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2021 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan timely,
- – *OR*– You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 1.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2021*, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to www.medicare.gov/plan-compare. **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

Step 2: Change your coverage

- To change **to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Health Net Violet 3 (PPO).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Health Net Violet 3 (PPO).
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Member Services if you need more information on how to do this (phone numbers are in Section 7.1 of this booklet).
    - – *OR* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2021.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area may be allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage.*

If you enrolled in a Medicare Advantage Plan for January 1, 2021, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2021. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

SECTION 5 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Oregon, the SHIP is called Senior Health Insurance Benefits Assistance Program (SHIBA).

Senior Health Insurance Benefits Assistance Program (SHIBA) is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. Senior Health Insurance Benefits Assistance Program (SHIBA) counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call Senior Health Insurance Benefits Assistance Program (SHIBA) at 1-800-722-4134 (TTY 711). You can learn more about Senior Health Insurance Benefits Assistance Program (SHIBA) by visiting their website (http://shiba.oregon.gov/).

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;

- The Social Security Office at 1-800-772-1213 between 7 am and 7 pm, Monday through Friday. TTY users should call 1-800-325-0778 (applications); or
- Your State Medicaid Office (applications).

Prescription Cost-sharing Assistance for Persons with HIV/AIDS. The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the CAREAssist AIDS Drug Assistance Program (ADAP). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-800-805-2313 (TTY 711) from Monday - Friday: 8 a.m. - 5 p.m.

SECTION 7 Questions?

Section 7.1 – Getting Help from Health Net Violet 3 (PPO)

Questions? We're here to help. Please call Member Services at 1-888-445-8913. (TTY only, call 711). We are available for phone calls from October 1 to March 31, you can call us 7 days a week from 8 a.m. to 8 p.m. From April 1 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. A messaging system is used after hours, weekends, and on federal holidays. Calls to these numbers are free.

Read your 2021 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2021. For details, look in the 2021 *Evidence of Coverage* for Health Net Violet 3 (PPO). The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at or.healthnetadvantage.com. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at or.healthnetadvantage.com. As a reminder, our website has the most up-to-date information about our provider network (Provider & Pharmacy Directory) and our list of covered drugs (Formulary/Drug List).

Section 7.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

You can visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to www.medicare.gov/plan-compare.)

Read *Medicare & You 2021*

You can read *Medicare & You 2021* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov) or 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.

Section 1557 Non-Discrimination Language
Notice of Non-Discrimination

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, audio, 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 Member Services telephone number listed for your state on the Member Services Telephone Numbers by State Chart. From October 1 to March 31, you can call us 7 days a week from 8 a.m. to 8 p.m. From April 1 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. A messaging system is used after hours, weekends, and on federal holidays.
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 in the chart below and telling them you need help filing a grievance; Health Net's Member Services 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 (TTY: 1-800-537-7697).
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Member Services Telephone Numbers by State Chart

State	Telephone Number and Plan Type
California	1-800-431-9007 (Jade, Sapphire, Amber and HMO SNP), 1-800-275-4737 (all other HMO); (TTY: 711)
Oregon	1-888-445-8913 (HMO and PPO); (TTY: 711)

English: Language assistance services, auxiliary aids and services, and other alternative formats are available to you free of charge. To obtain this, please call the number above.

Español (Spanish): Servicios de asistencia de idiomas, ayudas y servicios auxiliares, y otros formatos alternativos están disponibles para usted sin ningún costo. Para obtener esto, llame al número de arriba.

简体中文(Chinese)：可以免费为您提供语言协助服务、辅助用具和服务以及其他格式。如有需要，请拨打上述电话号码。

Tiếng Việt (Vietnamese): Các dịch vụ trợ giúp ngôn ngữ, các trợ cụ và dịch vụ phụ thuộc, và các dạng thức thay thế khác hiện có miễn phí cho quý vị. Để có được những điều này, xin gọi số điện thoại nêu trên.

Tagalog (Tagalog): Mayroon kang makukuhang libreng tulong sa wika, auxiliary aids at mga serbisyo, at iba pang mga alternatibong format. Upang makuha ito, mangyaring tawagan ang numerong nakasulat sa itaas.

한국어(Korean): 언어 지원 서비스, 보조적 지원 및 서비스, 기타 형식의 자료를 무료로 이용하실 수 있습니다. 이용을 원하시면 상기 전화번호로 연락해 주십시오.

Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ

فارسي (Persian): خدمات ترجمه، حمایت های ؛ خدمات کمکی و سایر انواع دیگر به صورت رایگان در اختیار شما قرار می گیرند. برای به دست یابی به این خدمات، لطفا با شماره تلفن بالا تماس بگیرید.

Русский язык (Russian): Вам могут быть бесплатно предоставлены услуги по переводу, вспомогательные средства и услуги, а также материалы в других, альтернативных, форматах. Чтобы получить их, позвоните, пожалуйста, по указанному выше номеру телефона.

日本語 (Japanese): 言語支援サービス、補助器具と補助サービス、その他のオプション形式を無料でご利用いただけます。ご利用をお考えの方は、上記の番号にお電話ください。

العربية (Arabic) : خدمات المساعدة اللغوية والمعينات والخدمات الإضافية وغيرها من الأشكال البديلة متاحة لك مجانا. للحصول عليها، يرجى الاتصال بالرقم أعلاه.

ਪੰਜਾਬੀ (Panjabi): ਤੁਹਾਡੇ ਲਈ ਭਾਸ਼ਾ ਸਬੰਧੀ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ, ਸਹਾਇਕ ਸਾਧਨ ਅਤੇ ਸੇਵਾਵਾਂ ਅਤੇ ਦੂਜੇ ਬਦਲਵੇਂ ਫਾਰਮੈਟ ਮੁਫ਼ਤ ਉਪਲਬਧ ਹਨ। ਇਹਨਾਂ ਦੇ ਲਈ ਕਿਰਪਾ ਕਰਕੇ ਉੱਪਰ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ।

ខ្មែរ (Mon-Khmer, Cambodian): សេវាកម្មជំនួយភាសា ជំនួយជំនួយ និងសេវាកម្មនានា និងទម្រង់ដែលមានជសម្មរចើ សសេងៗសទៀត ដែលសោកអ្នកអាចរកបានសោយឥតគិតថ្លៃ។
សែចើម្បីទទួលបានព័ត៌មានសនេះ ចេូមេ្យាទូរេពាទតាមេ្យាលខខាងសលើ។

Ntawv Hmoob (Hmong): Muaj kev pab txhais lus, khoom pab mloog txhais lus thiab lwm yam kev pab pub dawb rau koj. Xav tau tej no, thov hu rau tus nab npawb saum toj saud.

हिंदी (Hindi): भाषा सहायता सेवाएं, सहायक उपकरण और सेवाएं, और अन्य वैकल्पिक प्रारूप आपके लिए निःशुल्क उपलब्ध हैं। इन्हें प्राप्त करने के लिए, कृपया उपरोक्त नंबर पर कॉल करें।

ไทย Thai): การช่วยเหลือด้านภาษา อุปกรณ์และบริการเสริม รวมทั้งรูปแบบทางเลือกอื่น ๆ มีให้ท่านใช้ได้โดยไม่เสียค่าใช้จ่าย หากต้องการขอรับบริการเหล่านี้ กรุณาติด

Українська мова (Ukrainian): Вам можуть бути безкоштовно надані послуги з перекладу, допоміжні засоби та послуги, а також матеріали в інших, альтернативних, форматах. Щоб одержати їх, зателефонуйте, будь ласка, за номером телефону, який зазначений вище.

Română (Romanian): Servicii de asistență lingvistică, ajutoare și servicii auxiliare, precum și alte formate alternative vă stau la dispoziție în mod gratuit. Pentru a le obține, apelați numărul de mai sus.

Cushite (Cushite): Tajaajila qarqaarsa afaanii, qarqaarsa deeggarsaa fi tajaajilaa, fi qarqaarsi akkaataa biroo bilisaan siif laatama. Tajaajila kanniin argachuuf maaloo lakkoofsa asii olii bilbili.

Deutsch (German): Sprachunterstützung, Hilfen und Dienste für Hörbehinderte und Gehörlose sowie weitere alternative Formate werden Ihnen kostenlos zur Verfügung gestellt. Um eines dieser Serviceangebote zu nutzen, wählen Sie die o. a. Rufnummer.

Français (French) : Des services gratuits d’assistance linguistique, ainsi que des services d’assistance supplémentaires et d’autres formats sont à votre disposition. Pour y accéder, veuillez appeler le numéro ci-dessus.