AdventHealth Advantage Plans

Health First Health Plans

2020 Summary of Benefits

Medicare Advantage

(Employer Group Plans)

This is a summary of drug and health services covered by AdventHealth Advantage Plans effective January 1, 2020

Benefits	AdventHealth Group Plus C (HMO)	AdventHealth Group Plus D (HMO)	AdventHealth Group POS B (HMO-POS)
Monthly Plan Premium In addition, you must keep paying your Medicare Part B	Please contact the employer's or union's benefit administrator for information about your plan premium	Please contact the employer's or union's benefit administrator for information about your plan premium	Please contact the employer's or union's benefit administrator for information about your plan premium
Deductibles	This plan does not have a deductible	This plan does not have a deductible	This plan does not have a deductible
Maximum Out-of-Pocket Responsibility	$2,000 for services you receive from in-network providers	$3,000 for services you receive from in-network providers	$3,000 for services you receive from in-network providers $6,000 for services you receive from out-of-network providers
Inpatient Hospital Coverage (PA) (90 days covered/benefit period†)	You pay $250 per admission	▪ You pay $150 each day for days 1-5 of a covered inpatient stay during a benefit period ▪ You pay $0 per day for days 6-90 of a covered inpatient stay during a benefit period ▪ There is a $750 maximum out-of-pocket limit per benefit period	▪ You pay $150 each day for days 1-5 of a covered inpatient stay during a benefit period ▪ You pay $0 per day for days 6-90 of a covered inpatient stay during a benefit period ▪ There is a $750 maximum out-of-pocket limit per benefit period

Benefits	AdventHealth Group Plus C (HMO)	AdventHealth Group Plus D (HMO)	AdventHealth Group POS B (HMO-POS)
Outpatient Hospital Coverage (PA)	You pay $125 for each Medicare-covered outpatient admission to either an ambulatory surgical center or outpatient hospital facility	You pay $150 for each Medicare-covered outpatient admission to either an ambulatory surgical center or outpatient hospital facility	You pay $150 for each Medicare-covered outpatient admission to either an ambulatory surgical center or outpatient hospital facility
Doctor Visits (Primary Care Providers and Specialists)	▪ You pay $0 for each visit to a primary care physician office ▪ You pay $20 for each visit to a specialty physician office	▪ You pay $0 for each visit to a primary care physician office ▪ You pay $25 for each visit to a specialty physician office	▪ You pay $0 for each visit to a primary care physician office ▪ You pay $25 for each visit to a specialty physician office
Preventive Care	You pay $0	You pay $0	In-Network: You pay $0 Out-of-Network: You pay 20% of the cost
Emergency Care*	You pay $80 for each Medicare-covered visit	You pay $80 for each Medicare-covered visit	You pay $80 for each Medicare-covered visit
Urgently Needed Services*	You pay $10 for each Medicare-covered urgently needed care visit	You pay $15 for each Medicare-covered urgently needed care visit	You pay $15 for each Medicare-covered urgently needed care visit
Diagnostic Services/Labs/Imaging (PA)	▪ You pay $0 for Medicare-covered lab services ▪ You pay $0 for each outpatient X-ray, diagnostic procedure & tests ▪ You pay $150 for each type of Medicare-covered diagnostic radiology service including MRI, CT, Nuclear Scans and PET scans per date of service	▪ You pay $0 for Medicare-covered lab services ▪ You pay $0 for each outpatient X-ray, diagnostic procedure & tests ▪ You pay $150 for each type of Medicare-covered diagnostic radiology service including MRI, CT, Nuclear Scans and PET scans per date of service	▪ You pay $0 for Medicare-covered lab services ▪ You pay $0 for each outpatient X-ray, diagnostic procedure & tests ▪ You pay $150 for each type of Medicare-covered diagnostic radiology service including MRI, CT, Nuclear Scans and PET scans per date of service
Hearing Services	▪ You pay $15 for Medicare-covered hearing exams ▪ You pay $15 for one routine hearing test every calendar year ▪ You can be reimbursed up to $250 for the purchase of hearing aid devices per calendar year	▪ You pay $25 for Medicare-covered hearing exams ▪ You pay $25 for one routine hearing test every calendar year ▪ You can be reimbursed up to $250 for the purchase of hearing aid devices per calendar year	▪ You pay $25 for Medicare-covered hearing exams ▪ You pay $25 for one routine hearing test every calendar year ▪ You can be reimbursed up to $250 for the purchase of hearing aid devices per calendar year

Benefits	AdventHealth Group Plus C (HMO)	AdventHealth Group Plus D (HMO)	AdventHealth Group POS B (HMO-POS)
Dental Services (PA)	▪ You pay $0 for Medicare-covered dental benefits ▪ You can be reimbursed up to $200 for dental services per calendar year	▪ You pay $0 for Medicare-covered dental benefits ▪ You can be reimbursed up to $100 for dental services per calendar year	▪ You pay $0 for Medicare-covered dental benefits ▪ You can be reimbursed up to $100 for dental services per calendar year
Vision Services	▪ You pay $15 for each Medicare-covered exam (diagnosis and treatment for diseases and conditions of the eye) ▪ You pay $15 for one routine eye exam every year ▪ You pay $0 for one pair of eyeglasses or contacts after cataract surgery ▪ You can be reimbursed up to $250 for contact lenses and eyeglasses per calendar year	▪ You pay $15 for each Medicare-covered exam (diagnosis and treatment for diseases and conditions of the eye) ▪ You pay $25 for one routine eye exam every year ▪ You pay $0 for one pair of eyeglasses or contacts after cataract surgery ▪ You can be reimbursed up to $250 for contact lenses and eyeglasses per calendar year	▪ You pay $15 for each Medicare-covered exam (diagnosis and treatment for diseases and conditions of the eye) ▪ You pay $25 for one routine eye exam every year ▪ You pay $0 for one pair of eyeglasses or contacts after cataract surgery ▪ You can be reimbursed up to $250 for contact lenses and eyeglasses per calendar year
Mental Health Services (PA) (90 days covered / benefit period†)	Inpatient: ▪ You $250 copay per covered hospital stay Outpatient: ▪ You pay $20 for each individual/group therapy visit	Inpatient: ▪ You pay $150 each day for days 1-5 of a covered inpatient stay during a benefit period ▪ You pay $0 each day for days 6-90 of a covered inpatient stay during a benefit period ▪ There is a $750 maximum out-of-pocket limit per benefit period Outpatient: ▪ You pay $25 for each individual/group therapy visit	Inpatient: ▪ You pay $150 each day for days 1-5 of a covered inpatient stay during a benefit period ▪ You pay $0 each day for days 6-90 of a covered inpatient stay during a benefit period ▪ There is a $750 maximum out-of-pocket limit per benefit period Outpatient: ▪ You pay $25 for each individual/group therapy visit

Benefits	AdventHealth Group Plus C (HMO)	AdventHealth Group Plus D (HMO)	AdventHealth Group POS B (HMO-POS)
Skilled Nursing Facility (PA) (100 days covered / benefit period†)	▪ You pay $20 each day for days 1-20 for a covered stay during a benefit period ▪ You pay $0 each day for days 21-100 for a covered stay during a benefit period ▪ 1- day prior inpatient hospital stay is required	▪ You pay $20 each day for days 1-20 for a covered stay during a benefit period ▪ You pay $0 each day for days 21-100 for a covered stay during a benefit period ▪ 1- day prior inpatient hospital stay is required	▪ You pay $20 each day for days 1-20 for a covered stay during a benefit period ▪ You pay $0 each day for days 21-100 for a covered stay during a benefit period ▪ 1- day prior inpatient hospital stay is required
Physical Therapy and other Rehabilitation Services (PA)	You pay $15 for each Medicare-covered therapy visit	You pay $20 for each Medicare-covered therapy visit	You pay $20 for each Medicare-covered therapy visit
Ambulance (PA)	You pay $50 for a Medicare-covered one way trip	You pay $75 for a Medicare-covered one way trip	You pay $75 for a Medicare-covered one way trip
Transportation	Not covered	Not covered	Not covered
Medicare Part B Drugs (PA)	For Part B drugs such as chemotherapy drugs, you pay: 0% of the cost Other Part B drugs, you pay: 0% of the cost	For Part B drugs such as chemotherapy drugs, you pay: 0% of the cost Other Part B drugs, you pay: 0% of the cost	For Part B drugs such as chemotherapy drugs, you pay: 0% of the cost Other Part B drugs, you pay: 0% of the cost
Foot Care (podiatry services)	You pay $10 for each Medicare-covered visit	You pay $25 for each Medicare-covered visit	You pay $25 for each Medicare-covered visit
Medical Equipment/Supplies (PA)	▪ Durable Medical Equipment • You pay 10% of the Medicare-allowable amount for each Medicare-covered item ▪ Diabetes Programs / Supplies • You pay $0 for diabetes self-management training • You pay $0 for diabetes monitoring supplies, therapeutic shoes or inserts	▪ Durable Medical Equipment • You pay 10% of the Medicare-allowable amount for each Medicare-covered item ▪ Diabetes Programs / Supplies • You pay $0 for diabetes self-management training • You pay $0 for diabetes monitoring supplies, therapeutic shoes or inserts	▪ Durable Medical Equipment • You pay 10% of the Medicare-allowable amount for each Medicare-covered item ▪ Diabetes Programs / Supplies • You pay $0 for diabetes self-management training • You pay $0 for diabetes monitoring supplies, therapeutic shoes or inserts

Benefits	AdventHealth Group Plus C (HMO)	AdventHealth Group Plus D (HMO)	AdventHealth Group POS B (HMO-POS)
Wellness Programs	These services are offered at no additional cost: ▪ Health First Fitness Program ▪ Healthy Living ▪ Health Coach	These services are offered at no additional cost: ▪ Health First Fitness Program ▪ Healthy Living ▪ Health Coach	These services are offered at no additional cost: ▪ Health First Fitness Program ▪ Healthy Living ▪ Health Coach
Home Health Care (PA)	You pay $0 for Medicare-covered home health visits	You pay $0 for Medicare-covered home health visits	You pay $0 for Medicare-covered home health visits
Opioid Treatment Program Services (PA)	You pay $20 for each Medicare-covered opioid use disorder treatment service furnished by opioid treatment programs	You pay $25 for each Medicare-covered opioid use disorder treatment service furnished by opioid treatment programs	You pay $25 for each Medicare-covered opioid use disorder treatment service furnished by opioid treatment programs
Supervised Exercise Therapy (SET) (PA)	You pay $5 for each Medicare-covered supervised exercise therapy visit	You pay $15 for each Medicare-covered supervised exercise therapy visit	You pay $15 for each Medicare-covered supervised exercise therapy visit
Point-of-Service**	Not covered	Not covered	You pay 20% of the cost for all Medicare-covered services

Benefits	AdventHealth Group Plus C (HMO)	AdventHealth Group Plus D (HMO)	AdventHealth Group POS B (HMO-POS)
Part D Prescription Drugs – Initial Coverage Stage			
Retail network pharmacy (30-day supply) Tier 1 – Preferred Generic Drugs Tier 2 – Generic Drugs Tier 3 – Preferred Brand Drugs Tier 4 – Non-Preferred Drugs Tier 5 – Specialty Tier Drugs Tier 6 – Select Care Drugs	▪ Tier 1 – $2 ▪ Tier 2 – $5 ▪ Tier 3 – $25 ▪ Tier 4 – $45 ▪ Tier 5 – $90 ▪ Tier 6 – $0	▪ Tier 1 – $2 ▪ Tier 2 – $5 ▪ Tier 3 – $45 ▪ Tier 4 – $90 ▪ Tier 5 – 33% ▪ Tier 6 – $0	▪ Tier 1 – $2 ▪ Tier 2 – $5 ▪ Tier 3 – $45 ▪ Tier 4 – $90 ▪ Tier 5 – 33% ▪ Tier 6 – $0
Retail network pharmacy (90-day supply) Tier 1 – Preferred Generic Drugs Tier 2 – Generic Drugs Tier 3 – Preferred Brand Drugs Tier 4 – Non-Preferred Drugs Tier 5 – Specialty Tier Drugs Tier 6 – Select Care Drugs	▪ Tier 1 – $6 ▪ Tier 2 – $15 ▪ Tier 3 – $75 ▪ Tier 4 – $135 ▪ Tier 5 – N/A ▪ Tier 6 – $0	▪ Tier 1 – $6 ▪ Tier 2 – $15 ▪ Tier 3 – $135 ▪ Tier 4 – $270 ▪ Tier 5 – N/A ▪ Tier 6 – $0	▪ Tier 1 – $6 ▪ Tier 2 – $15 ▪ Tier 3 – $135 ▪ Tier 4 – $270 ▪ Tier 5 – N/A ▪ Tier 6 – $0
Mail order (90-day supply) Tier 1 – Preferred Generic Drugs Tier 2 – Generic Drugs Tier 3 – Preferred Brand Drugs Tier 4 – Non-Preferred Drugs Tier 5 – Specialty Tier Drugs Tier 6 – Select Care Drugs	▪ Tier 1 – $0 ▪ Tier 2 – $0 ▪ Tier 3 – $62.50 ▪ Tier 4 – $112.50 ▪ Tier 5 – N/A ▪ Tier 6 – $0	▪ Tier 1 – $0 ▪ Tier 2 – $0 ▪ Tier 3 – $112.50 ▪ Tier 4 – $225 ▪ Tier 5 – N/A ▪ Tier 6 – $0	▪ Tier 1 – $0 ▪ Tier 2 – $0 ▪ Tier 3 – $112.50 ▪ Tier 4 – $225 ▪ Tier 5 – N/A ▪ Tier 6 – $0
Coverage Gap Stage	Coverage for All Tiers	Coverage for Tiers 1, 2 & 6	Coverage for Tiers 1, 2 & 6
	This plan does not have a Coverage Gap Stage.	After your total yearly drug costs reach $4,020, you will pay no more than 25% on brand name drugs and 25% of the plan's costs for generic drugs until your yearly out-of-pocket drug costs reach $6,350.	
Catastrophic Coverage Stage	After your yearly out-of-pocket drug costs reach $6,350, you pay a $3.60 copay for generic and $8.95 copay for all other drugs, or 5% coinsurance *(whichever is greater)*.		
Prescription Drug Cost-Sharing	Cost-sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information on the additional pharmacy-specific cost-sharing and the phases of the benefit, please call us or access our Evidence of Coverage online.		

A Medicare Advantage plan is not a Medigap Policy.

AdventHealth Advantage Plans is administered by Health First Health Plans. Health First Health Plans is an HMO plan with a Medicare contract. Enrollment in Health First Health Plans depends on contract renewal.

(PA) Covered services that need approval in advance.

†A benefit period begins the day you are admitted to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.

*Worldwide urgent/emergency care coverage: Health First Medicare Advantage Plans cover emergency services and unforeseen urgently needed medical care outside the United States, including when you are on a cruise ship. If you receive covered care from a provider outside the United States that does not participate with Medicare, you may be asked to pay up front for the services and be reimbursed from the plan later. We will pay up to 115% of the Medicare-allowed amount in our service area (Medicare's limiting charge for non-participating providers), less any applicable cost-share. Please note that Medicare-allowed amounts can be much less than the provider charges you, and you will be responsible for paying the difference.

**Any Medicare-covered benefit that is covered in-network is also available out-of-network. Please refer to the Evidence of Coverage for out-of-pocket and annual maximum coverage. Facilities may charge different amounts, so your final cost may vary depending on which facility you choose.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for up to seventy- five (75) percent 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. You may be able to get Extra Help to pay for your prescription drug premiums and costs. To see if you qualify for Extra Help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
- Social Security Office at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call 1-800-325-0778
- State Medicaid Office at 1-866-762-2237. TTY users should call 1-800-955-8771; or
- My Advocate™ (Third Party Administrator for Health First Health Plans) at 1.866.743.5282 between 9 a.m. – 6 p.m., Monday through Friday. TTY users should call 1.855.368.9643

For further assistance: You may call Customer Service toll-free at 1.855.882.6467 (TTY/TDD relay: 1.800.955.8771) weekdays from 8 a.m. to 8 p.m. and Saturdays from 8 a.m. to noon. From October 1-March 31, we're available seven days a week from 8 a.m. to 8 p.m. You may also visit our web site at myAHplan.com or visit our office Monday through Friday, 8 a.m. to 5 p.m., or write to us at 1425 W. Granada Blvd., Suite 4, Ormond Beach, FL 32174.

To join AdventHealth Advantage Plans, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in Florida: Volusia, Flagler, Highlands, Hardee and Seminole.

AdventHealth Advantage Plans has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our

network, the plan may not pay for these services.

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please request the "Evidence of Coverage" online at myAHplan.com or by calling Customer Service toll-free at 1.855.882.6467 (TTY/TDD relay: 1.800.955.8771) weekdays from 8 a.m. to 8 p.m. and Saturdays from 8 a.m. to noon. From October 1-March 31, we're available seven days a week from 8 a.m. to 8 p.m.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at http://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.

An **HMO** is a type of Medicare managed care plan where a group of doctors, hospitals, and other health care providers agree to give health care to Medicare beneficiaries for a set amount of money from Medicare every month. You usually must get your care from the providers in the plan.

An **HMO-POS** is a Medicare Advantage Plan that is a Health Maintenance Organization with a more flexible network allowing Plan Members to seek care outside of the traditional HMO network under certain situations or for certain treatment.

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

You can see our plan's provider/pharmacy directory at our website at myAHplan.com/myorder.

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website at myAHplan.com/myorder.

AdventHealth Advantage Plans

Health First Health Plans

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1.855.882.6467 (TTY/TDD relay: 1.800.955.8771) weekdays from 8 a.m. to 8 p.m. and Saturdays from 8 a.m. to noon. From October 1 to March 31, we're available seven days a week from 8 a.m. to 8 p.m.

Understanding the Benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor. Visit myAHplan.com or call 1.855.882.6467 (TTY/TDD relay: 1.800.955.8771) to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

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/co-insurance may change on January 1, 2021.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.

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AdventHealth Advantage Plans

Health First Health Plans

Nondiscrimination Notice

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

AdventHealth Advantage Plans:

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

If you need these services, please contact our Civil Rights Coordinator.

If you believe that AdventHealth Advantage Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Civil Rights Coordinator, 6450 US Highway 1, Rockledge, FL 32955, 321-434-4521, 1-800-955-8771 (TTY), Fax: 321-434-4362, civilrightscoordinator@hf.org. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance our Civil Rights Coordinator, 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, 800-537-7697 (TDD).

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

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English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-882-6467 (TTY: 1-800-955-8771).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-882-6467 (TTY: 1-800-955-8771).

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-882-6467 (TTY: 1-800-955-8771).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-882-6467 (TTY: 1-800-955-8771).

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-882-6467 (TTY: 1-800-955-8771).

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 1-855-882-6467（TTY：1-800-955-8771）。

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-882-6467 (ATS : 1-800-955-8771).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-882-6467 (TTY: 1-800-955-8771).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-882-6467 (телетайп: 1-800-955-8771).

Arabic:

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-882-6467 (رقم هاتف الصم والبكم: 1-800-955-8771).

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-882-6467 (TTY: 1-800-955-8771).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-882-6467 (TTY: 1-800-955-8771).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-882-6467 (TTY: 1-800-955-8771)번으로 전화해 주십시오.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-882-6467 (TTY: 1-800-955-8771).

Gujarati: સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-855-882-6467 (TTY: 1-800-955-8771).

Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-855-882-6467 (TTY: 1-800-955-8771).

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