



# 2022 SUMMARY OF BENEFITS

**January 1, 2022 – December 31, 2022**

The Health Plan SecureCare - Option II (HMO)

H3672-020

A Medicare Advantage Plan with Prescription Drugs

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

Belmont, Guernsey, Harrison, Jefferson, Monroe, Muskingum, Noble, and Washington

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

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

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

## **INTRODUCTION**

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

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

The Health Plan SecureCare (HMO) is an HMO plan with a Medicare contract. Enrollment in The Health Plan SecureCare (HMO) depends on contract renewal.

## **ELIGIBILITY**

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

## **WHICH DOCTORS, HOSPITALS AND PHARMACIES CAN I USE?**

This is a Health Maintenance Organization (HMO) plan. This means that The Health Plan SecureCare - Option II (HMO) has a network of doctors, hospitals, pharmacies and other providers. You can see current provider lists on our website at [healthplan.org/medicare](http://healthplan.org/medicare). Or call us and we will send you a copy.

Our plan requires you to choose an in-network doctor to be your primary care provider (PCP). We do not require a referral from your PCP to see network providers, including network specialists, for covered services. However, some services do require prior authorization from the plan. Contact us for additional information. Even though your PCP is not required to refer you, we recommend that they help with coordinating your care. If you use providers that are not in our network, the plan may not pay for these services.

## **HOW TO REACH US**

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

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

Hours of operation:

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

Or visit our website: [healthplan.org/medicare](http://healthplan.org/medicare)



## Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at **1.877.847.7915 (TTY: 711)**.

### Understanding the Benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. Visit [healthplan.org/medicare](https://healthplan.org/medicare) or call **1.877.847.7915 (TTY: 711)** to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

### 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, 2023.
- ☐ 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).

PREMIUMS & BENEFITS	THE HEALTH PLAN SECURECARE OPTION II (HMO) H3672-020	MAY REQUIRE PRIOR APPROVAL*
Monthly Plan Premium	\$40  You must continue to pay your Medicare Part B premium.	
Annual Medical Deductible	This plan does not have a deductible.	
Maximum Out-of-Pocket Responsibility (Does not include prescription drugs)	\$6,700 annually  This is the most that you will pay out of pocket for in-network covered Part A and Part B services in 2022. The amounts you pay for copayments and coinsurance for these covered services count towards the maximum out-of-pocket amount.	
<b>MEDICAL AND HOSPITAL SERVICES</b>		
Inpatient Hospital Coverage (Per admission or stay)	Days 1-5: \$250 copay per day Days 6-90: \$0 copay Days 91 and beyond: \$0 copay  Our plan covers an unlimited number of days for an inpatient hospital stay.	<input checked="" type="checkbox"/>
Outpatient Hospital Coverage	\$250 copay for outpatient surgeries \$0 copay for diagnostic colonoscopies \$0 copay for observation visits	<input checked="" type="checkbox"/>
Doctor Visit - Primary Care Provider	\$0 copay	<input type="checkbox"/>
Doctor Visit - Specialist	\$45 copay  No referral needed. However, organizational authorization may be required for out-of-network and tertiary specialists.	<input checked="" type="checkbox"/>
Preventive Care (Medicare-covered zero cost sharing preventive services)	\$0 copay	<input checked="" type="checkbox"/>

PREMIUMS & BENEFITS	THE HEALTH PLAN SECURECARE OPTION II (HMO) H3672-020	MAY REQUIRE PRIOR APPROVAL*
<b>Emergency Care (Worldwide)</b>	\$90 copay  If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. Covered emergency services outside of U.S. have a \$25,000 annual plan maximum.	<input type="checkbox"/>
<b>Urgently Needed Services</b>	\$45 copay  If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgently needed services.	<input type="checkbox"/>
<b>Diagnostic Radiological Service (such as MRIs, CT scans)</b>	\$0 or \$150 copay  \$150 for CT scans, MRI, MRA, PET and SPECT scans. \$0 copay for all diagnostic mammograms and diagnostic bone density exams.	<input checked="" type="checkbox"/>
<b>Therapeutic Radiological Services (such as radiation treatment for cancer)</b>	20% co-insurance	<input checked="" type="checkbox"/>
<b>Lab Services</b>	\$0 copay	<input type="checkbox"/>
<b>Diagnostic Tests and Procedures</b>	\$50 copay	<input type="checkbox"/>
<b>Outpatient X-rays</b>	\$50 copay for Medicare-covered X-ray services	<input checked="" type="checkbox"/>

PREMIUMS & BENEFITS	THE HEALTH PLAN SECURECARE OPTION II (HMO) H3672-020	MAY REQUIRE PRIOR APPROVAL*
<b>Hearing Services</b>	<p>Medicare-covered hearing exam: \$45 copay</p> <p><u>Routine Hearing</u></p> <p>Hearing exam: \$0 copay for one exam every year</p> <p>Hearing aids: Hearing aids are covered up to one per ear, every two years</p> <ul style="list-style-type: none"> <li>- \$599 copayment for Advanced level hearing aid</li> <li>- \$899 copayment for Premium level hearing aid</li> <li>- Includes 2-year supply of batteries per aid (non-rechargeable models only) after purchase</li> <li>- \$0 copay for provider visits for fittings and adjustments, covered for 12 months after hearing aid purchase</li> </ul> <p>TruHearing provider must be used.</p>	<input type="checkbox"/>
<b>Medicare-Covered Dental Services</b>	<p>\$45 copay</p> <p>This does not include services in connection with care, treatment, filling, removal, or replacement of teeth.</p>	<input checked="" type="checkbox"/>

PREMIUMS & BENEFITS	THE HEALTH PLAN SECURECARE OPTION II (HMO) H3672-020	MAY REQUIRE PRIOR APPROVAL*
<b>Routine Dental Services</b>	<p>This plan covers preventive and comprehensive dental services</p> <p>You pay a \$0 copay for:</p> <ul style="list-style-type: none"> <li>• 2 oral exams every year</li> <li>• 2 cleanings and 1 set of bitewing X-rays every year</li> <li>• 1 full mouth X-ray every 3 years</li> </ul> <p>This plan also covers up to a \$1,000 allowance for covered comprehensive dental services every year. You pay \$0 for covered diagnostic service charges, 20%-50% for covered restorative dental service charges and 50% for covered endodontic, periodontic, prosthodontic and oral surgery service charges. This includes but is not limited to:</p> <ul style="list-style-type: none"> <li>• Fillings</li> <li>• Root canal</li> <li>• Periodontal scaling and root planing</li> <li>• Extractions</li> <li>• Crowns</li> <li>• Dentures</li> </ul> <p>Not every covered dental service is listed here. Also, most services have limits that are not included above. Contact us for more details.</p> <p>You must use participating providers for routine dental services. You can find the dental directory on our website at <a href="http://healthplan.org/medicare">healthplan.org/medicare</a>, or by calling us at 1.877.847.7915 (TTY: 711).</p>	<div data-bbox="1354 1020 1393 1062">☑</div>

<b>PREMIUMS &amp; BENEFITS</b>	<b>THE HEALTH PLAN SECURECARE OPTION II (HMO) H3672-020</b>	<b>MAY REQUIRE PRIOR APPROVAL*</b>
<b>Optional Supplemental Dental</b>	Additional comprehensive dental benefits are available for purchase, with a separate monthly premium. See the "Optional Supplemental Benefits" section in the back of this book.	<input type="checkbox"/>
<b>Vision Services: Medicare-covered exam to diagnose and treat conditions of the eye</b>	\$0 copay	<input type="checkbox"/>
<b>Vision Services: Medicare-covered eyewear</b>	\$0 copay  Limited coverage of eyewear related to cataract surgery.	<input type="checkbox"/>
<b>Vision Services: Routine eye exam</b>	\$0 copay for one exam every year  Routine vision services are provided through plan participating providers. Contact the plan for more details.	<input type="checkbox"/>
<b>Vision Services: Routine eyewear</b>	\$0 copay  This plan has a coverage limit for routine eyewear. We will cover up to \$100 toward glasses (lens and frames) or contacts (including fitting exam) every two years if purchased at a participating provider.	<input type="checkbox"/>
<b>Inpatient Mental Health Services (Per admission or stay)</b>	Days 1-5: \$250 copay per day Days 6-90: \$0 copay	<input checked="" type="checkbox"/>
<b>Outpatient Individual or Group Mental Health Therapy Visit</b>	\$40 copay for Medicare-covered sessions	<input checked="" type="checkbox"/>
<b>Skilled Nursing Facility (Per benefit period, as defined by Original Medicare)</b>	Days 1-20: \$0 copay Days 21-100: \$178 copay per day  This plan covers up to 100 days in a skilled nursing facility during each benefit period.	<input checked="" type="checkbox"/>
<b>Physical Therapy</b>	\$40 copay	<input checked="" type="checkbox"/>



PREMIUMS & BENEFITS	THE HEALTH PLAN SECURECARE OPTION II (HMO) H3672-020	MAY REQUIRE PRIOR APPROVAL*
<b>Ambulance</b> Authorization required for non-emergency Medicare services.	\$250 copay for all other ambulance services. \$500 copay for air ambulance services The above cost shares are for Medicare-covered ambulance services only. Emergency transportation is covered worldwide. Covered emergency transportation services outside of the U.S. have a \$25,000 annual plan maximum.	<input type="checkbox"/>
<b>Transportation (Routine)</b>	\$0 copay Covered up to 35 round trips to any health-related location, with a plan coverage maximum of \$1,000 per year. Services must be arranged with our approved vendor.	<input checked="" type="checkbox"/>
<b>Medicare Part B Drugs</b> Part B drugs may be subject to step therapy. See Evidence of Coverage for details	20% co-insurance	<input checked="" type="checkbox"/>
<b>Ambulatory Surgery Center</b>	\$250 copay	<input checked="" type="checkbox"/>
<b>ADDITIONAL BENEFITS</b>		
<b>Medicare-Covered Foot Exams and Treatment (Podiatry)</b>	\$45 copay	<input checked="" type="checkbox"/>
<b>Routine Foot Care (Podiatry)</b>	\$45 copay Routine foot care is covered for up to 2 visits every year.	<input checked="" type="checkbox"/>
<b>Durable Medical Equipment (like wheelchairs and oxygen) and Prosthetics (like braces and artificial limbs)</b>	20% co-insurance Must meet certain criteria to be covered. Contact the plan for more details.	<input checked="" type="checkbox"/>

PREMIUMS & BENEFITS	THE HEALTH PLAN SECURECARE OPTION II (HMO) H3672-020	MAY REQUIRE PRIOR APPROVAL*
<b>Diabetic Monitoring Supplies</b>	<p>\$7.50 copay for a 30-day supply of test strip/lancet items. Coverage is limited to 100 strips for a 30-day supply. Additional quantity requires coverage review.</p> <p>0% co-insurance for preferred blood glucose monitors.</p> <p>Diabetic monitoring devices and test strips are limited to LifeScan products.</p>	<input checked="" type="checkbox"/>
<b>Medicare-Covered Diabetes Self-Management</b>	<p>\$0 copay</p> <p>Diabetes self-management training is covered under certain conditions. Contact the plan for details</p>	<input type="checkbox"/>
<b>Diabetic Therapeutic Shoes or Inserts</b>	20% co-insurance	<input checked="" type="checkbox"/>
<b>Health/Wellness Programs (e.g., fitness, tobacco cessation, etc.)</b>	<p>\$0 copay</p> <p>SilverSneakers is the fitness program covered by this plan.</p>	<input type="checkbox"/>
<b>Home Health Services</b>	\$0 copay	<input checked="" type="checkbox"/>
<b>Cardiac/Pulmonary Rehabilitation Services</b>	\$0 copay	<input checked="" type="checkbox"/>
<b>Chiropractic Services</b>	<p>\$20 copay</p> <p>Medicare covered chiropractic services only</p>	<input checked="" type="checkbox"/>
<b>Over-the-Counter Items (OTC)</b>	<p>\$60 allowance every 3 months</p> <p>The unused quarterly allowance amount will not carry over to the next quarter. Unused amounts will not carry over to the next calendar year.</p> <p>Services must be accessed through our contracted vendor.</p>	<input type="checkbox"/>

PREMIUMS & BENEFITS	THE HEALTH PLAN SECURECARE OPTION II (HMO) H3672-020	MAY REQUIRE PRIOR APPROVAL*
<b>Telehealth Services</b>	\$0 copay  This applies to phone or virtual visits with our telehealth vendor providers: <ul style="list-style-type: none"> <li>• Primary Care Physician Services</li> <li>• Physician Specialist Services</li> <li>• Individual Sessions for Mental Health Specialty Services</li> <li>• Individual Sessions for Psychiatric Services</li> <li>• Individual Sessions for Outpatient Substance Abuse</li> </ul> Services must be accessed through our contracted vendor.	<input type="checkbox"/>
<b>Meals</b>	\$0 copay for meals provided through the approved vendor.  When you get home after an inpatient hospital stay or immediately following surgery, we cover up to 2 home delivered meals per day for 7 days after discharge. Covered up to 4 times per year.	<input checked="" type="checkbox"/>
<b>Personal Emergency Response System (PERS)</b>	\$0 copay  Includes the monitoring device and monthly monitoring fees.  Services must be accessed through our contracted vendor.	<input type="checkbox"/>

\*SERVICES WITH ☒ MAY REQUIRE YOUR PROVIDER TO OBTAIN PRIOR AUTHORIZATION FROM THE PLAN.

## Prescription Coverage

THE HEALTH PLAN SECURECARE – OPTION II (HMO) H3672-020				
<b>Outpatient Prescription Drugs</b>	This plan provides Part D Rx coverage.			
<b>Cost Sharing</b>	<p>Costs may differ based on pharmacy type/status (i.e., preferred/non-preferred, mail order, long term care, home infusion) and prescription day supply.</p> <p>There are preferred retail pharmacies in our network. You will generally pay a lower copay at a preferred network pharmacy.</p> <p><b>If you qualify for low-income subsidy (LIS), also known as Medicare’s “Extra Help” program, the amount you pay in some stages may be different than what is listed.</b></p> <p>For more information, please call us or access our Evidence of Coverage or formulary online at <a href="http://healthplan.org/medicare">healthplan.org/medicare</a>.</p>			
<b>Stage 1: Annual Prescription (Part D) Deductible</b>	<p>\$0 per year for Tier 1 and Tier 2 Part D prescription drugs</p> <p>\$100 per year for Tier 3, Tier 4, and Tier 5 Part D prescription drugs</p>			
<b>Stage 2: Initial Coverage</b>	<p>After you pay your yearly deductible, you pay the amount listed in the table(s) until your total yearly drug costs reach <b>\$4,430</b>.</p> <p>Total yearly drug costs are the total drug costs paid by both you and our Part D plan.</p>			
	<b>Preferred Retail Pharmacy 30-day supply</b>	<b>Standard Retail Pharmacy 30-day supply</b>	<b>Preferred Mail Order Pharmacy 30-day supply</b>	<b>Standard Mail Order Pharmacy 30-day supply</b>
<b>Tier 1: Preferred Generic</b>	\$3	\$13	\$3	\$13
<b>Tier 2: Generic</b>	\$10	\$20	\$10	\$20
<b>Tier 3: Preferred Brand</b>	\$47	\$47	\$47	\$47
<b>Tier 4: Non-Preferred Drug</b>	\$100	\$100	\$100	\$100
<b>Tier 5: Specialty (Extended day supply not available in this Tier)</b>	31%	31%	31%	31%

THE HEALTH PLAN SECURECARE – OPTION II (HMO) H3672-020				
	Preferred Retail Pharmacy 90-day supply	Standard Retail Pharmacy 90-day supply	Preferred Mail Order Pharmacy 90-day supply	Standard Mail Order Pharmacy 90-day supply
<b>Tier 1: Preferred Generic</b>	\$9	\$39	\$0	\$39
<b>Tier 2: Generic</b>	\$30	\$60	\$0	\$60
<b>Tier 3: Preferred Brand</b>	\$141	\$141	\$94	\$141
<b>Tier 4: Non-Preferred Drug</b>	\$300	\$300	\$200	\$300
<b>Tier 5: Specialty (Extended day supply not available)</b>	N/A	N/A	N/A	N/A
<b>Stage 3: Coverage Gap</b>	Most Medicare drug plans have a coverage gap. This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches \$4,430. After you enter the coverage gap, you pay 25% of the price for brand name drugs plus a portion of the drug dispensing fee, and 25% of the price for generic drugs until your costs total \$7,050.			
<b>Stage 4: Catastrophic Coverage</b>	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$7,050, you pay the greater of 5% of the cost, or \$3.95 copay for generic (or a preferred multi-source drug) and a \$9.85 copayment for all other drugs.			

## Optional Supplemental Benefits - Dental

This coverage is available to you for an additional monthly cost of **\$22.90**. This will be in addition to your The Health Plan SecureCare HMO monthly premium.

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

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

<b>Monthly Premium</b>	<b>\$22.90</b>
<b>Maximum Benefit – Plan Coverage Limit</b>	<b>\$1,500 per year</b>

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

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



## Discrimination is Against the Law

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

- 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, audio, accessible electronic formats, other 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, contact The Health Plan Customer Service Department.

If you believe that The Plan 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: The Health Plan Appeals Coordinator, 1110 Main Street, Wheeling, WV 26003, Phone: 1.877.847.7907, TTY: 711, Fax 740.699.6163, Email: [info@healthplan.org](mailto:info@healthplan.org). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance The Health Plan Customer Service Department is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1.800.368.1019, 1.800.537.7697 (TDD).

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

ATTENTION: If you speak English, language assistance services, free of charge, are available to you.  
Call 1-877-847-7907 (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-847-7907 (TTY: 711).

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 1-877- 847-7907 (TTY : 711)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-847-7907 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان.  
اتصل برقم 1.877.847.7907 (رقم هاتف الصم والبكم: 711).

Wann du Deutsch (Pennsylvania German / Dutch) schwetzschst, kannsch du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-877-847-7907 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-847-7907 (телетайп: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-847-7907 (ATS: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-847-7907 (TTY: 711).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-877-847-7907 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-847-7907 (TTY: 711).번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-847-7907 (TTY: 711).

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。1-877-847-7907 (TTY: 711) まで、お電話にてご連絡ください。

AANDACHT: Als u Nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-877-847-7907 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-877-847-7907 (телетайп: 711).

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-877-847-7907 (TTY: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877- 847-7907 (TTY : 711).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-877-847-7907 (TTY: 711).

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-877- 847-7907 (टिटीवाइ: 711)।

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای تماس بگیرید. 1-877- 847-7907 (TTY: 711) شما فراهم می باشد.

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں 1-877- 847-7907 (TTY: 711) دستیاب ہیں۔ کال کریں

