2027

Summary of Benefits

SCAN Embrace Together (HMO-POS I-SNP)

Maricopa and Pima Counties

January 1, 2027 – December 31, 2027

SCAN Embrace Together (HMO-POS I-SNP) is an HMO plan with a Medicare contract. Enrollment in SCAN Health Plan depends on contract renewal. You must continue to pay your Medicare Part B premium.

The benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please request the *"Evidence of Coverage"* by calling our Member Services Department at the phone number listed in this document or online at www.scanhealthplan.com.

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27C-SBH1822008

scan™

SUMMARY OF BENEFITS

JANUARY 1, 2027 – DECEMBER 31, 2027

PREMIUM AND BENEFITS	SCAN Embrace Together		WHAT YOU SHOULD KNOW
	In-Network Services	**Out-of-Network Services**	
Monthly Health Plan Premium	$0		You must continue to pay your Medicare Part B premium **Those with Full Medicaid pay $0**.
Plan Deductible	You pay a $283 deductible per year combined for in-network and out-of-network services in 2026. This amount may change for 2027. See outpatient prescription drugs section for Part D deductible.		The deductible applies to Medicare-covered medical services **Those with Full Medicaid pay $0.**
Maximum Out-of-Pocket Responsibility (this does not include prescription drugs)	$9,850 combined In-Network and Out-of-Network		The most you pay for copays and coinsurance for **Medicare-covered medical services** for the year.
Inpatient Hospital Coverage	In 2026, the amounts for each benefit period* are: • $1,736 deductible per benefit period • $0 per day for days 1-60 • $434 copay per day for days 61-90 • $868 copay per day for each "lifetime reserve day" 1-60 These are 2026 copays. The amounts may change in 2027.	Not covered	**Prior authorization** rules may apply. You are covered for up to 90 days per benefit period*. You are also covered up to 60 additional days for days 91 and beyond per lifetime. **Those with Full Medicaid pay $0**

PREMIUM AND BENEFITS	SCAN Embrace Together		WHAT YOU SHOULD KNOW
	In-Network Services	**Out-of-Network Services**	
Outpatient Hospital Services			**Prior authorization** rules apply for outpatient hospital services. **Those with Full Medicaid pay $0.**
• Ambulatory Surgical Center	20% of the total cost	Not covered	
• Outpatient Hospital	20% of the total cost	Not covered	
• Observation services	20% of the total cost	Not covered	
Doctor Visits			
• Primary Care	$0	Not covered	
• Specialists	20% of the total cost	20% of the total cost	**Prior authorization** rules apply for specialist visits. **Those with Full Medicaid pay $0.**
Preventive Care	$0	Not covered	**Prior authorization** rules apply.
Emergency Care	20% of the total cost for up to $115 per visit		You are covered for worldwide emergency services at Original Medicare reimbursable rates. **Those with Full Medicaid pay $0 (within the U.S.).**
Urgently Needed Services	20% of the total cost for up to $40 copay per visit		You are covered for worldwide urgent care services at Original Medicare reimbursable rates. **Those with Full Medicaid pay $0 (within the U.S.).**
Diagnostic Services/Labs/ Imaging			**Prior authorization** rules apply for diagnostic lab, and imaging services. **Those with Full Medicaid pay $0.**
• Lab services	$0	$0	
• Diagnostic tests and procedures	20% of the total cost	20% of the total cost	

PREMIUM AND BENEFITS	SCAN Embrace Together		WHAT YOU SHOULD KNOW
	In-Network Services	**Out-of-Network Services**	
• Outpatient X-rays	20% of the total cost	20% of the total cost	
• Therapeutic radiology	20% of the total cost	20% of the total cost	
• Diagnostic radiology (e.g., MRI, CT)	20% of the total cost	20% of the total cost	
Hearing Services			
• Medicare-covered diagnostic hearing and balance exam	20% of the total cost per visit	20% of the total cost per visit	**Prior authorization** rules apply for Medicare-covered diagnostic hearing and balance exams. **Those with Full Medicaid pay $0 for Medicare-covered services.**
• Non-Medicare-covered (routine) hearing exam	$0 for up to 1 visit every year	Not covered	You must go to a SCAN-contracted provider to obtain a routine hearing exam and hearing aids.
• Non-Medicare-covered (routine) hearing aids	$2,200 allowance You are covered for up to 2 hearing aids every 2 years	Not covered	
Dental Services			
Medicare-covered dental services	20%	20%	**Prior authorization** rules apply for Medicare-covered dental services.
Non-Medicare-covered dental services (routine)			
Benefit Maximum (Comprehensive)	Up to $2,000 every year	Not covered	You must go to a SCAN contracted dental provider.
Diagnostic and Preventive Services			Diagnostic and preventive services do not count toward the benefit maximum. Once the benefit maximum is reached, you are responsible for remaining costs.
• Oral Exams	$0 (2 per 12 months)	Not covered	
• Dental X-Rays (bitewing)	$0 (1 per 12 months)	Not covered	
• Prophylaxis (routine cleaning)	$0 (2 per 12 months)	Not covered	
• Fluoride Treatment	$0 (2 per 12 months)	Not covered	

PREMIUM AND BENEFITS	SCAN Embrace Together		WHAT YOU SHOULD KNOW
	In-Network Services	**Out-of-Network Services**	
Comprehensive Services			This plan does not cover all dental codes within each category. See your **Evidence of Coverage** for additional details on plan covered dental services, limitations and exclusions, and prior authorization requirements. **Prior authorization** rules may apply for Non-Medicare-covered dental services (routine).
• Restorative	$0	Not covered	
• Endodontics	$0	Not covered	
• Periodontics	$0	Not covered	
• Prosthodontics, Removable	$0	Not covered	
• Prosthodontics, Fixed	$0	Not covered	
• Oral and Maxillofacial Surgery	$0	Not covered	
Vision Services			
• Medicare-covered vision exam to diagnose/treat diseases of the eye	20%	20% of the total cost per visit	**Prior authorization** rules apply for Medicare-covered vision exam and glasses after cataract surgery. **Those with Full Medicaid pay $0 for Medicare-covered services.**
• Medicare-covered glasses after cataract surgery	20%	20% of the total cost	
• Non-Medicare-covered (routine) vision exam	$0 for up to 1 visit every year	Not covered	Routine vision services do not require prior authorization.
• Non-Medicare-covered (routine) vision coverage limit	You have an annual allowance for routine eyewear: • $300 if using an **EyeMed Select** vision provider • $350 if using an **EyeMed PLUS** vision provider	Not covered	Your allowance covers frames, lenses and lens options or contact lenses every 12 months. You must go to a SCAN-contracted vision provider to obtain routine vision services.

PREMIUM AND BENEFITS	SCAN Embrace Together		WHAT YOU SHOULD KNOW
	In-Network Services	**Out-of-Network Services**	
Mental Health Services			
• Inpatient visit	In 2026, the amounts for each benefit period* are: • $1,736 deductible per benefit period • $0 per day for days 1-60 • $434 copay per day for days 61-90 • $868 copay per day for each "lifetime reserve day" 1-60 These are 2026 copays. The amounts may change in 2027.	Not covered	**Prior authorization** rules apply for inpatient mental health hospitalization. You are covered for up to 90 days per benefit period.*You are also covered up to 60 additional days for days 91 and beyond per lifetime. **Those with Full Medicaid pay $0.**
• Outpatient individual/ group therapy visit	$0	20% of the total cost	**Prior authorization** rules apply for outpatient individual/ group therapy visits. **Those with Full Medicaid pay $0.**
• Outpatient individual/ group therapy visit with a psychiatrist	20% of the total cost	20% of the total cost	
Skilled Nursing Facility	In 2026, the amounts for each benefit period* are: • $0 for days 1-20 • $217 copay per day for days 21-100 These are 2026 copays. The amounts may change in 2027.	Not covered	**Prior authorization** rules apply for skilled nursing facility services. You are covered for up to 100 days per benefit period.* No prior hospitalization is required. **Those with Full Medicaid pay $0.**
Physical Therapy	20% of the total cost	Not covered	**Prior authorization rules** apply for

PREMIUM AND BENEFITS	SCAN Embrace Together		WHAT YOU SHOULD KNOW
	In-Network Services	**Out-of-Network Services**	
			outpatient physical therapy services. **Those with Full Medicaid pay $0.**
Ambulance	20% of the total cost	Not covered	**Prior authorization** rules apply for non-emergency and air ambulance services. **Those with Full Medicaid pay $0.**
Transportation (Non-Medicare-covered - routine)	$0 for up to 24 one-way trips per year You may use up to 24 of your 24 one-way trips to non-medical destinations (grocery store, health club, senior center, or places of worship) per year. This is an SSBCI benefit. Members must meet qualifying conditions.† 50-mile limit applies to each one-way trip	Not covered	You must use a SCAN-contracted provider to obtain routine transportation services.
Medicare Part B Drugs	$0 for Part B chemotherapy and other Part B drugs received at a pharmacy No more than 20% coinsurance for Part B chemotherapy and other Part B drugs received in any other setting	Not covered	**Prior authorization** rules apply to select drugs.

PREMIUM AND BENEFITS	SCAN Embrace Together		WHAT YOU SHOULD KNOW
	In-Network Services	**Out-of-Network Services**	
	$0 for a Part B insulin received at a pharmacy and furnished through an item of durable medical equipment, such as a medically necessary insulin pump No more than $35 for a one-month supply of a Part B insulin received in any other setting and furnished through an item of durable medical equipment, such as a medically necessary insulin pump		

* A benefit period begins the day you go into a hospital or SNF. The benefit period ends when you haven't received any inpatient hospital or SNF care for 60 days in a row.

OUTPATIENT PRESCRIPTION DRUGS (PART D DRUGS):

SCAN Embrace Together

You pay the following:

Part D Deductible	You pay the full cost of your Tier 3 through Tier 5 drugs until you have paid $700.

Drug Tier		**Retail**				**Mail-Order**	
		Preferred		**Standard**		**Preferred**	**Standard**
		30-day supply	**100-day supply**	**30-day supply**	**100-day supply**	**100-day supply**	**100-day supply**
Initial Coverage Stage							
Tier 1 (Preferred Generic)		$0	$0	$0	$0	$0	$0
Tier 2 (Generic)		$0	$0	$0	$0	$0	$0
Tier 3 (Preferred Brand)	Insulin	$0	$0	$0	$0	$0	$0
	Other Drugs	$42	$126	$47	$141	$126	$141
Tier 4 (Non-Preferred Drug)		30%	30%	30%	30%	30%	30%
Tier 5 (Specialty Tier)		25%	Not available	25%	Not available	Not available	Not available

Catastrophic Coverage Stage
After your yearly out-of-pocket drug costs reach $2,400, you pay $0 for all covered prescription drugs for the remainder of the year.

You won't pay more than $0 for a one-month supply of each insulin product covered by our plan on our "Drug List" (Formulary), no matter what cost-sharing tier it's on, even if you haven't paid your deductible. You won't pay more than $35 for a one-month supply of each insulin product covered through a coverage determination, appeal, or transition. During the Catastrophic Coverage Stage, you pay $0 for all covered insulin products.

Most adult Part D vaccines, including shingles, tetanus and travel vaccines, are covered by our plan at no cost to you across all Part D benefit stages, even if you haven't paid your deductible. Refer to your plan's "Drug List" (Formulary) or contact Embrace Member Services for coverage and cost-sharing details about specific vaccines.

Some of our network pharmacies have preferred cost-sharing. You may pay less for certain drugs if you use these pharmacies. Your cost-sharing may vary depending on the pharmacy you choose (e.g., Preferred Retail, Standard Retail, Preferred Mail-Order, Standard Mail-Order, Long Term Care (LTC), Home infusion, etc.) or whether you receive a one-month or a three-month supply or when you enter another phase of the Part D benefit or if you receive "Extra Help." For more information, please call our Embrace Member Services at the number provided in this document or access your Evidence of Coverage online. If you reside in a long-term care facility, your cost-sharing for a 31-day supply is the same as at a standard retail pharmacy for a 30-day supply. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.

ADDITIONAL BENEFITS

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

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	In-Network Services	**Out-of-Network Services**	
Acupuncture Services • Medicare-covered acupuncture care	20% of the total cost	20% of the total cost	**Prior authorization** rules apply. **Those with Full Medicaid pay $0.**
Chiropractic Services • Medicare-covered chiropractic care	20% of the total cost	Not covered	**Prior authorization** rules apply. **Those with Full Medicaid pay $0.**
FlexEssentials This includes: • Over-the-Counter (OTC) Products • Groceries (SSBCI)†	$200 per quarter with the FlexEssentials card $25 per month with the FlexEssentials card	Not covered Not covered	You receive a quarterly allowance to be used for eligible OTC items in-store at CVS retailers or home delivery. Unused balances will **not** roll over to the following quarter. You receive a monthly allowance for eligible grocery items at select grocery retailers. The benefit does **not** carry over to the following month. (SSBCI) stands for Special Supplemental Benefits for the Chronically Ill. Members must meet eligibility requirements before the benefit is provided.†

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	In-Network Services	**Out-of-Network Services**	
Best Buy Health Tech • Technology support to help you track and manage your health • Services are available by phone, remote, and at Best Buy locations	$0	Not covered	
Home Health Care (Medicare-covered)	$0	Not covered	**Prior authorization** rules apply.
Medical Equipment/Supplies			
• Durable Medical Equipment (e.g., wheelchairs, oxygen)	$0 for items $0-$99 20% of the total cost for items $100 or more	Not covered	**Prior authorization** rules apply for covered durable medical equipment, prosthetic devices, and certain diabetic supplies.
• Prosthetics (e.g., braces, artificial limbs)	$0 for items $0-$99	Not covered	
• Diabetic supplies	$0	Not covered	SCAN covers diabetic supplies such as glucose monitors, test strips, and control solution from a select manufacturer. Lancets are also covered and are available from all manufacturers.
• Continuous Glucose Monitors	$0 at the pharmacy; 20% of the total cost at the DME provider	Not covered	Preferred Continuous Glucose Monitors (i.e., Dexcom and Freestyle Libre) are available at network pharmacies with a prescription. All Medicare Part B covered Continuous Glucose Monitors are available through contracted Durable Medical Equipment providers. **Prior authorization** rules apply.

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	In-Network Services	**Out-of-Network Services**	
			Those with Full Medicaid pay $0
Telehealth Services • Urgent Care and Mental Health	$0	Not covered	**Urgent Care:** This benefit is for non-life threatening conditions such as, but not limited to, cough, flu, nausea, sore throat, fever and allergies. Visits with providers can be conducted by telephone or secure video capabilities from your computer or smart phone. Telehealth is not intended to replace your primary care doctor or specialist. **Behavioral Health:** This benefit allows you to connect with licensed Psychologists, Master's level therapists, or Psychiatrists via video visits 7 days a week by appointment. Behavioral telehealth visits with practitioners can be conducted by secure video capabilities from your computer, tablet, or smart phone. Behavioral telehealth is not intended to replace your medical groups mental health provider.

ADDITIONAL DETAILS AND CONTACT INFORMATION

SCAN Embrace Together	
Who can join?	**You must:** • have both Medicare Part A and Part B • live in the plan service area (Maricopa and Pima Counties, Arizona) • be a United States citizen or be lawfully present in the United States
Phone Number (Members)	**1-855-828-7226**
Phone Number (Non-Members)	**1-877-814-7226** Calling this number will direct you to a licensed insurance agent.
TTY	**711**
Hours of Operation	**October 1 to March 31:** 8 am to 8 pm, 7 days a week **April 1 to September 30:** 8 am to 8 pm, Monday through Friday Messages received on holidays and outside of our business hours will be returned within one business day.
Website	www.scanhealthplan.com

SCAN Embrace Together 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.

To get more information about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at https://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 call 1-877-486-2048.

This information is not a complete description of benefits. Call 1-855-828-7226 (TTY: 711) for more information.

†This is a special supplemental benefit for chronically ill members. That means, to get this benefit, you must have an eligible chronic condition such as heart disease, diabetes, cancer, lung disease, or dementia. Other chronic conditions may apply. Not all members with chronic conditions may qualify. See your Evidence of Coverage for a complete list of eligible chronic conditions and coverage criteria. For more information, please call Embrace Member Services.

You can get prescription drugs shipped to your home through our network mail-order delivery program. Express Scripts Pharmacy℠ is our Preferred mail-order pharmacy. While you can fill your prescription medications at any of our network mail-order pharmacies, you may pay less at the Preferred mail-order pharmacy. Typically, you should expect to receive your prescription drugs within 14 days from the time that Express Scripts mail-order pharmacy receives the order. If you do not receive your prescription drug(s) within this time, please contact SCAN Health Plan's Embrace Member Services at 1-855-828-7226, 8 am to 8 pm,

7 days a week from October 1 to March 31. From April 1 to September 30, hours are 8 am to 8 pm Monday through Friday (messages received on holidays and outside of our business hours will be returned within one business day). TTY: 711. For your mail-order prescriptions, you have the option to sign up for an automatic refill program by contacting Express Scripts Pharmacy at 1-866-553-4125, 24 hours a day, 7 days a week. TTY users call 711. You may opt out of automatic deliveries at any time. Other pharmacies are available in our network.

Out-of-network/non-contracted providers are under no obligation to treat plan members, except in emergency situations. Please call our Embrace Member Services number or see your Evidence of Coverage (EOC) for more information, including the cost-sharing that applies to out-of-network services.

Notice of Non-Discrimination and Accessibility

Discrimination is against the law

SCAN 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 (as defined in 45 CFR § 92.101(a)(2)). **SCAN Health Plan** does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

SCAN Health Plan:

- Provides reasonable modifications and free aids and services to people with disabilities to ensure effective communication 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 SCAN Health Plan Member Services between 8 am to 8 pm, 7 days a week from October 1 to March 31. From April 1 to September 30, hours are 8 am to 8 pm Monday through Friday (messages received on holidays and outside of our business hours will be returned within one business day) by calling a number listed below.

SCAN Member Services	
SCAN Health Plan (California)	1-800-559-3500
SCAN Health Plan (Arizona)	1-855-650-7226
SCAN Health Plan (Nevada)	1-855-827-7226
SCAN Health Plan (Oregon)	1-988-746-4712
SCAN Health Plan (Texas)	1-855-844-7226
SCAN Health Plan (Washington)	1-833-944-7226
SCAN DaVita Dialysis plans	1-800-399-7226
TTY: 711	

Filing a complaint

If you believe that SCAN Health Plan has not provided these services or has otherwise discriminated on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: **Peter Yanez, Civil Rights Coordinator, Attn: Grievance and Appeals Department, P.O. Box 22644, Long Beach, CA 90801-5644, 562) 989-5140, or FAX (562) 989-0958.** You can file a grievance in person or by mail, or fax. If you need help filing a grievance, **Peter Yanez, Civil Rights Coordinator**, is available to help you.

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the OCR 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
Phone: 1-800-368-1019, TDD 1-800-537-7697

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

English - ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-855-650-7226 (TTY: 711) or speak to your provider.

Spanish - ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-855-650-7226 (TTY: 711) o hable con su proveedor.

Simplified Chinese - 中文 - 注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-855-650-7226（文本电话：711）或咨询您的服务提供商。

Traditional Chinese - 台語

注意：如果您說台語，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-855-650-7226（TTY：711）或與您的提供者討論。」

Korean – 한국어 - 주의: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-855-650-7226(TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.

Vietnamese - Việt - LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-855-650-7226 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

Arabic

العربية

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-855-650-7226 (711) أو تحدث إلى مقدم الخدمة.

French - ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-855-650-7226 (TTY: 711) ou parlez à votre fournisseur.

Tagalog - PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-855-650-7226 (TTY: 711) o makipag-usap sa iyong provider.

German - ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-855-650-7226 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

Hindi - हिंदी - ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-855-650-7226 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

Japanese - 日本語 - 注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-855-650-7226（TTY：711）までお電話ください。または、ご利用の事業者にご相談ください。

Farsi

فارسي

توجه: اگر وارد کردن زبان صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. با شماره 1-855-650-7266 (تله‌تایپ: 711) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید.

Russian – РУССКИЙ - ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-855-650-7226 (TTY: 711) или обратитесь к своему поставщику услуг.

Telugu – తెలుగు - సావధానం: మీరు తెలుగు మాట్లాడితే, మీకు ఉచిత భాషా సహాయ సేవలు అందుబాటులో ఉంటాయి. యాక్సెస్ చేయగల ఫార్మాట్‌లలో సమాచారాన్ని అందించడానికి తగిన సహాయక సహాయాలు మరియు సేవలు కూడా ఉచితంగా అందుబాటులో ఉంటాయి. 1-855-650-7226 (TTY: 711)కి కాల్ చేయండి లేదా మీ ప్రొవైడర్‌తో మాట్లాడండి.

Portuguese - ATENÇÃO: Se você fala português, serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-855-650-7226
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