# 2027

# Summary of Benefits

## SCAN Inclusive (HMO)

## San Francisco County

January 1, 2027 – December 31, 2027

SCAN Inclusive (HMO) 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-SBH5425149

scan™

## SUMMARY OF BENEFITS

JANUARY 1, 2027 – DECEMBER 31, 2027

| PREMIUM AND BENEFITS | SCAN Inclusive | WHAT YOU SHOULD KNOW |
|---|---|---|
| **Monthly Health Plan Premium** | $2 | You must continue to pay your Medicare Part B premium. |
| **Plan Deductible** | No deductible for medical services.<br>See outpatient prescription drugs section for Part D deductible. | |
| **Maximum Out-of-Pocket Responsibility (this does not include prescription drugs)** | $2,500 | The most you pay for copays and coinsurance for **Medicare-covered medical services** for the year. |
| **Inpatient Hospital Coverage** | $250 copay per day for days 1-4<br>$0 for days 5-90+<br>Unlimited days per admission | **Prior authorization** rules may apply. |
| **Outpatient Hospital Services** | | **Prior authorization** rules apply for outpatient hospital services. |
| • Ambulatory Surgical Center | $125 copay | |
| • Outpatient Hospital | $175 copay | |
| • Observation services | $0 | |
| **Doctor Visits** | | |
| • Primary Care | $0 | |
| • Specialists | $0 | **Prior authorization** rules apply for specialist visits. |
| **Preventive Care** | $0 | **Prior authorization** rules apply. |
| **Emergency Care** | $120 copay per visit | The emergency room copay will be waived if you are immediately admitted to the hospital. You are covered for worldwide emergency services at Original Medicare reimbursable rates. |

| PREMIUM AND BENEFITS | SCAN Inclusive | WHAT YOU SHOULD KNOW |
|---|---|---|
| **Urgently Needed Services** | $0 | You are covered for worldwide urgent care services at Original Medicare reimbursable rates. |
| **Diagnostic Services/Labs/Imaging** | | **Prior authorization** rules apply for diagnostic, lab, and imaging services. |
| • Lab services | $0 | |
| • Diagnostic tests and procedures | $0 | |
| • Outpatient X-rays | $0 | |
| • Therapeutic radiology | 20% of the total cost | |
| • Diagnostic radiology (e.g., MRI, CT) | $50 copay per visit | |
| **Hearing Services** | | |
| • Medicare-covered diagnostic hearing and balance exam | $0 | **Prior authorization** rules apply for Medicare-covered diagnostic hearing and balance exams. |
| • Non-Medicare-covered (routine) hearing exam | $0 for up to 1 visit every year | You must go to a SCAN-contracted provider to obtain a routine hearing exam and hearing aids. |
| • Non-Medicare-covered (routine) hearing aids | $550 copay per aid for a NationsHearing Basic hearing aid or $950 copay per aid for a NationsHearing Prime hearing aid<br>You are covered for up to 2 hearing aids every year | |
| **Dental Services** | | |
| **Medicare-covered dental services** | $0 | **Prior authorization** rules apply for Medicare-covered dental services. |
| **Non-Medicare-covered dental services (routine)** | | You must go to a SCAN contracted dental provider. |
| **Benefit Maximum (Comprehensive)** | Up to $1,000 every year | Diagnostic and preventive services do not count toward the benefit maximum. Once the benefit maximum is reached, you are responsible for remaining costs. |
| **Diagnostic and Preventive Services** | | This plan does not cover all dental codes within each |
| • Oral Exams | $0 (2 per 12 months) | |
| • Dental X-Rays (bitewing) | $0 (1 per 12 months) | |
| • Prophylaxis (routine cleaning) | $0 (2 per 12 months) | |
| • Fluoride Treatment | $0 (2 per 12 months) | |

| PREMIUM AND BENEFITS | SCAN Inclusive | WHAT YOU SHOULD KNOW |
|---|---|---|
| **Comprehensive Services** | | category. Member cost-share and periodicity vary by the applicable dental code. See your **Evidence of Coverage** for additional details on plan covered dental services, limitations and exclusions, and prior authorization requirements.<br><br>**Prior authorization** rules may apply for Non-Medicare-covered dental services (routine). |
| • Restorative | 25% | |
| • Endodontics | 25% | |
| • Periodontics | $0-25% | |
| • Prosthodontics, Removable | 25% | |
| • Prosthodontics, Fixed | 25% | |
| • Oral and Maxillofacial Surgery | 25% | |
| **Vision Services** | | |
| • Medicare-covered vision exam to diagnose/treat diseases of the eye | $0 | **Prior authorization** rules apply for Medicare-covered vision exam and glasses after cataract surgery. |
| • Medicare-covered glasses after cataract surgery | $0 | Routine vision services do not require prior authorization. |
| • Non-Medicare-covered (routine) vision exam | $0 for up to 1 visit every year | Your allowance covers frames, lenses and lens options or contact lenses every 12 months.<br><br>You must go to a SCAN-contracted vision provider to obtain routine vision services. |
| • Non-Medicare-covered (routine) vision coverage limit | You have an annual allowance for routine eyewear:<br>• $250 if using an **EyeMed Select** vision provider<br>• $300 if using an **EyeMed PLUS** vision provider | |
| **Mental Health Services** | | |
| • Inpatient visit | $900 copay per stay | **Prior authorization** rules apply for inpatient mental health hospitalization. You are covered for up to 90 days per benefit period.* |
| • Outpatient individual/group therapy visit | $10 copay per visit | **Prior authorization** rules apply for outpatient individual/group therapy visits. |
| • Outpatient individual/group therapy visit with a psychiatrist | $10 copay per visit | |

| PREMIUM AND BENEFITS | SCAN Inclusive | WHAT YOU SHOULD KNOW |
|---|---|---|
| **Skilled Nursing Facility** | $0 for days 1-20<br>$125 copay per day for days 21-100 | **Prior authorization** rules apply for skilled nursing facility services. You are covered for up to 100 days per benefit period.*<br>No prior hospitalization is required. |
| **Physical Therapy** | $15 copay per visit | **Prior authorization** rules apply for outpatient physical therapy services. |
| **Ambulance** | $175 copay per one-way trip | **Prior authorization** rules apply for non-emergency and air ambulance services. |
| **Transportation (Non-Medicare-covered - routine)** | $0 for up to 32 one-way trips per year<br>You may use up to 32 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.†<br>50-mile limit applies to each one-way trip | You must use a SCAN-contracted provider to obtain routine transportation services. |
| **Medicare Part B Drugs** | No more than 20% coinsurance for Part B chemotherapy and other Part B drugs<br>No more than $35 for a one-month supply of a Part B insulin furnished through an item of durable medical equipment, such as a medically necessary insulin pump | **Prior authorization** rules apply to select drugs. |

* 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 Inclusive**

**You pay the following:**

| | |
|---|---|
| **Part D Deductible** | You pay the full cost of your Tier 3 through Tier 5 drugs until you have paid $250. |

| **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 | $10 | $20 | $0 | $20 |
| **Tier 2** (Generic) | $0 | $0 | $12 | $24 | $0 | $24 |
| **Tier 3** (Preferred Brand) – Insulin | $35 | $85 | $35 | $85 | $85 | $85 |
| **Tier 3** (Preferred Brand) – Other Drugs | $42 | $126 | $47 | $141 | $126 | $141 |
| **Tier 4** (Non-Preferred Drug) | 35% | 35% | 35% | 35% | 35% | 35% |
| **Tier 5** (Specialty Tier) | 30% | Not available | 30% | 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 $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible. 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 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 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.

| PREMIUM AND BENEFITS | SCAN Inclusive | WHAT YOU SHOULD KNOW |
|---|---|---|
| **Acupuncture Services** | | |
| • Medicare-covered acupuncture care | $0 | **Prior authorization** rules apply. |
| • Routine acupuncture care | $10 for up to 30 visits per year (in combination with routine chiropractic services) | You do not need a referral for an initial routine acupuncture visit. Any subsequent visits require **prior authorization**.<br>You must use a SCAN-contracted provider to obtain routine acupuncture services. |
| **At-Home Support** | | **Prior authorization** rules apply. |
| • In-home care | $0 up to 40 hours of personal in-home care per year, delivered in 4 hour increments, after recent hospitalization or hip/knee replacement or when to assist with two or more activities of daily living. | |
| • Meals (home-delivered) | $0 up to 63 meals per year, delivered in installments of 21 meals per week, after recent hospitalization.<br>$0 up to 63 meals per year, delivered in installments of 21 meals per week, due to record of qualifying chronic condition. | |
| • Respite care | $0 up to 20 hours per year, delivered in 4 hour increments, to provide temporary relief to unpaid caregivers of member. | |
| **Chiropractic Services** | | |
| • Medicare-covered chiropractic care | $0 | **Prior authorization** rules apply. |
| • Routine chiropractic care | $10 for up to 30 visits per year (in combination with routine acupuncture services) | You do not need a referral for an initial routine chiropractor visit. Any subsequent visits require **prior authorization**. |

| PREMIUM AND BENEFITS | SCAN Inclusive | WHAT YOU SHOULD KNOW |
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| | | You must use a SCAN-contracted provider to obtain routine chiropractic services. |
| **FlexEssentials**<br>This includes:<br>• Over-the-Counter (OTC) Products | $50 per quarter with the FlexEssentials card | You receive a quarterly allowance to be used for eligible OTC items in-store at CVS retailers or home delivery.<br>The benefit does **not** carry over to the following quarter. |
| **Best Buy Health Tech**<br>• Technology support to help you track and manage your health<br>• Services are available by phone, remote, and at Best Buy locations | $0 | |
| **Home Health Care (Medicare-covered)** | $0 | **Prior authorization** rules apply. |
| **Legal Fee Reimbursement (SSBCI)†** | $200 per year reimbursement for health-related legal services, such as durable power of attorney and advanced directives | (SSBCI) stands for Special Supplemental Benefits for the Chronically Ill.<br>Members must meet eligibility requirements before the benefit is provided.† |
| **Medical Equipment/Supplies** | | |
| • Durable Medical Equipment (e.g., wheelchairs, oxygen) | $0 for items $0-$99<br>20% of the total cost for items $100 or more | **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<br>20% of the total cost for items $100 or more | |
| • Diabetic supplies | $0 | 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. |

| PREMIUM AND BENEFITS | SCAN Inclusive | WHAT YOU SHOULD KNOW |
|---|---|---|
| • Continuous Glucose Monitors | 20% of the total cost at the pharmacy or DME provider | 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.<br><br>**Prior authorization** rules apply. |
| **Fitness** | $0 fitness benefit through One Pass, including gym memberships, on-demand workouts, and community classes | |
| **Personal Emergency Response System (PERS) (NationsResponse)** | $0 for personal emergency response device and monitoring service to help you get assistance quickly during a fall or emergency | |
| **Telehealth Services**<br>• Urgent Care and Mental Health | $0 | **Urgent Care:**<br><br>This benefit is for non-life threatening conditions such as, but not limited to, cough, flu, nausea, sore throat, fever and allergies.<br><br>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.<br><br>**Behavioral Health:**<br><br>This benefit allows you to connect with licensed Psychologists, Master's level therapists, or Psychiatrists via video visits 7 days a week by appointment.<br><br>Behavioral telehealth visits with practitioners can be conducted by secure video capabilities |

| PREMIUM AND BENEFITS | SCAN Inclusive | WHAT YOU SHOULD KNOW |
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| | | 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 Inclusive | |
|---|---|
| **Who can join?** | **You must:**<br>• have both Medicare Part A and Part B<br>• live in the plan service area (San Francisco County, California)<br>• be a United States citizen or be lawfully present in the United States |
| **Phone Number (Members)** | **1-800-559-3500** |
| **Phone Number (Non-Members)** | **1-877-870-4867**<br><br>Calling this number will direct you to a licensed insurance agent. |
| **TTY** | **711** |
| **Hours of Operation** | **October 1 to March 31:**<br>8 am to 8 pm, 7 days a week<br><br>**April 1 to September 30:**<br>8 am to 8 pm, Monday through Friday<br><br>Messages received on holidays and outside of our business hours will be returned within one business day. |
| **Website** | www.scanhealthplan.com |

**SCAN Inclusive** 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 1-800-559-3500 (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 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 Member Services at 1-800-559-3500, 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.

**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 1-800-559-3500 (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 1-800-559-3500 (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 1-800-559-3500（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 1-800-559-3500（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. 1-800-559-3500(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 1-800-559-3500 (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 1-800-559-3500 (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 1-800-559-3500 (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 1-800-559-3500 (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 1-800-559-3500 (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। 1-800-559-3500 (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。1-800-559-3500（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 1-800-559-3500 (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 1-800-559-3500 (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. 1-800-559-3500 (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 1-800-559-3500
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