2027 Summary of Benefits

Banner Medicare Advantage Prime HMO (H5843-001)

This is a summary of drug and health services covered January 1, 2027 - December 31, 2027.

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. The Evidence of Coverage (EOC) provides a complete list of services we cover. You can see it online at www.BannerHealth.com/MA or you can call our Customer Care Center for help.

Hours of Operation

You can call us from 8 a.m. to 8 p.m., seven days a week.

How to Contact Us

If you are a member of this plan, call toll-free 844-549-1857, TTY 711.

If you are not a member of this plan, call toll-free 844-549-1858, TTY 711.

Our website: www.BannerHealth.com/MA.

Who Can Join?

To join Banner Medicare Advantage Prime, 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 county in Arizona: Maricopa.

Which Doctors, Hospitals, and Pharmacies Can I Use?

Banner Medicare Advantage Prime has a network of doctors, hospitals, pharmacies, and other providers. If you use providers that are not in our network, the plan may not pay for these services.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. You can view our provider and pharmacy directories on our website: www.BannerHealth.com/MA.

Or call us, and we will send you a copy of the provider directory and pharmacy directory.

What Do We Cover?

Like all Medicare health plans, we cover everything that Original Medicare covers – *however, we cover even more.*

- Our plan members get all the benefits covered by Original Medicare.
- Our plan members also get more than what is covered by Original Medicare.
- Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website at www.BannerHealth.com/MA.
- Or call us, and we will send you a copy of the formulary.

H5843_MApd001S27_M

Tips For Comparing Your Medicare Choices

This Summary of Benefits booklet gives you a summary of what Banner Medicare Advantage Prime covers and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklet, or use the Medicare Plan Finder on medicare.gov
- 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, or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

Legal Information

Banner Medicare Advantage Prime HMO has a contract with Medicare. Enrollment depends on contract renewal.

Out-of-network / non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our Customer Care Center or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year.



Plan Premium, Deductible, and Maximum Out-of-Pocket (MOOP)

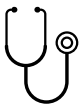
Out-of-Pocket Costs	
Monthly Plan Premium	**$0** per month. You must continue to pay your Medicare Part B premium.
Annual Medical Deductible	This plan does not have a medical deductible.
Maximum Out-of-Pocket (does not include prescription drugs)	**$2,995** This is the most you will pay out-of-pocket each year for Medicare-covered services and supplies received from network providers. When you reach the maximum out-of-pocket, our plan pays 100% of covered medical services. Out-of-pocket costs paid for your Part D prescription drugs are not included in this amount.

Medical and Hospital Benefits



Hospital Coverage and Ambulatory Surgery Center

Benefit	What you pay
Inpatient Hospital Stay	Per benefit period: **$275 copayment** per day for days 1-7 **$0 copayment** per day for days 8-90 Our plan covers 90 days per benefit period for Medicare-covered inpatient hospital stays. A benefit period begins the day you go into a hospital. The benefit period ends when you haven't received any inpatient hospital care for 60 days in a row. If you go into a hospital after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods. Prior authorization is required.
Outpatient Hospital Services	**$200 copayment** per visit. **$0 copayment** per visit for diagnostic preventive colonoscopy. May require prior authorization.
Hospital Observation Services	**$200 copayment per stay**
Ambulatory Surgery Center	**$100 copayment** per visit. **$0 copayment** per visit for diagnostic preventive colonoscopy. May require prior authorization.



Primary Care Provider (PCP) and Specialist Visits

Benefit	What you pay
PCP	**$0 copayment**
Specialist	**$35 copayment** May require prior authorization.

Preventive Care Screenings and Annual Physical Exam

Here's a list of the covered Medicare preventive services:

- Abdominal aortic aneurysm screenings
- Alcohol misuse screenings & counseling
- Bone mass measurements
- Cardiovascular disease screenings
- Cardiovascular disease (behavioral therapy)
- Cervical and vaginal cancer screenings
- Colorectal cancer screenings:
  - Blood based biomarker tests
  - Colonoscopies
  - Computed tomography (CT) colonography
  - Fecal occult blood tests
  - Flexible sigmoidoscopies
  - Multi-target stool DNA tests
- Counseling to prevent tobacco use and tobacco-caused disease
- Depression screenings
- Diabetes screenings
- Diabetes self-management training
- Glaucoma screenings
- Hepatitis B (HBV) virus screenings
- Hepatitis C virus screenings
- Human immunodeficiency virus (HIV) services:
  - HIV screenings
  - Pre-exposure prophylaxis (PrEP) for HIV prevention
- Lung cancer screenings
- Mammograms (screening)
- Medical nutrition therapy services
- Medicare Diabetes Prevention Program
- Obesity behavioral therapy
- Preventive visits:
  - "Welcome to Medicare" preventive visit
  - Yearly "Wellness" visit
- Prostate cancer screenings
- Sexually transmitted infections screenings and counseling
- Vaccines (or shots):
  - COVID-19 vaccines
  - Flu vaccines
  - Hepatitis B vaccines
  - Pneumococcal vaccines

Any additional preventive services approved by Medicare during the contract year will be covered. For more information on Medicare covered preventive services, please refer to the Evidence of Coverage online at www.BannerHealth.com/MA or call us.

Benefit	What you pay
Preventive Care (Medicare-covered)	**$0 copayment**
Annual Physical Exam	**$0 copayment**

Emergency and Urgent Care

Benefit	What you pay
Emergency Care	**$150 copayment**
Worldwide Emergency Care	This plan includes a **$25,000** annual benefit amount (allowance) every year for the worldwide benefit. **$150 copayment**
Urgent Care	**$0 copayment**

Diagnostic Labs, Tests, and Radiological Services

Benefit	What you pay
Diagnostic Tests and Procedures	**$0 copayment** May require prior authorization.
Lab Services	**$0 copayment** May require prior authorization.
Diagnostic Radiology Services (e.g., MRIs, CT scan, Nuclear Medicine Services, etc.)	**$125 copayment** May require prior authorization.
Outpatient X-rays	**$0 copayment** May require prior authorization.
Therapeutic Radiology Services (e.g. Radiation Therapy for Cancer, etc.)	**$60 copayment** Prior authorization is required.

Hearing Services

You must use Banner Medicare Advantage Prime's network of contracted providers for these services.

Benefit	What you pay
Hearing Exam (Medicare-covered)	**$0 copayment**



Hearing Services (continued)

Benefit	What you pay
Routine Hearing Exam	**$0 copayment** Limit 1 exam every year.



Dental Services

You must use Banner Medicare Advantage Prime's network of contracted providers for these services.

Benefit	What you pay
Dental Services (Medicare-covered)	**20% coinsurance**
Combined Preventive and Comprehensive Dental Services	This plan includes up to a **$1,000** annual allowance for preventive and comprehensive dental services. Cost of all visits will be deducted from yearly coverage amount. Any cost above **$1,000** is your responsibility.
Preventive Dental Services	**$0 copayment** Preventive coverage includes: • Oral exam – 2 per calendar year • Cleaning – 2 per calendar year • Fluoride - 2 per calendar year • Bitewing x-ray – 1 per calendar year Covered dental services are subject to conditions, limitations, exclusions, and maximums. Please refer to the plan's Evidence of Coverage for details.



Dental Services (continued)

Benefit	What you pay
Comprehensive Dental Services	**50% coinsurance** per service for all comprehensive dental services. Comprehensive coverage includes: • Restorative services • Endodontics • Periodontics • Removable prosthodontics • Maxillofacial prosthetics • Fixed prosthodontics • Oral and maxillofacial Surgery • Adjunctive general services Covered dental services are subject to conditions, limitations, exclusions, and maximums. Please refer to the plan's Evidence of Coverage for details. Prior authorization is required for all comprehensive dental services with the exception of removable prosthodontics.

Network dentists have agreed to provide services at an in-network rate. If you see a network dentist, you can't be billed more than the in-network rate.



Vision Services

You must use a VSP Advantage network provider for non-Medicare vision services.

Benefit	What you pay
Eye Exam (Medicare-covered)	**0% coinsurance** Includes annual glaucoma screening.
Eyewear (Medicare-covered)	**20% coinsurance** for Medicare-covered eyeglasses or contact lenses after cataract surgery.
Routine Eye Exam	**$0 copayment** for annual routine eye (eye refraction) exam. Limit 1 exam every year.



Vision Services (continued)

Benefit	What you pay
Routine Eyewear	This plan includes up to a **$100** annual allowance for frames or contact lenses (fitting). Eyeglasses (lenses and frames) are limited to one pair every year or contact lenses. • Single vision, lined bifocal, lined trifocals covered every year. • Standard progressive lenses covered every year. • Additional savings of 20%-25% on additional lens upgrades. Discounts do not apply at Costco or Walmart / Sams Club. Any costs above annual allowances or additional lens upgrades are member responsibility. **$25 copayment** for routine eyeglasses (lenses and frames). **$0 copayment** for routine contact lenses (in lieu of glasses).



Mental Health Services

Benefit	What you pay
Outpatient Mental Health Services (Individual or Group Sessions)	**$25 copayment** per individual or group visit with a mental health professional (non-psychiatrist).
Psychiatric Services (Individual or Group Sessions)	**$25 copayment** per individual or group visit with a psychiatrist.
Intensive Outpatient Program Services	**$55 copayment** May require prior authorization.
Partial Hospitalization Program	**$55 copayment** May require prior authorization.

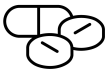
Skilled Nursing Facility and Rehabilitation Services

Benefit	What you pay
Skilled Nursing Facility (Medicare-covered)	Per benefit period: **$0 copayment per day for days 1-20** **$178 copayment per day for days 21-100** Our plan covers 100 days per benefit period for Medicare-covered skilled nursing facility (SNF). A benefit period begins the day you go into a SNF. The benefit period ends when you haven't received any inpatient skilled care in a SNF for 60 days in a row. If you go into a SNF after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods. Prior authorization is required.
Occupational Therapy	**$20 copayment** Prior authorization is required.
Physical Therapy and Speech Therapy	**$20 copayment** Prior authorization is required.
Cardiac Rehabilitation Services	**$25 copayment** Prior authorization is required.
Intensive Cardiac Rehabilitation Services	**$25 copayment** Prior authorization is required.
Pulmonary Rehabilitation Services	**$20 copayment**
Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD)	**$25 copayment** Prior authorization is required.



Ambulance and Transportation Services

Benefit	What you pay
Ambulance Services	**$265 copayment** for Medicare-covered ground or air transport. Cost sharing applies to each one-way trip. Prior authorization is required for non-emergency Medicare ambulance services.
Routine Transportation (non-emergent)	**Not covered.**



Medicare Part B Drugs

Medicare-covered Part B Drugs may be subject to step therapy requirements.

Benefit	What you pay
Medicare Part B Drugs	**0% to 20% coinsurance** for chemotherapy, radiation, and other Medicare Part B drugs. May require prior authorization.
Medicare Part B Insulin	**0% to 20% coinsurance, up to a $35 maximum per month**

Cost sharing shown is the maximum you will pay for Part B prescription drugs. You may pay less for certain drugs.

Other Benefits



Chiropractic Care

Benefit	What you pay
Chiropractic Visit (Medicare-covered)	**$20 copayment** Prior authorization is required.



Dialysis and Kidney Disease Services

Benefit	What you pay
Dialysis Services (Medicare-covered)	**20% coinsurance**
Kidney Disease Education Services	**$0 copayment** Referral is required.



Fitness Benefit

Benefit	What you pay
Physical Fitness Benefit	**$0 copayment** for access to fitness clubs, classes and kits. Fitness classes/fitness kits provided by the Silver&Fit® program. The Silver&Fit program® is one of the largest and most diverse healthy aging and exercise programs nationally, which focuses on: • Fitness center membership • Digital fitness videos • Home fitness tools The Silver&Fit program is provided by American Specialty Health Fitness, Inc., a subsidiary of American Specialty Health Incorporated (ASH). Silver&Fit and the Silver&Fit logo are trademarks of ASH and used with permission here. Kits are based on availability and subject to change. Fitness center participation may vary by location and is subject to change.



Foot Care (Podiatry Services)

Benefit	What you pay
Foot Exams and Treatment (Medicare-covered)	**$0 copayment** Prior authorization is required.



Home Delivered Meals

Benefit	What you pay
Home Delivered Meals	**$0 copayment** for up to 14 meals delivered to the member's home immediately following surgery or after each inpatient stay in a hospital or skilled nursing facility. Meals must be ordered within 30 days of discharge. Benefit coordination assistance from the plan will be provided as needed. Referral is required.



Home Health Care

Benefit	What you pay
Home Health Care	**$0 copayment** May require prior authorization.



Medical Equipment and Supplies

Benefit	What you pay
Durable Medical Equipment (e.g., wheelchairs, oxygen)	**20% coinsurance** May require prior authorization.
Prosthetics (e.g., braces, artificial limbs)	**20% coinsurance** May require prior authorization.
Medical Supplies	**20% coinsurance** May require prior authorization.
Diabetic Shoes and Inserts	**20% coinsurance** for Medicare-covered therapeutic shoes and inserts. Prior authorization is required.
Diabetic Monitors	**$0 copayment** for Medicare-covered diabetic monitors. Prior authorization is required.



Medical Equipment and Supplies (continued)

Benefit	What you pay
Diabetic Monitoring Supplies	**$0 copayment** for Medicare-covered diabetic monitoring supplies such as blood glucose test strips, lancets, supplies for external infusion pumps, supply allowance for continuous glucose monitors, and blood glucose control/calibration solutions. Diabetic monitoring supplies and services are limited to certain manufacturers. When diabetic supplies are obtained at a pharmacy, select insulin supplies are available at a **$0 copayment** after the Part D deductible has been met. For a list of select insulin supplies that have a $0 copayment, refer to the plan's formulary located on our website at www.BannerHealth.com/MA. May require prior authorization.



Nurse Advice Line

Benefit	What you pay
Nurse On Call	**$0 copayment** for health care advice, 24 hours a day, 7 days a week, from a nursing professional to help answer your immediate health care questions.



Opioid Treatment Program Services and Outpatient Substance Use Disorder

Benefit	What you pay
Opioid Treatment Program Services (Medicare-covered)	**$20 copayment** Prior authorization is required.
Outpatient Substance Use Disorder Services (Individual or Group Sessions)	**$20 copayment**



Other Medicare-covered Preventive Services

Benefit	What you pay
Digital Rectal Exam	**$0 copayment**
EKG Following Welcome to Medicare Visit	**$0 copayment**



Over the Counter (OTC) Benefit

Benefit	What you pay
OTC Benefits	Each quarter you are enrolled with the plan you receive a **$65** allowance loaded to your &more card to purchase OTC items such as aspirin, vitamins, cold and cough preparations, and bandages. OTC items are non-prescription drugs that are not normally covered by a Medicare Prescription Drug Plan. Unused funds do not roll over and expire at the end of the quarter. For complete program details including instructions, store locator, for a list of eligible OTC items that may be accessed using your &more card, for issues using your &more card and terms and conditions, please visit andmorehealth.com or the andmore mobile app or by calling 1-855-AND-MORE (1-855-263-6673). &more Benefits Prepaid Mastercard® is issued by Avidia Bank, pursuant to a license from Mastercard Incorporated. Use of this card is subject to the terms and conditions of the Cardholder Agreement.



Rewards

Rewards	
Annual Wellness Visit	**$50 reward** for completion during the plan benefit year.
Breast Cancer Screening	**$25 reward** for completion during the plan benefit year.
Colorectal Cancer Screening	**$25 reward** for completion during the plan benefit year.



Telehealth Services

Benefit	What you pay
Telehealth Services (Medicare-covered)	**$0 to $35 copayment** May require prior authorization.

Medicare Part D Prescription Drugs

As shown below, there are “drug payment stages” for your Medicare Part D prescription drug coverage under Banner Medicare Advantage Prime. How much you pay for a drug depends on which of these stages you are in at the time you get a prescription filled or refilled. You may get drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy. Please call us or access our Evidence of Coverage online at www.BannerHealth.com/MA.

Prescription Drug Stages	
Out-of-Pocket Threshold	**$2,400**
Prescription Drug Deductible	There is no deductible for drugs in Tier 1 and Tier 2. Coverage for drugs on these tiers begin in the Initial Coverage Stage. There is a **$540** deductible for drugs in Tier 3, Tier 4, Tier 5. You pay the full cost for your drugs in these tiers until you reach the deductible amount. When the deductible amount has been met, you will move to the Initial Coverage Stage.
Initial Coverage Limit	During the Initial Coverage Stage, the plan pays its share of the cost of your drugs, and you pay your share of the cost until your total yearly out-of-pocket drug costs reach **$2,400**. Total yearly out-of-pocket drug costs are the total copayment or coinsurance costs paid by you. You may get your drugs at network retail pharmacies and mail order pharmacies.
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$2,400**, the plan pays the full cost for your covered Part D drugs. You pay nothing.

Generally, we cover drugs filled at an out-of-network pharmacy only when you are not able to use a network pharmacy. Prescriptions filled at an out-of-network pharmacy are covered at the same cost sharing as an in-network pharmacy. For more information on your prescription drug benefit, please call us, or access the Evidence of Coverage online at www.BannerHealth.com/MA.

Initial Coverage Stage

Every drug on the plan's Drug List is on one of 5 cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug.

One-month Supply

This chart shows your share of the cost when you get a **one-month (31-day) supply** of a covered Part D prescription drug:

Tier	What you pay	
	Standard Retail	**Standard Mail Order**
Tier 1: Preferred Generic	$0 copayment	$0 copayment
Tier 2: Generic	$5 copayment	$5 copayment
Tier 3: Preferred Brand	$47 copayment	$47 copayment
Tier 4: Non-Preferred Brand	44% coinsurance	44% coinsurance
Tier 5: Specialty	27% coinsurance	27% coinsurance

This chart shows your share of the cost when you get a **one-month (31-day) supply** of a covered Part D prescription insulin drug:

Tier	What you pay	
	Standard Retail	**Standard Mail Order**
Tier 1: Covered Insulin	$0 copayment	$0 copayment
Tier 2: Covered Insulin	You pay the lesser of 25% coinsurance or $5 copayment	You pay the lesser of 25% coinsurance or $5 copayment
Tier 3: Covered Insulin	You pay the lesser of 25% coinsurance or $35 copayment	You pay the lesser of 25% coinsurance or $35 copayment
Tier 4: Covered Insulin	You pay the lesser of 25% coinsurance or $35 copayment	You pay the lesser of 25% coinsurance or $35 copayment

Long-term Supply

This chart shows your share of the cost when you get a **long-term (90-day) supply** of a covered Part D prescription drug:

Tier	What you pay	
	Standard Retail	**Standard Mail Order**
Tier 1: Preferred Generic	$0 copayment	$0 copayment
Tier 2: Generic	$15 copayment	$10 copayment
Tier 3: Preferred Brand	$141 copayment	$94 copayment
Tier 4: Non-Preferred Brand	44% coinsurance	44% coinsurance
Tier 5: Specialty	A long-term supply is not available for drugs in Tier 5	A long-term supply is not available for drugs in Tier 5

This chart shows your share of the cost when you get a **long-term (90-day) supply** of a covered Part D prescription insulin drug:

Tier	What you pay	
	Standard Retail	**Standard Mail Order**
Tier 1: Covered Insulin	$0 copayment	$0 copayment
Tier 2: Covered Insulin	You pay the lesser of 25% coinsurance or $15 copayment	You pay the lesser of 25% coinsurance or $10 copayment
Tier 3: Covered Insulin	You pay the lesser of 25% coinsurance or $105 copayment	You pay the lesser of 25% coinsurance or $70 copayment
Tier 4: Covered Insulin	You pay the lesser of 25% coinsurance or $105 copayment	You pay the lesser of 25% coinsurance or $70 copayment
Tier 5: Covered Insulin	A long-term supply is not available for drugs in Tier 5	A long-term supply is not available for drugs in Tier 5

If you receive “Extra Help”:

If you receive "Extra Help" for your drugs you will have a $0 deductible. Prior to reaching your annual **$2,400** out-of-pocket limit you will pay one of the following depending on your level of "Extra Help":

- Generics (including brand drugs treated as generics): $0, $1.65, or $5.80 (each prescription)
- All other drugs: $0, $5.00, or $14.40 (each prescription)

After reaching your annual $2,400 out-of-pocket limit, you will pay $0 for the remainder of the calendar year, regardless of the level of "Extra Help" you receive. Additional information will be available on your Low-Income Subsidy (LIS) rider.

Cost sharing may change depending on the pharmacy you choose, when you enter another phase of the Part D benefit and if you qualify for "Extra Help." To find out if you qualify for "Extra Help," please contact the Social Security Office at 1-800-772-1213 (TTY: 1-800-325-0778), Monday – Friday, 8 a.m. – 7 p.m. For more information on your prescription drug benefit, please call us or access your Evidence of Coverage online at www.BannerHealth.com/MA.

Important message about what you pay for Part D vaccines: Our plan covers many vaccines at no cost to you.

Important message about what you pay for Part D insulins: 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 or Part D phase you are in.

Please refer to the Drug List for a list of covered drugs, vaccines and insulin. A copy of the Drug List can be found on our website, www.BannerHealth.com/MA.

Banner Medicare Advantage

Banner Medicare Advantage Prime HMO

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English: We provide free language assistance services and auxiliary aids and services. To request these free services, call us at 844-549-1857, TTY 711, 8 a.m. to 8 p.m., seven days a week.

Spanish: Ofrecemos servicios gratuitos de asistencia lingüística y ayudas y servicios auxiliares. Para solicitar estos servicios gratuitos, llámenos al 844-549-1857, TTY 711, de 8 a.m. a 8 p.m., siete días a la semana.

Navajo: Bilagáana bizaad bee áká'a'doowoł dóó bee áká'a'doowołígíí t'áá jíík'é bee nihił yá'át'éehgo áńdaalyaa. Díí t'áá jíík'e bee áká'a'doowoł biniiyé, kojį' béésh bee hodíilnih 844-549-1857, TTY 711, 8 a.m. dóó 8 p.m. t'áá ákwíí jí bee.

Chinese: 我们提供免费的语言帮助服务以及辅助设备和服务。如需这些免费服务，请致电 844-549-1857 (TTY 711)，工作时间为每周七天，每天上午 8 点至晚上 8 点。

Vietnamese: Chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ và thiết bị hỗ trợ hoàn toàn miễn phí. Để yêu cầu các dịch vụ miễn phí này, vui lòng gọi cho chúng tôi theo số 844-549-1857, TTY 711, từ 8 giờ sáng đến 8 giờ tối, bảy ngày trong tuần.

Arabic: نقدِّم خدمات مساعدة لغوية مجانية، ووسائل وأدوات مساعدة إضافية. لطلب هذه الخدمات المجانية، يُرجى الاتصال بنا على الرقم 844-549-1857، أو عبر هاتف TTY على الرقم 711، طوال أيام الأسبوع من الساعة 8 صباحًا حتى الساعة 8 مساءً.

Tagalog: Nagbibigay kami ng mga libreng serbisyo na tulong sa wika at mga auxiliary aid at serbisyo. Upang humiling ng mga libreng serbisyo na ito, tawagan kami sa 844-549-1857, TTY 711, 8 a.m. hanggang 8 p.m., pitong araw sa isang linggo.

Korean: 당사는 언어 지원 서비스와 지원 도구 및 서비스를 무료로 제공합니다. 이러한 무료 서비스를 요청하려면 844-549-1857, TTY 711 번으로 연락해 주십시오. 주 7일, 오전 8시부터 오후 8시까지 운영합니다.

French: Nous offrons des services d'assistance linguistique gratuits ainsi que des aides et services auxiliaires. Pour demander ces services gratuits, appelez-nous au 844-549-1857, TTY 711, de 8 h a.m. à 8 h p.m., sept jours sur sept.

German: Wir bieten kostenlose Sprachunterstützung sowie Hilfsmittel und Dienstleistungen an. Um diese kostenlosen Dienstleistungen in Anspruch zu nehmen, rufen Sie uns bitte unter der Nummer 844-549-1857, TTY 711, von 8 a.m. bis 8 p.m., sieben Tage die Woche, an.

Russian: Мы бесплатно оказываем услуги языковой поддержки, а также дополнительные услуги и поддержку. Чтобы запросить такие бесплатные услуги, свяжитесь с нами по номеру 844-549-1857, TTY 711, в любой день недели с 8 утра до 8 вечера.

Japanese: 無料の言語および補助器具の支援サービスを提供しています。これらの無料サービスをご希望の場合は、844-549-1857（TTY 711）までお電話ください。一週間（月曜日から日曜日まで）8 a.m.から8 p.m.まで対応しております。

Persian: ما خدمات رایگان کمک زبانی و تسهیلات و خدمات جانبی را فراهم می‌کنیم. برای درخواست این خدمات رایگان، با شماره تلفن 844-549-1857، TTY 711 از ساعت 8 صبح تا 8 شب، هفت روز هفته تماس بگیرید.

Syriac: ܒܫܢܝ ܕܥ ܬܫܡܫ ܒܠܫܢܐ ܕܐܬܪܐ ܘܓܝܪ ܫܘܠ ܕܐܬܪ ܕܐܦ ܫܘܠ ܕܐܬܪ ܕܐܦ ܫܘܠ ܕܐܬܪ ܕܐܦ