

# Benefits for the whole you.

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## 2022 Summary of Benefits

January 1 - December 31, 2022

Highmark Wholecare  
Medicare Assured  
Diamond<sup>SM</sup>

Highmark Wholecare  
Medicare Assured  
Ruby<sup>SM</sup>

The benefit information provides a summary of what we cover and what you pay.

It does not list every benefit, limit or exclusion. To get a complete list of benefits we cover, go to [HighmarkWholecare.com](https://www.HighmarkWholecare.com) where you can view or download the Evidence of Coverage. Or you can call 1-877-428-3929 (TTY 711) and request one be mailed to you.

Our hours of operation are 8 a.m. to 8 p.m.,  
seven days a week from October 1 to March 31.  
From April 1 to September 30, you can  
call us Monday through Friday from  
8 a.m. to 8 p.m.



# Pennsylvania Service Area

To join Highmark Wholecare Medicare Assured Diamond or Highmark Wholecare Medicare Assured Ruby, you must live in our service area, which includes the following counties.



- Bucks • Chester • Delaware • Montgomery • Philadelphia

Highmark Wholecare offers HMO plans with a Medicare contract. Enrollment in these plans depends on contract renewal.

Health benefits or health benefit administration may be provided by or through Highmark Wholecare, coverage by Gateway Health Plan, an independent licensee of the Blue Cross Blue Shield Association (“Highmark Wholecare”).

# Highmark Wholecare Medicare Advantage Plans

## Dual Eligible Special Needs (DSNP) Plan Highlights

	Highmark Wholecare Medicare Assured Diamond <sup>SM</sup> (HMO SNP) <sup>†</sup>		Highmark Wholecare Medicare Assured Ruby <sup>SM</sup> (HMO SNP) <sup>††</sup>
Monthly Plan Premium	\$0	Monthly Plan Premium	\$0*
Primary Care Visits	\$0	Primary Care Visits	\$0
Deductible	\$0	Deductible	\$0
Preventive Care	\$0	Preventive Care	\$0
Urgent & Emergency Care	In and out-of-network	Urgent & Emergency Care	In and out-of-network
Diagnostic Services/ Labs/Imaging	\$0	Diagnostic Services/ Labs/Imaging	as low as \$0
Generic Prescriptions	as low as \$0	Generic Prescriptions	as low as \$0

<sup>†</sup> To be eligible for the Diamond plan, you must have Medicare Parts A and B and Medical Assistance (FBDE, QMB+, SLMB+, or QMB) and you must live in our service area.

<sup>††</sup> To be eligible for the Ruby plan, you must have Medicare Parts A and B and Medical Assistance (SLMB or QI) and you must live in our service area.

\* \$0-\$40.70 depending on your level of Medicaid eligibility and/or level of Extra Help.

### GUIDE TO ACRONYMS:

**(FBDE) Full Benefit Dual Eligible:** An individual is medically needy or in certain special income levels for institutionalized or home and community-based waivers.

**(QMB+) Qualified Medicare Beneficiary Plus:** Helps pay Medicare Part A and Part B premiums and other cost-sharing (like deductibles, coinsurance and copayments). People with QMB+ also have "full Medicaid benefits."

**(QMB) Qualified Medicare Beneficiary:** Helps pay Medicare Part A and Part B premiums and other cost-sharing like deductibles, coinsurance and copayments.

**(SLMB+) Specified Low-Income Medicare Beneficiary Plus:** Helps pay Part B premium, as well as all "full Medicaid benefits."

**(QI) Qualifying Individual:** Helps pay Part B premium but is limited to a first-come, first-served basis.

**(SLMB) Specified Low-Income Medicare Beneficiary:** Helps pay Part B premium.

Premiums and Benefits	Highmark Wholecare Medicare Assured Diamond <sup>SM</sup> (HMO SNP)	Highmark Wholecare Medicare Assured Ruby <sup>SM</sup> (HMO SNP)
Monthly Plan Premium	You pay \$0	You pay \$0*
Deductible	No deductible	No deductible
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	You pay no more than \$3,450 annually for in-network Medicare-covered services	You pay no more than \$6,700 annually for in-network Medicare-covered services
Inpatient Hospital <sup>^</sup>	You pay \$0 per day for days 1-90	You pay \$275 per day for days 1-5 You pay \$0 per day for days 6-90
Outpatient Hospital <sup>^</sup>	You pay \$0	Depending on the service provided, you pay between \$0 copay and 20% coinsurance
Ambulatory Surgery Center	You pay \$0	You pay \$200
Doctor Visits		
• Primary Care	You pay \$0	You pay \$0
• Specialists	You pay \$0	You pay \$25
Preventive Care (e.g., flu vaccine, cancer screenings)	You pay \$0	You pay \$0
Emergency Care	You pay \$0	You pay \$90+
Urgently Needed Services	You pay \$0	You pay \$45 <sup>#</sup>
Diagnostic Services/ Labs/Imaging <sup>^</sup>		
• Diagnostic tests and procedures	You pay \$0	You pay \$0
• Lab services	You pay \$0	You pay \$0
• MRI, CAT Scan	You pay \$0	You pay \$175
• X-Rays	You pay \$0	You pay \$35

\*\$0-\$40.70 depending on your level of Medicaid eligibility and/or level of Extra Help

<sup>^</sup>Prior authorization may be required

<sup>#</sup>Copay will not be waived if admitted to the hospital and cannot be applied toward deductible

<sup>+</sup>Copay will be waived if admitted to the hospital within 24 hours

Premiums and Benefits	Highmark Wholecare Medicare Assured Diamond <sup>SM</sup> (HMO SNP)	Highmark Wholecare Medicare Assured Ruby <sup>SM</sup> (HMO SNP)
<b>Hearing Services</b>		
<ul style="list-style-type: none"> <li>Routine hearing exam</li> <li>Hearing aid allowance</li> </ul>	<p>You pay \$0</p> <p>You pay \$0 copay for one TruHearing aid per ear every two years</p>	<p>You pay \$0</p> <p>You pay \$0 copay for one TruHearing aid every two years</p>
<b>Dental Services</b>		
<ul style="list-style-type: none"> <li>Preventive dental services</li> <li>Comprehensive dental services</li> <li>Dentures</li> <li>Annual Allowance</li> </ul>	<p>You pay \$0 for one cleaning, one oral exam, one x-ray every six months and one panoramic x-ray every five years</p> <p>You pay \$0 for fillings, simple extractions, two root canals, two crowns and periodontal maintenance every year</p> <p>You pay \$0 for dentures every year (applies to the \$5,000 comprehensive allowance)</p> <p>\$5,000 allowance for comprehensive services every year</p>	<p>You pay \$0 for one cleaning, one oral exam, one x-ray every six months and one panoramic x-ray every five years</p> <p>You pay \$0 for fillings, simple extractions, one root canal, one crown and periodontal maintenance every year</p> <p>You pay \$0 for dentures every five years (does not apply to the \$2,500 comprehensive allowance)</p> <p>\$2,500 allowance for comprehensive services every year</p>
<b>Vision Services (Davis Vision Network)</b>		
<ul style="list-style-type: none"> <li>Routine eye exam</li> <li>Eyewear</li> </ul>	<p>You pay \$0 for an annual exam</p> <p>You get one pair of glasses or contact lenses per year. Choose from the Davis Vision Collection of frames/contacts or use your \$600 allowance toward your choice of frames/contacts. Standard lenses are covered in full. Limited upgraded lens options are covered in full.</p>	<p>You pay \$0 for an annual exam</p> <p>You get one pair of glasses or contact lenses per year. Choose from the Davis Vision Collection of frames/contacts or use your \$200 allowance toward your choice of frames/contacts. Standard lenses covered in full.</p>
<b>Mental Health Services</b>		
<ul style="list-style-type: none"> <li>Outpatient group therapy/individual therapy visit</li> </ul>	<p>You pay \$0</p>	<p>You pay \$25</p>

Premiums and Benefits	Highmark Wholecare Medicare Assured Diamond <sup>SM</sup> (HMO SNP)	Highmark Wholecare Medicare Assured Ruby <sup>SM</sup> (HMO SNP)
Skilled Nursing Facility <sup>^</sup>	You pay \$0 per day for days 1-100	You pay \$0 per day for days 1-20 You pay \$184 per day for days 21-100
Outpatient Therapy <sup>^</sup> (Physical, Occupational and Speech)	You pay \$0	You pay \$25
Ambulance <sup>^</sup>	You pay \$0 each way for ground and air ambulance  Authorization required for non-emergency services	You pay \$200 each way for ground and air ambulance  Authorization required for non-emergency services
Transportation	You pay \$0 for 100 one-way trips each year (within a 60-mile radius) to plan approved, non-emergency health-related locations, such as doctor offices, pharmacies or fitness locations	You pay \$0 for 30 one-way trips each year (within a 60-mile radius) to plan approved, non-emergency health-related locations, such as doctor offices, pharmacies or fitness locations
Medicare Part B Drugs <sup>^</sup>	You pay \$0	You pay a 20% coinsurance of the total cost
Over-the-Counter Allowance	\$0 copay for OTC items. Up to \$375 allowance per quarter. Unused allowance amounts expire at the end of each quarter. All unused amounts expire at the end of the calendar year.	\$0 copay for OTC items. Up to \$125 allowance per quarter. Unused allowance amounts expire at the end of each quarter. All unused amounts expire at the end of the calendar year.
Home-Delivered Meals	You pay a \$0 copay for home-delivered meals. Limit of up to 28 meals (two per day) for 14 days.	You pay a \$0 copay for home-delivered meals. Limit of up to 14 meals (two per day) for seven days.
24/7 Nurse Line	There is no coinsurance, copayment or deductible for the toll-free Nurse Line. Provides telephonic coaching and nurse advice from trained clinicians, 24 hours a day, seven days a week.	There is no coinsurance, copayment or deductible for the toll-free Nurse Line. Provides telephonic coaching and nurse advice from trained clinicians, 24 hours a day, seven days a week.
Home Safety Items	\$0 copay for home and bathroom safety devices Limited to six items per year	\$0 copay for home and bathroom safety devices Limited to two items per year

<sup>^</sup>Prior authorization may be required

Premiums and Benefits	Highmark Wholecare Medicare Assured Diamond <sup>SM</sup> (HMO SNP)	Highmark Wholecare Medicare Assured Ruby <sup>SM</sup> (HMO SNP)
Personal Emergency Response System	You pay a \$0 copay for one personal emergency response system device per lifetime	You pay a \$0 copay for one personal emergency response system device per lifetime
Fitness Benefit	Provides membership at participating network fitness centers at no cost. Includes at-home fitness packs and access to virtual fitness classes.	Provides membership at participating network fitness centers at no cost. Includes at-home fitness packs and access to virtual fitness classes.

Part D drugs on next page



Premiums and Benefits	Highmark Wholecare Medicare Assured Diamond <sup>SM</sup> (HMO SNP)	Highmark Wholecare Medicare Assured Ruby <sup>SM</sup> (HMO SNP)
<b>Outpatient Prescription Drugs</b>		
Part D Deductible	You pay \$0	You pay \$0 or \$99*
<b>Initial Coverage Stage</b> Tier 1: <b>Preferred Generic</b>  Tier 2: <b>Generic</b>  Tier 3: <b>Preferred Brand</b>  Tier 4: <b>Non-Preferred</b>  Tier 5: <b>Specialty</b>	You pay \$0  You pay \$0, \$1.35 or \$3.95*  You pay \$0, \$1.35 or \$3.95, \$4.00 or \$9.85*  You pay \$0, \$1.35 or \$3.95, \$4.00 or \$9.85*  You pay \$0, \$1.35 or \$3.95, \$4.00 or \$9.85*	You pay \$0  You pay \$0, \$1.35 or \$3.95 or 15% of the total cost*  You pay \$0, \$1.35 or \$3.95, \$4.00 or \$9.85, or 15% of the total cost*  You pay \$0, \$1.35 or \$3.95, \$4.00 or \$9.85, or 15% of the total cost*  You pay \$0, \$1.35 or \$3.95, \$4.00 or \$9.85, or 15% of the total cost*
Coverage Gap Stage	For Tiers 1, 2, 3, 4 and 5 drugs you will pay your LIS level cost sharing	For Tiers 1, 2, 3, 4 and 5 drugs you will pay your LIS level cost sharing
Catastrophic Coverage Stage	During this stage, the plan will pay all of the costs for your drugs	During this stage, your share of the cost for a covered drug will be either: \$0; or a coinsurance or a copayment, whichever is the larger amount:  – <i>either</i> – Coinsurance of 5% of the cost of the drug – <i>or</i> – \$3.95 for a generic drug or a drug that is treated like a generic and \$9.85 for all other drugs. <b>Our plan pays the rest of the cost.</b>

\*Depending on your level of Medicaid eligibility and/or level of Extra Help

Some drugs may require prior authorization.

If you want to know more about the cost and coverage of Original Medicare, look in your current “Medicare & You” handbook. You can view it online at <http://www.medicare.gov> or get a copy by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, seven days a week. (TTY **1-877-486-2048**)





**At Highmark Wholecare,  
we're in the business of  
people care.**

# Summary of Medicaid-Covered Benefits

The benefits described below are covered by Medicaid. For each benefit listed below, you can see what Pennsylvania Medical Assistance (Medicaid) covers. What you pay for covered services may depend on your level of Medicaid eligibility.

This information is a summary of covered benefits, for additional information on the benefits covered by **Pennsylvania Medical Assistance (Medicaid)**, please contact them at 1-800-692-7462 (TTY users call 1-800-451-5886), or visit their website at <http://www.dhs.pa.gov>

Benefits	What You Pay Under Medicaid
<b>Inpatient Hospital Coverage</b>	\$3 Copay per day up to \$21 per admission Includes general hospitals, rehabilitation hospitals, drug and alcohol and private psychiatric hospitals
<b>Doctor Visits</b> (Primary Care and Specialists)	\$0-\$3.80 Copay for Medicaid-covered services Physician (Medical Doctor), Certified Registered Nurse Practitioner and Rural Health Clinic
<b>Emergency Care</b>	\$0 Copay for Emergency Services
<b>Urgently Needed Services</b>	\$0-\$3.80 Copay for Medicaid-covered services
<b>Diagnostic Services/ Labs/ Imaging</b>	\$0 Copay (laboratory); \$1 Copay (portable x-ray) \$1 Copay for each x-ray or \$0 for other medical diagnostic test or for treatment by nuclear medicine or radiation therapy
<b>Dental Services</b>	\$0-\$3.80 Copay for Medicaid-covered services <ul style="list-style-type: none"><li>• Diagnostic, preventive, restorative, surgical dental procedures, prosthodontics and sedation</li><li>• Key Limitations: Dentures: 1 per lifetime; Exams/prophylaxis: 1 per 180 days; Crowns, periodontics and endodontics: only via approved benefit limit exception</li></ul>
<b>Vision Services</b>	\$0-\$3.80 Copay for Medicaid-covered services <ul style="list-style-type: none"><li>• Optometrist (Eye Doctor)</li><li>• 2 exams per calendar year</li><li>• Eyeglass lenses, frames and contact lenses are limited to individuals with aphakia; 4 eyeglass lenses per calendar year; 2 eyeglass frames per calendar year; and 4 contact lenses per calendar</li></ul>
<b>Skilled Nursing Facility (SNF)</b>	\$0-\$3.80 Copay for Medicaid-covered services Nursing Facilities
<b>Ambulance (Emergency)</b>	\$0-\$3.80 Copay for Medicaid-covered services
<b>Transportation</b>	\$0 Copay for Medicaid-covered services Contact Medical Assistance Transportation (MATP) for information
<b>Foot Care</b>	\$0-\$3.80 Copay for Medicaid-covered services
<b>Medical Equipment/ Supplies</b>	\$0-\$3.80 Copay for Medicaid-covered services

Benefits	What You Pay Under Medicaid
<b>Prescription Drugs</b>	\$1-\$3 Copay for Medicaid-covered prescriptions <ul style="list-style-type: none"> <li>• \$1 for each prescription and prescription refill of a generic drug</li> <li>• \$3 for each prescription and prescription refill of a brand name drug</li> <li>• Nutritional supplements</li> </ul>
<b>Outpatient Surgery</b>	\$0-\$3.80 Copay for Medicaid-covered services Ambulatory Surgery Center (ASC) and Same Day Surgery (SPU); Independent Medical/Surgical Clinic
<b>Chiropractic Care</b>	\$0-\$3.80 Copay for Medicaid-covered services
<b>Drug and Alcohol Clinic Services</b>	\$0-\$3.80 Copay for Medicaid-covered services <ul style="list-style-type: none"> <li>• Includes methadone maintenance and clozapine</li> <li>• Refer to your Behavioral Health Managed Care Organization for details</li> </ul>
<b>Psychiatric Clinic</b>	\$0.50 per unit copay for Medicaid-covered services <ul style="list-style-type: none"> <li>• Includes mobile mental health treatment</li> <li>• Refer to your Behavioral Health Managed Care Organization for details</li> </ul>
<b>Psychiatric Partial Hospitalization Facility</b>	\$0 per unit copay for Medicaid-covered services Refer to your Behavioral Health Managed Care Organization for details
<b>Psychiatric Rehabilitation</b>	\$0-\$3.80 Copay for Medicaid-covered services Refer to your Behavioral Health Managed Care Organization for details
<b>Federally Qualified Health Center</b>	\$0-\$3.80 Copay for Medicaid-covered services
<b>Home Health Services</b>	\$0 Copay for Medicaid-covered services Includes nursing, aide and therapy services. Unlimited for the first 28 days; limited to 15 days every month thereafter.
<b>Hospice Care</b>	\$0-\$3.80 Copay for Medicaid-covered services Respite care may not exceed a total of 5 days in a 60-day certification period
<b>Long-Term Nursing Facility</b>	\$0-\$3.80 Copay for Medicaid-covered services In order to receive Long-term Nursing Facility or Home and Community-Based Waiver Services, individuals must meet clinical criteria to be considered Nursing Facility Clinically Eligible (NFCE)
<b>Home and Community Based Waiver Services</b>	\$0 Copay for Medicaid-covered services For more information, contact your Community HealthChoices MCO or the Office of Long-term Living
<b>Renal Dialysis</b>	\$0-\$3.80 Copay for Medicaid-covered services Renal Dialysis Center; Initial training for home dialysis is limited to 24 sessions per patient per calendar year. Backup visits to the facility are limited to 75 per calendar year.
<b>Therapy (Physical, Occupational, Speech)</b>	\$0-\$3.80 Copay for Medicaid-covered services Only when provided by a hospital, outpatient clinic, or home health provider
<b>Prosthetics and Orthotics</b>	\$0-\$3.80 Copay for Medicaid-covered services Orthopedic shoes and hearing aids are not covered. Coverage for low vision aids is limited to 1 per 2 calendar years. Coverage for an eye ocular is limited to 1 per calendar year.

# Important information for those receiving Extra Help.

Highmark Wholecare  
Medicare Assured  
Diamond<sup>SM</sup>

Highmark Wholecare  
Medicare Assured  
Ruby<sup>SM</sup>



## Monthly Plan Premium for People who Get Extra Help from Medicare to Help Pay for their Prescription Drug Costs

If you get Extra Help from Medicare to help pay for your Medicare prescription drug plan costs, your monthly plan premium will be lower than what it would be if you did not get Extra Help from Medicare. The amount of Extra Help you get will determine your total monthly plan premium as a member of our plan.

This table shows you what your monthly plan premium will be if you get Extra Help.

Your level of Extra Help	Highmark Wholecare Medicare Assured Diamond <sup>SM</sup> (HMO SNP)	Highmark Wholecare Medicare Assured Ruby <sup>SM</sup> (HMO SNP)
100%	\$0	\$0
75%	Does not apply	\$10.20
50%	Does not apply	\$20.30
25%	Does not apply	\$30.50

The amounts above do not include any Medicare Part B premium you may have to pay.

Highmark Wholecare Medicare Assured Diamond and Highmark Wholecare Medicare Assured Ruby premiums include coverage for both medical services and prescription drug coverage.

If you aren't getting Extra Help, you can see if you qualify by calling one of the following:

- 1-800-Medicare (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.
- Pennsylvania Medical Assistance (Medicaid) at 1-800-692-7462 between 8:30 a.m. and 4:45 p.m., Monday through Friday. TTY users should call 1-800-451-5886 or 711.
- Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call 1-800-325-0778.

**Highmark Wholecare sees a future in  
which everyone has equal opportunity to  
achieve their best health.**



# Enrollment information you need.

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## Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, we're here to help. To speak to a customer service representative, call 1-800-685-5209 (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 [HighmarkWholecare.com](https://www.HighmarkWholecare.com) or call 1-800-685-5209 (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 medicine 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. Depending on your level of Extra Help, part or all of this premium could be paid by Medicare. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213 (TTY 1-800-325-0778). You can also apply for Extra Help online at [www.socialsecurity.gov/prescriptionhelp](https://www.socialsecurity.gov/prescriptionhelp).
- Benefits, premiums and/or copayments/coinsurance 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).
- This plan is a dual eligible Special Needs Plan (DSNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and Medical Assistance from a state plan under Medicaid. Other restrictions may apply.

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

Highmark Wholecare:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- o 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:

- o Qualified interpreters
- o Information written in other languages

If you need these services, contact Member Services at 1-800-685-5209, 8 a.m - 8 p.m., 7 days a week from October 1 through March 31. From April 1 through September 30 our business hours are 8 a.m. - 8p.m., Monday through Friday. TTY users should call 711.

If you believe that Highmark Wholecare 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:

Appeals and Grievances

PO Box 22278

Pittsburgh, PA 15222

Phone: 1-844-207-0336

Fax: 1-412-255-4503

You can file a grievance by mail, or by fax. If you need help filing a grievance, Appeals and Grievances is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

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

## **ENGLISH**

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-685-5209 (TTY 711).

## **SPANISH**

ATENCIÓN: Si usted habla español, tenemos servicios de asistencia lingüística disponibles para usted sin costo alguno. Llame al 1-800-685-5209 (TTY 711).

## **CHINESE**

小贴士：如果您说普通话，欢迎使用免费语言协助服务。请拨 1-800-685-5209 (TTY 711)。

## **VIETNAMESE**

CHÚ Ý: Nếu quý vị nói tiếng Việt, thì có sẵn các dịch vụ trợ giúp ngôn ngữ miễn phí dành cho quý vị. Hãy gọi số 1-800-685-5209 (TTY 711).

## **KOREAN**

알림: 한국어를 하시는 경우 무료 통역 서비스가 준비되어 있습니다. 1-800-685-5209 (TTY 711)로 연락주시기 바랍니다.

## **TAGALOG**

Pansinin: Kung nagsasalita ka ng Tagalog, mga serbisyo ng tulong sa wika, nang walang bayad, ay magagamit sa iyo. Tawagan ang 1-800-685-5209 (TTY 711).

## **RUSSIAN**

ВНИМАНИЕ: Если вы говорите на русском языке, вам будут бесплатно предоставлены услуги переводчика. Звоните по телефону 1-800-685-5209 (телетайп 711).

## **ARABIC**

1-800-685-5209 ملاحظة: إذا كنت تتحدث العربية، تتوفر خدمات المساعدة اللغوية مجانًا من أجلك. اتصل بالرقم (الهاتف النصي 711).

## **FRENCH CREOLE**

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-685-5209 (TTY 711).

## **FRENCH**

ATTENTION : Si vous parlez français, des services gratuits d'interprétation sont à votre disposition. Veuillez appeler le 1-800-685-5209 (TTY 711).

## **POLISH**

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer 1-800-685-5209 (TTY 711).

## **PORTUGUESE**

ATENÇÃO: Se fala português, estão disponíveis serviços gratuitos de assistência linguística na sua língua. Telefone para 1-800-685-5209 (TTY 711).

## **ITALIAN**

ATTENZIONE: Se lei parla italiano, sono disponibili servizi gratuiti di assistenza linguistica nella sua lingua. Chiami 1-800-685-5209 (TTY 711).

## **JAPANESE**

お知らせ: 日本語での対応を望まれる方には、無料で通訳サービスをご利用になれます。電話番号 1-800-685-5209 (TTY 711) までお問い合わせ下さい。

## **GERMAN**

BITTE BEACHTEN: Wenn Sie Deutsch sprechen, stehen Ihnen unsere Dolmetscher unter der Nummer 1- 800-685-5209 (TTY 711) kostenlos zur Verfügung.





**DUTCH**

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-800-685-5209 (TTY 711).

**UKRAINIAN**

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-685-5209 (телетайп 711).

**ROMANIAN**

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistentă lingvistică, gratuit. Sunați la 1-800-685-5209 (TTY 711).