



# **2021 Summary of Benefits**

## **Bright Advantage Part B Savings (PPO)**

### **H3281-007**

January 1, 2021 – December 31, 2021

## SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

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. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage." You can also see the Evidence of Coverage on our website, <https://brighthouseplan.com/medicare-advantage>.

### You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **Bright Advantage Part B Savings (PPO)**).

### Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Bright Advantage Part B Savings (PPO)** 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 booklets. Or, use the Medicare Plan Finder on <https://www.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 <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 should call 1-877-486-2048.

### Sections in this booklet

- Things to Know About **Bright Advantage Part B Savings (PPO)**.
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services.
- Covered Medical and Hospital Benefits.
- Additional Benefits
- Prescription Drug Benefits.
- Optional Supplemental Benefits

### Things to Know About Bright Advantage Part B Savings (PPO)

#### Hours of Operation & Contact Information

- From October 1 to March 31 we're open 8 a.m. – 8 p.m. Local Time, 7 days a week, excluding Federal holidays.
- From April 1 to September 30, we're open 8 a.m. – 8 p.m. Local Time, Monday through Friday, excluding Federal holidays.
- If you are a member of this plan, call us at 1-844-221-7736, TTY: 711.
- If you are not a member of this plan, call us at 1-844-221-7736, TTY: 711.
- Our website: <https://brighthouseplan.com/medicare-advantage>.

## **Who can join?**

To join **Bright Advantage Part B Savings (PPO)**, you must have both Medicare Part A and Part B, and you must live in our service area, and be a United States citizen or are lawfully present in the United States. Our service area includes this county in Florida: Broward.

## **Which doctors, hospitals, and pharmacies can I use?**

**Bright Advantage Part B Savings (PPO)** 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.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

You can see our plan's provider and pharmacy directory at our website (<https://brighthouseplan.com/medicare-advantage>).

## **What do we cover?**

Like all Medicare health plans, we cover everything that Original Medicare covers – and *more*. Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs including 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, <https://brighthouseplan.com/medicare-advantage>.

## **How will I determine my drug costs?**

Our plan groups each medication into one of six "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Deductible, Initial Coverage, Coverage Gap and Catastrophic Coverage.

**If you have any questions about this plan's benefits or costs, please contact  
Bright Health**

## SECTION II - SUMMARY OF BENEFITS

### Bright Advantage Part B Savings (PPO) H3281-007

#### MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES

Monthly Plan Premium	\$0
Monthly Part B Premium Rebate	\$80
Deductible	Medical Deductible: \$0
Maximum Out-of-Pocket Responsibility	<p>Your yearly limit(s) in this plan:</p> <ul style="list-style-type: none"><li>• \$5,500 for services you receive from in-network providers.</li><li>• \$10,000 for services you receive from in and out-of-network providers combined.</li></ul> <p>If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.</p> <p>Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.</p>

#### COVERED MEDICAL AND HOSPITAL BENEFITS

Inpatient Hospital	<p><b><u>In-Network:</u></b> Days 1-7: \$170 copay per day for each admission. Days 8-90: \$0 copay per day. Our plan covers an unlimited number of days for an inpatient hospital stay.</p> <p><b><u>Out-of-Network:</u></b> 30% coinsurance each day for Medicare-covered hospital care. May require prior authorization.</p>
Ambulatory Surgical Center	<p><b><u>In-Network:</u></b> Ambulatory Surgical Center: \$250 copay.</p> <p><b><u>Out-of-Network:</u></b> Ambulatory Surgical Center: 30% coinsurance. May require prior authorization.</p>
Outpatient Hospital	<p><b><u>In-Network:</u></b> Outpatient hospital: \$275 copay.</p> <p><b><u>Out-of-Network:</u></b> Outpatient hospital: 30% coinsurance. May require prior authorization.</p>

## SECTION II - SUMMARY OF BENEFITS

### Bright Advantage Part B Savings (PPO) H3281-007

<b>Doctor's Office Visits</b>	<p><b><u>In-Network:</u></b> Primary care physician visit: \$0 copay. Specialist visit: \$30 copay.</p> <p><b><u>Out-of-Network:</u></b> Primary care physician visit: \$0 copay. Specialist visit: \$30 copay. May require prior authorization.</p>
<b>Preventive Care</b> <i>(e.g., flu vaccine, diabetic screenings)</i>	<p><b><u>In-Network:</u></b> You pay nothing for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare during the contract year will be covered.</p> <p><b><u>Out-of-Network:</u></b> 30% coinsurance for all preventive services covered under Original Medicare at zero cost sharing. May require prior authorization.</p>
<b>Emergency Care</b>	<p>\$90 copay per visit.</p> <p>If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care.</p> <p>Worldwide Emergency Coverage: \$90 copay.</p>
<b>Urgently Needed Services</b>	<p>\$65 copay per visit.</p>
<b>Diagnostic Services / Labs/ Imaging</b>	<p><b><u>In-Network:</u></b> Diagnostic tests and procedures: \$0 - \$250 copay. Lab services: \$10 copay. Diagnostic Radiology Services (such as MRI, CAT Scan): \$35 - \$250 copay. X-rays: \$35 copay. Therapeutic radiology services (such as radiation treatment for cancer): 20% coinsurance.</p> <p><b><u>Out-of-Network:</u></b> Diagnostic tests and procedures: 30% coinsurance. Lab services: 30% coinsurance. Diagnostic Radiology Services (such as MRI, CAT Scan): 30% coinsurance. X-rays: 30% coinsurance.</p>

## SECTION II - SUMMARY OF BENEFITS

### Bright Advantage Part B Savings (PPO) H3281-007

	Therapeutic radiology services (such as radiation treatment for cancer): 30% coinsurance. May require prior authorization.
Hearing Services	<p><b><u>In-Network:</u></b> Exam to diagnose and treat hearing and balance issues: \$0 copay. Routine hearing exam (up to 1 visit(s) every year): \$0 copay.</p> <p><b><u>Out-of-Network:</u></b> Exam to diagnose and treat hearing and balance issues: 30% coinsurance. Routine hearing exam (up to 1 visit(s) every year): 30% coinsurance.</p>
Dental Services	<p><b><u>In-Network:</u></b> Medicare Covered: \$0 copay. Preventive dental services:</p> <ul style="list-style-type: none"><li>• Oral exam (up to 2 visit(s) every year): \$0 copay.</li><li>• Cleaning (up to 2 visit(s) every year): \$0 copay.</li><li>• Fluoride treatment (up to 1 visit(s) every year): \$0 copay.</li><li>• Dental X-rays (up to 2 visit(s)): \$0 copay.</li><li>• Annual Dental Benefit Maximum: \$1,500 per year.</li></ul> <p><b><u>Out-of-Network:</u></b> Medicare Covered : 30% coinsurance. Preventive dental services:</p> <ul style="list-style-type: none"><li>• Oral Exams (up to 2 visit(s) every year): 30% coinsurance.</li><li>• Cleaning (up to 2 visit(s) every year): 30% coinsurance.</li><li>• Fluoride treatment (up to 1 visit(s) every year): 30% coinsurance.</li><li>• Dental X-rays (up to 2 visit(s)): 30% coinsurance.</li></ul> <p>We also offer optional supplemental benefits to enhance your dental benefit for an additional premium. For details please see the Optional Supplemental Benefit Section.</p>
Vision Services	<p><b><u>In-Network:</u></b> Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): \$0 copay. Routine eye exam (up to 1 visit(s) every year): \$0 copay. Eyeglasses or contact lenses after cataract surgery: \$0 copay.</p>

## SECTION II - SUMMARY OF BENEFITS

### Bright Advantage Part B Savings (PPO) H3281-007

	<p><b><u>Out-of-Network:</u></b></p> <p>Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): 30% coinsurance.</p> <p>Routine eye exam (up to 1 visit(s) every year): 30% coinsurance.</p> <p>Eyeglasses or contact lenses after cataract surgery: 30% coinsurance.</p> <p>We also offer optional supplemental benefits to enhance your vision benefit for an additional premium. For details please see the Optional Supplemental Benefit Section.</p> <p>May require prior authorization.</p>
<b>Mental Health Care</b>	<p><b><u>In-Network:</u></b></p> <p>Outpatient group therapy visit: \$40 copay.</p> <p>Individual therapy visit: \$40 copay.</p> <p>Inpatient Mental Health Care:</p> <p>Days 1-7: \$170 copay per day for each admission.</p> <p>Days 8-90: \$0 copay per day.</p> <p><b><u>Out-of-Network:</u></b></p> <p>Outpatient group therapy visit: 30% coinsurance.</p> <p>Individual therapy visit: 30% coinsurance.</p> <p>Inpatient Mental Health Care:</p> <p>30% coinsurance each day for Medicare-covered hospital care.</p> <p>May require prior authorization.</p>
<b>Skilled Nursing Facility (SNF)</b>	<p><b><u>In-Network:</u></b></p> <p>Days 1-20: \$0 copay per day.</p> <p>Days 21-100: \$178 copay per day.</p> <p><b><u>Out-of-Network:</u></b></p> <p>30% coinsurance each day for days 1-100.</p> <p>May require prior authorization.</p>
<b>Outpatient Rehabilitation</b>	<p><b><u>In-Network:</u></b></p> <p>Occupational therapy visit: \$0 copay.</p> <p>Physical therapy and speech and language therapy visit: \$0 copay.</p> <p><b><u>Out-of-Network:</u></b></p> <p>Occupational therapy visit: 30% coinsurance.</p>

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### Bright Advantage Part B Savings (PPO) H3281-007

	Physical therapy and speech and language therapy visit: 30% coinsurance. May require prior authorization.
Ambulance	<b><u>In-Network:</u></b> Ground Ambulance: \$200 copay. Air Ambulance: 20% coinsurance. <b><u>Out-of-Network:</u></b> Ground Ambulance: \$200 copay. Air Ambulance: 20% coinsurance. May require prior authorization.
Transportation	<b><u>In-Network:</u></b> Not Covered. <b><u>Out-of-Network:</u></b> Not Covered.
Medicare Part B Drugs	<b><u>In-Network:</u></b> For Part B drugs such as chemotherapy drugs: 20% coinsurance. Other Part B drugs: 20% coinsurance. <b><u>Out-of-Network:</u></b> For Part B drugs such as chemotherapy drugs: 20% coinsurance. Other Part B drugs: 20% coinsurance. May require prior authorization.
<b>ADDITIONAL BENEFITS</b>	
Health Club & Fitness Membership	<b><u>In-Network:</u></b> \$0 copay at participating locations. <b><u>Out-of-Network:</u></b> Not Covered.
Medical Equipment and Supplies	<b><u>In-Network:</u></b> 20% coinsurance. <b><u>Out-of-Network:</u></b> 20% coinsurance. May require prior authorization.



## SECTION II - SUMMARY OF BENEFITS

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Over-the-Counter (OTC) Allowance	<u>In-Network:</u> Not Covered. <u>Out-of-Network:</u> Not Covered.
<b>Podiatry Services</b> Covered services include: <ul style="list-style-type: none"><li>• Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs).</li></ul> Routine foot care for members with certain medical conditions affecting the lower limbs.	<u>In-Network:</u> \$0 copay. <u>Out-of-Network:</u> 30% coinsurance. May require prior authorization.
Telehealth Services	<u>In-Network:</u> \$0 copay. <u>Out-of-Network:</u> Not Covered.

## PRESCRIPTION DRUG BENEFITS

Deductible	Prescription Drug Deductible: \$400 for Tiers 2, 3, 4 and 5.									
Initial Coverage	You pay the following until your total yearly drug costs reach \$4,130. Total yearly drug costs are the drug costs paid by both you and our Part D plan. <b>Standard Retail Cost-Sharing</b> <table border="1"><thead><tr><th>Tier</th><th>30-day supply</th><th>90-day supply</th></tr></thead><tbody><tr><td>Tier 1 (Preferred Generic)</td><td>\$0 copay</td><td>\$0 copay</td></tr><tr><td>Tier 2 (Generic)</td><td>\$20 copay</td><td>\$40 copay</td></tr></tbody></table>	Tier	30-day supply	90-day supply	Tier 1 (Preferred Generic)	\$0 copay	\$0 copay	Tier 2 (Generic)	\$20 copay	\$40 copay
Tier	30-day supply	90-day supply								
Tier 1 (Preferred Generic)	\$0 copay	\$0 copay								
Tier 2 (Generic)	\$20 copay	\$40 copay								

## SECTION II - SUMMARY OF BENEFITS

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Tier 3 (Preferred Brand)	\$47 copay	\$94 copay
Tier 4 (Non-Preferred Drug)	\$100 copay	\$200 copay
Tier 5 (Specialty Tier)	25% coinsurance	Not Applicable
Tier 6 (Select Care Drugs)	\$0 copay	\$0 copay

#### Standard Mail Order

Tier	30-day supply	90-day supply
Tier 1 (Preferred Generic)	\$0 copay	\$0 copay
Tier 2 (Generic)	\$20 copay	\$40 copay
Tier 3 (Preferred Brand)	\$47 copay	\$94 copay
Tier 4 (Non-Preferred Drug)	\$100 copay	\$200 copay
Tier 5 (Specialty Tier)	25% coinsurance	Not Applicable
Tier 6 (Select Care Drugs)	\$0 copay	\$0 copay

Cost-sharing may differ based on pharmacy type or status (mail-order, retail, long term care (LTC), home infusion), or whether the prescription is short-term (30-day supply) or long-term (90-day supply).

Please call us or see the plan's "Evidence of Coverage" on our website (<https://brighthealthplan.com/medicare-advantage>) for complete information about your costs for covered drugs.

#### Coverage Gap

The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches \$4,130.

After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total \$6,550, which is the end of the coverage gap.

Our plan covers Tier 6 Select Care Drugs in the coverage gap.

#### Standard Retail Cost-Sharing

Tier	30-day supply
Tier 6 (Select Care Drugs)	\$0 copay

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### Bright Advantage Part B Savings (PPO) H3281-007

<b>Catastrophic Amount</b>	After your yearly out-of-pocket drug costs reach \$6,550, you pay the greater of: <ul style="list-style-type: none"><li>• \$3.70 copay for generic (including brand drugs treated as generic) and a \$9.20 copayment for all other drugs, or</li><li>• 5% of the cost.</li></ul>
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**Optional Supplemental Benefits  
Bright Advantage Part B Savings (PPO)  
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<p><b>Comprehensive Dental 002 for \$19 per month.</b></p>	<p><b>Dental</b></p>	<p>In-network: You pay \$0 copay to 50% coinsurance for all covered services. Out-of-network: You pay 30% to 75% coinsurance for all covered services. There is a \$1,500 maximum benefit for all in-network and out-of-network covered services combined every year. May require prior authorization.</p>
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**Optional Supplemental Benefits  
Bright Advantage Part B Savings (PPO)  
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<p><b>Comprehensive Vision 002 for \$3.50 per month.</b></p>	<p><b>Vision</b></p>	<p>You pay a \$25 copay for basic lenses. You pay a \$0 to \$60 copay for contact lenses. You have a \$130 allowance every other year for eyeglasses (lenses and frames) or contact lenses. May require prior authorization.</p>
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**DISCLAIMERS**

Bright Health plans are HMOs and PPOs with a Medicare contract. Bright Health's New York D-SNP plan is an HMO with a Medicare contract and a Coordination of Benefits Agreement with New York State Department of Health. Our plans are issued through Bright Health Insurance Company or one of its affiliates. Bright Health Insurance Company is a Colorado Life and Health company that issues indemnity products, including EPOs offered through Medicare Advantage. An EPO is an exclusive provider organization plan that may be written on an HMO license in some states and on a Life and Health license in some states, including Colorado. Enrollment in our plans depends on contract renewal.

## Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-844-221-7736 (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 <https://brighthouseplan.com/medicare-advantage> or 1-844-221-7736 (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. This premium is normally taken out of your Social Security check each month.
- Benefits, premiums and/or copayments/co-insurance may change on January 1, 2022.
- Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.
- Out-of-network/non-contracted providers are under no obligation to treat Bright Advantage Part B Savings (PPO) members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information.



## **Nondiscrimination Notice and Assistance with Communication**

Bright Health does not exclude, deny benefits to, or otherwise discriminate against any individual on the basis of sex, age, race, color, national origin, or disability. "Bright Health" means Bright Health plans and their affiliates.

### **Language assistance and alternate formats:**

Assistance is available at *no cost* to help you communicate with us. The services include, but are not limited to:

- Interpreters for languages other than English;
- Written information in alternative formats such as large print; and
- Assistance with reading Bright Health websites.

To ask for help with these services, please call **1-844-221-7736**.

If you think that we failed to provide language assistance or alternate formats, or you were discriminated against because of your sex, age, race, color, national origin, or disability, you can send a complaint to:

Bright Health Civil Rights Coordinator  
P.O. Box 853943  
Richardson, TX 75085-3943  
Phone: **1-844-202-2154**  
Email: OAG@brighthealthplan.com

You can also file a complaint with the U.S Dept. of Health and Human Services, the Office of Civil Rights:

- **Online:** <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>
- Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>
- **Phone:** Toll-free **1-800-368-1019, 1-800-537-7697** (TDD)
- **Mail:** U.S Dept. of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

If you need help with your complaint, please call **1-844-202-2154**. You must send the complaint within 60 days of discovering the issue.

## Language Assistance and Alternate Formats

This information is available in other formats like large print. To ask for another format, please call **1-844-221-7736**.

English	ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call (844) 221-7736.
Spanish (US)	ATENCIÓN: Si no habla inglés, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (844) 221-7736.
Chinese (S)	注意：如果您使用的语言并非英语，则可获得免费的语言协助服务请拨打电话 (844) 221-7736。
Arabic	انتباه: إذا كنت تتحدث لغة غير الإنجليزية، فخدمات المساعدة اللغوية متاحة من أجلك، دون تكلفة. بالرقم (844) 221-7736.
Bengali	মনোযোগ দিন: আপনি যদি ইংরাজী ব্যতীত অন্য কোনও ভাষায় কথা বলেন তাহলে ভাষা সহায়তা সংক্রান্ত পরিষেবাগুলি নিখরচায় আপনার জন্য উপলব্ধ। (844) 221-7736 নম্বরে কল করুন।
French	ATTENTION : Si vous parlez une autre langue que l'anglais, des services d'assistance linguistique sont mis gratuitement à votre disposition. Appelez (844) 221-7736.
German	ACHTUNG: Falls Sie eine andere Sprache als Englisch sprechen, steht Ihnen eine kostenfreie fremdsprachliche Unterstützung zur Verfügung. Wählen Sie die (844) 221-7736.
Greek	ΠΡΟΣΟΧΗ: Αν μιλάτε κάποια γλώσσα διαφορετική από τα Αγγλικά, παρέχονται δωρεάν υπηρεσίες γλωσσικής βοήθειας. Καλέστε το (844) 221-7736.
Italian	ATTENZIONE: se parla una lingua diversa dall'inglese, sono disponibili servizi di assistenza linguistica gratuiti. Chiami il numero (844) 221-7736.
Japanese	ご注意: 英語以外の言語を話される場合は、無料の言語支援サービスをご利用いただけます。(844) 221-7736 までお電話ください。
Korean	주의: 영어가 아닌 다른 언어를 사용할 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 연락하십시오(844) 221-7736으로
Polish	UWAGA: Jeśli nie mówisz po angielsku, możesz skorzystać z darmowych usług tłumaczeniowych. Zadzwoń pod numer (844) 221-7736.
Portuguese	ATENÇÃO: Se falar um idioma que não o inglês, estão disponíveis serviços gratuitos de assistência de idioma para si. Contacte o número (844) 221-7736.
Russian	ВНИМАНИЕ: если вы не говорите на английском языке, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по телефону (844) 221-7736.
Tagalog	PAALALA: Kung nagsasalita ka ng isang wika bukod sa Ingles, magagamit mo ang mga serbisyong tulong sa wika nang walang bayad. Tumawag sa (844) 221-7736.
Urdu	

دھیان دیں: اگر آپ انگریزی کے علاوہ کوئی دوسری زبان بولتے ہیں تو، آپ کے لئے زبان کی مدد کی خدمات مفت دستیاب ہیں۔  
(844) 221-7736 پر کال کریں۔





- Nepali ध्यान दिनुहोस्: यदि तपाईं अङ्ग्रेजी बाहेक अन्य भाषा बोल्नुहुन्छ भने तपाईंको लागि शुल्क रूपमा भाषा सहायता सेवा उपलब्ध छ। (844) 221-7736 मा कल गर्नुहोस्।
- Persian Farsi توجه: اگر به زبانی غیر از انگلیسی صحبت می‌کنید، خدمات تسهیلات زبانی، رایگان در دسترس شما قرار می‌گیرند. با شماره (844) 221-7736 تماس بگیرید.
- Serbo-Croatian PAŽNJA: ako ne govorite engleski, nego neki drugi jezik, na raspolaganju su vam besplatne usluge jezične pomoći. Nazovite (844) 221-7736.
- Syriac ܘܪܘܟܢܘܢܐ ܘܟܘܢܢܐ ܘܟܘܢܢܐ ܟܘܢܢܐ ܟܘܢܢܐ: ܟܘܢܢܐ ܟܘܢܢܐ ܟܘܢܢܐ ܟܘܢܢܐ ܟܘܢܢܐ ܟܘܢܢܐ (844) 221 7736
- Thai ข้อควรทราบ: หากคุณใช้ภาษาอื่นที่ไม่ใช่ภาษาอังกฤษ เรามีบริการความช่วยเหลือทางภาษา จัดให้แก่คุณโดยไม่คิดค่าใช้จ่ายใด ๆ ติดต่อหมายเลขโทรศัพท์ (844) 221-7736.
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