SCAN Prime (HMO) is an HMO plan with a Medicare contract. Enrollment in SCAN Health Plan depends on contract renewal.
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 Service Department at the phone number listed in this document or online at www.scanhealthplan.com.
<table>
<thead>
<tr>
<th>PREMIUM AND BENEFITS</th>
<th>SCAN PRIME</th>
<th>WHAT YOU SHOULD KNOW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Health Plan Premium</td>
<td>You pay $26</td>
<td>You must continue to pay your Medicare Part B premium.</td>
</tr>
<tr>
<td>Deductible</td>
<td>You pay $0</td>
<td>This plan does not have a deductible.</td>
</tr>
<tr>
<td>Maximum Out-of-Pocket Responsibility (this does not include prescription drugs)</td>
<td>$1,500 annually</td>
<td>The most you pay for copays and coinsurance for Medicare-covered medical services for the year.</td>
</tr>
<tr>
<td>Inpatient Hospital Coverage</td>
<td>You pay $0</td>
<td>Our plan covers an unlimited number of days for an inpatient hospital stay. Prior authorization rules apply.</td>
</tr>
<tr>
<td>Outpatient Hospital Services</td>
<td></td>
<td>Prior authorization is required for outpatient hospital services.</td>
</tr>
<tr>
<td>• Ambulatory Surgical Center</td>
<td>You pay $0</td>
<td></td>
</tr>
<tr>
<td>• Outpatient Hospital</td>
<td>You pay $0</td>
<td></td>
</tr>
<tr>
<td>Doctor Visits</td>
<td></td>
<td>Prior authorization is required for specialist visits.</td>
</tr>
<tr>
<td>• Primary Care</td>
<td>You pay $0</td>
<td></td>
</tr>
<tr>
<td>• Specialists</td>
<td>You pay $0</td>
<td></td>
</tr>
<tr>
<td>Preventive Care</td>
<td>You pay $0</td>
<td>Any additional preventive services approved by Medicare during the contract year will be covered. Prior authorization rules apply.</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>You pay $90 copay per visit</td>
<td>The emergency room copay will be waived if you are immediately admitted to the hospital. You are covered for worldwide emergency services.</td>
</tr>
<tr>
<td>Urgently Needed Services</td>
<td>You pay $0</td>
<td>You are covered for worldwide urgent care services.</td>
</tr>
<tr>
<td>PREMIUM AND BENEFITS</td>
<td>SCAN PRIME</td>
<td>WHAT YOU SHOULD KNOW</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>--------------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Diagnostic Services/Labs/Imaging</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Lab services</td>
<td>You pay $0</td>
<td>Prior authorization is required for diagnostic, lab, and imaging services.</td>
</tr>
<tr>
<td>• Diagnostic tests and procedures</td>
<td>You pay $0</td>
<td></td>
</tr>
<tr>
<td>• Outpatient X-rays</td>
<td>You pay $0</td>
<td></td>
</tr>
<tr>
<td>• Therapeutic radiology</td>
<td>You pay $50 copay per visit</td>
<td></td>
</tr>
<tr>
<td>• Diagnostic radiology (e.g., MRI, CT)</td>
<td>You pay $0</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Medicare-covered diagnostic hearing and balance exam</td>
<td>You pay $0</td>
<td>Prior authorization is required for Medicare-covered diagnostic hearing and balance exams.</td>
</tr>
<tr>
<td>• Non-Medicare-covered (routine) hearing exam</td>
<td>You pay $0 for up to 1 visit per year</td>
<td>You must go to a SCAN-contracted provider to obtain a routine hearing exam and hearing aids.</td>
</tr>
<tr>
<td>• Non-Medicare-covered (routine) hearing aids</td>
<td>You pay $699 copay per aid for a basic hearing aid or $999 copay per aid for an enhanced hearing aid</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Medicare-covered dental services</td>
<td>You pay $0</td>
<td>Prior authorization is required for Medicare-covered dental services.</td>
</tr>
<tr>
<td>• Non-Medicare-covered (routine) oral exam</td>
<td>You pay $13 copay per visit</td>
<td>Routine dental services do not require a prior authorization.</td>
</tr>
<tr>
<td>• Non-Medicare-covered (routine) dental cleaning</td>
<td>You pay $15 copay per visit (1 every 6 months)</td>
<td>You must go to a SCAN-contracted dentist to obtain routine dental services.</td>
</tr>
<tr>
<td>• Non-Medicare-covered (routine) dental X-rays</td>
<td>You pay $15 copay per visit (1 every 6 months)</td>
<td></td>
</tr>
<tr>
<td>PREMIUM AND BENEFITS</td>
<td>SCAN PRIME</td>
<td>WHAT YOU SHOULD KNOW</td>
</tr>
<tr>
<td>---------------------</td>
<td>------------</td>
<td>---------------------</td>
</tr>
<tr>
<td><strong>Vision Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Medicare-covered vision exam to diagnose/treat diseases of the eye</td>
<td>You pay $0</td>
<td>Prior authorization is required for Medicare-covered vision exam and glasses after cataract surgery. Routine vision services do not require prior authorization. You must go to a SCAN-contracted vision provider to obtain routine vision services.</td>
</tr>
<tr>
<td>• Medicare-covered glasses after cataract surgery</td>
<td>You pay $0</td>
<td></td>
</tr>
<tr>
<td>• Non-Medicare-covered (routine) vision exam</td>
<td>You pay $0 for up to 1 visit per year</td>
<td></td>
</tr>
<tr>
<td>• Non-Medicare-covered (routine) glasses or contact lenses</td>
<td>You pay $30 copay per pair every 2 years</td>
<td></td>
</tr>
<tr>
<td>• Non-Medicare-covered (routine) vision coverage limit</td>
<td>You are covered for up to $175 for frames or contact lenses every 2 years</td>
<td></td>
</tr>
<tr>
<td><strong>Mental Health Services</strong></td>
<td></td>
<td>Prior authorization is required for inpatient mental health hospitalization. You are covered for up to 90 days per benefit period.*</td>
</tr>
<tr>
<td>• Inpatient visit</td>
<td>You pay $0 per day for days 1-90</td>
<td>Prior authorization is required for outpatient mental health services.</td>
</tr>
<tr>
<td>• Outpatient individual/group therapy visit</td>
<td>You pay $0</td>
<td></td>
</tr>
<tr>
<td>• Outpatient individual/group therapy visit with a psychiatrist</td>
<td>You pay $0</td>
<td></td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility</strong></td>
<td>You pay $0 per day for days 1-20</td>
<td>Prior authorization is required for skilled nursing facility services. You are covered for up to 100 days per benefit period.*</td>
</tr>
<tr>
<td></td>
<td>You pay $50 copay per day for days 21-100</td>
<td>No prior hospitalization is required.</td>
</tr>
</tbody>
</table>

*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.*
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Physical Therapy</td>
<td>You pay $0</td>
<td>Prior authorization is required for outpatient physical therapy services.</td>
</tr>
<tr>
<td>Ambulance</td>
<td>You pay $100 copay per one-way trip</td>
<td></td>
</tr>
</tbody>
</table>
| Transportation (Non-Medicare-covered—routine) | You pay $0 for up to 24 one-way trips per year  
75-mile limit applies to each one-way trip | Prior authorization is required for routine transportation services.  
You must use a SCAN-contracted provider to obtain routine transportation services. |
| Medicare Part B Drugs                     | You pay 20% of the total cost for chemotherapy and other Part B drugs        | Prior authorization rules apply to select drugs.                                     |
## OUTPATIENT PRESCRIPTION DRUGS

You pay the following:

### SCAN PRIME

<table>
<thead>
<tr>
<th>Tier</th>
<th>Preferred Retail Pharmacy 30-day supply cost-sharing</th>
<th>Standard Retail Pharmacy 30-day supply cost-sharing</th>
<th>Preferred Retail Pharmacy 90-day supply cost-sharing</th>
<th>Standard Retail Pharmacy 90-day supply cost-sharing</th>
<th>Mail-Order Pharmacy 90-day supply cost-sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial Coverage Stage</strong></td>
<td>You pay $0</td>
<td>You pay $5</td>
<td>You pay $0</td>
<td>You pay $10</td>
<td>You pay $0</td>
</tr>
<tr>
<td>Tier 1 (Preferred Generic)</td>
<td>You pay $5</td>
<td>You pay $12</td>
<td>You pay $10</td>
<td>You pay $24</td>
<td>You pay $0</td>
</tr>
<tr>
<td>Tier 2 (Generic)</td>
<td>You pay $42</td>
<td>You pay $47</td>
<td>You pay $116</td>
<td>You pay $131</td>
<td>You pay $116</td>
</tr>
<tr>
<td>Tier 3 (Preferred Brand)</td>
<td>You pay $95</td>
<td>You pay $100</td>
<td>You pay $275</td>
<td>You pay $290</td>
<td>You pay $275</td>
</tr>
<tr>
<td>Tier 4 (Non-Preferred Drug)</td>
<td>You pay 33%</td>
<td>You pay 33%</td>
<td>Not available</td>
<td>Not available</td>
<td>Not available</td>
</tr>
<tr>
<td>Tier 5 (Specialty Tier)</td>
<td>You pay 33%</td>
<td>You pay 33%</td>
<td>Not available</td>
<td>Not available</td>
<td>Not available</td>
</tr>
</tbody>
</table>

### Coverage Gap Stage

Begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,820.

You pay the same copays as in the Initial Coverage Stage for Tier 1 and Tier 2 drugs. For drugs in other tiers, you pay 25% of the negotiated price (and a portion of the dispensing fee) for your brand name drugs and 37% of the cost for your generic drugs.

### Catastrophic Coverage Stage

After your yearly out-of-pocket drug costs reach $5,100, you pay the greater of:

- 5% of the cost, or
- $3.40 copay for generic (including drugs that are treated like a generic) and $8.50 copay for all other drugs.

Some of our network pharmacies have preferred cost-sharing. You may pay less for certain drugs if you use these pharmacies. Cost-sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information, please call our Member Services Department at the number provided in this document or access your Evidence of Coverage online.

You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.

Your Cost-Sharing may differ depending on the pharmacy you choose (e.g., Preferred Retail, Standard Retail, Mail-Order, Long Term Care (LTC) or Home infusion, etc.) and whether you receive a 30- or 90-day supply. For more information on the pharmacy-specific copays, please call SCAN Member Services Department at the phone number in this document or access your Evidence of Coverage online.
## Medical Equipment/Supplies

- Durable Medical Equipment (e.g., wheelchairs, oxygen)
- Prosthetics (e.g., braces, artificial limbs)
- Diabetic supplies

### SCAN PRIME

- You pay 0% to 20% of the total cost
- You pay 0% to 20% of the total cost
- You pay $0

### WHAT YOU SHOULD KNOW

**Prior authorization** is required for covered durable medical equipment, prosthetic devices, and certain diabetic supplies.

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.

## Generic Viagra

(Sildenafil tabs 25 mg, 50 mg and 100 mg)

### SCAN PRIME

- Covered under Tier 2

### WHAT YOU SHOULD KNOW

This prescription drug has a quantity limit of 4 tablets per 30 days

For more information about how much you pay for your prescription drugs, go to Outpatient Prescription Drugs section in this booklet.

The amount you pay when you fill a prescription for this drug does not count toward your out-of-pocket costs. If you are receiving extra help to pay for your prescriptions, you will not get any extra help to pay for this drug.
SCAN Prime 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.

<table>
<thead>
<tr>
<th>ABOUT SCAN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Who can join?</strong></td>
</tr>
<tr>
<td>- have both Medicare Part A and Part B</td>
</tr>
<tr>
<td>- live in the plan service area (Orange County, California)</td>
</tr>
<tr>
<td>- be a United States citizen or be lawfully present in the United States</td>
</tr>
<tr>
<td>- not be medically determined to have end-stage renal disease (ESRD)</td>
</tr>
</tbody>
</table>

| **Phone Number (Members)** | 1-800-559-3500 |
| **Phone Number (Non-Members)** | 1-877-870-4867 |
| **TTY** | 711 |

| **Hours of Operation** | **October 1 to March 31:** 8 A.M. to 8 P.M., 7 days a week |
| **April 1 to September 30:** 8 A.M. to 8 P.M., Monday through Friday |
| Messages received on holidays and outside of our business hours will be returned within one business day. |

| **Website** | http://www.scanhealthplan.com |

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. Other providers are available in our network. You must continue to pay your Medicare Part B premium. The Formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary. Premium, copays, coinsurance, and deductibles may vary based on the level of Extra Help you receive. Please contact the plan for further details.

You can get prescription drugs shipped to your home through our network mail-order delivery program. Typically, you should expect to receive your prescription drugs within 14 days from the time that the 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 A.M. to 8 P.M., 7 days a week from October 1 to March 31. From April 1 to September 30, hours are 8 A.M. to 8 P.M. Monday through Friday (messages received on holidays and outside of our business hours will be returned within one business day). TTY: 711.
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 1-877-870-4867 (TTY users call 711) Hours are 8 A.M. to 8 P.M., seven days a week from October 1 to March 31. From April 1 to September 30 hours are 8 A.M. to 8 P.M., Monday through Friday. Messages received on holidays and outside of our business hours will be returned within one business day.

Understanding the Benefits

☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor. Visit www.scanhealthplan.com or call 1-877-870-4867 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 medicines 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, 2020.

☐ 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).
SCAN Health Plan complies with applicable federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of, or because of, race, color, national origin, age, disability, or sex.

SCAN Health Plan provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).

SCAN Health Plan provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact SCAN Member Services.

If you believe that SCAN Health Plan 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 in person, by phone, mail, or fax, at:

SCAN Member Services  
Attention: Grievance and Appeals Department  
P.O. Box 22616, Long Beach, CA 90801-5616  
1-800-559-3500 (TTY: 711)  
FAX: 1-562-989-5181

Or by filling out the “File a Grievance” form on our website at:  
https://www.scanhealthplan.com/contact-us/file-a-grievance

If you need help filing a grievance, SCAN Member Services 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, D.C. 20201  
1-800-368-1019 (TTY: 1-800-537-7697)


SCAN Health Plan is an HMO plan with a Medicare contract. Enrollment in SCAN Health Plan depends on contract renewal.
ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-800-559-3500. (TTY: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-559-3500. (TTY: 711).

Chinese Traditional: 注意：如果您使用中文，您可以免費獲得語言援助服務。請致電1-800-559-3500。（TTY: 711）。

Chinese Simplified: 注意：如果您使用中文，您可以免费获得语言援助服务，请致电1-800-559-3500。（TTY: 711）。

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Xin vui lòng gọi số 1-800-559-3500. (TTY: 711).


Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա Ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարե'ք 1-800-559-3500 հեռախոսահամարով: Հեռատիպի համարն է՝ 711:

Persian: توجه: اگر به زبان فارسی گفتگو می‌کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می‌آید. با شماره 1-800-559-3500 تماس بگیرید. (TTY: 711).

Russian: ВНИМАНИЕ! Если вы говорите по-русски, вы можете бесплатно получить услуги переводчика. Звоните по телефону 1-800-559-3500 (TTY: 711).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。お問合せ先 1-800-559-3500. (TTY: 711).

Arabic: ملاحظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تنطوي لك بالمجاني. اتصل برقم 1-800-559-3500-12-800-559-3500. (الهاتف النصي: 711).

Punjabi: ਧਿਆਨ ਦੇਣਾਂ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਿੇ ਹੋਂਦਾ ਤੋਂ ਜਦੋਂ ਦੋਹਾਂ ਦੇ ਲਈ ਮਫਤ ਮੰਗ ਲੈਣਾ ਮੁਕਾਬਲੇ ਆ ਦੇਣਾ ਮੁਫਤ ਮੰਗ ਦੀ ਵਿਚਾਰ ਕਰਨਾ ਹੁੰਦਾ ਹੈ।

1-800-559-3500 ਦੇ ਰੂਪ ਵਿਚ ਕਾਲ ਚਰਨ। (TTY: 711)

Mon-Khmer, Cambodian: បារាំងដែលអក្សរព្រោះ ដែលមិនឈ្នះអក្សរខ្មែរ ដែលមិនឈ្នះអក្សរខ្មែរ ដែលមិនឈ្នះអក្សរខ្មែរ ដែលមិនឈ្នះអក្សរខ្មែរ ដែលមិនឈ្នះអក្សរខ្មែរ ដែលមិនឈ្នះអក្សរខ្មែរ ដែលមិនឈ្នះអក្សរខ្មែរ ដែលមិនឈ្នះអក្សរខ្មែរ ដែលមិនឈ្នះអក្សរខ្មែរ ដែលមិនឈ្នះអក្សរខ្មែរ ដែលមិនឈ្នះអក្សរខ្មែរ ដែលមិនឈ្នះអក្សរខ្មែរ ដែលមិនឈ្នះអក្សរខ្មែរ ដែលមិនឈ្នះអក្សរខ្មែរ ដែលមិនឈ្នះអក្សរខ្មែរ ដែលមិនឈ្នះអក្សរខ្មែរ ដែលមិនឈ្នះអក្សរខ្មែរ ដែលមិនឈ្នះអក្សរខ្មែរ ដែលមិនឈ្នះអក្សរខ្មែរ ដែលមិនឈ្នះអក្សរខ្មែរ ដែលមិនឈ្នះអក្សរខ្មែរ ដែលមិនឈ្នះអក្សរខ្មែរ ដែលមិនឈ្នះអក្សរខ្មែរ ដែលមិនឈ្នះអក្សរខ្មែរ ដែលមិនឈ្នះអក្សរខ្មែរ ដែលមិនឈ្នះអក្សរខ្មែរ ដែលមិនឈ្នះអក្សរខ្មែរ ដែលមិនឈ្នះអក្សរខ្មែរ ដែលមិនឈ្នះអក្សរខ្មែរ ដែលមិនឈ្នះអក្សរខ្មែរ ដែលមិនឈ្នះអក្សរខ្មែរ ដែលមិនឈ្នះអក្សរខ្មែរ ដែលមិនឈ្នះអក្សរខ្មែរ ដែលមិនឈ្នះអក្សរខ្មែរ ដែលមិនឈ្នះអក្សរខ្មែរ ដែលមិនឈ្នះអក្សរខ្មែរ ដែលមិនឈ្នះអក្សរខ្មែរ ដែលមិនឈ្នះអក្សរខ្មែរ ដែលមិនឈ្នះអក្សរខ្មែរ ដែលមិនឈ្នះអក្សរខ្មែរ ដែលមិនឈ្នះអក្សរខ្មែរ ដែលមិនឈ្នះអក្សរខ្មែរ ដែលមិនឈ្នះអក្សរខ្មែរ ដែលមិនឈ្នះអក្សរខ្មែរ ដែលមិនឈ្នះអក្សរខ្មែរ ដែលមិនឈ្នះអក្សរខ្មែរ ដែលមិនឈ្នះអក្សរខ្មែរ ដែលមិនឈ្នះអក្សរខ្មែរ ដែលមិនឈ្នះអក្សរខ្មែរ ដែលមិនឈ្នះអក្សរខ្មែរ ដែលមិនឈ្នះអក្សរខ្មែរ ដែលមិនឈ្នះអក្សរខ្មែរ ដែលមិនឈ្នះអក្សរខ្មែរ ដែលមិនឈ្នះអក្សរខ្មែ� 1-800-559-3500 ।


Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।

कॉल करें 1-800-559-3500, (TTY: 711)

Thai: โปรดทราบ: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรีโทร 1-800-559-3500 (TTY: 711)

Lao: โปรดทราบ: ถ้าคุณพูดภาษาลาว คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-559-3500 (TTY: 711).