HIGHMARK WHOLECARE

Southeastern Pennsylvania

Highmark Wholecare Medicare Assured (HMO SNP)

Summary of Benefits

January 1, 2026 to December 31, 2026

To enroll in the following plan(s), you need to live in one of these counties:

Bucks, Chester, Delaware, Philadelphia, Montgomery

This summary of benefits doesn't list every service, limitation, or special circumstance.

Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directories.)

Visit us at **highmark.com/wholecare/medicare** to get more benefit information including:

- **Evidence of Coverage** *(full list of benefits)*
- **Provider and Pharmacy Directories**
- **Formulary** *(full Part D prescription drug list)*

If you need printed copies, call us at **1-800-685-5209** (TTY 711). We're available October 1 – March 31, 8 a.m. to 8 p.m., April 1 – September 30 8 a.m. to 8 p.m., Monday – Friday.

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 call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY 1-877-486-2048.

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	Highmark Wholecare Medicare Assured Diamond (HMO SNP)	Highmark Wholecare Medicare Assured Ruby (HMO SNP)
Premium	$0	$0
Deductible	$0	$0
Max Out-Of-Pocket	$9,250	$8,000
Inpatient Hospital Stay*	$0 copay per admit IN	Days 1 - 6: $275 copay per day per admit & Days 7 - 90: $0 copay per admit IN
Outpatient Hospital Coverage*	ASC[1]: 0% coinsurance Facility: 0% coinsurance	ASC[1]: 0% coinsurance Facility: 0% coinsurance
Doctor Office Visit	PCP: $0 copay Specialist: $0 copay	PCP: $0 copay Specialist: $30 copay
Preventive/Screening	Covered in Full	Covered in Full
Emergency Room	$0 copay	$115 copay
Urgently Needed Services	$0 copay	$25 copay
Lab* & Diagnostic Tests*	Office /Lab: $0 copay; Outpatient: $0	Office /Lab: $5 copay; Outpatient: $5
X-Rays*/ Advanced Imaging*	X-ray: $0 copay Advanced Imaging: $0 copay	X-ray: $20 copay Advanced Imaging: 10% coinsurance
Hearing Services	Medicare Covered: $0 copay. Routine: $0 copay (1 Per Year). TruHearing Advanced: $0 copay (2 Aids every 3 years)	Medicare Covered: $30 copay. Routine: $0 copay (1 Per Year). TruHearing Advanced: $0 copay (2 Aids every 3 years)
Dental Services	Medicare Covered: $0 copay.* Routine Office Visit: $0 copay (1 per six months). Routine X-rays: $0 copay (1 per six months). Comprehensive/Preventive: 0% coinsurance with a maximum $6,500 (per year). See the EOC for full benefits.	Medicare Covered: $30 copay.* Routine Office Visit: $0 copay (1 per six months). Routine X-rays: $0 copay (1 per six months). Comprehensive: 0% copay with a maximum $2,000 (per year). See the EOC for full benefits.
Vision Services	Medicare Covered: $0 copay. Routine Office Visit: $0 copay for one routine eye exam per calendar year. $600 eye wear allowance towards the purchase of frames or contact lenses. $0 copay for standard lenses. $0 copay limited lens upgrades. Plan restrictions apply.	Medicare Covered: $0-30 copay. Routine Office Visit: $0 copay for one routine eye exam per calendar year. $150 eye wear allowance towards the purchase of frames or contact lenses. $0 copay for standard lenses.
Mental Health Services	Inpatient: $0 copay per admit*; Outpatient: $0 copay	Inpatient: Days 1 - 6: $275 copay per day per admit & Days 7 - 90: $0 copay per admit*; Outpatient: $10 copay
Skilled Nursing Facility*	$0 copay/day (days 1-20), $0 copay/day (days 21-100)	$0 copay/day (days 1-20), CMS Maximum copay/day (days 21-100)
Physical Therapy*	$0 copay	$25 copay
Ambulance (per one-way trip)*	Emergent/Non-Emergent: $0 copay	Emergent/Non-Emergent: $250 copay
Transportation	You pay a $0 copay. Up to 24 one-way health related trips up to a 60 mile radius.	Not Covered
Medicare Part B Drugs*†	$35 for Medicare Part B Insulin. 20% Coinsurance. As you are enrolled in a DSNP (Medicare) and Medicaid plan, your secondary coverage, Medicaid, covers the 20% coinsurance. Providing your pharmacy with both identification numbers for Medicare and Medicaid will help ensure the lowest out of pocket costs.	$35 for Medicare Part B Insulin. 20% coinsurance of the total cost for chemotherapy and other Medicare Part B prescription drugs.
OTC	Included in Flex Card allowance	Included in Flex Card allowance
Flex Card	SSBCI Member receive $300 per month combined allowance for OTC, Home/Bathroom Safety, Food (SSBCI), Utility (SSBCI), and Pay-at-the-Pump gas (SSBCI). Members can use the $300 per month allowance to pay plan	SSBCI Member receive $165 per quarter combined allowance for OTC, Home/Bathroom Safety, Food (SSBCI), Utility (SSBCI), and Pay-at-the-Pump gas (SSBCI). Members can use the $165 per quarter allowance to pay

	Highmark Wholecare Medicare Assured Diamond (HMO SNP)	Highmark Wholecare Medicare Assured Ruby (HMO SNP)
	approved utility expenses or to purchase healthy foods or OTC at select retail locations, online, or via catalog; or Home/Bathroom Safety items via online catalog. Pay-at-the-Pump Gas requires card balance of at least $50 and a hold will be placed on the card until payment clears. Members may not pay for gas inside a store. Unused allowances expire at the end of the month. Fees and plan restrictions apply. Non-SSBCI Members receive $100 per month combined allowance for OTC and Home/Bathroom Safety. Members can use the $100 per month allowance to pay plan approved expenses for OTC items at select retail stores, online, or via catalog; or Home/Bathroom Safety items via online catalog. Unused allowances expire at the end of the month. Fees and plan restrictions apply.	plan approved utility expenses or to purchase healthy foods or OTC at select retail locations, online, or via catalog; or Home/Bathroom Safety items via online catalog. Pay-at-the-Pump Gas requires card balance of at least $50 and a hold will be placed on the card until payment clears. Members may not pay for gas inside a store. Unused allowances expire at the end of the month. Fees and plan restrictions apply. Non-SSBCI Members receive $45 per quarter combined allowance for OTC and Home/Bathroom Safety. Members can use the $45 per quarter allowance to pay plan approved expenses for OTC items at select retail stores, online, or via catalog; or Home/Bathroom Safety items via online catalog. Unused allowances expire at the end of the month. Fees and plan restrictions apply.
Durable Medical Equipment*	0% copay	10% coinsurance for diabetic supplies and diabetic shoes or inserts. 20% coinsurance for all other DME.
Eligibility Requirements	• Must have Medicare Parts A and B • Must be enrolled in one of the following Medicare Savings Programs offered by Medicaid for individuals with limited income and resources FDBE, QMB+, SLMB+, or QMB • Live within our service area	• Must have Medicare Parts A and B • Must be enrolled in one of the following Medicare Savings Programs offered by Medicaid for individuals with limited income and resources QMB, SLMB or QI • Live within our service area
Formulary	Covered	Covered

MEDICARE SAVINGS PROGRAMS DEFINITIONS:
(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."
(SLMB) Specified Low-Income Medicare Beneficiary: Helps pay Part B premium.
(QI) Qualifying Individual: Helps pay Part B premium but is limited to a first-come, first-served basis.

*Indicates a service that requires prior authorization.

**Indicates a service that requires prior authorization for non-emergent trips. ASC[1]=Ambulatory Surgery Center

†Certain rebatable drugs may be subject to a lower coinsurance. Insulin cost sharing is subject to a coinsurance cap of $35 for a one-month's supply of insulin.

Highmark Wholecare Medicare Assured Diamond (HMO SNP)

DRUG

Deductible	$615 If you're in a program that helps pay for your drugs (Extra Help) you do not pay a deductible.
Initial Coverage	You will pay your assigned LIS copays for generic and brand drugs. • LIS Level 3 (Institutionalized/Home Based Care): $0 copays Generic and Brand • LIS Level 2 (Non-Institutionalize): $1.60 Generics / $4.90 Brand • LIS Level 3 (Other): $5.10 Generics / $12.65 Brand
Catastrophic Coverage	Once your cumulative yearly out-of-pocket expenses for covered medications (Part D drugs) reach **$2,100**, you will enter the catastrophic coverage stage. During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy.

Highmark Wholecare Medicare Assured Ruby (HMO SNP)

DRUG

Deductible	$615 If you're in a program that helps pay for your drugs (Extra Help) you do not pay a deductible.
Initial Coverage	You will pay your assigned LIS copays for generic and brand drugs. • LIS Level 3 (Institutionalized/Home Based Care): $0 copays Generic and Brand • LIS Level 2 (Non-Institutionalize): $1.60 Generics / $4.90 Brand • LIS Level 3 (Other): $5.10 Generics / $12.65 Brand
Catastrophic Coverage	Once your cumulative yearly out-of-pocket expenses for covered medications (Part D drugs) reach **$2,100**, you will enter the catastrophic coverage stage. During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

This information is not a complete description of benefits. Call 1-877-428-3929 (TTY users may call 711), October 1 – March 31, 8 a.m. to 8 p.m., 7 days a week; April 1 – September 30, 8 a.m. to 8 p.m., Monday – Friday for more information.

TruHearing® is a registered trademark of TruHearing, Inc. TruHearing is an independent company that administers the routine hearing exam and hearing-aid benefit.

If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy.

Gateway Health Plan, Inc. d/b/a Highmark Wholecare is an independent licensee of the Blue Cross Blue Shield Association. Highmark Wholecare offers HMO plans with a Medicare Contract.

Enrollment in these plans depends on contract renewal.

Pennsylvania

Summary of Medicaid-covered Benefits

January 1, 2026 – December 31, 2026

The enclosed benefits are covered by Medicaid. Your services are paid first by your Medicare plan, and then by Medicaid. If a benefit is used up or not covered by Medicare, then Medicaid may provide coverage.

If you have questions about your Medicaid eligibility and which benefits you are entitled to, call Pennsylvania Department of Human Services, **1-800-692-7462** (TTY users call **1-800-451-5886**), or visit their website at **www.dhs.pa.gov**.

ENR-469 (7-25)

Benefits	What you pay under Medicaid
Inpatient Hospital Coverage	$3 copay per day up to $21 per admission Includes general hospitals, rehabilitation hospitals, drug and alcohol and private psychiatric hospitals
Doctor Visits (Primary Care and Specialists)	$0-$3.80 copay for Medicaid-covered services Physician (Medical Doctor), Certified Registered Nurse Practitioner and Rural Health Clinic
Emergency Care	$0 copay for Emergency Services
Urgently Needed Services	$0-$3.80 copay for Medicaid-covered services
Diagnostic Services/ Labs/ Imaging	$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
Dental Services	$0-$3.80 copay for Medicaid-covered services • Diagnostic, preventive, restorative, surgical dental procedures, prosthodontics,and sedation • Key Limitations: Dentures: one per lifetime; Exams/prophylaxis: one per 180 days; Crowns, periodontics and endodontics: only via approved benefit limit exception
Vision Services	Under age 21: Wholecare covers all medically necessary vison services from in-network providers Age 21 and over: $0-$3.80 copay for Medicaid-covered services • Optometrist (Eye Doctor) • Two exams per calendar year • Eyeglass lenses, frames and contact lenses are limited to individuals with aphakia; four eyeglass lenses per calendar year; two eyeglass frames per calendar year; and four contact lenses per calendar
Skilled Nursing Facility (SNF)	$0-$3.80 copay for Medicaid-covered services Nursing Facilities
Ambulance (Emergency)	$0-$3.80 copay for Medicaid-covered services
Transportation	$0 copay for Medicaid-covered services Contact Medical Assistance Transportation (MATP) for information
Foot Care	$0-$3.80 copay for Medicaid-covered services
Medical Equipment/Supplies	$0-$3.80 copay for Medicaid-covered services
Podiatrist Services	$0
Family Planning Services	$0
Maternity Care	$0
Tobacco Cessation	$0

Benefits	What you pay under Medicaid
Prescription Drugs	$1-$3 copay for Medicaid-covered prescriptions • $1 for each prescription and prescription refill of a generic drug • $3 for each prescription and prescription refill of a brand name drug • Nutritional supplements
Outpatient Surgery	$0-$3.80 copay for Medicaid-covered services Ambulatory Surgery Center (ASC) and Same Day Surgery (SPU); Independent Medical/Surgical Clinic
Chiropractic Care	$0-$3.80 copay for Medicaid-covered services
Drug and Alcohol Clinic Services	$0-$3.80 copay for Medicaid-covered services • Includes methadone maintenance and clozapine • Refer to your Behavioral Health Managed Care Organization for details
Psychiatric Clinic	$0.50 per unit copay for Medicaid-covered services • Includes mobile mental health treatment • Refer to your Behavioral Health Managed Care Organization for details
Psychiatric Partial Hospitalization Facility	$0 per unit copay for Medicaid-covered services Refer to your Behavioral Health Managed Care Organization for details
Psychiatric Rehabilitation	$0-$3.80 copay for Medicaid-covered services Refer to your Behavioral Health Managed Care Organization for details
Federally Qualified Health Center/Rural Health Center	$0-$3.80 copay for Medicaid-covered services
Home Health Services	$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.
Hospice Care	$0-$3.80 copay for Medicaid-covered services Respite care may not exceed a total of five days in a 60-day certification period
Long-Term Nursing Facility	$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)
Home and Community Based Waiver Services	$0-$3.80 copay for Medicaid-covered services For more information, contact your Community HealthChoices MCO or the Office of Long-term Living
Renal Dialysis	$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.
Therapy (Physical, Occupational, Speech)	$0-$3.80 copay for Medicaid-covered services Only when provided by a hospital, outpatient clinic, or home health provider
Prosthetics and Orthotics	$0-$3.80 copay for Medicaid-covered services Orthopedic shoes and hearing aids are not covered. Coverage for low-vision aids is limited to one per two calendar years. Coverage for an eye ocular is limited to one per calendar year.

Highmark Wholecare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex, gender, gender identity or expression, or sexual orientation.

Highmark Wholecare does not exclude people or treat them differently because of their race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex, gender, gender identity or expression, or sexual orientation.

Highmark Wholecare provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters.
- Written information in a different way, including large print, audio, and Braille.

Highmark Wholecare provides free language services to people whose primary language is not English, such as:

- Qualified interpreters.
- Information written in other languages.

If you need these services, call Member Services at 1-800-685-5209 (TTY: 711), 8 a.m. – 8 p.m., seven days a week, Oct. 1 through March 31. From April 1 through Sept. 30, business hours are 8 a.m. – 8 p.m., Monday through Friday.

If you believe that Highmark Wholecare has failed to provide these services or discriminated against you in another way on the basis of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex, gender, gender identity or expression, or sexual orientation, you can file a complaint with Highmark Wholecare:

Highmark Wholecare
Attn: Grievances Department
P.O. Box 890034
Camp Hill, PA 17089
1-800-207-0336 (TTY: 711)
Fax: 1-412-255-4503

You can file a complaint by mail, phone, or fax. If you need help filing a complaint, Highmark Wholecare 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 online at OCRPortal.hhs.gov, and by mail, phone, or email:

U.S. Department of Health and Human Services
200 Independence Avenue SW
HHH Building Room 509F
Washington, DC 20201
1-800-368-1019 (TTY: 1-800-537-7697)
OCRMail@hhs.gov

A printable version of the complaint form in English is available at hwc.fyi/complaint-form.

ATTENTION: If you speak English, free language translation and interpretation services are available to you. Appropriate auxiliary aids and services (such as large print, audio, and Braille) to provide information in accessible formats are also available free of charge. Call the number on the back of your ID card (TTY: 711) for help.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de traducción e interpretación de idiomas. También hay disponibles ayudas y servicios auxiliares adecuados (como letra grande, audio y Braille) para proporcionar información en formatos accesibles sin cargo. Llame al número que figura al dorso de su tarjeta de identificación (TTY: 711) si necesita ayuda.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Übersetzungs- und Dolmetscherdienste zur Verfügung. Außerdem sind kostenlos entsprechende Hilfsmittel und Dienstleistungen (wie Großdruck, Audio und Blindenschrift) zur Bereitstellung von Informationen in barrierefreien Formaten erhältlich. Wählen Sie hierfür bitte die Nummer auf der Rückseite Ihrer Ausweiskarte (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis tradiksyon ak entèpretasyon aladispozisyon w gratis nan lang ou pale a. Èd ak sèvis siplemantè apwopriye (tèlke gwo lèt, odyo, Braille) pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele nimewo ki sou do Kat ID w lan (TTY: 711) pou jwenn èd.

ВНИМАНИЕ: Если Вы говорите на русском языке, Вам доступны бесплатные услуги перевода на другой язык. Также предоставляется дополнительная бесплатная помощь и услуги отображения информации в доступных форматах (например, крупным шрифтом, шрифтом Брайля или в виде аудиозаписи). Для получения помощи позвоните по номеру, указанному на обратной стороне вашей идентификационной карты (TTY: 711).

ATTENZIONE: se parla italiano, sono disponibili servizi gratuiti di traduzione e interpretariato. Sono inoltre disponibili gratuitamente adeguati supporti e servizi ausiliari (ad esempio caratteri grandi, audio e Braille) per fornire informazioni in formati accessibili. Per assistenza, chiami il numero riportato sul retro della Sua tessera di identificazione (TTY: 711).

ATTENTION : si vous parlez français, des services de traduction et d'interprétation gratuits sont à votre disposition. Vous pouvez aussi bénéficier gratuitement de l'accès à des outils et services auxiliaires appropriés (affichage en gros caractères, audio et le braille) dans des formats accessibles. Veuillez appeler le numéro qui se trouve au verso de votre carte d'identification (TTY : 711) pour obtenir de l'aide.

ÀKÍYÈSÍ: Tí o bá nsọ èdè Yorùbá, àwọn iṣẹ ìtumọ ati ògbufọ èdè wà ní àrọwọtọ lọ́fẹ̀ẹ́ fún ọ. Awọn iṣẹ ìtọ́jú ati ìrànlọ́wọ́ tó yẹ (bíi titẹwé nla, gbigbọ ohùn, ati ìwé afọ́jú) lati pèsè iwifúnni ni awọn ọna ìrááyè si wà pẹlu lọ́fẹ̀ẹ́. Pe nọmba tó wà lẹhin kaádì ìdánimọ rẹ (TTY: 711) fún ìranlọwọ.

אכטונג: אויב איר רעדט אידיש, קענט איר באקומען שפראך איבערזעצונג און דאלמעטשונג סערוויסעס פריי פון אפצאל. געהעריגע הילפסמיטלען און סערוויסעס (אזויווי גרויסע דרוק, אודיא און ברעיל) צו צושטעלן אינפארמאציע אין צוגענגליכע פארמאטן זענען אויך דא צו באקומען פריי פון אפצאל. רופט דעם נומער אויף די אנדערע זייט פון אייער אידענטיטעט קארטל (TTY: 711) פאר הילף.

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات الترجمة التحريرية والترجمة الفورية مجانًا. تتوفر أيضًا الوسائل والخدمات المساعدة المناسبة (مثل الطباعة الكبيرة، والوسائل الصوتية، وطريقة برايل) لتقديم المعلومات بتنسيقاتٍ يمكن الوصول إليها من دون أي تكلفة. اتصل على الرقم المدوّن على ظهر بطاقة هويتك (TTY: 711) للحصول على المساعدة.

注意：如果您说中文，我们将为您提供免费的语言翻译和口译服务。此外，我们还免费提供相应的辅助工具和服务（如大字体、音频和盲文），以便您获取无障碍格式的信息。如需帮助，请拨打您的 ID 卡背面的号码（听障人士专用号码： 711）。

ધ્યાન આપશો: જો તમે ગુજરાતી બોલતા હોવ, તો તમારા માટે નિઃશુલ્ક ભાષા અનુવાદ અને ઇન્ટરપ્રિટેશન સેવાઓ ઉપલબ્ધ છે. સુલભ ફોર્મેટમાં માહિતી પૂરી પાડવા માટે યોગ્ય સહાયક સાધનસામગ્રી અને સેવાઓ (જેમ કે મોટી પ્રિન્ટ, ઓડિયો અને બ્રેઇલ) પણ નિઃશુલ્ક ઉપલબ્ધ છે. મદદ માટે તમારા આઇડી કાર્ડની પાછળ આપેલા નંબર (TTY: 711) પર કૉલ કરો.

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi có dịch vụ biên dịch và phiên dịch ngôn ngữ miễn phí dành cho quý vị. Chúng tôi cũng cung cấp miễn phí các dịch vụ và hỗ trợ bổ sung thích hợp (như chữ in lớn, tệp âm thanh và chữ nổi) để cung cấp thông tin ở các định dạng dễ tiếp cận. Vui lòng gọi số điện thoại trên mặt sau của thẻ nhận dạng của quý vị (TTY: 711) để được trợ giúp.

ध्यान दिनुहोस्: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंलाई निःशुल्क भाषा अनुवाद र दोभासे सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायक प्रविधि र सेवाहरू (जस्तै ठूलो प्रिन्ट, अडियो र ब्रेल) पनि निःशुल्क उपलब्ध छन्। मद्दतको लागि तपाईंको ID कार्डको पछाडिको नम्बरमा कल गर्नुहोस् (TTY: 711)।

कृपया ध्यान दें: यदि आप हिंदी भाषा बोलते हैं, तो आपके लिए मुफ़्त भाषा अनुवाद और व्याख्या संबंधी सेवाएं उपलब्ध हैं। एक्सेस करने योग्य फ़ॉर्मेट में सूचना उपलब्ध कराने के लिए उपयुक्त सहायक सामग्री और सेवाएं (जैसे बड़े प्रिंट, ऑडियो और ब्रेल) भी निःशुल्क उपलब्ध हैं। सहायता के लिए अपने पहचान कार्ड के पीछे लिखे नंबर (TTY: 711) पर कॉल करें।

주의: 한국어를 사용하는 경우 무료 언어 번역 및 통역 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공받을 수 있는 적절한 보조 수단 및 서비스(예: 큰 활자, 오디오, 점자)도 무료로 이용할 수 있습니다. 도움이 필요하시면 ID 카드 뒷면에 있는 번호로 전화하십시오(TTY: 711).