

MAGNO (HMO-POS) SUMMARY OF BENEFITS





ABOUT THIS PLAN

Magno (HMO-POS) is a Medicare Advantage HMO plan with a Medicare contract. Enrollment in the Plan depends on contract renewal.

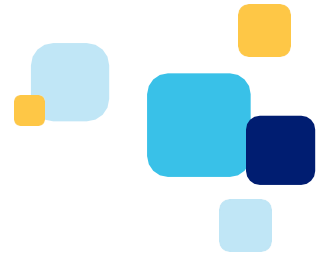
Triple-S Advantage, Inc. is a health maintenance organization (HMO) with a Medicare contract. Enrollment in Triple-S Advantage, Inc. depends on contract renewal. Triple-S Advantage, Inc. is an independent licensee of the BlueCross BlueShield Association.

To join **Magno (HMO-POS)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, be a U.S. citizen or lawfully present in the United States, not have End Stage Renal Disease (ESRD) and live in our service area. Our service area includes the following counties in Puerto Rico: Adjuntas, Aguada, Aguadilla, Aguas Buenas, Aibonito, Añasco, Arecibo, Arroyo, Barceloneta, Barranquitas, Bayamón, Cabo Rojo, Caguas, Camuy, Canóvanas, Carolina, Cataño, Cayey, Ceiba, Ciales, Cidra, Coamo, Comerío, Corozal, Culebra, Dorado, Fajardo, Florida, Guánica, Guayama, Guayanilla, Guaynabo, Gurabo, Hatillo, Hormigueros, Humacao, Isabela, Jayuya, Juana Díaz, Juncos, Lajas, Lares, Las Marías, Las Piedras, Loíza, Luquillo, Manatí, Maricao, Maunabo, Mayagüez, Moca, Morovis, Naguabo, Naranjito, Orocovis, Patillas, Peñuelas, Ponce, Quebradillas, Rincón, Río Grande, Sabana Grande, Salinas, San Germán, San Juan, San Lorenzo, San Sebastián, Santa Isabel, Toa Alta, Toa Baja, Trujillo Alto, Utuado, Vega Alta, Vega Baja, Vieques, Villalba, Yabucoa, and Yauco.

Benefits, premium, and/or copayments/coinsurance may change on January 1 of each year.

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GETTING CARE

Magno (HMO-POS) 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. Under this plan you have a **Point-of-Service (POS)** option. The POS option allows you to get care from non-contracted providers and hospitals. You may receive all plan covered services, but you will need to pay a higher cost sharing than the one you pay when using in network providers.

Out-of-network/non-contracted providers are under no obligation to treat Triple-S Advantage, Inc. members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

You can go to www.sssadvantage.com to see your plan's provider and pharmacy directories. You can also view the complete plan formulary (list of Part D prescription drugs) to see what drugs are covered and if there are any restriction.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

IF YOU HAVE QUESTIONS

For more information, please call Member Service at the phone number below or visit us at www.sssadvantage.com.

If you are a member of this plan, call toll-free **1-888-620-1919 (TTY/TDD 1-866-620-2520)**. If you are not a member of this plan, call toll-free **1-877-207-8777 (TTY/TDD 1-866-620-2520)**. You can call us Monday through Sunday from 8:00 a.m. to 8:00 p.m. Atlantic standard time.

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 <http://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**.





NOTICE OF NON-DISCRIMINATION

This document is available for free in Spanish.

This document is also available in alternate formats such as Braille, large print and audio. Please contact Members Services if you need plan information on other format or language.

COVERED BENEFITS, PREMIUMS AND LIMITATIONS

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 covered services, please request the **Evidence of Coverage** calling our Member Services department or visiting our website www.sssadvantage.com.

Under the **Point-of-Service (POS)** option for Out-of-Network services, you have a maximum benefit limit of \$5,000 every year, for some services.

Premiums and Benefits	Magno (HMO-POS)	What you should know
Monthly Plan Premium	\$0.	You must continue to pay your Medicare Part B premium.
Medicare Part B monthly reduction	\$25 per month.	This means that your Part B Premium will be less while you are a member of Magno
Deductible	You pay nothing.	This plan does not have a deductible.



MAGNO (HMO-POS)



Premiums and Benefits	Magno (HMO-POS)	What you should know
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	\$3,400 annually.	This is the most you will pay for copays, coinsurance and other costs for in-network medical services for the year.
Inpatient Hospital Coverage	Preferred Provider Network: You pay nothing. Provider Network: \$40 copay. Out of Network: (Point of Service Option) 35% coinsurance.	This plan covers an unlimited number of days for an inpatient hospital stay.
Outpatient Hospital Coverage	\$25 copay. Out of Network: (Point of Service Option) 35% coinsurance	Some services may require prior authorization.
Doctor Visits <ul style="list-style-type: none"> ○ Primary ○ Specialists 	<ul style="list-style-type: none"> ○ You pay nothing. ○ Preferred Provider Network: You pay nothing. Provider Network: \$5 copay. Out of Network: (Point of Service Option) 35% coinsurance.	You pay nothing at SALUS Clinics. Other providers are available in our network. Surgery and procedures in a physician's office may require prior authorization.
Preventive Care	You pay nothing. Out of Network: (Point of Service Option) 35% coinsurance.	Any additional preventive services approved by Medicare during the contract year will be covered.



MAGNO (HMO-POS)



Premiums and Benefits	Magno (HMO-POS)	What you should know
Emergency Care	\$50 copay.	<p>If you are admitted to the hospital within 24 hours for the same condition for which you were evaluated in the emergency room, you pay nothing for the emergency room visit.</p> <p>Services in the United States may also be managed through reimbursement according to Medicare rates and the location where the services were provided, minus the copay.</p>
Urgently Needed Services	You pay nothing.	<p>Services in the United States may also be managed through reimbursement according to Medicare rates and the location where the services were provided, minus the copay.</p>



MAGNO (HMO-POS)



Premiums and Benefits	Magno (HMO-POS)	What you should know
Diagnostic Services/Labs/ Imaging <ul style="list-style-type: none"> ○ Diagnostic radiology service (e.g., MRI) ○ Lab services ○ Diagnostic tests and procedures ○ X-rays ○ Therapeutic Radiology services 	<ul style="list-style-type: none"> ○ General: You pay nothing. Complex: \$20 copay. ○ You pay nothing. ○ You pay nothing. ○ You pay nothing. ○ You pay nothing. <p>Out of Network: (Point of Service Option) 35% coinsurance.</p>	<p>You pay nothing at SALUS Clinics. Other providers are available in our network.</p> <p>Some services may require prior authorization.</p>
Hearing Services <ul style="list-style-type: none"> ○ Hearing exam ○ Routine hearing exam ○ Hearing aid fitting /evaluation ○ Hearing aid 	<ul style="list-style-type: none"> ○ You pay nothing. ○ You pay nothing. ○ You pay nothing. ○ You pay nothing. <p>Out of Network: (Point of Service Option) 35% coinsurance.</p>	<p>One (1) routine hearing exam every year.</p> <p>One (1) hearing fitting/evaluation every year.</p> <p>Up to \$500 every 3 years for hearing aids.</p>



MAGNO (HMO-POS)



Premiums and Benefits	Magno (HMO-POS)	What you should know
<p>Dental Services</p> <ul style="list-style-type: none"> ○ Preventive: Oral exam, Cleaning, Fluoride and x-rays ○ Comprehensive: Endodontics, Prosthodontics, Oral/Maxillofacial surgery, Restorative services, Periodontics and other general services. 	<ul style="list-style-type: none"> ○ You pay nothing. ○ 10% coinsurance. <p>Out of Network: (Point of Service Option) 35% coinsurance.</p>	<ul style="list-style-type: none"> ● One (1) Cleaning; every six months ● Dental x-ray(s) ● One (1) Fluoride treatment every six months ● One (1) Oral exam every six months <p>Up to \$2,000 plan coverage limit for supplemental comprehensive dental benefits every year</p> <p>A maximum benefit limit applies for some services.</p> <p>Some comprehensive dental services may require prior authorization. Ask your Dentist if the service you need requires prior authorization before rendering it.</p>



MAGNO (HMO-POS)



Premiums and Benefits	Magno (HMO-POS)	What you should know
Vision Services <ul style="list-style-type: none"> ○ Eye exam ○ Routine eye exam ○ One pair of eyeglasses or contact lenses after each cataract surgery ○ Contact lenses, Eyeglasses (frame & lenses), Eyeglasses Frame, Eyeglasses Lenses 	<ul style="list-style-type: none"> ○ You pay nothing. ○ You pay nothing. ○ You pay nothing. ○ You pay nothing. <p>Out of Network: (Point of Service Option) 35% coinsurance.</p>	<p>\$600 for prescription eyeglasses (frame and lenses) or contact lenses every year.</p> <p>You are responsible for the balance that exceeds the amount of the benefit stipulated in your coverage.</p>
Mental Health Services <ul style="list-style-type: none"> ○ Inpatient ○ Outpatient individual therapy visit ○ Outpatient group therapy visit ○ Partial Hospitalization 	<ul style="list-style-type: none"> ○ You pay nothing. ○ You pay nothing. ○ You pay nothing. ○ You pay nothing. <p>Out of Network: (Point of Service Option) 35% coinsurance.</p>	<p>Up to 190-day lifetime limit for inpatient services in a psychiatric hospital.</p> <p>Some partial hospitalization services may require prior authorization.</p>



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Premiums and Benefits	Magno (HMO-POS)	What you should know
Skilled Nursing Facility (SNF)	<p>You pay nothing.</p> <p>Out of Network: (Point of Service Option) 35% coinsurance.</p>	<p>Up to 100 days in a SNF per benefit period.</p> <p>A 3-day prior hospital stay is required.</p> <p>Requires prior authorization.</p>
Physical therapy	<p>You pay nothing.</p> <p>Out of Network: (Point of Service Option) 35% coinsurance.</p>	<p>Services in a Comprehensive Outpatient Rehabilitation Facility (CORF) requires prior authorization.</p>
Ambulance	<p>You pay nothing.</p> <p>Out of Network: (Point of Service Option) 35% coinsurance.</p>	<p>Non-emergency transportation requires prior authorization.</p>
Transportation	<p>You pay nothing.</p> <p>Out of Network: (Point of Service Option) 35% coinsurance.</p>	<p>We cover sixteen (16) one-way trips per year for medical appointments in any medical facility and picking up prescriptions in pharmacies.</p> <p>Method of transportation includes but is not limited to taxi, bus, van or other available methods of transportation, such as an automobile through a contracted provider. The service must be coordinated and have plan approval.</p> <p>Some services may require prior authorization by exception after exhausting coverage limit.</p>



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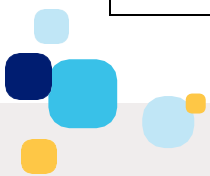
Premiums and Benefits	Magno (HMO-POS)	What you should know
Medicare Part B Drugs	<ul style="list-style-type: none"> ○ You pay nothing for Respiratory Therapy drugs. ○ 10% coinsurance for Chemotherapy drugs. ○ 20% coinsurance for Part B drugs. <p>Out of Network: (Point of Service Option) 35% coinsurance.</p>	<p>Some services may require prior authorization.</p> <p>Step Therapy may apply from: Part B to Part B, Part B to Part D, Part D to Part B.</p>
Other Rehabilitation Services <ul style="list-style-type: none"> ○ Occupational therapy visit ○ Speech and language therapy visit ○ Pulmonary rehabilitation services ○ Cardiac rehabilitation services 	<ul style="list-style-type: none"> ○ You pay nothing. ○ You pay nothing. ○ You pay nothing. ○ You pay nothing. <p>Out of Network: (Point of Service Option) 35% coinsurance.</p>	<p>Services in a Comprehensive Outpatient Rehabilitation Facility (CORF), cardiac and pulmonary rehabilitation services require prior authorization.</p>



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Premiums and Benefits	Magno (HMO-POS)	What you should know
<p>Foot Care (podiatry services)</p> <ul style="list-style-type: none"> ○ Foot exams and treatment ○ Routine foot care 	<ul style="list-style-type: none"> ○ You pay nothing. ○ You pay nothing. <p>Out of Network: (Point of Service Option) 35% coinsurance.</p>	<p>Up to four (4) routine footcare visits every year, including the initial visit.</p>
<p>Medical Equipment/Supplies</p> <ul style="list-style-type: none"> ○ Durable Medical Equipment (e.g., wheelchairs, oxygen) ○ Prosthetics (e.g., braces, artificial limbs) ○ Medical supplies ○ Diabetes supplies 	<ul style="list-style-type: none"> ○ Preferred brands and manufacturers: You pay nothing. ○ Non-preferred brands and manufacturers: 10% coinsurance. ○ Orthotic and non-surgically implanted prosthetic devices: You pay nothing. ○ Surgically implanted prosthetic devices, urinary system & neurostimulator: 10% coinsurance. ○ Preferred brands and manufacturers: You pay nothing. ○ Non-preferred brands and manufacturers: 10% coinsurance. ○ You pay nothing. 	<p>Some durable medical equipment, prosthetics and medical supplies may require prior authorization.</p>



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Premiums and Benefits	Magno (HMO-POS)	What you should know
	Out of Network: (Point of Service Option) 35% coinsurance.	
Wellness Programs <ul style="list-style-type: none"> ○ Wellness program ○ Teleconsulta ○ Teleconsejo 	<ul style="list-style-type: none"> ○ You pay nothing. ○ You pay nothing. ○ You pay nothing. 	<p>Wellness program; this program provides health education material, group interventions and telephone-based education on nutrition and weight management based on your health profile.</p> <p>Teleconsulta nurse line for health consultations, available 24 hours, 7 days a week.</p> <p>Teleconsejo emotional support line available 24 hours, 7 days a week.</p>
Outpatient Surgery	<ul style="list-style-type: none"> ○ Ambulatory Surgical Center: \$25 copay. ○ Ambulatory Hospital Facility: \$25 copay. <p>Out of Network: (Point of Service Option) 35% coinsurance.</p>	<p>Some services may require prior authorization.</p>



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Premiums and Benefits	Magno (HMO-POS)	What you should know
Chiropractic <ul style="list-style-type: none"> ○ Medicare-covered visits to correct subluxation ○ Routine visits 	<ul style="list-style-type: none"> ○ \$5 copay. ○ \$5 copay. <p>Out of Network: (Point of Service Option) 35% coinsurance.</p>	<p>Manipulation of the spine to correct a subluxation (When one or more of the bones of your spine move out of position).</p> <p>Up to five (5) routine chiropractic visits every year, including the initial visit</p>

Outpatient Prescription Drugs			
<p>For more information on the additional pharmacy- specific cost-sharing and the phases of the benefit, please call us or access our Evidence of Coverage online.</p>			
	Rx Preferred Retail 30-day supply	Rx Preferred Retail 90-day supply	Rx Mail Order Supply
Phase 1: Initial Coverage			
Tier 1: Preferred Generic	You pay nothing.	You pay nothing.	You pay nothing.
Tier 2: Generic	\$3 copay.	\$6 copay.	\$6 copay.
Tier 3: Preferred Brand	\$10 copay.	\$20 copay.	\$20 copay.
Tier 4: Non-Preferred Brand	\$30 copay.	\$60 copay.	\$60 copay.
Tier 5: Specialty Drugs	33% coinsurance.	33% coinsurance.	33% coinsurance.
Tier 6: Select Care Drugs	You pay nothing.	You pay nothing.	You pay nothing.

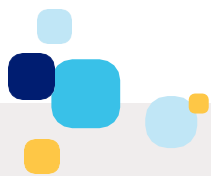


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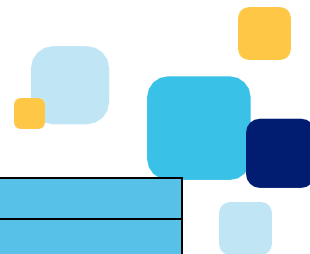


Outpatient Prescription Drugs		
For more information on the additional pharmacy- specific cost-sharing and the phases of the benefit, please call us or access our Evidence of Coverage online.		
	Rx Standard Retail 30-day supply	Rx Standard Retail 90-day supply
Phase 1: Initial Coverage		
Tier 1: Preferred Generic	\$5 copay.	\$10 copay.
Tier 2: Generic	\$8 copay.	\$16 copay.
Tier 3: Preferred Brand	\$30 copay.	\$60 copay.
Tier 4: Non-Preferred Brand	\$55 copay.	\$110 copay.
Tier 5: Specialty Drugs	33% coinsurance.	33% coinsurance.
Tier 6: Select Care Drugs	\$3 copay.	\$6 copay.

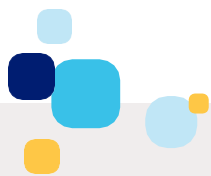
Supplemental Benefits		
Premiums and Benefits	Magno (HMO-POS)	What you should know
Worldwide emergency/urgently needed care	You pay nothing.	<p>We cover emergency/urgent care visits outside the United States and its territories as a supplemental benefit. Services are covered through reimbursement in accordance to Triple-S Advantage, Inc. rates.</p> <p>Maximum coverage limit up to \$75.00 for incurred costs for emergency/urgent care services.</p>



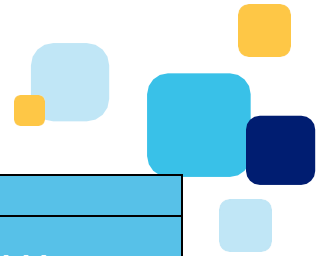
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Supplemental Benefits		
Premiums and Benefits	Magno (HMO-POS)	What you should know
Alternative Medicine/Acupuncture	<ul style="list-style-type: none"> ○ Alternative Medicine: You pay nothing. ○ Acupuncture: You pay nothing. 	Up to twelve (12) combined visits every year.
Erectile Dysfunction Drugs	<p>Sildenafil Citrate (25, 50 y 100mg) - Preferred Retail- \$3 copay. - Standard Retail- \$8 copay.</p> <p>Tadalafil (10 mg y 20 mg) - Preferred Retail- \$3 copay. - Standard Retail- \$8 copay.</p> <p>Cialis (10 y 20 mg) - Preferred Retail- \$30 copay. - Standard Retail- \$55 copay.</p> <p>Viagra (25, 50 y 100mg) - Preferred Retail- \$30 copay. - Standard Retail- \$55 copay.</p>	Up to 6 pills per month.
Nutritional/Dietary Benefit	You pay nothing.	A maximum of 4 individual visits per year to a nutritionist.



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Supplemental Benefits		
Premiums and Benefits	Magno (HMO-POS)	What you should know
Over-the-Counter drugs	<p>You pay nothing.</p> <p>\$40 every 3 months.</p> <p>The plan will pay the item up to the quarterly coverage limit. The member must pay the difference, if any, and any applicable taxes. The amounts must be used in full as they do not accumulate from quarter to quarter.</p>	<p>Some covered categories are: Non-narcotic analgesics, anorectal agents, antidiarrheal, antiemetic, artificial tears and eye lubricants, allergy, cough and cold medications, dermatological agents, laxatives, minerals & electrolytes, multivitamins, nasal agent, nutrients (Omega 3 or fish oil), otic agents, smoking deterrents, urinary analgesics, vaginal products, vitamins, adult diapers and pads and blood pressure monitor.</p> <p>The Blood Pressure Monitor is covered up to one (1) every 5 years.</p>



 **TRIPLE-S ADVANTAGE**
Multi-language Interpreter Services

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-888-620-1919 (TTY: 1-866-620-2520).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-620-1919 (TTY: 1-866-620-2520).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-888-620-1919 (TTY: 1-866-620-2520)。

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-620-1919 (TTY: 1-866-620-2520).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-620-1919 (TTY: 1-866-620-2520).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-620-1919 (TTY: 1-866-620-2520).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-620-1919 (TTY: 1-866-620-2520) 번으로 전화해 주십시오.

Arabic: بالمجان لك تتوافر اللغوية المساعدة خدمات فإن، اللغة اذكر تتحدث كنت إذا :ملحوظة 1-888-620-1919 (والبكم الصم هاتف رقم) 1-866-620-2520).

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-888-620-1919 (TTY: 1-866-620-2520) पर कॉल करें।

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-620-1919 (TTY: 1-866-620-2520).

Português: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-888-620-1919 (TTY: 1-866-620-2520).

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-888-620-1919 (TTY: 1-866-620-2520).

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-620-1919 (TTY: 1-866-620-2520).

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。1-888-620-1919 (TTY: 1-866-620-2520)まで、お電話にてご連絡ください。

Ukrainian: УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-620-1919 (телетайп: 1-866-620-2520).

Catalan: ATENCIÓ: Si parleu Català, teniu disponible un servei d'ajuda lingüística sense cap càrrec. Truqueu al 1-888-620-1919 (TTY o teletip: 1-866-620-2520).

**NOTICE INFORMING INDIVIDUALS ABOUT NONDISCRIMINATION AND
ACCESSIBILITY REQUIREMENTS AND NONDISCRIMINATION STATEMENT:
DISCRIMINATION IS AGAINST THE LAW**

Triple-S Advantage, Inc. complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Triple-S Advantage, Inc. does not exclude people or treat them differently because of race, color national origin, age, disability, or sex.

Triple-S Advantage, Inc.:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not Spanish, such as:
 - Qualified interpreters
 - Information written in other languages.

If you need these services, contact a Service Representative.

If you believe that Triple-S Advantage, Inc. 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:

Service Representative

P.O Box 11320, San Juan, PR

00922-1320

Telephone: 1-888-620-1919, TTY: 1-866-620-2520

Fax. 787-993.3261, e-mail: TSACompliance@sssadvantage.com

You can file a grievance in person or by mail, fax, or e-mail. If you need help filing a grievance, a Service Representative is available to help you.

You can also file a civil rights complaint with the US Department of Health and Human Services, Office of Civil Rights electronically through the Office of 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>.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-888-620-1919 (TTY: 1-866-620-2520).

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