

# 2018

## Summary of Benefits

### Sanford Heart of America Health Plan, a Medicare Cost Plan (HMO)

H3503, Plan 003

This is a summary of drug and health services covered by Sanford Heart of America Health Plan (Cost)

January 1, 2018 - December 31, 2018

**Sanford Heart of America Health Plan (HMO)** is a Medicare Cost plan with a Medicare contract. Enrollment in the Plan depends on contract renewal.

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, please request the "Evidence of Coverage" (EOC).

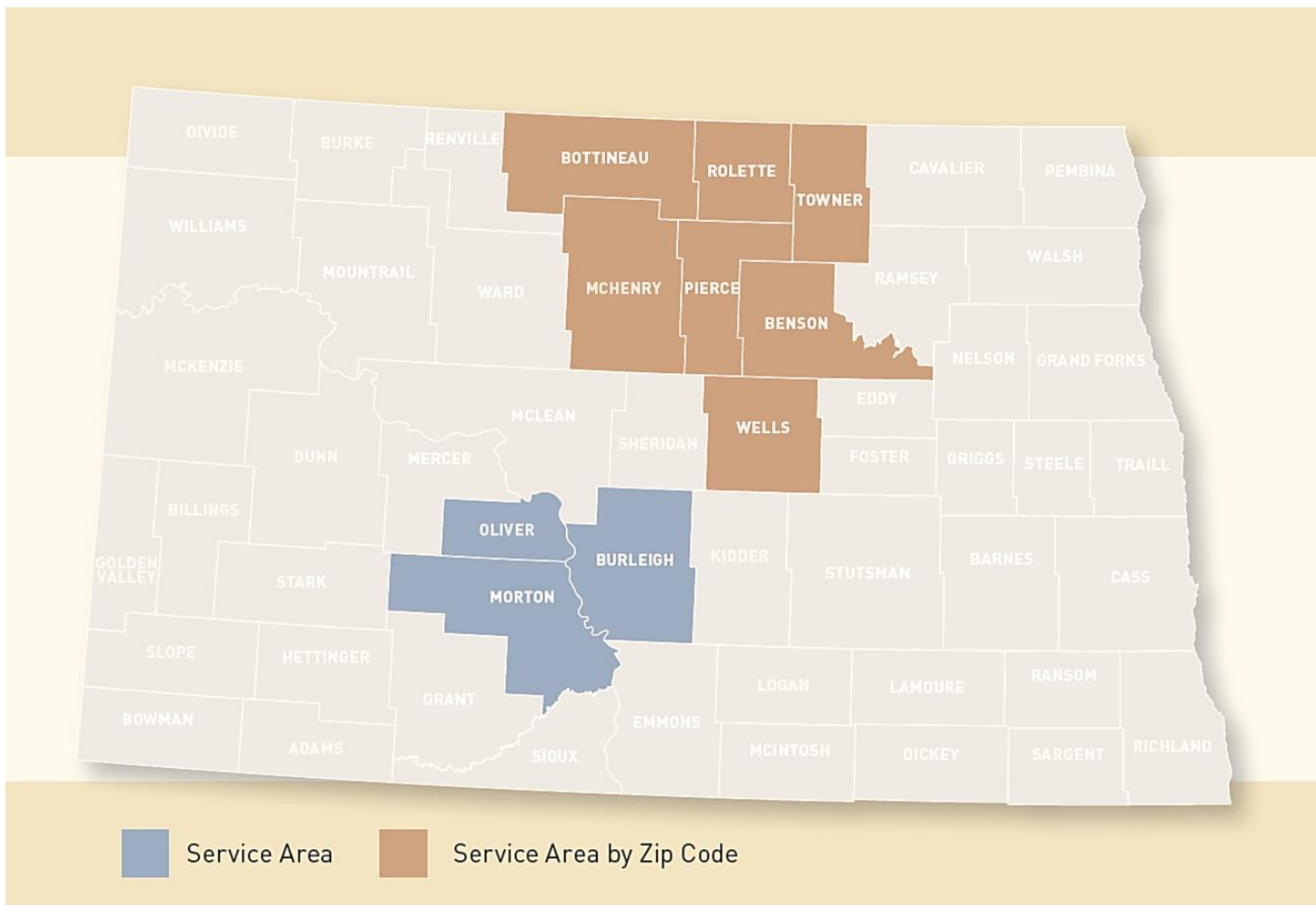
To join the **Sanford Heart of America Health Plan**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the counties and zip codes in North Dakota, listed on the next page.

**Sanford Heart of America Health Plan** has a network of doctors, hospitals, and other providers. If you use the providers that are not in our network, the Plan may not pay for these services. Most health services require a referral from your Primary Care Provider (PCP) unless otherwise noted in the EOC.



**SANFORD**  
HEALTH PLAN

*Heart of America*



### What is Sanford Heart of America Health Plan’s Service Area?

Our Service Area includes these counties in North Dakota: Burleigh, Morton and Oliver.

Our Service Area also includes the following zip codes within the North Dakota counties of Benson, Bottineau, McHenry, Pierce, Rolette, Towner and Wells:

|       |       |       |       |       |       |       |
|-------|-------|-------|-------|-------|-------|-------|
| 58313 | 58346 | 58372 | 58502 | 58535 | 58631 | 58778 |
| 58316 | 58348 | 58377 | 58503 | 58545 | 58638 | 58783 |
| 58317 | 58352 | 58384 | 58504 | 58553 | 58710 | 58788 |
| 58318 | 58353 | 58385 | 58505 | 58554 | 58712 | 58789 |
| 58323 | 58357 | 58386 | 58506 | 58558 | 58713 | 58792 |
| 58324 | 58359 | 58418 | 58507 | 58560 | 58736 | 58793 |
| 58329 | 58363 | 58422 | 58520 | 58563 | 58740 |       |
| 58331 | 58365 | 58438 | 58521 | 58566 | 58741 |       |
| 58332 | 58366 | 58463 | 58523 | 58570 | 58744 |       |
| 58337 | 58367 | 58477 | 58524 | 58571 | 58748 |       |
| 58341 | 58368 | 58494 | 58530 | 58572 | 58758 |       |
| 58343 | 58369 | 58501 | 58532 | 58579 | 58762 |       |

### How do I get more information about Sanford Heart of America Health Plan?

Visit [www.sanfordhealthplan.com/heartofamerica](http://www.sanfordhealthplan.com/heartofamerica) to learn more or call toll-free (888) 605-9277 | TTY/TDD: (877) 652-1844. To contact us in a language other than English, call toll-free (800) 892-0675. Our hours of operation are Monday through Friday from 8:00 a.m. to 8:00 p.m. Central Time.

**NOTE:** This is a summary document and the complete list of services is found in the Evidence of Coverage (EOC). To access and/or order the EOC free of charge, contact us using the information on the last page of this booklet, visit [www.sanfordhealthplan.com/heartofamerica](http://www.sanfordhealthplan.com/heartofamerica), or download a copy from your Member portal at [www.sanfordhealthplan.com/memberlogin](http://www.sanfordhealthplan.com/memberlogin).

| Premiums and Benefits   | Sanford Heart of America Health Plan (Medicare Cost)   | What you should know   |
|---|--|--|
| <b>Monthly Plan Premium</b>   | You pay \$150.00   | <p><b>You must continue to pay your Medicare Part B premium.</b></p> <p>This Premium only includes your Part C Premium. It <u>does not</u> include Part D outpatient prescription drug supplemental coverage you may choose to buy separately from this plan.</p>  |
| <b>Deductible</b>   | You pay nothing.   | This plan does not have a deductible.  |
| <b>Maximum Out-of-Pocket Responsibility (does not include prescription drugs)</b>                   | Not applicable.  | The most you pay for copays, co-insurance and other costs for medical services for the year.   |
| <b>Inpatient Hospital Coverage</b><br><i>(includes Substance Abuse and Rehabilitation Services)</i> | <ul style="list-style-type: none"> <li>○ You pay nothing for each Medicare-covered stay in a network hospital up to 150 days per benefit period.</li> <li>○ You pay 100% per day for each additional day beyond 150 days for each benefit period in a network hospital.</li> <li>○ Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. Lifetime reserve days can only be used once.</li> </ul> | <ul style="list-style-type: none"> <li>○ A referral may be required by your PCP for some services. Please contact the plan for more information.</li> <li>○ A “benefit period” starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care.</li> <li>○ If you go into the hospital after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.</li> </ul> |

| Premiums and Benefits   | Sanford Heart of America Health Plan (Medicare Cost)                                    | What you should know   |
|---|---|--|
| <b>Doctor Visits</b> <ul style="list-style-type: none"> <li>○ Primary Care Provider (PCP)</li> <li>○ Specialists</li> </ul> | <p>You pay nothing.</p> <p>You pay nothing. <i>Referral from a PCP is required.</i></p> | <ul style="list-style-type: none"> <li>○ In most cases, you must go to network doctors, specialists, and hospitals. You will need a referral to go to a specialist or any provider out of the plan's network. If you go to a provider without a referral and the provider accepts Medicare patients, you're covered under Original Medicare.</li> <li>○ You may go to any doctor, specialist or hospital that accepts Medicare. If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you pay more.</li> </ul> |
| <b>Preventive Care</b>  | <p>You pay nothing.</p>   | <p>Any additional preventive services approved by Medicare during the contract year will be covered. There are some items not covered at \$0 cost.</p>   |
| <b>Emergency Care</b>   | <p>You pay nothing.</p>   | <ul style="list-style-type: none"> <li>○ If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care.</li> <li>○ If the Plan authorizes your inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a network hospital.</li> <li>○ NOT covered outside the U.S. except under limited circumstances.</li> </ul>  |
| <b>Urgently Needed Services</b><br><i>(This is NOT emergency care, and in most cases, is out of the Service Area.)</i>      | <p>You pay nothing.</p>   | <p>NOT covered outside the U.S. except under limited circumstances.</p>  |

| Premiums and Benefits  | Sanford Heart of America Health Plan (Medicare Cost)   | What you should know  |
|--|--|---|
| <b>Diagnostic Services/ Labs/ Imaging</b> <ul style="list-style-type: none"> <li>○ Diagnostic radiology service (e.g., MRI)</li> <li>○ Lab services</li> <li>○ Diagnostic tests and procedures</li> <li>○ Outpatient x-rays</li> </ul> | <p>You pay nothing.</p> <p>You pay nothing.</p> <p>You pay nothing.</p> <p>You pay nothing.</p>  | <p>A referral may be required by your PCP for some services. Please contact the plan for more information.</p>  |
| <b>Hearing Services</b> <ul style="list-style-type: none"> <li>○ Hearing exam</li> <li>○ Hearing aids</li> </ul>   | <p>You pay nothing for diagnostic hearing exam.</p> <p>Not Covered.</p>  | <p>A referral may be required by your PCP for some services. Please contact the plan for more information. Supplemental routine hearing exams and hearing aids not covered.</p> |
| <b>Dental Services</b>   | <p>—— Preventive dental benefits (such as cleaning) not covered ——</p>   |   |
| <b>Vision Services</b>   | <p>————— Not Covered —————</p>   |   |
| <b>Vision Services</b> <ul style="list-style-type: none"> <li>○ Diagnosis &amp; treatment of diseases and conditions of the eye</li> <li>○ Supplemental routine eye exams and glasses</li> <li>○ Annual glaucoma screenings</li> </ul> | <p>You pay nothing. One pair of eyeglasses or contact lenses covered after cataract surgery.</p> <p>Not Covered.</p> <p>You pay nothing. Covered for people at risk.</p> | <p>A referral may be required by your PCP for some services. Please contact the plan for more information.</p>  |

| Premiums and Benefits   | Sanford Heart of America Health Plan (Medicare Cost)   | What you should know   |
|---|--|--|
| <b>Mental Health Services</b> <ul style="list-style-type: none"> <li>○ Inpatient stays</li> <li>○ Outpatient group/individual therapy visit</li> <li>○ All other outpatient services</li> </ul> | <p>You pay nothing for each Medicare-covered hospital stay for days 1-190. You pay 100% for each day beyond the 190-day limit. There is a 190-day lifetime limit in a psychiatric hospital.</p> <p>You pay nothing per outpatient group/individual therapy visit</p> <p>You pay nothing for Medicare-covered services, e.g. "Partial Hospitalization" or "Intensive Outpatient" treatment programs</p> | <ul style="list-style-type: none"> <li>○ A referral may be required by your PCP for some services. Please contact the plan for more information.</li> <li>○ Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.</li> <li>○ "Partial hospitalization program" is a structured program of active outpatient psychiatric treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.</li> </ul> |
| <b>Skilled Nursing Facility</b><br><i>(in a Medicare-certified skilled nursing facility)</i>  | <ul style="list-style-type: none"> <li>○ You pay nothing each day for days 1-20 each benefit period.</li> <li>○ You pay nothing each day for days 21-100 each benefit period for Medicare-covered services.</li> <li>○ You pay 100% for each additional day beyond 100 days each benefit period.</li> </ul>  | <p>A referral may be required by your PCP for some services. Please contact the plan for more information. There is a limit of 100 days for each benefit period.</p>   |
| <b>Rehabilitation Services</b> <ul style="list-style-type: none"> <li>○ Occupational therapy visit</li> <li>○ Physical therapy, and speech and language therapy visit</li> </ul>                | <p>You pay nothing.</p> <p>You pay nothing.</p>  | <p>A referral may be required by your PCP for some services. Please contact the plan for more information.</p>   |
| <b>Ambulance</b>  | <p>You pay nothing.</p>  |  |
| <b>Non-Emergency Transportation</b>   | <p>————— Not Covered —————</p>   |  |



| Premiums and Benefits  | Sanford Heart of America Health Plan (Medicare Cost)   | What you should know   |
|--|--|--|
| <b>Foot Care (podiatry services)</b> <ul style="list-style-type: none"> <li>○ Foot exams and treatment</li> <li>○ Routine foot care</li> </ul>   | <p>You pay nothing.</p> <p>You pay nothing for medically necessary foot care. Supplemental routine care not covered.</p>   | <p>A referral may be required by your PCP for some services. Please contact the plan for more information.</p> |
| <b>Medical Equipment/Supplies</b> <ul style="list-style-type: none"> <li>○ Durable Medical Equipment (e.g., wheelchairs, oxygen)</li> <li>○ Prosthetics (e.g., braces, artificial limbs)</li> <li>○ Diabetes supplies</li> </ul> | <p>You pay nothing.</p> <p>You pay nothing.</p> <p>You pay nothing.</p>  | <p>A referral may be required by your PCP for some services. Please contact the plan for more information.</p> |
| <b>Wellness Programs (e.g., fitness)</b>   | <p>————— Not Covered —————</p>   |  |
| <b>Medicare Part B Drugs</b>   | <p>You pay nothing.</p>  | <p>A referral may be required by your PCP for some services. Please contact the plan for more information.</p> |
| <b>Home Health Care</b><br><i>(includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)</i>   | <ul style="list-style-type: none"> <li>○ You pay nothing for Medicare-covered home health visits.</li> <li>○ You pay 100% for custodial care and respite care.</li> <li>○ You pay 100% for homemaker services.</li> </ul>                                | <p>A referral may be required by your PCP for some services. Please contact the plan for more information.</p> |
| <b>Hospice</b>   | <p>When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal condition are not paid for by Sanford Heart of America Health Plan, but instead by Original Medicare.</p> | <p>You must get care from a Medicare-certified hospice</p>   |

| Premiums and Benefits                                | Sanford Heart of America Health Plan (Medicare Cost)   | What you should know   |
|--|--|--|
| <b>Chiropractic Services</b>                         | You pay nothing for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers. | Supplemental routine care not covered. A referral may be required by your PCP for some services. Please contact the plan for more information. |
| <b>Outpatient Substance Abuse Care</b>               | You pay nothing for each individual visit for Medicare-covered benefits. You pay nothing for each group visit for Medicare-covered benefits.   | A referral may be required by your PCP for some services. Please contact the plan for more information.  |
| <b>Outpatient Services/Surgery</b>                   | You pay nothing for each Medicare-covered visit to an ambulatory surgical center. You pay nothing for each Medicare-covered visit to an outpatient hospital facility.                                | A referral may be required by your PCP for some services. Please contact the plan for more information.  |
| <b>Diabetes Programs and Supplies</b>                | You pay nothing.   | A referral may be required by your PCP for some services. Please contact the plan for more information.  |
| <b>Cardiac and Pulmonary Rehabilitation Services</b> | You pay nothing.   | A referral may be required by your PCP for some services. Please contact the plan for more information.  |
| <b>Outpatient (Part D) Prescription Drugs</b>        |  |  |
| ————— Not Covered —————                              |  |  |

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.

**This document is available in other formats such as Braille, large print or audio.**



# Multi-Language Insert

## Multi-language Interpreter Services

For help in a language other than English, please call us toll-free at (800) 892-0675. Both oral and written translation services are available for free in at least 150 languages. If you have any questions, for example, about your benefits, this document, or how Sanford Health Plan pays for your care, please call us.

### English

**This Notice has Important Information.** This notice has important information about your application or coverage through Sanford Health Plan. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 1-800-752-5863 (toll-free) | TTY/TDD: 1-877-652-1844 (*toll-free*). For assistance in a language other than English, call 1-800-892-0675 (toll-free).

### Spanish

**Este Aviso contiene información importante.** Este aviso contiene información importante acerca de su solicitud o cobertura a través de Sanford Health Plan. Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 1-800-892-0675.

### German

**Diese Benachrichtigung enthält wichtige Informationen.** Diese Benachrichtigung enthält wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch Sanford Health Plan. Suchen Sie nach wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter 1-800-892-0675.

### Chinese

**本通知有重要的訊息。**本通知有關於您透過 插入 Sanford Health Plan 項目的名稱 Sanford Health Plan 提交的申請或保險的重要訊息。請留意本通知內的重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險或者費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話 [在此插入數字 1-800-892-0675]。

### Cushite

**Beeksisni kun odeeffannoo barbaachisaa qaba.** Beeksisti kun sagantaa yookan karaa Sanford Health Plan tiin tajaajila keessan ilaalchisee odeeffannoo barbaachisaa qaba. Guyyaawwan murteessaa ta'an beeksisaa kana keessatti ilaalaa. Tarii kaffaltiidhaan deeggaramuuf yookan tajaajila fayyaa keessaniif guyyaa dhumaa irratti wanti raawwattan jiraachuu danda'a. Kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabaattu. Lakkoofsa bilbilaa 1-800-892-0675 tii bilbilaa.

## Vietnamese

**Thông báo này cung cấp thông tin quan trọng.** Thông báo này có thông tin quan trọng bản về đơn nộp hoặc hợp đồng bảo hiểm qua chương trình Sanford Health Plan. Xin xem ngày then chốt trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ giúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số 1-800-892-0675.

## Bantu

**Iyi notice ifise akamaro k'ingenzi.** Iyi notice ifise akamaro kingene utegerezwa gusaba canke ivyerekeye Sanford Health Plan, ucuraba ko ibikenewe kuriyi notice, ushobora gufata umwanzuro ukungene wokurikirana ubuzima bwawe uburihiye. Kandi ukongera kugira uburenganzira bwo kwigenga kuronka amakuru n'ubufasha mu rurimi gwawe atacyo utanze. Hamagara 1-800-892-0675.

## Arabic

تمامه تامولعم راعشلا اذه يوحى. للاح نم قيطغتلا بلع لوصحلل كبلط صوصخب قمهم تامولعم راعشلا اذه يوحى Sanford Health Plan. راعشلا اذه يف قماهلا خير او تلا نع ثحبا. عفد يف قدعاسملل وا قتيحصلا كتيطغت بلع ظافحل قتيعم خير او ت يف ءارجا ذاختلا جاتحت بق فيلاكتلا. قفلكت يا نود نم كتغلب قدعاسملاو تامولعملا بلع روصحلا يف قحلا كل. بب لصتا 1-800-892-0675.

## Swahili

**Ilani hii ina Taarifa Muhimu.** Ilani hii ina taarifa muhimu kuhusu maombi yako au chanjo kupitia Sanford Health Plan. Angalia kwa ajili ya tarehe muhimu katika ilani hii. Waweza pia hitajika kuchukua hatua katika muda ulio pangwa fulani ili uweze ku hifadhi bima yako ya afya au msaada wa gharama zake. Una haki ya kupata habari hii na msaada kwa lugha yako bila gharama. Piga nambari hii: 1-800-892-0675.

## Russian

Настоящее уведомление содержит важную информацию. Это уведомление содержит важную информацию о вашем заявлении или страховом покрытии через Sanford Health Plan. Посмотрите на ключевые даты в настоящем уведомлении. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону 1-800-892-0675.

## Japanese

この通知には重要な情報が含まれています。この通知には、Sanford Health Plan の申請または補償範囲に関する重要な情報が含まれています。この通知に記載されている重要な日付をご確認ください。健康保険や有料サポートを維持するには、特定の期日までに行動を取らなければならない場合があります。ご希望の言語による情報とサポートが無料で提供されます。1-800-892-0675までお電話ください。

## Nepali

**यो सूचनामा महत्त्वपूर्ण जानकारी छ । यो सूचनामा तपाईंको आवेदिनी वा Sanford Health Plan का माध्यमबाट प्राप्त हुने सुदवाबारे महत्त्वपूर्ण जानकारी छ । यो सूचनामा भएका महत्त्वपूर्ण दमदतहरू खयाल िनुहोस् । तपाईंले पाइरहेको स्वास्थ्य दबमा पाइरहन वा तपाईंको खचुको भुक्तानीमा सहायता पाउन केही समय-सीमामा काम-कारवाही िनुपने हुनसक्छ । तपाईंले यो जानकारी र सहायता आफ्नो मातृभाषामा दनःशुल्क पाउनु तपाईंको अधिकार हो । 1-800-892-0675 मा फोन िनुहोस् ।**

## French

Cet avis a d'importantes informations. Cet avis a d'importantes informations sur votre demande ou la couverture par l'intermédiaire de Sanford Health Plan. Rechercher les dates clés dans le présent avis. Vous devrez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l'aide dans votre langue à aucun coût. Appelez 1-800-892-0675.

## Korean

본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 Sanford Health Plan 을 통한 커버리지 에 관한 정보를 포함하고 있습니다.

본 통지서에서 핵심이 되는 날짜들을 찾으십시오. 귀하는 귀하의 건강 커버리지를 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 1-800-892-0675 로 전화하십시오.

## Tagalog

Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon. Ang paunawa na ito ay naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng Sanford Health Plan. Tingnan ang mga mahalagang petsa dito sa paunawa. Maaring mangailangan ka na magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagsakop sa kalusugan o tulong na walang gastos. May karapatan ka na makakuha ng ganitong impormasyon at tulong sa iyong wika ng walang gastos. Tumawag sa 1-800-892-0675.

## Norwegian

Denne kunngjøringen har viktig informasjon. Kunngjøringen inneholder viktig informasjon om programmet eller dekning gjennom Sanford Health Plan. Se etter viktige datoer i denne kunngjøringen. Du må kanskje ta affære ved visse frister for å beholde helsedekning eller økonomisk bistand. Du har rett til å få denne informasjonen og hjelp i ditt språk uten kostnad. Ring 1-800-892-0675.

### **Help understanding this document is free.**

If you would like this policy in another format (for example, a larger font size or a file for use with assistive technology, like a screen reader), please call us at (800) 752-5863 (*toll-free*) | TTY/TDD: (877) 652-1844 (*toll-free*).

Sanford Health Plan does not discriminate against any future, current, or past Member on the basis of race; ethnicity; color; national origin; disability; sex; gender; sexual orientation; gender identity; religion; spiritual beliefs; medical condition, including a current or past history of mental health and substance use disorders; sources of payment for care; or age, in its coverage, treatment, or benefit decisions.



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For more information, please call us at (877) 652-1845 (*toll-free*) | TTY/TDD: (877) 652-1844 (*toll-free*) or visit us at [www.sanfordhealthplan.com/heartofamerica](http://www.sanfordhealthplan.com/heartofamerica)

You can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. Central Time.

You can see our plan's Provider Directory at [www3.viiad.com/shp/public/hoamc.asp](http://www3.viiad.com/shp/public/hoamc.asp). If you want a paper copy, contact us. We will mail you a copy at no cost.

We do cover Part B drugs such as chemotherapy and some drugs administered by your provider. **We do not cover Part D outpatient prescription drugs.**

You can see complete plan coverage details and any restrictions on our website at [www.sanfordhealthplan.com/heartofamerica](http://www.sanfordhealthplan.com/heartofamerica) or visit your Member account at [www.sanfordhealthplan.com/memberlogin](http://www.sanfordhealthplan.com/memberlogin)

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Please call (800) 892-0675 (*toll-free*) to connect with us using free translation services.