Plan N
Certificate of Coverage

Important Information About Your Medicare Supplement Coverage:

If you have questions about your coverage, call our customer service team toll free at (800) 247-2583 (TTY/TDD: 711).

The Vermont Health Plan

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Plan N

Certificate of Coverage

Offered by The Vermont Health Plan

Examination Right

You have the right to return this certificate within 30 days of its delivery and to have your subscription premium refunded (reduced by any claims payable) if, after examination of this Certificate, you are not satisfied for any reason.

Agreement

By paying for and accepting this Contract, you are entitled to Benefits under the terms and conditions explained in this document. Coverage begins on the effective date and continues until the Contract is terminated.

Subscription Payments

You must pay the initial subscription premium on or before the effective date of this Contract. This Contract will not be in force until we receive and accept your initial subscription payment. We reserve the right to change your subscription premiums and will notify you in advance of any change. Your premiums must be approved by the Vermont Department of Financial Regulation.

Direct Enroll Monthly Premium — Plan N

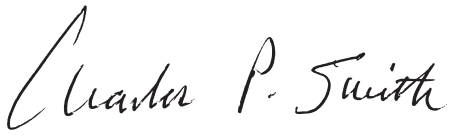
Disabled individual: $506.62

Note to Buyer:

This coverage may not cover all of your medical expenses.

Renewal

We guarantee that you may renew this Contract for further consecutive periods by paying the subscription premium as specified in Section Eleven herein and within the grace period provided in Section Ten.



Charles P. Smith
Chair of the Board

Don C. George
President and CEO

Rebecca Heintz
General Counsel and Corporate Secretary

The Vermont Health Plan

PLAN N

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
– First 60 days	All but $1,676	$1,676 (Part A deductible)	$0
– 61st through 90th day	All but $419 a day	$419 a day	$0
– 91st day and after, while using 60 lifetime reserve days	All but $838 a day	$838 a day	$0
– Once lifetime reserve days are used: additional 365 days	$0	100% of Medicare eligible expenses	$0**
– Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
– First 20 days	All approved amounts	$0	$0
– 21st through 100th day	All but $209.50 a day	Up to $209.50 a day	$0
– 101st day and after	$0	$0	All costs
BLOOD			
First three pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

** Notice: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES in or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests and durable medical equipment			
First $257 of Medicare-approved amounts*	$0	$0	$257 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	**
PART B EXCESS CHARGES (above Medicare-approved amounts)	$0	$0	All costs
BLOOD			
First three pints	$0	All costs	$0
Next $257 of Medicare-approved amounts*	$0	$0	$257(Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
Tests for diagnostic services	100%	$0	$0

MEDICARE PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE Medicare-approved services			
Medically necessary skilled care services and medical supplies	100%	$0	$0
DURABLE MEDICAL EQUIPMENT: – First $257 of Medicare-approved amounts*	$0	$0	$257 (Part B deductible)
– Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL (Not Covered By Medicare) Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

* Once you have been billed $257 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

** The copayment of up to $50 is waived if you are admitted to any hospital and the emergency visit is covered by Medicare Part A.

Introduction

This Certificate provides coverage designed to coordinate with your federal Medicare coverage. To fully understand this Certificate, you should read it alongside the Medicare handbook, Medicare and You. Except for the terms defined in Section One, all terms used in this Certificate are used as defined in Medicare and You. We will provide Benefits as if you are enrolled in both Part A and Part B of Medicare and as if Medicare has paid its portion.

SECTION ONE

General Definitions

These terms have special meaning. All defined terms except "You," "Your," "We," "Us," and "Our" are capitalized in the text of the document to show that they convey the meaning defined here.

Contract: (consists of):

- the Outline of Coverage;
- this Certificate;
- any supplements and endorsements issued by us;
- your Identification Card; and
- your application and any supplemental applications submitted by you and approved by us.

Benefit: the amount we pay for a covered service or supply as shown on your Summary of Health Plan Payments.

Benefit Period: A Medicare Benefit Period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Medicaid: medical assistance under Title XIX of the Social Security Act.

Providers: physicians, hospitals, skilled nursing facilities, home health agencies and other Providers approved by Medicare or approved by us for services under this Contract.

You, Your: the individual who is entitled to Medicare, who has applied for and been accepted for Vermont Medigap Blue and whose name appears on the Identification Card issued by us.

We, Us and Our: The Vermont Health Plan or its designated agent(s).

SECTION TWO

Benefits for Covered Services

Core Benefits

Coinsurance for Hospitalization (61st — 90th Day)

We provide Benefits for Medicare Part A-eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare Benefit Period.

Coinsurance for Hospitalization (During Reserve Days)

We provide Benefits for Medicare Part A-eligible expenses incurred for hospitalization, to the extent not covered by Medicare, for each Medicare lifetime inpatient reserve day used.

Hospitalization (Additional Reserve Days)

When you exhaust Medicare hospital inpatient coverage, including your lifetime reserve days, we provide Benefits for Medicare Part A-eligible expenses for hospitalization, subject to a lifetime maximum Benefit of an additional 365 days. Your Provider must accept Medicare's allowance as payment in full and may not bill you for any balances between our payment and the full charge.

Blood

We provide Benefits for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) you receive per calendar year. (Note: Refer to your Medicare handbook, Medicare and You, for more information on "non-replacement fees" and how you may replace any blood you may have used.)

Part B Coinsurance, Copayments

After your Medicare Part B deductible is paid, we provide Benefits for your coinsurance and/or copayment share of Medicare-eligible expenses under Part B, regardless of hospital confinement.

Hospice Care Benefit

We will pay the copayment and coinsurance amounts for all hospice care and respite care expenses covered by Medicare.

Plan N Additional Benefits

Medicare Part A Deductible

We provide Benefits for 100 percent of the Medicare Part A inpatient hospital deductible amount for each Medicare Benefit Period.

Skilled Nursing Facility Care Coinsurance

We provide Benefits for your coinsurance share from the 21st day through the 100th day in a Medicare Benefit Period for post-hospital care in a Medicare-eligible skilled nursing facility. If the actual billed charges are less than your coinsurance share, we will pay the actual billed charge.

Medically Necessary Emergency Care in a Foreign Country

We provide limited Benefits for emergency care you receive in a foreign country when these services are not covered by Medicare. After you pay a $250 deductible, we pay 80% of the billed charges for Medicare-eligible expenses to a lifetime maximum Benefit of $50,000 (U.S.) under the following conditions:

- if your hospital, physician and medical care are medically necessary and an emergency;
- your care would have been covered by Medicare if it were provided in the United States; and
- your care begins during the first sixty (60) consecutive days of a trip outside the United States.

Please Note: For purposes of this Benefit, "emergency care" means care needed immediately because of an injury or an illness of sudden and unexpected onset.

SECTION THREE

Limitations and Exclusions

Limitations

We only provide Benefits for approved Medicare-eligible services provided on or after the effective date of this Contract.

Exclusions

No Benefits will be provided for services and supplies not specifically covered in this Contract.

SECTION FOUR

Provider Relationships

The choice of a Provider is solely yours. We are not liable for any act, omission or refusal to act by any Provider. Also, we do not guarantee the availability of any Provider. We do not furnish services, but only provide Benefits for services performed by Medicare-approved Providers covered under this Contract.

SECTION FIVE

Claim Filing

Remember, when you contact a Provider, it is your responsibility to:

- identify yourself as having Medicare coverage; and
- identify yourself as having supplemental coverage with The Vermont Health Plan.

Claim Submission

In most cases, your Provider will submit your claim to Medicare. Medicare, in turn, will submit your processed claim to us electronically. This means that, in most cases, you will not have to submit a claim to us.

If your plan includes foreign travel coverage and you receive services in a foreign country, you are required to submit your claims directly to us. Do not send these claims to Medicare first.

We must receive all claims processed by Medicare within one calendar year after Medicare processes the claim. Claims received after this date are ineligible for Benefits.

You may obtain claim forms from us by calling our customer service department or visiting our website at **www.bluecrossvt.org/members/member-forms**.

Release of Information

We need specific information in order to administer your Benefits. This information includes records, copies of records, and verbal statements. By accepting this Contract, you give us the right to obtain from any source all information we need to administer your Benefits. We also have the right to obtain this information to perform utilization review studies and analyses of Benefit programs. Our approval of your Benefits is conditional upon your furnishing us with such information, even if we provide Benefits before we obtain the information.

In order to avoid duplicate payments, we may furnish this information to other entities who provide similar Benefits, unless otherwise prohibited by law.

SECTION SIX

Benefit Determination and Payments

Benefit Determination

When we receive your claim, we determine:

- whether this Contract covers your services; and
- your Benefit amount.

Your Vermont Medigap Blue Summary of Health Plan Payments shows your Benefit.

Benefit Payments

We usually pay:

- Medicare-participating Providers directly; and
- you directly for services you receive from other Providers (however, we reserve the right to pay any Provider directly).

Your rights under this Contract are personal. This means that you may not assign your Benefit rights to any other party.

Payment In Error

If we pay Benefits incorrectly to you, we require you to repay us any overpayment. We will send you written notice requesting a refund. If we pay your Provider incorrectly, we reserve the right to seek reimbursement. In either case, your future Benefits may be reduced or withheld to recover incorrect payments made to you or your Provider.

Regardless of whether we seek recovery, erroneous payments on one occasion will not obligate us to provide Benefits on another occasion.

Claim Review and Appeal

You may request a review of how we determined your Benefit by contacting our customer service center. You must, however, request this review within 60 days after we mail your Summary of Health Plan Payments.

Remember, whenever you contact us, please note:

- your certificate number as shown on your Identification Card;
- the date of the service in question; and
- the number of the claim as it appears on your Summary of Health Plan Payments.

If you do not agree with the results of the claim review, you may request a claim appeal. If, however, you have a claim appeal pending with Medicare, please don't notify us until Medicare has resolved the appeal. You must make this appeal within 60 days after we mail you the results of the claim review. Send your appeal with the information noted above and any comments, in writing to:

Claim Appeal Committee
The Vermont Health Plan
P. O. Box 186
Montpelier, Vermont 05601-0186

You have the right to review data related to your appeal. We usually review your claim appeal and mail you a written decision within 60 days after we receive your appeal. If, however, we determine that a more extensive review is necessary, we will notify you that a decision will be made within 120 days.

The written decision of the claim appeal committee is our final determination of your Benefits. By accepting this Contract, you agree to seek a decision of the claim appeal committee before taking any judicial action.

SECTION SEVEN

Other Insurance Coverage Prohibited

You may not obtain any other supplemental health insurance coverage, including Medicaid or Medicare Advantage, if you are covered under this Contract.

Suspension of Coverage

If you become eligible for Medicaid, you may suspend this coverage for up to 24 months. To do this, you must notify us within 90 days after you are determined Medicaid-eligible. If this occurs, we will refund any amount of unearned prepaid subscription fees.

If within 24 months, you are no longer eligible for Medicaid, you may be reinstated under this Contract if:

- you notify us within 90 days of the loss of Medicaid eligibility; and
- you pay us the subscription rate due from the date of loss of Medicaid.

If you are entitled to Benefits under Section 226(b) of the Social Security Act and covered under a group health plan, we will suspend Benefits and subscription fees under this policy at your request. This suspension of coverage can last as long as the period provided by federal regulation.

Upon our receipt of your timely notification, we will refund any unearned prepaid subscription fees for the period

of time you are covered under the group health plan.

If you lose coverage under the group health plan during this suspension of coverage, your policy will be automatically reinstituted as long as you notify us of such loss of coverage within 90 days after it occurs. We will automatically reinstate your coverage effective on the date the group health plan terminated. You must pay the applicable subscription rate. Upon reinstatement, we will:

- provide coverage substantially equivalent to the coverage in effect prior to the date of suspension; and
- charge the rate approved at that time.

SECTION EIGHT

Subrogation

If another person or organization caused or contributed to your illness or injuries, or is supposed to pay for your treatment (such as another insurance carrier), then we have a right to recoup benefits provided by this contract. This is called our "right of subrogation." In this section we will call the person or organization a "third party." The third party might or might not be an insurer. Our right of subrogation means that:

- If we pay benefits for your health care services and then you recover expenses for those services from a third party through a suit, settlement or other means, you must reimburse us. We will have a lien on your recovery from a third party up to the amount of benefits we paid.
- You must reimburse us whether or not you have been "made whole" by the third party. We might reduce what you owe us to cover a share of attorneys' fees and other costs you incur in the process.
- We reserve the right to bring a lawsuit in your name or in our name against a third party or parties to recover benefits we have advanced. We may also settle our claim with a third party.
- This right of subrogation extends to any kind of auto, workers' compensation, property or liability insurance providing medical benefits.
- You must cooperate with us and furnish information and assistance that we require to enforce our rights.
- You must take no action interfering with our rights and interests under your contract.
- If you refuse to pay us or to cooperate with us, we may take legal action against you. We may seek reimbursement from the funds you recovered from a third party, up to the amount of benefits we paid. If we do, you must also pay our attorney's fees and collection expenses. We may reduce or withhold future benefits to recover what you owe us.
- You agree that you will not settle your claim against a third party without first notifying us. In some cases, we will compromise the amount of our claim.

SECTION NINE

Membership

Eligibility

This Contract is specifically intended for only those individuals enrolled in Parts A and B of Medicare.

Effective Date of Coverage

Your enrollment under this Contract begins on the effective date shown on our records unless you are hospitalized on that date. If you are hospitalized on the membership effective date, your effective date is on the hospital discharge date.

SECTION TEN

Termination of Coverage

You may terminate this Contract without cause at the end of any calendar month by giving 15 days prior written notice.

We may terminate this Contract due to:

- nonpayment;
- material misrepresentation, which could include fraud;
- failure to maintain Parts A and B of Medicare;

Upon Contract termination, we will refund to you any unearned prepaid subscription premiums we hold. Such payment constitutes a full and final discharge of all our obligations under this Contract, unless otherwise required by law. We will continue to provide Benefits for all covered services received before the date of termination.

Default in Subscription Payment

We allow at least a month grace period for payment.

If we do not receive your payment on or before the end of the grace period:

- we will mail you a cancellation notice; and
- this Contract will automatically terminate at midnight on the last day of the grace period after we send you a cancellation notice.

Termination for nonpayment is considered cancellation by you.

Fraud, Misrepresentation or Concealment of a Material Fact

If you obtain or attempt to obtain coverage or Benefits through material misrepresentation, which could include fraud, this Contract is void. You will be permanently disenrolled. If you are disenrolled due to material misrepresentation, we will not provide any extension of Benefits after this Contract is terminated.

Any material misrepresentation regarding eligibility on your application for coverage shall void this Contract if discovered within three years of the effective date. After you have been enrolled for three years, only fraudulent misstatements regarding eligibility made on your application shall be used to void this Contract or as a basis to deny a claim.

If you commit fraud, we are entitled to all remedies provided by law and in equity, including, but not limited to, recovery from you for the charges for Benefits provided, attorneys' fees, costs of suit and interest.

Warning: Any person who knowingly presents a false statement in an application may be guilty of a criminal offense and subject to penalties under state law.

Contract Reinstatement

We may reinstate a terminated Contract solely at our discretion and only on such terms and conditions as we decide, as allowed by law. Please note that if you terminate this coverage, you may need to pay more for coverage at a future date.

Voidance and Modification

No representation by you on your application for a Contract shall make this Contract void, or be used in any legal proceeding under this Contract unless your application or an exact copy of it is included in or attached to your Contract.

Only an officer of The Vermont Health Plan is authorized to bind us legally by changing or waiving any provisions of this Contract.

Benefits After Termination of Coverage

We will continue to provide Benefits under this Contract for services performed while coverage was active. If the date of service occurs after your coverage has been terminated, we will not cover it.

SECTION ELEVEN

General Contract Provisions

Applicable Law

This Contract is intended for sale and delivery in, and is subject to the laws of, the State of Vermont.

Entire Agreement

Your Contract is the entire agreement between you and us. You shall have no rights or privileges not specifically provided in this Contract. This Contract may only be changed in writing and with the approval of the Vermont Department of Financial Regulation. Notification of any change in this Contract will be in accordance with applicable law.

Non-Waiver of Our Rights

Occasionally, we may choose not to enforce certain terms or conditions of this Contract. This does not mean we give up the right to enforce these terms or conditions later.

Term of Contract

Coverage continues from month to month until this Contract is discontinued, terminated or voided as allowed by this Contract and applicable law.

Subscription Premium

Your subscription premium is payable in advance directly to us. We allow at least a one month grace period for payment.

Your premium has been filed with and approved by the Vermont Department of Financial Regulation. We may change premiums only if we receive approval from the Vermont Department of Financial Regulation. We will notify you of any premium change in accordance with state law.

Each year, the coinsurance and/or deductible amounts established by Medicare may change and this coverage will change with them.

Your Address

You must notify us, in writing, of any change of address.

We send all notices by first class postage to your address that we have on file. This constitutes our full responsibility to notify you, regardless of whether you receive such notice.

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The Vermont Health Plan

An Independent Licensee of the Blue Cross and Blue Shield Association.

The Vermont Health Plan
P.O. Box 186
Montpelier, VT 05601-0186

www.bluecrossvt.org/medigapblue

Plan N Certificate of Coverage 280.536 (01/2025)

Disclaimers

General Exclusions

A Medicare Supplement plan provides coverage designed to coordinate with your federal Medicare coverage. To fully understand a Medicare Supplement plan, you should read it alongside the Medicare Handbook, Medicare and You. We will provide Benefits as if you are enrolled in both Part A and Part B of Original Medicare and as if Medicare has paid its portion. You can find the Medicare and You handbook by visiting **Medicare.gov/Medicare-and-you**. Once you enroll, you will receive a Certificate of Coverage. Please read both carefully as they govern your specific benefits.

How We Protect Your Privacy

The law requires us to maintain the privacy of your health information by using or disclosing it only with your authorization or as otherwise allowed by law. You may find information about our privacy practices at **bluecrossvt.org/privacypolicies**.

NOTICE: Discrimination is Against the Law

BlueCross® and BlueShield® of Vermont (Blue Cross VT) and its affiliate The Vermont Health Plan (TVHP) comply with applicable federal and state civil rights laws and do not discriminate, exclude people or treat them differently on the basis of race, color, national origin, age, disability, gender identity or sex, ethnicity, sexual orientation, or HIV-status.

Blue Cross VT provides free aids and services to people with disabilities to communicate effectively with us. We provide, for example, qualified sign language interpreters and written information in other formats (e.g., large print, audio or accessible electronic format).

Blue Cross VT provides free language services to people whose primary language is not English. We provide, for example, qualified interpreters and information written in other languages.

If you need these services, contact **civilrightscoordinator@bcbsvt.com**

If you believe that Blue Cross VT has failed to provide these services or discriminated in another way based on race, color, national origin, age, disability, gender identity or sex, ethnicity, sexual orientation, or HIV-Status, you can file a grievance with: Civil Rights Coordinator, P.O. Box 186, Montpelier, VT 05601-0186, call (800) 247-2583 (TTY/TDD: 711), fax (802) 229-0511, or email **civilrightscoordinator@bcbsvt.com**. You can file a grievance in person, by mail, via fax, or by email. If you need help filing a grievance, the Civil Rights Coordinator 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 or 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, 800-537-7697 (TDD)

Complaint forms are available at
https://www.hhs.gov/ocr/complaints/index.html

For free language-assistance services, call (800) 247-2583 (TTY/TDD: 711).

ARABIC	للحصول على خدمات المساعدة اللغوية المجانية ، اتصل (800) 247 2583 (TTY/TTD: 711). lilhusul ealaa khadmat almusaeadat allughawiat almajaaniat, atasal (800) 247-2583 (TTY/TDD: 711).
CHINESE	如需免费语言协助服务，请致电, (800) 247-2583 (TTY/TDD: 711). Rú xū miǎnfèi yǔyán xiézhù fúwù, qǐng zhìdiàn (800) 247-2583 TTY/TDD: 711).
CUSHITE (OROMO)	Tajaajila gargaarsa afaanii bilisaa argachuuf, (800) 247-2583 (TTY/TDD: 711) bilbili.
FRENCH	Pour des services d'assistance linguistique gratuits, appelez le (800) 247-2583 (TTY/TDD: 711).
GERMAN	Für kostenlose Sprachunterstützungsdienste rufen Sie (800) 247-2583 (TTY/TDD: 711) an.
ITALIAN	Per i servizi di assistenza linguistica gratuiti, chiamare il numero (800) 247-2583 (TTY/TDD: 711).
JAPANESE	無料の言語支援サービスについては, (800) 247-2583 (TTY/TDD: 711). Muryō no gengo shien sābisu ni tsuite wa, (800) 247-2583 (TTY/TDD: 711) made o denwa kudasai.
NEPALI	निःशुल्क भाषा-सहायता सेवाहरूको लागि, कल गर्नुहोस् , (800) 247-2583 (TTY/TDD: 711). Niḥśulka bhāṣā-sahāyatā sēvāharūkō lāgi, kala garnuhōs (800) 247-2583 (TTY/TDD: 711).
PORTUGUESE	Para serviços gratuitos de assistência linguística, ligue para (800) 247-2583 TTY/TDD: 711).
RUSSIAN	Чтобы получить бесплатную языковую помощь, позвоните по телефону (800) 247-2583 (TTY/TDD: 711).
SERBO-CROATIAN (SERBIAN)	За бесплатне услуге језичке помоћи позовите (800) 247-2583 (TTY/TTD: 711). Za besplatne usluge jezičke pomoći pozovite (800) 247-2583 (TTY/TDD: 711).
SPANISH	Para servicios gratuitos de asistencia lingüística, llame al (800) 247-2583 (TTY/TDD: 711).
TAGALOG	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (800) 247-2583 (TTY/TDD: 711).
THAI	สำหรับบริการช่วยเหลือด้านภาษาฟรี โทร, (800) 247-2583 (TTY/TDD: 711). Ŝảĥŗạb brikār ch̀wyĥelp̈x d̂ān phās'ā frī thor (800) 247-2583 (TTY/TDD: 711).
UKRAINIAN	Щоб отримати безкоштовні мовні послуги, телефонуйте (800) 247-2583 (TTY/TDD: 711). Shchob otrymaty bezkoshtovni movni posluhy, telefonuyte (800) 247-2583 (TTY/TDD: 711)
VIETNAMESE	Đối với các dịch vụ hỗ trợ ngôn ngữ miễn phí, hãy gọi (800) 247-2583 (TTY/TDD: 711).