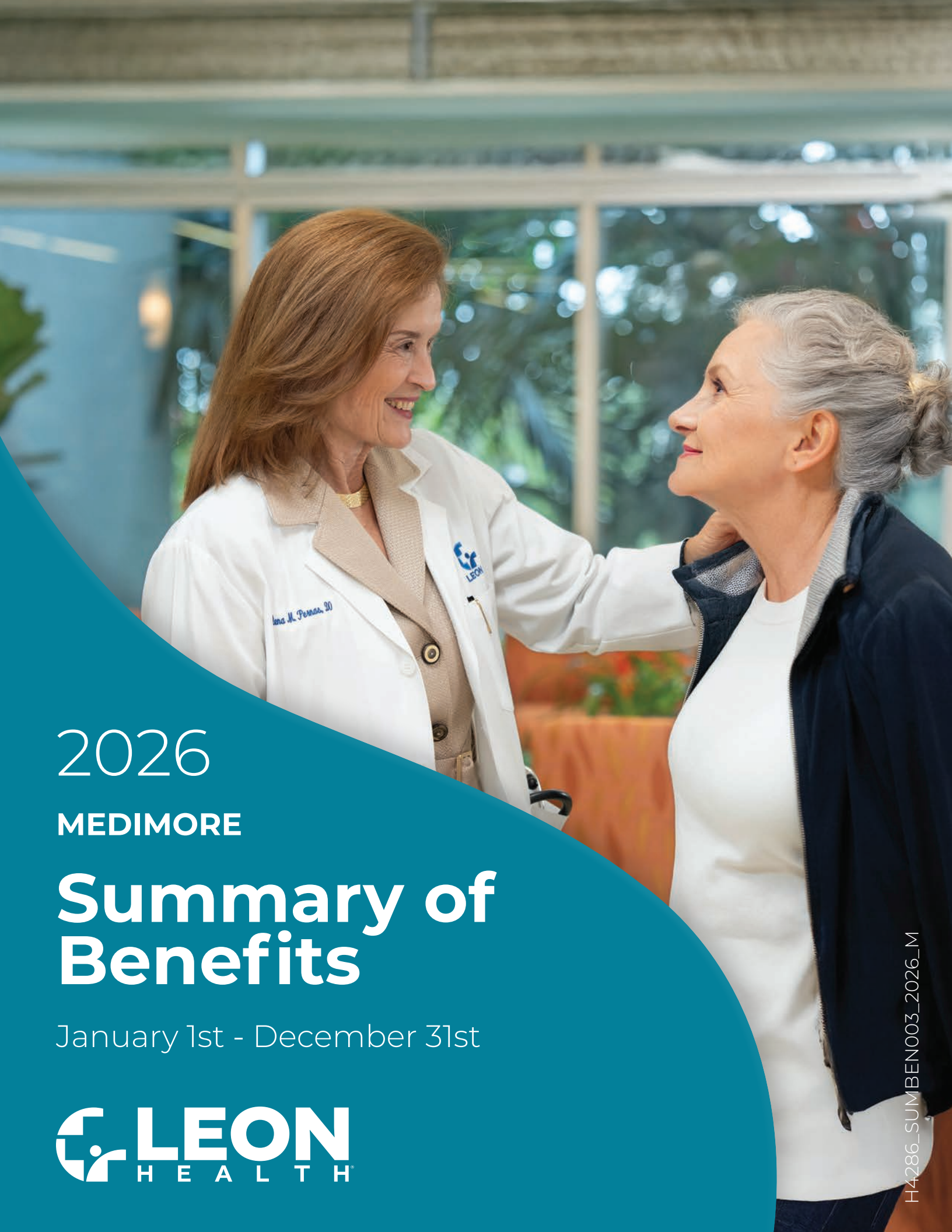

2026

MEDIMORE

Summary of Benefits

January 1st - December 31st

LEON HEALTH

H4286_SUMBEN003_2026_M

2026 Summary of Benefits
Leon MediMore (HMO)
Leon Health, Inc. – H4286, Plan 003

January 1, 2026 – December 31, 2026

Leon Health, Inc. is a Medicare Advantage HMO plan with a Medicare Contract. Enrollment in the plan depends on contract renewal.

This booklet gives you a summary of what ***Leon MediMore (HMO)*** covers and what you pay. This Summary of Benefits does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, refer to the plan's *Evidence of Coverage* (EOC) online at www.leonhealth.com, or give us a call to request a copy.

Can I join this plan?

To join ***Leon MediMore (HMO)***, the following must apply to you:

- You must be entitled to Medicare Part A.
- You must be enrolled in Medicare Part B.
- You must live in Miami-Dade County, Florida.

Check if your PCP is part of our plan's network

Leon MediMore (HMO) has a network of doctors, hospitals, pharmacies, and other providers. Except in emergency situations, if you use the providers that are not in our network, we may not pay for these services. To find out which providers and pharmacies are part of the plan's network, consult the Provider and Pharmacy Directory. This directory is available on our website, or you can get a copy by calling us.

Check if your prescription drugs are covered

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. For a complete list of covered drugs and any restrictions, visit our website or call us to request the Formulary (List of Covered Drugs).

How can I learn about Original Medicare?

For coverage and costs of Original Medicare, look in the current "Medicare & You" handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 7 days a week, 24 hours a day. TTY users should call 1-877-486-2048.

For additional information and assistance…

Call Leon Health Member Services Department at 1-844-969-5366 (TTY: 711) or visit us online at www.leonhealth.com. Hours are Monday – Sunday 8 a.m. – 8 p.m. from October to March, and Monday – Friday 8 a.m. – 8 p.m. from April to September. This call is free.

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

H4286_SUMBEN003_2026_M

Premium, Deductible and Maximum-Out-of-Pocket	What You Should Know
Monthly Plan Premium	**$0** You must keep paying your Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).
Part B Premium Refund	Leon Health, Inc. will cover **$185** of your Part B premium. You will receive the premium refund amount back on your monthly Social Security check. This process usually takes 90 days to go into effect.
Medical Deductible	**$0** *Leon MediMore* does not have a medical deductible.
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	**$3,450** per year for covered services you receive from in-network providers. This amount is the most you pay for copayments, coinsurance, and other costs for covered Medicare Part A (hospital) and Part B (medical) services for the year. Once you reach this limit, we will pay the full cost of your covered services in our plan for the rest of the year. You will still need to pay your cost sharing for your Part D prescription drugs.

Benefits Information	What You Pay	What You Should Know
Inpatient Hospital Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services.	**Day(s) 1 – 5:** **$50** copay per day **Days 6 – 90:** **$0** copay **Days 91+:** **$0** copay	Referral and/or prior authorization is required.
Outpatient Hospital Services	**$50** copay **$0** copay for transfusions	
Outpatient Observation	**$120** copay per stay	
Ambulatory Surgical Center (ASC)	**$30** copay	

Benefits Information	What You Pay	What You Should Know
Doctor Visits		
Primary Care Physician (PCP)	**$0** copay	Includes Medicare-covered telehealth (virtual) doctor visits.
Specialist	**$0** copay	Includes Medicare-covered telehealth (virtual) doctor visits. Referral and/or prior authorization is required.
Preventive Care		
• Abdominal aortic aneurysm screening • Alcohol misuse screening • Annual wellness visit • Bone mass measurement (bone density) • Breast cancer screening (mammograms) • Cardiovascular disease risk reduction visit • Cardiovascular disease testing • Cervical and vaginal cancer screening (pap test), • Colorectal cancer screening • Depression screening • Diabetes screening • Diabetes self-management training, • Glaucoma screening* • HIV screening • Immunizations (Flu shot, Pneumonia, Hepatitis B, COVID-19 Vaccines) • Medical Nutrition Therapy • Medicare Diabetes Prevention Program (MDPP) • Lung cancer screening (Low Dose Computed Tomography)	**$0** copay	Any additional preventive services approved by Medicare during the benefit year will be covered. Please see our *Evidence of Coverage* (EOC) for frequency of covered services. Referral is required. Prior authorization is required for Glaucoma screening.

Benefits Information	What You Pay	What You Should Know
• Obesity screening and therapy • Prostate cancer screening • Sexually Transmitted Infection (STI) screening & counseling • Smoking and tobacco cessation counseling • "Welcome to Medicare" preventive visit		
Emergency Care and Urgently Needed Services		
Emergency Care Services	**$120** copay per visit	Copayment is waived if patient is admitted to hospital.
Worldwide Coverage	**$100** copay for Worldwide Emergency **$100** copay for Worldwide Urgent Care **$100** copay for Worldwide Emergency Ground Transportation **20%** coinsurance for Worldwide Emergency Air Transportation	Copayment is waived if patient is admitted to hospital. Coverage provided through direct member reimbursement after plan approval of supporting documentation. The plan will reimburse Medicare allowable rates.
Urgent Care Services	**$0** copay	

Benefits Information	What You Pay	What You Should Know
Diagnostic Services / Lab / Imaging		
Diagnostic Procedures and Tests	**$0** copay	Referral and/or prior authorization is required. Prior authorization is not required for COVID-19 related testing.
Lab Services	**$0** copay	
Therapeutic Radiological Services	**20%** of the cost	
Outpatient X-Ray Services	**$0** copay	
Diagnostic Radiological Services (such as MRI, CT scans)	**$0** copay	
Hearing Services		
Hearing Services (Medicare-covered) - Exam to diagnose and treat hearing and balance issues.	**$0** copay	Referral is required.
Routine Hearing Exams (**1** every year)	**$0** copay	
Hearing Aid Evaluation/Fitting (**1** every **3** years)	**$0** copay	
Hearing Aids	**$0** copay	Up to **$1,050** allowance per hearing aid per ear (**$2,100** maximum) every three (**3**) years. A referral is required.
Dental Services		
Dental Services (Medicare-covered) - Limited dental services (excludes services in connection with care, treatment, filling, removal, or replacement of teeth).	**$0** copay	Referral and/or prior authorization is required.

Benefits Information	What You Pay	What You Should Know
Preventive Dental Services: • Cleaning (**1** every **6** months) • Dental X-Ray(s) (**1** every **6** months) • Fluoride treatment (**1** every year) • Oral Exam (**1** every **6** months)	**$0** copay	Up to **$5,250** *yearly* allowance for combined preventive and comprehensive benefits. Member cost sharing is **zero** for services up to the maximum plan benefit coverage amount. After the maximum plan benefit amount is exhausted, the member is liable for any additional costs for preventive or comprehensive dental services. Referral and/or prior authorization is required. Unused amounts expire at the end of each year. For a complete list of covered dental services and limitations, refer to the 2026 Dental Schedule of Benefits.
Comprehensive Dental Services: • Non-Routine Services • Diagnostic services • Restorative services (Fillings) • Endodontics • Periodontics (Gum and Bone treatment) • Prosthodontics (Dentures) • Dental Implants (**2** every year) • Oral and Maxillofacial Surgery (Extractions)	**$0** copay	
Vision Services		
Eye Exam (Medicare-covered)	**$0** copay	Diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Diabetic Retinopathy Screening (once a year). Referral and/or prior authorization is required.
Routine Eye Exam (**1** every year)	**$0** copay	Referral and/or prior authorization is required.

Benefits Information	What You Pay	What You Should Know
Routine Eyewear: • Eyeglasses (lenses and frames) • Contact lenses • Upgrades	**$0** copay	Up to two (**2**) pairs of eyeglasses each year, including upgrades, no limit per pair, for a maximum benefit amount of **$320**. *or* Up to four (**4**) boxes of soft contact lenses each year, not to exceed **$35** per box, for a maximum annual benefit of **$140**. One (**1**) pair of eyeglasses or contact lenses after each cataract surgery that includes the insertion of an intraocular lens. You are responsible for the cost above the maximum annual benefit amount. Unused amounts expire at the end of each year. Vision services are only available for Leon Medical Centers' on-site optical center. Referral and/or prior authorization is required. Some restrictions apply.

Benefits Information	What You Pay	What You Should Know
Mental Health Services	**Day(s) 1-5:** **$50** copay per day **Days 6-90:** **$0** copay **Lifetime reserve days:** **$0** copay (up to 60 days per lifetime) **Beyond lifetime reserve day:** Member is responsible for all costs.	**Mental Health Services:** *Leon MediMore* covers up to **90** days each benefit period for an inpatient mental health hospital care. A benefit period begins the day you enter a hospital and ends when you have not received inpatient hospital for 60 days in a row. The benefit period is not tied to the calendar year. Our plan also covers **60** "lifetime reserve days". These are "extra" covered days that can be used only once. Once you exhaust these additional 60 days, your coverage for inpatient hospital stays will be restricted to 90 days. **Inpatient Psychiatric Hospital Services:** *Leon MediMore* has a lifetime limit of **190** days for inpatient mental health care in a psychiatric hospital. If you get inpatient mental health care in a psychiatric unit of a general hospital, it does not count toward your 190 days. Referral and/or prior authorization is required.
Mental Health Care - Outpatient individual and group therapy sessions	**$0** copay	Referral and/or prior authorization is required.

Benefits Information	What You Pay	What You Should Know
Skilled Nursing Facility (SNF)	**Day(s) 1-20:** **$0** copay **Days 21-100:** **$20** copay per day	You are covered for up to **100** days in a Skilled Nursing Facility per benefit period. A benefit period begins the day you enter a SNF and ends when you have not received Medicare-covered skilled care in a SNF for 60 days in a row. The benefit period is not tied to the calendar year. Referral and/or prior- authorization is required.
Physical Therapy	**$0** copay	Referral and/or prior authorization is required.
Ambulance		
Ground Service	**$100** copay	Prior authorization rules may apply for non-emergency services.
Air Service	**20%** of the cost	
Transportation	**$0** copay	Transportation provided by Leon Health transportation services. Unlimited trips to in-network doctor appointments, medical facilities, and other approved locations. Transportation is only available to the closest geographically located center from the patient's home. Trips must be scheduled at least 48 hours in advance. Prior authorization is required for trips over 30 miles one-way.

Benefits Information	What You Pay	What You Should Know
Medicare Part B Drugs	**$0** copay for Hyaluronate Sodium Injection, Intravitreal Bevacizumab (Avastin) Injection, Enoxaparin Injection, and inhalation drugs via nebulizer. **0% - 20%** coinsurance for all other Part B drugs and Part B vaccines. **0% - 20%** coinsurance for chemotherapy/ radiation drugs. You pay no more than **$35** for a one-month (up to 30-day) supply of each covered insulin product. **$0** copay for Flu shot, Pneumonia, Hepatitis B and COVID vaccines.	Prior authorization may be required. Medicare Part B drugs may be subject to step therapy requirements. Step Therapy is a process that requires trying first another drug before the drug initially prescribed. For certain rebatable Part B drugs, you might pay nothing (0% coinsurance), and never more than 20% of the cost. The drugs that qualify can change every three months.

Additional Benefits with your plan *Leon MediMore (HMO)*

Benefits Information	What You Pay	What You Should Know
Cardiac and Pulmonary Rehabilitation Services	**$0** copay	Referral and/or prior authorization is required.
Dialysis (Kidney Disease Services)		
Outpatient/Inpatient Dialysis Treatments	**20%** of the cost	Referral and/or prior authorization is required.
Self-dialysis Training	**$0** copay	
Kidney Disease Education	**$0** copay	

Benefits Information	What You Pay	What You Should Know
Outpatient Surgery	**$40** copay	Referral and/or prior authorization is required.
Fitness Program	**$0** copay	Leon Healthy Living Centers have strength and cardiovascular training equipment to help you reach your fitness goals. Leon Healthy Living Centers offer information on a number of health-related topics, as well as programs to aid in personal development. Enjoy health seminars on important issues that include: • Preventive Medicine • Diet and Nutrition • Diabetes • Fall prevention The benefit includes access to exercise equipment and group exercise classes, where available. Fitness services that require additional fees are not part of the fitness benefit and will not be reimbursed.
Home Health Services	**$0** copay	Referral and/or prior authorization is required.
Hospice Care		
Medicare-certified Hospice Program	Your hospice services are paid by Original Medicare, not by our plan.	You may receive care from any Medicare certified hospice program.
Hospice Consultation Services	**$0** copay	Our plan covers hospice consultation services (one time only) before you select hospice.

Benefits Information	What You Pay	What You Should Know
Meals – Post Discharge	**$0** copay	You may be eligible to receive **14** home delivered nutritious meals (**2** meals per day for **7** days) following discharge from an inpatient hospitalization or skilled nursing facility admission only. You are eligible to receive this benefit up to three (**3**) times per year for a total annual maximum benefit of **42** meals. Calls to schedule benefits will be scheduled by the plan provider.
Medical Equipment & Supplies		
Durable Medical Equipment (wheelchairs, oxygen, etc.)	**0%*** coinsurance for durable medical equipment (DME) obtained from plan-approved vendors. **20%** coinsurance applies to necessary and reasonable comfort DME items obtained from patient-requested vendors that are not on the plan's approved list. *Coinsurance amount varies per item	Prior authorization is required. Leon Health has preferred vendors/manufactures for DME.
Prosthetic Devices (braces, artificial limbs, etc.) and related Medical Supplies	**$0** copay	Prior authorization is required.
Diabetes Supplies & Services	**$0** copay	*Leon MediMore* limits diabetic supplies to True Metrix, Prodigy, iGlucose, Freestyle, and Glucocard exclusively.

Benefits Information	What You Pay	What You Should Know
Opioid Use Treatment Services	**$0** copay	Covered services include: • FDA-approved opioid agonist and antagonist treatment medications. • Dispensing and administration of such medications, if applicable. • Substance use counseling. • Individual and group therapy, and toxicology testing. Referral and/or prior authorization is required.
Over-the-Counter (OTC) Items	**$0** copay	**$50** *monthly* allowance on approved, non-prescription, over-the-counter (OTC) items and health-related products available at Leon Medical Center's pharmacies or approved retail locations. The eligible items available through LMC pharmacies are listed in the OTC catalog. Members are required to complete an OTC order form or call Member Services each month to receive their choice of eligible OTC items and health-related products through LMC pharmacies. Unused amounts expire at the end of each month.
Podiatry Services (Medicare-covered)	**$0** copay	Prior authorization is required.
Routine Foot Care	**$0** copay	Prior authorization is required. Unlimited routine foot care visits are allowed each year.

Benefits Information	What You Pay	What You Should Know
Routine Acupuncture	**$0** copay	Up to **six** (**6**) routine acupuncture visits per year for any health condition. Referral and/or prior authorization is required.

Part D Prescription Drug Benefits

✔ Refer to the Summary Chart of 2026 Prescription Drug Coverage below to understand your plan's specific coverage for each stage.

✔ This plan uses a list of covered drugs, called "Formulary". Check this guide to find out if your drugs are covered and know of any restrictions such as quantity limitations, prior authorization or step therapy.

Deductible	**$0** This plan does not have a Part D deductible.		
Initial Coverage	**$2,100** In this stage, our plan pays its share of the cost of your drugs, and you pay your share of the cost. You generally stay in this stage until your year-to-date total drug costs reach **$2,100.**		
Preferred Retail Cost-Sharing			
Tier	30 days	60 days	90 days
Tier 1 – Generic	$0	$0	$0
Tier 2 – Preferred Brand	$30	$60	$90
Tier 3 – Non-Preferred Drugs	$40	N/A	N/A
Tier 4 – Specialty Tier	33%	N/A	N/A
Tier 5 – Supplemental Drugs	$0	N/A	N/A

Standard Retail Cost-Sharing			
Tier	30 days	60 days	90 days
Tier 1 – Generic	$10	$20	$30
Tier 2 – Preferred Brand	$40	$80	$120
Tier 3 – Non-Preferred Drugs	$50	N/A	N/A
Tier 4 – Specialty Tier	33%	N/A	N/A
Tier 5 – Supplemental Drugs	$10	N/A	N/A
Catastrophic Coverage	**$0** If you reach the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs. You can have a cost sharing for excluded drugs that are covered under our enhanced benefit. Generally, you remain in this stage for the rest of the calendar year.		

Additional Part D Benefit Information

Insulin Coverage: covered insulin products by our plan for preferred and standard retail pharmacy: You pay no more than **$35** for a one-month (up to 30-day) supply of each insulin product covered by our plan, regardless of the cost-sharing tier. Refer to the Formulary to find all Part D insulins covered by our plan.

Excluded Drug Coverage: medications used to treat anorexia, weight loss, or weight gain; fertility treatments; drugs for cosmetic purposes or hair growth; and medications for erectile dysfunction. Additional drugs may also be excluded from Part D coverage.

Part D Vaccines: our plan covers most adult Part D vaccines at no cost to you. Refer to the Formulary or contact Member Services for coverage and cost-sharing details about specific vaccines.

Medicare Prescription Payment Plan: The Medicare Prescription Payment Plan is a payment option that began in 2025 and can help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January-December). If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2026. To learn more about this payment option, call us at *1-844-969-5366* (TTY users call 711) or visit www.Medicare.gov.

DISCLAIMERS

Leon Health, Inc. is an HMO with a Medicare contract. Enrollment in Leon Health, Inc. depends on contract renewal.

Leon Health Inc.'s pharmacy network offers limited access to pharmacies with preferred cost sharing in Miami-Dade, FL. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including pharmacies with preferred cost sharing, please call 1-844-969-5366 (TTY: 711) or consult the online Provider and Pharmacy Directory at www.leonhealth.com/directory/.

Benefits vary by plan benefit packages.

This information is not a complete description of benefits. Call Member Services at 1-844-969-5366, TTY users call 711 for more information.

Leon Health, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: Si usted habla español, los servicios gratuitos de asistencia lingüística están disponibles para usted. También están disponibles de forma gratuita ayudas y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-844-969-5366 (TTY:711) o hable con su proveedor.

Notice of Availability

English — English
ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-844-969-5366 (TTY: 711) or speak to your provider.

Español — Spanish
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia en su idioma. También se encuentran disponibles sin costo ayudas y servicios auxiliares para obtener información en formatos accesibles. Llame al 1-844-969-5366 (TTY: 711) o consulte a su proveedor.

中文 — Chinese
注意：如果您讲中文，可免费使用语言援助服务。为提供可访问格式的信息，也可免费使用适当的辅助工具和服务。请拨打 1-844-969-5366 (TTY: 711) 或联系您的服务提供者。

Srpski / Hrvatski / Bosanski — Serbo-Croatian
PAŽNJA: Ako govorite Srpski / Hrvatski / Bosanski, besplatne usluge jezične pomoći su vam dostupne. Također su dostupne odgovarajuće pomoćne usluge za pružanje informacija u pristupačnim formatima bez naknade. Pozovite 1-844-969-5366 (TTY: 711) ili se obratite svom pružatelju usluga.

한국어 — Korean
주의: 한국어를 사용하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공하기 위한 적절한 보조 도구 및 서비스도 무료로 제공됩니다. 1-844-969-5366 (TTY: 711)로 전화하거나 제공자에게 문의하십시오.

Tiếng Việt — Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí sẽ có sẵn cho bạn. Các phương tiện trợ giúp thích hợp để cung cấp thông tin ở các định dạng dễ tiếp cận cũng có sẵn miễn phí. Gọi 1-844-969-5366 (TTY: 711) hoặc liên hệ nhà cung cấp dịch vụ của bạn.

العربية — Arabic
تنبيه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية مجانًا. كما تتوفر المساعدات والخدمات المناسبة لتوفير المعلومات بصيغ يسهل الوصول إليها مجانًا. اتصل على 1-844-969-5366 (TTY: 711) أو تحدث إلى مقدم الخدمة الخاص بك.

Deutsch — German
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachunterstützungsdienste zur Verfügung. Geeignete Hilfsmittel und Dienstleistungen zur Bereitstellung von Informationen in barrierefreien Formaten sind ebenfalls kostenlos verfügbar. Rufen Sie 1-844-969-5366 (TTY: 711) an oder wenden Sie sich an Ihren Anbieter.

Tagalog — Tagalog
PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyo sa tulong sa wika. Angkop ding magagamit nang libre ang mga tulong at serbisyo upang maipahayag ang impormasyon sa naa-access na mga format. Tumawag sa 1-844-969-5366 (TTY: 711) o maki-pag-ugnayan sa iyong tagapagbigay.

Русский — Russian
ВНИМАНИЕ: Если вы говорите на Русский, для вас доступны бесплатные услуги языковой поддержки. Также доступны соответствующие вспомогательные средства и услуги для предоставления информации в доступных форматах бесплатно. Позвоните 1-844-969-5366 (TTY: 711) или обратитесь к своему поставщику услуг.

Français — French
ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-844-969-5366 (TTY : 711) ou contactez votre prestataire.

日本語 — Japanese
注意:　日本語を話す場合、無料の言語支援サービスをご利用いただけます。情報をアクセス可能な形式で提供するための適切な補助具およびサービスも無料で利用可能です。1-844-969-5366 (TTY: 711) に電話するか、提供者にお問い合わせください。

Română — Romanian
ATENȚIE: Dacă vorbiți Română, serviciile gratuite de asistență lingvistică sunt disponibile pentru dumneavoastră. Ajutoarele și serviciile adecvate pentru furnizarea informațiilor în formate accesibile sunt, de asemenea, disponibile gratuit. Apelați 1-844-969-5366 (TTY: 711) sau contactați furnizorul dumneavoastră.

سوداني — Sudanese Arabic
تنبيه: إذا كنت تتحدث سوداني، فإن خدمات المساعدة اللغوية المجانية متاحة لك. كما تتوفر الوسائل المساعدة والخدمات المناسبة أو تحدث إلى مقدم الخدمة (TTY: 711) لتقديم المعلومات بصيغ يسهل الوصول إليها مجانًا. اتصل بالرقم 1-844-969-5366 الخاص بك.

فارسی — Persian (Farsi)
توجه: اگر به فارسی صحبت می‌کنید، خدمات کمک زبانی رایگان برای شما در دسترس است. ابزارها و خدمات کمکی مناسب برای ارائه اطلاعات به فرمت‌های قابل دسترسی نیز به صورت رایگان ارائه می‌شود. با شماره 1-844-969-5366 (TTY: 711) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید.

Українська — Ukrainian
УВАГА: Якщо ви розмовляєте Українська, безкоштовні послуги мовної підтримки доступні для вас. Відповідні допоміжні засоби та послуги для надання інформації в доступних форматах також доступні безкоштовно. Зателефонуйте за номером 1-844-969-5366 (TTY: 711) або зверніться до вашого постачальника послуг.

LEON HEALTH