2017

Summary of Benefits
Optional Supplemental Benefits

HumanaChoice®
H6609-108 (PPO)

Texas
Select Counties in Texas

Humana®

2017

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Texas
Select Counties in Texas

Humana®

Our service area includes the following county/counties in Texas: Anderson, Aransas, Armstrong, Atascosa, Austin, Bandera, Bee, Bexar, Callahan, Camp, Carson, Chambers, Cherokee, Coleman, Collin, Colorado, Comal, Comanche, Cooke, Dallas, Dawson, Deaf Smith, Delta, Denton, Dimmit, Eastland, Ector, Edwards, Ellis, Erath, Fannin, Fort Bend, Franklin, Frio, Gray, Grayson, Gregg, Guadalupe, Hardin, Harris, Harrison, Henderson, Hood, Howard, Jefferson, Jim Wells, Johnson, Jones, Kendall, Kinney, Kleberg, Liberty, Marion, Martin, Maverick, Medina, Midland, Montgomery, Morris, Navarro, Nueces, Orange, Palo Pinto, Panola, Polk, Potter, Randall, Real, Rockwall, Rusk, San Jacinto, San Patricio, Shackelford, Shelby, Smith, Tarrant, Taylor, Tyler, Upshur, Uvalde, Van Zandt, Victoria, Walker, Waller, Washington, Webb, Wharton, Wilson, Wood, Zavala, TX;.

Let's talk about **HumanaChoice®**

H6609-108 (PPO)

Find out more about the HumanaChoice H6609-108 (PPO) plan - including the health and drug services it covers - in this easy-to-use guide.

HumanaChoice H6609-108 (PPO) is a Medicare Advantage PPO plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

The benefit information provided is a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. For a complete list of services we cover, ask us for the "Evidence of Coverage" or you will receive one after you enroll.

To be eligible

To join HumanaChoice H6609-108 (PPO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

Plan name:

HumanaChoice H6609-108 (PPO)

How to reach us:

If you're a member of this plan, call toll-free: **1-800-457-4708 (TTY: 711)**.

If you're **not** a member of this plan, call toll free: **1-800-833-2364 (TTY: 711)**.

October 1 - February 14:
Call 7 days a week from 8 a.m. - 8 p.m.

February 15 - September 30:
Call Monday - Friday, 8 a.m. - 8 p.m.

Or visit our website:
Humana-medicare.com.

As a member you must select an in-network doctor to act as your Primary Care Physician (PCP). HumanaChoice H6609-108 (PPO) has a network of doctors, hospitals, pharmacies and other providers. If you use providers who aren't in our network, you may be subject to higher copayments/coinsurance.

A healthy partnership

Get more from your plan — with extra services and resources provided by Humana!

This document is available in other formats such as Braille and large print. This information is available for free in other languages. Please contact a licensed Humana sales agent at 1-800-833-2364 (TTY: 711).
Esta información está disponible gratuitamente en otros idiomas. Póngase en contacto con un agente de ventas certificado de Humana al 1-800-833-2364 (TTY: 711).

Monthly Premium, Deductible and Limits

	IN-NETWORK	OUT-OF-NETWORK
PLAN COSTS		
Monthly premium You must keep paying your Medicare Part B premium.	**$77**	
Medical deductible	This plan does not have a deductible.	
Pharmacy (Part D) deductible	**$200** only applies to Tier 4,Tier 5.	
Maximum out-of-pocket responsibility The most you pay for copays, coinsurance and other costs for medical services for the year.	**$6,700** in-network	**$9,000** combined in- and out-of-network

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
ACUTE INPATIENT HOSPITAL CARE		
	$325 copay per day for days 1-5 **$0** copay per day for days 6-90 Your plan covers an unlimited number of days for an inpatient stay	**40%** of cost
DOCTOR OFFICE VISITS		
Primary care Physician (PCP)	**$15** copay	**40%** of cost
Specialists	**$45** copay	**40%** of cost
PREVENTIVE CARE		
Including**:** Annual Wellness Visit, flu vaccine, colorectal cancer and breast cancer screenings. Covered at no cost when you see an in-network provider. Any additional preventive services approved by Medicare during the contract year will be covered.	**Covered at no cost** when you see an in-network provider.	**0%** to **50%** of the cost, depending on the service and where service is provided

You do not need a referral to receive covered services from in-network providers.
Certain procedures, services and drugs may need advance approval before your plan will cover any of the costs. This is called "prior authorization" or "preauthorization."

Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
EMERGENCY CARE		
Emergency room If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for the emergency care.	**$75** copay	**$75** copay
Urgently needed services Urgently needed services are care provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.	**$35** copay at an urgent care center	**40%** of cost at an urgent care center
OUTPATIENT CARE AND DIAGNOSTIC SERVICES, LABS AND IMAGING Cost share may vary depending on the service and where service is provided		
Diagnostic Mammography	**$45** to **$100** copay	**40%** of the cost
Diagnostic radiology	**$275** to **$325** copay	**40%** of the cost
Lab services	**$0** to **$100** copay	**40%** of the cost
Diagnostic tests and procedures	**$0** to **$100** copay	**40%** of the cost
Outpatient X-rays	**$15** to **$100** copay	**40%** of the cost
Radiation Therapy	**$45** or **20%** of the cost	**40%** of the cost
HEARING SERVICES		
Medicare covered hearing	**$45** copay	**40%** of cost
DENTAL SERVICES		
Medicare covered dental	**$45** copay	**40%** of cost

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Certain procedures, services and drugs may need advance approval before your plan will cover any of the costs. This is called "prior authorization" or "preauthorization."

Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
Routine dental	• **$0** copayment for Amalgam Filling, Denture Reline, Extractions up to 1 per year. • **$0** copayment for Bitewing X-rays up to 1 set(s) per year. • **$0** copayment for Composite Filling, Periodic Oral Exam and/or Comprehensive Oral Evaluation, Prophylaxis (cleaning) up to 2 per year. • **$0** copayment for Necessary Anesthesia with Covered Service up to unlimited per year.	• **50%** coinsurance for Amalgam Filling, Denture Reline, Extractions up to 1 per year. • **50%** coinsurance for Bitewing X-rays up to 1 set(s) per year. • **50%** coinsurance for Composite Filling, Periodic Oral Exam and/or Comprehensive Oral Evaluation, Prophylaxis (cleaning) up to 2 per year. • **50%** coinsurance for Necessary Anesthesia with Covered Service up to unlimited per year. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
VISION SERVICES		
Medicare covered vision services	**$45** copay	**40%** of cost
Glaucoma screening	**$0** copay	**40%** of cost
Eyewear (post-cataract)	**$0** copay	**$0** copay
Routine vision	• **$75** maximum benefit coverage amount per year for Routine Exam, which includes refraction, up to 1 per year. (Visit any in-network provider and routine exam charge will not exceed the **$75** maximum benefit coverage amount.) • **$100** maximum benefit coverage amount per year for Contact Lenses or Eyeglasses - Lenses and Frames. • Includes ultraviolet protection and scratch resistant coating.	• **$75** maximum benefit coverage amount per year for Routine Exam, which includes refraction, up to 1 per year. • **$100** maximum benefit coverage amount per year for Contact Lenses or Eyeglasses - Lenses and Frames. • Includes ultraviolet protection and scratch resistant coating. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

You do not need a referral to receive covered services from in-network providers.
Certain procedures, services and drugs may need advance approval before your plan will cover any of the costs. This is called "prior authorization" or "preauthorization."

Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
MENTAL HEALTH SERVICES		
Inpatient Your plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital	**$318** copay per day for days 1-5 **$0** copay per day for days 6-90	**40%** of cost
Outpatient group and individual therapy visits Cost share may vary depending on where service is provided.	**$40** to **$100** copay	**40%** of the cost
SKILLED NURSING FACILITY		
Your plan covers up to 100 days in a SNF	**$0** copay per day for days 1-20 **$164.50** copay per day for days 21-100	**40%** of cost
REHABILITATION SERVICES		
Physical, occupational and speech therapy	**$25** copay	**40%** of the cost
Cardiac and pulmonary rehabilitation	**$30** copay	**40%** of the cost
AMBULANCE		
Ambulance (ground)	**$265** copay	**$265** copay
Ambulance (air)	**20%** of cost	**20%** of cost
TRANSPORTATION		
	Not covered	Not covered
FOOT CARE (PODIATRY)		
Medicare covered foot care	**$45** copay	**40%** of cost
MEDICAL EQUIPMENT/SUPPLIES		
Durable medical equipment (like wheelchairs or oxygen)	**20%** of the cost	**40%** of the cost
Medical Supplies	**20%** of cost	**40%** of cost
Prosthetics (artificial limbs or braces)	**20%** of cost	**40%** of cost
Preferred diabetes monitoring supplies Cost share may vary depending on where service is provided.	**0%** to **20%** of the cost	**40%** of the cost

You do not need a referral to receive covered services from in-network providers.
Certain procedures, services and drugs may need advance approval before your plan will cover any of the costs. This is called "prior authorization" or "preauthorization."

Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
Non-preferred diabetes monitoring supplies Cost share may vary depending on where service is provided.	**10%** to **20%** of the cost	**40%** of the cost
FITNESS AND WELLNESS		
	SilverSneakers® Fitness Program - Basic fitness center membership including fitness classes. The plan covers more benefits that promote health and well-being. To see more benefits, check out "More benefits with your plan," listed later in this document.	

Prescription Drug Benefits

MEDICARE PART B DRUGS		
Chemotherapy drugs	**20%** of the cost	**40%** of the cost
Other part B drugs	**20%** of the cost	**20%** of the cost
PRESCRIPTION DRUGS		

Initial coverage (after you pay your deductible, if applicable)
You pay the following until your total yearly drug costs reach $3,700. Total yearly drug costs are the total drug costs paid by both you and our plan.

Tier	Preferred Retail Pharmacy	Standard Retail Pharmacy	Preferred Mail Order	Standard Mail Order
30-day supply				
1 (Preferred Generic)	**$7** copay	**$10** copay	**$7** copay	**$10** copay
2 (Generic)	**$12** copay	**$17** copay	**$12** copay	**$17** copay
3 (Preferred Brand)	**$47** copay	**$47** copay	**$47** copay	**$47** copay
4 (Non-Preferred Drug)	**$99** copay	**$100** copay	**$99** copay	**$100** copay
5 (Specialty)	**29%** of cost	**29%** of cost	**29%** of cost	**29%** of cost
90-day supply				
1 (Preferred Generic)	**$21** copay	**$30** copay	**$0** copay	**$30** copay
2 (Generic)	**$36** copay	**$51** copay	**$0** copay	**$51** copay
3 (Preferred Brand)	**$141** copay	**$141** copay	**$131** copay	**$141** copay
4 (Non-Preferred Drug)	**$297** copay	**$300** copay	**$287** copay	**$300** copay

Specialty drugs are limited to a 30 day supply.

Cost sharing may change depending on the pharmacy you choose, when you enter another phase of the Part D benefit and if you qualify for "Extra Help." To find out if you qualify for "Extra Help," please contact the Social Security Office at 1-800-772-1213 Monday — Friday, 7 am. — 7 p.m. TTY users should call

You do not need a referral to receive covered services from in-network providers.
Certain procedures, services and drugs may need advance approval before your plan will cover any of the costs. This is called "prior authorization" or "preauthorization."

1-800-325-0778. 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.

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

You may get drugs from an out-of-network pharmacy but may pay more than you pay at an in-network pharmacy.

Days' Supply Available
Unless otherwise specified, you can get your Part D medicine in the following days' supply amounts:
- One month supply (up to 30 days)*
- Two month supply (31-60 days)
- Three month supply (61-90 days)

*Long term care pharmacy (one month supply = 31 days)

Coverage Gap

After you enter the coverage gap, you pay **40 percent** of the plan's cost for covered brand name drugs and **51 percent** of the plan's cost for covered generic drugs until your costs total **$4,950** — which is the end of the coverage gap. Not everyone will enter the coverage gap.

Under this plan, you may pay even less for the following: **Tier 1** (Preferred Generic) - Home Infusion Drugs; **Tier 2** (Generic) - Home Infusion Drugs; **Tier 3** (Preferred Brand) - Home Infusion Drugs; **Tier 4** (Non-Preferred Drug) - Home Infusion Drugs; **Tier 5** (Specialty) - Home Infusion Drugs;. For more information on cost sharing in the coverage gap, please call us or access our Evidence of Coverage online.

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$4,950**, you pay the greater of:
- **5%** of the cost, or
- **$3.30** copay for generic (including brand drugs treated as generic) and a **$8.25** copayment for all other drugs

More benefits with **your plan**

Enjoy some of these extra benefits included in your plan.

Additional smoking cessation
A smoking cessation program available on-line, email and phone. Personal coaches assist via establishing goals and providing articles and resources to aid in the effort to quit smoking.

Counseling
Member Assistance Program includes counseling by phone to help you cope with life changes, including adult care and child care issues. Online resources are also available.

Health education
One-on-one wellness coaching with email, phone and online chat options.

Meals
Well Dine Meal Program - Humana's meal program for members following an inpatient stay in the hospital or nursing facility

HumanaFirst nurse advice line
Health advice from a registered nurse, available 24 hours a day, seven days a week.

Over-the-counter allowance
$0 copay; up to **$25** every 3 months for the purchase of OTC supplies from Humana Pharmacy mail delivery.

Go365™ by Humana
Rewards for completing preventive health screenings and activities.

Optional **Supplemental Benefits**

Customize your coverage for an extra premium when you enroll. You can choose from the following to help create your best Medicare plan.

$21.30

MyOption Dental Advantage PPO
Enhances the dental coverage already included in your Medicare Advantage plan with additional benefits for certain preventive, basic, and major services at both in- and out-of-network dentists. These extra benefits - in addition to your basic benefits - have an additional monthly premium.

Humana MyOption optional supplemental benefits (OSB) are only available to members of certain Humana Medicare Advantage (MA) plans. Members of Humana plans that offer OSBs may enroll in OSBs throughout the year. Benefits may change on January 1 each year. Enrollees must use network providers for specific OSBs when stated in the Evidence of Coverage (EOC); otherwise, covered services may be received from non-network providers at a higher cost. Enrollees must continue to pay the Medicare Part B premium, their Humana plan premium and the OSB premium.

Find out **more**

You can see our plan's **provider and pharmacy directory** at our website at **www.humana.com/members/tools** or call us at the number listed at the beginning of this booklet and we will send you one.

You can see our plan's **drug formulary** at our website at **www.humana.com/medicare/medicare_prescription_drugs/medicare_drug_tools/medicare_drug_list/** or call us at the number listed at the beginning of this booklet and we will send you one.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments and restrictions may apply. Benefits, premiums and/or member cost-share may change on January 1 of each year. You must continue to pay your Medicare Part B premium.

To find out more about the coverage and costs of Original Medicare, look in the 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, seven days a week. TTY users should call 1-877-486-2048.

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

Out-of-network/non-contracted providers are under no obligation to treat Humana 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.

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My Options, My Choice
Adding Benefits to Your Plan

You're unique and have unique needs for staying healthy. That's why Humana offers optional supplemental benefits (OSB). For an extra premium you can customize your Humana Medicare Advantage plan.

You can add these extra benefits when you sign up for your Medicare Advantage plan or any time during the year.

The information in this booklet will tell you about the benefits you can add to your plan. If you have questions, you can call us at 1-888-866-3154 (TTY: 711). We are available seven days a week, from 8 a.m. - 8 p.m. local time. However, please note that our automated phone system may answer your call during weekends and holidays from February 15 - September 30. Please leave your name and telephone number, and we will call you back by the end of the next business day.

MyOption Dental Advantage℠ PPO

The MyOption℠ Dental Advantage PPO benefit helps you plan for your dental care. This benefit has no deductible and pays the full cost for two routine exams per year with an in-network provider.

Here's how the benefit works:

Monthly Premium	**$21.30**		
Annual Deductible	There is no annual deductible for all services		
Maximum Benefit	Humana pays up to **$1,500** per calendar year		
Covered Dental Services	**In-Network* You Pay**	**Out-Of-Network** You Pay**	**Benefit Limitations Per Calendar Year**
Preventive and Diagnostic Dental Services			
Oral examinations	**0%**	**50%**	Two per year
Dental prophylaxis (cleanings)	**0%**	**50%**	Two per year
Bitewing X-ray	**0%**	**50%**	One set per year
Intraoral X-ray	**0%**	**50%**	One set per year
Extraoral X-ray	**0%**	**50%**	One set per year
Panoramic and Diagnostic X-rays	**0%**	**50%**	One set every five years
Emergency Exam	**0%**	**50%**	One per year
Basic Dental Services (Minor Restorative)			
Amalgam restorations (silver fillings)	**0%**	**50%**	One per year
Composite resin restorations (white fillings)***	**0%**	**50%**	One per year

OPTIONAL SUPPLEMENTAL BENEFITS (continued)

Covered Dental Services	In-Network* You Pay	Out-Of-Network** You Pay	Benefit Limitations Per Calendar Year
Basic Dental Services (Minor Restorative)			
Extractions (pulling teeth), nonsurgical and surgical	**0%**	**50%**	Unlimited procedures per year
Emergency treatment for pain	**25%**	**25%**	Two per year
Anesthesia - frequent anesthesia	**0%**	**50%**	Unlimited procedures per year
Major Dental Services (Endodontics, Periodontics, and Oral Surgery)			
Root canal treatment	**70%**	**70%**	One per year
Crowns	**70%**	**70%**	One per year
Periodontal scaling and root planing (deep cleaning)	**25%**	**25%**	Two procedures for each quadrant per year
Denture adjustments (not covered within six months of initial placement)	**70%**	**70%**	One per year
Complete dentures (including routine post-delivery care)	**70%**	**70%**	One upper and/or one lower complete denture every five years
Immediate dentures	**70%**	**70%**	One upper and/or one lower complete denture every five years
Partial dentures	**70%**	**70%**	One per year
Unilateral Partial dentures	**70%**	**70%**	One per year
Denture reline (not allowed on spare dentures)	**70%**	**70%**	One per year

Covered dental services are subject to conditions, limitations, exclusions, and maximums. Please see your Evidence of Coverage for details.

*Network dentists have agreed to provide services at an in-network rate. If you see a network dentist, you can't be billed more than the in-network rate.

**If you see an out-of-network dentist, your share of the cost may be higher.

*** Composite resin restorations (white fillings) benefit as follows:
- Anterior (front) teeth: Composite restoration (white filling) benefit as previously displayed
- Posterior (back) teeth: Member is responsible for the remaining cost difference between a composite restoration (white filling) and an amalgam restoration (silver filling).

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This information is available for free in other languages. Please call our customer service number at 1-800-457-4708, Monday - Sunday 8 a.m. - 8 p.m. TTY users, please call 711.

Esta información está disponible gratuitamente en otros idiomas. Comuníquese con el número de Atención al cliente al 1-800-457-4708, de lunes a domingo, de 8 a. m. a 8 p. m. Los usuarios de TTY deben llamar al 711.

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Notes

Discrimination is Against the Law

CHA HMO, INC., CAREPLUS HEALTH PLANS, INC., HUMANA MEDICAL PLAN, INC, HUMANA HEALTH PLAN, INC., HUMANA BENEFIT PLAN OF ILLINOIS, INC., HUMANA INSURANCE COMPANY, HUMANA HEALTH BENEFIT PLAN OF LOUISIANA, INC., HUMANA INSURANCE OF PUERTO RICO, INC., HUMANA MEDICAL PLAN OF UTAH, INC., HUMANA HEALTH COMPANY OF NEW YORK, INC., HUMANA HEALTH PLANS OF PUERTO RICO, INC., HUMANA EMPLOYERS HEALTH PLAN OF GEORGIA, INC., HUMANA REGIONAL HEALTH PLAN, INC. CARITEN HEALTH PLAN INC., HUMANA HEALTH INSURANCE COMPANY OF FLORIDA, INC., ARCADIAN HEALTH PLAN, INC., HUMANA INSURANCE COMPANY OF NEW YORK, HUMANA WI HEALTH ORGANIZATION INSURANCE CORP, HUMANA MEDICAL PLAN OF PENNSYLVANIA, INC., HUMANA MEDICAL PLAN OF MICHIGAN, INC. ("Humana") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Humana does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Humana:

- 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
- Provides free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Dr. Michelle Griffin, PhD.

If you believe that Humana 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:
Dr. Michelle M. Griffin, PhD (FACHE)
Civil Rights/LEP/ADA/Section 1557 Compliance Officer: 500 W. Main Street -10th floor Louisville, Kentucky 40202 Phone: 1-877-320-1235 Fax: 877-320-1269
Email: Mgriffin5@humana.com or Accessibility@humana.com
You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Dr. Michelle Griffin PHD, Civil Rights/LEP/ADA/Section 1557 Compliance Officer is available to help you at the contact information listed above.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically 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 http://www.hhs.gov/ocr/office/file/index.html.

Multi-Language Interpreter Services

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-457-4708 (TTY: 711).

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-457-4708 (TTY: 711).

繁體中文 (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 1-800-457-4708（TTY: 711）。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-457-4708 (TTY: 711).

한국어 (Korean): 주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 . 1-800-457-4708 (TTY: 711)번으로 전화해 주십시오 .

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-457-4708 (TTY: 711).

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-457-4708 (телетайп: 711).

Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-457-4708 (TTY: 711).

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-457-4708 (ATS : 711).

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-457-4708 (TTY: 711).

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-457-4708 (TTY: 711).

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-457-4708 (TTY: 711).

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-457-4708 (TTY: 711).

日本語 (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。1-800-457-4708（TTY: 711）まで、お電話にてご連絡ください。

فارسی (Farsi):

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-457-4708 (رقم هاتف الصم والبكم: 711).

Diné Bizaad (Navajo): Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-800-457-4708 (TTY: 711)

العربية (Arabic):

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-457-4708 (رقم هاتف الصم والبكم: 711).

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