

2017

# Summary of Benefits

## Optional Supplemental Benefits

Humana Gold Plus<sup>®</sup>  
H6622-010 (HMO)

Delaware  
Kent and New Castle Counties



**Humana<sup>®</sup>**



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Our service area includes the following county/counties in Delaware: Kent, New Castle, DE;.



# Let's talk about **Humana Gold Plus®** **H6622-010 (HMO)**

Find out more about the Humana Gold Plus H6622-010 (HMO) plan - including the health and drug services it covers - in this easy-to-use guide.

Humana Gold Plus H6622-010 (HMO) is a Medicare Advantage HMO 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 Humana Gold Plus H6622-010 (HMO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

## Plan name:

Humana Gold Plus H6622-010 (HMO)

## 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). Humana Gold Plus H6622-010 (HMO) has a network of doctors, hospitals, pharmacies and other providers. If you use providers who aren't in our network, the plan may not pay for these services.



## 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

<b>Monthly premium</b>	<b>\$27</b> You must keep paying your Medicare Part B premium.
<b>Medical deductible</b>	This plan does not have a deductible.
<b>Pharmacy (Part D) deductible</b>	<b>\$280</b> only applies to Tier 3, Tier 4, Tier 5.
<b>Maximum out-of-pocket responsibility</b>	<b>\$6,700</b> in-network The most you pay for copays, coinsurance and other costs for medical services for the year.



## Covered Medical and Hospital Benefits

<b>Acute inpatient hospital care</b>	<b>\$279</b> copay per day for days 1-7 <b>\$0</b> copay per day for days 8-90 Your plan covers an unlimited number of days for an inpatient stay
<b>Doctor visits</b>	<ul style="list-style-type: none"> <li>Primary care physician: <b>\$10</b> copay</li> <li>Specialist: <b>\$50</b> copay</li> </ul>
<b>Preventive care</b>	<b>Including:</b> 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.

### EMERGENCY CARE

<b>Emergency room</b>	<b>\$75</b> copay 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.
<b>Urgently needed services</b>	<b>\$35</b> copay at an urgent care center Urgently needed services are care provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.

### OUTPATIENT CARE AND SERVICES

<b>Diagnostic services, labs and imaging</b> Cost share may vary depending on the service and where service is provided	<ul style="list-style-type: none"> <li>Diagnostic mammography: <b>\$50 to \$110</b> copay</li> <li>Diagnostic radiology: <b>\$229 to \$279</b> copay</li> <li>Lab services: <b>\$0 to \$100</b> copay</li> <li>Diagnostic tests and procedures: <b>\$0 to \$110</b> copay</li> <li>Outpatient X-rays: <b>\$10 to \$110</b> copay</li> <li>Radiation therapy: <b>\$50</b> or <b>20%</b> of the cost</li> </ul>
<b>Hearing</b>	Medicare covered hearing exam: <b>\$50</b> copay
<b>Dental</b>	Medicare covered dental services: <b>\$50</b> copay

Your plan may require approval in advance from your primary care physician (PCP) before you see a specialist or certain other providers. This is called a "referral." If you don't have a referral, you may have to pay for these services yourself.

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.)

### Vision

- Medicare-covered vision services: **\$50** copay
- Glaucoma screening: **\$0** copay
- Eyewear (post-cataract): **\$0** copay

#### Routine vision:

- **\$0** copayment 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.

### Mental health services

#### Inpatient:

- **\$279** copay per day for days 1-5
- **\$0** copay per day for days 6-90
- Your plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital

**Outpatient** (group and individual therapy visits): **\$40** to **\$110** copay  
Cost share may vary depending on where service is provided.

### Skilled nursing facility

- **\$0** copay per day for days 1-20
- **\$164.50** copay per day for days 21-100
- Your plan covers up to 100 days in a SNF

### Rehabilitation services

Cost share may vary depending on the service and where service is provided.

- Physical, occupational and speech therapy: **\$10** to **\$40** copay
- Cardiac and pulmonary rehabilitation: **\$10** copay

## ADDITIONAL BENEFITS

### Ambulance (ground)

**\$265** copay

### Ambulance (air)

**20%** of cost

### Transportation

Not covered

### Foot care (podiatry)

Medicare covered foot care: **\$50** copay

### Medical equipment/ supplies

Cost share may vary depending on the service and where service is provided

- Durable medical equipment (like wheelchairs or oxygen): **20%** of the cost
- Medical supplies: **20%** of cost
- Prosthetics (artificial limbs or braces): **20%** of cost
- Preferred diabetes monitoring supplies: **0%** to **20%** of the cost
- Non-preferred diabetes monitoring supplies: **10%** to **20%** 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.

*Your plan may require approval in advance from your primary care physician (PCP) before you see a specialist or certain other providers. This is called a "referral." If you don't have a referral, you may have to pay for these services yourself.*

*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."*

# Prescription Drug Benefits

## Medicare Part B drugs

- Chemotherapy drugs: **20%** of the cost
- Other Part B drugs: **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
<b>30-day supply</b>				
<b>1 (Preferred Generic)</b>	<b>\$7</b> copay	<b>\$10</b> copay	<b>\$7</b> copay	<b>\$10</b> copay
<b>2 (Generic)</b>	<b>\$12</b> copay	<b>\$17</b> copay	<b>\$12</b> copay	<b>\$17</b> copay
<b>3 (Preferred Brand)</b>	<b>\$47</b> copay	<b>\$47</b> copay	<b>\$47</b> copay	<b>\$47</b> copay
<b>4 (Non-Preferred Drug)</b>	<b>\$95</b> copay	<b>\$100</b> copay	<b>\$95</b> copay	<b>\$100</b> copay
<b>5 (Specialty)</b>	<b>27%</b> of cost	<b>27%</b> of cost	<b>27%</b> of cost	<b>27%</b> of cost
<b>90-day supply</b>				
<b>1 (Preferred Generic)</b>	<b>\$21</b> copay	<b>\$30</b> copay	<b>\$0</b> copay	<b>\$30</b> copay
<b>2 (Generic)</b>	<b>\$36</b> copay	<b>\$51</b> copay	<b>\$0</b> copay	<b>\$51</b> copay
<b>3 (Preferred Brand)</b>	<b>\$141</b> copay	<b>\$141</b> copay	<b>\$131</b> copay	<b>\$141</b> copay
<b>4 (Non-Preferred Drug)</b>	<b>\$285</b> copay	<b>\$300</b> copay	<b>\$275</b> copay	<b>\$300</b> 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 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

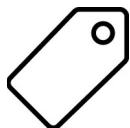
After you enter the coverage gap, you pay **40 percent** of the plan's cost for covered brand name drugs and **51 percent** of the plan's cost for covered generic drugs until your costs total **\$4,950** — which is the end of the coverage gap. Not everyone will enter the coverage gap.

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.

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### **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 **\$30** 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.

**\$30.60**

### **MyOption Platinum Dental**

Offers coverage for preventive, basic, and major services with both in- and out-of-network dentists. These extra 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**

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You can see our plan's **provider and pharmacy directory** at our website at **[www.humana.com/members/tools](http://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/](http://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.

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# Optional Supplemental Benefits

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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<sup>SM</sup> Platinum Dental

The MyOption<sup>SM</sup> Platinum Dental 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:

<b>Monthly Premium</b>	<b>\$30.60</b>		
<b>Annual Deductible</b>	There is no annual deductible for all services		
<b>Maximum Benefit</b>	Humana pays up to <b>\$2,000</b> per calendar year		
<b>Covered Dental Services</b>	<b>In-Network* You Pay</b>	<b>Out-Of-Network** You Pay</b>	<b>Benefit Limitations Per Calendar Year</b>
<b>Preventive and Diagnostic Dental Services</b>			
Oral examinations	<b>0%</b>	<b>50%</b>	Two per year
Cancer screening	<b>0%</b>	<b>50%</b>	One per year
Emergency exam	<b>0%</b>	<b>50%</b>	Two per year
Dental prophylaxis (cleanings)	<b>0%</b>	<b>50%</b>	Two per year
Bitewing X-ray	<b>0%</b>	<b>50%</b>	One set per year
<b>Basic Dental Services (Minor Restorative)</b>			
Amalgam restorations (silver fillings)	<b>0%</b>	<b>50%</b>	Two per year
Composite resin restorations (white fillings)***	<b>0%</b>	<b>50%</b>	
Extractions (pulling teeth), nonsurgical and surgical	<b>50%</b>	<b>55%</b>	Two per year
Crown or bridge re-cement	<b>50%</b>	<b>55%</b>	One per year

## OPTIONAL SUPPLEMENTAL BENEFITS (continued)

Covered Dental Services	In-Network* You Pay	Out-Of-Network** You Pay	Benefit Limitations Per Calendar Year
<b>Basic Dental Services (Minor Restorative)</b>			
Emergency treatment for pain	<b>50%</b>	<b>55%</b>	Two per year
<b>Major Dental Services (Endodontics, Periodontics, and Oral Surgery)</b>			
Root canal treatment	<b>70%</b>	<b>75%</b>	One per year
Crowns	<b>70%</b>	<b>75%</b>	One per year
Periodontal scaling and root planing (deep cleaning)	<b>70%</b>	<b>75%</b>	One procedure for each quadrant every three years
Periodontal maintenance	<b>70%</b>	<b>75%</b>	Two per year
Denture adjustments (not covered within six months of initial placement)	<b>70%</b>	<b>75%</b>	One per year
Complete dentures (including routine post-delivery care)	<b>70%</b>	<b>75%</b>	One upper and/or one lower complete denture every five years
Immediate dentures	<b>70%</b>	<b>75%</b>	One upper and/or one lower complete denture every five years
Partial dentures	<b>70%</b>	<b>75%</b>	One upper and/or one lower partial denture every five years
Unilateral partial dentures	<b>70%</b>	<b>75%</b>	One upper and/or one lower partial denture every five years
Denture reline (not allowed on spare dentures)	<b>70%</b>	<b>75%</b>	One per year
Restoration implant services	<b>70%</b>	<b>75%</b>	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.

# Humana®

Humana.com



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[illegible]

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## **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. Tumawagsa 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 yánílti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, kojí' 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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