2018

Summary of Benefits

Optional Supplemental Benefits

HumanaChoice®
R1390-002 (Regional PPO)

Region 7
States of North Carolina and Virginia

Our service area includes the following state(s): North Carolina, Virginia.

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2018

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Let's talk about **HumanaChoice®**
R1390-002 (Regional PPO)

Find out more about the HumanaChoice R1390-002 (Regional PPO) plan - including the health and drug services it covers - in this easy-to-use guide.

HumanaChoice R1390-002 (Regional 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 R1390-002 (Regional PPO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

Plan name:

HumanaChoice R1390-002 (Regional 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.com/medicare.

As a member you may have to select an in-network doctor to act as your Primary Care Provider (PCP). HumanaChoice R1390-002 (Regional 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.
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. 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.	**$79**	
Medical deductible	**$500** combined in- and out-of-network All services received from in network providers are excluded from the combined deductible. Services not covered by Original Medicare, Ambulance services, Emergency Room services, Urgently Needed Services at Urgent Care Centers, Immunizations (Flu & Pneumonia) and Preventive services are also excluded from the combined IN/OON deductible.	**$500** combined in- and out-of-network All services received from in network providers are excluded from the combined deductible. Services not covered by Original Medicare, Ambulance services, Emergency Room services, Urgently Needed Services at Urgent Care Centers, Immunizations (Flu & Pneumonia) and Preventive services are also excluded from the combined IN/OON deductible.
Pharmacy (Part D) deductible	**$390** only applies to Tier 3,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 **$10,000** combined in- and out-of-network	**$10,000** combined in- and out-of-network

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
ACUTE INPATIENT HOSPITAL CARE		
	$360 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.	**$360** copay per day for days 1-5 **$0** copay per day for days 6-90
OUTPATIENT HOSPITAL COVERAGE		
Surgery services at outpatient hospital	**$360** copay	**$360** copay

You do not need a referral to receive covered services from providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.

Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
Surgery services at ambulatory surgical center	**$310** copay	**$310** copay
DOCTOR OFFICE VISITS		
Primary care provider (PCP)	**$15** copay	**$15** copay
Specialists	**$50** copay	**$50** copay
PREVENTIVE CARE		
	Our plan covers many preventive services at no cost when you see an in-network provider, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including flu shots, hepatitis B shots, pneumococcal shots • "Welcome to Medicare" preventive visit (one-time)	**$0** copay

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Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
	• Annual Wellness Visit • Lung cancer screening • Routine physical exam **Any additional preventive services approved by Medicare during the contract year will be covered.**	
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.	**$80** copay	**$80** copay
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.	**$50** copay at an urgent care center	**$50** copay 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	**$50** to **$70** copay	**$50** to **$70** copay
Diagnostic radiology	**$310** to **$360** copay	**$310** to **$360** copay
Lab services	**$0** to **$50** copay	**$0** to **$50** copay
Diagnostic tests and procedures	**$0** to **$85** copay	**$0** to **$100** copay
Outpatient X-rays	**$15** to **$85** copay	**$15** to **$100** copay
Radiation Therapy	**$50** or **20%** of the cost	**$50** or **20%** of the cost
HEARING SERVICES		
Medicare covered hearing	**$50** copay	**$50** copay

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Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
Routine hearing	• **$0** copayment for routine hearing exams up to 1 per year. • **$0** copayment for fitting/evaluation up to 3 per year. • **$699** copayment for advanced level hearing aid up to 1 per ear per year. • **$999** copayment for premium hearing aid purchase up to 1 per ear per year. • Note: Includes 48 batteries per aid and 3 year warranty.	• **$0** copayment for routine hearing exams up to 1 per year. • **$0** copayment for fitting/evaluation up to 3 per year. • **$699** copayment for advanced level hearing aid up to 1 per ear per year. • **$999** copayment for premium hearing aid purchase up to 1 per ear per year. • Note: Includes 48 batteries per aid and 3 year warranty. • TruHearing provider must be used for in and out-of-network hearing aid benefit. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
DENTAL SERVICES Additional dental benefits are available with a separate monthly premium. Please see the "Optional Supplemental Benefits" page for details.		
Medicare covered dental	**$50** copay	**$50** copay
VISION SERVICES Additional vision benefits are available with a separate monthly premium. Please see the "Optional Supplemental Benefits" page for details.		
Medicare covered vision services	**$50** copay	**$50** copay
Diabetic Eye Exam	**$0** copay	**$0** copay
Glaucoma screening	**$0** copay	**$0** copay
Eyewear (post-cataract)	**$0** copay	**$0** copay

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Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
Routine vision	• **$0** copayment for refraction, routine exam up to 1 per year. • **$40** combined maximum benefit coverage amount per year for refraction, routine exam.	• **$0** copayment for refraction, routine exam up to 1 per year. • **$40** combined maximum benefit coverage amount per year for refraction, routine exam. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
MENTAL HEALTH SERVICES		
Inpatient Your plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital	**$360** copay per day for days 1-4 **$0** copay per day for days 5-90	**$360** copay per day for days 1-4 **$0** copay per day for days 5-90
Outpatient group and individual therapy visits Cost share may vary depending on where service is provided.	**$40** to **$85** copay	**$40** to **$100** copay
SKILLED NURSING FACILITY (SNF)		
Your plan covers up to 100 days in a SNF	**$0** copay per day for days 1-20 **$167** copay per day for days 21-100	**$0** copay per day for days 1-20 **$167** copay per day for days 21-100
PHYSICAL THERAPY		
Cost share may vary depending on the service and where service is provided.	**$15** to **$40** copay	**$15** to **$40** copay
AMBULANCE		
Ambulance (ground)	**$265** per date of service	**$265** per date of service
TRANSPORTATION		
	Not covered	Not covered

Prescription Drug Benefits

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

You do not need a referral to receive covered services from providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.

PRESCRIPTION DRUGS

Pharmacy (Part D) Deductible
$390 only applies to Tier 3,Tier 4,Tier 5.

Initial coverage (after you pay your deductible, if applicable)
You pay the following until your total yearly drug costs reach $3,750. Total yearly drug costs are the total drug costs paid by both you and our plan.

	Preferred Retail Pharmacy	Standard Retail Pharmacy	Preferred Mail Order	Standard Mail Order
30-day supply				
Tier 1: Preferred Generic	**$9** copay	**$10** copay	**$9** copay	**$10** copay
Tier 2: Generic	**$20** copay	**$20** copay	**$20** copay	**$20** copay
Tier 3: Preferred Brand	**$47** copay	**$47** copay	**$47** copay	**$47** copay
Tier 4: Non-Preferred Drug	**$99** copay	**$100** copay	**$99** copay	**$100** copay
Tier 5: Specialty	**25%** of the cost	**25%** of the cost	**25%** of the cost	**25%** of the cost
90-day supply				
Tier 1: Preferred Generic	**$27** copay	**$30** copay	**$0** copay	**$30** copay
Tier 2: Generic	**$60** copay	**$60** copay	**$0** copay	**$60** copay
Tier 3: Preferred Brand	**$141** copay	**$141** copay	**$131** copay	**$141** copay
Tier 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 a.m. — 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 **35 percent** of the plan's cost for covered brand name drugs and **44 percent** of the plan's cost for covered generic drugs until your costs total **$5,000** — which is the end of the coverage gap. Not everyone will enter the coverage gap.

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$5,000**, you pay the greater of:

- **5%** of the cost, or
- **$3.35** copay for generic (including brand drugs treated as generic) and a **$8.35** copayment for all other drugs

Additional benefits

	IN-NETWORK	OUT-OF-NETWORK
Medicare covered foot care	**$50** copay	**$50** copay
MEDICAL EQUIPMENT/SUPPLIES		
Durable medical equipment (like wheelchairs or oxygen)	**20%** of the cost	**20%** of the cost
Medical Supplies	**20%** of the cost	**20%** of the cost
Prosthetics (artificial limbs or braces)	**20%** of the cost	**20%** of the cost
Diabetic monitoring supplies Cost share may vary depending on where service is provided.	**$0** copay or **10%** to **20%** of the cost	**20%** of the cost
REHABILITATION SERVICES		
Physical, occupational and speech therapy Cost share may vary depending on the service and where service is provided.	**$15** to **$40** copay	**$15** to **$40** copay
Cardiac rehabilitation	**$15** copay	**$15** copay
Pulmonary rehabilitation	**$15** copay	**$15** copay

More benefits with **your plan**

Enjoy some of these extra benefits included in your plan.

Travel Coverage
As a member of a HumanaChoice (PPO), you have the benefit to use Humana's network of providers across the U.S. (not available in all counties). If you are visiting another HumanaChoice (PPO) service area, simply access a Humana network provider to receive your in-network level of benefits for up to twelve consecutive months. You pay your in-network copay or coinsurance when you visit a participating provider for non-emergency care, including preventive care, specialist care and hospitalizations. Visit **Humana.com** or contact Customer Service on the back of your ID card if you need help finding an in-network provider.

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 (OTC) allowance
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 health and wellness activities.

Fitness benefit
SilverSneakers® Fitness Program – Basic fitness center membership including fitness classes.

Optional **Supplemental Benefits**

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

$24.60

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.

$21

MyOption Plus
Includes benefits for preventive and basic dental services with both in- and out-of-network dentists as well as vision benefits. This optional supplemental benefit provides members with extra vision benefits - in addition to their basic vision benefits - for 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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Optional Supplemental Benefits

HumanaChoice®
R1390-002 (Regional PPO)

Region 7
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Humana®

My Options, My Choice
Adding Benefits to Your Plan

You're unique and have unique needs. That's why Humana offers optional supplemental benefits (OSB). For an extra monthly 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℠ Plus

MyOption℠ Plus helps make it easy to plan for both your dental and vision care.

Here's how the benefit works:

Monthly Premium	**$21**		
Annual Deductible	Dental: There is no annual deductible for preventive services, **$50** for basic services per calendar year Vision: There is no annual deductible		
Maximum Benefit	Dental: Humana pays up to **$1,000** per calendar year Vision: Humana pays up to **$290** for one set of eyeglass frames and one pair of lenses **OR** contact lenses (includes conventional or disposable)		
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%**	**30%**	Two per year
Dental prophylaxis (cleanings)	**0%**	**30%**	Two per year
Bitewing X-ray	**0%**	**30%**	One set per year
Basic Dental Services (Minor Restorative)			
Amalgam restorations (silver fillings)	**50%**	**55%**	Two per year
Composite resin restorations (white fillings)**	**50%**	**55%**	
Extractions (pulling teeth) nonsurgical and surgical	**50%**	**55%**	Two 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)			
Crown or bridge re-cement	**50%**	**55%**	One per year
Emergency treatment for pain	**50%**	**55%**	Two per year
Covered Vision Benefits	**EyeMed Network Vision Provider You Pay**	**Non-EyeMed Network Vision Provider*** You Pay**	**Benefit Limitations**
Routine exam with refraction/dilation as necessary - **$40** allowance	Any amount over **$40**	Any amount over **$40**	One per year
$290 (combined in and out-of-network) benefit toward the purchase and fitting of eyeglasses and pair of lenses or contact lenses Eyeglasses will include ultraviolet protection and scratch resistance coating. Contact lenses will include conventional or disposable. The benefit can only be used one time per plan year. Any remaining benefit dollars do not "roll over" to a future purchase.	Any amount over **$290**	Any amount over **$290**	One per year

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

*If you use an out-of-network dental provider, 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).

Your routine eye exam charge will not exceed **$40** at an **EyeMed Vision Care Select network optical provider**.

***When using an out-of-network provider, you will be responsible for costs above the plan-approved amount. You are responsible for submitting an EyeMed Vision Care out-of-network claim form with itemized receipt when seeing a Non-EyeMed select provider. Claim forms can be found on Myhumana.com

or you can call EyeMed Customer service at 1-844-828-8703 Monday thru Saturday 7:30 a.m. – 11 p.m. Eastern Time and Sunday 11 a.m. – 8 p.m. Eastern Time.

MyOption℠ Platinum Dental

The MyOption℠ 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:

Monthly Premium	**$24.60**		
Annual Deductible	There is no annual deductible for all services		
Maximum Benefit	Humana pays up to **$2,000** 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
Cancer screening	**0%**	**50%**	One per year
Emergency exam	**0%**	**50%**	Two per year
Dental prophylaxis (cleanings)	**0%**	**50%**	Two per year
Bitewing X-ray	**0%**	**50%**	One set per year
Basic Dental Services (Minor Restorative)			
Amalgam restorations (silver fillings)	**0%**	**50%**	Two per year
Composite resin restorations (white fillings)	**0%**	**50%**	
Extractions (pulling teeth), nonsurgical and surgical	**50%**	**55%**	Two per year
Crown or bridge re-cement	**50%**	**55%**	One per year
Emergency treatment for pain	**50%**	**55%**	Two per year
Major Dental Services (Endodontics, Periodontics, and Oral Surgery)			
Root canal treatment	**70%**	**75%**	One per year
Crowns	**70%**	**75%**	One per year
Periodontal scaling and root planing (deep cleaning)	**70%**	**75%**	One procedure for each quadrant every three years
Periodontal maintenance	**70%**	**75%**	Two per year

OPTIONAL SUPPLEMENTAL BENEFITS (continued)

Covered Dental Services	In-Network* You Pay	Out-Of-Network** You Pay	Benefit Limitations Per Calendar Year
Major Dental Services (Endodontics, Periodontics, and Oral Surgery)			
Complete dentures (including routine post-delivery care)	**70%**	**75%**	One upper and/or one lower complete denture every five years
Partial dentures	**70%**	**75%**	One upper and/or one lower partial denture every five years
Denture adjustments (not covered within six months of initial placement)	**70%**	**75%**	One per year
Denture reline (not allowed on spare dentures)	**70%**	**75%**	One per year
Restoration implant services	**70%**	**75%**	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.

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Notes

Notes

Notes

Discrimination is Against the Law

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Humana Inc. and its subsidiaries do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Humana Inc. and its subsidiaries provide:

- Free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.
- Free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as translated documents or oral interpretation.

If you need these services, call 1-800-281-6918 or if you use a TTY, call 711.

If you believe that Humana Inc. and its subsidiaries have 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:

Discrimination Grievances
P.O. Box 14618
Lexington, KY 40512 - 4618

If you need help filing a grievance, call 1-800-281-6918 or if you use a TTY, call 711.

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 do not speak English, language assistance services, free of charge, are available to you. Call **1-800-281-6918 (TTY: 711)**.

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-281-6918 (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 **1-800-281-6918** (**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 **1-800-281-6918 (TTY: 711)**.

한국어 (Korean): 주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 . **1-800-281-6918 (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 **1-800-281-6918 (TTY: 711)**.

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-281-6918 (телетайп: 711)**.

Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-800-281-6918 (TTY: 711)**.

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-281-6918 (ATS : 711)**.

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-800-281-6918 (TTY: 711)**.

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-800-281-6918 (TTY: 711)**.

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-800-281-6918 (TTY: 711)**.

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-800-281-6918 (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。**1-800-281-6918** (**TTY：711**) まで、お電話にてご連絡ください。

فارسی (Farsi):
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-281-6918** **(TTY: 711)** تماس بگیرید.

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 **1-800-281-6918 (TTY: 711)**.

العربية (Arabic):
ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-281-6918** (هاتف الصُم: **711**).

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