2017 Summary *of* Benefits

Health Net Violet Option 1 (PPO)

Benton, Clackamas, Lane, Linn, Marion, Multnomah, Polk, Washington and Yamhill counties, OR; Clark County, WA

H5520-002

Benefits effective January 1, 2017
Health Net Life Insurance Company

H5520_2017_0304 CMS Accepted 09112016

Health Net®
MEDICARE PROGRAMS

This booklet provides you with a summary of what we cover and your cost-sharing. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please call us at the number listed on the last page, and ask for the "Evidence of Coverage"(EOC), or you may access the EOC on our website at www.healthnet.com/medicare.

You are eligible to enroll in Health Net Violet Option 1 (PPO) if:

- You are entitled to Medicare Part A and enrolled in Medicare Part B. Members must continue to pay their Medicare Part B premium, if not otherwise paid for under Medicaid or by another third party.

- You permanently reside in the service area of the plan (in other words, your permanent residence is within one of the Health Net Violet Option 1 (PPO) service area counties). Our service area includes the following counties in Oregon: Benton, Clackamas, Lane, Linn, Marion, Multnomah, Polk, Washington, and Yamhill; Washington: Clark.

- You do not have end-stage renal disease (ESRD). (Exceptions may apply for individuals who develop ESRD while enrolled in a Health Net commercial or group health plan, or a Medicaid plan.)

With Health Net's PPO Medicare Advantage Violet Option 1 plan, you'll enjoy the freedom and flexibility to access your health care where you want it and when you want it. You may seek care from any Medicare provider in the country who agrees to see you as a Medicare member, but you'll generally pay less when you use in-network providers. In-network providers are those providers who contract with Health Net. Out-of-network providers are those who do not have a contract with Health Net and who accept Medicare. Members enrolled in Health Net PPO plans can choose to receive care from in-network or out-of-network providers. Either way, doctor visits, hospital stays and many other services have a simple copayment, which helps make health care costs more predictable. You can see our plan's provider directory at our website at www.healthnet.com/medicare.

This Health Net PPO plan also includes prescription drug coverage and access to our large network of pharmacies. Our drug plan is designed specifically for Medicare beneficiaries and includes a comprehensive selection of affordable generic and brand-name drugs.

SUMMARY OF BENEFITS

January 1, 2017 – December 31, 2017

Premiums and Benefits	Health Net Violet Option 1 (PPO)	What you should know
Monthly Plan Premium, including Part C and Part D premium.	$116	You must continue to pay your Medicare Part B premium.
Deductible	$220 combined in-network and out-of-network	Deductible does not apply to all services. Once you have paid your deductible, we will begin to pay our share of the costs for covered medical services and you will pay your share (your copayment or coinsurance amount) for the rest of the calendar year.
Maximum Out-of-Pocket Responsibility ***(does not include prescription drugs)***	$2,900 in- network annually $4,000 combined in- and out-of-network annually	This is the most you pay in copays, coinsurance and other costs for medical services for the year.
Inpatient Hospital Coverage	**In-network** $225 copay per day, days 1 through 7, $0 copay per day, days 8 and beyond **Out-of-network** $250 copay per day, days 1 through 7, $0 copay per day, days 8 and beyond	Deductible applies in-and out-of-network. Our plan covers an unlimited number of days per benefit period for an inpatient hospital stay. Some services may require Prior Authorization (approval in advance) to be covered, except in an emergency.
Doctor Visits	**In-network** • Primary care: $12 copay per visit • Specialist: $25 copay per visit **Out-of-network** • Primary care: $20 copay per visit • Specialist: $40 copay per visit	Deductible waived in-network. Deductible applies out-of-network.

Premiums and Benefits	Health Net Violet Option 1 (PPO)	What you should know
Preventive Care	$0 copay	Deductible may apply to some services received out of network. For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. Cost-sharing may apply when other services are received in addition to the preventive service.
Emergency Care	**In-network** $75 copay per visit **Out-of-network** $75 copay per visit	Deductible waived in- and out-of- network. If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care.
Urgently Needed Services	**In-network** $35 copay per visit **Out-of-network** $50 copay per visit	Deductible waived in-and out-of- network. If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgently needed services.
Diagnostic Services/Labs/Imaging	**In-network** • Diagnostic radiology services (i.e., MRI, MRA, CT, PET): 17% coinsurance • Lab services: $12 copay • Diagnostic tests and/or procedures: 17% coinsurance • EKG tests: 0% coinsurance • Outpatient x-ray: $12 copay • Therapeutic Radiological services (Radiation therapy): 17% coinsurance **Out-of-network** • Diagnostic radiology services (i.e., MRI, MRA, CT, PET): 19% coinsurance • Lab services: $20 copay	Deductible waived in-network for lab services and outpatient x-ray. Deductible applies in-network for diagnostic radiology services, diagnostic tests and/or procedures, EKG tests, and therapeutic radiological services. Deductible applies out-of-network for all diagnostic, lab, imaging, and therapeutic radiological services.

Premiums and Benefits	Health Net Violet Option 1 (PPO)	What you should know
Diagnostic Services/Labs/Imaging (continued)	• Diagnostic tests and/or procedures: 19% coinsurance • EKG tests: 0% coinsurance • Outpatient x-ray: $20 copay • Therapeutic Radiological services (Radiation therapy): 19% coinsurance	Some services may require Prior Authorization (approval in advance) to be covered, except in an emergency.
Hearing Services	**In-network** Hearing exams (Medicare-covered): $25 copay **Out-of-network** Hearing exams (Medicare-covered): $40 copay	Deductible waived in-network. Deductible applies out-of-network.
Dental Services	**In-network** Dental services (Medicare-covered): $25 copay **Out-of-network** Dental services (Medicare-covered): $40 copay	Deductible waived in-network. Deductible applies out-of-network. **Medicare-covered services:** Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth). Preventive/comprehensive dental benefits are available for an additional premium. See optional supplemental benefits section.
Vision Services	**In-network** • Vision exams to diagnose and treat diseases and conditions of the eye (Medicare-covered): $10 copay per visit • Yearly glaucoma screening (Medicare-covered): $0 copay • Eyeglasses or contact lenses after cataract surgery(Medicare-covered): $0 copay	Deductible waived in- and out-of-network for routine vision exam and routine eyewear. Deductible waived in-network for Medicare-covered vision exams, yearly glaucoma screening, and Medicare-covered eyewear.

Premiums and Benefits	Health Net Violet Option 1 (PPO)	What you should know
Vision Services (continued)	• Routine vision exam (non Medicare-covered) (once every 12 months): $10 copay • Routine (non Medicare-covered) eyewear: up to $250 allowance **Out-of-network** • Vision exams to diagnose and treat diseases and conditions of the eye (Medicare-covered): $40 copay per visit • Yearly glaucoma screening (Medicare-covered): $0 copay • Eyeglasses or contact lenses after cataract surgery (Medicare-covered): $0 copay • Routine vision exam (non Medicare-covered) (once every 12 months): Plan pays first $45; member pays balance, up to billed charge • Routine (non Medicare-covered) eyewear: up to $250 allowance	Deductible applies out-of-network for Medicare-covered vision exams, yearly glaucoma screening, and Medicare-covered eyewear. Our plan pays up to $250 every 24 months for in-network and out-of-network services combined for routine (non Medicare-covered) eyewear.
Mental Health Services	**In-network** Outpatient: $25 copay per visit Inpatient services: $225 copay per day, days 1 through 7, $0 copay per day, days 8 through 90 **Out-of-network** Outpatient: $40 copay per visit Inpatient services: $250 copay per day, days 1 through 7, $0 copay per day, days 8 through 90	Deductible waived in-network for outpatient visits. Deductible applies out-of-network for outpatient visits. Deductible applies in-and out-of-network for inpatient services. Our plan covers 90 days per benefit period for an inpatient mental health stay. Some services may require Prior Authorization (approval in advance) to be covered, except in an emergency.

Premiums and Benefits	Health Net Violet Option 1 (PPO)	What you should know
Skilled Nursing Facility	**In-network** $0 copay per day, days 1 through 20, $150 copay per day, days 21 through 100 **Out-of-network** $0 copay per day, days 1 through 20, $200 copay per day, days 21 through 100	Deductible applies in- and out-of-network. Our plan covers up to 100 days in a SNF per benefit period. You pay all costs for each day after day 100 in the benefit period. Some services may require Prior Authorization (approval in advance) to be covered, except in an emergency.
Rehabilitation Services	**In-network** Outpatient rehabilitation services: $25 copay per visit **Out-of-network** Outpatient rehabilitation services: $40 copay per visit	Deductible applies in- and out-of-network. Covered services include: physical therapy, occupational therapy, and speech language therapy. Some services may require Prior Authorization (approval in advance) to be covered, except in an emergency.
Ambulance	**In-network** $295 copay **Out-of-network** $295 copay	Deductible applies in- and out-of-network. Cost is per one-way trip for Medicare-covered ambulance services. No charge for more than one trip in a single day. Some services may require Prior Authorization (approval in advance) to be covered, except in an emergency.
Transportation	Not covered	

Premiums and Benefits	Health Net Violet Option 1 (PPO)	What you should know
Foot Care (podiatry services)	**In-network** Foot exams and treatment (Medicare-covered): $25 copay per visit **Out-of-network** Foot exams and treatment (Medicare-covered): $40 copay per visit	Deductible waived in-network. Deductible applies out-of-network.
Medical Equipment/Supplies	**In-network** • Durable medical equipment (i.e., wheelchairs, oxygen): 17% coinsurance • Prosthetics (i.e., braces, artificial limbs): 17% coinsurance • Diabetic supplies: $0 copay **Out-of-network** • Durable medical equipment (i.e., wheelchairs, oxygen): 19% coinsurance • Prosthetics (i.e., braces, artificial limbs): 19% coinsurance • Diabetic supplies: $0 copay	Deductible waived in-network for diabetic supplies. Deductible applies out-of-network for diabetic supplies. Deductible applies in- and out-of-network for durable medical equipment and prosthetics. Some services may require Prior Authorization (approval in advance) to be covered, except in an emergency.
Wellness Programs	$0 copay	For a detailed list of wellness program benefits offered, please refer to the Evidence of Coverage.
Medicare Part B Drugs	**In-network** • 17% coinsurance for chemotherapy drugs • 17% coinsurance for other Part B drugs **Out-of-network** • 19% coinsurance for chemotherapy drugs • 19% coinsurance for other Part B drugs	Deductible applies in- and out-of- network. Prior Authorization (approval in advance) may be required to be covered, except in an emergency.

<table>
<tr><th colspan="5">Outpatient Prescription Drugs</th></tr>
<tr><td>Deductible Phase</td><td colspan="4">$95 Deductible. Deductible does not apply to tiers 1, 2 and 6. You begin in this payment phase when you fill your first prescription of the calendar year. During this phase, you pay the full cost of your drugs on tiers 3, 4 and 5. You generally stay in this phase until you (or others on your behalf) have paid your deductible. Once you have paid your deductible, you move to the next payment phase (Initial Coverage).</td></tr>
<tr><td rowspan="8">Initial Coverage Phase
(After you pay your deductible, if applicable)
Cost-Sharing may change depending on the pharmacy you choose (i.e., preferred, non-preferred, mail-order, Long Term Care or Home Infusion), whether you receive a 30 or 90 day supply, and when you enter another phase of the Part D benefit. For more information about the costs for Long Term Supply, Home infusion or additional pharmacy-specific cost-sharing and the phases of the benefit, please call us or access our Evidence of Coverage online.</td><td colspan="4">After you have met your deductible (if applicable), the plan pays its share of the cost of your drugs and you pay your share of the cost. You generally stay in this phase until the amount of your year-to-date “total drug costs” reaches $3,700 in 2017. “Total drug costs” is the total of all payments made for your covered Part D drugs. It <u>includes</u> what the plan pays, and what you pay. Once your “total drug costs” reach $3,700 in 2017 you move to the next payment phase (Coverage Gap).</td></tr>
<tr><td></td><td>Preferred Retail Rx 30-day supply</td><td>Standard Retail Rx 30-day supply</td><td>Mail Order 90-day supply</td></tr>
<tr><td>Tier 1: Preferred Generic</td><td>$5 copay</td><td>$10 copay</td><td>$10 copay</td></tr>
<tr><td>Tier 2: Generic</td><td>$10 copay</td><td>$20 copay</td><td>$20 copay</td></tr>
<tr><td>Tier 3: Preferred Brand</td><td>$37 copay</td><td>$47 copay</td><td>$74 copay</td></tr>
<tr><td>Tier 4: Non-Preferred Brand</td><td>$90 copay</td><td>$100 copay</td><td>$225 copay</td></tr>
<tr><td>Tier 5: Specialty Tier</td><td>31% coinsurance</td><td>31% coinsurance</td><td>31% coinsurance</td></tr>
<tr><td>Tier 6: Select Care Drugs</td><td>$0 copay</td><td>$0 copay</td><td>$0 copay</td></tr>
</table>

Outpatient Prescription Drugs	
Coverage Gap Phase	During this payment phase, you receive a 50% manufacturer's discount on covered brand name drugs and the plan will cover another 10%, so you will pay 40% of the negotiated price on brand-name drugs. In addition you pay 51% coinsurance of generic drugs. You generally stay in this phase until the amount of your year-to-date "out-of-pocket costs" reaches $4,950. "Out of pocket costs" includes what you pay when you fill or refill a prescription for a covered Part D drug and payments made for your drugs by any of the following programs or organizations: "Extra Help" from Medicare; Medicare's Coverage Gap Discount Program; Indian Health Service; AIDS drug assistance programs; most charities; and most State Pharmaceutical Assistance Programs (SPAPs). Once your "out-of-pocket costs" reach $4,950 in 2017, you move to the next payment phase (Catastrophic Coverage).
Catastrophic Phase	During this payment phase, the plan pays most of the cost for your covered drugs. For each prescription, you pay whichever of these is greater: a payment equal to 5% coinsurance of the drug, or a copayment ($3.30 for a generic drug or a drug that is treated like a generic, $8.25 for all other drugs).
Important Info:	Tier 3 includes preferred brand drugs and may include some generic drugs. Brand drugs in this tier are not eligible for exceptions for payment at a lower tier. Tier 4 includes non-preferred brand drugs and may include some generic drugs. We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider. You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website at www.healthnet.com/medicare. You can see our plan's pharmacy directory at our website at www.healthnet.com/medicare.

Additional Covered Benefits		
Premiums and Benefits	**Health Net Violet Option 1 (PPO)**	**What you should know**
Outpatient surgery (hospital care)	**In-network** $225 copay per visit **Out-of-network** $250 copay per visit	Deductible applies in- and out-of-network. Some services may require Prior Authorization (approval in advance) to be covered, except in an emergency.
Outpatient surgery (ambulatory care)	**In-network** $200 copay per visit **Out-of-network** $225 copay per visit	Deductible applies in- and out-of-network. Some services may require Prior Authorization (approval in advance) to be covered, except in an emergency.
Worldwide Emergency/ Urgent Care	$0 copay	$50,000 plan coverage limit for supplemental worldwide emergency/urgent care services outside the U.S. and its territories every year.
Fitness Benefit	**In-network** $0 copay **Out-of-network** Not covered	Deductible waived in-network. Includes a basic gym membership at participating facilities.
Annual Routine Physical Exam	$0 copay	Deductible waived in- and out-of-network. Covered in addition to the Medicare-covered Annual Wellness visit. The annual routine physical exam allows you to get a separate visit with your physician to discuss general health questions or issues without presentation of a specific chief complaint and includes a comprehensive review of systems and physical examination.

Additional Covered Benefits		
Premiums and Benefits	**Health Net Violet Option 1 (PPO)**	**What you should know**
Complementary/Alternative care: routine chiropractic, acupuncture, naturopathy	**In-Network** $15 copay per visit **Out-of-Network** $15 copay per visit	Deductible waived in- and out-of-network. There is an annual combined in- and out-of-network benefit maximum of $500 for all three benefits. In-network services may require prior authorization (approval in advance) to be covered, except in an emergency. Prior Authorization is recommended, although not required, for out-of-network services.

Optional Supplemental Benefits ***(you must pay an extra premium each month for these benefits)***
You may choose to add an Optional Supplemental Benefit Package to your plan for an additional monthly premium. The Optional Supplemental Benefit packages you can choose from are shown below. You may choose **either** the Preventive Dental Optional Package **or** the Comprehensive Dental Optional Package.

Optional Supplemental Benefits	
Preventive Dental Optional Package	
Monthly Premium This additional monthly premium is in addition to your monthly plan premium and the monthly Medicare Part B premium.	$15 per month
Annual deductible	$35 in- and out-of-network combined
Annual benefit maximum	$500 in- and out-of-network combined
Preventive services Every year: 2 routine cleanings, 2 exams, 1 bitewing X-rays; Every 3 years* : panoramic X-ray	**In-Network:** 0% coinsurance of MAC** **Out-of-Network:** 20% coinsurance of UCR***
*Multi-year benefits may not be available in subsequent years. **MAC: Maximum Allowable Charge (MAC) is the maximum dollar amount allowed by the plan for a covered dental service. Balance billing occurs when a dentist bills you for the difference between the plan's Maximum Allowable Charge (MAC) and the dentist's total billed charge. Network dentists cannot balance bill you for covered services which exceed the Maximum Allowable Charge (MAC) they have contractually agreed to; however, it is possible that non-network dentists may balance bill you for treatment rendered. ***UCR: Usual, Customary, and Reasonable means the maximum allowable amount for a dental service based on fees usually charged by providers for that service in the same geographic area. Member is responsible for the difference between the UCR and billed charges.	

Optional Supplemental Benefits	
Comprehensive Dental Optional Package	
Monthly Premium This additional monthly premium is in addition to your monthly plan premium and the monthly Medicare Part B premium.	$39 per month
Annual deductible	$50 in-network $100 out-of-network
Annual benefit maximum	$1,000 in- and out-of-network combined
Preventive services Every year: 2 routine cleanings, 2 exams, 1 bitewing X-rays; Every 3 years*: panoramic X-ray	**In-Network:** 0% coinsurance **Out-of-Network:** 50% coinsurance of MAC**
Restorative services Amalgam and resin composite fillings	**In-Network:** 20% coinsurance **Out-of-Network:** 50% coinsurance of MAC**
Major services Crowns, removable and fixed bridges, complete and partial dentures, oral surgery, periodontics, endodontics	**In-Network:** 50% coinsurance **Out-of-Network:** 50% coinsurance of MAC**
*Multi-year benefit may not be available in subsequent years. **MAC: Maximum Allowable Charge (MAC) is the maximum dollar amount allowed by the plan for a covered dental service. Balance billing occurs when a dentist bills you for the difference between the plan's Maximum Allowable Charge (MAC) and the dentist's total billed charge. Network dentists cannot balance bill you for covered services which exceed the Maximum Allowable Charge (MAC) they have contractually agreed to; however, it is possible that non-network dentists may balance bill you for treatment rendered.	

Health Net complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Health Net does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Health Net:
• Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).

• Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Health Net's Customer Contact Center at 1-888-445-8913 (TTY: 711), 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.

If you believe that Health Net 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 by calling the number above and telling them you need help filing a grievance; Health Net's Customer Contact Center is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically 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, DC 20201, 1-800-368-1019, (TDD: 1-800-537-7697).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

For more information please contact

Health Net Violet Option 1 (PPO)
Post Office Box 10420
Van Nuys, CA 91410-0420
www.healthnet.com/medicare

Current members should call: 1-888-445-8913 (TTY: 711)

Prospective members should call: 1-800-949-6192 (TTY: 711)

From October 1 through February 14, our office hours are 8:00 a.m. to 8:00 p.m., 7 days a week, excluding certain holidays. However, after February 14, our office hours are 8:00 a.m. to 8:00 p.m., Monday through Friday. On weekends and certain holidays, your call will be handled by our automated phone system.

If you want to know more about the coverage and costs of Original Medicare, look in your 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, 7 days a week.
TTY users should call 1-877-486-2048.

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 co-payments/co-insurance may change on January 1 of each year. **"Coinsurance"** is the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. Out-of-network/non-contracted providers are under no obligation to treat members, except in emergency situations. For a decision about whether we will cover an out-of-network service, you or your provider may ask us for a pre-service organization determination before you receive the service. Please call our member services number or see Evidence of Coverage (EOC) for more information, including the cost-sharing that applies to out-of-network services.

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

This document is available in other formats such as Braille and large print.

This information is available for free in other languages. Please call our member services number at 1-888-445-8913 (TTY: 711), From October 1 through February 14, our office hours are 8:00 a.m. to 8:00 p.m., 7 days a week, excluding certain holidays. However, after February 14, our office hours are 8:00 a.m. to 8:00 p.m., Monday through Friday. On weekends and certain holidays, your call will be handled by our automated phone system.

Health Net Life Insurance Company has a contract with Medicare to offer PPO plans. Enrollment in a Health Net Medicare Advantage plan depends on contract renewal.

BKT008633EK00 (9/16)

Multi-Language Insert

Multi-language Interpreter Services

English:
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Spanish:
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

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 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711)。

Tagalog:
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

French:
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (ATS :711).

Vietnamese:
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

German:
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Korean:
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711) 번으로 전화해 주십시오.

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Russian:
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (телетайп: 711).

Arabic:
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (رقم هاتف الصم والبكم: 711).

Hindi:
ध्यान दें: यदि आप हदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।
1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711) पर कॉल करें।

Italian:
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Portuguese:
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

French Creole:
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Polish:
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

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。1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711)まで、お電話にてご連絡ください。

Farsi:
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با تماس 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711) بگیرید.

Armenian:
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY (հեռատիպ)՝ 711):

Cambodian:
ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711)។

Punjabi:
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

Thai:
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Laotian:
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ ທ່ານ. ໂທຣ 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Serbo-Croatian:
OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

Ukranian:
УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (телетайп: 711).

Syriac:
ܙܘܗܪܐ: ܐܢ ܐܢܫܘܬܘܢ ܟܐ ܡܡܠܠܝܬܘܢ ܠܫܢܐ ܐܬܘܪܝܐ، ܟܡܐ ܡܨܝܬܘܢ ܕܡܫܬܡܠܝܬܘܢ ܡܢ ܡܫܡܫܢܘܬܐ ܕܗܝܪܬܐ
ܒܠܫܢܐ ܡܓܢܐܝܬ. ܩܪܘܢ ܥܠ ܡܢܝܢܐ
1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711)

Hmong:
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Romanian:
ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Amharic:
ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (መስማት ለተሳናቸው: 711).

Navajo:
Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dę́ę́', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Cushite:
XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711.)