2017 Summary *of* Benefits

Health Net Seniority Plus Sapphire Premier (HMO)

Fresno, Los Angeles, Orange, San Diego, and San Francisco Counties, CA

H3561-002

Health Net®
MEDICARE PROGRAMS

Benefits effective January 1, 2017
Health Net Community Solutions, Inc.
H3561_2017_0301 CMS Accepted 09112016

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 http://www.healthnet.com/medicare.

You are eligible to enroll in Health Net Seniority Plus Sapphire Premier (HMO) 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 Seniority Plus Sapphire Premier (HMO) service area counties). Our service area includes the following counties in California: Fresno, Los Angeles, Orange, San Diego, and San Francisco Counties.

- 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.)

The Health Net Seniority Plus Sapphire Premier (HMO) plan gives you access to our network of highly skilled medical providers in your area. You can look forward to choosing a primary care provider (PCP) to work with you and coordinate your care. You can ask for a current Provider Directory or, for an up-to-date list of network providers, visit www.healthnet.com/medicareplans. (Please note that, except for emergency care, urgently needed care when you are out of the network, out-of-area dialysis services, and cases in which our plan authorizes use of out-of-network providers, if you obtain medical care from out-of-plan providers, neither Medicare nor Health Net will be responsible for the costs.)

You can see our plan’s provider directory at our website at http://www.healthnet.com/medicare.

This Health Net (HMO) plan also includes Part D coverage, which provides you with the ease of having both your medical and prescription drug needs coordinated through a single convenient source.

SUMMARY OF BENEFITS

January 1, 2017 – December 31, 2017

Premiums and Benefits	Health Net Seniority Plus Sapphire Premier (HMO)	What you should know
Monthly Plan Premium, including Part C and Part D premium	$36.20	You must continue to pay your Medicare Part B premium.
Deductible	This plan has a deductible amount of $1,288 for days 1 through 60 per benefit period for inpatient hospital services (which includes mental health inpatient stays). This amount may change for 2017.	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 benefit period.
Maximum Out-of-Pocket Responsibility ***(does not include prescription drugs)***	$6,700 annually	This is the most you pay in copays, coinsurance and other costs for medical services for the year.
Inpatient Hospital Coverage	In 2016 the amounts for each benefit period were: •$1,288 deductible for days 1 through 60 •$322 copay per day for days 61 through 90 •$644 copay per day for 60 lifetime reserve days These amounts may change in 2017.	Deductible Applies Our plan covers 90 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.

Premiums and Benefits	Health Net Seniority Plus Sapphire Premier (HMO)	What you should know
Doctor Visits	• Primary Care: $0 copay per visit • Specialist: $0 copay per visit	Some specialist services may require Prior Authorization (approval in advance) to be covered, except in an emergency.
Preventive Care	$0 copay	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. Some services may require Prior Authorization (approval in advance) to be covered, except in an emergency.
Emergency Care	$75 copay per visit	If you are immediately admitted to the hospital, you do not have to pay your share of the cost for emergency care.
Urgently Needed Services	20% coinsurance (up to $65) per visit	If you are immediately admitted to the hospital, you do not have to pay your share of the cost for urgently needed services.

Premiums and Benefits	Health Net Seniority Plus Sapphire Premier (HMO)	What you should know
Diagnostic Services/Labs/ Imaging	• Diagnostic radiology service (e.g., MRI, MRA, CT, PET) : 20% coinsurance • Lab service: $0 copay • Diagnostic tests and/or procedure: 20% coinsurance • EKG: 20% coinsurance • Outpatient x-ray: 20% coinsurance • Therapeutic Radiological services (Radiation therapy): 20% coinsurance	Some services may require Prior Authorization (approval in advance) to be covered, except in an emergency.
Hearing Services	• Hearing exam (Medicare-covered): 20% coinsurance per visit • Routine hearing services (non Medicare-covered): $0 copay per visit (1 every year) • Hearing aid: $0 copay	$2,000 benefit maximum for 2 hearing aids (for both ears combined) every 3 years. Members have no out-of-pocket cost sharing. Some services may require Prior Authorization (approval in advance) to be covered, except in an emergency.
Dental Services	Dental services (Medicare-covered): 20% coinsurance **Preventive dental services**: • Oral exam: $0 copay (unlimited) • Cleaning: $0 copay (up to 2 every year) • Dental x-ray and Fluoride treatment : $0 copay (up to 1 every year) **Additional comprehensive dental benefits are available.**	**Medicare-covered services**: Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth). Some services may require Prior Authorization (approval in advance) to be covered, except in an emergency.

Premiums and Benefits	Health Net Seniority Plus Sapphire Premier (HMO)	What you should know
Vision Services	• Vision exam to diagnose and treat diseases and conditions of the eye (Medicare-covered): 20% coinsurance per visit • Yearly Glaucoma screening (Medicare-covered): $0 copay • Eyeglasses or contact lenses after cataract surgery (Medicare-covered): $0 copay • Routine eye exam (non Medicare-covered) (once every 12 months): $0 copay per visit • Routine (non Medicare-covered) eyewear: up to $550 allowance	Our plan pays up to $550 every 24 months for routine (non Medicare-covered) eyewear. Some services may require Prior Authorization (approval in advance) to be covered, except in an emergency.
Mental Health Services	Outpatient: 20% coinsurance per visit Inpatient Visits: In 2016 the amounts for each benefit period were: •$1,288 deductible for days 1 through 60 •$322 copay per day for days 61 through 90 •$644 copay per day for 60 lifetime reserve days These amounts may change in 2017.	Deductible Applies to Inpatient Visits. 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.
Skilled Nursing Facility	In 2016 the amounts for each benefit period were: •$0 copay per day, days1 through 20 •$161 copay per day, days 21 through 100 These amounts may change for 2017.	Our plan covers up to 100 days in a SNF. 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.

Premiums and Benefits	Health Net Seniority Plus Sapphire Premier (HMO)	What you should know
Rehabilitation Services	Outpatient rehabilitation services: 20% coinsurance per visit	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	20% coinsurance	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	$0 copay per trip	Up to 40 one-way trips to plan approved locations every year. Some services may require Prior Authorization (approval in advance) to be covered, except in an emergency.
Foot Care (podiatry services)	• Foot exams and treatment (Medicare-covered): 20% coinsurance per visit • Routine foot care (non Medicare-covered): $0 copay per visit	Up to 12 visits every year for routine (non Medicare-covered) foot care.

Premiums and Benefits	Health Net Seniority Plus Sapphire Premier (HMO)	What you should know
Medical Equipment/Supplies	• Durable Medical Equipment (e.g., wheelchairs, oxygen): 20% coinsurance • Prosthetics (e.g., braces, artificial limbs): 20% coinsurance • Diabetic supplies: 20% coinsurance	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	• 20% coinsurance for chemotherapy drugs • 20% coinsurance for other Part B drugs	Prior Authorization (approval in advance) may be required to be covered, except in an emergency.

<table>
<tr><th colspan="4">Outpatient Prescription Drugs</th></tr>
<tr><td>Deductible Phase</td><td colspan="3">$170 Deductible. Tiers 1 and 6 are excluded from the deductible.
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 2, 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). If you receive “Extra Help” to pay for your prescription drugs, your deductible amount will be either $0 or $82 depending on the level of “Extra Help” you receive. If you are not eligible for “Extra Help”, refer to the Evidence of Coverage, Chapter 6, for outpatient prescription drug cost-sharing information.</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., standard, 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="3">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, 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>Standard Retail Rx 30-day supply</td><td>Mail Order 90-day supply</td></tr>
<tr><td>Tier 1: Preferred Generic</td><td>$0 copay</td><td>$0 copay</td></tr>
<tr><td>Tier 2: Generic</td><td>$20 copay</td><td>$40 copay</td></tr>
<tr><td>Tier 3: Preferred Brand</td><td>$47 copay</td><td>$131 copay</td></tr>
<tr><td>Tier 4: Non-Preferred Brand</td><td>$100 copay</td><td>$290 copay</td></tr>
<tr><td>Tier 5 Specialty Tier</td><td>29% coinsurance</td><td>29% coinsurance</td></tr>
<tr><td>Tier 6: Select Care Drugs</td><td>$0 copay</td><td>$0 copay</td></tr>
<tr><td>Coverage Gap Phase</td><td colspan="3">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.</td></tr>
</table>

Outpatient Prescription Drugs	
Coverage Gap Phase *(continued)*	"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). If you qualify for extra help this phase doesn't apply- If you are not eligible for "Extra Help", call the plan or refer to the Evidence of Coverage, Chapter 6, for outpatient prescription drug cost-sharing information.
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. Premium, co-pays, co-insurance and deductibles may vary based on the level of "Extra Help" you receive. Please contact the plan for further details. If you qualify for "Extra Help" with your prescription drug costs, the "Extra Help" program will pay all or part of your monthly plan premium and your prescription drug deductibles and copays/coinsurance. If you are not eligible for "Extra Help", refer to the Evidence of Coverage, Chapter 6, for outpatient prescription drug cost-sharing information. 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 http://www.healthnet.com/medicare. You can see our plan's pharmacy directory at our website at http://www.healthnet.com/medicare.

Additional Covered Benefits		
Premiums and Benefits	**Health Net Seniority Plus Sapphire Premier (HMO)**	**What you should know**
Outpatient services/surgery (ambulatory care)	20% coinsurance per visit	Some services may require Prior Authorization (approval in advance) to be covered, except in an emergency.
Outpatient services/surgery (hospital care)	20% coinsurance per visit	Some services may require Prior Authorization (approval in advance) to be covered, except in an emergency.
Worldwide Emergency/Urgent Coverage	$0 copay	$50,000 plan coverage limit for supplemental Worldwide Emergency/Urgent Coverage outside the U.S. and its territories every year.
Fitness Benefit	$0 copay	Includes a basic gym membership at a participating facility.
Annual Routine Physical Exam	$0 copay	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.

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 & 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 & Information written in other languages

If you need these services, contact Health Net's Customer Contact Center at 1-800-431-9007 (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, 1-800–537–7697 (TDD).

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

For more information please contact

Health Net Seniority Plus Sapphire Premier (HMO)
Post Office Box 10420
Van Nuys, CA 91410-0420
http://www.healthnet.com/medicare

Current members should call: 1-800-431-9007 (TTY: 711)

Prospective members should call: 1-800-977-6738 (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 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.

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

This information is available for free in other languages. Please call our member services number at 1-800-431-9007 (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.

Esta información está disponible en forma gratuita en otros idiomas. Llame a nuestro Departamento de Servicios al Afiliado al 1-800-431-9007 (TTY: 711). Desde el 1.º de octubre hasta el 14 de febrero, nuestro horario de atención es de 8:00 a. m. a 8:00 p. m., los 7 días a la semana, excepto ciertos días feriados. Sin embargo, luego del 14 de febrero, nuestro horario de atención es de 8:00 a.m. a 8:00 p.m., de lunes a viernes. Durante los fines de semana y ciertos días feriados, su llamada será atendida por nuestro sistema automático de teléfono.

Health Net Community Solutions, Inc. has a contract with Medicare to offer HMO plans. Enrollment in a Health Net Medicare Advantage plan depends on contract renewal.

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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:
ܙܘܼܗܵܪܵܐ: ܐܢ ܐܢ̄ܬܘܢ ܟܐ ܗܡܙܡܝܬܘܢ ܠܫܢܐ ܐܬܘܪܝܐ، ܟܐ ܡܨܝܬܘܢ ܕܡܫܬܡܫܝܬܘܢ ܒܚܠܡܬܐ 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 hóló̜, koji̜' 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.)