2018

Summary of Benefits

Humana Gold Plus®
SNP-DE H1036-167 (HMO SNP)

Charlotte
Charlotte Metro Area

Our service area includes the following county/counties in North Carolina: Anson, Burke, Cabarrus, Caldwell, Catawba, Gaston, Iredell, Mecklenburg, Rowan, Stanly.

Humana®

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Humana®

Let's talk about **Humana Gold Plus®** **SNP-DE H1036-167 (HMO SNP)**

Find out more about the Humana Gold Plus SNP-DE H1036-167 (HMO SNP) plan - including the health and drug services it covers - in this easy-to-use guide.

Humana Gold Plus SNP-DE H1036-167 (HMO SNP) is a Coordinated Care plan with a Medicare contract and a contract with the North Carolina Division of Medical Assistance Medicaid Program. 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.

As a member you must select an in-network doctor to act as your Primary Care Provider (PCP). Humana Gold Plus SNP-DE H1036-167 (HMO SNP) 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. You have access to Care Managers. Care Managers are nurses or care coordinators who support your health and well-being by providing additional services including: acute- and chronic-care management, telephonic and in-person health support; assistance in coordinating Medicare and Medicaid benefits, educational resources and workshops and support for families and caregivers.

To be eligible

To enroll in Humana Gold Plus SNP-DE H1036-167 (HMO SNP), a Dual Eligible Special Needs Plan, you must be entitled to Medicare Part A and enrolled in Medicare Part B, live in our service area and also receive certain levels of assistance from the North Carolina Medical Assistance Program (Medicaid). If you receive both Medicare and Medicaid benefits, this means you are a dual eligible.

Humana Gold Plus SNP-DE H1036-167 (HMO SNP) may enroll dual eligibles who are FBDE, SLMB Plus, QMB Plus and QMB.

Plan name:

Humana Gold Plus SNP-DE H1036-167 (HMO SNP)

More about Humana Gold Plus SNP-DE H1036-167 (HMO SNP)

As a member of this plan, you will not be responsible for cost sharing for plan benefits. The Comprehensive Benefit Chart shows the benefits you will receive from Humana and how Medicaid covers your cost sharing for those plan benefits. The chart also lists some benefits you could receive from Medicaid if you are eligible for full Medicaid benefits. If you are entitled to Medicaid benefits your care coordinator will work with you to assist you in understanding and accessing the Medicare and Medicaid benefits you may be entitled to.

How to reach us:

If you have questions about your benefits or your level of eligibility for assistance from Medicaid, you should contact Humana's customer service department or your state Medicaid office for further details.

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**.

For the most current North Carolina Medicaid coverage information, please visit the North Carolina Medicaid website at http://www.ncdhhs.gov/dma/medicaid/medicare.htm or call the Medicaid Hotline at **1-800-662-7030**.

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

Monthly premium	**$0** You must keep paying your Medicare Part B premium. The Part B premium may be covered through your State Medicaid Program.
Medical deductible	This plan does not have a deductible.
Pharmacy (Part D) deductible	This plan does not have a deductible.
Maximum out-of-pocket responsibility	**$6,700** in-network The most you pay for copays, coinsurance and other costs for medical services for the year.

Covered Medical and Hospital Benefits

For members protected by the State Medicaid Program from cost sharing, Medicaid pays coinsurance, copays and deductibles for Original Medicare covered services.

	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID USUAL LIMITS AND COPAYS
ACUTE INPATIENT HOSPITAL CARE		
	$0 copay	
OUTPATIENT HOSPITAL COVERAGE		
Surgery services at outpatient hospital	**$0** copay	• **$3** copay for Medicaid-covered services
Surgery services at ambulatory surgical center	**$0** copay	
DOCTOR OFFICE VISITS		
Primary care provider (PCP)	**$0** copay	**$3** copay for Medicaid-covered services
Specialists	**$0** copay	**$3** copay for Medicaid-covered services
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)	• **$3** copay for mammograms, pap smears and pelvic exams

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.)

	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID USUAL LIMITS AND COPAYS
	• 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) • 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.	**$0** 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.)

	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID USUAL LIMITS AND COPAYS
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.	**$0** copay	
DIAGNOSTIC SERVICES, LABS AND IMAGING		
Diagnostic Mammography	**$0** copay	
Diagnostic radiology	**$0** copay	
Lab services	**$0** copay	
Diagnostic tests and procedures	**$0** copay	
Outpatient X-rays	**$0** copay	
Radiation Therapy	**$0** copay	
HEARING SERVICES		
Medicare covered hearing	**$0** copay	
Routine hearing	• **$0** copayment for fitting/evaluation, routine hearing exam up to 1 per year. • **$1000** maximum benefit coverage amount for hearing aids (all types) up to 1 every 3 years.	

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.)

	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID USUAL LIMITS AND COPAYS
DENTAL SERVICES		
Medicare covered dental	**$0** copay	• **$3** copay (only one copay for services that require more than one visit) • Some services require prior approval
Routine dental	• **0%** coinsurance for panoramic film or diagnostic x-rays up to 1 every 5 years. • **0%** coinsurance for bitewing x-rays up to 1 set(s) per year. • **0%** coinsurance for amalgam or composite filling, extraoral x-rays, intraoral x-rays up to 1 per year. • **0%** coinsurance for emergency diagnostic exam, emergency treatment for pain, fluoride treatment, periodic oral exam and/or comprehensive oral evaluation, prophylaxis (cleaning) up to 2 per year. • **0%** coinsurance for extractions up to unlimited per year.	
VISION SERVICES		
Medicare covered vision services	**$0** copay	• **$3** copay (Note: Effective 10-1-2011 non-covered for adults) • Visits are counted toward your 22 doctor visit limit per year
Diabetic eye exam	**$0** copay	
Glaucoma screening	**$0** copay	
Eyewear (post-cataract)	**$0** copay	
Routine vision	• **$0** copayment for routine exam, refraction up to 1 per year. • **$200** maximum benefit coverage amount per year for contact lenses or eyeglasses - lenses and frames (includes fitting). Eyeglasses include ultraviolet protection and scratch resistant coating.	

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.)

	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID USUAL LIMITS AND COPAYS
MENTAL HEALTH SERVICES		
Inpatient Your plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital	**$0** copay	• **$3** copay for Outpatient Medicaid-covered services
Outpatient group and individual therapy visits	**$0** copay	
SKILLED NURSING FACILITY (SNF)		
Your plan covers up to 100 days in a SNF	**$0** copay	• Medicaid covers additional days beyond Medicare 100 day limit
PHYSICAL THERAPY		
	$0 copay	
AMBULANCE		
Ambulance (ground)	**$0** copay	
TRANSPORTATION		
	$0 copay for up to 24 one-way trips to plan approved locations. Not to exceed 25 miles per trip.	• **$0** copay to Medicaid-covered services

Prescription Drug Benefits

	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID USUAL LIMITS AND COPAYS
MEDICARE PART B DRUGS		
Chemotherapy drugs	**$0** copay	
Other part B drugs	**$0** copay	
PRESCRIPTION DRUGS		
Medicare Part D Drugs	See chart below for plan coverage information for prescription drugs	Medicaid may cover some drugs that are not covered by Part D. Contact your Medicaid agency for questions on drug coverage. • **$0.50** - **$3** copay for Medicaid covered prescription drugs not covered by a Medicare Prescription Drug Plan.

Pharmacy (Part D) Deductible
This plan does not have a deductible.

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.

	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID USUAL LIMITS AND COPAYS
Initial coverage		
30-day supply		
For generic drugs (including brand drugs treated as generic), either:	**$0** copay; or **$1.25** copay; or **$3.35** copay	
For all other drugs, either:	**$0** copay; or **$3.70** copay; or **$8.35** copay	
90-day supply		
For generic drugs (including brand drugs treated as generic), either:	**$0** copay; or **$1.25** copay; or **$3.35** copay	
For all other drugs, either:	**$0** copay; or **$3.70** copay; or **$8.35** copay	

You will always pay **$0** for Tier 1 drugs on this plan at a Preferred Cost-Sharing Retail or Preferred Cost-Sharing Mail Order Pharmacy.

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)

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 nothing for all drugs.

Additional benefits

	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID USUAL LIMITS AND COPAYS
Medicare covered foot care	**$0** copay	• **$3** copay for Medicaid-covered services
MEDICAL EQUIPMENT/SUPPLIES		
Durable medical equipment (like wheelchairs or oxygen)	**$0** copay	
Medical Supplies	**$0** copay	
Prosthetics (artificial limbs or braces)	**$0** copay	• Prescription footwear coverage is limited to treatment of diabetics or when shoe is part of a leg brace (orthotic) or if there are foot complications in children under age 21
Diabetic monitoring supplies	**$0** copay	
REHABILITATION SERVICES		
Physical, occupational and speech therapy	**$0** copay	
Cardiac rehabilitation	**$0** copay	
Pulmonary rehabilitation	**$0** copay	

Additional Medicaid Covered Services

Dual eligible members who meet financial criteria for full Medicaid coverage may also be eligible to receive all Medicaid services not covered by Medicare. Humana Gold Plus may also offer coverage for these services. The benefits described below are covered by Medicaid. The benefits described in the Covered Medical and Hospital Benefits section of the Summary of Benefits are covered by Medicare. For each benefit listed below, you can see what the North Carolina Division of Medical Assistance Medicaid Program covers and what our plan covers. What you pay for covered services may depend on your level of Medicaid eligibility. If you have questions about your Medicaid eligibility and what benefits you are entitled to call: 1-800-662-7030.

BENEFIT	WHAT YOU PAY ON THIS HUMANA PLAN	MEDICAID STATE PLAN
PRODUCTS AND DEVICES		
Dentures	See “Dental” benefit in the “Covered Medical and Hospital Benefits” chart above	• **$0** copay

Eyeglasses	See "Vision" benefit in the "Covered Medical and Hospital Benefits" chart above	• **$0 - no copays for children** • Contact lenses covered in special circumstances • Prior approval required for all visual aids • **$3** copay for Medicaid vision services • **$2** copay for optical repair over $5 • **$2** copay for optical supplies
Hearing Aids	See "Hearing" benefit in the "Covered Medical and Hospital Benefits" chart above	• **$0** copay • Under age 21 only • 1 monaural or binaural hearing aid covered with prior approval • Replacements based on medical necessity and require prior approval • Supplies related to hearing aid are covered with prior approval • Batteries are covered
TRANSPORTATION		
Non-Emergency Medical Transportation Services	See "Transportation" benefit in the "Covered Medical and Hospital Benefits" chart above	• **$0** copay • Prior scheduling required
INPATIENT LONG TERM CARE SERVICES		
Inpatient Hospital, Nursing Facility and Intermediate Care Facility Services in Institutions for Mental Diseases (IMD), age 65 and older	Not covered	• **$0** copay
Inpatient Psychiatric Services, under age 21	See "Mental Health" benefit in the "Covered Medical and Hospital Benefits" chart above	• **$0** copay
Intermediate Care Facility Services for Individuals with Intellectual Disabilities	Not Covered	• **$0** copay
Nursing Facility Services, other than in an Institution for Mental Diseases	See "Skilled Nursing" benefit in the "Covered Medical and Hospital Benefits" chart above	• **$0** copay
Other Medicaid Covered Services		
Over-the-Counter (OTC) benefit	See "Over-the-Counter benefits" on the "More benefits with your plan" page later in this document	• Certain OTC drugs are covered.
Chiropractic Services	Medicare-covered Chiropractic Services: **$0** copay	• **$2** copay for Medicaid-covered services

HOME AND COMMUNITY BASED WAIVER SERVICES
Dual eligible members, who meet the financial criteria for full Medicaid coverage, may also be eligible to receive Waiver services. Waiver services are limited to individuals who meet additional waiver eligibility criteria. For information on waiver services and eligibility, contact Medicaid at 1-800-662-7030.

The Additional Medicaid Covered Services table above reflects Medicaid services available on a fee for service basis for dual eligibles who meet the eligibility requirements for full Medicaid benefits.

The Medicaid information included in this section is current as of 7/1/2017. All Medicaid covered services are subject to change at any time. For the most current North Carolina Medicaid coverage information, please visit the North Carolina Medicaid website at http://www.ncdhhs.gov/dma/medicaid/medicare.htm or call the Medicaid Hotline at 1-800-662-7030.

More benefits with **your plan**

Enjoy some of these extra benefits included in your plan.

Additional smoking and tobacco use cessation
To further assist in your effort to quit smoking or tobacco product use, we cover one additional counseling quit attempt within a 12-month period as a service with no cost to you. This is in addition to the two counseling attempt provided by Medicare and includes up to four face-to-face visits. This service can be used for either preventive measures or for diagnosis with a tobacco related disease.

Chiropractic services
Medicare-covered Chiropractic Services:
- **$0** copay

Routine Chiropractic Services:
- **$0** copay per visit for up to 12 visits copay

Enhanced nutrition therapy
Additional one-on-one nutrition therapy counseling.

Routine foot care
$0 copay per visit for up to 6 visits in network

Meals
Well Dine Meal Program - Humana's meal program for members with certain special needs plan (SNP) specific conditions or 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 **$50** monthly value for the purchase of OTC supplies from Humana Pharmacy mail delivery.

Wigs
Wigs for hair loss related to chemotherapy.

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.

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.

Humana has been approved by the National Committee for Quality Assurance (NCQA) to operate as a Special Needs Plan (SNP) until 12/31/2018 based on a review of Humana's Model of Care.

Premiums, co-pays, co-insurance, and deductibles may vary based on the level of Extra Help you receive. Please contact the plan for more details.

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

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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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