2021

Summary of Benefits

HumanaChoice H5525-034 (PPO)

Wilmington
Wilmington Area

Humana®

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at **1-800-833-2364 (TTY: 711)**.

Understanding the Benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor. Visit **Humana.com/medicare** or call **1-800-833-2364 (TTY: 711)** to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2022.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you may pay a higher co-pay for services received by non-contracted providers.

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HumanaChoice H5525-034 (PPO)

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Our service area includes the following county/counties in North Carolina: Bladen, Brunswick, Columbus, New Hanover, Pender.

Let's talk about HumanaChoice H5525-034 (PPO)

Find out more about the HumanaChoice H5525-034 (PPO) plan - including the health and drug services it covers - in this easy-to-use guide.

HumanaChoice H5525-034 (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".

To be eligible

To join HumanaChoice H5525-034 (PPO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

Plan name:

HumanaChoice H5525-034 (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 - March 31:

Call 7 days a week from 8 a.m. - 8 p.m.

April 1 - September 30:

Call Monday - Friday, 8 a.m. - 8 p.m.

Or visit our website:
Humana.com/medicare.

More about HumanaChoice H5525-034 (PPO)

Do you have Medicare and Medicaid? If you are a dual-eligible beneficiary enrolled in both Medicare and the state's program, you may not have to pay the medical costs displayed in this booklet and your prescription drug costs will be lower, too.

If you have Medicaid, be sure to show your Medicaid ID card in addition to your Humana membership card to make your provider aware that you may have additional coverage. Your services are paid first by Humana and then by Medicaid.

As a member it's a good idea to select a doctor as your Primary Care Provider (PCP). HumanaChoice H5525-034 (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!

Monthly Premium, Deductible and Limits

PLAN COSTS		
Monthly plan premium You must keep paying your Medicare Part B premium.	**$135** Depending on your level of Medicaid eligibility, your plan premium may be reduced.	
PLAN COSTS	**IN-NETWORK**	**OUT-OF-NETWORK**
Medical deductible	This plan does not have a deductible.	
Pharmacy (Part D) deductible	**$190** for 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		
	$0 copayment per stay Your plan covers an unlimited number of days for an inpatient stay.	**$0** copayment per stay
OUTPATIENT HOSPITAL COVERAGE		
Outpatient surgery at outpatient hospital	**$350** copay	**$350** copay
Outpatient surgery at ambulatory surgical center	**$300** copay	**$300** copay
DOCTOR OFFICE VISITS		
Primary care provider (PCP)	**$0** copay	**$0** copay
Specialists	**$0** copay	**$0** copay

You do not need a referral to receive covered services from plan 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
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) • Annual Wellness Visit • Lung cancer screening • Routine physical exam • Medicare diabetes prevention program	**$0** copay Any additional preventive services approved by Medicare during the contract year will be covered.

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Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
	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.	**$90** copay	**$90** 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.	**$0** copay at an urgent care center	**$0** 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	**$0** copay	**$0** copay
Diagnostic radiology	**$180** to **$275** copay	**$180** to **$275** copay
Lab services	**$0** copay	**$0** copay
Diagnostic tests and procedures	**$0** copay	**$0** copay
Outpatient X-rays	**$0** copay	**$0** copay
Radiation therapy	**$0** copay or **20%** of the cost	**$0** copay or **20%** of the cost
HEARING SERVICES		
Medicare-covered hearing	**$0** copay	**$0** copay

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Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
Routine hearing	**HER949** • **$0** copayment for fitting, routine hearing exams up to 1 per year. • **$0** copayment for adjustments up to 2 per year. • **$99** copayment for Advanced level hearing aid up to 1 per ear per year. • **$399** copayment for Premium level hearing aid up to 1 per ear per year. • Note: Includes 48 batteries per aid and 3 year warranty. • Fitting and adjustments are covered for 1 year after TruHearing hearing aid purchase. TruHearing provider must be used.	**HER949** • **$0** copayment for fitting, routine hearing exams up to 1 per year. • **$0** copayment for adjustments up to 2 per year. • **$99** copayment for Advanced level hearing aid up to 1 per ear per year. • **$399** copayment for Premium level hearing aid up to 1 per ear per year. • Note: Includes 48 batteries per aid and 3 year warranty. • Fitting and adjustments are covered for 1 year after TruHearing hearing aid purchase. • 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 The cost-share indicated below is what you pay for the covered service.		
Medicare-covered dental	**$0** copay	**$0** copay
Routine dental Dental benefits may not cover all American Dental Association procedure codes. Information regarding each plan is available at **Humana.com/sb** Use the HumanaDental Medicare network for the Mandatory Supplemental Dental. The provider locator can be found at **Humana.com** > Find a Doctor > from the Search Type drop down select Dental > under Coverage	**DEN187** • **0%** coinsurance for comprehensive oral evaluation or periodontal exam up to 1 every 3 years. • **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 intraoral x-rays up to 1 per year. • **0%** coinsurance for fluoride treatment, periodic oral exam and/or emergency diagnostic	**DEN187** • **50%** coinsurance for comprehensive oral evaluation or periodontal exam up to 1 every 3 years. • **50%** coinsurance for panoramic film or diagnostic x-rays up to 1 every 5 years. • **50%** coinsurance for bitewing x-rays up to 1 set(s) per year. • **50%** coinsurance for intraoral x-rays up to 1 per year. • **50%** coinsurance for fluoride treatment, periodic oral exam and/or emergency diagnostic

You do not need a referral to receive covered services from plan 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
Type select All Dental Networks > enter zip code > from the network drop down select HumanaDental Medicare.	exam, prophylaxis (cleaning) up to 2 per year. • **0%** coinsurance for necessary anesthesia with covered service up to unlimited per year. • **50%** coinsurance for recementation up to 1 every 5 years. • **50%** coinsurance for amalgam and/or composite filling, emergency treatment for pain up to 2 per year. • **50%** coinsurance for simple or surgical extraction up to unlimited per year. • **70%** coinsurance for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years. • **70%** coinsurance for complete dentures, partial dentures up to 1 set(s) every 5 years. • **70%** coinsurance for adjustments to dentures, denture reline, root canal up to 1 per year. • **70%** coinsurance for crown, oral surgery up to 2 per year. • **70%** coinsurance for periodontal maintenance up to 4 per year. • **$2000** combined maximum benefit coverage amount per year for preventive and comprehensive benefits.	exam, prophylaxis (cleaning) up to 2 per year. • **50%** coinsurance for necessary anesthesia with covered service up to unlimited per year. • **55%** coinsurance for recementation up to 1 every 5 years. • **55%** coinsurance for amalgam and/or composite filling, emergency treatment for pain up to 2 per year. • **55%** coinsurance for simple or surgical extraction up to unlimited per year. • **75%** coinsurance for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years. • **75%** coinsurance for complete dentures, partial dentures up to 1 set(s) every 5 years. • **75%** coinsurance for adjustments to dentures, denture reline, root canal up to 1 per year. • **75%** coinsurance for crown, oral surgery up to 2 per year. • **75%** coinsurance for periodontal maintenance up to 4 per year. • **$2000** combined maximum benefit coverage amount per year for preventive and comprehensive benefits. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
VISION SERVICES		
Medicare-covered vision services	**$0** copay	**$0** copay

You do not need a referral to receive covered services from plan 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
Medicare-covered diabetic eye exam	**$0** copay	**$0** copay
Medicare-covered glaucoma screening	**$0** copay	**$0** copay
Medicare-covered eyewear (post-cataract)	**$0** copay	**$0** copay
Routine vision The provider locator for routine vision can be found at **Humana.com** > Find a Doctor > from the Search Type drop down select Vision > Vision coverage through Medicare Advantage plans.	**VIS752** • **$0** copayment for refraction, routine exam up to 1 per year. • **$75** combined maximum benefit coverage amount per year for refraction, routine exam. • **$200** combined maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. • Eyeglasses include ultraviolet protection and scratch resistant coating.	**VIS752** • **$0** copayment for refraction, routine exam up to 1 per year. • **$75** combined maximum benefit coverage amount per year for refraction, routine exam. • **$200** combined maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. • Eyeglasses include ultraviolet protection and scratch resistant coating. • 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	**$350** copayment per stay	**$350** copayment per stay
Outpatient group and individual therapy visits	**$0** copay	**$0** copay
SKILLED NURSING FACILITY (SNF)		
Your plan covers up to 100 days in a SNF	**$0** copay per day for days 1-20 **$184** copay per day for days 21-100	**$0** copay per day for days 1-20 **$184** copay per day for days 21-100
PHYSICAL THERAPY		
	$0 copay	**$0** copay

You do not need a referral to receive covered services from plan 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
AMBULANCE		
Ambulance (ground)	**$290** copay per date of service	**$290** copay per date of service
Ambulance (air)	**20%** of the cost	**20%** of the cost
TRANSPORTATION		
	$0 copay for up to 24 one-way trips to plan approved locations. Not to exceed 50 miles per trip. The member *must* contact transportation vendor to arrange transportation.	

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
PRESCRIPTION DRUGS		

If you don't receive Extra Help for your drugs, you'll pay the following:

Deductible This plan has a **$190** deductible for Tier 3, Tier 4, Tier 5 drugs. You pay the full cost of these drugs until you reach $190. Then, you only pay your cost-share.

Initial coverage (after you pay your deductible, if applicable)
You pay the following until your total yearly drug costs reach **$4,130**. Total yearly drug costs are the total drug costs paid by both you and our plan. Once you reach this amount, you will enter the Coverage Gap.

Preferred cost-sharing

Pharmacy options	**Retail** To find the preferred cost-share retail pharmacies near you, go to **Humana.com/pharmacyfinder**		**Mail order** Humana Pharmacy®	
	30-day supply	**90-day supply**	**30-day supply**	**90-day supply**
Tier 1: Preferred Generic	$4	$12	$4	$0
Tier 2: Generic	$12	$36	$12	$0
Tier 3: Preferred Brand	$47	$141	$47	$131
Tier 4: Non-Preferred Drug	$99	$297	$99	$287
Tier 5: Specialty Tier	29%	N/A	29%	N/A

You do not need a referral to receive covered services from plan 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.

Standard cost-sharing				
Pharmacy options	**Retail** All other network retail pharmacies.		**Mail order** Walmart Mail, PillPack	
	30-day supply	**90-day supply**	**30-day supply**	**90-day supply**
Tier 1: Preferred Generic	$10	$30	$10	$30
Tier 2: Generic	$20	$60	$20	$60
Tier 3: Preferred Brand	$47	$141	$47	$141
Tier 4: Non-Preferred Drug	$100	$300	$100	$300
Tier 5: Specialty Tier	29%	N/A	29%	N/A

Generic drugs may be covered on tiers other than Tier 1 and Tier 2 so please check this plan's Humana Drug Guide to validate the specific tier on which your drugs are covered.

Specialty drugs are limited to a 30 day supply.

If you receive Extra Help for your drugs, you'll pay the following:

Deductible You may pay **$0** or **$92** depending on your level of Extra Help (for Tier 3, Tier 4, Tier 5). If your deductible is **$92**, you pay the full cost of these drugs until you reach **$92**. Then, you only pay your cost-share.

Pharmacy cost-sharing		
For generic drugs (including brand drugs treated as generic), either:	**30-day supply**	**90-day supply**
	$0 copay; or **$1.30** copay; or **$3.70** copay ; or **15%** of the cost	**$0** copay; or **$1.30** copay; or **$3.70** copay ; or **15%** of the cost
For all other drugs, either:	**$0** copay; or **$4** copay; or **$9.20** copay ; or **15%** of the cost	**$0** copay; or **$4** copay; or **$9.20** copay ; or **15%** of the cost

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 drug 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 **25 percent** of the plan's cost for covered brand name drugs and **25 percent** of the plan's cost for covered generic drugs until your costs total **$6,550** — 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 **$6,550**, you pay the greater of:
- **5%** of the cost, or
- **$3.70** copay for generic (including brand drugs treated as generic) and a **$9.20** copayment for all other drugs

Additional Benefits

	IN-NETWORK	OUT-OF-NETWORK
Medicare-covered foot care (podiatry)	**$0** copay	**$0** copay
Medicare-covered chiropractic services	**$0** copay	**$0** 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	**10%** to **20%** of the cost
REHABILITATION SERVICES		
Physical, occupational and speech therapy	**$0** copay	**$0** copay
Cardiac rehabilitation	**$0** copay	**$0** copay
Pulmonary rehabilitation	**$0** copay	**$0** copay
TELEHEALTH SERVICES (in addition to Original Medicare)		
Primary care provider (PCP)	**$0** copay	Not Covered

Specialist	**$0** copay	Not Covered
Urgent care services	**$0** copay	Not Covered
Substance abuse or behavioral health services	**$0** copay	Not Covered

More benefits with **your plan**

Enjoy some of these extra benefits included in your plan.

COVID-19 Testing and Treatment

$0 copay for testing and treatment services for COVID-19.

Health Essentials Kit

Kit includes over the counter items useful for preventing the spread of COVID-19 and other viruses.
Limit one per year.

Travel Coverage

As a member of a Humana 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 Humana 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 Care on the back of your ID card if you need help finding an in-network provider.

Humana Well Dine® Meal Program

Humana's meal program for members following an inpatient stay in the hospital or nursing facility.

Over-the-Counter (OTC) mail order

$75 every quarter (3 months) for approved select over-the-counter health and wellness products from Humana Pharmacy mail delivery.

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 **humana.com/finder/search** 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 guide** at our website at **humana.com/medicaredruglist** or call us at the number listed at the beginning of this booklet and we will send you one.

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.

Telehealth services shown are in addition to the Original Medicare covered telehealth. Your cost may be different for Original Medicare telehealth.

Limitations on telehealth services, also referred to as virtual visits or telemedicine, vary by state. These services are not a substitute for emergency care and are not intended to replace your primary care provider or other providers in your network. Any descriptions of when to use telehealth services are for informational purposes only and should not be construed as medical advice. Please refer to your evidence of coverage for additional details on what your plan may cover or other rules that may apply.

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

Out-of-network/non-contracted providers are under no obligation to treat Humana members, except in emergency situations. 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.

Humana®

Humana.com

Important!

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status or religion. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618.
  If you need help filing a grievance, call **1-877-320-1235** 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 their Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019, 800-537-7697 (TDD)**. Complaint forms are available at https://www.hhs.gov/ocr/office/file/index.html.
- **California residents:** You may also call California Department of Insurance toll-free hotline number: **1-800-927-HELP (4357)**, to file a grievance.

Auxiliary aids and services, free of charge, are available to you. 1-877-320-1235 (TTY: 711)

Humana provides 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.

Language assistance services, free of charge, are available to you.
1-877-320-1235 (TTY: 711)

Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.

繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。

Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.

한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오 .

Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.

Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.

Kreyòl Ayisyen (French Creole): Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.

Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.

Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.

Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.

Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.

Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.

日本語 (Japanese): 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。

فارسی (Farsi)

برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.

Diné Bizaad (Navajo): Wódahí béésh bee hani'í bee wolta'ígíí bich'į' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'dęę́ niká'adoowoł.

العربية (Arabic)

الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

HumanaChoice H5525-034 (PPO)

H5525034000 ENG

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