

# 2017 Summary of Benefits

HumanaChoice<sup>®</sup>  
H6609-083 (PPO)  
Columbus, OH  
Columbus Metro Area



**Humana<sup>®</sup>**



2017

# Summary of Benefits

HumanaChoice®

H6609-083 (PPO)

Columbus, OH

Columbus Metro Area

**Humana®**

Our service area includes the following county/counties in Ohio: Delaware, Fairfield, Franklin, Licking, Madison, Morrow, Pickaway, Union, OH;



# Let's talk about **HumanaChoice<sup>®</sup>** **H6609-083 (PPO)**

Find out more about the HumanaChoice H6609-083 (PPO) plan - including the health and drug services it covers - in this easy-to-use guide.

HumanaChoice H6609-083 (PPO) is a Medicare Advantage PPO plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

The benefit information provided is a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. For a complete list of services we cover, ask us for the "Evidence of Coverage" or you will receive one after you enroll.

## To be eligible

To join HumanaChoice H6609-083 (PPO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

## Plan name:

HumanaChoice H6609-083 (PPO)

## How to reach us:

If you're a member of this plan, call toll-free: **1-800-457-4708 (TTY: 711)**.

If you're **not** a member of this plan, call toll free: **1-800-833-2364 (TTY: 711)**.

## October 1 - February 14:

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

## February 15 - September 30:

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

Or visit our website:

**Humana-medicare.com.**

As a member you must select an in-network doctor to act as your Primary Care Physician (PCP). HumanaChoice H6609-083 (PPO) has a network of doctors, hospitals, pharmacies and other providers. If you use providers who aren't in our network, you may be subject to higher copayments/coinsurance.



## A healthy partnership

Get more from your plan — with extra services and resources provided by Humana!

**This document is available in other formats** such as Braille and large print. This information is available for free in other languages. Please contact a licensed Humana sales agent at 1-800-833-2364 (TTY: 711). Esta información está disponible gratuitamente en otros idiomas. Póngase en contacto con un agente de ventas certificado de Humana al 1-800-833-2364 (TTY: 711).



## Monthly Premium, Deductible and Limits

	IN-NETWORK	OUT-OF-NETWORK
<b>PLAN COSTS</b>		
<b>Monthly premium</b> You must keep paying your Medicare Part B premium.	<b>\$67</b>	
<b>Medical deductible</b>		<b>\$1,500</b> combined in- and out-of-network All services received from in network providers are excluded from the combined deductible. Services not covered by Original Medicare, Ambulance services, Emergency room services, Urgently Needed Services at Urgent Care Centers, Immunizations (Flu & Pneumonia) received from out-of network providers are also excluded from the combined deductible.
<b>Pharmacy (Part D) deductible</b>	<b>\$175</b> only applies to Tier 3, Tier 4, Tier 5.	
<b>Maximum out-of-pocket responsibility</b> The most you pay for copays, coinsurance and other costs for medical services for the year.	<b>\$6,700</b> in-network	<b>\$10,000</b> combined in- and out-of-network



## Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
<b>ACUTE INPATIENT HOSPITAL CARE</b>		
	<b>\$360</b> copay per day for days 1-5 <b>\$0</b> copay per day for days 6-90 Your plan covers an unlimited number of days for an inpatient stay	<b>30%</b> of cost
<b>DOCTOR OFFICE VISITS</b>		
<b>Primary care Physician (PCP)</b>	<b>\$15</b> copay	<b>30%</b> of cost
<b>Specialists</b>	<b>\$45</b> copay	<b>30%</b> of cost

You do not need a referral to receive covered services from in-network providers.

Certain procedures, services and drugs may need advance approval before your plan will cover any of the costs. This is called "prior authorization" or "preauthorization."



## Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
<b>PREVENTIVE CARE</b>		
Including: Annual Wellness Visit, flu vaccine, colorectal cancer and breast cancer screenings. Covered at no cost when you see an in-network provider. Any additional preventive services approved by Medicare during the contract year will be covered.	<b>Covered at no cost</b> when you see an in-network provider.	<b>0% to 30%</b> of the cost, depending on the service and where service is provided
<b>EMERGENCY CARE</b>		
<b>Emergency room</b> 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.	<b>\$75</b> copay	<b>\$75</b> copay
<b>Urgently needed services</b> Urgently needed services are care provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.	<b>\$35</b> copay at an urgent care center	<b>30%</b> of cost at an urgent care center
<b>OUTPATIENT CARE AND DIAGNOSTIC SERVICES, LABS AND IMAGING</b> Cost share may vary depending on the service and where service is provided		
<b>Diagnostic Mammography</b>	<b>\$45 to \$105</b> copay	<b>30%</b> of the cost
<b>Diagnostic radiology</b>	<b>\$330 to \$360</b> copay	<b>30%</b> of the cost
<b>Lab services</b>	<b>\$0 to \$95</b> copay	<b>30%</b> of the cost
<b>Diagnostic tests and procedures</b>	<b>\$0 to \$105</b> copay	<b>20% to 30%</b> of the cost
<b>Outpatient X-rays</b>	<b>\$15 to \$105</b> copay	<b>30%</b> of the cost
<b>Radiation Therapy</b>	<b>\$45 or 20%</b> of the cost	<b>30%</b> of the cost
<b>HEARING SERVICES</b>		
<b>Medicare covered hearing</b>	<b>\$45</b> copay	<b>30%</b> of cost
<b>DENTAL SERVICES</b>		
<b>Medicare covered dental</b>	<b>\$45</b> copay	<b>30%</b> of cost

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## Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
<b>Routine dental</b>	<ul style="list-style-type: none"> <li>• <b>25%</b> coinsurance for Panoramic Film up to 1 every 5 years.</li> <li>• <b>25%</b> coinsurance for extraoral X-rays, intraoral X-rays up to 1 per year.</li> <li>• <b>25%</b> coinsurance for Bitewing X-rays up to 1 set(s) per year.</li> <li>• <b>25%</b> coinsurance for Emergency Diagnostic Exam, Fluoride Treatment, Periodic Oral Exam and/or Comprehensive Oral Evaluation, Prophylaxis (cleaning) up to 2 per year.</li> <li>• <b>50%</b> coinsurance for Emergency treatment for pain up to 2 per year.</li> <li>• <b>50%</b> coinsurance for Extractions up to unlimited per year.</li> <li>• <b>75%</b> coinsurance for Composite Filling up to 1 every 3 years.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>50%</b> coinsurance for Panoramic Film up to 1 every 5 years.</li> <li>• <b>50%</b> coinsurance for extraoral X-rays, intraoral X-rays up to 1 per year.</li> <li>• <b>50%</b> coinsurance for Bitewing X-rays up to 1 set(s) per year.</li> <li>• <b>50%</b> coinsurance for Emergency Diagnostic Exam, Fluoride Treatment, Periodic Oral Exam and/or Comprehensive Oral Evaluation, Prophylaxis (cleaning) up to 2 per year.</li> <li>• <b>55%</b> coinsurance for Emergency treatment for pain up to 2 per year.</li> <li>• <b>55%</b> coinsurance for Extractions up to unlimited per year.</li> <li>• <b>80%</b> coinsurance for Composite Filling up to 1 every 3 years.</li> <li>• Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.</li> </ul>
<b>VISION SERVICES</b>		
<b>Medicare covered vision services</b>	<b>\$45</b> copay	<b>30%</b> of cost
<b>Glaucoma screening</b>	<b>\$0</b> copay	<b>30%</b> of cost
<b>Eyewear (post-cataract)</b>	<b>\$0</b> copay	<b>\$0</b> copay

You do not need a referral to receive covered services from in-network providers. Certain procedures, services and drugs may need advance approval before your plan will cover any of the costs. This is called "prior authorization" or "preauthorization."





## Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
<b>Routine vision</b>	<ul style="list-style-type: none"> <li>• <b>\$40</b> maximum benefit coverage amount per year for Routine Exam, which includes refraction, up to 1 per year. (Visit any in-network provider and routine exam charge will not exceed the <b>\$40</b> maximum benefit coverage amount.)</li> <li>• <b>\$100</b> maximum benefit coverage amount per year for Contact Lenses or Eyeglasses - Lenses and Frames.</li> <li>• Includes ultraviolet protection and scratch resistant coating.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>\$40</b> maximum benefit coverage amount per year for Routine Exam, which includes refraction, up to 1 per year.</li> <li>• <b>\$100</b> maximum benefit coverage amount per year for Contact Lenses or Eyeglasses - Lenses and Frames.</li> <li>• Includes ultraviolet protection and scratch resistant coating.</li> <li>• Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.</li> </ul>
<b>MENTAL HEALTH SERVICES</b>		
<b>Inpatient</b> Your plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital	<b>\$360</b> copay per day for days 1-4 <b>\$0</b> copay per day for days 5-90	<b>30%</b> of cost
<b>Outpatient group and individual therapy visits</b> Cost share may vary depending on where service is provided.	<b>\$40</b> to <b>\$105</b> copay	<b>30%</b> of the cost
<b>SKILLED NURSING FACILITY</b>		
Your plan covers up to 100 days in a SNF	<b>\$0</b> copay per day for days 1-20 <b>\$164.50</b> copay per day for days 21-100	<b>30%</b> of cost
<b>REHABILITATION SERVICES</b>		
<b>Physical, occupational and speech therapy</b> Cost share may vary depending on the service and where service is provided.	<b>\$15</b> to <b>\$40</b> copay	<b>30%</b> of the cost
<b>Cardiac and pulmonary rehabilitation</b>	<b>\$15</b> copay	<b>30%</b> of the cost
<b>AMBULANCE</b>		
<b>Ambulance (ground)</b>	<b>\$265</b> copay	<b>\$265</b> copay
<b>Ambulance (air)</b>	<b>20%</b> of cost	<b>20%</b> of cost

You do not need a referral to receive covered services from in-network providers.

Certain procedures, services and drugs may need advance approval before your plan will cover any of the costs. This is called "prior authorization" or "preauthorization."



## Covered Medical and Hospital Benefits (cont.)

	IN-NETWORK	OUT-OF-NETWORK
<b>TRANSPORTATION</b>		
	Not covered	Not covered
<b>FOOT CARE (PODIATRY)</b>		
Medicare covered foot care	<b>\$45</b> copay	<b>30%</b> of cost
<b>MEDICAL EQUIPMENT/SUPPLIES</b>		
Durable medical equipment (like wheelchairs or oxygen)	<b>20%</b> of the cost	<b>20%</b> of the cost
Medical Supplies	<b>20%</b> of cost	<b>20%</b> of cost
Prosthetics (artificial limbs or braces)	<b>20%</b> of cost	<b>20%</b> of cost
Preferred diabetes monitoring supplies Cost share may vary depending on where service is provided.	<b>0% to 20%</b> of the cost	<b>20%</b> of the cost
Non-preferred diabetes monitoring supplies Cost share may vary depending on where service is provided.	<b>10% to 20%</b> of the cost	<b>20%</b> of the cost

### FITNESS AND WELLNESS

SilverSneakers® Fitness Program - Basic fitness center membership including fitness classes.

The plan covers more benefits that promote health and well-being. To see more benefits, check out “More benefits with your plan,” listed later in this document.



## Prescription Drug Benefits

### MEDICARE PART B DRUGS

Chemotherapy drugs	<b>20%</b> of the cost	<b>30%</b> of the cost
Other part B drugs	<b>20%</b> of the cost	<b>20%</b> of the cost

### PRESCRIPTION DRUGS

Initial coverage (after you pay your deductible, if applicable)

You pay the following until your total yearly drug costs reach \$3,700. Total yearly drug costs are the total drug costs paid by both you and our plan.

*You do not need a referral to receive covered services from in-network providers.*

*Certain procedures, services and drugs may need advance approval before your plan will cover any of the costs. This is called “prior authorization” or “preauthorization.”*

Tier	Preferred Retail Pharmacy	Standard Retail Pharmacy	Preferred Mail Order	Standard Mail Order
<b>30-day supply</b>				
<b>1 (Preferred Generic)</b>	<b>\$7</b> copay	<b>\$10</b> copay	<b>\$7</b> copay	<b>\$10</b> copay
<b>2 (Generic)</b>	<b>\$17</b> copay	<b>\$20</b> copay	<b>\$17</b> copay	<b>\$20</b> copay
<b>3 (Preferred Brand)</b>	<b>\$47</b> copay	<b>\$47</b> copay	<b>\$47</b> copay	<b>\$47</b> copay
<b>4 (Non-Preferred Drug)</b>	<b>\$100</b> copay	<b>\$100</b> copay	<b>\$100</b> copay	<b>\$100</b> copay
<b>5 (Specialty)</b>	<b>29%</b> of cost	<b>29%</b> of cost	<b>29%</b> of cost	<b>29%</b> of cost
<b>90-day supply</b>				
<b>1 (Preferred Generic)</b>	<b>\$21</b> copay	<b>\$30</b> copay	<b>\$0</b> copay	<b>\$30</b> copay
<b>2 (Generic)</b>	<b>\$51</b> copay	<b>\$60</b> copay	<b>\$0</b> copay	<b>\$60</b> copay
<b>3 (Preferred Brand)</b>	<b>\$141</b> copay	<b>\$141</b> copay	<b>\$131</b> copay	<b>\$141</b> copay
<b>4 (Non-Preferred Drug)</b>	<b>\$300</b> copay	<b>\$300</b> copay	<b>\$290</b> copay	<b>\$300</b> copay

Specialty drugs are limited to a 30 day supply.

Cost sharing may change depending on the pharmacy you choose, when you enter another phase of the Part D benefit and if you qualify for “Extra Help.” To find out if you qualify for “Extra Help,” please contact the Social Security Office at 1-800-772-1213 Monday — Friday, 7 am. — 7 p.m. TTY users should call 1-800-325-0778. For more information on the additional pharmacy-specific cost-sharing and the phases of the benefit, please call us or access our “Evidence of Coverage” online.

If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy.

You may get drugs from an out-of-network pharmacy but may pay more than you pay at an in-network pharmacy.

### Days' Supply Available

Unless otherwise specified, you can get your Part D medicine in the following days' supply amounts:

- One month supply (up to 30 days)\*
- Two month supply (31-60 days)
- Three month supply (61-90 days)

\*Long term care pharmacy (one month supply = 31 days)

### Coverage Gap

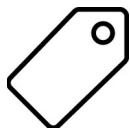
After you enter the coverage gap, you pay **40 percent** of the plan's cost for covered brand name drugs and **51 percent** of the plan's cost for covered generic drugs until your costs total **\$4,950** — which is the end of the coverage gap. Not everyone will enter the coverage gap.

Under this plan, you may pay even less for the following: **Tier 1** (Preferred Generic) - Home Infusion Drugs; **Tier 2** (Generic) - Home Infusion Drugs; **Tier 3** (Preferred Brand) - Home Infusion Drugs; **Tier 4** (Non-Preferred Drug) - Home Infusion Drugs; **Tier 5** (Specialty) - Home Infusion Drugs;. For more information on cost sharing in the coverage gap, please call us or access our Evidence of Coverage online.

### Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **\$4,950**, you pay the greater of:

- **5%** of the cost, or
- **\$3.30** copay for generic (including brand drugs treated as generic) and a **\$8.25** copayment for all other drugs



## More benefits with **your plan**

Enjoy some of these extra benefits included in your plan.

### **Additional smoking cessation**

A smoking cessation program available on-line, email and phone. Personal coaches assist via establishing goals and providing articles and resources to aid in the effort to quit smoking.

### **Counseling**

Member Assistance Program includes counseling by phone to help you cope with life changes, including adult care and child care issues. Online resources are also available.

### **Health education**

One-on-one wellness coaching with email, phone and online chat options.

### **Meals**

Well Dine Meal Program - Humana's meal program for members following an inpatient stay in the hospital or nursing facility

### **HumanaFirst nurse advice line**

Health advice from a registered nurse, available 24 hours a day, seven days a week.

### **Over-the-counter allowance**

**\$0** copay; up to **\$30** every 3 months for the purchase of OTC supplies from Humana Pharmacy mail delivery.

### **Remote access technologies**

Be "seen" by doctors and other healthcare providers via phone and video technology for diagnosis and treatment. You pay a **\$10** copay to receive a remote medical consultation.

### **Wigs**

Wigs for hair loss related to chemotherapy.

### **Go365™ by Humana**

Rewards for completing preventive health screenings and activities.



## Find out **more**

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You can see our plan's **provider and pharmacy directory** at our website at [www.humana.com/members/tools](http://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/](http://www.humana.com/medicare/medicare_prescription_drugs/medicare_drug_tools/medicare_drug_list/) or call us at the number listed at the beginning of this booklet and we will send you one.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments and restrictions may apply. Benefits, premiums and/or member cost-share may change on January 1 of each year. You must continue to pay your Medicare Part B premium.

To find out more about the coverage and costs of Original Medicare, look in the current "Medicare & You" handbook. View it online at <http://www.medicare.gov> or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

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

Out-of-network/non-contracted providers are under no obligation to treat Humana members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.



## **Discrimination is Against the Law**

CHA HMO, INC., CAREPLUS HEALTH PLANS, INC., HUMANA MEDICAL PLAN, INC, HUMANA HEALTH PLAN, INC., HUMANA BENEFIT PLAN OF ILLINOIS, INC., HUMANA INSURANCE COMPANY, HUMANA HEALTH BENEFIT PLAN OF LOUISIANA, INC., HUMANA INSURANCE OF PUERTO RICO, INC., HUMANA MEDICAL PLAN OF UTAH, INC., HUMANA HEALTH COMPANY OF NEW YORK, INC., HUMANA HEALTH PLANS OF PUERTO RICO, INC., HUMANA EMPLOYERS HEALTH PLAN OF GEORGIA, INC., HUMANA REGIONAL HEALTH PLAN, INC. CARITEN HEALTH PLAN INC., HUMANA HEALTH INSURANCE COMPANY OF FLORIDA, INC., ARCADIAN HEALTH PLAN, INC., HUMANA INSURANCE COMPANY OF NEW YORK, HUMANA WI HEALTH ORGANIZATION INSURANCE CORP, HUMANA MEDICAL PLAN OF PENNSYLVANIA, INC., HUMANA MEDICAL PLAN OF MICHIGAN, INC. (“Humana”) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Humana does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Humana:

- 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
- Provides free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Dr. Michelle Griffin, PhD.

If you believe that Humana 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 with:

Dr. Michelle M. Griffin, PhD (FACHE)

Civil Rights/LEP/ADA/Section 1557 Compliance Officer: 500 W. Main Street -10th floor Louisville, Kentucky 40202 Phone: 1-877-320-1235 Fax: 877-320-1269

Email: Mgriffin5@humana.com or Accessibility@humana.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Dr. Michelle Griffin PHD, Civil Rights/LEP/ADA/Section 1557 Compliance Officer is available to help you at the contact information listed above.

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 speak English, language assistance services, free of charge, are available to you. Call 1-800-457-4708 (TTY: 711).

**Español (Spanish):** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-457-4708 (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 1-800-457-4708 (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 1-800-457-4708 (TTY: 711).

**한국어 (Korean):** 주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 . 1-800-457-4708 (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 1-800-457-4708 (TTY: 711).

**Русский (Russian):** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-457-4708 (телетайп: 711).

**Kreyòl Ayisyen (French Creole):** ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-457-4708 (TTY: 711).

**Français (French):** ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-457-4708 (ATS : 711).

**Polski (Polish):** UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-457-4708 (TTY: 711).

**Português (Portuguese):** ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-457-4708 (TTY: 711).

**Italiano (Italian):** ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-457-4708 (TTY: 711).

**Deutsch (German):** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-457-4708 (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。1-800-457-4708 (TTY: 711) まで、お電話にてご連絡ください。

**فارسی (Farsi):**

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-457-4708 (رقم هاتف الصم والبكم: 711).

**Diné Bizaad (Navajo):** Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, koji' hódíłnih 1-800-457-4708 (TTY: 711)

**العربية (Arabic):**

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-457-4708 (رقم هاتف الصم والبكم: 711).





HumanaChoice H6609-083 (PPO)  
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