

Summary of Benefits

HumanaChoice[®] H5970-023 (PPO)

New York City and Long Island
Select Counties in New York City and Long Island

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, 2020.
- ☐ 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.

Summary of Benefits

HumanaChoice[®] H5970-023 (PPO)

New York City and Long Island
Select Counties in New York City and Long Island

Humana[®]

Our service area includes the following county/counties in New York: Bronx, Kings, Nassau, New York, Queens, Richmond.



Let's talk about HumanaChoice H5970-023 (PPO)

Find out more about the HumanaChoice H5970-023 (PPO) plan - including the health and drug services it covers - in this easy-to-use guide.

HumanaChoice H5970-023 (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 H5970-023 (PPO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

Plan name:

HumanaChoice H5970-023 (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 H5970-023 (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 H5970-023 (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

| | IN-NETWORK | OUT-OF-NETWORK |
|--|---|--|
| PLAN COSTS | | |
| Monthly plan premium You must keep paying your Medicare Part B premium. | \$199 | |
| 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 The most you pay for copays, coinsurance and other costs for medical services for the year. | \$3,000 in-network \$3,000 combined in- and out-of-network | \$3,000 combined in- and out-of-network |



Covered Medical and Hospital Benefits

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|--|
| ACUTE INPATIENT HOSPITAL CARE | | |
| | \$0 per admit Your plan covers an unlimited number of days for an inpatient stay. | \$0 per admit |
| OUTPATIENT HOSPITAL COVERAGE | | |
| Outpatient surgery at outpatient hospital | \$0 copay | \$0 copay |
| Outpatient surgery at ambulatory surgical center | \$0 copay | \$0 copay |
| DOCTOR OFFICE VISITS | | |
| Primary care provider (PCP) | \$0 copay | \$0 copay |
| Specialists | \$20 copay | \$20 copay |
| PREVENTIVE CARE | | |
| | Our plan covers many preventive services at no cost when you see an in-network provider including: <ul style="list-style-type: none"> Abdominal aortic aneurysm screening | \$0 to \$20 copay, depending on the service and where service is provided |

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.)

IN-NETWORK

- 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

Any additional preventive services approved by Medicare during the contract year will be covered.

OUT-OF-NETWORK

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.)

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| 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. | \$50 copay | \$50 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 to \$20 copay | \$0 to \$20 copay |
| Diagnostic radiology | \$0 to \$20 copay | \$0 to \$20 copay |
| Lab services | \$0 copay | \$0 copay |
| Diagnostic tests and procedures | \$0 to \$20 copay | \$0 to \$20 copay |
| Outpatient X-rays | \$0 to \$20 copay | \$0 to \$20 copay |
| Radiation Therapy | \$0 to \$20 copay | \$0 to \$20 copay |
| HEARING SERVICES | | |
| Medicare covered hearing | \$20 copay | \$20 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.)

| | IN-NETWORK | OUT-OF-NETWORK |
|-------------------------------|---|--|
| Routine hearing HER944 | <ul style="list-style-type: none"> • \$0 copayment for routine hearing exams up to 1 per year. • \$0 copayment for fitting/evaluation up to 3 per year. • \$399 copayment for advanced level hearing aid up to 1 per ear per year. • \$699 copayment for premium hearing aid purchase up to 1 per ear per year. • Note: Includes 48 batteries per aid and 3 year warranty. | <ul style="list-style-type: none"> • \$0 copayment for routine hearing exams up to 1 per year. • \$0 copayment for fitting/evaluation up to 3 per year. • \$399 copayment for advanced level hearing aid up to 1 per ear per year. • \$699 copayment for premium hearing aid purchase up to 1 per ear per year. • Note: Includes 48 batteries per aid and 3 year warranty. • 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 | \$20 copay | \$20 copay |
|--|---|---|
| Routine dental DEN982 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 Type select All Dental Networks > enter zip code > from the network drop down select HumanaDental Medicare. | <ul style="list-style-type: none"> • 0% coinsurance for bitewing (set), intraoral x-ray up to 1 per year • 0% coinsurance for panoramic film or diagnostic x-ray up to 1 every 5 years • 0% coinsurance for perio exam up to 1 every 3 years • 0% coinsurance for periodic oral exam, emergency exam, and/or comprehensive oral eval, prophylaxis, fluoride up to 2 per year • 0% coinsurance for anesthesia with covered service • 50% coinsurance for recement up to 1 every 5 years • 50% coinsurance for simple/surgical extractions, emergency pain treatment, | <ul style="list-style-type: none"> • 50% coinsurance for bitewing (set), intraoral x-ray up to 1 per year • 50% coinsurance for panoramic film or diagnostic x-ray up to 1 every 5 years • 50% coinsurance for perio exam up to 1 every 3 years • 50% coinsurance for periodic oral exam, emergency exam, and/or comprehensive oral eval, prophylaxis, fluoride up to 2 per year. • 50% coinsurance for anesthesia with covered service • 55% coinsurance for recement up to 1 every 5 years • 55% coinsurance for simple/surgical extractions, emergency pain treatment, |

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.)

| | IN-NETWORK | OUT-OF-NETWORK |
|--|---|--|
| | amalgam and/or composite filling up to 2 per year • 70% coinsurance for scaling/root planing up to 1 per quadrant every 3 years • 70% coinsurance for denture adjustment, denture reline, root canal up to 1 per year • 70% coinsurance for complete, partial dentures up to 1 set every 5 years • 70% coinsurance for crown, perio maintenance, oral surgery up to 2 per year • \$2000 max benefit amount per year | amalgam and/or composite filling up to 2 per year • 75% coinsurance for scaling/root planing up to 1 per quadrant every 3 years • 75% coinsurance for denture adjustment, denture reline, root canal up to 1 per year • 75% coinsurance for complete, partial dentures up to 1 set every 5 years • 75% coinsurance for crown, perio maintenance, oral surgery up to 2 per year • \$2000 max benefit amount per year • Out-of-network benefits are subject to any in-network benefit maximum/limit/exclusion |

VISION SERVICES

| | | |
|---|---|---|
| Medicare covered vision services | \$20 copay | \$20 copay |
| Diabetic Eye Exam | \$0 copay | \$0 copay |
| Glaucoma screening | \$0 copay | \$0 copay |
| Eyewear (post-cataract) | \$0 copay | \$0 copay |
| Routine vision VIS752 The provider locator can be found at Humana.com > Find a Doctor > from the Search Type drop down select Vision > Eyemed Select Network. | • \$75 maximum benefit coverage amount per year 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 will include ultraviolet protection and scratch resistant coating. | • \$75 maximum benefit coverage amount per year 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 will include ultraviolet protection and scratch resistant coating. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. |

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.)

| | IN-NETWORK | OUT-OF-NETWORK |
|--|--------------------------------|--------------------------------|
| MENTAL HEALTH SERVICES | | |
| Inpatient Your plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital | \$0 per admit | \$0 per admit |
| Outpatient group and individual therapy visits Cost share may vary depending on where service is provided. | \$0 to \$20 copay | \$0 to \$20 copay |
| SKILLED NURSING FACILITY (SNF) | | |
| Your plan covers up to 100 days in a SNF | \$0 per admit | \$0 per admit |
| PHYSICAL THERAPY | | |
| Cost share may vary depending on the service and where service is provided. | \$0 to \$20 copay | \$0 to \$20 copay |
| AMBULANCE | | |
| Ambulance (ground) | \$0 per date of service | \$0 per date of service |
| TRANSPORTATION | | |
| | Not covered | Not covered |



Prescription Drug Benefits

| | | |
|------------------------------|--------------------------|--------------------------|
| MEDICARE PART B DRUGS | | |
| Chemotherapy drugs | \$0 to \$20 copay | \$0 to \$20 copay |
| Other part B drugs | \$0 to \$20 copay | \$0 to \$20 copay |
| PRESCRIPTION DRUGS | | |

Deductible This plan does not have a deductible.

Initial coverage

You pay the following until your total yearly drug costs reach **\$3,820**. 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.

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.

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 | \$5 | \$15 | \$5 | \$0 |
| Tier 2: Generic | \$12 | \$36 | \$12 | \$0 |
| Tier 3: Preferred Brand | \$47 | \$141 | \$47 | \$131 |
| Tier 4: Non-Preferred Drug | \$100 | \$300 | \$100 | \$290 |
| Tier 5: Specialty Tier | 33% | N/A | 33% | N/A |

Standard cost-sharing

| Pharmacy options | Retail All other network retail pharmacies. | | Mail order Walmart Mail | |
|-----------------------------------|---|----------------------|-----------------------------------|----------------------|
| | 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 | 33% | N/A | 33% | N/A |

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

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 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 **37 percent** of the plan's cost for covered generic drugs until your costs total **\$5,100** — 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 **\$5,100**, you pay the greater of:

- **5%** of the cost, or
- **\$3.40** copay for generic (including brand drugs treated as generic) and a **\$8.50** copayment for all other drugs



Additional benefits

| | IN-NETWORK | OUT-OF-NETWORK |
|---|--------------------------|--------------------------|
| Medicare-covered foot care (podiatry) | \$20 copay | \$20 copay |
| Medicare-covered chiropractic services | \$20 copay | \$20 copay |
| MEDICAL EQUIPMENT/SUPPLIES | | |
| Durable medical equipment (like wheelchairs or oxygen) | \$0 copay | \$0 copay |
| Medical Supplies | \$0 copay | \$0 copay |
| Prosthetics (artificial limbs or braces) | \$0 copay | \$0 copay |
| Diabetic monitoring supplies | \$0 copay | \$0 copay |
| REHABILITATION SERVICES | | |
| Physical, occupational and speech therapy | \$0 to \$20 copay | \$0 to \$20 copay |
| Cost share may vary depending on the service and where service is provided. | | |

Cardiac rehabilitation**\$0 to \$20** copay**\$0 to \$20** copay

Cost share may vary depending on the service and where service is provided.

Pulmonary rehabilitation**\$0 to \$20** copay**\$0 to \$20** copay

Cost share may vary depending on the service and where service is provided.



More benefits with **your plan**

Enjoy some of these extra benefits included in your plan.

Travel Coverage

As a member of a HumanaChoice (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 HumanaChoice (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.

Well Dine Meal Program

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

HumanaFirst® Nurse Hotline

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

Over-the-Counter (OTC) mail order

Up to **\$25** allowance every 3 months for the purchase of OTC supplies from Humana Pharmacy mail delivery.

Virtual Visits - Medical

Access to doctors and other practitioners via phone and/or video technology for diagnosis and treatment of certain non-emergency medical issues.

You pay a **\$10** copay to receive a remote medical consultation.

Virtual Visits – Mental and Behavioral Health

Access to doctors and other mental health professionals via phone and/or video technology for diagnosis and treatment of certain non-emergency mental or behavioral issues.

You pay a **\$20** copay to receive a remote mental and behavioral consultation.

Go365™ by Humana

Rewards for completing certain preventive health screenings and health and wellness activities.

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 list** 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. Call 1-800-457-4708 (TTY: 711) for more information.

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.

This information is available in a different format, including Braille, large print, and audio tapes. Please call Customer Care at the number listed in the beginning of this document if you need plan information in another format.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-833-2364 (TTY: 711).

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

Limitations on healthcare and prescription services delivered via virtual visits and communications options vary by state. Virtual visit services are not a substitute for emergency care and not intended to replace your primary care provider or other providers in your network. This material is provided for informational use only and should not be construed as medical advice or used in place of consulting a licensed medical professional.

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.

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, sex, sexual orientation, gender identity, or religion. Humana Inc. and its subsidiaries do not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion.

Humana Inc. and its subsidiaries provide: (1) 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; and, (2) 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 **1-877-320-1235** 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, sex, sexual orientation, gender identity, or religion, you can file a grievance with Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618.

If you need help filing a grievance, call **1-877-320-1235** 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 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, 800-537-7697 (TDD)**.

Complaint forms are available at **<https://www.hhs.gov/ocr/office/file/index.html>**.

Multi-Language Interpreter Services

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-877-320-1235 **(TTY: 711)**... ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-320-1235 **(TTY: 711)** 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 1-877-320-1235 **(TTY: 711)**。... CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-320-1235 **(TTY: 711)**... 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-320-1235 **(TTY: 711)** 번으로 전화해 주십시오 ... PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-320-1235 **(TTY: 711)**... ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-320-1235 **(телетайп: 711)**... ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-320-1235 **(TTY: 711)**... ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-320-1235 **(ATS: 711)**... UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-320-1235 **(TTY: 711)**... ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-320-1235 **(TTY: 711)**... ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-320-1235 **(TTY: 711)**... ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-320-1235 **(TTY: 711)**... 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。1-877-320-1235 **(TTY: 711)** まで、お電話にてご連絡ください。...

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-877-320-1235 **(TTY: 711)** تماس بگیرید.

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, kóji' hódíłnih 1-877-320-1235 **(TTY: 711)**...

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-320-1235 **(رقم هاتف الصم والبكم: 711)**.

HumanaChoice H5970-023 (PPO)
H5970023000 ENG
Select Counties in New York City and
Long Island

