2019

Summary of Benefits

Optional Supplemental Benefits

Humana Gold Plus® H6622-057 (HMO)

Charlotte
Charlotte Metro Area

Our service area includes the following county/counties in North Carolina: Alexander, Lincoln, Union.

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.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).

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Summary of Benefits

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Charlotte
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Our service area includes the following county/counties in North Carolina: Alexander, Lincoln, Union.

Humana®

Let's talk about Humana Gold Plus H6622-057 (HMO)

Find out more about the Humana Gold Plus H6622-057 (HMO) plan - including the health and drug services it covers - in this easy-to-use guide.

Humana Gold Plus H6622-057 (HMO) is a Medicare Advantage HMO 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 Humana Gold Plus H6622-057 (HMO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

Plan name:

Humana Gold Plus H6622-057 (HMO)

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 Humana Gold Plus H6622-057 (HMO)

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 you must select an in-network doctor to act as your Primary Care Provider (PCP). Humana Gold Plus H6622-057 (HMO) 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.

A healthy partnership

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

Monthly Premium, Deductible and Limits

Monthly Plan Premium	**$22** You must keep paying your Medicare Part B premium.
Medical deductible	This plan does not have a deductible.
Pharmacy (Part D) deductible	**$160** for Tier 4,Tier 5.
Maximum out-of-pocket responsibility	**$3,400** in-network The most you pay for copays, coinsurance and other costs for medical services for the year.

Covered Medical and Hospital Benefits

Acute inpatient hospital care	**$345** copay per day for days 1-4 **$0** copay per day for days 5-90 Your plan covers an unlimited number of days for an inpatient stay.
Outpatient hospital coverage	• Outpatient surgery at Outpatient Hospital: **$345** copay • Outpatient surgery at Ambulatory Surgical Center: **$295** copay
Doctor visits	• Primary care provider: **$0** copay • Specialist: **$35** 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.)

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 **Any additional preventive services approved by Medicare during the contract year will be covered.**
EMERGENCY CARE	
Emergency room	**$120** copay 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.
Urgently needed services	**$25** copay at an urgent care center Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.
OUTPATIENT CARE AND SERVICES	
Diagnostic services, labs and imaging Cost share may vary depending on the service and where service is provided	• Diagnostic mammography: **$35** to **$70** copay • Diagnostic radiology: **$180** to **$250** copay • Lab services: **$0** to **$40** copay • Diagnostic tests and procedures: **$0** to **$85** copay • Outpatient X-rays: **$0** to **$85** copay • Radiation therapy: **$35** or **20%** of the cost

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.)

Hearing	Medicare covered hearing exam: **$35** copay **Routine hearing: HER937** • **$0** copayment for routine hearing exams up to 1 per year. • **$0** copayment for fitting/evaluation up to 3 per year. • **$699** copayment for advanced level hearing aid up to 1 per ear per year. • **$999** 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.
Dental	Medicare covered dental services: **$35** copay **Routine dental: DEN110** The cost-share indicated below is what you pay for the covered service. • **0%** coinsurance for bitewing x-rays up to 1 set(s) per year. • **0%** coinsurance for periodic oral exam or comprehensive oral evaluation, prophylaxis (cleaning) up to 2 per year. • **0%** coinsurance for necessary anesthesia with covered service up to unlimited per year. • **50%** coinsurance for amalgam and/or composite filling up to 2 per year. • **$1000** maximum benefit coverage amount per year for amalgam and/or composite filling, bitewing x-rays, necessary anesthesia with covered service, periodic oral exam or comprehensive oral evaluation, prophylaxis (cleaning). 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. Additional dental benefits are available with a separate monthly premium. Please see the "Optional Supplemental Benefits" page for details.

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.)

Vision	• Medicare-covered vision services: **$35** copay • Diabetic eye exam: **$0** copay • Glaucoma screening: **$0** copay • Eyewear (post-cataract): **$0** copay **Routine vision: VIS734** • **$0** copayment for routine exam, refraction up to 1 per year. • **$100** 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. The provider locator can be found at Humana.com > Find a Doctor > from the Search Type drop down select Vision > Eyemed Select Network.
Mental health services	**Inpatient:** • **$345** copay per day for days 1-4 • **$0** copay per day for days 5-90 • Your plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. **Outpatient** (group and individual therapy visits): **$35** to **$85** copay Cost share may vary depending on where service is provided.
Skilled nursing facility (SNF)	• **$0** copay per day for days 1-20 • **$172** copay per day for days 21-100 • Your plan covers up to 100 days in a SNF
Physical Therapy Cost share may vary depending on the service and where service is provided.	• **$10** to **$40** copay
ADDITIONAL BENEFITS	
Ambulance (ground)	**$265** per date of service
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 • Other Part B drugs: **20%** of the cost

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.

PRESCRIPTION DRUGS

DeductibleThis plan has a **$160** deductible for Tier 4,Tier 5 drugs. You pay the full cost of these drugs until you reach $160. 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 **$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.

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	$2	$6	$2	$0
Tier 2: Generic	$8	$24	$8	$0
Tier 3: Preferred Brand	$45	$135	$45	$125
Tier 4: Non-Preferred Drug	$95	$285	$95	$275
Tier 5: Specialty Tier	30%	N/A	30%	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	30%	N/A	30%	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

Medicare-covered foot care (podiatry)	**$35** copay
Medicare-covered chiropractic services	**$20** copay
Medical equipment/ supplies Cost share may vary depending on the service and where service is provided	• Durable medical equipment (like wheelchairs or oxygen): **20%** of the cost • Medical supplies: **20%** of the cost • Prosthetics (artificial limbs or braces): **20%** of the cost • Diabetic monitoring supplies: **$0** copay or **10%** to **20%** of the cost
Rehabilitation services Cost share may vary depending on the service and where service is provided.	• Physical, occupational and speech therapy: **$10** to **$40** copay • Cardiac rehabilitation: **$10** copay • Pulmonary rehabilitation: **$10** copay

More benefits with **your plan**

Enjoy some of these extra benefits included in your plan.

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 **$50** allowance every 3 months for the purchase of OTC supplies from Humana Pharmacy mail delivery.

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.

Optional **Supplemental Benefits**

Customize your coverage for an extra monthly premium when you enroll. You can choose from the following to help create your Medicare plan.

$26.30

MyOption Enhanced Dental DEN839
Enhances the dental coverage already included in your Medicare Advantage plan with additional benefits for preventive, basic, and major services in the HumanaDental Medicare network. These extra benefits – in addition to your basic benefits – have an additional monthly premium.

$30.90

MyOption Total Dental DEN983
Enhances the dental coverage already included in your Medicare Advantage plan with additional benefits for certain preventive, basic, and major services in the HumanaDental Medicare network. These extra benefits – in addition to your basic benefits – have an additional monthly premium.

Humana MyOption optional supplemental benefits (OSB) are only available to members of certain Humana Medicare Advantage (MA) plans. Members of Humana plans that offer OSBs may enroll in OSBs throughout the year. Benefits may change on January 1 each year. Enrollees must use network providers for specific OSBs when stated in the Evidence of Coverage (EOC); otherwise, covered services may be received from non-network providers at a higher cost. Enrollees must continue to pay the Medicare Part B premium, their Humana plan premium and the OSB premium.

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.

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2019

Optional Supplemental Benefits

Humana Gold Plus®
H6622-057 (HMO)

Charlotte
Charlotte Metro Area

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My Options, My Choice
Adding Benefits to Your Plan

You're unique and have unique needs. That's why Humana offers optional supplemental benefits (OSB). For an extra monthly premium you can customize your Humana Medicare Advantage plan.

You can add these extra benefits when you sign up for your Medicare Advantage plan or any time during the year.

The information in this booklet will tell you about the benefits you can add to your plan. If you have questions, you can call us at 1-888-866-3154 (TTY: 711). We are available seven days a week, from 8 a.m. - 8 p.m. local time. However, please note that our automated phone system may answer your call during weekends and holidays from April 1 - September 30. Please leave your name and telephone number, and we will call you back by the end of the next business day.

MyOption℠ Enhanced Dental (DEN839)

The MyOption℠ Enhanced Dental benefit helps make it easy for you to plan for your dental care.

Here's how the benefit works:

Monthly Premium	**$26.30**	
Maximum Benefit	Humana pays up to **$2,000** per calendar year	
Covered Dental Services	**In-Network You Pay**	**Benefit Limitations Per Calendar Year**
Preventive and Diagnostic Dental Services		
Oral examinations	**0%**	Two per year
Periodontal exam	**0%**	One procedure every three years
Dental prophylaxis (cleanings)	**0%**	Two per year
Fluoride treatment	**0%**	Two per year
Bitewing X-ray	**0%**	One set per year
Intraoral X-ray	**0%**	One set per year
Panoramic or diagnostic X-rays	**0%**	One set every five years
Basic Dental Services (Minor Restorative)		
Amalgam restorations (silver fillings)	**50%**	Two per year
Composite resin restorations (white fillings)	**50%**	
Extractions (pulling teeth), simple or surgical	**50%**	Two per year
Recementation	**50%**	One procedure every five years
Emergency treatment for pain	**50%**	Two per year
Anesthesia	**0%**	Unlimited per calendar year

Covered Dental Services	In-Network You Pay	Benefit Limitations Per Calendar Year
Major Dental Services (Endodontics, Periodontics and Oral Surgery)		
Periodontal Maintenance	**70%**	Two per year
Crowns	**70%**	Two per year
Periodontal scaling and root planing (deep cleaning)	**70%**	One procedure for each quadrant every three years

Covered dental services are subject to conditions, limitations, exclusions, and maximums. Please see your Evidence of Coverage for details.

The Humana Optional Supplemental Dental benefits are provided through the Humana Dental Medicare Network. The provider locator can be found at Humana.com > Find a Doctor > from the Search Type drop down select Dental > HumanaDental Medicare.

MyOption℠ Total Dental (DEN983)

The MyOption℠ Total Dental benefit helps make it easy for you to plan for your dental care.

Here's how the benefit works:

Monthly Premium	**$30.90**	
Maximum Benefit	Humana pays up to **$2,000** per calendar year	
Covered Dental Services	**In-Network You Pay**	**Benefit Limitations Per Calendar Year**
Preventive and Diagnostic Dental Services		
Oral examinations	**0%**	Two per year
Periodontal exam	**0%**	One every three years
Dental prophylaxis (cleanings)	**0%**	Two per year
Intraoral X-rays	**0%**	One set per year
Panoramic or Diagnostic X-rays	**0%**	One set per year
Bitewing X-ray	**0%**	One set per year
Fluoride treatment	**0%**	Two per year
Basic Dental Services (Minor Restorative)		
Amalgam restorations (silver fillings)	**50%**	Two per year
Composite resin restorations (white fillings)	**50%**	

OPTIONAL SUPPLEMENTAL BENEFITS (continued)

Covered Dental Services	In-Network You Pay	Benefit Limitations Per Calendar Year
Basic Dental Services (Minor Restorative)		
Extractions (pulling teeth), simple or surgical	**50%**	Two per year
Recementation	**50%**	One procedure every five years
Emergency treatment for pain	**50%**	Two per year
Anesthesia	**0%**	Unlimited procedures per year
Major Dental Services (Endodontics, Periodontics and Oral Surgery)		
Root canal treatment	**70%**	One per year
Crowns	**70%**	Two per year
Periodontal scaling and root planing (deep cleaning)	**70%**	One procedure for each quadrant per year
Periodontal maintenance	**70%**	Two per year
Oral surgery	**70%**	Two per year
Complete dentures (including routine post-delivery care)	**70%**	One upper and/or one lower complete denture every five years
Partial dentures	**70%**	One upper and/or one lower partial denture every five years
Denture adjustments (not covered within six months of initial placement)	**70%**	One per year
Denture reline (not allowed on spare dentures)	**70%**	One per year

Covered dental services are subject to conditions, limitations, exclusions, and maximums. Please see your Evidence of Coverage for details.

The Humana Optional Supplemental Dental benefits are provided through the Humana Dental Medicare Network. The provider locator can be found at Humana.com > Find a Doctor > from the Search Type drop down select Dental > HumanaDental Medicare.

Humana is a Medicare Advantage HMO plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal. Humana MyOption Optional Supplemental Benefits (OSB) are only available to members of certain Humana Medicare Advantage (MA) plans. Members of Humana plans that offer OSBs may enroll in OSBs throughout the year. Benefits may change on January 1st each year. Enrollees must use network providers for specific OSBs when stated in the Evidence of Coverage (EOC); otherwise, covered services may be received from non-network providers at a higher cost. Enrollees must continue to pay the Medicare Part B premium, their Humana premium, and the OSB premium.

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Notes

Notes

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 تماس بگیرید. **(TTY: 711)**

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 1-877-320-1235 **(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)**.

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