



OUTLINE OF MEDICARE SUPPLEMENT COVERAGE

Humana Connect Medicare Supplement Plans

for Iowa residents Medicare supplement benefit plans: A, F and G

Insured by Humana Insurance Company

IA81077HCM20

Humana[®]

Humana Insurance Company offers Plans A, F and G

Benefit Chart of Medicare Supplement Plans Sold on or After January 1, 2020

This chart shows the benefits included in each of the standard Medicare supplement plans. Some plans may not be available. Only applicants **first** eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F. Note: A ✓ means 100% of the benefit is paid.

| Benefits | Plans Available to All Applicants | | | | | | | | Medicare first eligible before 2020 only | |
|--|-----------------------------------|---|---|----------------|----------------------|----------------------|-----|--------------------------------|--|----------------|
| | A | B | D | G ¹ | K | L | M | N | C | F ¹ |
| Medicare Part A Coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up) | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Medicare Part B Coinsurance or Copayment | ✓ | ✓ | ✓ | ✓ | 50% | 75% | ✓ | ✓ copays apply ³ | ✓ | ✓ |
| Blood (first three pints) | ✓ | ✓ | ✓ | ✓ | 50% | 75% | ✓ | ✓ | ✓ | ✓ |
| Part A Hospice Care Coinsurance or Copayment | ✓ | ✓ | ✓ | ✓ | 50% | 75% | ✓ | ✓ | ✓ | ✓ |
| Skilled Nursing Facility Coinsurance | | | ✓ | ✓ | 50% | 75% | ✓ | ✓ | ✓ | ✓ |
| Medicare Part A Deductible | | ✓ | ✓ | ✓ | 50% | 75% | 50% | ✓ | ✓ | ✓ |
| Medicare Part B Deductible | | | | | | | | | ✓ | ✓ |
| Medicare Part B Excess Charges | | | | ✓ | | | | | | ✓ |
| Foreign Travel Emergency (up to plan limits) | | | ✓ | ✓ | | | ✓ | ✓ | ✓ | ✓ |
| Out of Pocket Limit in 2022 ² | | | | | \$6,620 ² | \$3,310 ² | | | | |

¹ Plans F and G also have a high deductible option which require first paying a plan deductible of \$2,490 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High Deductible Plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

² Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

³ Plan N pays 100% of the Part B coinsurance, except for a copayment of up to \$20 for some office visits and up to a \$50 copayment for emergency room visits that do not result in an inpatient admission.

Humana Connect Medicare Supplement Statewide Monthly Premiums

Effective Date: 03-01-2022

| Attained Age & Gender | Plan A | Plan F | Plan G |
|-----------------------|----------|----------|----------|
| 65-Male | \$115.54 | \$178.03 | \$144.04 |
| 65-Female | \$115.23 | \$177.58 | \$143.69 |
| 66-Male | \$120.08 | \$185.06 | \$149.73 |
| 66-Female | \$118.65 | \$182.84 | \$147.94 |
| 67-Male | \$124.79 | \$192.38 | \$155.63 |
| 67-Female | \$123.31 | \$190.09 | \$153.78 |
| 68-Male | \$129.71 | \$200.00 | \$161.78 |
| 68-Female | \$128.16 | \$197.62 | \$159.85 |
| 69-Male | \$134.81 | \$207.91 | \$168.16 |
| 69-Female | \$131.94 | \$203.47 | \$164.57 |
| 70-Male | \$140.12 | \$216.15 | \$174.82 |
| 70-Female | \$135.86 | \$209.54 | \$169.48 |
| 71-Male | \$145.64 | \$224.70 | \$181.73 |
| 71-Female | \$139.87 | \$215.75 | \$174.48 |
| 72-Male | \$151.39 | \$233.63 | \$188.91 |
| 72-Female | \$144.01 | \$222.18 | \$179.67 |
| 73-Male | \$157.38 | \$242.89 | \$196.39 |
| 73-Female | \$148.26 | \$228.75 | \$185.00 |
| 74-Male | \$163.59 | \$252.52 | \$204.17 |
| 74-Female | \$152.64 | \$235.58 | \$190.49 |
| 75-Male | \$170.07 | \$262.55 | \$212.27 |
| 75-Female | \$157.18 | \$242.58 | \$196.14 |
| 76-Male | \$176.78 | \$272.97 | \$220.67 |
| 76-Female | \$161.84 | \$249.80 | \$201.96 |
| 77-Male | \$183.76 | \$283.80 | \$229.41 |
| 77-Female | \$166.62 | \$257.21 | \$207.96 |
| 78-Male | \$189.22 | \$292.27 | \$236.25 |
| 78-Female | \$171.56 | \$264.88 | \$214.13 |

Note: If you are going to have a birthday within the month of your requested coverage effective date, please use the age you will be turning on that birthday to determine your plan premium rate.

(Continued on next page)

Humana Connect Medicare Supplement Statewide Monthly Premiums

Effective Date: 03-01-2022

| Attained Age & Gender | Plan A | Plan F | Plan G |
|-----------------------|----------|----------|----------|
| 79-Male | \$194.84 | \$300.99 | \$243.27 |
| 79-Female | \$174.97 | \$270.16 | \$218.39 |
| 80-Male | \$200.62 | \$309.94 | \$250.51 |
| 80-Female | \$178.39 | \$275.49 | \$222.70 |
| 81-Male | \$206.58 | \$319.18 | \$257.96 |
| 81-Female | \$181.94 | \$280.99 | \$227.13 |
| 82-Male | \$212.71 | \$328.69 | \$265.64 |
| 82-Female | \$185.53 | \$286.55 | \$231.61 |
| 83-Male | \$219.04 | \$338.50 | \$273.54 |
| 83-Female | \$189.21 | \$292.24 | \$236.24 |
| 84-Male | \$225.53 | \$348.59 | \$281.69 |
| 84-Female | \$192.95 | \$298.06 | \$240.92 |
| 85+-Male | \$232.25 | \$359.00 | \$290.08 |
| 85+-Female | \$196.78 | \$303.97 | \$245.69 |

Note: If you are going to have a birthday within the month of your requested coverage effective date, please use the age you will be turning on that birthday to determine your plan premium rate.

Medicare Supplement Discounts*

ACH Discount

Save \$2 on your monthly premium by electing to make payments electronically. If you wish to take advantage of this discount be sure to select an automatic payment option in Section 4 of your enrollment application.

Household Discount**

Save 5% on your monthly premium when more than one member of your household enrolls or is enrolled in a Humana Medicare Supplement plan. This discount is only applicable to policyholders with effective dates of June 1, 2010 or after. To apply for the discount, please include the name and Medicare claim number of the person enrolled or enrolling in a Humana Medicare Supplement policy living at your address in Section 3 of your enrollment application.

Calculate Your Premium

Base monthly premium (please refer to pages 2-3): _____

ACH Discount (applied to base premium): _____

Household Discount (applied to base premium): _____

Premium Quote (base premium minus discounts): _____

* We reserve the right to make changes to the premium discount structure. If a change to the discount structure occurs to your policy, it will affect all policies we issue like yours.

** The household premium discount will be removed if the other Medicare supplement policyholder whose policy status entitles you to the discount no longer resides with you. However, if that person becomes deceased, your discount will still apply. This premium change will occur on the billing cycle following the date we learn your eligibility has ended. Household is defined as a condominium unit, a single family home, or an apartment unit within an apartment complex.

Premium Information

We, Humana Insurance Company, can only change the renewal premium for your policy if we also change the renewal premium for all policies that we issue like yours in this State. No change in premium will be made because of the number of claims you file, nor because of a change in your health or your type of work.

This is an attained age rated policy, which means that your premiums will increase based on age. Your attained age premium increase will go into effect on the first monthly renewal date which falls on or follows the policy annual anniversary date. The premium increase will be based on your age attained on or before the last day of the renewal calendar month. A premium change will not be made more than once in a 12-month period.

Premium discounts may be applied or discontinued based on eligibility.

Disclosure

Use this outline to compare benefits and premiums among policies.

Read your policy very carefully

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

Right to return policy

If you find that you are not satisfied with your policy, you may return it to:

Humana Insurance Company
Attn: Medicare Enrollments
P.O. Box 14168
Lexington, KY 40512-4168

If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments less any claims paid.

Policy replacement

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

Notice

This policy may not fully cover all of your medical costs.

Neither Humana Insurance Company nor its agents are connected with Medicare.

This Outline of Coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult the "Medicare & You" handbook for more details.

Complete answers are very important

When you fill out the application for the new policy, be sure to truthfully and completely answer all questions.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

Plan A

Medicare (Part A) - Hospital Services - Per Benefit Period

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

| Services | Medicare Pays | Plan Pays | You Pay |
|---|--|------------------------------------|--------------------------------|
| Hospitalization* | | | |
| Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but \$1,556 | \$0 | \$1,556 (Part A deductible) |
| 61st through 90th day | All but \$389 a day | \$389 a day | \$0 |
| 91st day and after: | | | |
| while using 60 lifetime reserve days | All but \$778 a day | \$778 a day | \$0 |
| once lifetime reserve days are used: | | | |
| • additional 365 days | \$0 | 100% of Medicare eligible expenses | \$0** |
| • beyond the additional 365 days | \$0 | \$0 | All costs |
| Skilled Nursing Facility Care* | | | |
| You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | \$0 | \$0 |
| 21st through 100th day | All but \$194.50 a day | \$0 | Up to \$194.50 a day |
| 101st day and after | \$0 | \$0 | All costs |
| Blood | | | |
| First three pints | \$0 | Three pints | \$0 |
| Additional amounts | 100% | \$0 | \$0 |
| Hospice Care | | | |
| You must meet Medicare's requirements, including a doctor's certification of terminal illness. | All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/coinsurance | \$0 |

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan A

Medicare (Part B) - Medical Services - Per Calendar Year

* Once you have been billed \$233 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

| Services | Medicare Pays | Plan Pays | You Pay |
|--|---------------|---------------|------------------------------|
| Medical Expenses | | | |
| IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | | | |
| First \$233 of Medicare-approved amounts* | \$0 | \$0 | \$233 (Part B deductible) |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 20% | \$0 |
| Part B Excess Charges | | | |
| (above Medicare-approved amounts) | \$0 | \$0 | All costs |
| Blood | | | |
| First three pints | \$0 | All costs | \$0 |
| Next \$233 of Medicare-approved amounts* | \$0 | \$0 | \$233 (Part B deductible) |
| Remainder of Medicare-approved amounts | 80% | 20% | \$0 |
| Clinical Laboratory Services | | | |
| TESTS FOR DIAGNOSTIC SERVICES | 100% | \$0 | \$0 |

Medicare (Parts A and B)

| Services | Medicare Pays | Plan Pays | You Pay |
|--|---------------|-----------|------------------------------|
| Home Health Care | | | |
| MEDICARE-APPROVED SERVICES | | | |
| Medically necessary skilled care services and medical supplies | 100% | \$0 | \$0 |
| Durable medical equipment | | | |
| First \$233 of Medicare-approved amounts* | \$0 | \$0 | \$233 (Part B deductible) |
| Remainder of Medicare-approved amounts | 80% | 20% | \$0 |

Plan F

Medicare (Part A) - Hospital Services - Per Benefit Period

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

| Services | Medicare Pays | Plan Pays | You Pay |
|---|--|------------------------------------|-----------|
| Hospitalization* | | | |
| Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but \$1,556 | \$1,556 (Part A deductible) | \$0 |
| 61st through 90th day | All but \$389 a day | \$389 a day | \$0 |
| 91st day and after: | | | |
| while using 60 lifetime reserve days once lifetime reserve days are used: | All but \$778 a day | \$778 a day | \$0 |
| • additional 365 days | \$0 | 100% of Medicare eligible expenses | \$0** |
| • beyond the additional 365 days | \$0 | \$0 | All costs |
| Skilled Nursing Facility Care* | | | |
| You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | \$0 | \$0 |
| 21st through 100th day | All but \$194.50 a day | Up to \$194.50 a day | \$0 |
| 101st day and after | \$0 | \$0 | All costs |
| Blood | | | |
| First three pints | \$0 | Three pints | \$0 |
| Additional amounts | 100% | \$0 | \$0 |
| Hospice Care | | | |
| You must meet Medicare's requirements, including a doctor's certification of terminal illness. | All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/coinsurance | \$0 |

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan F

Medicare (Part B) - Medical Services - Per Calendar Year

* Once you have been billed \$233 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

| Services | Medicare Pays | Plan Pays | You Pay |
|--|---------------|------------------------------|---------|
| Medical Expenses | | | |
| IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | | | |
| First \$233 of Medicare-approved amounts* | \$0 | \$233 (Part B deductible) | \$0 |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 20% | \$0 |
| Part B Excess Charges | | | |
| (above Medicare-approved amounts) | \$0 | 100% | \$0 |
| Blood | | | |
| First three pints | \$0 | All costs | \$0 |
| Next \$233 of Medicare-approved amounts* | \$0 | \$233 (Part B deductible) | \$0 |
| Remainder of Medicare-approved amounts | 80% | 20% | \$0 |
| Clinical Laboratory Services | | | |
| TESTS FOR DIAGNOSTIC SERVICES | 100% | \$0 | \$0 |

Medicare (Parts A and B)

| Services | Medicare Pays | Plan Pays | You Pay |
|--|---------------|------------------------------|---------|
| Home Health Care | | | |
| MEDICARE-APPROVED SERVICES | | | |
| Medically necessary skilled care services and medical supplies | 100% | \$0 | \$0 |
| Durable medical equipment | | | |
| First \$233 of Medicare-approved amounts* | \$0 | \$233 (Part B deductible) | \$0 |
| Remainder of Medicare-approved amounts | 80% | 20% | \$0 |

Plan F

Other Benefits - Not Covered By Medicare

| Services | Medicare Pays | Plan Pays | You Pay |
|---|---------------|---|--|
| Foreign Travel Not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside of the USA | | | |
| First \$250 each calendar year | \$0 | \$0 | \$250 |
| Remainder of charges | \$0 | 80% to a lifetime maximum benefit of \$50,000 | 20% and amounts over the \$50,000 lifetime maximum |

Plan G

Medicare (Part A) - Hospital Services - Per Benefit Period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

| Services | Medicare Pays | Plan Pays | You Pay |
|---|--|---------------------------------------|-----------|
| Hospitalization* | | | |
| Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but \$1,556 | \$1,556 (Part A deductible) | \$0 |
| 61st through 90th day | All but \$389 a day | \$389 a day | \$0 |
| 91st day and after: | | | |
| while using 60 lifetime reserve days once lifetime reserve days are used: | All but \$778 a day | \$778 a day | \$0 |
| • additional 365 days | \$0 | 100% of Medicare eligible expenses | \$0** |
| • beyond the additional 365 days | \$0 | \$0 | All costs |
| Skilled Nursing Facility Care* | | | |
| You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | \$0 | \$0 |
| 21st through 100th day | All but \$194.50 a day | Up to \$194.50 a day | \$0 |
| 101st day and after | \$0 | \$0 | All costs |
| Blood | | | |
| First three pints | \$0 | Three pints | \$0 |
| Additional amounts | 100% | \$0 | \$0 |
| Hospice Care | | | |
| You must meet Medicare's requirements, including a doctor's certification of terminal illness. | All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/coinsurance | \$0 |

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan G

Medicare (Part B) - Medical Services - Per Calendar Year

*Once you have been billed \$233 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

| Services | Medicare Pays | Plan Pays | You Pay |
|--|---------------|---------------|------------------------------|
| Medical Expenses | | | |
| IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | | | |
| First \$233 of Medicare-approved amounts* | \$0 | \$0 | \$233 (Part B deductible) |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 20% | \$0 |
| Part B Excess Charges | | | |
| (above Medicare-approved amounts) | \$0 | 100% | \$0 |
| Blood | | | |
| First three pints | \$0 | All costs | \$0 |
| Next \$233 of Medicare-approved amounts* | \$0 | \$0 | \$233 (Part B deductible) |
| Remainder of Medicare-approved amounts | 80% | 20% | \$0 |
| Clinical Laboratory Services | | | |
| TESTS FOR DIAGNOSTIC SERVICES | 100% | \$0 | \$0 |

Medicare (Parts A and B)

| Services | Medicare Pays | Plan Pays | You Pay |
|--|---------------|-----------|------------------------------|
| Home Health Care | | | |
| MEDICARE-APPROVED SERVICES | | | |
| Medically necessary skilled care services and medical supplies | 100% | \$0 | \$0 |
| Durable medical equipment | | | |
| First \$233 of Medicare-approved amounts* | \$0 | \$0 | \$233 (Part B deductible) |
| Remainder of Medicare-approved amounts | 80% | 20% | \$0 |

Plan G

Other Benefits - Not Covered By Medicare

| Services | Medicare Pays | Plan Pays | You Pay |
|---|---------------|---|--|
| Foreign Travel Not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside of the USA | | | |
| First \$250 each calendar year | \$0 | \$0 | \$250 |
| Remainder of charges | \$0 | 80% to a lifetime maximum benefit of \$50,000 | 20% and amounts over the \$50,000 lifetime maximum |

Notes

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 **1-800-866-0581** 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. 1-800-866-0581 (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. 1-800-866-0581 (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): Wóda hí béésh bee hani'í bee wolta'ígíí bich'í' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'déé nika'adoowoł.

العربية (Arabic)

الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

GCHJV5REN 0220

Humana®

Insured by Humana Insurance Company

IA81077HCM20