2023

Summary of Benefits

Humana Value Plus H5619-134 (HMO)

Washington
Select Counties in WA

Our service area includes the following county/counties in Washington: Benton, Clark, Cowlitz, Franklin, Island, King, Kitsap, Pierce, Skagit, Snohomish, Spokane, Thurston, Walla Walla, Whatcom.

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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

- [ ] The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs and benefits before you enroll. 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.
- [ ] Review the formulary to make sure your drugs are covered.

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, 2024.
- [ ] 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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Let's talk about Humana Value Plus H5619-134 (HMO)

Find out more about the Humana Value Plus H5619-134 (HMO) plan - including the health and drug services it covers - in this easy-to-use guide.

Humana Value Plus H5619-134 (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".

To be eligible

To join Humana Value Plus H5619-134 (HMO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

Plan name:

Humana Value Plus H5619-134 (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 Value Plus H5619-134 (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 Value Plus H5619-134 (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	**$31** You must keep paying your Medicare Part B premium. If you receive premium assistance, your plan premium may be reduced.
Medical deductible *You pay the same amount as you would with Original Medicare. In 2022, the amounts are as listed. These amounts may change in 2023.	**$233*** in-network Part B deductible Services not covered by Original Medicare, Part A services (IP, Skilled Nursing and Home Health), Medicare Covered Preventive services, Ambulance and Emergency Room services, Urgently Needed Services at Urgent Care Centers, Diabetic Monitoring Supplies, Chemotherapy Drugs and Administration, and Medicare Part B Covered Drugs do not apply to the in-network Part B deductible.
Pharmacy (Part D) deductible	**$450**
Maximum out-of-pocket responsibility	**$6,700** in-network The most you pay for copays, coinsurance and other costs for covered medical services for the year.

Covered Medical and Hospital Benefits

Acute inpatient hospital care	**$1,859** copay per admit Your plan covers an unlimited number of days for an inpatient stay.
Outpatient hospital coverage	• Outpatient surgery at Outpatient Hospital: **20%** of the cost • Outpatient surgery at Ambulatory Surgical Center: **20%** of the cost
Doctor visits	• Primary care provider: **20%** of the cost • Specialist: **20%** of the cost

Your primary care provider (PCP) will work with you to coordinate the care you need with specialists or certain other providers in the network. This is called a "referral." 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 referral and/or prior authorization from the plan.

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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	**$95** 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	**20%** of the cost 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.

Your primary care provider (PCP) will work with you to coordinate the care you need with specialists or certain other providers in the network. This is called a "referral." 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 referral and/or prior authorization from the plan.

Covered Medical and Hospital Benefits (cont.)

OUTPATIENT CARE AND SERVICES

Diagnostic services, labs and imaging Cost share may vary depending on the service and where service is provided	• Diagnostic mammography: **$0** copay • Diagnostic colonoscopy **$0** copay • Diagnostic radiology: **20%** of the cost • Lab services: **$0** copay or **20%** of the cost • Diagnostic tests and procedures: **$0** copay or **20%** of the cost • Outpatient X-rays: **20%** of the cost • Radiation therapy: **20%** of the cost
Hearing	Medicare-covered hearing exam: **20%** of the cost **Routine hearing:** In-Network: **HER945** • **$0** copay for routine hearing exams up to 1 every year. • **$0** copay for each Advanced level hearing aid up to 1 per ear every 3 years. Hearing aid purchase includes: • Unlimited follow-up provider visits during first year following TruHearing hearing aid purchase • 60-day trial period • 3-year extended warranty • 80 batteries per aid for non-rechargeable models **You must see a TruHearing provider to use this benefit. Call 1-844-255-7144 to schedule an appointment (for TTY, dial 711).**
Dental	Medicare-covered dental services: **20%** of the cost **Routine dental:** The cost-share indicated below is what you pay for the covered service. In-Network: **DEN345** • **$0** copay for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years. • **$0** copay for comprehensive oral evaluation or periodontal exam, occlusal adjustment, scaling for moderate inflammation up to 1 every 3 years. • **$0** copay for bridges, crown recementation, denture recementation, panoramic film or diagnostic x-rays up to 1 every 5 years. • **$0** copay for crown, root canal, root canal retreatment up to 1 per tooth per lifetime. • **$0** copay for bitewing x-rays, intraoral x-rays up to 1 set(s) per year. • **$0** copay for emergency diagnostic exam up to 1 per year. • **$0** copay for emergency treatment for pain, fluoride treatment, oral surgery, periodic oral exam, prophylaxis (cleaning) up to 2 per year. • **$0** copay for periodontal maintenance up to 4 per year.

Your primary care provider (PCP) will work with you to coordinate the care you need with specialists or certain other providers in the network. This is called a "referral." 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 referral and/or prior authorization from the plan.

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	• **$0** copay for amalgam and/or composite filling, necessary anesthesia with covered service, simple or surgical extraction up to unlimited per year. • **$3000** maximum benefit coverage amount per year for preventive and comprehensive benefits. Dental services are subject to our standard claims review procedures which could include dental history to approve coverage. Dental benefits under this plan may not cover all American Dental Association procedure codes. Information regarding each plan is available at **Humana.com/sb**. Network dentists have agreed to provide services at contracted fees (the in-network fee schedules, of INFS). If a member visits a participating network dentist, the member will not receive a bill for charges more than the negotiated fee schedule on covered services (coinsurance payment still applies). 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.
Vision	• Medicare-covered vision services: **20%** of the cost • Medicare-covered diabetic eye exam: **$0** copay • Medicare-covered glaucoma screening: **$0** copay • Medicare-covered eyewear (post-cataract): **20%** of the cost **Routine vision:** In-Network: **VIS733** • **$0** copay for routine exam up to 1 per year. • **$300** maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. • Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. • Maximum benefit coverage amount is limited to one time use per year. The provider locator for routine vision can be found at **Humana.com** > Find a Doctor > select Vision care icon > Vision coverage through Medicare Advantage plans.

Your primary care provider (PCP) will work with you to coordinate the care you need with specialists or certain other providers in the network. This is called a "referral." 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 referral and/or prior authorization from the plan.

Covered Medical and Hospital Benefits (cont.)

Mental health services	**Inpatient:** • **$1,650** copay per admit • 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): **$0** to **$60** copay or **20%** of the cost Cost share may vary depending on where service is provided.
Skilled nursing facility (SNF)	• **$0** copay per day for days 1-20 • **$196** copay per day for days 21-60 • **$0** copay per day for days 61-100 • Your plan covers up to 100 days in a SNF
Physical Therapy	• **20%** of the cost
ADDITIONAL BENEFITS	
Ambulance (ground)	**20%** of the cost
Ambulance (air)	**$1250** copay per date of service
Transportation	**$0** copay for plan approved location up to 100 one-way trip(s) per year. This benefit is not to exceed 75 miles per trip. The member *must* contact transportation vendor to arrange transportation and should contact Customer Care to be directed to their plan's specific transportation provider.
Medicare Part B drugs	• Chemotherapy drugs: **20%** of the cost • Other Part B drugs: **$0** copay or **20%** of the cost

Prescription Drug Benefits

PRESCRIPTION DRUGS

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

Deductible This plan has a **$450** deductible. You pay the full cost of your drugs until you reach **$450**. Then, you only pay your cost-share.

Initial coverage (after you pay your deductible)

You pay the following until your total yearly drug costs reach **$4,660**. 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.

Your primary care provider (PCP) will work with you to coordinate the care you need with specialists or certain other providers in the network. This is called a "referral." 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 referral and/or prior authorization from the plan.

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Mail Order Cost-Sharing				
Pharmacy options	**Standard** Walmart Mail, PillPack Other pharmacies are available in our network. To find pharmacy mail order options go to **Humana.com/pharmacyfinder**		**Preferred** CenterWell Pharmacy™	
	30-day supply	**100-day supply***	**30-day supply**	**100-day supply***
Tier 1: Preferred Generic	$5	$15	$1	$0
Tier 2: Generic	$20	$60	$15	$0
Tier 3: Preferred Brand	25%	25%	25%	25%
Tier 4: Non-Preferred Drug	25%	25%	25%	25%
Tier 5: Specialty Tier	25%	N/A	25%	N/A

Retail Cost-Sharing		
Pharmacy options	**Retail** All network retail pharmacies. To find the retail pharmacies near you, go to **Humana.com/pharmacyfinder**	
	30-day supply	**100-day supply***
Tier 1: Preferred Generic	$1	$3
Tier 2: Generic	$15	$45
Tier 3: Preferred Brand	25%	25%
Tier 4: Non-Preferred Drug	25%	25%
Tier 5: Specialty Tier	25%	N/A

If you receive Extra Help for your drugs, you'll pay the following:
Deductible You may pay **$0** or **$104** depending on your level of "Extra Help". If your deductible is **$104**, you pay the full cost of your drugs until you reach **$104**. Then, you only pay your cost-share.

Pharmacy cost-sharing		
For generic drugs (including	**30-day supply**	**100-day supply***
brand drugs treated as generic), either:	**$0** copay; or **$1.45** copay; or **$4.15** copay ; or **15%** of the cost	**$0** copay; or **$1.45** copay; or **$4.15** copay ; or **15%** of the cost
For all other drugs, either:	**$0** copay; or **$4.30** copay; or **$10.35** copay ; or **15%** of the cost	**$0** copay; or **$4.30** copay; or **$10.35** copay ; or **15%** of the cost

Other pharmacies are available in our network.
*Some drugs are limited to a 30-day supply and others may be eligible for up to a 100-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 your prescription drug benefit, please call us or access your "Evidence of Coverage" online.

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

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

Coverage Gap

After you enter the coverage gap, you pay **25 percent** of the plan's cost for covered brand name drugs and **25 percent** of the plan's cost for covered generic drugs until your out-of-pocket costs total **$7,400** — 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 **$7,400** you pay the greater of:
- **5%** of the cost, or
- **$4.15** copay for generic (including brand drugs treated as generic) and a **$10.35** copay for all other drugs

Additional Benefits

Medicare-covered foot care (podiatry)	**20%** of the cost
Medicare-covered chiropractic services	**20%** of the cost

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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 **20%** of the cost
Rehabilitation services	• Occupational and speech therapy: **20%** of the cost • Cardiac rehabilitation: **20%** of the cost • Pulmonary rehabilitation: **$20** copay
Telehealth services (in addition to Original Medicare)	• Primary care provider (PCP): **$0** copay • Specialist: **20%** of the cost • Urgent care services: **$0** copay • Substance abuse and behavioral health services: **$0** copay

More benefits with **your plan**

Enjoy some of these extra benefits included in your plan.
This is a summary of what we cover. It doesn't list every service that we cover or list every limitation or exclusion. The Evidence of Coverage (EOC) provides a complete list of coverage and services. Visit **Humana.com/medicare** to view a copy of the EOC or call **1-800-833-2364**.

Over-the-Counter (OTC) Allowance

$350 maximum benefit coverage amount per quarter (3 months) for over-the-counter (OTC) prepaid card to purchase eligible OTC health and wellness products at participating retailers.

Unused amount expires at the end of the quarter.

Allowance amounts cannot be combined with other benefit allowances. Limitations and restrictions may apply.

Humana Spending Account Card

The allowance listed below will be loaded onto this prepaid card. Each allowance is separate from any other allowance listed. Allowances shown are accessed by using this card. Allowance amounts cannot be combined with other benefit allowances. Limitations and restrictions may apply.

*OTC Allowance

Special Supplemental Benefits for the Chronically Ill (SSBCI) Humana Flexible Care Assistance

Humana Flexible Care Assistance is available to members with chronic health conditions, who are participating in care management services, and meet program criteria. Eligible members may receive medical expense assistance and other additional benefits, either primarily health related or non-primarily health related, to address the member's unique individual needs. Benefits are limited up to **$1,000** per year and must be coordinated and authorized by a care manager. There is no cost to participate.

Acupuncture

$0 copay for acupuncture visits up to 25 visit(s) per year.

Authorization rules may apply

Chiropractic services

Routine chiropractic:
$0 copay per visit for up to 12 visits.

Smoking cessation program

To further assist in your effort to quit smoking or tobacco product use, we cover one additional counseling quit attempt within a 12-month period as a service with no cost to you. This is in addition to the two counseling attempts provided by Medicare and includes up to four face-to-face visits. This service can be used for either preventive measures or for diagnosis with a tobacco related disease.

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Humana Well Dine® Meal Program
Humana's meal program for members with certain special needs plan (SNP) specific conditions or following an inpatient stay in the hospital or nursing facility.

Personal Emergency Response System
The personal emergency response system provides help in emergency situations. The medical alert service comes with an installed in-home communication device and a wearable button. You have the choice between a push button unit (with or without AutoAlert fall detection) or a wrist unit (without AutoAlert).

Rewards and Incentives
Go365 by Humana® a Rewards and Incentive program for completing certain preventive health screenings and health and wellness activities.

Wigs (related to chemotherapy treatment)
Up to an unlimited maximum benefit per year.

SilverSneakers® fitness program
Basic fitness center membership including fitness classes.

Find out **more**

You can see our plan's **provider and pharmacy directory** at our website at **humana.com/finder/search** or call us at the number listed at the beginning of this booklet and we will send you one.

You can see our plan's **drug guide** at our website at **humana.com/medicaredruglist** or call us at the number listed at the beginning of this booklet and we will send you one.

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

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

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

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

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Notes

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, ethnicity, marital status, religion, or language. Discrimination is against the law. Humana and its subsidiaries comply with applicable federal civil rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618.
  If you need help filing a grievance, call **1-877-320-1235** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through their Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019, 800-537-7697 (TDD)**. Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html.**
- **California residents:** You may also call California Department of Insurance toll-free hotline number: **1-800-927-HELP (4357)**, to file a grievance.

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

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

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Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-877-320-1235 (TTY: 711). Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-877-320-1235 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-877-320-1235 (TTY: 711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-877-320-1235 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-877-320-1235 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-877-320-1235 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-877-320-1235 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-877-320-1235 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다 . 통역 서비스를 이용하려면 전화 1-877-320-1235 (TTY: 711) 번으로 문의해 주십시오 . 한국어를 하는 담당자가 도와 드릴 것입니다 . 이 서비스는 무료로 운영됩니다 .

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Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-877-320-1235 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-877-320-1235 (TTY: 711). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-877-320-1235 (TTY: 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-877-320-1235 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugues: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-877-320-1235 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-877-320-1235 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-877-320-1235 (TTY: 711). Ta usługa jest bezpłatna.

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