



Health Alliance Medicare POS Enrich Rx (HMO-POS)

2024 Summary of Benefits

January 1, 2024 – December 31, 2024

Call toll-free 1-888-382-9771 daily from 8 a.m. to 8 p.m. local time. Voicemail is used on holidays and weekends from April 1 to September 30.

TTY 711

www.healthalliancemedicare.org

H1463_24_113441_M

This booklet gives you a summary of what our plan covers and what you pay. It doesn't list every service we cover or every limitation or exclusion. For a complete list of covered services, call us and ask for the Evidence of Coverage.

Options for Getting Medicare Benefits

- Original Medicare (fee-for-service), which is run by the federal government
- Medicare Advantage through a private company, like Health Alliance Medicare

Tips for Comparing Medicare Options

This booklet allows you to compare costs and benefits for our plan

- If you want to compare our plan with other Medicare Advantage plans, ask other plans for their Summary of Benefits booklets or use the Medicare Plan Finder at medicare.gov.
- If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare and You* handbook. You can find it at medicare.gov. You can also get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Booklet Sections

- Things to Know
- Monthly Premium, Deductible and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits
- Additional Covered Benefits
- About Us

This document is available in other formats, such as Braille and large print. For more information, call 1-800-965-4022 (TTY 711), daily from 8 a.m. to 8 p.m. local time. Voicemail is used on holidays and weekends from April 1 to September 30.

THINGS TO KNOW

Hours of Operation

Call daily from 8 a.m. to 8 p.m. local time. Voicemail is used on holidays and weekends from April 1 to September 30.

Contact Info

- If you're a current member: 1-800-965-4022 (TTY 711)
- If you're not yet a member: 1-888-382-9771 (TTY 711)
- www.healthalliancemedicare.org

Eligibility

To join any of our Medicare Advantage plans, you must be entitled to Medicare Part A, enrolled in Medicare Part B and live in our service area.

Our service area includes these counties in Illinois: Boone, Bureau, De Witt, Henderson, Henry, Knox, La Salle, Livingston, Marshall, McLean, Peoria, Putnam, Stark, Tazewell, Warren and Winnebago

Doctors, Hospitals and Pharmacies

Our plan has a large network of doctors, hospitals, pharmacies, and other providers to choose from.

With our POS plans, you must have a primary care provider (PCP) to oversee your care and refer you to the specialists, but you also have the flexibility to see out-of-network providers. You generally pay less staying in-network.

You must use network pharmacies to fill your prescriptions in most cases.

You can see our provider directory and pharmacy directory at our website (www.healthalliancemedicare.org). You can call us, and we will send you a copy.

What We Cover

Like all Medicare Advantage plans, we cover everything Original Medicare covers, but we also cover more.

For some benefits, you may pay less in our plan than you would in Original Medicare, and for some, you may pay more. This booklet outlines many of our extra benefits and perks that Original Medicare doesn't cover.

We cover the prescriptions drugs listed in our formulary at www.healthalliancemedicare.org. You can read it online or call us for a copy.

Determining Drug Costs

Each of the drugs we cover is grouped into one of five tiers. The amount you pay depends on the drug's tier and what stage of the benefit you've reached (Initial Coverage, Coverage Gap or Catastrophic Coverage). You can find out what tier your drug is on in our formulary at www.healthalliancemedicare.org, and we discuss the benefit stages later in this booklet.

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 Medicare Sales Associate at 1-888-382-9771.

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 HealthAllianceMedicare.org or call 1-888-382-9771 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, 2025.
- 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).
- For HMO-POS plans only: 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.
- Your current health care coverage will end once your new Medicare coverage starts. For example, if you are in Tricare or a Medicare plan, you will no longer receive benefits from that plan once your new coverage starts.

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MONTHLY PREMIUM, DEDUCTIBLE AND LIMITS ON HOW MUCH YOU PAY

Premium Each Month You must continue to pay your Medicare Part B premium.	\$165
<i>This plan includes prescription drug coverage. For information on non-Rx plans, contact your broker or Health Alliance Medicare.</i>	
Medical Deductible — In-network	\$0
Medical Deductible — Out-of-network	\$500
Prescription Drugs Deductible (Does not apply to Tier 1 or Tier 2 Drugs)	\$250
Maximum Out-of-Pocket Each Year The most you pay for copays, coinsurance and other costs for medical services for the year. You still need to pay your monthly premiums.	
In-network providers	\$0
In-network and Out-of-network providers	\$500

COVERED MEDICAL AND HOSPITAL BENEFITS

Inpatient Hospital Care

Our plan covers an unlimited number of days for an inpatient hospital stay. (may require prior authorization)

In-network:	\$0 copay per day for days 1 through 60 \$0 copay per day for days 61 and beyond
Out-of-network:	\$0 copay per day for days 1 through 60 \$0 copay per day for days 61 through 90

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Outpatient Hospital Care (may require prior authorization)

In-network: **\$0 copay**

Out-of-network: **\$0 copay**

Outpatient Surgery at an Ambulatory Surgical Center (may require prior authorization)

In-network: **\$0 copay**

Out-of-network: **\$0 copay**

DOCTOR VISITS

Primary Care Physician Office Visits

In-network: **\$0 copay**

Out-of-network: **\$0 copay**

Specialist Office Visits

In-network: **\$0 copay**

Out-of-network: **\$0 copay**

Virtual Visits

Our plan covers visits with a provider by phone or online, 24/7. Connect by phone or secure video through your Hally® account on the MyChart app or hally.com/.

In-network: **\$0 copay**

Out-of-network: **\$0 copay**

Preventive Care

Our plan covers many preventive services, including but not limited to:

- Abdominal aortic aneurysm screening • Annual “Wellness” visit • Bone mass measurement • Breast cancer screening

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(mammogram) • Cardiovascular disease risk reduction visit • Cardiovascular disease testing • Cervical and vaginal cancer screening • Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening • Immunizations, including Flu shots, Hepatitis B shots, Pneumococcal shots • Obesity screening and therapy • Prostate cancer screenings (PSA) • Screening and counseling to reduce alcohol misuse • Screening for sexually transmitted infections (STIs) and counseling to prevent STIs • Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) • “Welcome to Medicare” preventive visit (one-time)

In-network:	\$0 copay
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Out-of-network:	\$0 copay
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EMERGENCY SERVICES

Emergency Care

If you are immediately admitted to the hospital, you do not have to pay your share of the cost for emergency care. See the “Inpatient Hospital Care” section of this booklet for other costs.

In-network:	\$0 copay
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Out-of-network:	\$0 copay
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Urgent Care Services

In-network:	\$0 copay
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Out-of-network:	\$0 copay
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DIAGNOSTIC SERVICES

Costs for these services may vary based on place of service and may require prior authorization.

Diagnostic Tests, Procedures and Lab Services

In-network:	\$0 copay
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Out-of-network:	\$0 copay
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Diagnostic Radiology (such as MRIs, CT scans)

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In-network:	\$0 copay
Out-of-network:	\$0 copay
Outpatient X-rays (such as x-rays and ultrasounds)	
In-network:	\$0 copay
Out-of-network:	\$0 copay
HEARING, DENTAL AND VISION	
Diagnostic Hearing Exam (Exam to diagnose and treat hearing and balance issues)	
In-network:	\$0 copay
Out-of-network:	\$0 copay
Advanced & Premium: (Out-of-network)	Not Covered
Medicare-covered Comprehensive Dental Services	
<ul style="list-style-type: none"> • Extractions of teeth to prepare jaw for radiation treatment of neoplastic disease • Non-covered procedures or services (e.g. tooth removal) if performed by a dentist incident to and as an integral part of an otherwise Medicare-covered procedure • Dental exams prior to kidney transplantation 	
In-network:	\$0 copay
Out-of-network:	\$0 copay
Non-Medicare-covered Dental Services (up to \$2,000 per plan year)	
<p>You pay the applicable cost-sharing amount for Non-Medicare-covered Dental Services and your plan will pay a maximum of \$2,000 per contract year. You will be responsible for 100% of the cost for the rest of the year once the plan has paid the \$2,000 maximum amount. You or your dental provider can submit a claim directly to your plan utilizing the instructions on the back of your health plan ID card. For additional help, you can call member services listed on the back of your health plan ID card.</p>	

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<p>Class 1: Diagnostic and Preventive Services Emergency Palliative Treatment Radiographs</p> <p>Class 2: Oral Surgery Services Endodontic Periodontics Restorative Non-Routine Services</p> <p>Class 3: Prosthodontic Dentures</p>	<p>0% Coinsurance for class 1 Dental.</p> <p>20% Coinsurance for class 2 Dental.</p> <p>40% Coinsurance for class 3 Dental.</p>
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Vision Services

Exam to diagnose and treat diseases and conditions of the eye.

In-network:	\$0 copay
Out-of-network:	\$0 copay

Eyewear After Cataract Surgery

One pair of eyeglasses or contact lenses after each cataract surgery.

In-network:	\$0 copay
Out-of-network:	\$0 copay

Glaucoma Screening

In-network:	\$0 copay
Out-of-network:	\$0 copay

MENTAL HEALTH CARE

Outpatient Individual Mental Health Therapy Visit

In-network: **\$0 copay**

Out-of-network: **\$0 copay**

Outpatient Group Mental Health Therapy Visit

In-network: **\$0 copay**

Out-of-network: **\$0 copay**

Inpatient Mental Health Visit

Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. Our plan also covers 60 “lifetime reserve days.” These are “extra” days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. (may require prior authorization)

In-network: **\$0 copay per day for days 1 through 60**
\$0 copay per day for days 61 through 90

Out-of-network: **\$0 copay per day for days 1 through 60**
\$0 copay per day for days 61 through 90

SKILLED NURSING FACILITIES

Skilled Nursing Facility (SNF)

Our plan covers up to 100 days in an SNF. (may require prior authorization)

In-network: **\$0 copay per day for days 1 through 20**
\$0 copay per day for days 21 through 100

Out-of-network: **\$0 copay per day for days 1 through 20**
\$0 copay per day for days 21 through 100

PHYSICAL THERAPY

Outpatient Physical Therapy
(may require prior authorization)

In-network: **\$0 copay**

Out-of-network: **\$0 copay**

TRANSPORTATION SERVICES

Ambulance

Authorization for non-emergency transportation by ambulance is required.

In- and out-of-network emergent: **\$0 copay (Ground Ambulance)**
\$0 copay (Air Ambulance)

Transportation

(within the U.S. and its territories)

Not covered

Worldwide Emergency Transportation

(outside the U.S. and its territories)

\$0 copay (Ground Ambulance)
\$0 copay (Air Ambulance)

MEDICARE PART B DRUGS

Medicare Part B Drugs such as Chemotherapy Drugs

(may require prior authorization)

In-network: **0% of the cost**

Out-of-network: **0% of the cost**

Other Medicare Part B Drugs

(may require prior authorization)

In-network: **0% of the cost**

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Out-of-network: **0% of the cost**

PART D PRESCRIPTION DRUGS

You pay the following until your total yearly drug costs reach \$5,030. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. Once you have reached this amount, you will move to the next stage (the Coverage Gap Stage).

Costs may differ based on pharmacy type or status (e.g., mail order, long-term care (LTC) or home infusion, and 30 day or 90 day supply). You may get your drugs at network retail pharmacies and mail-order pharmacies. If you reside in a long-term care facility, you pay the same as at a retail pharmacy.

Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. Call Member Services for more information.

You won't pay more than \$35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.

Initial Coverage for Standard Retail Cost-Sharing

Tier 1 - Preferred Generic	
30-day supply:	\$2 copay
90-day supply:	\$6 copay
Tier 2 - Generic	
30-day supply:	\$15 copay
90-day supply:	\$45 copay
Tier 3 - Preferred Brand	
30-day supply:	\$47 copay
90-day supply:	\$141 copay
Tier 4 - Non-Preferred Drug	
30-day supply:	50% of the cost
90-day supply:	50% of the cost
Tier 5 - Specialty Tier	
30-day supply:	29% of the cost
90-day supply:	Not covered

Initial Coverage for Standard Mail-Order Cost-Sharing

Tier 1 - Preferred Generic	
30-day supply:	\$2 copay
90-day supply:	\$4 copay
Tier 2 - Generic	
30-day supply:	\$15 copay
90-day supply:	\$30 copay
Tier 3 - Preferred Brand	
30-day supply:	\$47 copay
90-day supply:	\$94 copay
Tier 4 - Non-Preferred Drug	
30-day supply:	50% of the cost
90-day supply:	50% of the cost
Tier 5 - Specialty Tier	
30-day supply:	29% of the cost
90-day supply:	Not covered

Coverage Gap

Most Medicare drug plans have a coverage gap (also called the “donut hole”). This means that there’s a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches \$5,030.

After you enter the coverage gap, for Tier 1, you continue to pay your copay; for Tiers 2-5 you pay 25% of the plan’s cost for covered brand name drugs and 25% of the plan’s cost for covered generic drugs until your costs total \$8,000, which is the end of the coverage gap. Our plan offers additional gap coverage for select insulins. During the Coverage Gap stage, your out-of-pocket costs for select insulins will be \$15 - \$35 per month.

Our plan covers most Part D vaccines at no cost to you, even if you haven’t paid your deductible. Call Member Services for more information.

You won’t pay more than \$35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it’s on, even if you haven’t paid your deductible.

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 \$8,000, you enter a catastrophic coverage stage. During this stage, the plan pays full cost of covered Part D drugs. You pay nothing and will remain in this phase until the end of the plan year.

ADDITIONAL BENEFITS

Chemotherapy

For Part B chemotherapy drugs. (may require prior authorization)

In-network:	0% of the cost
Out-of-network:	0% of the cost

Chiropractic Care

Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position). (may require prior authorization)

In-network:	\$0 copay
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Out-of-network:	\$0 copay
Durable Medical Equipment Wheelchairs, oxygen, etc. (may require prior authorization)	
In-network:	\$0 copay
Out-of-network:	\$0 copay
Diabetes Monitoring Supplies Manufacturer (Abbott Laboratories) limitations apply only to Blood Glucose Meters and Strips, and these items have a member coinsurance of 0% in-network. (may require prior authorization)	
In-network:	0% of the cost
Out-of-network:	0% of the cost
Diabetes Self-Management Training	
In-network:	\$0 copay
Out-of-network:	\$0 copay
Foot Care (Podiatry Services) Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions.	
In-network:	\$0 copay
Out-of-network:	\$0 copay
Home Health Care	
In-network:	\$0 copay
Out-of-network:	\$0 copay
Hospice \$0 copay for hospice care from a Medicare-certified hospice. You may have to pay part of the costs for drugs and respite care.	

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Hospice is covered by Original Medicare. Please contact us for more details.

In-network: **\$0 copay**

Out-of-network: **\$0 copay**

Outpatient Cardiac Rehabilitation Service

For a maximum of two one-hour sessions per day for up to 36 sessions up to 36 weeks.

In-network: **\$0 copay**

Out-of-network: **\$0 copay**

Outpatient Occupational Therapy Visit

(may require prior authorization)

In-network: **\$0 copay**

Out-of-network: **\$0 copay**

Outpatient Speech and Language Therapy Visit

(may require prior authorization)

In-network: **\$0 copay**

Out-of-network: **\$0 copay**

Outpatient Substance Abuse Group Therapy Visit

In-network: **\$0 copay**

Out-of-network: **\$0 copay**

Outpatient Substance Abuse Individual Therapy Visit

In-network: **\$0 copay**

Out-of-network: **\$0 copay**

Outpatient Surgery at an Outpatient Hospital

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(may require prior authorization)

In-network: **\$0 copay**

Out-of-network: **\$0 copay**

Prosthetic Devices and Related Medical Supplies

Braces, Artificial Limbs, etc. (may require prior authorization)

In-network: **\$0 copay**

Out-of-network: **\$0 copay**

Renal Dialysis

In-network: **0% of the cost**

Out-of-network: **0% of the cost**

Therapeutic Shoes or Inserts for Diabetics

In-network: **\$0 copay**

Out-of-network: **\$0 copay**

WELLNESS PROGRAMS

Be Fit Fitness Benefit

Get the most out of your fitness activities with Be Fit. You get to choose how you want to work out, and your \$360-per-year Benefits Mastercard® Prepaid Card benefit will take care of the payment.

- Fitness class fees.
- Gym memberships.
- Online fitness subscriptions.
- Weight loss subscriptions.
- Ski memberships.
- Rowing.

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- Golf.
- Bowling.
- Tennis.
- Pickleball.
- Recreational league fees.
- Pool exercise classes.
- 5k/10k race fees.

If your fees are more than \$360 a year, you pay the difference. Be Fit doesn't cover fitness trackers or personal equipment.

Health Alliance Medicare is an HMO plan with a Medicare contract. Enrollment in Health Alliance Medicare depends on contract renewal.

Out-of-network/non-contracted providers are under no obligation to treat Health Alliance 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.

Other Pharmacies/Physicians/Providers are available in our network.

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

The Benefits Mastercard® Prepaid Card, is issued by The Bancorp Bank, N.A., Member FDIC, pursuant to license by Mastercard International Incorporated. Mastercard and the circles design are registered trademarks of Mastercard International Incorporated. Card can be used for eligible expenses wherever Mastercard is accepted. Valid only in the U.S. No cash access.

ABOUT US

Health Alliance Medicare is part of a company that has served Illinois for over 40 years. We have more than 26,000 Medicare members.

True Service with a Local Touch

When you call, you speak with one of our helpful representatives, right in Champaign. They know our plans inside and out and can help you with the following.

- Answering your questions
- Signing you up for a seminar
- Arranging for someone to meet with you
- Enrolling you over the phone

Stop by weekdays from 8:30 a.m. to 4:30 p.m. in southwest Champaign. We're at 3301 Fields South Drive, Suite 105, right off Interstate 57 at the Curtis Road exit.

Some of Our Many Extra Perks and Programs

- Assist America global emergency services to help connect you to medical services while traveling, like helping replace lost prescriptions and getting you back home if you're sick. Keep these important numbers with you while traveling: Reference #: 01-AA-HAM-031003, U.S. Phone Number (800) 872-1414, Outside of U.S. Phone Number (609) 986-1234.
- 24-hour Nurse Advice Line to answer your health-related questions, day or night. Contact information (855) 815-5188.
- Be Fit fitness benefit to pay you back up to \$360 per year for fitness activities
- Care coordination to help you deal with chronic conditions. Contact by phone located on the back of your health plan ID card.
- Health coaching to help you set and reach your health goals. Contact by phone located on the back of your health plan ID card.
- Get a 10% discount code for a wide variety of competitively priced over-the-counter (OTC) products with OTC4Me. You can order online or by phone, and all orders are shipped directly to you. Shipping is free on orders over \$25.
- Connected to 24/7 help from veterinary technicians with WhiskerDocs. You can call, chat or e-mail with questions about your animals' health or well-being. The service helps with cats, dogs, birds, reptiles, and pocket pets (like rabbits or hamsters). About 60% of issues are taken care of over the phone without a visit to the veterinarian. Contact by phone (888) 738-0030 or online at www.whiskerdocs.com/.

Call 1-888-382-9771 (TTY 711), daily from 8 a.m. to 8 p.m. local time. Voicemail is used on holidays and weekends from April 1 to September 30.



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 (800) 965-4022 (TTY: 711). Someone who speaks English/Language 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 (800) 965-4022 (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 (800) 965-4022 (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 (800) 965-4022 (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 panggagamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa (800) 965-4022 (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 (800) 965-4022 (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 quý vị cần thông dịch viên xin gọi (800) 965-4022 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.



German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter (800) 965-4022 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 (800) 965-4022 (TTY: 711)번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

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 (800) 965-4022 (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 بمساعدتك. هذه خدمة مجانية على (800-965-4022)TTY:711. سيقوم شخص ما يتحدث العربية.

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 (800) 965-4022 (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 (800) 965-4022 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: 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 (800) 965-4022 (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 (800) 965-4022 (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 (800) 965-4022 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、(800) 965-4022 (TTY: 711)にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。

Form CMS-10802
(Expires 12/31/25)

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Qualified sign language interpreters.

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ATENCIÓN: Si habla Español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. IA, IL, IN, OH: Llame (800) 965-4022, WA Llame: (877) 750-3350 (TTY: 711).

注意: 如果你講中文, 語言協助服務, 免費的, 都可以給你。IA, IL, IN, OH: 呼叫 1-800-965-4022, WA: 呼叫 (877) 750-3350 (TTY: 711)。

UWAGA: Jeśli mówić Polskie, usługi pomocy języka, bezpłatnie, są dostępne dla Ciebie. IA, IL, IN, OH: Zadzwoń (800) 965-4022, WA: Zadzwoń (877) 750-3350 (TTY: 711).

Chú ý: Nếu bạn nói Tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ, miễn phí, có sẵn cho bạn. IA, IL, IN, OH: Gọi (800) 965-4022, WA: Gọi (877) 750-3350 (TTY: 711).

주의: 당신이 한국어, 무료 언어 지원 서비스를 말하는 경우 사용할 수 있습니다. (800) 965-4022 IA, IL, IN, OH: 전화 WA: (877) 750-3350 전화 (TTY: 711).

ВНИМАНИЕ: Если вы говорите русский, вставки услуги языковой помощи, бесплатно, доступны для вас. IA, IL, IN, OH: Вызов (800) 965-4022, WA: Вызов (877) 750-3350 (TTY: 711).

Pansin: Kung magsalita ka Tagalog, mga serbisyo ng tulong sa wika, nang walang bayad, ay magagamit sa iyo. IA, IL, IN, OH: Tumawag (800) 965-4022, WA: Tumawag (877) 750-3350 (TTY: 711).

انتباه: إذا كنت تتكلم العربية، فإن خدمات المساعدة اللغوية متوفرة لك مجاناً. إيلينوي، إنديانا، أوهايو: اتصل بالرقم 1-800-965-4022، ولاية واشنطن: اتصل بالرقم: (877) 750-3350 (إذا كنت تعاني من الصمم أو صعوبة في السمع فاتصل على الرقم 711)

Aufmerksamkeit: Wenn Sie Deutsch sprechen, Sprachassistentendienste sind kostenlos, zur Verfügung. IA, IL, IN, OH: Anruf (800) 965-4022, WA: Anruf (877) 750-3350 (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. IA, IL, IN, OH: Appelez (800) 965-4022, WA: Appelez (877) 750-3350 (TTY: 711).

ध्यान: तमि वल तं गुजराती, ભાષા સહાય સેવાઓ, મફત, તમિરા માટે ઉપલબ્ધ છે. IA, IL, IN, OH: કોલ (800) 965-4022, WA: કોલ (877) 750-3350 (TTY: 711).

注意: あなたは、日本語、無料で言語支援サービスを、話す場合は、あなたに利用可能です。(800) 965-4022 IA, IL, IN, OH: コール (877) 750-3350 WA: コール (TTY: 711)。

LET OP: Services Wann du [Deutsch (Pennsylvania German / Dutch)] schwetzsch, kantscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: IA, IL, IN, OH: Call (800) 851-3379 WA: Call (877) 750-3515 (TTY: 711).

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ATTENZIONE: Se si parla italiano, servizi di assistenza linguistica, a titolo gratuito, sono a vostra disposizione. IA, IL, IN, OH: Chiamare (800) 965-4022, WA: Chiamare (877) 750-3350 (TTY: 711).