

Summary of Benefits

Humana USAA Honor (HMO) H1036-119

Tampa
Greater Tampa Bay

Our service area includes the following county/counties in Florida: Citrus, Hardee, Hernando, Highlands, Hillsborough, Manatee, Pasco, Pinellas, Polk, Sarasota.

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.

Understanding Important Rules

- 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.
- Effect on Current Coverage.** If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.
- 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).



Let's talk about Humana USAA Honor (HMO)

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

Humana USAA Honor (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, please refer to the plan's Evidence of Coverage on our website, [Humana.com/plandocuments](https://www.humana.com/plandocuments).

To be eligible

To join Humana USAA Honor (HMO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

Plan name:

Humana USAA Honor (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](https://www.humana.com/medicare)

More about Humana USAA Honor (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.

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 in your service area listed in this document to act as your Primary Care Provider (PCP). Humana USAA Honor (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	\$0 You must keep paying your Medicare Part B premium.
Part B premium reduction	Your plan will reduce your Monthly Part B premium by up to \$150 but by no more than Original Medicare's Part B Premium for 2024.
Medical deductible	This plan does not have a deductible.
Maximum out-of-pocket responsibility	\$3,900 in-network The most you pay for copays, coinsurance and other costs for covered medical services for the year.



Covered Medical and Hospital Benefits

INPATIENT HOSPITAL CARE

Your plan covers an unlimited number of days for an inpatient stay

\$195 copay per day for days 1-8
\$0 copay per day for days 9-90

OUTPATIENT HOSPITAL COVERAGE

Services listed below may also be covered at other places of treatment. Please refer to specific services listed in this document for additional information.

Advanced imaging services (MRI, MRA, PET and CT scan) **\$195** copay

Basic radiological services (X-rays) **\$100** copay

Cardiac rehabilitation services **\$30** copay

Chemotherapy drugs **20%** of the cost

Diagnostic colonoscopy **\$0** copay

Diagnostic mammography **\$0** copay

Diagnostic procedures and tests - other **\$125** copay

Lab services **\$0** copay

Medicare Part B covered drugs **20%** of the cost

Mental health services **\$0** copay

Nuclear medicine services **\$195** copay

Occupational therapy **\$30** copay

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.)

Opioid treatment program services	\$0 copay
Physical therapy	\$30 copay
Pulmonary rehabilitation services	\$15 copay
Renal dialysis services	20% of the cost
Sleep study (facility based)	\$125 copay
Speech therapy	\$30 copay
Substance abuse services	\$0 copay
Supervised Exercise Therapy (SET) for Peripheral Artery Disease (PAD)	\$25 copay
Surgery services	\$195 copay
Therapeutic radiology (Radiation therapy)	20% of the cost
Wound care	\$30 copay
AMBULATORY SURGERY CENTER	
Diagnostic colonoscopy	\$0 copay
Surgery services	\$170 copay
DOCTOR OFFICE VISITS	
Primary care provider (PCP)	\$0 copay
Specialist	\$30 copay

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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 screening & counseling
 - Annual Wellness Visit (AWV)
 - Bone mass measurement
 - Breast cancer screening (mammogram)
 - Cardiovascular disease risk reduction visit
 - Cardiovascular disease screening
 - Cervical and vaginal cancer screening
 - Colorectal cancer screening
 - Depression screening
 - Diabetes screening
 - Diabetes self-management training
 - Glaucoma screening
 - HIV screening
 - Immunizations
 - Lung cancer screening
 - Medical nutrition therapy
 - Medicare Diabetes Prevention Program (MDPP)
 - Obesity screening and therapy
 - Prostate cancer screening exams
 - Routine physical exam
 - Sexually transmitted infections (STIs) screening and counseling
 - Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)
 - "Welcome to Medicare" preventive visit
- Any additional preventive services approved by Medicare during the contract year will be covered.

EMERGENCY CARE

Emergency services at emergency room

\$90 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.

Physician and professional services at emergency room

\$0 copay

URGENTLY NEEDED SERVICES

\$15 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.

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Covered Medical and Hospital Benefits (cont.)

DIAGNOSTIC SERVICES, LABS & IMAGING

Advanced imaging services (MRI, MRA, PET and CT scan)	<ul style="list-style-type: none"> • Freestanding radiological facility: \$170 copay • Primary care physician's office: \$170 copay • Specialist's office: \$170 copay
Basic radiological services (X-rays)	<ul style="list-style-type: none"> • Freestanding radiological facility: \$0 copay • Primary care physician's office: \$0 copay • Specialist's office: \$30 copay • Urgent care center: \$15 copay
Diagnostic colonoscopy	<ul style="list-style-type: none"> • Ambulatory surgery center: \$0 copay
Diagnostic mammography	<ul style="list-style-type: none"> • Freestanding radiological facility: \$0 copay • Specialist's office: \$0 copay
Diagnostic procedures and tests	<ul style="list-style-type: none"> • Primary care physician's office: \$0 copay • Specialist's office: \$30 copay • Urgent care center: \$15 copay
Lab services	<ul style="list-style-type: none"> • Freestanding laboratory: \$0 copay • Primary care physician's office: \$0 copay • Specialist's office: \$0 copay • Urgent care center: \$15 copay
Nuclear medicine and services	<ul style="list-style-type: none"> • Freestanding radiological facility: \$100 copay
Sleep study	<ul style="list-style-type: none"> • Member's home: \$0 copay • Specialist's office: \$0 copay
Therapeutic radiology (Radiation therapy)	<ul style="list-style-type: none"> • Freestanding radiological facility: \$0 copay • Specialist's office: \$30 copay

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Covered Medical and Hospital Benefits (cont.)

H1036119000

HEARING SERVICES

Medicare-covered hearing

\$30 copay

Mandatory supplemental hearing benefit

In-Network:

HER692

- **\$0** copay for fitting/evaluation, routine hearing exams up to 1 per year.
- **\$199** copay for each Value Technology hearing aid up to 1 per ear per year.
- **\$699** copay for each Advanced Technology hearing aid up to 1 per ear per year.
- **\$1,299** copay for each Premium Technology hearing aid up to 1 per ear per year.
- Note: Includes 1 year warranty and 1 month battery supply.

The provider location for routine hearing can be found at **Humana.com** > Find a doctor > Medical > Enter Zip Code > Select look up method > Select Medicare > Select Network (your plan's Name) > Select > Select Category "Name" > HearUSA > Search > HearUSA provider appears.

DENTAL SERVICES

Medicare-covered dental

\$30 copay

Mandatory supplemental dental benefit

The cost-share indicated below is what you pay for the covered service.

In-Network:

DEN634

- **\$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 complete dentures, crown recementation, panoramic film or diagnostic x-rays, partial dentures up to 1 every 5 years.
- **\$0** copay for crown, other restorative services - core buildup and prefabricated post and core 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 adjustments to dentures, denture rebase, denture reline, denture repair, emergency

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Covered Medical and Hospital Benefits (cont.)

- diagnostic exam, tissue conditioning up to 1 per year.
- **\$0** copay for emergency treatment for pain, fluoride treatment, periodic oral exam, prophylaxis (cleaning) up to 2 per year.
- **\$0** copay for periodontal maintenance up to 4 per year.
- **\$0** copay for amalgam and/or composite filling, necessary anesthesia with covered service, simple or surgical extraction up to unlimited per year.
- **\$2,000** maximum benefit coverage amount per year for all preventive and comprehensive benefits.

Limitations and exclusions may apply. Submitted claims are subject to a review process which may include a clinical review and dental history to approve coverage. Dental benefits under this plan may not cover all ADA procedure codes. Any services received that are not listed will not be covered by the plan and will be the member's responsibility. The member is responsible for any amount above the dental coverage limit. Benefits are offered on a calendar year basis. Any amount unused at the end of the year will expire. Information regarding each plan is available at **Humana.com/sb**.

In-network dentists have agreed to provide covered services at contracted rates (per the in-network fee schedules, or INFS). If a member visits a participating network dentist, the member cannot be billed for charges that exceed the negotiated fee schedule (but coinsurance payment still applies).

Use the Florida GoldPlus Dental 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 Florida GoldPlus Dental.

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Covered Medical and Hospital Benefits (cont.)

VISION SERVICES

Eyewear (post cataract surgery)	\$0 copay
Medicare-covered diabetic eye exam	\$0 copay
Medicare-covered vision services	\$30 copay
Mandatory supplemental vision benefit	In-Network: VIS176 <ul style="list-style-type: none"> • \$0 copay for routine exam up to 1 per year. • \$400 maximum benefit coverage amount per year for contact lenses, eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames or 3 pairs of select eyeglasses at no cost. • Eyeglasses include ultraviolet protection and scratch resistant coating.

MENTAL HEALTH SERVICES

Inpatient Your plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital	\$195 copay per day for days 1-8 \$0 copay per day for days 9-90
Therapy visits	<ul style="list-style-type: none"> • Partial hospitalization: \$30 copay • Specialist's office: \$5 copay

SKILLED NURSING FACILITY (SNF)

Your plan covers up to 100 days in a SNF	\$0 copay per day for days 1-20 \$150 copay per day for days 21-100
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PHYSICAL THERAPY

Comprehensive outpatient rehab facility	\$20 copay
Specialist's office	\$20 copay

AMBULANCE

Air	20% of the cost
Ground	\$200 copay per date of service

TRANSPORTATION

\$0 copay for plan approved location up to 50 one-way trip(s) per year.
This benefit offers unlimited 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.

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Covered Medical and Hospital Benefits (cont.)

MEDICARE PART B DRUGS

Allergy shots and serum

- Primary care physician's office: **\$0** copay
- Specialist's office: **\$0** copay

Chemotherapy drugs

- Specialist's office: **20%** of the cost

Other Part B drugs

Some rebatable Part B drugs may be subject to a lower coinsurance.

You pay no more than \$35 for a one-month (up to 30-day) supply for all Part B insulin covered by our plan, and if your plan has a deductible it does not apply to Part B insulin.

- Pharmacy: **20%** of the cost
- Primary care physician's office: **20%** of the cost
- Specialist's office: **20%** of the cost



Prescription Drug Benefits

Your plan covers Part B drugs including, but not limited to, chemotherapy and some drugs administered by your provider. However, this plan does not cover Part D prescription drugs.



Additional Benefits

Chiropractic services (Medicare-covered)

\$20 copay

Podiatry services (Medicare-covered)

\$30 copay

Acupuncture services (Medicare-covered)

\$30 copay for acupuncture for chronic low back pain visits up to 20 visit(s) per year.

MEDICAL EQUIPMENT/SUPPLIES

Diabetic monitoring supplies

- Diabetic supplier: **20%** of the cost
- Network retail pharmacy: **\$0** copay
- Preferred diabetic supplier: **\$0** copay

Durable medical equipment (DME) and related supplies – High Cost

- Durable medical equipment provider: **20%** of the cost

Durable medical equipment (DME) and related supplies – All Other

- Durable medical equipment provider: **20%** of the cost

Medical supplies

- Medical supplier: **\$0** copay

Prosthetic devices and related supplies

- Prosthetics provider: **\$0** copay

REHABILITATION SERVICES

Cardiac rehabilitation services

- Specialist's office: **\$30** copay

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Occupational therapy	<ul style="list-style-type: none"> Comprehensive outpatient rehab facility: \$20 copay Specialist's office: \$20 copay
Physical therapy	<ul style="list-style-type: none"> Comprehensive outpatient rehab facility: \$20 copay Specialist's office: \$20 copay
Pulmonary rehabilitation services	<ul style="list-style-type: none"> Specialist's office: \$15 copay
Speech therapy	<ul style="list-style-type: none"> Comprehensive outpatient rehab facility: \$20 copay Specialist's office: \$20 copay
Supervised Exercise Therapy (SET) for Peripheral Artery Disease (PAD)	<ul style="list-style-type: none"> Specialist's office: \$25 copay

TELEHEALTH SERVICES (in addition to Original Medicare)

Primary care physician's office	\$0 copay
Specialist	\$30 copay
Substance abuse and behavioral health services	\$0 copay
Urgent care services	\$15 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/plandocuments](https://www.humana.com/plandocuments) to view a copy of the EOC or call **1-800-833-2364**.

Flex Allowance

\$250 annual allowance on a prepaid card to use for out-of-pocket expenses, including copays related to the current plan year covered dental, vision and hearing services.

Any unused amount expires at the end of the plan year.

This allowance can be used at **in-network** dental, vision and hearing providers that accept Visa® payments and the provider's main business is dental care, vision services, or hearing services. Limitations and restrictions may apply.

See the **Humana Spending Account Card** section for more information. Allowance amount cannot be combined with other benefit allowances which may be on the card.

Humana Spending Account Card

The Humana Spending Account Card is what you use to spend allowances included in this plan. If your previous plan had a USAA Health Flex Card and/or an OTC Allowance Card, you will be sent a Humana Spending Account Card. Please activate your card as soon as you receive it in the mail.

Please keep this card even after the allowance is spent as future allowance amounts will be added to this card.

- Humana is not responsible for lost or stolen cards.
- Please see the back of your card for more information.
- Allowance amounts cannot be combined with other benefit allowances on the card.
- Limitations and restrictions may apply.

Routine foot care

\$30 copay for routine podiatry visits up to unlimited visit(s) per year.

NationsMarket® Fresh, Prepared Meal Program

Humana's freshly made home delivered meal program for members following an inpatient stay in the hospital or nursing facility.

Over-the-Counter (OTC) mail order

\$30 monthly allowance to buy approved over-the-counter health and wellness products available through our OTC Mail Order provider.

Unused amount rolls over to the next month and expires at the end of the plan year.

- The allowance is available to use on the 1st of every month.
- Limitations and restrictions may apply.

Rewards and Incentives

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

SilverSneakers® fitness program

Basic fitness center membership including in person and digital fitness classes.

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.

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 (听障专线：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 (聽障專線：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 quý vị cần thông dịch viên xin gọi 1-877-320-1235 (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 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 대해 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.

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

Form Approved OMB# 0938-1421

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 بخططنا الصحية أو خطة الأدوية الموصوفة لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على (TTY: 711) 1-877-320-1235. 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.

Portuguese: 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.

Japanese: 当社の健康保険と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をご用意しています。通訳をご用命になるには、1-877-320-1235 (TTY:711) にお電話ください。日本語を話す者が支援いたします。これは無料のサービスです。



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