2024

Summary of Benefits

Humana Gold Plus H4007-021 (HMO)

Puerto Rico
Puerto Rico Island Wide

Our service area is Puerto Rico.

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 **1-800-681-3625 (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 **1-800-681-3625 (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

- ☐ 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 Gold Plus H4007-021 (HMO)

Find out more about the Humana Gold Plus H4007-021 (HMO) plan - including the health and drug services it covers - in this easy-to-use guide.

Humana Gold Plus H4007-021 (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**.

To be eligible

To join Humana Gold Plus H4007-021 (HMO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

Plan name:

Humana Gold Plus H4007-021 (HMO)

How to reach us:

If you're a member of this plan, call toll-free: **1-866-773-5959 (TTY: 711)**.

If you're **not** a member of this plan, call toll free: **1-800-681-3625 (TTY: 711)**.

October 1 - March 31:
Call 7 days a week from 8 a.m. - 8 p.m.

April 1 - September 30:
Call Monday - Friday, 8 a.m. - 8 p.m.

Or visit our website:

Humana.com/medicare

More about Humana Gold Plus H4007-021 (HMO)

Do you have Medicare and Medicaid? If you are a dual-eligible beneficiary enrolled in both Medicare and your state Medicaid program, you may not have to pay the medical costs displayed in this booklet and your prescription drug costs may 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 in your service area listed in this document to act as your Primary Care Provider (PCP). Humana Gold Plus H4007-021 (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!

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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 **$50** but by no more than Original Medicare's Part B Premium for 2024.
Medical deductible	This plan does not have a deductible.
Pharmacy (Part D) deductible	This plan has a **$0** deductible.
Maximum out-of-pocket responsibility	**$5,000** 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	**$0** copay per admit
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)	**$0** copay
Basic radiological services (X-rays)	**$0** copay
Cardiac rehabilitation services	**$0** copay
Chemotherapy drugs	**20%** of the cost
Diagnostic colonoscopy	**$20** copay
Diagnostic mammography	**$20** copay
Diagnostic procedures and tests - other	**$20** copay
Lab services	**$0** copay
Medicare Part B covered drugs	**20%** of the cost
Mental health services	**$20** copay
Nuclear medicine services	**$20** 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.)

Occupational therapy	**$6** copay
Opioid treatment program services	**$20** copay
Physical therapy	**$6** copay
Pulmonary rehabilitation services	**$5** copay
Renal dialysis services	**20%** of the cost
Sleep study (facility based)	**$20** copay
Speech therapy	**$6** copay
Substance abuse services	**$20** copay
Supervised Exercise Therapy (SET) for Peripheral Artery Disease (PAD)	**$0** copay
Surgery services	**$20** copay
Therapeutic radiology (Radiation therapy)	**20%** of the cost
Wound care	**$0** copay
AMBULATORY SURGERY CENTER	
Diagnostic colonoscopy	**$20** copay
Surgery services	**$20** copay
DOCTOR OFFICE VISITS	
Primary care provider (PCP)	**$0** copay
Specialist	**$0** 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	**$25** 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	
	$10 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)	• Freestanding radiological facility: **$0** copay • Primary care physician's office: **$0** copay • Specialist's office: **$0** copay
Basic radiological services (X-rays)	• Freestanding radiological facility: **$0** copay • Primary care physician's office: **$0** copay • Specialist's office: **$0** copay • Urgent care center: **$10** copay
Diagnostic colonoscopy	• Ambulatory surgery center: **$20** copay
Diagnostic mammography	• Freestanding radiological facility: **$0** copay • Specialist's office: **$0** copay
Diagnostic procedures and tests	• Primary care physician's office: **$0** copay • Specialist's office: **$0** copay • Urgent care center: **$10** copay
Lab services	• Freestanding laboratory: **$0** copay • Primary care physician's office: **$0** copay • Specialist's office: **$0** copay • Urgent care center: **$0** copay
Nuclear medicine and services	• Freestanding radiological facility: **$0** copay
Sleep study	• Member's home: **$0** copay • Specialist's office: **$0** copay
Therapeutic radiology (Radiation therapy)	• Freestanding radiological facility: **20%** of the cost • Specialist's office: **$0** copay
HEARING SERVICES	
Medicare-covered hearing	**$0** copay
Mandatory supplemental hearing benefit	In-Network: **HER905** • **$0** copay for fitting/evaluation, routine hearing exams up to 1 per year. • **$750** maximum benefit coverage amount for each hearing aid(s) (all types) up to 1 per ear per year.
DENTAL SERVICES	
Medicare-covered dental	**$0** copay
Mandatory supplemental dental benefit	The cost-share indicated below is what you pay for the covered service. In-Network: **DEN601**

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- **0%** of the cost for bitewing x-rays up to 1 set(s) every 2 years.
- **0%** of the cost for periodontal surgery up to 1 per quadrant every 3 years.
- **0%** of the cost for amalgam and/or composite filling up to 1 per tooth every 3 years.
- **0%** of the cost for comprehensive oral exam, cone beam CT imaging, panoramic film up to 1 every 3 years.
- **0%** of the cost for crown, implant supported prosthetics up to 1 per tooth every 5 years.
- **0%** of the cost for bridges, complete dentures, complete or partial denture reline, partial dentures up to 1 every 5 years.
- **0%** of the cost for implant services, other restorative services - core buildup and prefabricated post and core up to 1 per tooth per lifetime.
- **0%** of the cost for scaling and root planing (deep cleaning) up to 1 per quadrant per year.
- **0%** of the cost for periodontal debridement up to 1 per year.
- **0%** of the cost for pulp vitality test up to 2 per quadrant per year.
- **0%** of the cost for periodic oral exam, periodontal maintenance, prophylaxis (cleaning) up to 2 per year.
- **0%** of the cost for complete or partial denture repair up to 3 per year.
- **0%** of the cost for intraoral x-rays up to 6 per year.
- **0%** of the cost for adjustments to dentures, extractions, root canal up to unlimited per year.
- **$7,500** maximum benefit coverage amount per year for adjustments to dentures, bridges, complete dentures, complete or partial denture reline, complete or partial denture repair, crown, implant services, implant supported prosthetics, other restorative services - core buildup and prefabricated post and core, partial dentures comprehensive benefits.

Limitations and exclusions may apply. Dental benefits under this plan may not cover all ADA

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.

	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. 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).
VISION SERVICES	
Eyewear (post cataract surgery)	**$0** copay
Medicare-covered diabetic eye exam	**$0** copay
Medicare-covered vision services	**$0** copay
Mandatory supplemental vision benefit	In-Network: **VIS318** • **$0** copay for routine exam 1 per year. • **$600** maximum benefit coverage amount per year for contact lenses and/or eyeglasses-lenses and frames up to unlimited pair(s) per year, fitting for eyeglasses-lenses and frames up to unlimited per year. • 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	**$0** copay per admit
Therapy visits	• Partial hospitalization: **$0** copay • Specialist's office: **$0** copay
SKILLED NURSING FACILITY (SNF)	
Your plan covers up to 100 days in a SNF	**$0** copay per admit

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Covered Medical and Hospital Benefits (cont.)

PHYSICAL THERAPY	
Comprehensive outpatient rehab facility	**$6** copay
Specialist's office	**$6** copay
AMBULANCE	
Air	**20%** of the cost
Ground	**$0** copay per date of service
TRANSPORTATION	
	$0 copay for plan approved location up to 24 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.
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

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.

Prescription Drug Benefits

PLAN HIGHLIGHTS

$0 copays	**$0** copays at select pharmacy locations and tiers. Additional details below.
Deductible	**$0** Deductible
Insulin costs	You won't pay more than **$0** for a one-month (up to 30-day) supply of each insulin product covered by your plan
Additional gap coverage	Additional gap coverage for the following: Insulin
Excluded drug coverage	Additional drug coverage for the following: Erectile dysfunction (ED) drugs Prescription Vitamins
$0 vaccines	**$0** copay for adult Part D covered vaccines recommended by the Advisory Committee on Immunization Practices (ACIP)

DEDUCTIBLE

This plan has a **$0** deductible.

INITIAL COVERAGE

You pay the following until your total yearly drug costs for covered drugs reach **$5,030**. 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.

Pharmacy Cost-Sharing

	Retail Cost-Sharing Includes all in-network retail pharmacies		**Standard Mail-Order Cost-Sharing**		**Preferred Mail-Order Cost-Sharing** CenterWell Pharmacy™	
Day supply	**30-day**	**90-day***	**30-day**	**90-day***	**30-day**	**90-day***
Tier 1: Preferred Generic	$0	$0	$0	$0	$0	$0
Tier 2: Generic	$0	$0	$0	$0	$0	$0
Tier 3: Preferred Brand	$0	$0	$0	$0	$0	$0
Tier 4: Non-Preferred Drug	$15	$45	$16	$48	$15	$35
Tier 5: Specialty Tier	33%	N/A	33%	N/A	33%	N/A
Tier 6: Select Care Drugs	$0	$0	$0	$0	$0	$0

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Other pharmacies are available in your network. To find which pharmacies are available in your network, go to **Humana.com/pharmacyfinder**.

*Some drugs are limited to a 30-day supply.

You won't pay more than **$0** for a one-month (up to 30-day) supply of each plan-covered insulin product regardless of cost-sharing tier.

Insulin Cost-Sharing

	Retail Cost-Sharing Includes all in-network retail pharmacies		**Standard Mail-Order Cost-Sharing**		**Preferred Mail-Order Cost-Sharing** CenterWell Pharmacy™	
Day supply	**30-day**	**90-day***	**30-day**	**90-day***	**30-day**	**90-day***
Tier 3: Preferred Brand	$0	$0	$0	$0	$0	$0
Tier 5: Specialty Tier	$0	N/A	$0	N/A	$0	N/A

Other pharmacies are available in your network. To find which pharmacies are available in your network, go to **Humana.com/pharmacyfinder**.

*Some drugs are limited to a 30-day supply.

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 **$8,000** — which is the end of the coverage gap. Not everyone will enter the coverage gap.

Under this plan, **you may pay even less** for the following:

Tier 3 (Preferred Brand) - Insulin

Tier 5 (Specialty Tier) - Insulin

For more information on cost sharing in the coverage gap, please call us or access your Evidence of Coverage online.

CATASTROPHIC COVERAGE

After your yearly out-of-pocket drug costs reach **$8,000** you pay **$0** for plan-covered Part D and Excluded drugs.

EXCLUDED DRUG COVERAGE

Erectile dysfunction (ED) drugs	Covered at Tier 1 cost-share amount.
Prescription Vitamins	Covered at Tier 1 cost-share amount.

Cost sharing may change depending on the pharmacy you choose or when you enter another phase of the Part D benefit. For more information on your prescription drug benefit, please call us or access your Evidence of Coverage online.

If you reside at an in-network long-term care facility, you pay the same as you would at an in-network retail pharmacy. Under certain situations you may be able to get drugs from an out-of-network pharmacy but may pay more than you would pay at an in-network pharmacy.

Additional Benefits

Chiropractic services (Medicare-covered)	**$0** copay
Podiatry services (Medicare-covered)	**$0** copay
Acupuncture services (Medicare-covered)	**$0** copay for acupuncture for chronic low back pain visits up to 20 visit(s) per year.
MEDICAL EQUIPMENT/SUPPLIES	
Diabetic monitoring supplies	• Diabetic supplier: **$0** copay • Network retail pharmacy: **$0** copay • Preferred diabetic supplier: **$0** copay
Durable medical equipment (DME) and related supplies	• Durable medical equipment provider: **$0** copay
Medical supplies	• Medical supplier: **$0** copay
Prosthetic devices and related supplies	• Prosthetics provider: **$0** copay
REHABILITATION SERVICES	
Cardiac rehabilitation services	• Specialist's office: **$0** copay
Occupational therapy	• Comprehensive outpatient rehab facility: **$6** copay • Specialist's office: **$6** copay
Physical therapy	• Comprehensive outpatient rehab facility: **$6** copay • Specialist's office: **$6** copay
Pulmonary rehabilitation services	• Specialist's office: **$5** copay
Speech therapy	• Comprehensive outpatient rehab facility: **$6** copay • Specialist's office: **$6** copay
Supervised Exercise Therapy (SET) for Peripheral Artery Disease (PAD)	• Specialist's office: **$0** copay
TELEHEALTH SERVICES (in addition to Original Medicare)	
Primary care physician's office	**$0** copay
Specialist	**$0** copay
Substance abuse and behavioral health services	**$0** copay
Urgent care services	**$0** copay

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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** to view a copy of the EOC or call **1-800-681-3625**.

Humana Extra Debit Card
Members who are diagnosed with a chronic health condition will receive **$75** loaded on a debit card every month to use toward the purchase of OTC products, needed goods and services, and to pay monthly expenses.
Unused funds will roll over to the next month and expire at the end of the plan year.

Bathroom safety device
$0 copayment for one (1) contracted standard bath or shower chair with or without wheels, any size every 5 years to members who meet the medical criteria.
Prior authorization requirements may apply.

Blood pressure monitor
You may receive one blood pressure monitor every five (5) years.

Humana Well Dine® Meal Program
Humana's home delivered meal program for members following an inpatient stay in the hospital or nursing facility.

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 **1-866-773-5959** 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. 1-866-773-5959 (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 1-866-773-5959 (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 1-866-773-5959 (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 1-866-773-5959 (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 1-866-773-5959 (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 1-866-773-5959 (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 1-866-773-5959 (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 1-866-773-5959 (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 1-866-773-5959 (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 1-866-773-5959 (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 1-866-773-5959 (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 بخطتنا الصحية أو خطة الأدوية الموصوفة لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-866-773-5959 (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 1-866-773-5959 (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 1-866-773-5959 (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 1-866-773-5959 (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 1-866-773-5959 (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 1-866-773-5959 (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、1-866-773-5959 (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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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.

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