

2024

# Summary of Benefits

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**Humana Group Medicare Advantage PPO Plan  
PPO 079/611**

**Disabled American Veterans - Low**

**Humana®**

Our service area includes specific counties within the United States, Puerto Rico and all other major US Territories.



# Let's talk about the **Humana Group Medicare Advantage PPO Plan.**

Find out more about the Humana Group Medicare Advantage PPO plan – including the services it covers – in this easy-to-use guide.

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, refer to the "Evidence of Coverage".

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## **To be eligible**

To join the Humana Group Medicare Advantage PPO plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Humana Group Medicare Advantage PPO plan has a network of doctors, hospitals, and other providers. For more information, please call Group Medicare Customer Care.

## **Plan name:**

Humana Group Medicare Advantage PPO plan



## **A healthy partnership**

Get more from your plan — with extra services and resources provided by Humana!

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## **How to reach us:**

Members should call toll-free  
**1-800-849-4157** for questions  
**(TTY/TDD 711)**

Call Monday – Friday, 8 a.m. - 7 p.m.  
Eastern Time.

Or visit our website:  
**[my.viabenefits.com/DAV](https://my.viabenefits.com/DAV)**



# Monthly Premium, Deductible and Limits

	IN-NETWORK	OUT-OF-NETWORK
<b>PLAN COSTS</b>		
<b>Monthly premium</b>	<b>\$172.83</b> You must keep paying your Medicare Part B premium.	
<b>Medical deductible</b>	This plan does not have a deductible.	
<b>Maximum out-of-pocket responsibility</b> The most you pay for copays, coinsurance and other costs for medical services for the year.	<p><b>In-Network Maximum Out-of-Pocket</b>  <b>\$2,000</b> out-of-pocket limit for Medicare-covered services. The following services do not apply to the maximum out-of-pocket: Part D Pharmacy; Dental Services (Routine); Fitness Program; Health Education Services; Hearing Services (Routine); Meal Benefit; OTC Drugs and Supplies; Personal Emergency Response System; Post-Discharge Personal Home Care; Post-Discharge Transportation Services; Smoking Cessation (Additional); Transportation (Routine); Vision Services (Routine) and the Plan Premium.</p> <p>If you reach the limit on out-of-pocket costs, we will pay the full cost for the rest of the year on covered hospital and medical services.</p>	<p><b>Combined In and Out-of-Network Maximum Out-of-Pocket</b>  <b>\$2,000</b> out-of-pocket limit for Medicare-covered services.  In-Network Exclusions: Part D Pharmacy; Dental Services (Routine); Fitness Program; Health Education Services; Hearing Services (Routine); Meal Benefit; OTC Drugs and Supplies; Personal Emergency Response System; Post-Discharge Personal Home Care; Post-Discharge Transportation Services; Smoking Cessation (Additional); Transportation (Routine); Vision Services (Routine) and the Plan Premium do not apply to the combined maximum out-of-pocket.</p> <p>Out-of-Network Exclusions: Part D Pharmacy; Dental Services (Routine); Hearing Services (Routine); OTC Drugs and Supplies; Personal Emergency Response System; Transportation (Routine); Vision Services (Routine); Worldwide Coverage and the Plan Premium do not apply to the combined maximum out-of-pocket.</p> <p>Your limit for services received from in-network providers will count toward this limit.</p> <p>If you reach the limit on</p>

**Note:** A cost share range may display, depending on the service and where the service is provided. Some services require prior authorization.



## Monthly Premium, Deductible and Limits

### IN-NETWORK

### OUT-OF-NETWORK

out-of-pocket costs, we will pay the full cost for the rest of the year on covered hospital and medical services.



## Covered Medical and Hospital Benefits

### IN-NETWORK

### OUT-OF-NETWORK

#### ACUTE INPATIENT HOSPITAL CARE

Our plan covers an unlimited number of days for an inpatient hospital stay. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.

**\$150** per admit

**\$150** per admit

#### OUTPATIENT HOSPITAL COVERAGE

##### Outpatient hospital visits

**\$0** to **\$75** copay

**\$0** to **\$75** copay

##### Ambulatory surgical center

**\$50** copay

**\$50** copay

#### DOCTOR OFFICE VISITS

##### Primary care provider (PCP)

**\$0** copay

**\$0** copay

##### Specialists

**\$20** copay

**\$20** copay

#### PREVENTIVE CARE

Including: Annual Wellness Visit, flu vaccine, colorectal cancer and breast cancer screenings. Any additional preventive services approved by Medicare during the contract year will be covered.

**Covered at no cost**

**Covered at no cost**

#### EMERGENCY CARE

##### Emergency room

If you are admitted to the hospital within 24 hours for the same condition, 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.

**\$75** copay for Medicare-covered emergency room visit(s)

**\$75** copay for Medicare-covered emergency room visit(s)

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# Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
<b>Urgently needed services</b> Urgently needed services are care provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.	<b>\$0 to \$20</b> copay	<b>\$0 to \$20</b> copay
<b>DIAGNOSTIC SERVICES, LABS AND IMAGING</b>		
<b>Diagnostic radiology</b>	<b>\$0 to \$75</b> copay	<b>\$0 to \$75</b> copay
<b>Lab services</b>	<b>\$0</b> copay	<b>\$0</b> copay
<b>Diagnostic tests and procedures</b>	<b>\$0 to \$75</b> copay	<b>\$0 to \$75</b> copay
<b>Outpatient X-rays</b>	<b>\$0 to \$75</b> copay	<b>\$0 to \$75</b> copay
<b>Radiation therapy</b>	<b>\$20 to \$50</b> copay	<b>\$20 to \$50</b> copay
<b>HEARING SERVICES</b>		
<b>Medicare-covered hearing</b>	<b>\$20</b> copay	<b>\$20</b> copay
<b>Routine hearing</b>  TruHearing Provider must be used. Contact Customer Service to locate a provider.	<b>\$0</b> copay for routine hearing exams up to 1 per year. <b>\$0</b> copay for follow-up provider visits up to unlimited per year. <b>\$299</b> copay for each Advanced level hearing aid up to 1 per ear per year. <b>\$599</b> copay for each Premium level hearing aid up to 1 per ear per year. Note: Includes 80 batteries per aid and 3 year warranty. Unlimited follow-up provider visits during first year following TruHearing hearing aid purchase.	
<b>DENTAL SERVICES</b>		
<b>Medicare-covered dental</b>	<b>\$20</b> copay (services include surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments or neoplastic disease)	<b>\$20</b> copay (services include surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments or neoplastic disease)
<b>Routine dental</b>	<b>0%</b> of the cost for comprehensive oral evaluation or periodontal exam up to 1 every 3 years.	<b>0%</b> of the cost for comprehensive oral evaluation or periodontal exam up to 1 every 3 years.

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# Covered Medical and Hospital Benefits

IN-NETWORK	OUT-OF-NETWORK
<p><b>0%</b> of the cost for panoramic film or diagnostic x-rays up to 1 every 5 years.</p>	<p><b>0%</b> of the cost for panoramic film or diagnostic x-rays up to 1 every 5 years.</p>
<p><b>0%</b> of the cost for bitewing x-rays up to 1 set(s) per year.</p>	<p><b>0%</b> of the cost for bitewing x-rays up to 1 set(s) per year.</p>
<p><b>0%</b> of the cost for emergency diagnostic exam, intraoral x-rays up to 1 per year.</p>	<p><b>0%</b> of the cost for emergency diagnostic exam, intraoral x-rays up to 1 per year.</p>
<p><b>0%</b> of the cost for amalgam and/or composite filling, fluoride treatment, periodic oral exam, prophylaxis (cleaning), simple or surgical extraction up to 2 per year.</p>	<p><b>0%</b> of the cost for amalgam and/or composite filling, fluoride treatment, periodic oral exam, prophylaxis (cleaning), simple or surgical extraction up to 2 per year.</p>
<p><b>0%</b> of the cost for periodontal maintenance up to 4 per year.</p>	<p><b>0%</b> of the cost for periodontal maintenance up to 4 per year.</p>
<p><b>0%</b> of the cost for necessary anesthesia (inhalation of nitrous oxide/analgesia, anxiolysis) with covered service up to unlimited per year.</p>	<p><b>0%</b> of the cost for necessary anesthesia (inhalation of nitrous oxide/analgesia, anxiolysis) with covered service up to unlimited per year.</p>
<p><b>\$500</b> combined maximum benefit coverage amount per year for all preventive and comprehensive benefits.</p>	<p><b>\$500</b> combined maximum benefit coverage amount per year for all preventive and comprehensive benefits.</p>
	<p>Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.</p>

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](https://www.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).

Out-of-network dentists have not agreed to provide services at contracted fees. Benefits received out-of-network are subject to any in-network benefit maximums, limitations and/or exclusions. Members may be billed by the out-of-network provider for any amount greater than the payment made by Humana to the provider. Please see below for provider locator instructions. Network providers agree to bill us directly. If a provider who is not in our network is not willing to bill us directly, you may have to pay upfront and submit a request for reimbursement. The coinsurance level will apply to the average negotiated

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# Covered Medical and Hospital Benefits

## IN-NETWORK

## OUT-OF-NETWORK

in-network fee schedule (INFS) in your area. See Chapter 2 Payment Requests Contact Information or visit Humana.com for information on requesting reimbursement.

When visiting an out-of-network provider there could be a difference between Humana’s reimbursement and the dentist’s charges. Members are responsible for this difference when visiting an out-of-network provider; this is known as balanced billing.

The Mandatory Supplemental Dental benefits are provided through the Humana Dental Medicare Network. The provider locator can be found at **Humana.com > Find a doctor > Select the Dentist icon from the menu > From the Distance drop down select the preferred distance > Enter Zip code > From the look up method select All Dental Networks > Then select HumanaDental Medicare.**

### VISION SERVICES

<b>Medicare-covered vision services</b>	<b>\$20</b> copay (services include diagnosis and treatment of diseases and injuries of the eye)	<b>\$20</b> copay (services include diagnosis and treatment of diseases and injuries of the eye)
<b>Medicare-covered diabetic eye exam</b>	<b>\$0</b> copay	<b>\$0</b> copay
<b>Medicare-covered glaucoma screening</b>	<b>\$0</b> copay	<b>\$0</b> copay
<b>Medicare-covered eyewear (post-cataract)</b>	<b>\$20</b> copay	<b>\$20</b> copay
<b>Routine vision</b>  EyeMed is the In-Network provider for the routine vision benefit. Contact Customer Service to locate a provider.	<b>\$0</b> copay for routine exam (includes refraction) up to 1 per year. <b>\$100</b> combined maximum benefit coverage amount per year for contact lenses, eyeglasses (lenses and frames), including lens options such as ultraviolet protection and scratch resistant coating, fitting for eyeglasses (lenses and frames).	<b>\$175</b> combined maximum benefit coverage amount per year for routine exam (includes refraction). <b>\$0</b> copay for routine exam (includes refraction) up to 1 per year. <b>\$100</b> combined maximum benefit coverage amount per year for contact lenses, eyeglasses (lenses and frames), including lens options such as ultraviolet protection and scratch resistant coating, fitting for eyeglasses (lenses and frames). Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

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# Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
<b>MENTAL HEALTH SERVICES</b>		
<b>Inpatient</b> The inpatient hospital care limit applies to inpatient mental services provided in a general hospital. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. 190 day lifetime limit in a psychiatric facility.	<b>\$150</b> per admit	<b>\$150</b> per admit
<b>Outpatient group and individual therapy visits</b>	<b>Outpatient therapy visit:</b> <b>\$0 to \$40</b> copay <b>Partial Hospitalization:</b> <b>\$40</b> copay	<b>Outpatient therapy visit:</b> <b>\$0 to \$40</b> copay <b>Partial Hospitalization:</b> <b>\$40</b> copay
<b>SKILLED NURSING FACILITY</b>		
Our plan covers up to 100 days in a SNF.  No 3-day hospital stay is required. Plan pays \$0 after 100 days.	<b>\$0</b> copay per day for days 1-20 <b>\$25</b> copay per day for days 21-100	<b>\$0</b> copay per day for days 1-20 <b>\$25</b> copay per day for days 21-100
<b>PHYSICAL THERAPY</b>		
	<b>\$0 to \$20</b> copay	<b>\$0 to \$20</b> copay
<b>AMBULANCE</b>		
Per date of service regardless of the number of trips. Limited to Medicare-covered transportation.	<b>\$75</b> copay	<b>\$75</b> copay
<b>TRANSPORTATION</b>		
	<b>\$0</b> copay for plan approved location up to 12 one-way trip(s) per year. This benefit is not to exceed 50 miles per trip.	
<b>PART B PRESCRIPTION DRUGS</b>		
	<b>\$0</b> copay	<b>\$0</b> copay

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# Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
<b>ACUPUNCTURE SERVICES</b>		
<b>Medicare-covered acupuncture visit(s) for chronic low back pain</b>  Your plan allows services to be received by a provider licensed to perform acupuncture or by providers meeting the Original Medicare provider requirements.	<b>\$20</b> copay for acupuncture for chronic low back pain visits up to 20 combined in and out of network visit(s) per year.	<b>\$20</b> copay for acupuncture for chronic low back pain visits up to 20 combined in and out of network visit(s) per year. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
<b>ALLERGY</b>		
<b>Allergy shots &amp; serum</b>	<b>\$0 to \$20</b> copay	<b>\$0 to \$20</b> copay
<b>CHIROPRACTIC SERVICES</b>		
<b>Medicare-covered chiropractic visit(s)</b>	<b>\$20</b> copay	<b>\$20</b> copay
<b>DIABETES MANAGEMENT TRAINING</b>		
	<b>\$0</b> copay	<b>\$0</b> copay
<b>FOOT CARE (PODIATRY)</b>		
<b>Medicare-covered foot care</b>	<b>\$20</b> copay	<b>\$20</b> copay
<b>HOME HEALTH CARE</b>		
	<b>\$0</b> copay	<b>\$0</b> copay
<b>MEDICAL EQUIPMENT/SUPPLIES</b>		
<b>Durable medical equipment (like wheelchairs or oxygen)</b>	<b>\$0</b> copay	<b>\$0</b> copay
<b>Medical supplies</b>	<b>\$0</b> copay	<b>\$0</b> copay
<b>Prosthetics (artificial limbs or braces)</b>	<b>\$0</b> copay	<b>\$0</b> copay
<b>Diabetes monitoring supplies</b>	<b>\$0</b> copay	<b>\$0</b> copay
<b>OUTPATIENT SUBSTANCE ABUSE</b>		
<b>Outpatient group and individual substance abuse treatment visits</b>	<b>Outpatient therapy visit:</b> <b>\$0 to \$40</b> copay <b>Partial Hospitalization:</b> <b>\$40</b> copay	<b>Outpatient therapy visit:</b> <b>\$0 to \$40</b> copay <b>Partial Hospitalization:</b> <b>\$40</b> copay
<b>OVER-THE-COUNTER ITEMS</b>		
	<b>\$25</b> maximum benefit coverage amount per quarter (3 months) for select over-the-counter health and wellness products. Unused amount expires at the end of the quarter.	

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## Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
<b>REHABILITATION SERVICES</b>		
Occupational and speech therapy	\$0 to \$20 copay	\$0 to \$20 copay
Cardiac rehabilitation	\$0 to \$20 copay	\$0 to \$20 copay
Pulmonary rehabilitation	\$0 to \$20 copay	\$0 to \$20 copay
<b>RENAL DIALYSIS</b>		
Renal dialysis	\$25 copay	\$25 copay
Kidney disease education services	\$0 copay	\$0 copay
<b>TELEHEALTH SERVICES (in addition to Original Medicare)</b>		
Primary care provider (PCP)	\$0 copay	Not Covered
Specialist	\$20 copay	Not Covered
Urgent care services	\$0 copay	Not Covered
Substance abuse or behavioral health services	\$0 copay	Not Covered

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# Covered Medical and Hospital Benefits

## IN-NETWORK

## OUT-OF-NETWORK

### FITNESS AND WELLNESS

SilverSneakers® is a total health and physical activity program that provides access to exercise equipment, group fitness classes, and social events.

### HEALTH EDUCATION SERVICES

Personal Health Coaching is an interactive inbound and outreach on-line and telephonic wellness coaching for Medicare participants who elect to participate, for wellness improvement, including weight management, nutrition, exercise, back care, blood pressure management, and blood sugar management.

### MEAL BENEFIT

After a member's overnight inpatient stay in a hospital or skilled nursing facility, members are eligible for nutritious meals delivered to their door at no cost.

### POST-DISCHARGE PERSONAL HOME CARE

After a member's overnight inpatient stay in a hospital or skilled nursing facility, members may receive assistance performing activities of daily living within the home. Types of assistance include bathing, dressing, toileting, walking, eating and preparing meals.

### POST-DISCHARGE TRANSPORTATION SERVICES

After a member's overnight inpatient stay in a hospital or skilled nursing facility, members are provided transportation to plan approved locations by car, van or wheelchair accessible vehicle at no cost.

### SMOKING CESSATION (ADDITIONAL)

A comprehensive smoking cessation program available online, email and phone. Personal coaches assist via establishing goals and providing articles and resources to aid in the effort to quit smoking.

### HOSPICE

You must get care from a Medicare-certified hospice. You must consult with your plan before you select hospice.

**Note:** A cost share range may display, depending on the service and where the service is provided. Some services require prior authorization.

## Important

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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.

**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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