

Aetna Medicare Classic Prime (HMO-POS)
H0523 - 075 | \$0 Plan Premium



2025 Summary of Benefits

We're here to help

You may have questions as you read through this information. And that's OK — we're here to help.

Not a member yet?

Call 1-833-859-6031 (TTY: [711](tel:711))

October 1–March 31: 8 AM to 8 PM, 7 days a week

April 1–September 30: 8 AM to 8 PM, Monday–Friday

Already a member?

Call 1-833-570-6670 (TTY: [711](tel:711))

8 AM to 8 PM, 7 days a week

An Aetna team member will answer your call.

Keep in mind

This is a summary of the services we cover from January 1, 2025 through December 31, 2025.

Need a complete list of what we cover and any limitations? Just visit [AetnaMedicare.com/H0523-075](https://www.aetna.com/H0523-075) where you'll find the plan's *Evidence of Coverage* (EOC). You may call us to request a copy.

Are you eligible to enroll?

To join Aetna Medicare Classic Prime (HMO-POS), you must:

- Be entitled to Medicare Part A
- Have Medicare Part B
- Live in the plan's service area, which includes the following county:
California: San Diego

What you should know

- **Plan type:** Aetna Medicare Classic Prime (HMO-POS) is an HMO plan. This is a Medicare Advantage plan that covers prescription drugs.
- **Independent Practice Association (IPA)/Medical Group:** This is a group of physicians and other healthcare providers. They determine which specialists and hospitals you can use. They have a contract to provide services to our members.
- **Primary Care Provider (PCP):** A PCP helps coordinate your care and we require you to select one. Your PCP relationship is important, and we encourage you to choose a PCP close to your home. When you enroll, we'll ask who your PCP is. If you don't tell us, we'll assign one to you. You can change your PCP anytime by calling us or logging into your member portal. The IPA/Medical Group associated with your PCP determines which specialists and hospitals you can use. Your ID card will have the names of your PCP and IPA/Medical Group. You must see these providers for us to pay for your care.
- **Referrals:** Usually, your PCP must give approval before you use other network providers. You don't need a referral for emergency or urgently needed care. Your IPA/Medical Group determines which specialists and hospitals you can use.
- **Network:** Our plan has a network of select providers to provide you with patient-centered care, coordinated services and enhanced provider communication. To locate a network provider you may contact Member Services or search the online provider directory.
- **Prior authorizations:** Your provider will work with us to get approval before you receive certain services or drugs.
- **Helpful resources:** To find provider directories, network pharmacies, and other plan information, visit [AetnaMedicare.com/H0523-075](https://www.AetnaMedicare.com/H0523-075). The Contact Quick Reference chart at the end of this document contains important phone numbers and websites. For coverage and costs of Original Medicare, look in the *Medicare & You* handbook. View it online at [medicare.gov/medicare-and-you](https://www.medicare.gov/medicare-and-you), or get a copy by calling 1-800-MEDICARE (1-800-633-4227) (TTY: [1-877-486-2048](tel:1-877-486-2048)), 24 hours a day, 7 days a week.

Plan premium, deductible, and maximum out-of-pocket (MOOP)



| Out-of-pocket costs | |
|----------------------|---|
| Monthly plan premium | \$0 You must continue to pay your Medicare Part B premium. |
| Plan deductible | \$0 |
| MOOP | \$799 for in-network services Once you reach the maximum out-of-pocket, our plan pays 100% of covered medical services. Your premium and prescription drug costs don't count toward your MOOP. |

Medical and hospital benefits



Hospital coverage

Your provider often needs approval from us before we cover these services. This is called **prior authorization** or precertification.

| Benefit | Your costs in our plan |
|--|--|
| Inpatient (unlimited number of days) | \$100 per day, days 1-5; \$0 per day, days 6-90; \$0 for additional days Use your PCP or Medical Group for all your medical care, including referrals, authorizations, and procedures. Your IPA/Medical Group determines the hospitals you can use. |
| Outpatient hospital observation services | \$0 copay |
| Outpatient hospital | \$100 copay |
| Ambulatory surgical center | \$50 copay |



Primary Care Provider (PCP) and specialist visits

You must work with your PCP or Medical Group for all your medical care. This includes referrals, authorizations, and procedures. The IPA/Medical Group determines which specialists you can use.

| Benefit | Your costs in our plan |
|------------|--|
| PCP | \$0 copay This plan requires you to select a PCP. Your PCP will be part of an IPA/Medical Group. The IPA/Medical Group you choose will determine the specialists and hospitals you can use. |
| Specialist | \$0 copay The IPA/Medical Group you choose will determine the specialists you can use. You must work with your PCP or Medical Group for all medical care such as referrals, authorizations, and procedures. |



Preventive, emergency and urgent care

| Benefit | Your costs in our plan |
|---|--|
| Preventive care | \$0 copay For a full list of preventive services available, see the EOC. Some covered services may have an associated cost. |
| Emergency and urgent care (inside the U.S.) | \$140 copay for emergency care \$0 copay for urgent care |
| Emergency and urgent care, including ambulance (outside the U.S.) | \$140 copay for emergency care \$140 copay for urgent care \$245 copay for ambulance |



Diagnostic services, labs, imaging

Your provider often needs approval from us before we cover these services. This is called **prior authorization** or precertification. You may have to get a **referral from your PCP** before you can receive these services.

| Benefit | Your costs in our plan |
|--|------------------------|
| Diagnostic tests and procedures | \$0 copay |
| Lab services | \$0 copay |
| Diagnostic radiology services, such as MRI | \$0 copay |
| Outpatient x-rays | \$0 copay |



Hearing services

| Benefit | Your costs in our plan |
|-------------------------|---|
| Diagnostic hearing exam | \$0 copay |
| Routine hearing exam | \$0 copay You get one routine hearing exam every year with a provider in the NationsHearing network. |
| Hearing aids | You get an annual benefit amount (allowance) of \$1,250 per ear. If the cost is over the benefit amount, you pay the difference. This benefit amount can only be used to purchase hearing aids through a NationsHearing network provider. |

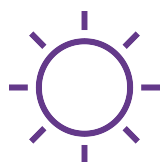
**Dental services**

| Benefit | Your in-network costs | Your out-of-network costs |
|-----------------|---|---|
| Dental services | <p>\$0 copay for covered services</p> <p>You get an annual benefit amount (allowance) of \$1,500 for covered services. You are responsible for any costs over this amount.</p> <p>Covered services include oral exams, x-rays, cleanings, fillings, extractions, and more.</p> <p>You can use a provider in or out of the Aetna Dental PPO Network for covered services. However, if you use a provider outside of the network, you may have to pay your cost share at the time of service and submit a request for reimbursement.</p> <p>Note: Implants are not covered. See EOC for additional details on exclusions and limitations.</p> | <p>20% coinsurance for covered services</p> |



Vision services

| Benefit | Your costs in our plan |
|---|--|
| Diagnostic eye exam (includes diabetic eye exams) | \$0 copay |
| Glaucoma screening | \$0 copay |
| Routine eye exam | \$0 copay |
| | Our plan covers one exam every year with an in-network provider. |
| Contacts and eyeglasses | <p>You get an annual benefit amount (allowance) of \$300 for covered prescription eyewear.</p> <p>This eyewear benefit is set up as an annual direct member reimbursement (DMR).</p> <ul style="list-style-type: none"> You can use your benefit amount at any licensed vision provider in the U.S. to purchase eyewear. You will have to pay at the time of service and then submit for reimbursement. However, if you see an EyeMed provider, they may provide a discount and automatically apply your benefit amount so you won't have to submit for reimbursement. |



Mental health services

Your provider often needs approval from us before we cover these services. This is called **prior authorization** or precertification.

| Benefit | Your costs in our plan |
|-------------------------------------|---|
| Inpatient psychiatric hospital stay | \$100 per day, days 1-5; \$0 per day, days 6-90 |
| Outpatient mental health therapy | \$0 copay for individual sessions \$0 copay for group sessions |
| Outpatient psychiatric therapy | \$0 copay for individual sessions \$0 copay for group sessions |



Skilled nursing facility (SNF) and therapy

Your provider often needs approval from us before we cover these services. This is called **prior authorization** or precertification. You may have to get a **referral from your PCP** before you can receive these services. Note: Members must meet the Centers for Medicare & Medicaid Services (CMS) criteria for medically necessary skilled care to be covered.

| Benefit | Your costs in our plan |
|-----------------------------|--|
| SNF care | \$0 per day, days 1-20; \$100 per day, days 21-100 Our plan covers up to 100 days per benefit period. |
| Physical and speech therapy | \$0 copay |
| Occupational therapy | \$0 copay |



Ambulance and routine transportation

Your provider often needs approval from us before we cover non-emergency air ambulance. This is called **prior authorization** or precertification.

| Benefit | Your costs in our plan |
|--|---|
| Ambulance (ground or air, one-way trip) | \$245 copay for ground ambulance services 20% coinsurance for air ambulance services |
| Routine, non-emergency transportation | \$0 copay You get up to 12 one-way trips every year to and from plan-approved locations (up to 60 miles each trip). Examples of plan-approved locations include medical offices and urgent care centers. We have teamed up with Access2Care to provide this benefit. |



Medicare Part B drugs

Medicare Part B only covers a limited number of medicines under certain conditions. These medicines are often given to you in your provider’s office. They can include things like vaccines, injections, and nebulizers, among others. They can also include medicines you take at home using special medical equipment. Your provider often needs approval from us before we cover these services. This is called **prior authorization** or precertification.

| Benefit | Your costs in our plan |
|--------------------|---|
| Chemotherapy drugs | 0% - 20% coinsurance Cost sharing shown is the maximum you will pay for Part B prescription drugs. You may pay less for certain drugs. |
| Part B Insulin | \$35 copay |
| Other Part B drugs | 0% - 20% coinsurance Cost sharing shown is the maximum you will pay for Part B prescription drugs. You may pay less for certain drugs. |

Medicare Part D drugs



Medicare Part D covers a wide range of prescription drugs. They can include medicines you take every day for conditions like high blood pressure or diabetes. Some drugs require **prior authorization**. This means you must get approval from us first before we'll cover them.

Prescription drugs (Your costs may be lower if you qualify for Extra Help)

Formulary name B2

Deductible phase

This plan doesn't have a deductible, so your coverage begins at the initial coverage phase. \$0

Initial coverage phase

The plan will pay its share of the cost and you'll pay a copayment or coinsurance (your share of the cost) for each prescription filled. For tiers with a copay, you will pay the lesser of the listed copay below or the negotiated cost of the drug. These cost shares may also apply to home infusion drugs when obtained through your Part D benefit. Costs may differ based on pharmacy type or status.

One-month Supply

Your share of the cost when you get a *one-month* supply of a covered Part D prescription drug:

| | Preferred Retail | Standard Retail | Preferred Mail | Standard Mail | Long-Term Care (LTC) |
|----------------------------|------------------|-----------------|----------------|---------------|----------------------|
| | 30-day | 30-day | 30-day | 30-day | 31-day |
| Tier 1: Preferred Generic | \$0 | \$2 | \$0 | \$2 | \$2 |
| Tier 2: Generic | \$5 | \$12 | \$5 | \$12 | \$12 |
| Tier 3: Preferred Brand | 25% | 25% | 25% | 25% | 25% |
| Tier 4: Non-Preferred Drug | 35% | 35% | 35% | 35% | 35% |
| Tier 5: Specialty | 33% | 33% | 33% | 33% | 33% |

Long-term Supply

Your share of the cost when you get a *long-term* supply of a covered Part D prescription drug:

| | Preferred Retail | Standard Retail | Preferred Mail | Standard Mail |
|----------------------------|--|-----------------|----------------|---------------|
| | 100-day | 100-day | 100-day | 100-day |
| Tier 1: Preferred Generic | \$0 | \$6 | \$0 | \$6 |
| Tier 2: Generic | \$15 | \$36 | \$10 | \$36 |
| Tier 3: Preferred Brand | 25% | 25% | 25% | 25% |
| Tier 4: Non-Preferred Drug | 35% | 35% | 35% | 35% |
| Tier 5: Specialty | A long-term supply is not available for drugs on Tier 5. | | | |

Out-of-pocket threshold

\$2,000 is the maximum amount you will pay for your yearly Part D out-of-pocket costs.

Catastrophic coverage phase

In this phase, the plan pays the full cost for your covered Part D drugs.

| | |
|------------------------------|-----|
| Generic and brand name drugs | \$0 |
|------------------------------|-----|

Insulins and vaccines

| | |
|--|--|
| Important message about what you pay for Part D vaccines | Our plan covers many vaccines at no cost to you. |
|--|--|

| | |
|--|---|
| Important message about what you pay for Part D insulins | 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 or Part D phase you are in. |
|--|---|

Check your formulary guide for a list of covered insulins and vaccines

Other covered benefits



Aetna Medicare Extra Benefits Card

You get an **Aetna Medicare Extra Benefits Card** to help pay for certain everyday expenses.

| Benefit | |
|-----------------------------------|--|
| CVS Over-the-Counter (OTC) Wallet | <p>You get a \$75 quarterly benefit amount (allowance).</p> <p>You can use your CVS Over-the-Counter (OTC) Wallet to help pay for certain OTC health and wellness products including allergy medicine, pain relievers, first aid supplies, and more.</p> |



Alternative medicine

Your provider often needs approval from us before we cover these services. This is called **prior authorization** or precertification.

| Benefit | Your costs in our plan |
|-----------------------|--|
| Acupuncture | <p>\$0 copay for Medicare-covered acupuncture visits \$0 copay for non-Medicare covered acupuncture visits</p> <p>Medicare coverage is limited to services to treat chronic low back pain. For non-Medicare covered services, we also cover unlimited visits every year as necessary. We have teamed up with American Specialty Health (ASH) to provide your acupuncture coverage.</p> |
| Chiropractic services | <p>\$0 copay for Medicare-covered chiropractic visits \$0 copay for non-Medicare covered chiropractic visits</p> <p>Medicare coverage is limited to fixing a subluxation. For non-Medicare covered services, we also cover unlimited visits every year as necessary. We have teamed up with American Specialty Health (ASH) to provide your chiropractic coverage.</p> |



Diabetic supplies

We exclusively cover **OneTouch®/LifeScan** blood glucose monitors and test strips as our preferred diabetic supplies.

| Benefit | Your costs in our plan |
|-------------------|--|
| Diabetic supplies | <p>0% - 20% coinsurance</p> <p>0% coinsurance for OneTouch/LifeScan supplies, including test strips, glucose monitors, solutions, lancets and lancing devices</p> <p>20% coinsurance for non-OneTouch/LifeScan supplies, including test strips, glucose monitors, solutions, lancets and lancing devices (prior authorization may be required)</p> |



Fitness benefits

| Benefit | Your costs in our plan |
|---|---|
| Annual physical fitness membership | <p>\$0 copay</p> <p>You get a basic membership to any SilverSneakers® participating fitness facility. If you prefer to exercise at home, you may order one at-home fitness kit per year through SilverSneakers. If you do not reside near a participating facility, online fitness classes are available at no additional cost to you.</p> |
| Direct member reimbursement (DMR) allowance | <p>You get a direct member reimbursement (DMR) benefit amount (allowance) of \$200 each quarter. The reimbursement period starts the first day of each calendar quarter. Calendar quarters begin in January, April, July, and October. Any unused amount will not roll over into the following quarter. See your EOC for more information about this benefit.</p> |



Foot care (podiatry services)

You may have to get a **referral from your PCP** before you can receive these services.

| Benefit | Your costs in our plan |
|--------------------------|--|
| Foot exams and treatment | \$0 copay for Medicare-covered podiatry visits |



Home care and support

Your provider often needs approval from us before we cover these services. This is called **prior authorization** or precertification.

| Benefit | Your costs in our plan |
|------------------|------------------------|
| Home health care | \$0 copay |



Medical equipment and supplies

Your provider often needs approval from us before we cover these services. This is called **prior authorization** or precertification.

| Benefit | Your costs in our plan |
|--|--|
| Durable medical equipment (DME), such as wheelchairs, crutches, oxygen equipment, and continuous glucose monitors (CGMs) | 0% - 20% coinsurance 0% coinsurance for continuous glucose monitors 20% coinsurance for all other Medicare-covered DME items |
| Prosthetics, such as braces and artificial limbs | 20% coinsurance |



Resources For Living®

| Benefit | |
|----------------------|--|
| Resources For Living | Resources For Living helps connect you to resources in your community such as senior housing, adult daycare, meal subsidies, community activities, and more. |



Substance use disorder services

Your provider often needs approval from us before we cover these services. This is called **prior authorization** or precertification.

| Benefit | Your costs in our plan |
|--|---|
| Outpatient substance use disorder services | \$0 copay for individual sessions \$0 copay for group sessions |



24-Hour Nurse Line

You can talk to a registered nurse anytime to discuss health-related questions.

| Benefit | Your costs in our plan |
|--------------------|------------------------|
| 24-Hour Nurse Line | \$0 copay |

Contact quick reference

Aetna: Before you enroll 1-833-859-6031 (TTY: [711](tel:711)) [AetnaMedicare.com](https://www.aetna.com)

Aetna Member Services 1-833-570-6670 (TTY: [711](tel:711)) [AetnaMedicare.com/H0523-075](https://www.aetna.com/H0523-075)

| | | |
|------------------------------------|-------------------------------------|--|
| Aetna Medicare Extra Benefits Card | CVS | 1-844-428-8147 (TTY: 711) 7 days a week, 8 AM - 8 PM local time excluding federal holidays CVS.com/Aetna |
| Dental | Aetna | 1-833-570-6670 (TTY: 711) AetnaMedicare.com/dental |
| Eyewear | Aetna (Direct Member Reimbursement) | 1-833-570-6670 (TTY: 711) AetnaMedicare.com/H0523-075 |
| Hearing Aids | NationsHearing | 1-877-225-0137 (TTY: 711) Aetna.NationsBenefits.com/Hearing |
| Nurse Hotline | 24-Hour Nurse Line | 1-855-493-7019 (TTY: 711) |
| SilverSneakers | SilverSneakers | 1-855-627-3795 (TTY: 711) SilverSneakers.com |
| Transportation | Access2Care | 1-855-814-1699 (TTY: 711) |

Aetna Medicare is a HMO, PPO plan with a Medicare contract. Our D-SNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal.

See *Evidence of Coverage* for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

Out-of-network/non-contracted providers are under no obligation to treat plan members, except in emergency situations. Please call our member services number or see your *Evidence of Coverage* for more information, including the cost sharing that applies to out-of-network services.

The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

The Aetna Medicare pharmacy network includes limited lower-cost, preferred pharmacies in: Suburban Arizona, Rural California, Urban Kansas, Rural Michigan, Urban Michigan, Urban Missouri, Rural North Dakota, and Suburban West Virginia. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including whether there are any lower-cost preferred pharmacies in your area, members please call the number on your ID card, non-members please call 1-833-859-6031 (TTY: [711](tel:711)) or consult the online pharmacy directory at [AetnaMedicare.com/findpharmacy](https://www.aetna.com/findpharmacy).

For mail order, you can get prescription drugs shipped to your home through the network mail-order delivery program. Typically, mail-order drugs arrive within 10 days. You can call 1-833-570-6670 (TTY: [711](tel:711)) 8 AM to 8 PM, 7 days a week if you do not receive your mail-order drugs within this timeframe. Members may have the option to sign up for automated mail-order delivery.

Participating health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.

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To send a complaint to Aetna, call the Plan or the number on your member ID card. To send a complaint to Medicare, call 1-800-MEDICARE (TTY users should call [1-877-486-2048](tel:18774862048)), 24 hours a day/7 days a week. If your complaint involves a broker or agent, be sure to include the name of the person when filing your grievance.

Resources For Living is the brand name used for products and services offered through the Aetna group of subsidiary companies.

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Pre-enrollment checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at **1-833-859-6031 (TTY: 711)**. From October 1 to March 31, you can call us 7 days a week from 8 AM to 8 PM local time. From April 1 to September 30, we're here Monday through Friday from 8 AM to 8 PM local time.

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 [AetnaMedicare.com](https://www.aetna.com) or call **1-833-859-6031 (TTY: 711)** to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the PCP you see now is in the network. If they're not, you will likely have to select a new doctor. Your PCP will be affiliated with an IPA/Medical Group and they will determine the specialists and hospitals you can use.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine 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

- ☐ 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.
- ☐ 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, 2026.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for certain covered services, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care.

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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 1-833-570-6670. 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 1-833-570-6670. 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 1-833-570-6670。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 1-833-570-6670。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 1-833-570-6670. 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 1-833-570-6670. 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 1-833-570-6670. 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 1-833-570-6670. 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 1-833-570-6670. 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 1-833-570-6670. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-833-570-6670. 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 1-833-570-6670 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 1-833-570-6670. 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 1-833-570-6670. 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 1-833-570-6670. 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 1-833-570-6670. 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、1-833-570-6670. 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。

Hawaiian: He kōkua māhele ‘ōlelo kā mākou i mea e pane ‘ia ai kāu mau nīnau e pili ana i kā mākou papahana olakino a lā‘au lapa‘au paha. I mea e loa‘a ai ke kōkua māhele ‘ōlelo, e kelepona mai iā mākou ma 1-833-570-6670. E hiki ana i kekahi mea ‘ōlelo Pelekānia/‘Ōlelo ke kōkua iā ‘oe. He pōmaika‘i manuahi kēia.

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In addition, our health plan provides auxiliary aids and services, free of charge, when necessary, to ensure that people with disabilities have an equal opportunity to communicate effectively with us. Our health plan also provides language assistance services, free of charge, for people with limited English proficiency. If you need these services, visit our website, call the phone number listed in this material or on your benefit ID card.

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Grievance Department (write to the address listed in your *Evidence of Coverage*). You can also file a grievance by phone by calling the Customer Service phone number listed on your benefit ID card (TTY: [711](#)). If you need help filing a grievance, call Customer Service Department at the phone number on your benefit ID card.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at https://ocrportal.hhs.gov/ocr/cp/complaint_frontpage.jsf.

ESPAÑOL (SPANISH): Si habla un idioma que no sea inglés, se encuentran disponibles servicios gratuitos de asistencia de idiomas. Visite nuestro sitio web o llame al número de teléfono que figura en este documento.

傳統漢語(中文) (CHINESE): 如果您使用英文以外的語言，我們將提供免費的語言協助服務。請瀏覽我們的網站或撥打本文件中所列的電話號碼。