

Aetna Medicare Premier (HMO-POS)
H0628 - 024 | \$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/H0628-024](https://www.aetnamedicare.com/H0628-024) where you'll find the plan's *Evidence of Coverage* (EOC). You may call us to request a copy.

[AetnaMedicare.com](https://www.aetnamedicare.com)

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2025-H0628.024.1

Are you eligible to enroll?

To join Aetna Medicare Premier (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 counties:
Kentucky: Bullitt, Henry, Jefferson, Nelson, Oldham, Owen, Shelby, Spencer, Trimble

What you should know

- **Plan type:** Aetna Medicare Premier (HMO-POS) is an HMO plan. This is a Medicare Advantage plan that covers prescription drugs.
- **Primary Care Provider (PCP):** You have the option to choose a PCP. We recommend choosing a PCP because when we know who your provider is we can better support your care.
- **Referrals:** Aetna Medicare Premier (HMO-POS) doesn't require a referral from a PCP to see a specialist. Keep in mind, some providers may require a recommendation or treatment plan from your provider in order to see you.
- **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/H0628-024](https://www.aetnamedicare.com/H0628-024). 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 | \$5,500 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) | \$280 per day, days 1-8; \$0 per day, days 9-90; \$0 for additional days |
| Outpatient hospital observation services | \$280 copay |
| Outpatient hospital | \$35 - \$375 copay \$35 copay for outpatient hospital services other than surgery \$375 copay for each outpatient hospital surgery |
| Ambulatory surgical center | \$300 copay |



Primary Care Provider (PCP) and specialist visits

| Benefit | Your costs in our plan |
|------------|------------------------|
| PCP | \$0 copay |
| Specialist | \$40 copay |



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.) | \$125 copay for emergency care \$45 copay for urgent care |
| Emergency and urgent care, including ambulance (outside the U.S.) | \$125 copay for emergency care \$125 copay for urgent care \$295 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.

| Benefit | Your costs in our plan |
|--|---|
| Diagnostic tests and procedures | \$200 copay |
| Lab services | \$0 copay |
| Diagnostic radiology services, such as MRI | \$200 copay |
| Outpatient x-rays | \$10 - \$90 copay \$10 copay for services performed at a non-hospital facility \$90 copay for services performed at a hospital facility |



Hearing services

| Benefit | Your costs in our plan |
|-------------------------|---|
| Diagnostic hearing exam | \$40 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 \$1,500 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. |



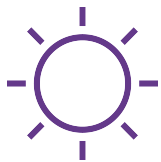
Dental services

| Benefit | Your in-network costs | Your out-of-network costs |
|-----------------|--|--|
| Dental services | <p>\$0 copay for preventive services</p> <p>20% - 50% coinsurance for comprehensive services</p> <p>You get an annual benefit amount (allowance) of \$1,000 for covered comprehensive services. You are responsible for the cost of any comprehensive services over this amount.</p> <p>Covered comprehensive services include fillings, extractions, crowns, and more.</p> <p>Covered preventive services include oral exams, cleanings, and x-rays. There is no copay for these services when using an in-network provider. Covered preventive services do not count toward your annual benefit amount.</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>50% coinsurance for preventive services</p> <p>50% - 70% coinsurance for comprehensive services</p> |



Vision services

| Benefit | Your costs in our plan |
|---|--|
| Diagnostic eye exam (includes diabetic eye exams) | \$0 - \$40 copay \$0 copay for diabetic eye exams \$40 copay for all other Medicare-covered eye exams |
| Glaucoma screening | \$0 copay |
| Routine eye exam | \$0 copay Our plan covers one exam every year with an in-network provider. |
| Contacts and eyeglasses | You get an annual benefit amount (allowance) of \$180 for covered prescription eyewear. You can only use this benefit amount at an EyeMed provider. Your benefit amount is applied at the time of purchase. If your eyewear purchase is more than your benefit amount, you'll need to pay the difference. |



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 | \$280 per day, days 1-8; \$0 per day, days 9-90 |
| Outpatient mental health therapy | \$40 copay for individual sessions \$40 copay for group sessions |
| Outpatient psychiatric therapy | \$40 copay for individual sessions \$40 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. 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; \$214 per day, days 21-100 Our plan covers up to 100 days per benefit period. |
| Physical and speech therapy | \$40 copay |
| Occupational therapy | \$40 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) | \$295 copay |
| 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

You'll pay the plan's negotiated drug cost up to the deductible limit.

The deductible applies to drugs on Tiers 3, 4, and 5 \$250

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 | \$10 | \$12 | \$10 | \$12 | \$12 |
| Tier 3: Preferred Brand | 25% | 25% | 25% | 25% | 25% |
| Tier 4: Non-Preferred Drug | 26% | 26% | 26% | 26% | 26% |
| Tier 5: Specialty | 30% | 30% | 30% | 30% | 30% |

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 | \$30 | \$36 | \$20 | \$36 |
| Tier 3: Preferred Brand | 25% | 25% | 25% | 25% |
| Tier 4: Non-Preferred Drug | 26% | 26% | 26% | 26% |
| 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, even if you haven't paid your deductible. |
|--|--|

| | |
|--|---|
| 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, even if you haven't paid your deductible. |
|--|---|

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

Other covered benefits



Alternative medicine

| Benefit | Your costs in our plan |
|-----------------------|--|
| Acupuncture | <p>\$40 copay for Medicare-covered acupuncture visits</p> <p>Medicare coverage is limited to services to treat chronic low back pain. Non-Medicare covered acupuncture services aren't covered.</p> |
| Chiropractic services | <p>\$20 copay for Medicare-covered chiropractic visits \$20 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.</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 benefit

| 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> |



Foot care (podiatry services)

| Benefit | Your costs in our plan |
|--------------------------|---|
| Foot exams and treatment | <p>\$40 copay for Medicare-covered podiatry visits</p> <p>\$40 copay for non-Medicare covered podiatry visits</p> <p>For non-Medicare covered services, we cover up to six visits every year.</p> |



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 |
| Meal benefit (post-discharge) | <p>\$0 copay for meals</p> <p>After you are discharged from a qualifying Inpatient Acute Hospital, Inpatient Psychiatric Hospital, or Skilled Nursing Facility stay, you may be eligible to get up to 14 freshly prepared meals for a 7-day period. These meals are provided to help support your recovery or manage your health conditions.</p> <p>We have teamed up with NationsMarket™ to provide this benefit.</p> |



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) | <p>0% - 20% coinsurance</p> <p>0% coinsurance for continuous glucose monitors 20% coinsurance for all other Medicare-covered DME items</p> |
| Prosthetics, such as braces and artificial limbs | 20% coinsurance |



Over-the-counter (OTC) benefit

The OTC benefit provides select health and wellness products.

| Benefit | |
|--------------------------------|--|
| OTC benefit amount (allowance) | <p>\$100 quarterly</p> <p>You will receive a quarterly benefit amount (allowance) to purchase approved OTC health and wellness products like first aid supplies, cold and allergy medicine, pain relievers, and more.</p> <ul style="list-style-type: none"> • The benefit amount is available the first day of each calendar quarter. Any unused amount will not roll over into the next quarter. • We have teamed up with OTC Health Solutions (OTCHS) to provide this benefit. • The benefit amount is not connected to a payment or debit card. You can get OTC products online, by phone, or in freestanding CVS stores. • Visit the OTCHS catalog for a full product listing and details on how the benefit works. |



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 | <p>\$40 copay for individual sessions</p> <p>\$40 copay for group sessions</p> |



Visitor/travel benefit

Plan rules continue to apply. **Prior authorizations** are required for certain services.

| Benefit | |
|---|--|
| Visitor/travel program: Travel Advantage | <p>Allows you to remain in your plan for up to 12 months when you are outside our plan’s service area.</p> <p>While traveling within the United States (except California), you can see an Aetna Medicare participating provider and pay in-network cost shares. Not all providers participate in the multi-state network. In most cases, non-urgent/non-emergency care you receive from an out-of-network provider will not be covered. Contact us for help finding a participating provider in the area you’re traveling to.</p> |



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

Aetna Member Services 1-833-570-6670 (TTY: [711](tel:711)) AetnaMedicare.com/H0628-024

| | | |
|--------------------------------|--------------------|--|
| Dental | Aetna | 1-833-570-6670 (TTY: 711) AetnaMedicare.com/dental |
| Eyewear | EyeMed | 1-844-486-3485 (TTY: 711) AetnaMedicareVision.com |
| 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) |
| Over-the-counter (OTC) Benefit | OTCHS | See OTC catalog at AetnaMedicare.com/H0628-024 |
| 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.aetnamedicare.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/medicare) 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 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 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.

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 आपको 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.

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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.

Y0001_NR_30475b_2023_C

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