Aetna Medicare Elite (PPO)
H5521 - 521 | $61 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)
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)
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/H5521-521** where you'll find the plan's *Evidence of Coverage* (EOC). You may call us to request a copy.

2025-H5521.521.1

Are you eligible to enroll?

To join Aetna Medicare Elite (PPO), you must:

- Be entitled to Medicare Part A
- Have Medicare Part B
- Live in the plan's service area, which includes the following counties:
  New York: Livingston, Monroe, Ontario, Orleans, Seneca, Wayne, Yates

What you should know

- **Plan type:** Aetna Medicare Elite (PPO) is a PPO plan. This is a Medicare Advantage plan that covers prescription drugs. You can use in-network and out-of-network providers. You will typically pay more for out-of-network care.
- **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 Elite (PPO) 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/H5521-521**. 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**, or get a copy by calling 1-800-MEDICARE (1-800-633-4227) (TTY: 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	$61 You must continue to pay your Medicare Part B premium.
Plan deductible	$1,250 for certain in-network and out-of-network services. Your deductible is what you'll pay before we begin to pay for services. The plan deductible applies to the following services provided by an in-network provider: inpatient hospital coverage, inpatient services in a psychiatric hospital, skilled nursing facility, therapeutic radiology, outpatient hospital services (including observation), ambulatory surgical center and dialysis. Additionally, the plan deductible applies to certain out-of-network services.
MOOP	$9,350 for in-network services $14,000 for in- and out-of-network services combined 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 in-network costs	Your out-of-network costs
Inpatient (unlimited number of days)	$395 per day, days 1-6; $0 per day, days 7-90 after your plan deductible is met; $0 for additional days	$500 per day, days 1-5; $0 per day, days 6-90 after your plan deductible is met; $0 for additional days
Outpatient hospital observation services	$395 copay after your plan deductible is met	40% coinsurance after your plan deductible is met
Outpatient hospital	$40 - $350 copay after your plan deductible is met $40 copay for outpatient hospital services other than surgery $350 copay for each outpatient hospital surgery	40% coinsurance after your plan deductible is met
Ambulatory surgical center	$300 copay after your plan deductible is met	40% coinsurance after your plan deductible is met

Primary Care Provider (PCP) and specialist visits

Benefit	Your in-network costs	Your out-of-network costs
PCP	$10 copay	$50 copay after your plan deductible is met
Specialist	$45 copay	$60 copay after your plan deductible is met

Preventive, emergency and urgent care

Benefit	Your in-network costs	Your out-of-network costs
Preventive care	$0 copay	0% - 40% coinsurance 0% coinsurance for the pneumonia, influenza, Hepatitis B, and COVID-19 vaccines 40% coinsurance for all other Medicare-covered preventive services
	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.)	$110 copay for emergency care $45 copay for urgent care	$110 copay for emergency care $45 copay for urgent care
Emergency and urgent care, including ambulance (outside the U.S.)	$110 copay for emergency care $110 copay for urgent care $300 copay for ambulance	$110 copay for emergency care $110 copay for urgent care $300 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 in-network costs	Your out-of-network costs
Diagnostic tests and procedures	$45 copay	40% coinsurance after your plan deductible is met
Lab services	$10 copay You'll pay $0 copay for certain lab services including hemoglobin A1c, urine protein, prothrombin (protime), urine albumin, fecal immunochemical test (FIT), kidney health evaluation for members with diabetes (KED) and COVID-19 testing	40% coinsurance after your plan deductible is met
Diagnostic radiology services, such as MRI	$200 - $275 copay $200 copay for CT/CAT scans $275 copay for all other complex imaging	40% coinsurance after your plan deductible is met
Outpatient x-rays	$45 copay	40% coinsurance after your plan deductible is met

Hearing services

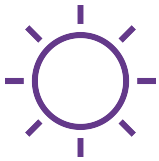
Benefit	Your in-network costs	Your out-of-network costs
Diagnostic hearing exam	$45 copay	$60 copay after your plan deductible is met
Routine hearing exam	$0 copay	$60 copay after your plan deductible is met
	You get one routine hearing exam every year. You can visit a provider in the NationsHearing network or an out-of-network provider.	
Hearing aids	Hearing aids are only covered when purchased through a NationsHearing provider. The copay amount is based on the level of hearing aid selected and will need to be paid at the time of purchase. • Level 1 (Standard): $0 copay per ear, per year • Level 2 (Select): $475 copay per ear, per year • Level 3 (Superior Plus): $650 copay per ear, per year • Level 4 (Advanced): $895 copay per ear, per year • Level 5 (Advanced Plus): $1,300 copay per ear, per year • Level 6 (Specialty): $1,700 copay per ear, per year	Not Covered

Dental services

Benefit	Your in-network costs	Your out-of-network costs
Dental services	$0 copay for preventive services	50% coinsurance for preventive services
	Covered preventive services include oral exams, cleanings, and x-rays. This plan does not include comprehensive services for things like fillings, extractions, crowns, and more. You can purchase comprehensive dental coverage through an Optional Supplemental Benefit (OSB) for an additional premium when you enroll or within 30 days of the plan's start date. 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.	

Vision services

Benefit	Your in-network costs	Your out-of-network costs
Diagnostic eye exam (includes diabetic eye exams)	$0 - $45 copay $0 copay for diabetic eye exams $45 copay for all other Medicare-covered eye exams	$60 copay after your plan deductible is met
Glaucoma screening	$0 copay	40% coinsurance after your plan deductible is met
Routine eye exam	$0 copay Our plan covers one exam every year.	$60 copay after your plan deductible is met
Contacts and eyeglasses	You get an annual benefit amount (allowance) of $150 for covered prescription eyewear. This eyewear benefit is set up as an annual direct member reimbursement (DMR). • 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 in-network costs	Your out-of-network costs
Inpatient psychiatric hospital stay	$339 per day, days 1-6; $0 per day, days 7-90 after your plan deductible is met	40% per stay after your plan deductible is met
Outpatient mental health therapy	$40 copay for individual sessions $40 copay for group sessions	40% coinsurance for individual sessions after your plan deductible is met 30% coinsurance for group sessions after your plan deductible is met
Outpatient psychiatric therapy	$40 copay for individual sessions $40 copay for group sessions	40% coinsurance for individual sessions after your plan deductible is met 30% coinsurance for group sessions after your plan deductible is met

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 in-network costs	Your out-of-network costs
SNF care	$0 per day, days 1-20; $214 per day, days 21-100 after your plan deductible is met	40% per stay after your plan deductible is met
	Our plan covers up to 100 days per benefit period.	
Physical and speech therapy	$30 copay	40% coinsurance after your plan deductible is met
Occupational therapy	$35 copay	40% coinsurance after your plan deductible is met

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 in-network costs	Your out-of-network costs
Ambulance (ground or air, one-way trip)	$300 copay	$300 copay after your plan deductible is met
Routine, non-emergency transportation	Not Covered	Not Covered

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 in-network costs	Your out-of-network costs
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.	40% coinsurance after your plan deductible is met
Part B Insulin	$35 copay	$35 copay after your plan deductible is met
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.	40% coinsurance after your plan deductible is met

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	B1
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	$590
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	$0	$12	$0	$12	$12
Tier 3: Preferred Brand	22%	22%	22%	22%	22%
Tier 4: Non-Preferred Drug	25%	25%	25%	25%	25%
Tier 5: Specialty	25%	25%	25%	25%	25%

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	$0	$36	$0	$36
Tier 3: Preferred Brand	22%	22%	22%	22%
Tier 4: Non-Preferred Drug	25%	25%	25%	25%
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 in-network costs	Your out-of-network costs
Acupuncture	$45 copay for Medicare-covered acupuncture visits Medicare coverage is limited to services to treat chronic low back pain. Non-Medicare covered acupuncture services aren't covered.	$60 copay for Medicare-covered acupuncture visits after your plan deductible is met
Chiropractic services	$15 copay for Medicare-covered chiropractic visits Medicare coverage is limited to fixing a subluxation. Non-Medicare covered chiropractic services aren't covered.	40% coinsurance for Medicare-covered chiropractic visits after your plan deductible is met

Diabetic supplies

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

Benefit	Your in-network costs	Your out-of-network costs
Diabetic supplies	0% - 20% coinsurance 0% coinsurance for OneTouch/LifeScan supplies, including test strips, glucose monitors, solutions, lancets and lancing devices 20% coinsurance for non-OneTouch/LifeScan supplies, including test strips, glucose monitors, solutions, lancets and lancing devices (prior authorization may be required)	0% - 20% coinsurance after your plan deductible is met 0% coinsurance for OneTouch/LifeScan supplies, including test strips, glucose monitors, solutions, lancets and lancing devices 20% coinsurance for non-OneTouch/LifeScan supplies, including test strips, glucose monitors, solutions, lancets and lancing devices (prior authorization may be required)

Fitness benefit

Benefit	Your costs in our plan
Annual physical fitness membership	$0 copay 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.

Foot care (podiatry services)

Benefit	Your in-network costs	Your out-of-network costs
Foot exams and treatment	$45 copay for Medicare-covered podiatry visits	$60 copay for Medicare-covered podiatry visits after your plan deductible is met

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 in-network costs	Your out-of-network costs
Home health care	$0 copay	40% coinsurance after your plan deductible is met
Meal benefit (post-discharge)	$0 copay for meals 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. We have teamed up with NationsMarket™ to provide this benefit.	

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 in-network costs	Your out-of-network costs
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	40% coinsurance after your plan deductible is met
Prosthetics, such as braces and artificial limbs	20% coinsurance	40% coinsurance after your plan deductible is met

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 in-network costs	Your out-of-network costs
Outpatient substance use disorder services	$40 copy for individual sessions $40 copy for group sessions	40% coinsurance for individual sessions after your plan deductible is met 30% coinsurance for group sessions after your plan deductible is met

Visitor/travel benefit

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

Benefit	
Visitor/travel program: Explorer	Allows you to remain in your plan for up to 12 months when you are outside our plan's service area. While traveling within the United States, 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, when you receive non-urgent/non-emergency care from an out-of-network provider, your share of the costs for your covered services may be higher. Contact us for help finding a participating provider in the area you're traveling to.

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

Optional Supplemental Benefits

This plan offers **Optional Supplemental Benefits (OSB)**. If you want these benefits, you must sign up for them when you enroll or within 30 days of the plan's start date and pay an additional monthly premium.

Benefit	Your in-network costs	Your out-of-network costs
Deluxe Comprehensive Dental Package **Monthly premium:** $33		
Dental services	20% - 50% coinsurance for comprehensive services	50% - 70% coinsurance for comprehensive services
	When you enroll in this OSB, 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. Covered services include fillings, extractions, crowns, and more. 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. Note: Implants are not covered. See EOC for additional details on exclusions and limitations.	

Special Supplemental Benefits

Our plan offers additional benefits to members with qualifying conditions. See the EOC for a full list of eligibility criteria.

Aetna In-Home Chronic Care Program
If you have been diagnosed by a medical professional with generally six or more of the chronic conditions listed in the EOC and you meet certain criteria, you may be eligible for certain in-home and/or telehealth primary care physician (PCP) services offered through Aetna-designated providers for $0.

See EOC for more information.

Contact quick reference

Aetna: Before you enroll	**1-833-859-6031 (TTY: 711)**	**AetnaMedicare.com**
Aetna Member Services	**1-833-570-6670 (TTY: 711)**	**AetnaMedicare.com/H5521-521**
Dental	Aetna	1-833-570-6670 (TTY: 711) **AetnaMedicare.com/dental**
Eyewear	Aetna (Direct Member Reimbursement)	1-833-570-6670 (TTY: 711) **AetnaMedicare.com/H5521-521**
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**

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) or consult the online pharmacy directory at **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) 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.

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), 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** 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.
- ☐ In addition to your monthly plan premium, 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 covered services, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay a higher copay for services received by non-contracted providers.

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Form Approved
OMB#0938-1421

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 quí vị cần thông dịch viên xin gọi 1-833-570-6670. 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 1-833-570-6670. 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 1-833-570-6670. 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ございます。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 ʻōlelo kā mākou i mea e pane ʻia ai kāu mau nīnau e pili ana i kā mākou papahana olakino a lāʻau lapaʻau paha. I mea e loaʻa ai ke kōkua māhele ʻōlelo, e kelepona mai iā mākou ma 1-833-570-6670. E hiki ana i kekahi mea ʻōlelo Pelekānia/ʻŌlelo ke kōkua iā ʻoe. He pōmaikaʻi manuahi kēia.

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We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex and does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. If you speak a language other than English, free language assistance services are available. Visit our website, call the phone number listed in this material or the phone number on your benefit ID card.

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。