2023

Summary of Benefits

Humana Gold Plus H1036-305 (HMO)

South Florida: Broward, Miami-Dade, Palm Beach
Broward, Miami-Dade, and Palm Beach counties

Our service area includes the following county/counties in Florida: Broward, Miami-Dade, Palm Beach.

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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 **1-800-833-2364 (TTY: 711)**.

Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs and benefits before you enroll. Visit **Humana.com/medicare** or call **1-800-833-2364 (TTY: 711)** to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- ☐ You must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2024.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).

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Let's talk about Humana Gold Plus H1036-305 (HMO)

Find out more about the Humana Gold Plus H1036-305 (HMO) plan - including the health and drug services it covers - in this easy-to-use guide.

Humana Gold Plus H1036-305 (HMO) is a Medicare Advantage HMO plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

The benefit information provided is a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. For a complete list of services we cover, ask us for the "Evidence of Coverage".

To be eligible

To join Humana Gold Plus H1036-305 (HMO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

Plan name:

Humana Gold Plus H1036-305 (HMO)

How to reach us:

If you're a member of this plan, call toll-free: **1-800-457-4708 (TTY: 711)**.

If you're **not** a member of this plan, call toll free: **1-800-833-2364 (TTY: 711)**.

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

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

Or visit our website:

Humana.com/medicare

More about Humana Gold Plus H1036-305 (HMO)

Do you have Medicare and Medicaid? If you are a dual-eligible beneficiary enrolled in both Medicare and the state's program, you may not have to pay the medical costs displayed in this booklet and your prescription drug costs will be lower, too.

If you have Medicaid, be sure to show your Medicaid ID card in addition to your Humana membership card to make your provider aware that you may have additional coverage. Your services are paid first by Humana and then by Medicaid.

As a member you must select an in-network doctor to act as your Primary Care Provider (PCP). Humana Gold Plus H1036-305 (HMO) has a network of doctors, hospitals, pharmacies and other providers. If you use providers who aren't in our network, the plan may not pay for these services.

A healthy partnership

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

Monthly Premium, Deductible and Limits

Monthly Plan Premium	**$0** You must keep paying your Medicare Part B premium.
Part B premium reduction	Your plan will reduce your Monthly Part B premium by up to **$150**
Medical deductible	This plan does not have a deductible.
Pharmacy (Part D) deductible	This plan does not have a deductible.
Maximum out-of-pocket responsibility	**$3,200** in-network The most you pay for copays, coinsurance and other costs for covered medical services for the year.

Covered Medical and Hospital Benefits

Acute inpatient hospital care	**$125** copay per day for days 1-7 **$0** copay per day for days 8-90 Your plan covers an unlimited number of days for an inpatient stay.
Outpatient hospital coverage	• Outpatient surgery at Outpatient Hospital: **$100** copay • Outpatient surgery at Ambulatory Surgical Center: **$50** copay
Doctor visits	• Primary care provider: **$0** copay • Specialist: **$20** copay

Your primary care provider (PCP) will work with you to coordinate the care you need with specialists or certain other providers in the network. This is called a "referral." Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a referral and/or prior authorization from the plan.

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Covered Medical and Hospital Benefits (cont.)

Preventive care	**Our plan covers many preventive services at no cost when you see an in-network provider including:** • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including flu shots, hepatitis B shots, pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Annual Wellness Visit • Lung cancer screening • Routine physical exam • Medicare diabetes prevention program Any additional preventive services approved by Medicare during the contract year will be covered.
EMERGENCY CARE	
Emergency room	**$100** copay If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for the emergency care.
Urgently needed services	**$20** copay at an urgent care center Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.

Your primary care provider (PCP) will work with you to coordinate the care you need with specialists or certain other providers in the network. This is called a "referral." Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a referral and/or prior authorization from the plan.

Covered Medical and Hospital Benefits (cont.)

OUTPATIENT CARE AND SERVICES

Diagnostic services, labs and imaging Cost share may vary depending on the service and where service is provided	• Diagnostic mammography: **$0** copay • Diagnostic colonoscopy **$0** copay • Diagnostic radiology: **$0** to **$125** copay • Lab services: **$0** to **$50** copay • Diagnostic tests and procedures: **$0** to **$100** copay • Outpatient X-rays: **$0** to **$100** copay • Radiation therapy: **$20** copay or **20%** of the cost
Hearing	Medicare-covered hearing exam: **$20** copay **Routine hearing:** In-Network: **HER751** • **$0** copay for fitting/evaluation, routine hearing exams up to 1 per year. • **$500** maximum benefit coverage amount for each hearing aid(s) (all types) up to 1 per ear per year. • Note: Includes 1 month battery supply and 2 year warranty. The provider location for routine hearing can be found at **Humana.com** > Find a doctor > Medical > Enter Zip Code > Select look up method > Select Medicare > Select Network (your plan's Name) > Select > Select Category "Name" > HearUSA > Search > HearUSA provider appears.
Dental	Medicare-covered dental services: **$20** copay **Routine dental:** The cost-share indicated below is what you pay for the covered service. In-Network: **DEN617** • **0%** of the cost for comprehensive oral evaluation or periodontal exam up to 1 every 3 years. • **0%** of the cost for panoramic film or diagnostic x-rays up to 1 every 5 years. • **0%** of the cost for bitewing x-rays, intraoral x-rays up to 1 set(s) per year. • **0%** of the cost for emergency diagnostic exam up to 1 per year. • **0%** of the cost for fluoride treatment, periodic oral exam, prophylaxis (cleaning) up to 2 per year. • **0%** of the cost for periodontal maintenance up to 4 per year. • **0%** of the cost for necessary anesthesia with covered service up to unlimited per year. • **$25** copay for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years. • **$25** copay for scaling for moderate inflammation up to 1 every 3 years.

Your primary care provider (PCP) will work with you to coordinate the care you need with specialists or certain other providers in the network. This is called a "referral." Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a referral and/or prior authorization from the plan.

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- **$25** copay for crown recementation up to 1 every 5 years.
- **$25** copay for emergency treatment for pain up to 2 per year.
- **$25** copay per tooth for amalgam and/or composite filling, simple or surgical extraction up to unlimited per year.
- **50%** of the cost for occlusal adjustment up to 1 every 3 years.
- **50%** of the cost for complete dentures, partial dentures up to 1 every 5 years.
- **50%** of the cost for crown, root canal, root canal retreatment up to 1 per tooth per lifetime.
- **50%** of the cost for adjustments to dentures, denture rebase, denture reline, denture repair, tissue conditioning up to 1 per year.
- **50%** of the cost for oral surgery up to 2 per year.
- **$1000** maximum benefit coverage amount per year for preventive and comprehensive benefits.

Dental services are subject to our standard claims review procedures which could include dental history to approve coverage. Dental benefits under this plan may not cover all American Dental Association procedure codes. Information regarding each plan is available at **Humana.com/sb**.

Network dentists have agreed to provide services at contracted fees (the in-network fee schedules, of INFS). If a member visits a participating network dentist, the member will not receive a bill for charges more than the negotiated fee schedule on covered services (coinsurance payment still applies).

Use the Florida GoldPlus Dental network for the Mandatory Supplemental Dental. The provider locator can be found at **Humana.com** > Find a Doctor > from the Search Type drop down select Dental > under Coverage Type select All Dental Networks > enter zip code > from the network drop down select Florida GoldPlus Dental.

Vision

- Medicare-covered vision services: **$20** copay
- Medicare-covered diabetic eye exam: **$0** copay
- Medicare-covered glaucoma screening: **$0** copay
- Medicare-covered eyewear (post-cataract): **$0** copay

Routine vision:
In-Network:
VIS131

- **$0** copay for routine exam up to 1 per year.
- **$200** maximum benefit coverage amount per year for contact lenses, eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames or 2 pairs of select eyeglasses at no cost.
- Eyeglasses include ultraviolet protection and scratch resistant coating.

Your primary care provider (PCP) will work with you to coordinate the care you need with specialists or certain other providers in the network. This is called a "referral." Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a referral and/or prior authorization from the plan.

Covered Medical and Hospital Benefits (cont.)

	The provider location for routine vision can be found at **Humana.com** > Find a doctor > Medical >Enter Zip Code >Select look up method > Select Medicare > Select Network (your plan's Name) > Select > Select Category "Specialty"> Optometrist > Search.
Mental health services	**Inpatient:** • **$125** copay per day for days 1-7 • **$0** copay per day for days 8-90 • Your plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. **Outpatient** (group and individual therapy visits): **$20** to **$100** copay Cost share may vary depending on where service is provided.
Skilled nursing facility (SNF)	• **$0** copay per day for days 1-20 • **$60** copay per day for days 21-100 • Your plan covers up to 100 days in a SNF
Physical Therapy	• **$20** copay
ADDITIONAL BENEFITS	
Ambulance (ground)	**$200** copay per date of service
Ambulance (air)	**20%** of the cost
Transportation	**$0** copay for plan approved location up to unlimited one-way trip(s) per year. The member *must* contact transportation vendor to arrange transportation and should contact Customer Care to be directed to their plan's specific transportation provider.
Medicare Part B drugs	• Chemotherapy drugs: **20%** of the cost • Other Part B drugs: **20%** of the cost

Prescription Drug Benefits

PRESCRIPTION DRUGS

If you don't receive Extra Help for your drugs, you'll pay the following:
Deductible This plan does not have a deductible.

Initial coverage
You pay the following until your total yearly drug costs reach **$4,660**. Total yearly drug costs are the total drug costs paid by both you and our plan. Once you reach this amount, you will enter the Coverage Gap.

Your primary care provider (PCP) will work with you to coordinate the care you need with specialists or certain other providers in the network. This is called a "referral." Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a referral and/or prior authorization from the plan.

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Mail Order Cost-Sharing				
Pharmacy options	**Standard** Walmart Mail, PillPack Other pharmacies are available in our network. To find pharmacy mail order options go to **Humana.com/pharmacyfinder**		**Preferred** CenterWell Pharmacy™	
	30-day supply	**90-day supply***	**30-day supply**	**90-day supply***
Tier 1: Preferred Generic	$5	$15	$0	$0
Tier 2: Generic	$20	$60	$0	$0
Tier 3: Preferred Brand	$47	$141	$40	$110
Tier 4: Non-Preferred Drug	$100	$300	$80	$230
Tier 5: Specialty Tier	33%	N/A	33%	N/A

Retail Cost-Sharing		
Pharmacy options	**Retail** All network retail pharmacies. To find the retail pharmacies near you, go to **Humana.com/pharmacyfinder**	
	30-day supply	**90-day supply***
Tier 1: Preferred Generic	$0	$0
Tier 2: Generic	$0	$0
Tier 3: Preferred Brand	$40	$120
Tier 4: Non-Preferred Drug	$80	$240
Tier 5: Specialty Tier	33%	N/A

Your plan participates in the Insulin Savings Program. You will pay no more than $35 for a one-month (up to a 30-day) supply for Select Insulins through the first three drug payment stages (Deductible (if applicable), Initial Coverage and Coverage Gap) of the Part D benefit. The Insulin Savings Program does not apply to the Catastrophic Coverage stage. To identify which Select Insulins are included within the Insulin Savings Program, look for the ***ISP*** indicator in your Prescription Drug Guide. You are not eligible for this program if you receive "Extra Help".

Your share of the cost for Select Insulins through the Deductible Stage (if applicable), Initial Coverage Stage and Coverage Gap Stage as part of the Insulin Savings Program:

Mail Order Cost-Sharing for Select Insulins				
Pharmacy options	**Standard** Walmart Mail, PillPack Other pharmacies are available in our network. To find pharmacy mail order options, go to **Humana.com/pharmacyfinder**		**Preferred** CenterWell Pharmacy™	
	30-day supply	**90-day supply***	**30-day supply**	**90-day supply***
Tier 2: Generic	**$20**	**$60**	**$0**	**$0**
Tier 3: Preferred Brand	**$35**	**$105**	**$35**	**$95**

Retail Cost-Sharing for Select Insulins		
Pharmacy options	**Retail** All network retail pharmacies. To find the retail pharmacies near you, go to **Humana.com/pharmacyfinder**	
	30-day supply	**90-day supply***
Tier 2: Generic	**$0**	**$0**
Tier 3: Preferred Brand	**$35**	**$105**

If you receive Extra Help for your drugs, you'll pay the following:
Deductible This plan does not have a deductible.

Pharmacy cost-sharing		
For generic drugs (including brand drugs treated as generic), either:	**30-day supply** **$0** copay; or **$1.45** copay; or **$4.15** copay ; or **15%** of the cost	**90-day supply*** **$0** copay; or **$1.45** copay; or **$4.15** copay ; or **15%** of the cost
For all other drugs, either:	**$0** copay; or **$4.30** copay; or **$10.35** copay ; or **15%** of the cost	**$0** copay; or **$4.30** copay; or **$10.35** copay ; or **15%** of the cost

Other pharmacies are available in our network.
*Some drugs are limited to a 30-day supply

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

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Cost sharing may change depending on the pharmacy you choose, when you enter another phase of the Part D benefit and if you qualify for "Extra Help." To find out if you qualify for "Extra Help," please contact the Social Security Office at 1-800-772-1213 Monday — Friday, 7 a.m. — 7 p.m. TTY users should call 1-800-325-0778. For more information on your prescription drug benefit, please call us or access your "Evidence of Coverage" online.

If you reside in a long-term care facility, you pay the same as at a retail pharmacy.

You may get drugs from an out-of-network pharmacy but may pay more than you pay at an in-network pharmacy.

Coverage Gap

After you enter the coverage gap, you pay **25 percent** of the plan's cost for covered brand name drugs and **25 percent** of the plan's cost for covered generic drugs until your out-of-pocket costs total **$7,400** — which is the end of the coverage gap. Not everyone will enter the coverage gap.

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

Tier 2 (Generic) - Select Insulin Drugs

Tier 3 (Preferred Brand) - Select Insulin Drugs

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

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$7,400** you pay the greater of:

- **5%** of the cost, or
- **$4.15** copay for generic (including brand drugs treated as generic) and a **$10.35** copay for all other drugs

Additional Benefits

Medicare-covered foot care (podiatry)	**$20** copay
Medicare-covered chiropractic services	**$20** copay
Medical equipment/ supplies Cost share may vary depending on the service and where service is provided	• Durable medical equipment (like wheelchairs or oxygen): **$0** copay or **20%** of the cost • Medical supplies: **$0** copay • Prosthetics (artificial limbs or braces): **$0** copay • Diabetic monitoring supplies: **$0** copay or **20%** of the cost
Rehabilitation services	• Occupational and speech therapy: **$20** copay • Cardiac rehabilitation: **$20** copay • Pulmonary rehabilitation: **$20** copay

Telehealth services (in addition to Original Medicare)	• Primary care provider (PCP): **$0** copay • Specialist: **$20** copay • Urgent care services: **$0** copay • Substance abuse and behavioral health services: **$0** copay

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More benefits with **your plan**

Enjoy some of these extra benefits included in your plan.
This is a summary of what we cover. It doesn't list every service that we cover or list every limitation or exclusion. The Evidence of Coverage (EOC) provides a complete list of coverage and services. Visit **Humana.com/medicare** to view a copy of the EOC or call **1-800-833-2364**.

Routine foot care

$20 copay per visit for unlimited visits

Deliver Fresh Meal Program

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

Over-the-Counter (OTC) mail order

$60 maximum benefit coverage amount per quarter (3 months) for select over-the-counter health and wellness products.
Unused quarterly funds carry over to the next quarter and expire at the end of the plan year.

Rewards and Incentives

Go365 by Humana® a Rewards and Incentive program for completing certain preventive health screenings and health and wellness activities.

SilverSneakers® fitness program

Basic fitness center membership including fitness classes.

Find out **more**

You can see our plan's **provider and pharmacy directory** at our website at **humana.com/finder/search** or call us at the number listed at the beginning of this booklet and we will send you one.

You can see our plan's **drug guide** at our website at **humana.com/medicaredruglist** or call us at the number listed at the beginning of this booklet and we will send you one.

To find out more about the coverage and costs of Original Medicare, look in the current "Medicare & You" handbook. View it online at http://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

Telehealth services shown are in addition to the Original Medicare covered telehealth. Your cost may be different for Original Medicare telehealth.

Limitations on telehealth services, also referred to as virtual visits or telemedicine, vary by state. These services are not a substitute for emergency care and are not intended to replace your primary care provider or other providers in your network. Any descriptions of when to use telehealth services are for informational purposes only and should not be construed as medical advice. Please refer to your evidence of coverage for additional details on what your plan may cover or other rules that may apply.

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

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Notes

Notes

Important

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, ethnicity, marital status, religion, or language. Discrimination is against the law. Humana and its subsidiaries comply with applicable federal civil rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618.
  If you need help filing a grievance, call **1-877-320-1235** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through their Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019, 800-537-7697 (TDD)**. Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html.**
- **California residents:** You may also call California Department of Insurance toll-free hotline number: **1-800-927-HELP (4357)**, to file a grievance.

Auxiliary aids and services, free of charge, are available to you. 1-877-320-1235 (TTY: 711)

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

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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 1-877-320-1235 (TTY: 711). Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-877-320-1235 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-877-320-1235 (TTY: 711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-877-320-1235 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-877-320-1235 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-877-320-1235 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-877-320-1235 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-877-320-1235 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다 . 통역 서비스를 이용하려면 전화 1-877-320-1235 (TTY: 711) 번으로 문의해 주십시오 . 한국어를 하는 담당자가 도와 드릴 것입니다 . 이 서비스는 무료로 운영됩니다 .

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Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-877-320-1235 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-877-320-1235 (TTY: 711). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-877-320-1235 (TTY: 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-877-320-1235 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugues: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-877-320-1235 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-877-320-1235 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-877-320-1235 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康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、1-877-320-1235 (TTY: 711) 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。

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