2024 | Summary of Benefits

California Institute of Technology

Sponsored by Aetna Medicare Plan (PPO)

Medium PPO, Medicare (C01) PPO, MAPD 1337

Keep in mind

This is just a summary. The complete list of services can be found in the *Schedule of Cost Sharing (SOC)/Evidence of Coverage* (EOC). You can request a copy of the SOC/EOC by contacting:

Member Services

1-888-267-2637 (TTY: 711)

Hours are 8 AM to 9 PM ET, Monday through Friday.

This is a summary of the services we cover from January 1, 2024 through December 31, 2024.

Are you eligible to enroll?

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

- Be entitled to Medicare Part A
- Be enrolled in Medicare Part B
- Live in the plan's service area

Service area: A complete list of service areas can be found in the *Evidence of Coverage* (EOC).

What You Should Know

Primary Care Physician (PCP): You have the option to choose a PCP. When we know who your provider is, we can better support your care.

Referrals: Your plan 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 doctor in order to see you.

Prior Authorizations: Your doctor will work with us to get approval before you receive certain services or drugs. Benefits that may require a prior authorization are listed with an asterisk (*) in the benefits grid.

Plan costs & information	In-network	Out-of-network
Premium	Please contact your former employer/union/trust for more information on your plan premium.	
Annual Deductible	$0	$0
	This is the amount you have to pay out of pocket before the plan will pay its share for your covered Medicare Part A and B services.	
Annual Maximum Out-of-Pocket	$6,700	$10,000 for in- and out-of-network services combined
	The maximum out-of-pocket (MOOP) is the **most you'll pay** for the medical services we cover each year. **It's in place to protect you**. 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.	

PRIMARY BENEFITS	Your costs for in-network care	Your costs for out-of-network care
Hospital Care*		
Inpatient Hospital Care	$500 per stay	25% per stay
	The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	
Observation Stay	Your cost share for Observation Care is based upon the services you receive.	Your cost share for Observation Care is based upon the services you receive.
Frequency:	per stay	per stay
Outpatient Hospital Services and Surgery	15%	25%
Ambulatory Surgery Center	15%	25%
Physician Services		
Primary Care Physician Visits	15%	25%
	Includes the services of an internist, general physician or family practitioner for routine care as well as diagnosis and treatment of an illness or injury and in-office surgery.	
Physician Specialist Visits	15%	25%
Preventive Services		
Abdominal aortic aneurysm screenings	$0	25%
Alcohol misuse screenings and counseling	$0	25%
Annual well visit - one exam every 12 months	$0	25%
Bone mass measurements	$0	25%
Breast exams	$0	25%
Breast cancer screening: mammogram - one baseline mammogram for members age 35-39; one annual mammogram for members age 40 and over	$0	25%

This continues on the next page

PRIMARY BENEFITS	Your costs for in-network care	Your costs for out-of-network care
Preventive Services (continued)		
Cardiovascular behavior therapy	$0	25%
Cardiovascular disease screenings	$0	25%
Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)	$0	25%
Depression screenings	$0	25%
Diabetes screenings	$0	25%
HBV infection screening	$0	25%
Hepatitis C screening tests	$0	25%
HIV screenings	$0	25%
Lung cancer screenings and counseling	$0	25%
Medicare Diabetes Prevention Program (MDPP)	$0	25%
Nutrition therapy services	$0	25%
Obesity behavior therapy	$0	25%
Pelvic exams - one routine GYN visit and Pap smear every 24 months	$0	25%
Prolonged Preventive Services - prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service	$0	25%
Prostate cancer screenings (PSA) - for all male patients aged 50 or older (coverage begins the day after 50th birthday)	$0	25%
Sexually transmitted infections screening and counseling	$0	25%
Tobacco use cessation counseling	$0	25%
“Welcome to Medicare” preventive visit	$0	25%

PRIMARY BENEFITS	Your costs for in-network care	Your costs for out-of-network care
Immunizations		
Flu	$0	$0
Hepatitis B	$0	$0
Pneumococcal	$0	$0
Additional Medicare Preventive Services		
Barium enema - one exam every 12 months	$0	25%
Diabetes self-management training (DSMT)	$0	25%
Digital rectal exam (DRE)	$0	25%
EKG following welcome exam	$0	25%
Glaucoma screening	$0	25%
Emergency and Urgent Medical Care		
Emergency Care (includes services worldwide)	$90 (waived if admitted immediately)	$90 (waived if admitted immediately)
Urgent Care (includes services worldwide)	$35	$35
Diagnostic Procedures*		
Diagnostic Radiology (CT scans)	15%	25%
Diagnostic Radiology (other than CT scans)	15%	25%
Diagnostic Testing and Procedures	15%	25%
Lab Services	15%	25%
Outpatient X-rays	15%	25%
Hearing Services		
Hearing Exam (routine)	$0 Coverage: one exam every twelve months	25%
Hearing Exam (Medicare-covered)	15%	25%
Hearing Aid Reimbursement	$500 once every 36 months	

PRIMARY BENEFITS	Your costs for in-network care	Your costs for out-of-network care
Dental Services*		
Dental Services	15%	25%
	Medicare-covered benefits only	
Vision Services		
Eye Exam (routine)	$0	25%
	Coverage: one exam every twelve months	
Diabetic Eye Exam	$0	25%
Eye Exam (Medicare-covered)	15%	25%
Mental Health Services*		
Inpatient Mental Health Care	$500 per stay	25% per stay
	The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	
Outpatient Mental Health Care	15% (individual sessions)	25% (individual sessions)
	15% (group sessions)	25% (group sessions)
Partial Hospitalization	15%	25%
Inpatient Substance Abuse	$500 per stay	25% per stay
	The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	
Outpatient Substance Abuse	15% (individual sessions)	25% (individual sessions)
	15% (group sessions)	25% (group sessions)
Skilled Nursing Services*		
Skilled Nursing Facility (SNF) Care	0% per day, days 1-20; 15% per day, days 21-100	25% per day, days 1-100

This continues on the next page

PRIMARY BENEFITS	Your costs for in-network care	Your costs for out-of-network care
Skilled Nursing Services* (continued)		
	Limited to 100 days per Medicare benefit period. The member cost sharing applies to covered benefits incurred during a member's inpatient stay. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.	
Outpatient Rehabilitation Services		
Occupational Therapy Rehabilitation Services	15%	25%
Physical and Speech Therapy Rehabilitation Services	15%	25%
Ambulance* and Transportation Services		
Ambulance Services	15%	25%
	Prior authorization rules may apply for	

This continues on the next page

PRIMARY BENEFITS	Your costs for in-network care	Your costs for out-of-network care
Ambulance* and Transportation Services (continued)		
	non-emergency transportation services received in-network. Your network provider is responsible for requesting prior authorization. Our plan recommends pre-authorization of non-emergency transportation services when provided by an out-of-network provider.	
Transportation (non-emergency)	Covered	Not Covered
	Coverage: up to 24 one-way rides per year with 60 miles allowed per trip.	
Medicare Part B Prescription Drugs*		
Medicare Part B Prescription Drugs	$0	25%
***These benefits may require prior authorization.**		

Medicare Part D Prescription Drugs

Part D drugs are covered. See PHARMACY - PRESCRIPTION DRUG BENEFITS section on page 14 for your plan benefits at each Part D phase, including cost share and other important pharmacy benefit information.

ADDITIONAL PROGRAMS AND SERVICES (Medicare-covered)	Your costs for in-network care	Your costs for out-of-network care
ADDITIONAL PROGRAMS AND SERVICES (Medicare-covered)		
Acupuncture Services	15%	25%
	Medicare-covered benefits only	
Allergy Shots	$0	25%
Allergy Testing	15%	25%
Blood	$0	25%
	All components of blood are covered beginning with the first pint.	
Cardiac Rehabilitation Services	15%	25%
Chiropractic Services*	15%	25%
	Medicare-covered benefits only	
Diabetic Supplies*	$0	25%
	Includes supplies to monitor your blood glucose from LifeScan, or from a non-preferred provider when a prior authorization is received.	
Durable Medical Equipment (DME)*	15%	25%
Home Health Agency Care*	$0	25%
Hospice Care	Covered by Original Medicare at a Medicare-certified hospice.	
Intensive Cardiac Rehabilitation Services	15%	25%
Medical Supplies*	Your cost share is based upon the provider of services	Your cost share is based upon the provider of services
Outpatient Dialysis Treatments*	15%	15%
Podiatry Services	15%	25%
	Medicare-covered benefits only	

This continues on the next page

ADDITIONAL PROGRAMS AND SERVICES (Medicare-covered)	Your costs for in-network care	Your costs for out-of-network care
ADDITIONAL PROGRAMS AND SERVICES (Medicare-covered)(Continued)		
Prosthetic Devices*	15%	25%
Pulmonary Rehabilitation Services	15%	25%
Supervised Exercise Therapy (SET) for PAD	15%	25%
Radiation Therapy*	15%	25%
***These benefits may require prior authorization.**		

ADDITIONAL PROGRAMS (not covered by Original Medicare)	Your costs for in-network care	Your costs for out-of-network care
ADDITIONAL PROGRAMS (not covered by Original Medicare)		
Fitness Program	SilverSneakers®	
Healthy Lifestyle Coaching Program	Offered through Healthyroads to provide members with ongoing support and coaching to make positive changes in their health. Healthy Lifestyle Coaching includes coaching sessions, online tools and educational resources.	
Healthy Rewards	Covered	
Meals	$0 After discharge from an inpatient stay to your home, you may be eligible to receive up to 14 home-delivered meals over a 7-day period.	
Resources for Living®	This program is offered to help you locate resources for everyday needs.	
Acupuncture Services (non-Medicare covered)	15%	25%
	Supplemental acupuncture services are covered for up to ten visits every year per year under the following circumstance(s): in lieu of anesthesia.	
Cervical and Vaginal Cancer Screening - Additional Visit	$0	25%
	We cover one exam every twelve months.	
Teladoc™	$0	
	Telemedicine services with a Teladoc provider. State mandates may apply.	
Telehealth Mental Health services provided by MD live	$0	

This continues on the next page

ADDITIONAL PROGRAMS (not covered by Original Medicare)	Your costs for in-network care	Your costs for out-of-network care
ADDITIONAL PROGRAMS (not covered by Original Medicare) (continued)		
Telehealth PCP	15%	25%
Telehealth Specialist	15%	25%
Telehealth Occupational Therapy Service	15%	25%
Telehealth PT and SP Services	15%	25%
Telehealth Other Health Care Providers	15%	25%
Telehealth Individual Mental Health*	15%	25%
Telehealth Group Mental Health*	15%	25%
Telehealth Individual Psychiatric Services*	15%	25%
Telehealth Group Psychiatric Services*	15%	25%
Telehealth Individual Substance Abuse Services*	15%	25%
Telehealth Group Substance Abuse Services*	15%	25%
Telehealth Kidney Disease Education Services	$0	25%
Telehealth Diabetes Self-Management Training	$0	25%
Telehealth Opioid Treatment Program Services*	15%	25%
Telehealth Urgent Care	$35	$35
Physical Exam	$0	25%
	A routine physical exam is offered once per calendar year.	
In-Home Support Services	In-Home Support Provides in home help for every day needs and activities of daily living.	
Coverage Type	Post Discharge	
Number of Hours	16 hours	
Frequency	per discharge	
Vendor	The Helper Bees	
Compression Stockings	$0	25%

This continues on the next page

ADDITIONAL PROGRAMS (not covered by Original Medicare)	Your costs for in-network care	Your costs for out-of-network care
ADDITIONAL PROGRAMS (not covered by Original Medicare) (continued)		
Wigs	$0	$0
Maximum	$375	
Frequency	every year	
***These benefits may require prior authorization.**		

PHARMACY - PRESCRIPTION DRUG BENEFITS

Deductible	**$0**
Pharmacy Network	**P1**

Your Medicare Part D plan uses the network above. To find a network pharmacy, you can visit our website (AetnaRetireePlans.com).

Formulary (Drug List)	**Comprehensive Plus**

INITIAL COVERAGE LIMIT (ICL)	**$5,030**

The Initial Coverage Limit includes the plan deductible, if applicable.

This is your cost sharing until covered Medicare prescription drug expenses reach the Initial Coverage Limit (and after the deductible is satisfied, if your plan has a deductible):

3 Tier plan	30-day Supply through Network Retail		90-day Supply through Network Retail or Mail		
	Preferred	**Standard**	**Preferred Retail**	**Preferred Mail**	**Standard Retail or Mail**
Tier 1 Generic drugs	You pay $4	You pay $5	You pay $8	You pay $8	You pay $10
Tier 2 Preferred Brand drugs	You pay $30	You pay $30	You pay $60	You pay $60	You pay $60
Tier 3 Non-Preferred Brand drugs	You pay $60	You pay $60	You pay $120	You pay $120	You pay $120

You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.

If you reside in a long-term care facility, your cost share is the same as a 30-day supply at a retail

pharmacy and you may receive up to a 31-day supply.

COVERAGE GAP

The Coverage Gap starts once covered Medicare prescription drug expenses have reached the Initial Coverage Limit. Your cost sharing for covered Part D drugs between the Initial Coverage Limit until you reach $8,000 in prescription drug expenses is indicated below.

Your former employer/union/trust provides additional coverage during the Coverage Gap stage for covered drugs. This means that you will generally continue to pay the same amount for covered drugs throughout the Coverage Gap stage of the plan as you paid in the Initial Coverage stage.
Coinsurance-based cost-sharing, if applicable, is applied against the overall cost of the drug, prior to the application of any discounts or benefits.

CATASTROPHIC COVERAGE

Catastrophic Coverage	You pay $0 for all covered Part D drugs.

Catastrophic Coverage benefits start once $8,000 in true out-of-pocket costs is incurred.

REQUIREMENTS

Precertification	Applies
Step Therapy	Applies

NON-PART D SUPPLEMENTAL BENEFIT

- Agents used for cosmetic purposes or hair growth
- Agents used to promote fertility
- Agents when used for anorexia, weight loss, or weight gain
- Agents when used for the symptomatic relief of cough and colds
- Agents when used for the treatment of sexual or erectile dysfunction (ED)
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations

MEDICAL DISCLAIMERS

For more information about Aetna plans, go to AetnaRetireePlans.com or call Member Services toll-free at **1-888-267-2637** (TTY: 711). Hours are 8 AM to 9 PM ET, Monday through Friday.

Not all PPO plans are available in all areas.

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.

In case of emergency, you should call 911 or the local emergency hotline. Or you should go directly to an emergency care facility.

The complete list of services can be found in the *Evidence of Coverage* (EOC). You can request a copy of the EOC by contacting Member Services at **1-888-267-2637** (TTY: 711). Hours are 8 AM to 9 PM ET, Monday through Friday.

The following is a partial list of what isn't covered or limits to coverage under this plan:

- Services that are not medically necessary unless the service is covered by Original Medicare or otherwise noted in your *Evidence of Coverage*.
- Plastic or cosmetic surgery unless it is covered by Original Medicare
- Custodial care
- Experimental procedures or treatments that Original Medicare doesn't cover
- Outpatient prescription drugs unless covered under Original Medicare Part B

You may pay more for out-of-network services. Prior approval from Aetna is required for some network services. For services from a non-network provider, prior approval from Aetna is recommended. Providers must be licensed and eligible to receive payment under the federal Medicare program and willing to accept the plan.

Out-of-network/non-contracted providers are under no obligation to treat Aetna 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.

Aetna will pay any non-contracted provider (that is eligible for Medicare payment and is willing to accept the Aetna Medicare Plan) the same as they would receive under Original Medicare for Medicare-covered services under the plan.

PHARMACY DISCLAIMERS

Aetna's retiree pharmacy coverage is an enhanced Part D Employer Group Waiver Plan that is offered as a single integrated product. The enhanced Part D plan consists of two components: basic Medicare Part D benefits and supplemental benefits. Basic Medicare Part D benefits are offered by Aetna based on our contract with CMS. We receive monthly payments from CMS to pay for basic Part D benefits. Supplemental benefits are non-Medicare benefits that provide enhanced coverage beyond basic Part D. Supplemental benefits are paid for by plan sponsors or members and may include benefits for non-Part D drugs. Aetna reports claim information to CMS according to the source of applicable payment (Medicare Part D, plan sponsor or member).

The Aetna Medicare pharmacy network includes limited lower-cost, preferred pharmacies in Suburban Arizona, Rural California, Urban Kansas, Rural Michigan, Suburban Michigan, Urban Michigan, Urban Missouri, Rural North Dakota, Suburban Utah, Suburban West Virginia and Suburban Wyoming. 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, please call **1-888-267-2637** (TTY: 711) or consult the online pharmacy directory at AetnaRetireePlans.com.

The formulary and/or pharmacy network may change at any time. You will receive notice when necessary. You must use network pharmacies to receive plan benefits except in limited, non-routine circumstances as defined in the EOC. In these situations, you are limited to a 30-day supply.

Pharmacy clinical programs such as precertification, step therapy and quantity limits may apply to your prescription drug coverage.

Specialty pharmacies fill high-cost specialty drugs that require special handling. Although specialty pharmacies may deliver covered medicines through the mail, they are not considered "mail-order pharmacies." Therefore, most specialty drugs are not available at the mail-order cost share.

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 7-10 days. You can call 1-866-241-0357 (TTY users should call 711), 24 hours a day, seven days a week, if you do not receive your mail-order drugs within this timeframe. You may have the option to sign up for automated mail-order delivery.

The Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs. The amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and moves you through the Coverage Gap.

PHARMACY DISCLAIMERS

Coinsurance-based cost sharing is applied against the overall cost of the drug, prior to the application of any discounts or benefits.

There are three general rules about drugs that Medicare drug plans will not cover under Part D. This plan cannot:

- Cover a drug that would be covered under Medicare Part A or Part B.
- Cover a drug purchased outside the United States and its territories.
- Generally cover drugs prescribed for "off label" use (any use of the drug other than indicated on a drug's label as approved by the Food and Drug Administration) unless supported by criteria included in certain reference books like the American Hospital Formulary Service Drug Information, the DRUGDEX Information System and the USPDI or its successor.

Additionally, by law, the following categories of drugs are not normally covered by a Medicare prescription drug plan unless we offer enhanced drug coverage for which an additional premium may be charged. These drugs are not considered Part D drugs and may be referred to as "exclusions" or "non-Part D drugs." These drugs include:

- Drugs used for the treatment of weight loss, weight gain or anorexia
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Outpatient drugs that the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- Drugs used to promote fertility
- Drugs used to relieve the symptoms of cough and colds
- Non-prescription drugs, also called over-the-counter (OTC) drugs
- Drugs when used for the treatment of sexual or erectile dysfunction

Your plan includes supplemental coverage for some drugs not typically covered by a Medicare Part D plan. Refer to the "Non-Part D Supplemental Benefit" section in the chart above. Non-Part D drugs covered under the non-Part D supplemental drug benefit can be purchased at the appropriate plan copay. Copayments and other costs for these prescription drugs will not apply toward the deductible, initial coverage limit or true out-of-pocket threshold. Some drugs may require prior authorization before they are covered under the plan.

PLAN DISCLAIMERS

Aetna Medicare is a PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal.

Plans are offered by Aetna Health Inc., Aetna Health of California Inc., Aetna Life Insurance Company and/or their affiliates (Aetna). 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.

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.

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

To send a complaint to Aetna, call the Plan or the number on your member ID card. To send a compliant 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.

If there is a difference between this document and the *Evidence of Coverage* (EOC), the EOC is considered correct.

You can read the *Medicare & You 2024* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

You can also visit our website at AetnaRetireePlans.com . As a reminder, our website has the most up-to-date information about our provider network (Provider Directory) and our list of covered drugs (Formulary/Drug List).

*****This is the end of this plan benefit summary*****

Y0001_GRP_5559_2024_M

September 2024

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 1-800-307-4830. Someone who speaks English/Language 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 1-800-307-4830. 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 1-800-307-4830。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 1-800-307-4830。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 1-800-307-4830. 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 1-800-307-4830. 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 1-800-307-4830. 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 1-800-307-4830. 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 1-800-307-4830. 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 1-800-307-4830. 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 1-800-307-4830 . 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 1-800-307-4830. 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 1-800-307-4830. 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 1-800-307-4830. 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 1-800-307-4830. 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 1-800-307-4830. 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、1-800-307-4830. 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 1-800-307-4830. E hiki ana i kekahi mea ʻōlelo Pelekānia/ʻŌlelo ke kōkua iā ʻoe. He pōmaikaʻi manuahi kēia.

Y0001_NR_30475b_2023_C

Form CMS-10802
(Expires 12/31/25)

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, your 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. Your health plan also provides language assistance services, free of charge, for people with limited English proficiency. If you need these services, call Customer Service at the phone number 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。