2025 Summary of Benefits

California Institute of Technology

Sponsored by Aetna Medicare Plan (PPO)
Value PPO, Medicare (V02) PPO, MAPD 1201

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, 2025 through December 31, 2025.

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	$3,400	$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	$200 per day, days 1-7; $0 unlimited additional days	30% 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	$185	30%
Ambulatory Surgery Center	$185	30%
Physician Services		
Primary Care Physician Visits	$15	30%
	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	$40	30%

PRIMARY BENEFITS	Your costs for in-network care	Your costs for out-of-network care
Preventive Services		
Medicare-covered Preventive Services • Abdominal aortic aneurysm screenings • Alcohol misuse screenings and counseling • Annual Wellness visit • Breast cancer screening: mammogram • Cardiovascular behavior therapy • Cardiovascular disease screenings • Cervical and vaginal cancer screenings • Depression screenings • Diabetes screenings • HIV screenings • Lung cancer screenings and counseling • Medical nutrition therapy • Obesity behavior therapy • Prostate cancer screenings (PSA) • Sexually transmitted infections screenings and counseling • Tobacco use cessation counseling • Welcome to Medicare preventive visit	$0	30%
Medicare-covered Preventive Services (continued)		
• Bone mass measurements	$0	30%
• Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)	$0	30%
• Medicare Diabetes Prevention Program	$0	$0
Immunizations • Flu • Hepatitis B • Pneumococcal	$0	$0
Additional Medicare Preventive Services • Barium enema • Diabetes self-management training • Digital rectal exam • EKG following welcome exam • Glaucoma screening	$0	30%

PRIMARY BENEFITS	Your costs for in-network care	Your costs for out-of-network care
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)	$50	$50
Diagnostic Procedures*		
Diagnostic Radiology (CT scans)	$200	30%
Diagnostic Radiology (other than CT scans)	$200	30%
Diagnostic Testing and Procedures	$35	30%
Lab Services	$35	30%
Outpatient X-rays	$35	30%
Hearing Services		
Hearing Exam (routine)	$0	30%
	Coverage: one exam every twelve months	
Hearing Exam (Medicare-covered)	$40	30%
Hearing Aid Reimbursement	$500 once every 36 months	
Dental Services*		
Dental Services	$40	30%
	Medicare-covered benefits only	
Vision Services		
Eye Exam (routine)	$0	30%
	Coverage: one exam every twelve months	
Diabetic Eye Exam	$0	30%
Eye Exam (Medicare-covered)	$40	30%

PRIMARY BENEFITS	Your costs for in-network care	Your costs for out-of-network care
Mental Health Services*		
Inpatient Mental Health Care	$200 per day, days 1-7; $0 unlimited additional days	30% per stay
	The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	
Outpatient Mental Health Care	$40 (individual sessions)	30% (individual sessions)
	$40 (group sessions)	30% (group sessions)
Partial Hospitalization Services and Intensive Outpatient Services	$40	30%
Inpatient Substance Use Disorder Services	$200 per day, days 1-7; $0 unlimited additional days	30% per stay
	The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	
Outpatient Substance Use Disorder Services	$40 (individual sessions)	30% (individual sessions)
	$40 (group sessions)	30% (group sessions)
Skilled Nursing Services*		
Skilled Nursing Facility (SNF) Care	$0 per day, days 1-20; $172 per day, days 21-100	30% per day, days 1-100
	Limited to 100 days per Medicare benefit period. See the *Evidence of Coverage* for details on the benefit periods.	
Outpatient Rehabilitation Services		
Occupational Therapy Rehabilitation Services	$40	30%
Physical and Speech Therapy Rehabilitation Services	$40	30%

PRIMARY BENEFITS	Your costs for in-network care	Your costs for out-of-network care
Ambulance* and Transportation Services		
Ambulance Services	$100	30%
	Prior authorization rules may apply for 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	20%	30%

***These benefits may require prior authorization.**

Medicare Part D Prescription Drugs

Part D drugs are covered. See PHARMACY - PRESCRIPTION DRUG BENEFITS section on page 11 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
Acupuncture Services	$40	30%
	Medicare-covered benefits only	
Allergy Shots	20%	30%
Allergy Testing	$40	30%
Blood NMC	$0	30%
	All components of blood are covered beginning with the first pint.	
Cardiac Rehabilitation Services	$40	30%
Chiropractic Services*	$20	30%
	Medicare-covered benefits only	
Diabetic Supplies*	$0	30%
	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)*	20%	30%
Home Health Agency Care*	$0	30%
Hospice Care	Covered by Original Medicare at a Medicare-certified hospice.	
Intensive Cardiac Rehabilitation Services	$40	30%
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*	20%	20%
Podiatry Services	$40	30%
	Medicare-covered benefits only	
Prosthetic Devices*	20%	30%
Pulmonary Rehabilitation Services	$20	30%
Supervised Exercise Therapy (SET) for PAD	$20	30%
Radiation Therapy*	$60	30%

***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
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)	$40	30%
	Supplemental acupuncture services are covered for up to ten visits every year per year under the following circumstance(s): in lieu of anesthesia.	
Frequency	ten visits every year	ten visits every year
Cervical and Vaginal Cancer Screening - Additional Visit	$0	30%
	We cover one exam every twelve months.	
Teladoc™	$0	
	Telemedicine services with a Teladoc provider. State mandates may apply.	
Telehealth PCP	$15	30%
Telehealth Specialist	$40	30%
Telehealth Occupational Therapy Service	$40	30%
Telehealth PT and SP Services	$40	30%
Telehealth Other Health Care Providers	$40	30%
Telehealth Individual Mental Health*	$40	30%
Telehealth Group Mental Health*	$40	30%
Telehealth Individual Psychiatric Services*	$40	30%
Telehealth Group Psychiatric Services*	$40	30%
Telehealth Individual Substance Use Disorder Services*	$40	30%
Telehealth Group Substance Use Disorder Services*	$40	30%
Telehealth Kidney Disease Education Services	$0	30%
Telehealth Diabetes Self-Management Training	$0	30%
Telehealth Opioid Treatment Program Services*	$40	30%

ADDITIONAL PROGRAMS (not covered by Original Medicare)	Your costs for in-network care	Your costs for out-of-network care
Telehealth Urgent Care	$50	$50
Routine Physical	$0	30%
	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	
The benefit mentioned is part of a special supplemental program for the chronically ill. Eligibility is determined by whether you have a chronic condition associated with this benefit. Standards may vary for each benefit. Conditions include Hypertension, Hyperlipidemia, Diabetes, Cardiovascular Disorders, Cancer. Other eligible conditions may apply. Contact us to confirm your eligibility for these benefits.		
Compression Stockings	$0	30%
Maximum	unlimited singles/pairs	unlimited singles/pairs
Frequency	every year	every year
Wigs	$0	$0
Maximum	$375	
Frequency	every year	

***These benefits may require prior authorization.**

PHARMACY - PRESCRIPTION DRUG BENEFITS

Deductible **$260**

Prescription drug calendar-year deductible must be satisfied before any Medicare prescription drug benefits are paid. Covered Medicare prescription drug expenses will accumulate toward the pharmacy deductible.

Pharmacy Network **S2**

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

Formulary (Drug List) **Classic**

INITIAL COVERAGE PHASE

This is your cost sharing after the deductible is satisfied until covered Medicare prescription drug expenses reach the annual out-of-pocket limit:

	30-day Supply through Network Retail	90-day Supply through Network Retail or Mail	
3 Tier plan	**Standard**	**Preferred Mail**	**Standard Retail or Mail**
Tier 1 Generic drugs - Includes low-cost generic drugs	You pay 20% for your drug	You pay 20% for your drug	You pay 20% for your drug
Tier 2 Preferred Brand drugs - Includes brand drugs and some high-cost generic drugs	You pay 25% for your drug	You pay 25% for your drug	You pay 25% for your drug
Tier 3 Non-Preferred drugs - Includes non-preferred brand drugs and some higher-cost generic drugs	You pay 45% for your drug	You pay 45% for your drug	You pay 45% for your drug

You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier even if you haven't paid your deductible.

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.

CATASTROPHIC COVERAGE

Catastrophic Coverage benefits start once the annual out-of-pocket threshold of $2,000 for covered Part D prescription drugs is reached. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

CATASTROPHIC COVERAGE

- During this payment stage, you pay nothing for your covered Part D drugs.
- You may have cost sharing for drugs that are covered under our Non-Part D Supplemental Benefit

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 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.

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 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. Members may have the option to sign up for automated mail-order delivery.

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 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.

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 2025* 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_2025_M

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。