Medicare Prescription Changes for 2025

Medicare significantly improved prescription drug coverage in 2025, making medications more affordable and predictable for beneficiaries.

Key Updates:

✅ Annual Out-of-Pocket Cap: Prescription drug costs are now capped at $2,000 per person annually.

✅ No More Donut Hole: The coverage gap, or "donut hole," has been eliminated, reducing unexpected costs.

✅ Monthly Payment Option: Medicare now allows you to spread your prescription costs over monthly payments, making expenses more manageable.

How to Take Advantage of These Benefits:

📌 To enroll in the monthly payment option, complete the attached form for your carrier or call your plan's customer service.

📌 If not using mail-order prescriptions, your Medicare plan will coordinate with your pharmacy to ensure you receive your medications at the agreed-upon price. Billing will be handled between your plan and the pharmacy.

💡 Take advantage of these benefits to manage your prescription costs effectively! If you have questions or need assistance, feel free to reach out.

425-530-5273
blake.caldwell@healthmarkets.com

Medicare Prescription Payment Plan
Participation request form

The Medicare Prescription Payment Plan is a voluntary payment option that works with your current drug coverage to help you manage your out-of-pocket Medicare Part D drug costs by spreading them across the calendar year (January – December). **This payment option may help you manage your expenses, but it doesn't save you money or lower your drug costs.**

This payment option might not be the best choice for you if you get help paying for your prescription drug costs through programs like Extra Help from Medicare or a State Pharmaceutical Assistance Program (SPAP). Call your plan for more information.

Complete all fields unless marked optional

FIRST name:	LAST name:	MIDDLE initial (optional):

Medicare Number: _____-_____-_____

Birth date: (MM/DD/YYYY) (___/___/_____)	Phone number: ( )

Permanent residence street address (don't enter a P.O. Box unless you're experiencing homelessness):

City:	County (Optional):	State:	ZIP code:

Mailing address, if different from your permanent address (P.O. Box allowed):
Street Address:

City: State: ZIP code:

Read and sign below

- I understand this form is a request to participate in the Medicare Prescription Payment Plan. Aetna Medicare will contact me if they need more information.
- I understand that signing this form means that I've read and understand this form and the attached terms and conditions.
- Aetna Medicare will send me a notice to let me know when my participation in the Medicare Prescription Payment Plan is active. Until then, I understand that I'm not a participant in the Medicare Prescription Payment Plan.

Signature:	**Date:**

If you're completing this form for someone else, complete the section below. Your signature certifies that you're authorized under State law to fill out this participation form and have documentation of this authority available if Medicare asks for it.

Name:	Address (Street, City, State, & ZIP code):
Phone number: ( )	Relationship to participant:

How to submit this form

You can also complete the participation request form online, or call us at the number on your ID card to submit your request via telephone.

Submit your completed form to:

Medicare Prescription Payment Plan
P.O. Box 7
Pittsburgh, PA 15230

If you have questions or need help completing this form, call us at the number on your ID card, TTY users can call 711, 24 hours a day, 7 days a week.

Medicare Prescription Payment Plan Terms and Conditions

The Medicare Prescription Payment Plan is a voluntary program that allows you to spread your out-of-pocket costs for covered Part D drugs across the remaining months of the plan year. The program does not affect your total prescription cost. Any applicable plan premiums are billed and should be paid separately from your Prescription Payment Plan billing statement. By opting in to the program, you (or your authorized representative) are indicating you understand these Medicare Prescription Payment Plan terms and conditions. You are agreeing to be financially responsible for all amounts billed under the program. If you do not pay the amounts due under the program you will be terminated from the program, and will not be allowed to opt in again until the amounts owed are repaid in full. You can choose to opt out of the program at any time, however any outstanding amounts owed will continue to be billed and must be paid.

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.

Humana®

Medicare Prescription Payment Plan Participation Request Form

The Medicare Prescription Payment Plan is an **optional** payment option that works with your current drug coverage to help you manage your out-of-pocket Medicare Part D drug costs by spreading them across the calendar year (January-December). **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

This payment option might not be the best choice for you if you get help paying for your prescription drug costs through programs like Extra Help from Medicare or a State Pharmaceutical Assistance Program (SPAP). Call your plan for more information.

Complete all fields unless marked optional

First name: _____ Last name: _____ Middle initial (optional): _____

Medicare Number---------- _____ | Humana ID: H _____

Birth date: (MM/DD/YYYY)
(_____/_____/_____)

Phone number:
(_____) _____

Permanent residence street address (don't enter a P.O. Box unless you're experiencing homelessness):

_____

City: _____ | County (optional): _____ | State: _____ | Zip code: _____

Mailing address, if different from your permanent address (P.O. Box allowed):

Address: _____

City: _____ State: _____ ZIP code: _____

Read and sign below

- I understand this form is a request to participate in the Medicare Prescription Payment Plan. Humana will contact me if they need more information.
- I understand that signing this form means that I've read and understand the form and the attached terms and conditions.
- **Humana will send me a notice to let me know when my participation in the Medicare Prescription Payment Plan is active.** Until then, I understand that I'm not a participant in the Medicare Prescription Payment Plan.

Signature: _____

Date: _____

If you're completing this form for someone else, complete the section below. Your signature certifies that you're authorized under State law to fill out this participation form and have documentation of this authority available if Medicare asks for it.

Name:	Address (Street, City, State, Zip code):
Phone number: (_____) _____	Relationship to participant: _____

How to submit this form

You can complete the participation request form online by visiting **Humana.com/MPPP** or scan this QR code to opt into the program.

To submit your request via telephone, call us at the number on the back of your ID card.

For questions or help completing this form, you can call us seven days a week, from 8 a.m. – 8 p.m. However, please note that our automated phone system may answer your call during weekends and holidays.

To submit this form by mail, send to:

Medicare Prescription Payment Plan
PO Box 14540
Lexington, KY 40512-4540

Humana.

Medicare Prescription Payment Plan Terms and Conditions

These terms and conditions ("Terms") govern the Humana Medicare Prescription Payment Plan (“the Program”), including, as available, participation in the Program. By participating in the Program, you agree to be bound by these Terms. Humana may change these Terms based on guidelines from The Center for Medicare and Medicaid Services (“CMS”) and reserve the right to change these Terms, but will notify you of any changes, as required.

Participation

Participation in the Program is voluntary and may only extend to the end of each plan year. You will need to be an active Humana or member with a Part D prescription drug benefit plan. You will also need to have paid any past due balances on any participation in the Program from a previous year to Humana if your participation in the Program was previously terminated due to past due and unpaid balances.

If you are eligible to participate in the Program, you can opt-in and opt-out at any time within the plan year.

Billing

By participating in the Program, you agree to pay all covered Part D prescription drug costs incurred up to the maximum out of pocket amount of $2000 (could be less depending on your plan), as permitted by law, spread over the remaining months of the plan year. You will only be billed once a month for Part D drug prescriptions obtained during the prior month, spread over the remaining months of the year. You understand that your payments may increase every billing cycle with each additional Part D drug that you obtain. At all times while you participate in the Program, you will no longer pay at point-of-sale at the pharmacy (including mail order and specialty pharmacies) but will be billed for the covered part D prescriptions you obtained at the pharmacy by your plan, Humana. If you obtained Part D drugs from the pharmacy in December, your last bill for the plan year will be received in January of the following plan year.

You will have the option to pay through a secure web portal, by phone or through the mail. Information on how to pay your balance will be provided on your monthly invoice.

Termination

Participation in the Program is not guaranteed. Humana will notify you if you miss a payment and will provide any past due balances on the next statement. Failure to pay the minimum balance due each month will result in a two-month grace period before you are terminated from the Program. If the minimum balance due and any past due payments are not paid within the two-month grace period, you will be terminated from the Program. Moving forward, you will pay for any additional prescriptions at point of sale at the pharmacy. Humana will notify you when your participation has been terminated and Humana will continue to bill you for any past due balances owed while you participated in the Program. Humana reserves all legal rights to collect unpaid balances from you. You may re-enter the Program with Humana once you pay any past due balances.

You will be removed from the Program if you switch Part D prescription drug plans during a current plan year, including if you switch plans within Humana. You will need to opt-in again to participate in the Program under

Humana.

your new Part D plan. If you switch Part D prescription drug plans, you will owe any outstanding balances to Humana owed during your participation in the Program and will need to opt-in with your new prescription drug plan if you want to continue participating in the Program. Balances are not carried over to new prescription drug plans.

If you continue to pay your required premiums, you will not be removed from your Humana insurance plan if you are terminated from the Program.

Communications

By participating in the Program, you agree to receive telephonic and mail communications regarding your participation status, billing statements and overdue notifications. You may receive electronic communications which include payment reminders, payment confirmations, auto-pay confirmation and status if you have an email on file with Humana. You will have the right to unsubscribe from email notifications pertaining to this program. By unsubscribing you will no longer receive electronic payment reminders and account status and billing confirmations.

Disputes

If you disagree with our decisions, you have the right to ask Humana to review our decision. You must submit your dispute within 60 days after the incident or event that caused the grievance.

You may mail, fax, or call the Grievance Department at:
Humana Grievances and Appeals Dept.
P.O. Box 14165
Lexington, KY 40512-4165
Customer Care: **800-457-4708 (TTY:711)**
Fax: **800-949-2961**

Puerto Rico Plan members use:
Humana Grievances and Appeals Dept.
P.O. Box 195560
San Juan, PR 00919-5560
Customer Care: **866-773-5959**
Fax: **800-595-0462**

To submit a grievance online:

- Go to **Humana.com/exceptions** and complete and submit the online form, or
- Sign into your MyHumana account and access the grievance form on the Documents and Forms page.

Release of information:

By joining this Medicare Prescription Payment Plan (the Program), you acknowledge that Humana and vendors on its behalf may share your information with Medicare, who may use it to track your participation, to make

payments, and for other purposes allowed by federal law that authorize the collection of this information (See Privacy Act Statement below).

Privacy Act Statement:

The Centers for Medicare and Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange participation data from Medicare beneficiaries as specified in the System of Records Notice (SORN) “Medicare Advantage Prescription Drug (MARx)”, System No. 09-70-0588**. Your response on this form is voluntary and will not affect enrollment in your Humana Prescription Drug Plan.**

Humana works with a third-party supplier ("Supplier") to help provide the Program, including to provide a website to view your account, schedule payments, make payments, and review payment history. Supplier owns the website, and grants you a non-transferable, non-exclusive, revocable, limited license to use the website. SUPPLIER PROVIDES THE WEBSITE ON AN "AS-IS" AND "AS AVAILABLE" BASIS AND EXPRESSLY DISCLAIMS ALL WARRANTIES OF ANY KIND, WHETHER EXPRESS, IMPLIED, OR STATUTORY. If you suspect that your account or password has been compromised, please promptly notify Humana.

Medicare Prescription Payment Plan Participation Request Form

The Medicare Prescription Payment Plan is a voluntary payment option that works with your current drug coverage to help you manage your out-of-pocket Medicare Part D drug costs by spreading them across the calendar year (January–December). **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

This payment option might not be the best choice for you if you get help paying for your prescription drug costs through programs like Extra Help from Medicare or a State Pharmaceutical Assistance Program (SPAP). Call your plan for more information.

Scan this code to save time and complete your request online.

Complete all fields unless marked optional.

First name	Last name	Middle initial (optional)

Medicare number

Birth date (MM/DD/YYYY)	Phone number
(_____ / _____ / _____)	( )

Permanent residence street address (don't enter a P.O. Box unless you're experiencing homelessness)

City	County (optional)	State	ZIP code

Mailing address, if different from your permanent address (P.O. Box allowed)

Address	City	State	ZIP code

Read and sign below

- I understand this form is a request to participate in the Medicare Prescription Payment Plan. My plan will contact me if they need more information.
- I understand that signing this form means that I've read and understand the form and the terms and conditions listed below.
- **My plan will send me a letter to let me know when my participation in the Medicare Prescription Payment Plan is active.** Until then, I understand that I'm not a participant in the Medicare Prescription Payment Plan.

Signature	**Date**

Participation terms and conditions

If your request is approved:

- You will no longer pay the pharmacy when you fill your Medicare-covered Part D prescriptions. Your plan will pay your cost share and send you a monthly bill.
- You understand that your Medicare Prescription Payment Plan monthly billing amounts may vary.
- You understand that failing to pay your Medicare Prescription Payment Plan monthly bill in full may result in your removal from the program.
- You may opt out of this program at any time and go back to paying the pharmacy directly for your Medicare-covered Part D medications. You will still be responsible to pay any outstanding Medicare Prescription Payment Plan balance.

If you're completing this form for someone else, complete the section below. Your signature certifies that you're authorized under state law to fill out this participation form and have documentation of this authority available if Medicare asks for it.

Name	Address (street, city, state, ZIP code)
Phone number ( )	Relationship to participant

How to submit this form

Submit your completed form to:

UnitedHealthcare
P.O. Box 30770
Salt Lake City, UT 84130-0770

Questions? We're here to help.

Call Customer Service at the toll-free number for members on your member ID card.

Medicare Prescription Payment Plan participation request form

The Medicare Prescription Payment Plan is a voluntary payment option that works with your current drug coverage to help you manage your out-of-pocket Medicare Part D drug costs by spreading them across the calendar year (January-December). **This payment option may help you manage your expenses, but it doesn't save you money or lower your drug costs.**

This payment option might not be the best choice for you if you get help paying for your prescription drug costs through programs like Extra Help from Medicare or a State Pharmaceutical Assistance Program (SPAP). Call your plan for more information.

Complete all fields unless marked optional

FIRST name:	LAST name:	MIDDLE initial (optional):
Medicare Number:		
Member ID Number: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _	RxGroup Number: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _	
Birth date: (MM/DD/YYYY) (/ /)	Phone number: ( )	
Permanent residence street address (don't enter a P.O. Box unless you're experiencing homelessness):		
City:	County (optional):	State: ZIP code:
Mailing address, if different from your permanent address (P.O. Box allowed): Address:	City:	State: ZIP code:

Read and sign below

- I understand this form is a request to participate in the Medicare Prescription Payment Plan. [Plan Name] will contact me if they need more information.
- I understand that signing this form means that I've read and understand the form and the attached terms and conditions.
- **[Plan Name] will send me a notice to let me know when my participation in the Medicare Prescription Payment Plan is active.** Until then, I understand that I'm not a participant in the Medicare Prescription Payment Plan.

Signature:	**Date:**

If you're completing this form for someone else, complete the section below. Your signature certifies that you're authorized under State law to fill out this participation form and have documentation of this authority available if Medicare asks for it.

Name:	Address (Street, City, State, ZIP code):
Phone number: ( )	Relationship to participant:

How to submit this form

You can also complete the participation request form online at https://www.express-scripts.com/mppp or call us at 1-833-750-9969 to submit your request via telephone.

Submit your completed form to:

Express Scripts MPPP
P.O. Box 801101
Kansas City, MO 64180-1101

If you have questions or need help completing this form, call us at 1-833-750-9969, 24 hours a day, 7 days a week. TTY users can call 1.800.716.3231.

TERMS AND CONDITIONS:

Upon acceptance into the Medicare Prescription Payment Plan:

- We will inform your pharmacy that you're using this payment option, which will apply only to Medicare Part D covered drugs that are processed after your election is confirmed.
- When you fill a prescription for an eligible drug, you will pay zero dollars at the pharmacy, but you will still be responsible for your cost share of the drug associated with your Medicare Part D benefit under your plan.
- You will receive a monthly invoice for the amount you owe, when it's due, and information on how to make a payment.
- Your payments may change every month because your monthly bill is based on what you would have paid for any prescriptions you get, plus your previous month's balance, divided by the number of months left in the year. However, you'll never pay more than the total amount you would have paid out of pocket or the total annual out-of-pocket maximum.
- If you miss a payment, you will receive a reminder notice. If you don't pay your bill by the date listed, you will be removed from this payment option. However, you are required to pay the amount you owe, and you may not be able to elect back into this payment option.
- You can leave this payment option at any time without affecting your Medicare drug coverage and other Medicare benefits.
- You can do this by selecting Opt-out through the website or calling the phone number listed on the back of your member ID card. However, after you opt out, you will receive an invoice each month for the amount you owe until your balance is paid.
- You'll pay the pharmacy directly for new out-of-pocket drug costs after you leave this payment option.
- Participation in this payment option will automatically make you eligible for important relevant emails.
- If you are disenrolled from your Medicare Part D plan for any reason, or you enroll in a new plan with drug coverage, your participation in this payment option will end. However, you will continue to receive a monthly invoice for the amount owed until your balance is paid in full. If you enroll in a new plan with drug coverage, you may be able to rejoin the Medicare Prescription Payment Plan by contacting your new plan.
- While this payment option helps to manage your costs, it doesn't lower your costs. If you have limited income or resources, you can learn more about programs to help lower drug costs by visiting Medicare.gov.
- If you have a concern, you have the right to follow the grievance process found in your Member Handbook or Evidence of Coverage.
- Express Scripts is administering this program on behalf of your Medicare Part D plan. If your address is different than what is on the form, you will need to work with your plan to update your address.
- If you suspect that your account or password has been compromised, please notify Express Scripts.
- Express Scripts works with a third-party supplier to offer the Medicare Prescription Payment Plan, including providing a website to view your account, schedule and make payments, and review payment history.
- I understand that my plan, Express Scripts and other third parties on behalf of them may contact me, by phone or text at the phone numbers I provide in conjunction with my coverage. I acknowledge these calls or text messages may be delivered using an automated system. I understand I can opt out of calls and texts related to the Medicare Prescription Payment Plan by contacting Express Scripts or my health plan at any time.

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 **1-877-374-4056 (TTY: 711)**. Someone who speaks English/ Language can help you. This is a free service.

Spanish: Contamos con los servicios de interpretación gratuitos para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para solicitar un intérprete, llámenos al **1-877-374-4056 (TTY: 711)**. Alguien que hable español puede ayudarlo. Este es un servicio gratuito.

Chinese (Mandarin): 我们提供免费的口译服务，可解答您对我们的健康或药物计划的有关疑问。如需译员，请拨打 **1-877-374-4056（TTY：711）**。您将获得中文普通话口译员的帮助。这是一项免费服务。

Chinese (Cantonese): 我們提供免費的口譯服務，可解答您對我們的健康或藥物計劃可能有的任何疑問。如需口譯員服務，請致電 **1-877-374-4056 (TTY：711)**。會說廣東話的人員可以幫助您。此為免費服務。

Tagalog: May mga libre kaming serbisyo ng interpreter para sagutin ang anumang posible ninyong tanong tungkol sa aming planong pangkalusugan o plano sa gamot. Para kumuha ng interpreter, tawagan lang kami sa **1-877-374-4056 (TTY: 711)**. May makakatulong sa inyo na nagsasalita ng Tagalog. Isa itong libreng serbisyo.

French: Nous mettons à votre disposition des services d'interprétation gratuits pour répondre à toutes vos questions sur notre régime de santé ou de médicaments. Pour obtenir les services d'un interprète, appelez-nous au **1-877-374-4056 (TTY : 711)**. Un interlocuteur francophone pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời bất kỳ câu hỏi nào của quý vị về chương trình sức khỏe hoặc chương trình thuốc của chúng tôi. Để nhận thông dịch viên, chỉ cần gọi cho chúng tôi theo số **1-877-374-4056 (TTY: 711)**. Một nhân viên nói tiếng Việt có thể giúp quý vị. Dịch vụ này được miễn phí.

German: Wir bieten Ihnen einen kostenlosen Dolmetschservice, wenn Sie Fragen zu unseren Gesundheits- oder Medikamentenplänen haben. Wenn Sie einen Dolmetscher brauchen, rufen Sie uns unter folgender Telefonnummer an: **1-877-374-4056 (TTY: 711)**. Ein deutschsprachiger Mitarbeiter wird Ihnen behilflich sein. Dieser Service ist kostenlos.

Korean: 당사의 건강 또는 의약품 플랜과 관련해서 물어볼 수 있는 모든 질문에 답변하기 위한 무료 통역 서비스가 있습니다**.** 통역사가 필요한 경우**, 1-877-374-4056(TTY: 711)**번으로 당사에 연락해 주십시오**.** 한국어를 구사하는 통역사가 도움을 드릴 수 있습니다**.** 통역 서비스는 무료로 제공됩니다**.**

Russian: Если у вас возникли какие-либо вопросы о нашем плане медицинского страхования или плане с покрытием лекарственных препаратов**,** вам доступны бесплатные услуги переводчика. Если вам нужен переводчик, просто позвоните нам по номеру **1-877-374-4056 (TTY: 711)**. Вам окажет помощь сотрудник, говорящий на русском языке. Данная услуга бесплатна.

Form CMS-10802
(Expires 12/31/25)
Y0020_WCM_159669M_C Internal Approval 07162024 LWc
NA5WCMINS62554M_MLWC 7/24

Form Approved
OMB# 0938-1421

Arabic: نوفّر خدمات ترجمة فورية مجانية للإجابة على أي أسئلة قد تكون لديك حول خطة الصحة أو الدواء الخاصة بنا. للحصول على مترجم فوري، ما عليك سوى الاتصال بنا على الرقم **1-877-374-4056 (TTY: 711)**. يمكن أن يساعدك شخص يتحدث العربية. وتتوفر هذه الخدمة بشكل مجاني.

Hindi: हमारे स्वास्थ्य या ड्रग प्लान के बारे में आपके किसी भी प्रश्न का उत्तर देने के लिए, हम मुफ़्त में दुभाषिया सेवाएं देते हैं। दुभाषिया सेवा पाने के लिए, बस हमें **1-877-374-4056 (TTY: 711)** पर कॉल करें। हिंदी बोलने वाला/वाली कोई सहायक आपकी मदद कर सकता/सकती है। यह एक नि:शुल्क सेवा है।

Italian: Sono disponibili servizi di interpretariato gratuiti per rispondere a qualsiasi domanda possa avere in merito al nostro piano farmacologico o sanitario. Per usufruire di un interprete, è sufficiente contattare il **1-877-374-4056 (TTY: 711)**. Qualcuno la assisterà in lingua italiana. È un servizio gratuito.

Portuguese: Temos serviços de intérprete gratuitos para responder a quaisquer dúvidas que possa ter sobre o nosso plano de saúde ou medicação. Para obter um intérprete, contacte nos através do número **1-877-374-4056 (TTY: 711)**. Um falante de português poderá ajudá-lo. Este serviço é gratuito.

French Creole: Nou gen sèvis entèprèt gratis pou reponn nenpòt kesyon ou ka genyen sou plan sante oswa plan medikaman nou an. Pou jwenn yon entèprèt, annik rele nou nan **1-877-374-4056 (TTY: 711)**. Yon moun ki pale Kreyol Ayisyen ka ede w. Se yon sèvis ki gratis.

Polish: Oferujemy bezpłatną usługę tłumaczenia ustnego, która pomoże Państwu uzyskać odpowiedzi na ewentualne pytania dotyczące naszego planu leczenia lub planu refundacji leków. Aby skorzystać z usługi tłumaczenia ustnego, wystarczy zadzwonić pod numer **1-877-374-4056 (TTY: 711)**. Zapewni to Państwu pomoc osoby mówiącej po polsku. Usługa ta jest bezpłatna.

Japanese: 弊社の健康や薬剤計画についてご質問がある場合は、無料の通訳サービスをご利用いただけます。通訳を利用するには、**1-877-374-4056**（TTY：711）にお電話ください。日本語の通訳担当者が対応します。これは無料のサービスです。

Hawaiian: Loaʻa iā mākou nā lawelawe unuhi ʻōlelo manuahi e pane i nā nīnau āu e pili ana i kā mākou papahana olakino a lāʻau paha. No ka loaʻa ʻana o ka unuhi ʻōlelo e kelepona iā mākou ma **1-877-374-4056 (TTY: 711)**. Hiki i kekahi kanaka ʻōlelo Hawaiʻi ke kōkua iā ʻoe. He lawelawe manuahi kēia.

Ilocano: Adda iti libre a serbisyo ti panagpatarus mi tapno masungbatan ti anyaman a saludsod mo maipanggep iti plano ti salun-at wenno agas mi. Tapno makaala ti maysa nga agipatpatarus pakiawagan dakami laeng iti **1-877-374-4056 (TTY: 711)**. Mabalin nga makatulong kenka ti maysa nga agsasao iti Ilocano. Daytoy ket libre a serbisio.

Samoan: E iai matou auaunaga faamatala upu e tali atu i soo se fesili e te ono fesili ai e uiga ia matou fuafuaga tau soifua maloloina poo fualaau. Ina ia maua se tagata faamatala upu na'o le vili mai a matou i le **1-877-374-4056 (TTY: 711)**. E mafai ona fesoasoani atu ia te oe se tasi e tautala i le gagana Samoan. E leai se totogi o lenei auaunaga.

Ukrainian: Ми безкоштовно надаємо послуги перекладачів, щоб ви могли отримати відповіді на будь-які запитання щодо нашого плану медичного обслуговування чи забезпечення лікарськими засобами. Щоб отримати допомогу перекладача, просто зателефонуйте нам за номером **1-877-374-4056 (TTY: 711)**. Спеціаліст, який володіє українською, допоможе вам. Ця послуга безкоштовна.

Lao: ພວກເຮົາມີບໍລິການຄົ້ນພາສາຟຣີ ເພື່ອຕອບຄຳຖາມທີ່ທ່ານອາດຈະມີກ່ຽວກັບແຜນສຸຂະພາບ ຫຼື ຢາຂອງ ພວກເຮົາ. ເພື່ອຂໍຄົ້ນແປພາສາ ພຽງແຕ່ໂທຫາພວກເຮົາໄດ້ທີ່ເບີ **1-877-374-4056 (TTY: 711)**. ມີຄົນທີ່ເວົ້າພາສາ ລາວສາມາດຊ່ວຍທ່ານໄດ. ນີ້ແມ່ນບໍລິການຟຣີ.

Cambodian: យើងមានសេវាបកប្រែផ្ទាល់មាត់ដោយឥតគិតថ្លៃសម្រាប់ឆ្លើយរាល់សំណួរដែលអ្នកមានអំពីគម្រោងឱសថ ឬគម្រោងសុខភាពរបស់យើង។ ដើម្បីទទួលបានអ្នកបកប្រែផ្ទាល់មាត់ គ្រាន់តែទូរសព្ទមកយើងខ្ញុំតាមរយៈលេខ 1-877-374-4056 (TTY: 711)។ មនុស្សម្នាក់ដែលនិយាយភាសាខ្មែរបានអាចជួយអ្នកបាន។ នេះជាសេវាកម្មឥតគិតថ្លៃ។

Hmong: Peb muaj cov kev pab cuam kws txhais lus pab dawb los teb cov nqe lus nug twg uas koj yuav muaj hais txog peb lub phiaj xwm duav roos kev noj qab haus huv thiab tshuaj. Yog xav tau ib tug kws txhais lus ces tsuas hu rau peb tau ntawm **1-877-374-4056 (TTY: 711)**. Ib tug neeg twg uas hais tau lus Hmoob yuav pab tau koj. Qhov no yog kev pab cuam pab dawb xwb.

Thai: เรามีบริการล่ามแปลภาษาให้ฟรีเพื่อตอบคำถามใดๆ ที่คุณอาจมีเกี่ยวกับแผนด้านสุขภาพหรือยาของเรา หากต้องการล่ามแปลภาษา โปรดติดต่อเราที่หมายเลข 1-877-374-4056 (TTY: 711) คนที่พูดภาษาไทยได้สามารถช่วยคุณได้ บริการนี้ไม่มีค่าใช้จ่าย