2024 SUMMARY OF BENEFITS

January 1, 2024 – December 31, 2024

The Health Plan SecureCare SNP (HMO D-SNP)

H3672–019

A Medicare Advantage Dual Eligible Special Needs Plan for Medicare beneficiaries who are also eligible for Medicaid.

Our service area includes the following counties in **Ohio**:

Adams, Allen, Ashland, Ashtabula, Athens, Auglaize, Belmont, Brown, Butler, Carroll, Champaign, Clark, Clermont, Clinton, Columbiana, Coshocton, Crawford, Cuyahoga, Darke, Delaware, Fairfield, Fayette, Franklin, Fulton, Gallia, Geauga, Greene, Guernsey, Hamilton, Hardin, Harrison, Henry, Highland, Hocking, Holmes, Jackson, Jefferson, Knox, Lake, Lawrence, Licking, Logan, Lorain, Madison, Mahoning, Medina, Meigs, Mercer, Miami, Monroe, Montgomery, Morgan, Morrow, Muskingum, Noble, Ottawa, Paulding, Perry, Pickaway, Pike, Portage, Preble, Putnam, Richland, Ross, Scioto, Seneca, Shelby, Stark, Summit, Trumbull, Tuscarawas, Van Wert, Vinton, Warren, Washington, Wayne, Wyandot.

Our service area includes the following counties in **West Virginia**:

Barbour, Berkeley, Boone, Braxton, Brooke, Cabell, Calhoun, Clay, Doddridge, Fayette, Gilmer, Grant, Greenbrier, Hampshire, Hancock, Hardy, Harrison, Jackson, Jefferson, Kanawha, Lewis, Lincoln, Logan, Marion, Marshall, Mason, McDowell, Mercer, Mineral, Mingo, Monongalia, Monroe, Morgan, Nicholas, Ohio, Pendleton, Pleasants, Pocahontas, Preston, Putnam, Raleigh, Randolph, Ritchie, Roane, Summers, Taylor, Tucker, Tyler, Upshur, Wayne, Webster, Wetzel, Wirt, Wood, Wyoming.

This document is available in other formats such as braille, large print and audio CD. For additional information on available formats, call us at **1.877.847.7915 (TTY: 711)**.

INTRODUCTION

The benefit information provided in this booklet is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, access our Evidence of Coverage online at healthplan.org/medicare. Or call us to request a copy.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at medicare.gov or get a copy 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.

The Health Plan SecureCare SNP (HMO D-SNP) is an HMO plan with a Medicare and a Medicaid contract. Enrollment in The Health Plan SecureCare SNP (HMO D-SNP) depends on contract renewal.

Based on a Model of Care review, The Health Plan SecureCare SNP (HMO D-SNP) has been approved by the National Committee for Quality Assurance (NCQA) to operate a Special Needs Plan (SNP) through 2025.

ELIGIBILITY

To join The Health Plan SecureCare SNP (HMO D-SNP) you must be entitled to Medicare Part A, be enrolled in Medicare Part B, be enrolled in Ohio or West Virginia Medicaid and live in our service area.

WHICH DOCTORS, HOSPITALS AND PHARMACIES CAN I USE?

This is a Health Maintenance Organization (HMO) plan. This means that The Health Plan SecureCare SNP (HMO D-SNP) has a network of doctors, hospitals, pharmacies and other providers. You can see current provider lists on our website at healthplan.org/medicare. Or call us and we will send you a copy.

Our plan requires you to choose an in-network doctor to be your primary care provider (PCP). We do not require a referral from your PCP to see network providers, including network specialists, for covered services. However, some services do require prior authorization from the plan. Contact us for additional information. Even though your PCP is not required to refer you, we recommend that they help with coordinating your care. If you use providers that are not in our network, the plan may not pay for these services.

Always show your SecureCare SNP (HMO D-SNP) card and your Medicaid card when receiving care, as a member of our plan.

HOW TO REACH US

If you are a member, call toll-free: 1.877.847.7907 (TTY:711)

If you are not a member, call toll free: 1.877.847.7915 (TTY:711)

Hours of operation:

- October 1 to March 31, 8:00 a.m. to 8:00 p.m. Eastern, 7 days a week.
- April 1 to September 30, 8:00 a.m. to 8:00 p.m. Eastern, Monday through Friday.

Or visit our website: healthplan.org/medicare

This plan is available to all dual-eligible West Virginia and Ohio Medicaid beneficiaries, as noted in the chart:

West Virginia Medicaid Who have Medicaid, as noted with the following eligible categories	**Ohio Medicaid** All dual-eligible Ohio Medicaid beneficiaries specified in Ohio administrative code, including:
QMB: Qualified Medicare beneficiary	**QMB:** Qualified Medicare beneficiary
QMB Plus: Qualified Medicare beneficiary with full Medicaid	**QMB Plus:** Qualified Medicare beneficiary with full Medicaid
FBDE: Full Medicaid benefits	**Non-QMB:** Medicaid only dual-eligible
SLMB: Specified low-income Medicare beneficiary	**SLMB:** Specified low-income Medicare beneficiary
SLMB Plus: Specified low-income Medicare beneficiary with full Medicaid	**SLMB Plus:** Specified low-income Medicare beneficiary with full Medicaid
QDWI: Qualified disabled and working individual	**QDWI:** Qualified disabled and working
QI: Qualifying individual	**QI:** Qualifying individual

The amount that a member of this plan pays for premiums, deductibles, copayments, and/or co-insurance may vary based on the level of Medicaid eligibility (above) and Medicare Part D "Extra Help" a member receives.

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 **1.877.847.7915 (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 healthplan.org/medicare or call **1.877.847.7915, (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

- ☐ **Effect on Current Coverage**. Your current health care coverage will end once your new Medicare coverage starts. For example, if you are in Tricare or a Medicare plan, you will no longer receive benefits from that plan once your new coverage starts.
- ☐ 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, 2025.
- ☐ 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).
- ☐ This plan is a dual eligible special needs plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid.

PREMIUMS & BENEFITS	THE HEALTH PLAN SECURECARE SNP (HMO D-SNP) H3672-019 THIS COLUMN LISTS WHAT YOU PAY
Monthly Plan Premium	**$0 - $40.20** You must continue to pay your Medicare Part B premium, if not already paid by a third party, like Medicaid.
Annual Medical Deductible	In 2023, the medical deductible is $0 or $226 per year for in-network Medicare-covered Part A and Part B benefits depending on your level of Medicaid eligibility. The amount of your medical services deductible may change for 2024.
Maximum Out-of-Pocket Responsibility (Does not include Part D prescription drugs)	$8,850 annually for in-network Medicare-covered Part A and Part B services. The amounts you pay for deductibles, copayments and coinsurance for Medicare-covered Part A or Part B services count towards this maximum out-of-pocket amount.
Inpatient Hospital Coverage*	In 2023 the amounts for each benefit period are: $0 or Days 1-60: $1,600 deductible Days 61-90: $400 copay per day Days 91-150: $800 copay while using 60 lifetime reserve days These amounts may change for 2024. The copays for hospital benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care for 60 days in a row. There's no limit to the number of benefit periods. You must pay the inpatient hospital deductible for each benefit period. We cover an additional 60 "lifetime reserve days." If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these additional 60 days, your inpatient hospital coverage will be limited to 90 days.
Outpatient Hospital Coverage*	$0–20% Outpatient Hospital Services $0–20% Outpatient Observation Services
Ambulatory Surgical Center*	$0–20%
Doctor Visit - Primary Care Provider	$0–20%
Doctor Visit – Specialist*	$0–20% No referral is needed. However, organizational authorization may be required for out-of-network and tertiary specialists.

PREMIUMS & BENEFITS	THE HEALTH PLAN SECURECARE SNP (HMO D-SNP) H3672-019 THIS COLUMN LISTS WHAT YOU PAY

Preventive Care (Medicare-covered zero cost sharing preventive services)	**Medicare–covered zero cost sharing preventive services**
	$0 copay for the following*:
	• Abdominal aortic aneurysm screenings
	• Alcohol misuse screenings & counseling
	• Blood-based biomarker tests
	• Cardiovascular disease screenings
	• Cardiovascular disease (behavioral therapy)
	• Cervical & vaginal cancer screenings
	• Colorectal cancer screenings
	  o Multi-target stool DNA tests
	  o Screening barium enemas
	  o Screening colonoscopies
	  o Screening fecal occult blood tests
	  o Screening flexible sigmoidoscopies
	• Depression screenings
	• Diabetes screenings
	• Diabetes self-management training
	• Flu shots
	• Glaucoma tests
	• Hepatitis B shots
	• Hepatitis B Virus (HBV) infection screenings
	• Hepatitis C screening tests
	• HIV screenings
	• Lung cancer screenings
	• Mammograms (screening)
	• Medicare Diabetes Prevention Program
	• Nutrition therapy services
	• Obesity screenings & counseling
	• One-time "Welcome to Medicare" preventive visit
	• Pneumococcal shots
	• Prostate cancer screenings
	• Sexually transmitted infections screenings & counseling
	• Shots:
	  o COVID-19 vaccines
	  o Flu shots
	  o Hepatitis B shots
	  o Pneumococcal shots
	• Tobacco use cessation counseling
	• Yearly "Wellness" visit
	
	Any other preventive services approved by Medicare during the contract year will be covered
	
	Annual Physical Exam
	$0 copay/1 per year

PREMIUMS & BENEFITS	THE HEALTH PLAN SECURECARE SNP (HMO D-SNP) H3672-019 THIS COLUMN LISTS WHAT YOU PAY
Emergency Care	$0–20% (up to a $100 copay) If you are admitted to the hospital within 3 days, you do not have to pay your share of the cost for emergency care.
Urgently Needed Services	$0–20% (up to a $55 co-pay) If you are admitted to the hospital within 3 days, you do not have to pay your share of the cost for urgently needed services.
Diagnostic Radiological Service* (such as MRIs, CT scans)	$0–20%
Therapeutic Radiological Services* (such as radiation treatment for cancer)	$0–20%
Lab Services	$0 copay
Diagnostic Tests and Procedures*	$0–20%
Outpatient X-rays*	$0–20%
Medicare-covered Hearing Exam	$0–20% Exam to diagnose and treat hearing issues and balance issues
Routine Hearing Exam	$0 copay for one exam every year
Routine Hearing Aid	$0 copay for hearing aids - This plan will cover up to $2,000 every two years towards hearing aids, both ears combined. There is a limit of one hearing aid per ear. After this plan has paid our share, you will be responsible for the remaining cost(s). - Includes 2-year supply of batteries per aid (non-rechargeable models only) after purchase. - $0 copay for provider visits for fittings and adjustments, covered for 12 months after hearing aid purchase. A TruHearing provider must be used.
Medicare-covered Dental Services*	$0

PREMIUMS & BENEFITS	THE HEALTH PLAN SECURECARE SNP (HMO D-SNP) H3672-019 THIS COLUMN LISTS WHAT YOU PAY
Routine Dental Services*	$0 copay for preventive and most dental services. Preventive dental services: • 2 exams every year • 2 cleanings and 1 set of bitewing X-rays every year • 1 full mouth X-ray every 3 years $4,000 plan coverage limit each year for preventive and most dental services. Dental services require the use of a plan participating provider. Liberty Dental providers are considered in-network for this plan. Contact us for more details.
Vision Services: Medicare-covered vision exam to diagnose and treat conditions of the eye	$0–20%
Vision Services: Medicare-covered eyewear	$0-20% copay Limited coverage of eyewear related to cataract surgery.
Vision Services: Routine eye exam	$0 copay for one exam per year Non-Medicare covered routine vision is provided through plan participating providers. Contact us for more details.
Vision Services: Routine eyewear	$0 copay Our plan pays up to $300 every year for routine eyewear that is purchased through a plan provider.
Inpatient Mental Health Services*	In 2023 the amounts for each benefit period are: $0 or Days 1-60: $1,600 deductible Days 61-90: $400 copay per day Days 91-150: $800 copay while using 60 lifetime reserve days These amounts may change for 2024.
Outpatient Individual and Group Mental Health Therapy Visit*	$0–20%

PREMIUMS & BENEFITS	THE HEALTH PLAN SECURECARE SNP (HMO D-SNP) H3672-019 THIS COLUMN LISTS WHAT YOU PAY
Skilled Nursing Facility* (Per benefit period, as defined by Original Medicare)	In 2023 the amounts for each benefit period are: $0 or Days 1-20: $0 copay per day Days 21-100: $200 copay per day Our plan covers up to 100 days in a skilled nursing facility during each benefit period. These amounts may change for 2024.
Physical Therapy*	$0–20%
Ambulance Authorization required for non-emergency Medicare services.	$0–20%
Transportation* (Routine)	$0 copay Benefit allows up to 35 round trips to plan approved locations, up to $1,000 annual plan limit. The member must contact our transportation vendor to arrange transportation.
Medicare Part B Drugs* Part B drugs may be subject to step therapy. See Evidence of Coverage for details.	Depending on your level of Medicaid, Part B drugs and biologicals will have a $0-20% coinsurance. Medicare publishes a list of certain Part B drugs and biologicals with prices that have increased faster than the rate of inflation. For these drugs and biologicals for members whose Medicaid level leaves them with remaining coinsurance, the coinsurance will be 20% of the inflation-adjusted payment amount, which will be less than what they would pay in coinsurance otherwise. The amount could change throughout the year depending on the rate of inflation.
ADDITIONAL BENEFITS	
Meals*	$0 copay for meals provided through the approved vendor. When you get home after an inpatient hospital stay or immediately following surgery, we cover up to 2 home delivered meals per day for 7 days after discharge. Covered up to 4 times per year.
Personal Emergency Response System (PERS)	$0 copay Plan covers a personal emergency response system and monthly monitoring fee. This must be received through our contracted vendor.

PREMIUMS & BENEFITS	THE HEALTH PLAN SECURECARE SNP (HMO D-SNP) H3672-019 THIS COLUMN LISTS WHAT YOU PAY
Flex Debit Card: **Over-the-Counter Items (OTC)** **Healthy Food** **Utility Bill Assistance**	$165 every month to spend at participating retailers toward the purchase of approved items and services. This is a combined limit and may be used for over-the-counter items (including personal supplies), healthy food purchases, and/or utility bill assistance. Any unused amounts will not carry over to the next month. Unused amounts will also not carry over to the next calendar year.
Medicare-covered Foot Exams and Treatment* (Podiatry)	$0–20%
Routine Foot Care* (Podiatry)	$0 copay Routine foot care is covered for up to 4 visits every year.
Durable Medical Equipment* (like wheelchairs and oxygen)	$0–20% Durable medical equipment must meet certain criteria to be covered. Contact the plan for more details.
Prosthetics* (like braces and artificial limbs)	$0–20%
Diabetic Monitoring Supplies*	$0-20% Coverage is limited to 100 strips for a 30-day supply. Additional quantities require coverage review.
Diabetic Therapeutic Shoes or Inserts*	$0–20%
Health/Wellness Programs (like fitness, tobacco cessation, etc.)	$0 copay SilverSneakers is the fitness program covered by this plan.
Home Health Care*	$0 copay
Cardiac/Pulmonary Rehabilitation Services*	$0–20%

PREMIUMS & BENEFITS	THE HEALTH PLAN SECURECARE SNP (HMO D-SNP) H3672-019 THIS COLUMN LISTS WHAT YOU PAY
Chiropractic Services*	$0–20% This plan covers Medicare-covered services only.
Telehealth Services	$0 copay This applies to: • Primary Care Physician Services • Physician Specialist Services • Individual Sessions for Mental Health Specialty Services • Individual Sessions for Psychiatric Services • Individual Sessions for Outpatient Substance Abuse Services must be accessed through our contracted vendor.
Wellness Incentive Program	Earn $25 on your InComm card after receiving any of these services: • Breast Cancer Screening • Colorectal Cancer Screening • Annual Wellness Visit Limit one incentive reward per service per year.

Services with an * may require your provider to obtain prior authorization from the plan.

Note: There are ranges listed in the above charts for some premiums and services. What <u>you</u> will pay will be determined by your level of Medicaid and/or Part D Extra Help. Please contact the plan for details.

Prescription Coverage

This plan includes Medicare Part D Prescription coverage. In most cases you need to get your drugs at participating network retail and mail order pharmacies. Please go to healthplan.org/medicare to see the most up to date pharmacy directory or call us to discuss.

Specialty Tier Drugs have a 30-day supply limit.

What You Will Pay

If you HAVE Low Income Subsidy (LIS) Extra Help you will pay the following for covered medications:

Annual Part D Prescription Drug Deductible	**$0**
Initial Coverage Limit (ICL) **Coverage Gap** **Catastrophic Coverage**	**$0** For all covered drugs in all benefit phases.

If you DO NOT have Low Income Subsidy (LIS) Extra Help you will pay the following for covered medications:

Annual Part D Prescription Drug Deductible	If you do not have Low Income Subsidy/Part D Extra Help, you will pay the standard Part D Prescription deductible of $545.
Initial Coverage Limit (ICL)	After you have paid the deductible amount, you will pay the standard Medicare Part D prescription cost shares.
	Please see The Health Plan SecureCare SNP (HMO D-SNP) Evidence of Coverage (EOC), or contact the plan, for complete details. You will pay these amounts until you have reached the ICL amount of $5,030.
Catastrophic Coverage	Beginning in 2024, if you reach the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs.
IMPORTANT MESSAGE ABOUT WHAT YOU PAY FOR INSULIN AND VACCINES	
If you have LIS/Extra Help, you will pay nothing for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on. If you do not have LIS/Extra Help, you will pay no more than $35 for a one-month supply for each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.	
Our plan covers most Part D vaccines at no cost to you. Call member services for more information.	

Summary of Medicaid-Covered Benefits for Plan H3672-019

January 1, 2024 – December 31, 2024

State of West Virginia

The benefits described below are covered by Medicaid.

Medicaid is usually the payer of last resort — this means that as a member of our plan, we will process your claims first. There may be a remaining balance after we have completed processing your claim. Your provider should then bill WV Medicaid directly, to see if they will pay all or a portion of the remainder. WV Medicaid will pay based on your level of Medicaid. This means that they may not pay the entire amount - you may be responsible for a part of the remaining balance.

If you are full-dual eligible (meaning you have full Medicaid benefits), you will likely pay nothing for most covered services on our plan.

If you have questions about your Medicaid eligibility and what benefits you are entitled to, call WV Medicaid at 1.877.716.1212, Monday–Friday, 8:00 a.m. until 5:00 p.m.

For more information, you can also visit the WV Medicaid website at dhhr.wv.gov/bms.

WV Medicaid Covered Medical and Hospital Benefits

For dual-eligible members, Medicaid pays co-insurance, copayments and deductibles for Medicare-covered services.

This chart describes Medicaid coverage only. To see what you will pay under The Health Plan SecureCare SNP (HMO D-SNP) as a member of our plan*, please see The Health Plan Premium and Benefits* chart above.

	MEDICAID	THE HEALTH PLAN D-SNP
Inpatient Hospital Care	Covered	Covered
Doctor Office Visits	Covered	Covered
Emergency Care	Covered	Covered
Diagnostic Tests, Lab, and Radiology Services and X-Rays	Covered	Covered
Inpatient Mental Health Care	Covered	Covered
Mental Health Care	Covered	Covered
Skilled Nursing Facility (SNF)	Covered	Covered
Ambulance	Covered	Covered
Transportation (Routine)	Covered	Covered
Prescription Drug Benefits	Covered	Covered
Chiropractic Care	Covered	Covered
Durable Medical Equipment	Covered	Covered
Foot Care	Covered	Covered
Home Health Care	Covered	Covered
Hospice	Covered	Covered
Outpatient Hospital Services	Covered	Covered
Prosthetic Devices	Covered	Covered

Summary of Medicaid-Covered Benefits for Contract H3672-019

January 1, 2024 – December 31, 2024

State of Ohio

The benefits described below are covered by Medicaid.

Medicaid is usually the payer of last resort — this means that as a member of our plan, we will process your claims first. There may be a remaining balance after we have completed processing your claim. Your provider should then bill Ohio Department of Medicaid (ODM) directly, to see if they will pay all or a portion of the remainder. ODM will pay based on your level of Medicaid. This means that they may not pay the entire amount - you may be responsible for a part of the remaining balance.

If you are full-dual eligible (meaning you have full Medicaid benefits), you will likely pay nothing for most covered services on our plan.

If you have questions about your Medicaid eligibility and what benefits you are entitled to, call ODM at **1.800.324.8680, (TTY 711),** Monday–Friday 7 am-8 pm, or Saturday 8 am-5 pm.

For more information, you can also visit the ODM website at Medicaid.ohio.gov.

Ohio Department of Medicaid Covered Medical and Hospital Benefits

For dual-eligible members, Medicaid pays coinsurance, co-payments and deductibles for Medicare-covered services.

To see what you will pay under The Health Plan SecureCare SNP (HMO D-SNP)*, please see The Health Plan Premium and Benefits* chart above.

	MEDICAID	THE HEALTH PLAN D-SNP
Inpatient Hospital Care	Covered	Covered
Doctor Office Visits	Covered	Covered
Preventive Care	Covered	Covered
Emergency Care	Covered	Covered
Urgently Needed Services	Covered	Covered
Diagnostic Test, Lab, and Radiology Services and X-Rays	Covered	Covered
Hearing Services	Covered	Covered
Dental Services	Covered	Covered
Vision Services	Covered	Covered
Inpatient Mental Health Care	Covered	Covered
Mental Health Care	Covered	Covered
Skilled Nursing Facility (SNF)	Covered	Covered
Ambulance	Covered	Covered
Transportation (Routine)	Covered	Covered
Prescription Drug Benefits	Covered	Covered
Chiropractic Care	Covered	Covered
Diabetes Supplies and Services	Covered	Covered
Durable Medical Equipment	Covered	Covered
Foot Care	Covered	Covered
Home Health Care	Covered	Covered
Hospice	Covered	Covered
Outpatient Hospital Services	Covered	Covered
Renal Dialysis	Covered	Covered
Prosthetic Devices	Covered	Covered
Additional Dental Services	Covered	Covered
Family Planning	Covered	Covered according to Medicare guidelines
Additional Vision Services	Covered	Covered

	MEDICAID	THE HEALTH PLAN D-SNP
Home and Community Based Services (HCBS)	Covered	Not Covered Beyond Original Medicare
Over the Counter Items	Covered	Covered
Physical Exam for Job Placement	Covered	Not Covered
Prenatal and Postpartum Care	Covered	Not Covered

Nondiscrimination Notice

Discrimination is Against the Law

The Health Plan complies with applicable Federal civil rights laws and does not discriminate because of race, religion, color, national origin, age, disability, or sex. The Health Plan does not exclude people or treat them differently because of race, religion, color, national origin, age, disability, or sex. The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact The Health Plan Customer Service Department. If you believe that The Plan has failed to provide these services or discriminated in another way on the basis of race, religion, color, national origin, age, disability, or sex, you can file a grievance with: The Health Plan Appeals Coordinator, 1110 Main Street, Wheeling, WV 26003, Phone: 1.877.847.7907, TTY: 711, Fax 740.699.6163, Email: info@healthplan.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance The Health Plan Customer Service Department is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1.800.368.1019, 1.800.537.7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

English:
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1.877.847.7907 (TTY: 711).

Spanish:
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.877.847.7907 (TTY: 711).

Chinese:
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1.877.847.7907（TTY：711）。

Tagalog:
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1.877.847.7907 (TTY: 711).

French:
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1.877.847.7907 (ATS : 711).

Vietnamese:
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1.877.847.7907 (TTY: 711).

German:
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.877.847.7907 (TTY: 711).

Korean:
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.877.847.7907 (TTY: 711)번으로 전화해 주십시오.

Russian:
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1.877.847.7907 (телетайп: 711).

Arabic:
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1.877.847.7907 (رقم هاتف الصم والبكم: 711).

Hindi:
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1.877.847.7907 (TTY: 711) पर कॉल करें।

Italian:
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1.877.847.7907 (TTY: 711).

Portugues:
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1.877.847.7907 (TTY: 711).

French Creole:
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1.877.847.7907 (TTY: 711).

Polish:
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1.877.847.7907 (TTY: 711).

Japanese:
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1.877.847.7907（TTY: 711）まで、お電話にてご連絡ください。

Dutch:
MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: 1.877.847.7907 (TTY: 711).

Pennsylvania Dutch:
Wann du (Deitsch (Pennsylvania German / Dutch)) schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1.877.847.7907 (TTY: 711).

Ukranian:
УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером (1.877.847.7907) (TTY: 711).

Romanian:
ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la (1.877.847.7907) (TTY: 711).

Cushite:
XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa (1.877.847.7907) (TTY: 711).

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 1-877-847-7915. 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 1-877-847-7915. 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 1-877-847-7915。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 1-877-847-7915。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 1-877-847-7915. 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 1-877-847-7915. 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 1-877-847-7915 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 1-877-847-7915. 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 1-877-847-7915번으로 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 1-877-847-7915. 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 على1-877-847-7915 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 1-877-847-7915 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 1-877-847-7915. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: 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 1-877-847-7915. 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 1-877-847-7915. 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 1-877-847-7915. 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、1-877-847-7915 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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TheHealthPlan