

INDIVIDUAL ENROLLMENT REQUEST FORM- MEDICARE ADVANTAGE

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15 – December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit Medicare.gov to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional – you can't be denied coverage because you didn't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15 – December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:

The Health Plan
1110 Main Street
Wheeling, WV
26003-2704

Once they process your request to join, they'll contact you.

How do I get help with this form?

Call The Health Plan at 1.877.847.7915. TTY users can call: 711.

Or, call Medicare at 1.800.MEDICARE (1.800.633.4227). TTY users can call 1.877.486.2048.

En español: Llame a The Health Plan al 1.877.847.7915 /TTY: 711 o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

Individuals experiencing homelessness

If you want to join a plan but have no permanent residence, a Post Office Box, and address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

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Section 1 – All fields on this page are required (unless marked optional).

Select the plan you want to join:

- SecureCare Integrity Plan 3 (HMO). Plan number H3672-014.
Plan Premium is \$0 per month.
 YES, I would like to enroll in the Optional Supplemental Dental Plan, with an additional premium of \$17.20 per month.

- SecureCare Option II (HMO). Plan number H3672-013.
Plan Premium is \$0 per month.
 YES, I would like to enroll in the Optional Supplemental Dental Plan, with an additional premium of \$17.20 per month.

- SecureChoice Option II (PPO). Plan number H8604-010.
Plan Premium is \$93.40 per month.
 YES, I would like to enroll in the Optional Supplemental Dental Plan, with an additional premium of \$17.50 per month.

- SecureChoice Optimum (PPO). Plan number H8604-014-1.
Plan Premium is \$0 per month.
 YES, I would like to enroll in the Optional Supplemental Dental Plan, with an additional premium of \$17.50 per month.

FIRST Name:	LAST Name:	(Optional) Middle Initial:
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Birth Date: (MM/DD/YYYY) ____/____/____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Phone Number: ()
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Permanent Residence Street Address: (Don't enter a P.O. Box)

City:	(Optional) County:	State:	ZIP Code:
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Mailing Address, if different from your permanent address: (P.O. Box allowed)			
Street Address:	City:	State:	ZIP Code:

Your Medicare information:

Medicare Number: - -

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to The Health Plan? Yes No

Name of other coverage: _____

Member number for this coverage: _____

Group number for this coverage: _____

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IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in The Health Plan.
- By joining this Medicare Advantage Plan, I acknowledge that The Health Plan will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my The Health Plan coverage begins, I must get all of my medical and prescription drug benefits from The Health Plan. Benefits and services provided by The Health Plan and contained in my The Health Plan “Evidence of Coverage” document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor The Health Plan will pay for benefits or services that are not covered.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
 - 1) This person is authorized under State law to complete this enrollment, and
 - 2) Documentation of this authority is available upon request by Medicare.
- By providing my contact information, including my phone number and email address, I grant consent to The Health Plan to contact me using this information regarding my benefits and/or to manage my care, including notifying me about benefits to which I may be entitled.

Signature:	Today's Date:
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If you're the authorized representative, sign above and fill out these fields:

Name:	Address:
Phone Number:	Relationship to Enrollee:

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Section 2– All fields on this page are optional.**Answering these questions is your choice. You can't be denied coverage because you don't fill them out.**

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- No, not of Hispanic, Latino/a, or Spanish origin Yes, Mexican, Mexican American, Chicano/a
- Yes, Puerto Rican Yes, Cuban
- Yes, another Hispanic, Latino/a, or Spanish origin **I choose not to answer**

What's your race? Select all that apply.

- American Indian or Alaska Native Asian Indian Black or African American
- Chinese Filipino Guamanian or Chamorro
- Japanese Korean Native Hawaiian
- Other Asian Other Pacific Islander Samoan
- Vietnamese White **I choose not to answer**

Select one if you want us to send you information in a language other than English.

-
- Please contact The Health Plan for materials that are available in other languages.

Select one if you want us to send you information in an accessible format.

-
- Braille
-
- Large Print
-
- Audio CD

Please contact The Health Plan at 1.877.847.7915 if you need information in an accessible format other than what's listed above. Our office hours are 8 a.m. to 8 p.m., seven days a week from October 1 through March 31 and 8 a.m. to 8 p.m., Monday through Friday from April 1 through September 30. TTY users can call 711.

Do you work? Yes NoDoes your spouse work? Yes No

List your Primary Care Physician (PCP), clinic or health center:

I want to get the following materials via email. Select one or more.

-
- Please contact The Health Plan for materials that are available to be sent by email.

E-mail address: _____

Paying your plan premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or Electronic Funds Transfer (EFT) each month. **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.**

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. DON'T pay The Health Plan the Part D-IRMAA.

Plan premium payment option (Please note: If you don't select a payment option, you will be billed directly by The Health Plan.)

Select a premium payment option:

- By Mail- Get payment coupons.
- Electronic Funds Transfer (EFT) from your bank account each month.
- * Additional forms may be needed to complete this authorization. Please contact the plan for details.
- Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.

I get monthly benefits from: Social Security RRB

If you have to pay a Part D Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. DON'T pay The Health Plan the Part D-IRMAA.

PRIVACY ACT STATEMENT The Centers for Medicare & 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 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 enrollment 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 to this form is voluntary. However, failure to respond may affect enrollment in the plan.

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Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

<input type="checkbox"/>	I am new to Medicare.
<input type="checkbox"/>	I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
<input type="checkbox"/>	I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date) _____.
<input type="checkbox"/>	I recently was released from incarceration. I was released on (insert date) _____.
<input type="checkbox"/>	I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.
<input type="checkbox"/>	I recently obtained lawful presence status in the United States. I got this status on (insert date) _____.
<input type="checkbox"/>	I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) _____.
<input type="checkbox"/>	I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) _____.
<input type="checkbox"/>	I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
<input type="checkbox"/>	I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date) _____.
<input type="checkbox"/>	I recently left a PACE program on (insert date) _____.
<input type="checkbox"/>	I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____.
<input type="checkbox"/>	I am leaving employer or union coverage on (insert date) _____.
<input type="checkbox"/>	I belong to a pharmacy assistance program provided by my state
<input type="checkbox"/>	My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
<input type="checkbox"/>	I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) _____.
<input type="checkbox"/>	I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) _____.
<input type="checkbox"/>	I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local government entity). One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.

If none of these statements applies to you or you're not sure, please contact The Health Plan at 1.877.847.7915 (TTY users should call 711) to see if you are eligible to enroll. We are open 8 a.m. to 8 p.m., seven days a week from October 1 through March 31 and 8 a.m. to 8 p.m., Monday through Friday from April 1 through September 30.

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AGENT USE ONLY

Appointment Type: _____ Scope of Appointment ID Number: _____

Print Agent name: _____

Agent Writing Number (AWN): _____ Agent Phone Number: _____

NOTE: If Agent takes receipt of this application, signature and date are required below:

Signature of Agent: _____

Date Individual Enrollment Request Form received By Agent: _____

Agent: Please be sure to copy and maintain this and all pages of the completed application for your records.

OFFICE USE ONLY:

Name of staff member/agent/broker (if assisted in enrollment): _____ Sales Method Code _____

Agent ID: ____ Plan ID #: _____ Group #: _____

Member/Client ID: _____ Effective Date of Coverage: _____

Date Received: _____ Check Number: _____ Check Amount: _____

ICEP/IEP: _____ AEP: _____ OEP: _____ SEP (type): _____

Not Eligible: _____

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Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at **1.877.847.7915 (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 medicine 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.
- In addition to your monthly plan premium (if applicable), 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.
- (**HMO plans**) 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).
- (**PPO plans**) Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.

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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 tofogi, mo oe, Telefoni mai: 1.877.847.7907 (TTY: 711).

Pennsylvania Dutch:

Wann du (Deutsch (Pennsylvania German / Dutch)) schwetzsch, 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 quý vị cần thông dịch viên xin gọi 1-877-847-7915 sẽ có nhân viên nói tiếng Việt giúp đỡ quý 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 بمساعدتك. على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-877-847-7915 سيقوم شخص ما يتحدث العربية بهذه 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.

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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.

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