TUFTS Health Plan

2027 Tufts Medicare Preferred Individual Enrollment Request Form

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 don'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:

Tufts Health Plan Medicare Preferred
P.O. Box 483
Canton, MA 02021-9936

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

How do I get help with this form?

Call Tufts Health Plan Medicare Preferred at **1-877-409-3499 (TTY: 711)**.

Or, call Medicare at **1-800-MEDICARE (1-800-633-4227**). TTY users can call 1-877-486-2048.

En español: Llame a Tufts Health Plan Medicare Preferred al **1-877-409-3499 (TTY: 711)** o a Medicare gratis al **1-800-633-4227** y oprima el 8 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, an 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.

Section 1 All fields in this section are required (unless marked optional)

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

Title: (optional) ◯ Mr. ◯ Mrs. ◯ Ms.

Birth date: (mm/dd/yyyy)

Sex: ◯ M ◯ F

Primary phone number:

☐ This is a mobile number (optional)

Alternate phone number: (optional)

☐ This is a mobile number (optional)

By providing an SMS-enabled phone number you are giving Tufts Health Plan permission to send you text messages about your plan and benefits. You may unsubscribe from text messages at any time. For texting terms of use, please visit https://tuftshealthplan.com/text-terms-of-use.

☐ Opt out of SMS text messages

Email address: (optional)

Permanent residence street address: (P.O. Box not allowed unless you do not have a permanent residence)

City: | State: | Zip code:

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

City: | State: | Zip code:

Emergency contact: (optional)

Phone number: (optional)

Relationship to you: (optional)

Select a primary care provider (PCP)

A PCP is a doctor, nurse practitioner, clinical nurse specialist or physician assistant who provides, coordinates and helps you access a range of health care services.

First name of your PCP: | Last name of your PCP:

PCP address and/or medical group:

Your PCP's NPI number*:

Are you a current patient? ◯ Yes ◯ No

HELPFUL INFORMATION

For HMO Plans: Please choose a Tufts Medicare Preferred HMO-contracted PCP and enter your PCP's information in the fields to the left. If you don't list a PCP here, we will automatically assign one to you. You can change your PCP at any time after you enroll.

For PPO Plans: Choosing a Tufts Medicare Preferred PPO-contracted PCP is strongly recommended, but not required. Enter your PCP's information in the fields to the left.

These questions are optional.

*To find a PCP in your area or to find your PCP's NPI number, use the search tool at **thpmp.org/doctor**.

SELECT THE PLAN YOU WANT TO JOIN

Requested effective date:
(mm/dd/yyyy; must be in the future)

The chart below shows available plans for each service area and standard monthly plan premiums (**in bold**).
The chart also shows plan premiums with the Tufts Medicare Preferred Dental Option included (*in italics*).
To enroll in the Tufts Medicare Preferred Dental Option, complete the *Optional Supplemental Benefit* section below.

HMO Tufts Medicare Preferred HMO Plans (H2256)

Barnstable, Bristol, Middlesex, Norfolk and Plymouth Counties	Plan Premium	*W/Dental Option*	Hampden and Hampshire Counties	Plan Premium	*W/Dental Option*
○ HMO Basic Rx	**$82/month**	*$123.50*	○ HMO Basic Rx	**$65/month**	*$106.50*
○ HMO Value No Rx	**$133/month**	*$174.50*	○ HMO Value Rx	**$108/month**	*$149.50*
○ HMO Value Rx	**$185/month**	*$226.50*	○ HMO Prime Rx	**$138/month**	*$176.50*
○ HMO Prime No Rx	**$163/month**	*$201.50*	○ HMO Prime Rx Plus	**$158/month**	*$196.50*
○ HMO Prime Rx	**$214/month**	*$252.50*			
○ HMO Prime Rx Plus	**$252/month**	*$290.50*			

Essex and Suffolk Counties	Plan Premium	*W/Dental Option*	Worcester County	Plan Premium	*W/Dental Option*
○ HMO Basic No Rx	**$58/month**	*$99.50*	○ HMO Basic No Rx	**$50/month**	*$91.50*
○ HMO Basic Rx	**$88/month**	*$129.50*	○ HMO Basic Rx	**$85/month**	*$126.50*
○ HMO Value No Rx	**$153/month**	*$194.50*	○ HMO Value No Rx	**$142/month**	*$183.50*
○ HMO Value Rx	**$207/month**	*$248.50*	○ HMO Value Rx	**$190/month**	*$231.50*
○ HMO Prime No Rx	**$186/month**	*$224.50*	○ HMO Prime No Rx	**$182/month**	*$220.50*
○ HMO Prime Rx	**$244/month**	*$282.50*	○ HMO Prime Rx	**$224/month**	*$262.50*
○ HMO Prime Rx Plus	**$280/month**	*$318.50*			

HMO Tufts Medicare Preferred HMO Smart Saver Rx (H2256)

	Counties	Plan Premium
○ HMO Smart Saver Rx	Hampden, Hampshire, Middlesex and Worcester Counties	**$0/month**
○ HMO Smart Saver Rx	Bristol, Essex, Norfolk, Plymouth and Suffolk Counties	**$0/month**
○ HMO Smart Saver Rx	Barnstable County	**$0/month**

OPTIONAL SUPPLEMENTAL BENEFIT: Tufts Medicare Preferred Dental Option

The Tufts Medicare Preferred Dental Option can only be elected along with a medical plan. The following is the additional cost to the premiums in the chart above for the Tufts Medicare Preferred Dental Option:

- *HMO Basic Rx, HMO Basic No Rx, HMO Value Rx and HMO Value No Rx:* **$41.50 per month**.
- *HMO Prime Rx, HMO Prime Rx Plus* and *HMO Prime No Rx:* **$38.50 per month**.
- *HMO Smart Saver Rx:* **NOT available.**

☐ **Yes, I would like to add the Tufts Medicare Preferred Dental Option.**

PPO Tufts Medicare Preferred PPO Rx (H9907)

	Counties	Plan Premium
○ PPO Rx	Bristol, Essex, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk and Worcester Counties	**$220/month**

YOUR MEDICARE INFORMATION

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.
- **Or** attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name: (as it appears on your Medicare card; optional)

Medicare number:

Is entitled to:

HOSPITAL (Part A) Effective date: (optional; mm/dd/yyyy)

MEDICAL (Part B)

ANSWER THESE IMPORTANT QUESTIONS

◯ **Yes**
◯ **No**

1. Will you have other prescription drug coverage (like VA, TRICARE) in addition to Tufts Health Plan Medicare Preferred? **If yes,** please list your other coverage and your member and group numbers for this coverage.

Name of other coverage:

Member number for this coverage:

Group number for this coverage:

◯ **Yes**
◯ **No**

2. OPTIONAL: Are you a resident in a long-term care facility, such as a nursing home?
If yes, please provide the following information and see question 5 on the following page.

Name of institution:

Phone number:

Street address:

City:

State:

Zip code:

◯ **Yes**
◯ **No**

3. OPTIONAL: Are you enrolled in your State Medicaid program? (In Massachusetts, this is called "MassHealth.")
If yes, please provide your Medicaid number.

Medicaid (MassHealth) number:

PLEASE SELECT ELIGIBILITY FOR ENROLLMENT PERIOD

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 (check all that apply). 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.

☐ **1.** Annual Enrollment Period (AEP). Your plan effective date will be January 1.

☐ **2.** I am new to Medicare.

☐ **3.** I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP) from January 1 through March 31.

☐ **4.** I recently moved outside of the service area for my current plan or I recently moved and have new options available to me.

I moved on: (mm/dd/yyyy) _____

☐ **5.** 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). If you currently reside in a long-term care facility, please answer question 2 on the previous page.

I moved on: (mm/dd/yyyy) _____

☐ **6.** I am leaving employer or union coverage.

I will leave this coverage on: (mm/dd/yyyy) _____

☐ **7.** I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid).

I had this change on: (mm/dd/yyyy) _____

☐ **8.** 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*).

I had this change on: (mm/dd/yyyy) _____

☐ **9.** I recently returned to the United States after living permanently outside of the U.S.

I returned to the U.S. on: (mm/dd/yyyy) _____

☐ **10.** I recently obtained lawful presence in the United States.

I got this status on: (mm/dd/yyyy) _____

☐ **11.** I recently was released from incarceration.

I was released on: (mm/dd/yyyy) _____

☐ **12.** I recently left a PACE program.

I left this program on: (mm/dd/yyyy)

☐ **13.** I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's).

I lost my drug coverage on: (mm/dd/yyyy)

☐ **14.** I'm in a qualified State Pharmaceutical Assistance Program, or I'm losing help from a State Pharmaceutical Assistance Program.

☐ **15.** My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

☐ **16.** 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: (mm/dd/yyyy)

☐ **17.** 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 this SNP on: (mm/dd/yyyy)

☐ **18.** I was affected by a weather-related emergency or major disaster as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

☐ **19.** I am currently enrolled in Medicare Part A and am enrolling in Medicare Part B (or recently enrolled in Medicare Part B with an effective date in the past).

Medicare Part B effective date: (mm/dd/yyyy)

☐ Other reason: (please describe Special Election Period)

If none of these statements apply to you or you're not sure, *please contact Tufts Health Plan Medicare Preferred at* ***1-877-409-3499 (TTY: 711)*** *to see if you are eligible to enroll. We are open 8 a.m.–8 p.m., 7 days a week (Mon.–Fri. from Apr. 1–Sept. 30).*

Important Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Tufts Health Plan Medicare Preferred.
- By joining this Medicare Advantage Plan, I acknowledge that Tufts Health Plan Medicare Preferred 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 or Part D plan at a time—and that enrollment in this plan will automatically end my enrollment in another MA or Part D plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my Tufts Health Plan Medicare Preferred coverage begins, I must get all of my medical and prescription drug benefits from Tufts Health Plan Medicare Preferred. Benefits and services provided by Tufts Health Plan Medicare Preferred and contained in my Tufts Health Plan Medicare Preferred "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Tufts Health Plan Medicare Preferred will pay for benefits or services that are not covered.
- **For HMO plans:** I understand that I must choose a primary care provider (PCP) and get a referral before seeing a specialist within my PCP's referral circle. If I obtain routine care from providers outside my PCP's referral circle neither Medicare nor Tufts Health Plan Medicare Preferred will be responsible for the cost.
- Dental benefits for members of Tufts Health Plan Medicare Preferred HMO plans are administered by Dominion Dental Services, Inc. For questions regarding your benefits or provider network, please contact Member Services.
- 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.

Signature: _____ **Today's date:** (mm/dd/yyyy) _____

If you're the authorized representative, sign above and fill out these fields.

Full name:

Street address:

City: State: Zip code:

Phone number: Relationship to Enrollee:

Section 2 All fields in this section are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Preferred written language:

Preferred spoken language:

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

☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

*Please contact Tufts Health Plan Medicare Preferred at **1-877-409-3499 (TTY: 711)** if you need information in an accessible format or language other than what is listed above. Our office hours are 7 days a week, 8 a.m.–8 p.m., 7 days a week (Mon.–Fri. from Apr. 1–Sept. 30).*

☐ I would like to sign up for eDelivery and get my Annual Notice of Change (ANOC), Evidence of Coverage (EOC), Formulary, Provider Directory and Pharmacy Directory electronically instead of by mail.

☐ I would like to get my medical Explanation of Benefits (EOB) electronically instead of by mail.

PAYING YOUR PLAN PREMIUM

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 Tufts Health Plan Medicare Preferred the Part D-IRMAA.

If you don't select a payment option, you will get a bill each month.

For plans with a $0 premium: If you currently owe a late enrollment penalty* or have selected the optional supplemental dental benefit, we need to know how you prefer to pay it. You can pay by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month. **If you do not owe a late enrollment penalty* or have not selected the optional supplemental dental benefit, a payment option is not required**.

*For more information on the late enrollment penalty, visit **thpmp.org/LEP.**

Please select a premium payment option:

◯ Get a bill each month.

◯ Electronic Funds Transfer (EFT) from your bank account each month.

(If this option is selected, an *EFT Authorization Form* will be mailed to you. Please continue to pay your monthly premium until we notify you of your enrollment in the EFT program.)

◯ Automatic deduction from your monthly Social Security benefit check.

◯ Automatic deduction from your monthly Railroad Retirement Board (RRB) benefit check.

The Social Security/RRB deduction may take two or more months to begin. There may be a delay in withholding your premium due to the Social Security Administration's monthly processing schedule, as the start date of premium withholding cannot be retroactive. If there is a delay, you will be billed directly for the first 1–2 months until your premium is deducted from your Social Security or RRB benefit check. You are responsible for paying all premiums due until premium withholding begins. If you do not pay your premium for the month(s) before premium withholding begins, you may be disenrolled from Tufts Health Plan Medicare Preferred. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.

FOR INDIVIDUALS HELPING ENROLLEE WITH COMPLETING THIS FORM ONLY

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members or other third parties) helping an enrollee fill out this form.

Name: (please print)

Signature:

Relationship to enrollee:

OFFICE/BROKER USE ONLY

Agent NPN: Agency name: FMO name:

Date application received: (mm/dd/yyyy) Effective date of coverage: (mm/dd/yyyy)

Plan ID#:

Tufts Medicare Preferred HMO (H2256)

Barnstable, Bristol, Middlesex, Norfolk and Plymouth Counties		Hampden and Hampshire Counties		Essex and Suffolk Counties		Worcester County	
◯ Basic Rx	**026/002**	◯ Basic Rx	**026/003**	◯ Basic No Rx	**042/000**	◯ Basic No Rx	**041/000**
◯ Value No Rx	**019/007**	◯ Value Rx	**018/008**	◯ Basic Rx	**026/001**	◯ Basic Rx	**036/000**
◯ Value Rx	**018/007**	◯ Prime Rx	**015/006**	◯ Value No Rx	**019/001**	◯ Value No Rx	**040/000**
◯ Prime No Rx	**016/002**	◯ Prime Rx Plus	**001/006**	◯ Value Rx	**018/001**	◯ Value Rx	**034/000**
◯ Prime Rx	**015/002**			◯ Prime No Rx	**016/001**	◯ Prime No Rx	**039/000**
◯ Prime Rx Plus	**001/002**			◯ Prime Rx	**015/001**	◯ Prime Rx	**033/000**
				◯ Prime Rx Plus	**001/001**		

Hampden, Hampshire, Middlesex and Worcester Counties		Bristol, Essex, Norfolk, Plymouth and Suffolk Counties		Barnstable County	
◯ Smart Saver Rx	**047/001**	◯ Smart Saver Rx	**047/002**	◯ Smart Saver Rx	**047/003**

Tufts Medicare Preferred PPO Rx (H9907)

Bristol, Essex, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk and Worcester Counties	
◯ PPO Rx	**003/000**

Enrollment period:

☐ ICEP/IEP ☐ AEP ☐ OEP ☐ SEP (type:) ☐ Not eligible

PRIVACY ACT STATEMENT The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 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.

Tufts Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity). ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-701-9000 (HMO)/1-866-623-0172/(PPO) (TTY: 711).

TUFTS Health Plan

a Point32Health company

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) (TTY: 711) or speak to your provider.

Español (Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) (TTY: 711) o hable con su proveedor.

Português (Portuguese) ATENÇÃO: Se fala Português, estão disponíveis para si serviços gratuitos de assistência linguística. Estão também disponíveis gratuitamente ajudas e serviços auxiliares adequados para fornecer informações em formatos acessíveis. Ligue para 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) (TTY - Dispositivo das telecomunicações para surdos: 711) ou fale com o seu prestador.

中文 (**Simplified Chinese**) 注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-800-701-9000 (HMO)/1-866-623-0172 (PPO)（文本电话：711）或咨询您的服务提供商。

Kreyòl Ayisyen (Haitian Creole) ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd aladispozisyon w gratis pou lang ou pale a. Èd ak sèvis siplemantè apwopriye pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele nan 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) (TTY: 711) oswa pale avèk founisè w la.

Việt (Vietnamese) LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

РУССКИЙ (Russian) ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) (TTY: 711) или обратитесь к своему поставщику услуг.

(Arabic) العربية تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 711 (1-800-701-9000 (PPO) 1-866-623-0172 (HMO)) أو تحدث إلى مقدم الخدمة.

ភាសាខ្មែរ (Khmer) សូមយកចិត្តទុកដាក់៖ ប្រសិនបើអ្នកនិយាយ ភាសាខ្មែរ សេវាកម្មជំនួយភាសាឥតគិតថ្លៃគឺមានសម្រាប់អ្នក។ ជំនួយ និងសេវាកម្មដែលជាការជួយដ៏សមរម្យ ក្នុងការផ្តល់ព័ត៌មានតាមទម្រង់ដែលអាចចូលប្រើប្រាស់បាន ក៏អាចរកបានដោយឥតគិតថ្លៃផងដែរ។ ហៅទូរសព្ទទៅ 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) (TTY: 711) ឬនិយាយទៅកាន់អ្នកផ្តល់សេវារបស់អ្នក។

Français (French) ATTENTION: Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) (TTY: 711) ou parlez à votre fournisseur.

Italiano (Italian) ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'1-800-701-9000 (HMO)/1-866-623-0172 (PPO) (tty: 711) o parla con il tuo fornitore.

한국어 **(Korean)** 주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-701-9000 (HMO)/1-866-623-0172 (PPO)(TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.

Ελληνικά (Greek) ΠΡΟΣΟΧΗ: Εάν μιλάτε ελληνικά, υπάρχουν διαθέσιμες δωρεάν υπηρεσίες υποστήριξης στη συγκεκριμένη γλώσσα. Διατίθενται δωρεάν κατάλληλα βοηθήματα και υπηρεσίες για παροχή πληροφοριών σε προσβάσιμες μορφές. Καλέστε το 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) (TTY: 711) ή απευθυνθείτε στον πάροχό σας.

POLSKI (Polish) UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) (TTY: 711) lub porozmawiaj ze swoim dostawcą.

हिंदी **(Hindi)**न दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

ગુજરાતી **(Gujarati)** ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-800-701-9000 (HMO)/1-866-623-0172 (PPO) (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.