2024 Summary of Benefits

eternalHealth Freedom (PPO)

Your
Forever Partner
In Healthcare.

H2694-001_SB24_FR_M

Summary of Benefits

What does this document contain?

This summary of benefits serves as a resource to understand the coverage and costs associated with eternalHealth's Freedom PPO plan. The information in this document is for the plan year beginning January 1, 2024 and ending December 31, 2024.

What are the eligibility requirements for this plan?

To be eligible for this plan, you must

- be enrolled in both Medicare Parts A & B and
- live in Suffolk, Worcester, Middlesex, Norfolk, Bristol, or Plymouth County in Massachusetts.

Does this plan cover my current healthcare needs?

To find out if this plan covers your current prescription drugs, doctors, and pharmacies, please visit us at www.eternalhealth.com to view our online drug list and directory. If you have questions or would like a paper copy mailed to you, please call us at 1-800-680-4568 (TTY 711).

Where can I learn more about Medicare?

The ***Medicare & You* handbook** is a great resource and can be found at www.medicare.gov. You can also request a paper copy to be mailed to you by calling 1-800-MEDICARE (1-800-633-4227). TTY users can dial 1-877-486-2048, 24 hours a day, 7 days a week.

What is a deductible?

A deductible is the amount of money you pay out of pocket before your health plan begins to pay. Once you reach the defined threshold, you will only have to pay coinsurance or a copayment.

What is a copayment?

A copayment (also known as copay) is a fixed amount of money you pay out of pocket when you receive care.

What is coinsurance?

Coinsurance is a percentage you pay out of pocket for the cost of your care.

Where can I find more information?

If you would like more information, please see eternalHealth's Evidence of Coverage at www.eternalhealth.com under Member Resources.

You can call customer service at 1-800-680-4568 (TTY 711) from:

October 1 to March 31, 8am to 8pm, 7 days a week.

April 1 to September 30, 8am to 8pm, Monday to Friday.

EternalHealth is an HMO and PPO Plan with a Medicare contract. Enrollment in eternalHealth depends on contract renewal. The benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please call 1-800-680-4568 (TTY 711) and request the "Evidence of Coverage" or access it online at www.eternalHealth.com.

Pre-Enrollment Checklist

Prior to making an enrollment decision, it is important that you fully understand the coverage you are going to be receiving. If you have any questions regarding your coverage options, you can call to speak to us at 1 (800) 893-9457 (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 that are important to you before enrolling. Visit www.eternalHealth.com/Forms-Documents or call 1 (800) 893-9457 (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

- ☐ You must continue to pay your Medicare Part B premium. This premium is typically 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).
- ☐ Select benefits and services may require a prior authorization.

My Monthly Premium, Deductible, and Maximum Out of Pocket

	Freedom (PPO) H2694-001	
	In-Network	**Out-Of-Network**
Monthly Premium	$0	
Medicare Part B Buy Down (Give Back)	This plan does not offer a Medicare Part B Buy Down.	
Medical Deductible	This plan does not have a deductible.	
Pharmacy (Part D) Deductible	**Tier 1 and Tier 2** $0 deductible. **Tier 3, Tier 4, and Tier 5** $185 deductible.	
Maximum Out-of-Pocket Responsibility This is the maximum amount you will pay during the plan year for copays, coinsurance, medical services, supplies, and Part B-covered medication. Any out-of-pocket expenses for prescription drugs and other benefits do not apply.	$6,000	$9,000 Combined.

My Covered Hospital and Medical Benefits and Services

	Freedom (PPO) H2694-001	
	In-Network	**Out-Of-Network**
Inpatient Hospital Coverage Prior Authorization will be required.	**Days 1-5;** $370 copay per day. **Day 6+;** $0 copay per day.	40% coinsurance per stay.
Outpatient Hospital Coverage Prior Authorization will be required for procedures performed in an Outpatient Hospital.	**Diagnostic Colonoscopy** $0 copay at any in-network location. **Outpatient Hospital** $350 copay for surgery performed at an outpatient hospital. **Observation Stays** $350 copay per stay.	**Diagnostic Colonoscopy** 40% coinsurance per procedure. **Outpatient Hospital** 40% coinsurance for surgery performed at an outpatient hospital. **Observation Stays** 40% coinsurance per stay.

Ambulatory Surgical Center (ASC) Services Prior Authorization will be required for procedures performed in an Ambulatory Surgical Center.	**Diagnostic Colonoscopy** $0 copay if performed at an ASC. **ASC** $250 copay for surgery performed at an ASC.	**Diagnostic Colonoscopy** 30% coinsurance if performed at an ASC. **ASC** 30% coinsurance for surgery performed at an ASC.
Doctor Visits You will need a referral from your Primary Care Provider (PCP) if you visit a specialist, acupuncturist, or chiropractor.	**Primary Care Provider (PCP) Visit** $0 copay per visit. **Specialist Visits** $0 copay per visit.	**Primary Care Provider (PCP) Visits** $0 copay per visit. **Specialist Visits** $20 copay per visit.
Preventive Care Preventive services are available at no cost if you use an in-network provider, including: • Abdominal Aortic Aneurysm (AAA) Screening • Alcohol Misuse Screening & Counseling • Annual Wellness Visit • Bone Mass Measurements (bone density) • Cardiovascular Disease Screening Tests • Cervical Cancer Screening • Colorectal Cancer Screening • Counseling to Prevent Tobacco Use • COVID-19 Vaccine Immunization • Depression Screening • Diabetes Screening • Diabetes Self-Management Training • Flu Shot & Administration • Glaucoma Screening • Hepatitis B Screening	$0 copay per service.	30% coinsurance per service.

• Hepatitis B Shot & Administration • Hepatitis C Screening • HIV Screening • Initial Preventive Physical Exam • Intensive Behavioral Therapy (IBT) for cardiovascular disease • Intensive Behavioral Therapy (IBT) for Obesity • Lung Cancer Screening • Mammography Screening • Medical Nutrition Therapy • Medicare Diabetes Prevention Program • Pap Tests Screening • Pneumococcal Shot & Administration • Prolonged Preventive Services • Prostate Cancer Screening • Screening Pelvic Exam • Sexually Transmitted Infection (STI) Screening & High Intensity Behavioral Counseling (HIBC) to Prevent STIs Any additional preventive services approved by Medicare during the contract year will be covered.		

Emergency Care You do not have to pay this copay if you are admitted to the hospital within 24 hours. If admitted, refer to the Inpatient Hospital Coverage section. This plan also covers your emergency services worldwide. If you pay the costs yourself at first, generally done outside the United States, you can submit a claim and we will reimburse you.	$100 copay per visit. $100 copay per visit for Worldwide Emergency care.	$100 copay per visit. $100 copay per visit for Worldwide Emergency care.
Urgently Needed Services Urgently needed services means services needed immediately as a result of an unforeseen illness, injury, or condition to prevent a serious deterioration in health. This plan also covers your emergency services worldwide. If you pay the costs yourself at first, generally done outside the United States, you can submit a claim and we will reimburse you. You do not have to pay this copay if you are admitted to the hospital within 24 hours. If admitted, refer to the Inpatient Hospital Coverage section.	$0 copay for urgently needed services from your PCP. $25 copay for urgently needed services from an urgent care center or walk-in center. $40 copay per visit for Worldwide Urgent care.	$0 copay for urgently needed services from your PCP. $25 copay for urgently needed services from an urgent care center or walk-in center. $40 copay per visit for Worldwide Urgent care.

Diagnostic Services/ Labs/Imaging **Lab Services:** Prior authorization required for high-cost genetic testing and molecular studies. **Diagnostic Radiology:** Prior authorization required. **Diagnostic Tests and Procedures:** Prior Authorization is required for high-tech imaging. **Radiation Therapy:** Prior authorization required.	**Lab Services** $0 copay for labs done in an office setting. $10 copay in a free-standing lab facility. **X-rays** $15 copay for X-rays done in an office setting or in a free-standing lab facility. **Diagnostic Radiology (Ie; CT, MRI, PET, etc)** $150 copay for Ultrasounds. $300 copay for all others. **Diagnostic Tests and Procedures (Ie; stress test)** $0 copay per service in an office setting. $30 copay per service at free standing lab facility. **Radiation Therapy** $60 copay.	**Lab Services** 30% coinsurance. **X-rays** 30% coinsurance. **Diagnostic Radiology (Ie; CT, MRI, PET, etc)** 30% coinsurance. **Diagnostic Tests and Procedures (Ie; stress test)** 30% coinsurance. **Radiation Therapy** 30% coinsurance.
Hearing Services Routine Hearing Exam & Hearing aid copayments do not apply towards your maximum out of pocket (MOOP).	**Medicare Covered Hearing Services** $15 copay per service. **Routine Hearing Exam** $0 copay per exam. **Hearing Aids (Up to 2 aids per year – 1 per ear, per year.)** $595 copay based on your selection through Amplifon. $895 copay based on your selection through Amplifon. Hearing aid purchase includes: • 60-day risk free trial • Complimentary aftercare • New virtual services including virtual screening, personalized coaching, and on-demand virtual visits.	**Medicare-covered Hearing Exam** 50% coinsurance per service. **Routine Hearing Exam** 50% coinsurance per exam. **Hearing Aids** 50% coinsurance.

	Must use our designated vendor for this benefit.	
Dental Services Preventive Services include: • Oral Exams • Prophylaxis (Cleaning) • Dental X-Rays • Non-Medicare-covered (routine) dental cleaning • Non-Medicare-covered (routine) dental X-rays Comprehensive Services include: • Diagnostic Services • Restorative Services • Endodontics • Periodontics • Extractions • Prosthodontics • Other Oral/Maxillofacial Surgery This is not an exhaustive list of covered dental services. This Dental Allowance benefit does not apply to your maximum out-of-pocket (MOOP).	**Medicare-covered Dental Services** $30 copay *An example of this is reconstruction of the jaw following an accidental injury.* **$4,000 Annual Allowance** eternalHealth will pay as much as **$4,000 per year** for comprehensive and preventive services, with **no required network.** This allowance will be available for use on a Mastercard Prepaid Flex Card and may be used at the dental provider of your choice. There are no restrictions or limitations.	**Medicare-covered Dental Services** $0 copay. *An example of this is reconstruction of the jaw following an accidental injury.* **$4,000 Annual Allowance** eternalHealth will pay as much as **$4,000 per year** for comprehensive and preventive services, with **no required network.** This allowance will be available for use on a Mastercard Prepaid Flex Card and may be used at the dental provider of your choice. There are no restrictions or limitations.
Vision Services Routine Eye Exams & Eyewear purchases do not apply towards your maximum out of pocket (MOOP).	**Medicare-covered Eye Exams** $15 copay per exam. **Routine Eye Exams** $0 copay per exam. **Eyewear Benefit** eternalHealth will pay as much as $200 per year towards eyewear. This can be used for frames, lenses, contact lenses, or eyeglass replacements.	**Medicare-covered Eye Exams** 50% coinsurance per exam. **Routine Eye Exams** 50% coinsurance per exam. **Eyewear Benefit** 50% coinsurance.

	Must use our designated vendor for this benefit.	
Mental Health and Substance Abuse Services Prior Authorization is required for Inpatient Mental Health Care.	**Mental Health Inpatient Services** **Days 1-5;** $370 copay per day. **Day 6-90;** $0 copay per day **Individual & Group Therapy Sessions (Psychologist or Other Medical professional)** $25 copay per visit. **Individual & Group Therapy Sessions (Psychiatric Services)** $25 copay per visit. **Medication Adherence Visits (Psychiatric Services & Psychologist or Other Medical professional)** $0 copay per visit. **Outpatient Substance Abuse Therapy Sessions (Individual & Group)** $25 copay per visit. **Opioid Treatment Program Services** $25 copay per visit.	**Mental Health Inpatient Services** 40% coinsurance per stay. **Individual & Group Therapy Sessions (Psychologist or Other Medical professional)** $50 copay per visit. **Individual & Group Therapy Sessions (Psychiatric Services)** 30 % Coinsurance per visit. **Medication Adherence Visits (Psychiatric Services)** 30 % Coinsurance per visit. **Medication Adherence Visits (Other Medical professional)** $50 copay per visit. **Outpatient Substance Abuse Therapy Sessions (Individual & Group)** $50 copay per visit. **Opioid Treatment Program Services** 30% copay per visit.
Skilled Nursing Facility (SNF) Prior Authorization is required for SNF. No prior hospital stay required.	**Days 1-20;** $0 copay per day. **Days 21-100;** $203 copay per day.	30% coinsurance per stay.
Occupational, Physical and Speech Therapy Prior Authorization is required for PT, OT, and ST. You will need a referral from your Primary Care Provider (PCP) for these services.	$40 copay per visit.	30% coinsurance per visit.

Ambulance Services This plan covers you for ambulance transportation. Prior Authorization will be required for non-emergency Medicare services. This plan also covers you for emergency transportation provided worldwide. If you pay the costs yourself at first, generally done outside the United States, you can submit a claim and we will reimburse you.	**Ground/Air Ambulance** $300 copay per service.	**Ground/Air Ambulance** $300 copay per service.
Transportation This benefit does not apply to your maximum out-of-pocket (MOOP).	Trips to and from healthcare-related locations such as your doctor appointments or the pharmacy $0 copay – unlimited rides. Rides can be pre-scheduled or booked on-demand. Forms of transportation include: • Uber and Lyft • Oxygen capable vehicles • Wheelchair vans • Stretcher and gurney services • Non-emergency ambulances/life support services • And more! Must use our designated vendor for this benefit.	50% coinsurance.
Part B Prescription Drugs Authorization rules may apply. Generally, Part B drugs are not self-administered. These drugs can be given in a doctor's office as part of a medical service. In a hospital outpatient department, coverage is generally limited	20% coinsurance.	30% coinsurance.

to drugs that are given by infusion or injection.		

My Prescription Drug Benefits

Use this section to learn about the four-Part D phases. The costs are what you'll pay at in-network pharmacies. Generally, you have to use network pharmacies to fill your prescription meds. Costs may change depending on your pharmacy and when you enter a new Part D phase.

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you. Call Member Services for more information.

Important Message About What You Pay for Insulin - You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on even if you haven't paid your deductible.

Deductible

After you pay your yearly deductible (for certain tiers), our plan starts to cover some of your costs. You stay in the Initial Coverage Stage until the total amount for the prescription drugs you and our plan pay reaches the **$5,030 limit.**

	eternalHealth Freedom (PPO) H2694-001
Deductible Tiers 1, 2	$0
Deductible Tiers 3-5	$185

Initial Coverage

	eternalHealth Freedom (PPO) H2694-001	
Supply	**Retail**	**Mail Order**
Tier 1 (Preferred Generic)	**30-Day Supply** $0 copay. **100-Day Supply** $0 copay.	**30-Day Supply** $0 copay. **100-Day Supply** $0 copay.
Tier 2 (Generic)	**30-Day Supply** $5 copay. **100-Day Supply** $15 copay.	**30-Day Supply** $5 copay. **100-Day Supply** $5 copay.

Tier 3 **(Preferred Brand)** You pay $35 per month supply of each covered insulin product on this tier.	**30-Day Supply** $47 copay. **100-Day Supply** $141 copay.	**30-Day Supply** $47 copay. **100-Day Supply** $47 copay.
Tier 4 **(Non-Preferred Brand)** You pay $35 per month supply of each covered insulin product on this tier.	**30-Day Supply** $100 copay. **100-Day Supply** $300 copay.	**30-Day Supply** $100 copay. **100-Day Supply** $300 copay.
Tier 5 **(Specialty)** You pay $35 per month supply of each covered insulin product on this tier.	**30-Day Supply** 30% coinsurance. **100-Day Supply** Not covered.	**30-Day Supply** 30% coinsurance. **100-Day Supply** Not covered.

- Costs may differ based on pharmacy type such as mail order, long-term care (LTC) or home infusion, and 30-day or 100-day supply.

Coverage Gap

During the Coverage Gap Stage, you will pay 25% of the plan's cost for covered brand-name drugs and 25% of the plan's cost for covered generic drugs.

During the Coverage Gap Stage, your out-of-pocket costs for insulin will be $35 for a one-month supply.

You stay in the Coverage Gap Stage until your out-of-pocket costs reach $8,000.

Catastrophic Coverage Stage

You qualify for the Catastrophic Coverage Stage when your yearly out-of-pocket costs have reached the $8,000 limit. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

Beginning in 2024, if you reach the Catastrophic Coverage Stage, you pay nothing for covered Part D prescription drugs.

My Additional Covered Benefits and Services

	eternalHealth Freedom (PPO) H2694-001	
	In-Network	**Out-Of-Network**
Telehealth Services Medicare covered Primary care Physician (PCP) and Physician Specialist Services. This benefit may not be offered by all providers. Check availability directly with your PCP or Specialist.	$0 copay for Primary care Physician (PCP) and Physician Specialist Services.	$0 copay per service for Primary care Physician (PCP) Services. $20 copay per service for Physician Specialist Services.
Medicare-Covered Acupuncture Visits	$25 copay per Medicare-Covered acupuncture. Not applicable for Non-Medicare Covered acupuncture.	$55 copay per Medicare-Covered acupuncture.
Medicare-Covered Chiropractic Care You will need a referral from your Primary Care Provider (PCP) for these services.	$15 copay per visit.	30% coinsurance per visit.
Kidney Disease Treatment Services	**Dialysis Treatment (both facility and clinic visits)** 20% coinsurance. Dialysis received as a hospital inpatient will be covered under your hospital inpatient benefit. **Kidney Disease Education Services** $0 copay per service.	**Dialysis Treatment (both facility and clinic visits)** 30% coinsurance. Dialysis received as a hospital inpatient will be covered under your hospital inpatient benefit. **Kidney Disease Education Services** 30% coinsurance.
Foot Care (Podiatry Services) Prior Authorization is required for visits other than routine.	$35 copay per service.	30% coinsurance.
Durable Medical Equipment (DME) and Prosthetic Devices	20% coinsurance.	30% coinsurance.

Diabetic Supplies Prior Authorization is required for Diabetic Supplies.	**Medicare-covered Diabetic Supplies** **Test Strips** You pay 0% coinsurance for preferred brand (LifeScan & Roche) test strips. All other brands are excluded and would need an approved exception. If approved, you pay 20% coinsurance. **Continuous Glucose Monitors** You pay 0% coinsurance for preferred brand (Dexcom and Freestyle Libre) Medicare covered Continuous Glucose Monitors (CGM) when ordered by a physician and filled at a network pharmacy. All other brands are excluded and would need an approved exception. If approved, you pay 20% coinsurance for diabetic supplies accessed at non-pharmacy networks (i.e., durable medical equipment (DME) suppliers). **Other Blood Glucose Testing Supplies** Other blood glucose testing supplies (e.g., lancets, glucose-control solution etc.), you pay 20% coinsurance. **Medicare-covered Diabetic Therapeutic Shoes or Inserts** 20% coinsurance.	**Medicare-covered Diabetic Supplies** 30% coinsurance. **Medicare-covered Diabetic Therapeutic Shoes or Inserts** 30% coinsurance.
Cardiac & Pulmonary Rehabilitation Services Prior Authorization is required for Cardiac and Pulmonary Rehabilitation services.	**Pulmonary Rehabilitation Services** $15 copay. **Cardiac Rehabilitation Services** $20 copay. **Supervised Exercise Therapy for Peripheral Arterial Disease (SET-PAD)** $25 copay.	**Pulmonary Rehabilitation Services** 30% coinsurance. **Cardiac Rehabilitation Services** 30% coinsurance. **Supervised Exercise Therapy for Peripheral Arterial Disease (SET-PAD)** 30% coinsurance.

Annual Wellness Exams	$0 copay per exam.	50% coinsurance.
Over the Counter (OTC) This benefit does not apply to your maximum out-of-pocket (MOOP) amount.	$50 Per calendar quarter (every three months). This amount does not roll over from quarter to quarter. Eligible items are listed in the OTC Catalog. To purchase eligible items, you can order online through your portal, over the phone, via mail order, or by visiting participating stores. Must use our designated vendor for this benefit.	
SSBCI Healthy Grocery Members having Diabetes, Cancer, Cardiovascular disorders, Chronic and disabling mental health conditions & End-stage renal disease (ESRD) are eligible to use their standard $50 OTC benefit combined with an additional $60 benefit every three months towards healthy food and produce or OTC products. This benefit does not apply to your maximum out-of-pocket (MOOP). *This benefit is for members who qualify. Not all members will qualify for this benefit.*	$60 Per calendar quarter (every three months). This amount does not roll over from quarter to quarter. Eligible items are listed in the OTC Catalog. To purchase eligible items, you can order online through your portal, over the phone, via mail order, or by visiting participating stores. Must use our designated vendor for this benefit.	
Fitness This benefit does not apply to your maximum out-of-pocket (MOOP).	OnePass offers a robust and flexible fitness benefit, which gives members access to various gyms, boutique fitness studios, online fitness videos and home kits. eternalHealth covers the full cost of this benefit. Must use our designated vendor for this benefit.	
In-Home Support This benefit does not apply to your maximum out-of-pocket (MOOP).	In-Home Support assistance through Papa includes 60 hours annually for services such as: • Household chores – light cleaning, organization, laundry • Technical Assistance – learning telehealth services to connect with physicians, accessing health plan portals, installing devices • Exercise and Activity- walking or biking assistance • Virtual services	

	Must use our designated vendor for this benefit.
Personal Emergency Response Device (PERS) This benefit does not apply to your maximum out-of-pocket (MOOP) amount.	eternalHealth offers a fully covered monthly subscription for In-home, Mobile LTE, and LTE Smartwatch PERS options. Must use our designated vendor for this benefit.

Notice of Non-Discrimination: Discrimination is Against the Law

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

eternalHealth:

- 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 eternalHealth Member Services at **1-800-680-4568 (TTY 711)**

If you believe that eternalHealth has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

eternalHealth (Mail)
eternalHealth, Inc.
eH Privacy Officer
C/O Appeals & Grievances
PO Box 1377
Westborough, MA 01581

eternalHealth (Phone/Fax)
Local Phone Number: 617-684-2348 (TTY 711)
Toll Free Phone Number: 1-800-680-4568 (TTY 711)
Fax: 1-866-326-1073

eternalHealth (In Person)
eternalHealth, Inc.
31 St. James Ave, Suite 950
Boston, MA 02116

You can file a grievance in person, by mail, or fax. If you need help filing a grievance, eternalHealth Member Services 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:

U.S. Department of Health and Human Services

200 Independence Avenue, SW Room 509F, HHH Building

Washington, D.C. 20201

Phone: 1-800-368-1019, 800-537-7697 (TDD)

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

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-680-4568 (TTY:711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-680-4568 (TTY:711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-800-680-4568 (TTY:711)。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-800-680-4568 (TTY:711)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-680-4568 (TTY:711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-680-4568 (TTY:711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-680-4568 (TTY:711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-680-4568 (TTY:711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-680-4568 (TTY:711)번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-680-4568 (TTY:711). 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 بمساعدتك. هذه خدمة فوري، ليس عليك سوى الاتصال بنا على (T1-800-680-4568, TTY:711. سيقوم شخص ما يتحدث العربية مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-680-4568 (TTY:711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-680-4568 (TTY:711). 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 1-800-680-4568 (TTY:711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-680-4568 (TTY:711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-680-4568 (TTY:711). Ta usługa jest bezpłatna.

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