2023 Summary of Benefits

eternalHealth Give Back PPO (PPO)

Your
Forever Partner
In Healthcare.

H2694-002_SB23_GBPPO__M

Changes to the
eternalHealth Give Back PPO
2023
Evidence of Coverage and Summary of Benefits

This is important information on changes in your eternalHealth Give Back PPO coverage.

We previously informed you that the Evidence of Coverage (EOC) and Summary of Benefits which provides information about your coverage as an enrollee in our plan is located on our website at *www.eternalHealth.com*. This notice is to let you know there were errors in your EOC and Summary of Benefits. Below you will find information describing and correcting the errors. Please keep this information for your reference. The corrected documents have been updated and can be found on our website *www.eternalHealth.com*.

Important Message About What You Pay For Part B Covered Drugs

Medicare beneficiaries have new benefits available under the Inflation Reduction Act (IRA) that apply to eternalHealth members.

Effective April 1, 2023
Your coinsurance for certain Part B rebatable drugs, as determined by Medicare, may be subject to a lower coinsurance (less than 20%).

Effective July 1, 2023
You will not pay more than $35 for a one-month supply of each insulin product covered by our plan, if you use with a traditional insulin pump that is covered under the Medicare durable medical equipment benefit (Part B). Service category or plan level deductibles do not apply to covered Part B insulins.

H2694-002_ER_GBPPO_C

Changes to your EOC

Where you can find the error in your 2023 EOC	Original Information	Corrected Information	What does this mean for you?
On page 72, in Chapter 4 Medical Benefits Chart, your Evidence of Coverage lists the Medicare Part B prescription drug coverage as:	You pay 20% coinsurance for Medicare-covered Part B prescription drugs, including chemotherapy drugs. This cost share will apply to the administration of these drugs in all places of treatment.	You pay 20% coinsurance for Medicare-covered Part B prescription drugs, including chemotherapy drugs. This cost share will apply to the administration of these drugs in all places of treatment. Effective 4/1/2023, certain Part B rebatable drugs, as determined by Medicare, may be subject to a lower coinsurance (less than 20%).	You may pay less than 20% coinsurance for certain Part B rebatable drugs.
On page 58, in Chapter 4 Medical Benefits Chart your Evidence of Coverage lists your Part B diabetic supplies as:	You pay 0 - 20% coinsurance.	Effective July 1, you will not pay more than $35 for a one-month supply of each insulin product covered by our plan, if used with a traditional insulin pump that is covered under the Medicare durable medical equipment benefit (Part B). Service category or plan level deductibles do not apply to covered Part B insulins.	Effective July 1, 2023, you will not pay more than $35 for one-month of insulin you use in a traditional insulin pump that is covered under the Medicare durable medical equipment benefit.

Changes to your Summary of Benefits

Where you can find the error in your 2023 Summary of Benefits	Original Information	Corrected Information	What does this mean for you?
On page 7, of your Summary of Benefits lists the Medicare Part B prescription drug coverage as:	20% coinsurance.	You pay 20% coinsurance for Medicare-covered Part B prescription drugs, including chemotherapy drugs. This cost share will apply to the administration of these drugs in all places of treatment. Effective 4/1/2023, certain Part B rebatable drugs, as determined by Medicare, may be subject to a lower coinsurance (less than 20%).	You may pay less than 20% coinsurance for certain Part B rebatable drugs.
On page 10, of your Summary of Benefits lists your Part B diabetic supplies as:	You pay 0 - 20% coinsurance.	Effective July 1, you will not pay more than $35 for a one-month supply of each insulin product covered by our plan, if used with a traditional insulin pump that is covered under the Medicare durable medical equipment benefit (Part B). Service category or plan level deductibles do not apply to covered Part B insulins.	Effective July 1, 2023, you will not pay more than $35 for one-month of insulin you use in a traditional insulin pump that is covered under the Medicare durable medical equipment benefit.

You are not required to take any action in response to this document, but we recommend you keep this information for future reference. If you have any questions, please call us at *1 (800) 680-4568 (TTY users should call 711).* **Hours are 8:00 a.m. through 8:00 p.m., 7 days a week, from October 1 – March 31, and 8:00 a.m. through 8:00 p.m. Monday through Friday and 10:00 a.m. through 2:00 p.m. on Saturdays, from April 1 – September 30.**

Sincerely,

eternalHealth Team

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 Give Back PPO plan. The information in this document is for the plan year beginning January 1, 2023 and ending December 31, 2023.

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 Middlesex, Suffolk, or Worcester 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, 10am to 2pm, Saturday.

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.

My Monthly Premium, Deductible, and Maximum Out of Pocket

	eternalHealth Give Back (PPO) H2694-002	
	In-Network	Out-Of-Network
Monthly Premium	$0	
Medicare Part B Buy Down (Give Back)	$65 per month.	
Medical Deductible	$0	
Pharmacy (Part D) Deductible	**Tier 1 and Tier 2** $0 deductible. **Tier 3, Tier 4, and Tier 5** $300 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.	$7,450	$12,000 Combined.

My Covered Hospital and Medical Benefits and Services

	eternalHealth Give Back (PPO) H2694-002	
	In-Network	**Out-Of-Network**
Inpatient Hospital Coverage Authorization will be required.	**Days 1-4;** $430 copay per day. **Day 5-90;** $0 copay per day.	40% coinsurance.
Outpatient Hospital Coverage Authorization may be required for procedures performed in an Outpatient Hospital.	$0 - $350 copay per visit.	40% coinsurance.
Ambulatory Surgical Center (ASC) Services Authorization may be required for procedures performed in an Ambulatory Surgical Center.	$0 - $250 copay per visit.	30% coinsurance.

Doctor Visits A referral may be required from your Primary Care Provider (PCP) if you visit a specialist, acupuncturist, or chiropractor for these services to be In-Network.	**Primary Care Provider (PCP) Visits** $0 copay per visit. **Specialist Visits** $40 copay per visit.	**Primary Care Provider (PCP) Visits** $20 copay per visit. **Specialist Visits** $55 copay per visit.
Preventive Care	$0 copay per service. 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 • 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	30% coinsurance.

Preventive Care Cont.	• 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	
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.	$95 copay per visit.	
Urgently Needed Services This plan also covers you for Urgent Care provided worldwide.	$0 - $40 copay per visit.	
Diagnostic Services/Labs /Imaging Authorization may be required. Diagnostic Test & Lab Services, Medicare – covered X-Rays, Medicare- covered Therapeutic Radiological Services, and Medicare-covered Diagnostic Services, which includes: • Computed Tomography (CT) • Magnetic Resonance Imaging (MRI) • Positron Emission Tomography (PET) • Other Diagnostic/ General Imaging	**Diagnostic Tests & Lab Services** $0 - $40 copay per service. **Medicare-covered X-ray Services** $20 copay per service. **Medicare-covered Diagnostic Radiological Services** $150 - $350 copay per service.	**Diagnostic Tests & Lab Services** 30% coinsurance. **Medicare-covered X-ray Services** 30% coinsurance. **Medicare-covered Diagnostic Radiological Services** 30% coinsurance.
Medicare Covered Hearing Services	$45 copay per service.	30% coinsurance.

Routine Hearing Care This benefit does not apply to your maximum out-of-pocket (MOOP) amount.	**Routine Hearing Exam** $0 copay per exam. **Hearing Aids** $395 - $695 Based upon your selection through Amplifon.	**Routine Hearing Exam** $45 copay per exam. **Hearing Aids** $395 - $695 Based upon your selection through Amplifon.
Medicare Covered Dental Services An example of this is reconstruction of the jaw following an accidental injury.	$45 copay per service.	50% coinsurance.
Preventive Dental Services This benefit does not apply to your maximum out-of-pocket (MOOP) amount. Preventive Services include: • Oral Exams (2 per 12 months) • Bitewing X-rays (1 per 12 months) • Cleaning (2 per 12 months) • Fluoride (2 per 12 months)	$0 copay per service.	30% coinsurance.
Comprehensive Dental Services This benefit does not apply to your maximum out-of-pocket (MOOP) amount. Comprehensive Services Include: • Fillings (1 per tooth, 1 per 24 months) • Crowns (1 per tooth every 60 months) • Dentures (1 per 60 months) • Implants (1 per 60 months per tooth) • Root Canal (1 per tooth per lifetime) • Extractions (1 per tooth per lifetime)	50% coinsurance.	

• Periodontics (1 per quadrant per 36 months)		
Medicare Covered Eye Exams	$45 copay per exam.	30% coinsurance.
Routine Eye Exams This benefit does not apply to your maximum out-of-pocket (MOOP) amount.	$0 copay per exam.	$45 copay per exam.
Eyewear Benefits This benefit does not apply to your maximum out-of-pocket (MOOP) amount.	A maximum of $200 is covered by the plan for eyewear Per Year.	
Mental Health and Substance Abuse Services	**Individual or Group Therapy Sessions** $0 - $40 copay per visit. **Mental Health Inpatient Services** Days 1-4; $430 copayment per day. Days 5-90; $0 copayment per day. *Authorization may be required.* **Mental Health Partial Hospitalization** $40 copay per visit. You will need a referral from you Primary Care Provider (PCP) for these services to be In-Network. **Opioid Treatment Program Services** $45 copay per visit.	**Individual or Group Therapy Sessions** $50 copay per visit. **Mental Health Inpatient Services** 40% coinsurance **Mental Health Partial Hospitalization** 30% coinsurance. You will need a referral from you Primary Care Provider (PCP) for these services to be In-Network. **Opioid Treatment Program Services** 30% coinsurance.
Skilled Nursing Facility (SNF) Authorization will be required. No prior hospital stay required.	**Days 1-20;** $0 copay per day. **Days 21-100;** $196 copay per day.	30% coinsurance.
Occupational, Physical and Speech Therapy Authorization will be required. You will need a referral from you Primary Care Provider (PCP) for these services to be In-Network.	$40 copay per visit.	30% coinsurance.
Ambulance Services	**Ground/Air Ambulance**	

This plan covers you for ambulance transportation. Authorization will be required for non-emergency Medicare services. This plan also covers you for emergency transportation provided worldwide.	$300 copay per service.	
Transportation (Non-Medicare-covered — routine)	Unlimited transportation to plan approved medical appointments and pharmacies. Various transportation options for on-demand or pre-scheduled services.	30% 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 to drugs that are given by infusion or injection.	20% coinsurance.	30% coinsurance.

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, even if you haven't paid your deducible. Call Pharmacy Member Services for more information at 1-800-891-6989.

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 **$4,660 limit.**

	eternalHealth Give Back PPO H2694-002
Deductible Tiers 1, 2	$0
Deductible Tiers 3-5	$300

Initial Coverage

	eternalHealth Give Back (PPO) H2694-002	
Supply	**Retail**	**Mail Order**
Tier 1 (Preferred Generic)	$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)	**30-Day Supply** $47 copay. **100-Day Supply** $141 copay.	**30-Day Supply** $47 copay. **100-Day Supply** $47 copay.
Tier 3 Insulins	**30-Day Supply** $35 copay. **100-Day Supply** $105 copay.	**30-Day Supply** $35 copay. **100-Day Supply** $47 copay.
Tier 4 (Non-Preferred Drug)	**30-Day Supply** $100 copay. **100-Day Supply** $300 copay.	**30-Day Supply** $100 copay. **100-Day Supply** $300 copay.
Tier 5 (Specialty)	**30-Day Supply** 28% 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- 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 $7,400.

Catastrophic Coverage Stage

You qualify for the Catastrophic Coverage Stage when your yearly out-of-pocket costs have reached the $7,400 limit. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

Your share of the cost for a covered drug will be either coinsurance or a copayment, whichever is the larger amount:

- *either* coinsurance of 5% of the cost of the drug
- *or* – $4.15 for a generic drug or a drug that is treated like a generic and $10.35 for all other drugs.

My Additional Covered Benefits and Services

	eternalHealth Give Back (PPO) H2694-002	
	In-Network	**Out-Of-Network**
Telehealth Services Medicare covered Primary Care Physician (PCP) and Physician Specialist Services.	$0 copay per service.	Not covered.
Medicare-Covered Acupuncture Visits	Not applicable for Non-Medicare covered acupuncture. $40 copay per Medicare-Covered acupuncture.	Not applicable for Non-Medicare covered acupuncture. $55 copay per Medicare-Covered acupuncture.
Medicare-Covered Chiropractic Care Authorization will be required.	$20 copay per visit.	30% coinsurance.
Kidney Disease Treatment Services You will need a referral from you Primary Care Provider	**Dialysis Treatment (both facility and clinic visits)** 20% coinsurance.	**Dialysis Treatment (both facility and clinic visits)** 30% coinsurance.

(PCP) for these services to be In-Network.	Dialysis received as a hospital inpatient will be covered under your hospital inpatient benefit. **Kidney Disease Education Services** $0 copay per service. **Other Medicare-covered Services** 0 - 20% coinsurance.	Dialysis received as a hospital inpatient will be covered under your hospital inpatient benefit. **Kidney Disease Education Services** 30% coinsurance. **Other Medicare-covered Services** 30% coinsurance.
Foot Care (Podiatry Services) You will need a referral from you Primary Care Provider (PCP) for these services to be In-Network.	$40 copay per service.	30% coinsurance.
Durable Medical Equipment (DME) and Prosthetic Devices Authorization may be required.	20% coinsurance.	30% coinsurance.
Diabetic Supplies	You pay 0 - 20% coinsurance. Preferred provider One Touch/Life scan brand test strips receive 0% coinsurance. Continuous Glucose Monitors (CGM) are limited to Abbott (Freestyle Libre) and Dexcom brands.	
Cardiac & Pulmonary Rehabilitation Services Authorization will be required. You will need a referral from you Primary Care Provider (PCP) for these services to be In-Network.	$20-$25 copay per service.	30% coinsurance.
Annual Physical Exams	$0 copay per exam.	30% coinsurance.
Over the Counter (OTC) This benefit does not apply to your maximum out-of-pocket (MOOP) amount.	$30 Per calendar quarter (every three months). This amount does not roll over from quarter to quarter.	
SSBCI Grocery Members eligible for SSBCI benefits due to having a Diabetic condition of an A1C 8 or above are eligible to use their standard $50 OTC	Not covered.	

benefit combined with an additional $70 benefit every three months towards a healthy grocery benefit or OTC. **This benefit is for members who qualify. Not all members will qualify for this benefit.*		
Fitness OnePass offers a robust and flexible fitness benefit, which gives members access to various gyms, boutique fitness studios, online fitness video and home kits.	Members have access to in-person fitness centers, digital fitness content, brain training, social activities, and home fitness kits at no cost to them.	Not covered.
In-Home Support	In-home support for services such as household chores, technical guidance, exercise and activity, grocery drop off, and general companionship. Virtual companionship also available. 60-hour limit annually.	Not covered.
Personal Emergency Response Device (PERS) This benefit does not apply to your maximum out-of-pocket (MOOP) amount.	Fully covered monthly subscription. In-home, Mobile LTE, and LTE Smartwatch options.	Not covered.

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
C/O Appeals & Grievances
PO Box 671
Southborough, MA 01772

Local Phone Number: 617-684-2348 (TTY 711)

Toll Free Phone Number: 1-800-680-4568 (TTY 711)

Fax: 1-866-326-1073

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 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 1-800-680-4568, 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.

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、1-800-680-4568 (TTY:711)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。