Advantage MD

SUMMARY OF BENEFITS

2024 Advantage MD Health Plans

Johns Hopkins Advantage MD Group (PPO)

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JOHNS HOPKINS
HEALTH PLANS

Section I: Introduction to Summary of Benefits

January 1, 2024 – December 31, 2024

This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us or go online to view the Evidence of Coverage.

You have choices about how to get your Medicare benefits

One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government. Another choice is to get your Medicare benefits by joining a Medicare health plan (such as Johns Hopkins Advantage MD Group (PPO).

Tips for comparing your Medicare choices:

This Summary of Benefits booklet gives you a summary of what Johns Hopkins Advantage MD Group (PPO) covers and what you pay. If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on www.medicare.gov. If you want to know more about the coverage and costs of Original Medicare, look in your current Medicare & You handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Sections in this booklet

- Things to Know About Johns Hopkins Advantage MD Group (PPO)
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits

This document is available in other formats, such as braille, audio, and large print. For additional information, call us at 1-800-970-0499 (TTY: 711).

Things to Know About Johns Hopkins Advantage MD Group (PPO):

Hours of Operation

From October 1 to March 31, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Eastern time.

From April 1 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern time.

Johns Hopkins Advantage MD Group (PPO) Phone Numbers and Website:

If you are a member of this plan, call toll-free 1-877-293-5325

(TTY: 711). If you are not a member of this plan, call toll-free

1-800-970-0499 (TTY: 711)

Our website: www.advantageMDGroup.com

Who can join?

To join Johns Hopkins Advantage MD Group (PPO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in the plan's service area. In addition, you must also meet company retirement criteria or be a spouse or dependent of an eligible retiree.

Our service area includes the following states: Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, Pennsylvania, South Carolina, and Virginia.

Which doctors, hospitals, and pharmacies can I use?

Johns Hopkins Advantage MD Group (PPO) has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers in our network, you may pay less for your covered services. But if you want to, you can also use providers that are not in our network. You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. You can see our plan's provider and pharmacy directory at our website (www.advantageMDGroup.com). Or, call us and we will send you a copy of the provider and pharmacy directories.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers and more. Our plan members get all of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare. For others, you may pay less. Our plan members also get more than what is covered by Original Medicare. Our plans may offer supplemental benefits in addition to Part C benefits and Part D benefits. Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs, such as chemotherapy/radiation and some drugs administered by your provider. You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, www.advantageMDGroup.com. Or, call us and we will send you a copy of the formulary.

How will I determine my drug costs?

Our plan groups each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

Section II: Summary of Benefits

Benefits & Coverage	Advantage MD Group (PPO)
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES	
Monthly Plan Premium (including Part C and Part D premium, combined)	$175 per month. In addition, you must keep paying your Medicare Part B premium.
Deductibles, including plan level and category level deductible	$100 per year.
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: $3,000 for services you receive from in-network providers. $10,000 for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs. Our plan has a coverage limit every year for certain benefits from any provider.

Benefits & Coverage	Advantage MD Group (PPO)
Inpatient Hospital Coverage (Services may require that your provider get prior authorization (approval in advance). Please see the *Evidence of Coverage* booklet for more information.)	Our plan covers 90 days for each Medicare-covered inpatient hospital stay. (Our plan also covers 60 lifetime reserve days.) *In-network:* You pay a $250 copay each day for days 1-7 of a Medicare-covered inpatient hospital stay. You pay nothing each day for days 8-90 of a Medicare-covered inpatient hospital stay. *Out-of-network:* 30% coinsurance
Outpatient Hospital Coverage (Services may require that your provider get prior authorization (approval in advance). Please see the *Evidence of Coverage* booklet for more information.)	*In-network:* $250 copay *Out-of-network:* 45% coinsurance
Ambulatory Surgical Center (ASC) Services (Services may require that your provider get prior authorization (approval in advance). Please see the *Evidence of Coverage* booklet for more information.)	*In-network:* $200 copay *Out-of-network:* 45% coinsurance
Doctor Visits • Primary Care Providers • Specialists	*In-network:* $5 copay *Out-of-network:* 30% coinsurance *In-network:* $35 copay *Out-of-network:* 30% coinsurance

Benefits & Coverage	Advantage MD Group (PPO)
Preventive Care (e.g., flu vaccine, diabetic screenings)	*In-network:* You pay nothing *Out-of-network:* 45% coinsurance Our plan covers many preventive services, including: Abdominal aortic aneurysm screening Annual routine physical exam Annual wellness visit Barium enemas Bone mass measurement (bone density) Breast cancer screening (mammogram) Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) Cardiovascular disease testing Cervical and vaginal cancer screening Colorectal cancer screenings (colonoscopy, FOBT and FIT kit) Depression screening Diabetes screenings Diabetes self-management training, diabetic services, and supplies Digital rectal exams EKG following a Welcome Visit Health and wellness education programs HIV screening Immunizations Medical nutrition therapy services Medicare diabetes prevention program (MDPP) Obesity screening and therapy to promote sustained weight loss Prostate cancer screening exams Screening and counseling to reduce alcohol misuse Screening for lung cancer with low dose computed tomography (LDCT) Screening for Sexually transmitted infections (STIs) and counseling to prevent STIs Smoking and tobacco use cessation (Counseling to stop smoking or tobacco use) Vision care “Welcome to Medicare” preventive visit (one-time) Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency Care	*In-network & Out-of-network:* $75 copay The copay is waived if you are admitted to the hospital within 24 hours for the same condition. Emergency care is covered worldwide.

Benefits & Coverage	Advantage MD Group (PPO)
Urgently Needed Services	*In-network & Out-of-network:* $40 copay The copay is not waived if you are admitted to the hospital. Urgently needed services are covered worldwide.
Diagnostic Services/Labs/Imaging (Services may require that your provider get prior authorization (approval in advance). Please see the *Evidence of Coverage* booklet for more information.)	**Lab services** *(e.g., Blood count, stool tests, creatinine, blood glucose)*: *In-network:* You pay nothing *Out-of-network:* 45% coinsurance **Diagnostic tests and procedures** *(e.g., Biopsies, Endoscopies, cat scans)*: *In-network:* 20% coinsurance *Out-of-network:* 45% coinsurance **Diagnostic X-rays** *(such as mammography and ultrasound)*: *In-network:* $20 copay *Out-of-network:* 20% coinsurance **Diagnostic radiology services** *(such as MRIs and CT scans)*: *In-network:* $250 copay *Out-of-network:* 45% coinsurance **Therapeutic radiology services** *(such as radiation treatment for cancer)*: *In-network:* 20% coinsurance *Out-of-network:* 45% coinsurance
Hearing Services • Routine hearing exam • Hearing aids	**Medicare-covered hearing exam to diagnose and treat hearing and balance issues:** *In-network:* $35 copay *Out-of-network:* 45% coinsurance **Routine hearing exam:** *In-network:* $35 copay (one routine hearing exam per year) *Out-of-network:* 45% coinsurance **Hearing aids:** You pay $699 copay per aid for Advanced hearing aids or $999 copay per aid for Premium hearing aids for up to two TruHearing-branded hearing aids every year (one per ear per year). Benefit is limited to the TruHearing's Advanced and Premium hearing aids.

Benefits & Coverage	Advantage MD Group (PPO)
Dental Services • Oral exam & cleaning (Non-Medicare comprehensive dental services may require that your provider get prior authorization (approval in advance). Please see the *Evidence of Coverage* booklet for more information.)	**Medicare-covered dental services:** *In-network:* $75 copay *Out-of-network:* 45% coinsurance **Preventive dental services:** **Cleaning** (2 cleanings per year)**:** *In-network:* $10 copay *Out-of-network:* 45% coinsurance **Dental X-ray(s)** *(Frequency determined by type of X-ray)***:** *In-network:* $20 copay *Out-of-network:* 45% coinsurance **Oral exam(s)** *(Frequency determined by type of oral exam)***:** *In-network:* $10 copay *Out-of-network:* 45% coinsurance **Comprehensive dental services:** *(Frequency dependent on procedure.)* **Restorative services** *(such as inlays, onlays, crowns, resin restoration, etc.)***:** *In-network:* $50-$400 copay depending on the service *Out-of-Network:* 50-70% coinsurance depending on the service

Benefits & Coverage	Advantage MD Group (PPO)
Dental Services (continued)	**Endodontics** *(such as root canals, retreatment, apicoectomy, etc.)*: *In-network:* $200 copay *Out-of-network:* 50% coinsurance **Periodontics** *(such as periodontal maintenance, periodontal scaling, root planning, etc.)*: *In-network:* $50 copay *Out-of-network:* 50% coinsurance **Extractions** *(such as extractions, coronectomy, surgical access of an unerupted tooth, etc.)*: *In-network:* $50 copay *Out-of-network:* 50% coinsurance **Prosthodontics/Other oral/Maxillofacial surgery/Other services** *(such as removable complete and partial dentures, repair or replace teeth in dentures, removal of exostosis, anesthesia, etc.)*: *In-network:* $50-$400 copay depending on the service *Out-of-Network:* 50-70% coinsurance depending on the service The plan has a maximum coverage amount of $1,200 per year for in- and out-of-network non-Medicare-covered comprehensive dental services. Unused amounts do not carry forward to future benefit years.

Benefits & Coverage	Advantage MD Group (PPO)
Vision Services	**Medicare-covered exam to diagnose and treat diseases and conditions of the eye:** *In-network:* You pay nothing *Out-of-network:* 45% coinsurance **Yearly Glaucoma Screening:** *In-network:* You pay nothing *Out-of-network:* 45% coinsurance **Routine eye exam** *(1 every year)*: *In-network:* You pay nothing *Out-of-network:* 45% coinsurance **Eyeglasses or contact lenses after cataract surgery:** *In-network:* You pay nothing *Out-of-network:* 45% coinsurance **Routine eyewear:** Our plan pays up to $300 every two years for supplemental eyewear (retail or online) from any provider.
Mental Health Services (Inpatient visit may require a prior authorization and/or referral. Please see the *Evidence of Coverage* booklet for more information.)	**Inpatient visit:** Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. *In-network:* You pay $200 copay each day for days 1-6 of a Medicare-covered inpatient hospital stay. You pay nothing each day for days 7-90 of a Medicare-covered inpatient hospital stay. *Out-of-network:* 30% coinsurance **Outpatient mental health visits:** Individual or Group therapy visit: *In-network:* $35 copay *Out-of-network:* 45% coinsurance **Outpatient substance abuse therapy visit:** Individual or Group therapy visit: *In-network:* $35 copay *Out-of-network:* 45% coinsurance

Benefits & Coverage	Advantage MD Group (PPO)
Skilled Nursing Facility (SNF) (Services may require that your provider get prior authorization (approval in advance). Please see the *Evidence of Coverage* booklet for more information.)	Our plan covers up to 100 days in a SNF. *In-network:* You pay nothing per day for days 1-20 $150 copay per day for days 21-100. *Out-of-network:* 30% coinsurance
Physical Therapy (Services may require that your provider get prior authorization (approval in advance). Please see the *Evidence of Coverage* booklet for more information.)	*In-network:* $30 copay *Out-of-network:* 30% coinsurance
Ambulance (Services may require that your provider get prior authorization (approval in advance). Please see the *Evidence of Coverage* booklet for more information.)	*In-network & Out-of-network:* $240 copay Copay includes one-way trip for emergency ambulance services and non-emergency ambulance services. The ambulance copay is not waived if you are admitted to the hospital. In some cases, Medicare may pay for limited non-emergency ambulance transportation if a beneficiary has orders from the doctor saying that ambulance transportation is medically necessary.
Transportation	Not covered
Medicare Part B Drugs (Services may require that your provider get prior authorization (approval in advance). Please see the *Evidence of Coverage* booklet for more information.) Medicare-covered Part B Drugs may be subject to step therapy requirements.	For Part B drugs such as chemotherapy/radiation drugs: *In-network:* 20% coinsurance *Out-of-network:* 30% coinsurance Other Part B drugs: *In-network:* 20% coinsurance *Out-of-network:* 30% coinsurance Other Insulin drugs: *In-network:* Member pays lesser of 20% or $35. *Out-of-network:* 30% coinsurance

Benefits & Coverage	Advantage MD Group (PPO)
Outpatient Prescription Drugs (Medicare Part D Drugs)	
Deductible	$0
Initial Coverage	You pay the following until your total yearly drug costs reach $5,030. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies. Cost-sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information on the additional pharmacy-specific cost-sharing and the phases of the benefit, please call us or access our Evidence of Coverage booklet.
• Standard Retail Cost-Sharing *(Insulin drug cost-share listed below*)	**Tier 1 (**Preferred Generic**)** $4 for a one-month supply $6 for a two-month supply $8 for a three-month supply **Tier 2 (**Generic**)** $12 for a one-month supply $18 for a two-month supply $24 for a three-month supply **Tier 3 (**Preferred Brand**)** $42 for a one-month supply $84 for a two-month supply $126 for a three-month supply **Tier 4 (**Non-Preferred Drug**)** $92 for a one-month supply $184 for a two-month supply $276 for a three-month supply **Tier 5 (**Specialty Tier**)** 33% of the total cost of a one-month supply (long-term supply is not available)

Benefits & Coverage	Advantage MD Group (PPO)
• Standard Mail Order Cost-Sharing *(Insulin drug cost-share listed below*)	**Tier 1 (**Preferred Generic**)** $4 for a one-month supply $6 for a two-month supply $8 for a three-month supply **Tier 2 (**Generic**)** $12 for a one-month supply $18 for a two-month supply $24 for a three-month supply **Tier 3 (**Preferred Brand**)** $42 for a one-month supply $63 for a two-month supply $84 for a three-month supply **Tier 4 (**Non-Preferred Drug**)** $92 for a one-month supply $138 for a two-month supply $184 for a three-month supply **Tier 5 (**Specialty Tier**)** 33% of the total cost of a one-month supply (long-term supply is not available) If you reside in a long-term care facility, you pay the same as at a retail pharmacy.
• Insulin Retail Cost-Sharing	**Tier 1 (**Preferred Generic**)** $4 copay for a one-month supply $6 copay for a two-month supply $8 copay for a three-month supply **Tier 2 (**Generic**)** $12 copay for a one-month supply $18 copay for a two-month supply $24 copay for a three-month supply **Tier 3 (**Preferred Brand**)** $35 copay for a one-month supply $70 copay for a two-month supply $105 copay for a three-month supply **Tier 4 (**Non-Preferred Drug**)** $35 copay for a one-month supply $70 copay for a two-month supply $105 copay for a three-month supply **Tier 5 (**Specialty Tier**)** $35 copay of a one-month supply (long-term supply is not available)

Benefits & Coverage	Advantage MD Group (PPO)
• Insulin Mail Order Cost-Sharing	**Tier 1 (**Preferred Generic**)** $4 copay for a one-month supply $6 copay for a two-month supply $8 copay for a three-month supply **Tier 2 (**Generic**)** $12 copay for a one-month supply $18 copay for a two-month supply $24 copay for a three-month supply **Tier 3 (**Preferred Brand**)** $35 copay for a one-month supply $52.50 copay for a two-month supply $70 copay for a three-month supply **Tier 4 (**Non-Preferred Drug**)** $35 copay for a one-month supply $52.50 copay for a two-month supply $70 copay for a three-month supply **Tier 5 (**Specialty Tier**)** $35 copay of a one-month supply (long-term supply is not available)
Coverage Gap	Most Medicare drug plans have a coverage gap *(also called the "donut hole")*. This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost *(including what our plan has paid and what you have paid)* reaches $5,030. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $8,000 which is the end of the coverage gap.
Catastrophic Coverage	After your yearly out-of-pocket drug costs *(including drugs purchased through your retail pharmacy and through mail order)* reach $8,000, you will stay in this payment stage until the end of the calendar year. During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing. For excluded drugs covered under our enhanced benefit, you pay up to a Tier 2 copay. Covered excluded drugs include select prescription vitamins, cough and cold medications, and erectile dysfunction medicine. These drugs and their quantity limits are listed in the Drug List booklet in the section titled "Coverage of additional drugs".

Benefits & Coverage	Advantage MD Group (PPO)
Additional Covered Medical and Hospital Benefits	
Acupuncture	**Medicare covered acupuncture:** *In-network:* 20% coinsurance *Out-of-network:* 30% coinsurance **Non-Medicare covered acupuncture:** *In-network and out-of-network:* Our plan will pay up to $300 annually for services.
Chiropractic Care (Services may require that your provider get prior authorization (approval in advance). Please see the *Evidence of Coverage* booklet for more information.)	Manipulation of the spine to correct a subluxation *(when one or more of the bones of your spine move out of position):* *In-network:* $20 copay *Out-of-network:* 30% coinsurance **Non-Medicare covered chiropractic care:** *In-network and out-of-network:* Our plan will pay up to $200 annually for services.
Home Health Care (Services may require that your provider get prior authorization (approval in advance). Please see the *Evidence of Coverage* booklet for more information.)	*In-network:* You pay nothing *Out-of-network:* 30% coinsurance
Over-the Counter Items	Not covered
Rehabilitation Services (Occupational therapy visits may require that your provider get prior authorization (approval in advance). Please see the *Evidence of Coverage* booklet for more information.)	**Cardiac (heart) rehab services** *(for a maximum of 2 on-hour sessions per day for up to 36 sessions up to 36 weeks)*: *In-network:* You pay nothing *Out-of-network:* 30% coinsurance **Occupational therapy visit:** *In-network:* $30 copay *Out-of-network:* 30% coinsurance
Renal Dialysis	*In-network:* 20% coinsurance *Out-of-network:* 45% coinsurance

Benefits & Coverage	Advantage MD Group (PPO)
Hospice	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part coinsurance for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.
Post Discharge Meals	Not covered
Visitor/Traveler Benefit	Our plan offers the visitor/traveler program *in the United States*, which will allow you to remain enrolled in our plan when you are outside of our service area for less than 12 months. Under our visitor/traveler program you may receive all plan covered services at in-network cost-sharing.
Worldwide Emergency Care	$75 copay for emergency care services $50,000 (USD) combined limit per year for urgently needed or emergency care services provided outside the U.S. and its territories. You are responsible for services rendered upfront and must submit your claim(s) and proof of payment for reimbursement consideration.
Worldwide Urgent Care	$40 copay for emergency care services $50,000 (USD) combined limit per year for urgently needed or emergency care services provided outside the U.S. and its territories. You are responsible for services rendered upfront and must submit your claim(s) and proof of payment for reimbursement consideration.

Notice of Nondiscrimination

Johns Hopkins Advantage MD (HMO) and Johns Hopkins Advantage MD (PPO) comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Johns Hopkins Advantage MD does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Johns Hopkins Advantage MD:

- 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, and other formats).

- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, please contact our Customer Service Department at 1-877-293-5325 (TTY: 711).

If you believe Johns Hopkins Advantage MD 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: Johns Hopkins Grievance Compliance Coordinator at 7231 Parkway Dr., Suite 100, Hanover, MD 21076, phone: 1-844-422-6957 (TTY: 711) Monday – Friday 8 a.m. to 5 p.m. or 1-844-SPEAK2US (1-844-773-2528, available 24/7), fax: 1-410-762-1527 or by email: compliance@jhhp.org.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, a Johns Hopkins Advantage MD Compliance Coordinator 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/smartscreen/main.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at https://www.hhs.gov/ocr/complaints/index.html.

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 1-877-293-5325 (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 1-877-293-5325 (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 1-877-293-5325 (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 1-877-293-5325 (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 1-877-293-5325 (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 1-877-293-5325 (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 1-877-293-5325 (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 1-877-293-5325 (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 1-877-293-5325 (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 1-877-293-5325 (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 فوري، ليس عليك سوى الاتصال بنا على 1-877-293-5325 (TTY: 711) . سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-877-293-5325 (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 1-877-293-5325 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-877-293-5325 (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 1-877-293-5325 (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 1-877-293-5325 (TTY: 711). Ta usługa jest bezpłatna.

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