2023 Summary of Benefits

ALTERWOOD ADVANTAGE
Quality Care. Better Health.

Call 1-866-550-1011 (TTY:711)

HMO Plans

H9306_23_1099-01_OE_M CMS Approved 9/14/2022

2023 Summary of Benefits

Alterwood Advantage Select (HMO), Alterwood Advantage Choice (HMO), Alterwood Advantage Choice Plus (HMO), & Alterwood Advantage Freedom (HMO)

H9306, Plans 005, 001, 002, 003

This is a summary of drug and health services covered by Alterwood Advantage Select, Alterwood Advantage Choice, Alterwood Advantage Choice Plus, and Alterwood Advantage Freedom from January 1, 2023 – December 31, 2023.

Alterwood Advantage is an HMO and HMO-SNP plan with a Medicare contract and a State of Maryland Medicaid contract. Enrollment in Alterwood Advantage depends on contract renewal.

Our plan(s) may offer supplemental benefits in addition to Part C benefits and Part D benefits. Some of the extra benefits are outlined in this booklet.

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 request the “Evidence of Coverage.” You can access this document by visiting our website at www.AlterwoodAdvantage.com or by calling the number on the back of this booklet.

To join Alterwood Advantage Select, Alterwood Advantage Choice, Alterwood Advantage Choice Plus, or Alterwood Advantage Freedom, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area for these plans include the following counties in Maryland: Anne Arundel, Baltimore, Baltimore City, Caroline, Carroll, Cecil, Charles, Dorchester, Harford, Howard, Kent, Montgomery, Prince George’s, Queen Anne’s, Somerset, Talbot, Washington, Wicomico, and Worcester.

Except in emergency situations, if you use the providers that are not in our network, we may not pay for these services.

For 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.

This document is available in other formats such as Braille, audio, or large print.

For more information, please call us at 1-866-550-1011 (TTY users should call 711), or visit us at www.AlterwoodAdvantage.com. We are available 8am to 8pm ET, 7 days a week, from October 1 to March 31 and 8am to 8pm ET, Monday through Friday, from April 1 to September 30.

PLAN HIGHLIGHTS*

Monthly Premium:
$0 - $125

Primary Care Physician Visits:
$0 copay

Generic Prescriptions:
As low as $0

Dental Care:
Preventive, Comprehensive, & Dentures

Vision Services:
$0 copay for a routine exam
Allowance towards eyewear

Hearing Services:
$0 copay for a routine exam
$475 - $1,950 copay per hearing aid

Over-the-Counter (OTC) Products and Essential Food Pantry Items:
Quarterly allowance to order items through plan's catalog

Transportation:
$0 copay to plan-approved locations

Routine Foot Care (Podiatry Services)
4 routine visits per year

Routine Chiropractic Services:
4 routine visits per year
1 chiropractic evaluation per year

Health & Wellness Program:
$150 annual reimbursement

*Listed benefits might not be offered on all plans.
Please refer to charts within this document for further detail.

HMO PLANS

Summary of Benefits

BENEFITS	Alterwood Advantage Select	Alterwood Advantage Choice	Alterwood Advantage Choice Plus	Alterwood Advantage Freedom
Monthly Plan Premium	$0	$35	$125	$0
	If you receive "Extra Help" or assistance through the Maryland Senior Prescription Drug Assistance Program (SPDAP), your premium may be reduced.			
Medicare Part B Buy-Down	N/A	N/A	N/A	up to $40 per month
Plan Level Deductible	$750 on select services	No Deductible	No Deductible	No Deductible
Maximum Out-of-Pocket (MOOP)	$8,300	$8,300	$8,300	$8,300
Inpatient Hospital Coverage[1]	**Deductible, then:** Days 1-3: $290 copay per day Days 4-90: $0 copay per day	Days 1-5: $290 copay per day Days 6-90: $0 copay per day	$300 copay per stay	Days 1-6: $335 copay per day Days 7-90: $0 copay per day
Outpatient Hospital Coverage[1]	**Deductible, then:** $300 copay	$250 copay	$150 copay	$300 copay
Ambulatory Surgical Center[1]	$225 copay	$150 copay	$100 copay	$245 copay
Doctor Visits Primary Care Physician (PCP)	$0 copay	$0 copay	$0 copay	$0 copay
Specialist	$45 copay	$35 copay	$20 copay	$35 copay
Preventive Care	$0 copay	$0 copay	$0 copay	$0 copay
Emergency Care	$90 copay	$90 copay	$90 copay	$90 copay
Urgently Needed Services	$35 copay	$35 copay	$20 copay	$35 copay

[1] May require prior authorization

HMO PLANS

Summary of Benefits

BENEFITS	Alterwood Advantage Select	Alterwood Advantage Choice	Alterwood Advantage Choice Plus	Alterwood Advantage Freedom
Diagnostic Tests, Lab and Radiology Services, and X-Rays[1]	• Diagnostic radiology services (such as MRIs, CT scans): **deductible, then** $195 copay • Diagnostic test and procedures: $15 copay • Lab services: $0 copay • Outpatient x-rays: $20 copay • Therapeutic radiology services (such as radiation treatment for cancer): **deductible, then** 20% coinsurance	• Diagnostic radiology services (such as MRIs, CT scans): $195 copay • Diagnostic test and procedures: $0 copay • Lab services: $0 copay • Outpatient x-rays: $20 copay • Therapeutic radiology services (such as radiation treatment for cancer): 20% coinsurance	• Diagnostic radiology services (such as MRIs, CT scans): $125 copay • Diagnostic test and procedures: $0 copay • Lab services: $0 copay • Outpatient x-rays: $10 copay • Therapeutic radiology services (such as radiation treatment for cancer): 20% coinsurance	• Diagnostic radiology services (such as MRIs, CT scans): $250 copay • Diagnostic test and procedures: $0 copay • Lab services: $0 copay • Outpatient x-rays: $20 copay • Therapeutic radiology services (such as radiation treatment for cancer): 20% coinsurance
Hearing Services	• Medicare-covered exam: $40 copay • Routine hearing exam: $0 copay - Limited to 1 exam per year • 1 fitting and evaluation with 3 follow up visits within the first year from date of initial fitting: $0 copay • Hearing Aids: $475 - $1,950 copay per hearing aid, available annually	• Medicare-covered exam: $40 copay • Routine hearing exam: $0 copay - Limited to 1 exam per year • 1 fitting and evaluation with 3 follow up visits within the first year from date of initial fitting: $0 copay • Hearing Aids: $475 - $1,950 copay per hearing aid, available annually	• Medicare-covered exam: $40 copay • Routine hearing exam: $0 copay - Limited to 1 exam per year • 1 fitting and evaluation with 3 follow up visits within the first year from date of initial fitting: $0 copay • Hearing Aids: $475 - $1,950 copay per hearing aid, available annually	• Medicare-covered exam: $40 copay • Routine hearing exam: $0 copay - Limited to 1 exam per year • 1 fitting and evaluation with 3 follow up visits within the first year from date of initial fitting: $0 copay • Hearing Aids: $475 - $1,950 copay per hearing aid, available annually

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BENEFITS	Alterwood Advantage Select	Alterwood Advantage Choice	Alterwood Advantage Choice Plus	Alterwood Advantage Freedom
Dental Services[1]	Medicare-covered: $40 copay	Medicare-covered: $40 copay	Medicare-covered: $40 copay	Medicare-covered: $40 copay
	$2,000 annual allowance towards preventive and comprehensive dental services.	$2,000 annual allowance towards preventive and comprehensive dental services.	$4,000 annual allowance towards preventive and comprehensive dental services.	$1,500 annual allowance towards preventive and comprehensive dental services.
	Preventive Dental Services: $0 copay for exams, cleanings, fluoride treatment, and x-rays.	Preventive Dental Services: $0 copay for exams, cleanings, fluoride treatment, and x-rays.	Preventive Dental Services: $0 copay for exams, cleanings, fluoride treatment, and x-rays.	Preventive Dental Services: $0 copay for exams, cleanings, fluoride treatment, and x-rays.
	Comprehensive Dental Services: 20% coinsurance for restorative services, crowns, endodontics, periodontics, extractions, dentures, & other services.	Comprehensive Dental Services: 20% coinsurance for restorative services, crowns, endodontics, periodontics, extractions, dentures, & other services.	Comprehensive Dental Services: 20% coinsurance for restorative services, crowns, endodontics, periodontics, extractions, dentures, & other services.	Comprehensive Dental Services: 20% coinsurance for restorative services, crowns, endodontics, periodontics, extractions, dentures, & other services.
Vision Services	• Medicare-covered exam: $40 copay • Medicare-covered eyewear after cataract surgery: 20% coinsurance • Routine eye exam: $0 copay - Limited to 1 exam per year • $150 annual allowance towards eyewear - includes contact lenses, eyeglass frames, eyeglass lenses, or any combination	• Medicare-covered exam: $40 copay • Medicare-covered eyewear after cataract surgery: 20% coinsurance • Routine eye exam: $0 copay - Limited to 1 exam per year • $150 annual allowance towards eyewear - includes contact lenses, eyeglass frames, eyeglass lenses, or any combination	• Medicare-covered exam: $40 copay • Medicare-covered eyewear after cataract surgery: 20% coinsurance • Routine eye exam: $0 copay - Limited to 1 exam per year • $275 allowance every 2 years towards eyewear - includes contact lenses, eyeglass frames, eyeglass lenses, or any combination	• Medicare-covered exam: $40 copay • Medicare-covered eyewear after cataract surgery: 20% coinsurance • Routine eye exam: $0 copay - Limited to 1 exam per year • $150 annual allowance towards eyewear - includes contact lenses, eyeglass frames, eyeglass lenses, or any combination

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BENEFITS	Alterwood Advantage Select	Alterwood Advantage Choice	Alterwood Advantage Choice Plus	Alterwood Advantage Freedom
Mental Health Services[1]	Inpatient: Days 1-6: $310 copay per day Days 7-90: $0 copay per day	Inpatient: Days 1-6: $310 copay per day Days 7-90: $0 copay per day	Inpatient: $350 copay per stay	Inpatient: Days 1-6: $310 copay per day Days 7-90: $0 copay per day
	Outpatient: • Group therapy visit: $20 copay • Individual therapy visit: $30 copay	Outpatient: • Group therapy visit: $20 copay • Individual therapy visit: $30 copay	Outpatient: • Group therapy visit: $20 copay • Individual therapy visit: $30 copay	Outpatient: • Group therapy visit: $30 copay • Individual therapy visit: $40 copay
Skilled Nursing Facility (SNF)[1]	Days 1-20: $0 copay per day Days 21-100: $196 copay per day	Days 1-20: $0 copay per day Days 21-100: $196 copay per day	Days 1-20: $0 copay per day Days 21-100: $196 copay per day	Days 1-20: $0 copay per day Days 21-100: $196 copay per day
Physical Therapy[1]	$40 copay	$30 copay	$20 copay	$40 copay
Ambulance[1]	• Ground: $240 copay • Air: $300 copay	• Ground: $240 copay • Air: $300 copay	• Ground: $240 copay • Air: $300 copay	• Ground: $235 copay • Air: $300 copay
Transportation	$0 copay for 10 one-way trips	$0 copay for 10 one-way trips	Not Covered	Not Covered
Medicare Part B Drugs[1]	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance

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PART D	Alterwood Advantage Select	Alterwood Advantage Choice	Alterwood Advantage Choice Plus	Alterwood Advantage Freedom
Deductible	$295 on Tiers 3, 4, & 5	No Part D Deductible	No Part D Deductible	
Initial Coverage Period	You begin this stage when you fill your first prescription on Tier 1 or Tier 2. If your prescription is on Tiers 3, 4, or 5, you will pay the drug cost up to the $295 deductible. After you meet your $295 deductible, you will pay the applicable cost-share(s) below.	You begin this stage when you fill your first prescription of the year.		
	During this stage, our plan pays its share of the cost of your drugs and you pay your share of the cost. You stay in this stage until your year-to-date "total drug costs" (your payments plus any Part D plan's payments) total $4,660.			
Retail Pharmacy and Mail Order Cost-Shares	• **Tier 1 (Preferred Generics)** 30-day Supply: $3 90-day Supply: $0 • **Tier 2 (Generics)** 30-day Supply: $8 90-day Supply: $8 • **Tier 3 (Preferred Brands)** 30-day Supply: $47 90-day Supply: $94 • **Tier 4 (Non-Preferred Drugs)** 30-day Supply: $100 90-day Supply: $300 • **Tier 5 (Specialty)** 30-day Supply: 28% 90-day Supply: not covered	• **Tier 1 (Preferred Generics)** 30-day Supply: $3 90-day Supply: $0 • **Tier 2 (Generics)** 30-day Supply: $8 90-day Supply: $8 • **Tier 3 (Preferred Brands)** 30-day Supply: $47 90-day Supply: $94 • **Tier 4 (Non-Preferred Drugs)** 30-day Supply: $100 90-day Supply: $300 • **Tier 5 (Specialty)** 30-day Supply: 33% 90-day Supply: not covered	• **Tier 1 (Preferred Generics)** 30-day Supply: $0 90-day Supply: $0 • **Tier 2 (Generics)** 30-day Supply: $0 90-day Supply: $0 • **Tier 3 (Preferred Brands)** 30-day Supply: $47 90-day Supply: $94 • **Tier 4 (Non-Preferred Drugs)** 30-day Supply: $100 90-day Supply: $300 • **Tier 5 (Specialty)** 30-day Supply: 33% 90-day Supply: not covered	**Not Covered**
Long Term Care Cost-Shares	• **Tier 1 (Preferred Generics)** 31-day Supply: $3 • **Tier 2 (Generics)** 31-day Supply: $8 • **Tier 3 (Preferred Brands)** 31-day Supply: $47 • **Tier 4 (Non-Preferred Drugs)** 31-day Supply: $100 • **Tier 5 (Specialty)** 31-day Supply: 28%	• **Tier 1 (Preferred Generics)** 31-day Supply: $3 • **Tier 2 (Generics)** 31-day Supply: $8 • **Tier 3 (Preferred Brands)** 31-day Supply: $47 • **Tier 4 (Non-Preferred Drugs)** 31-day Supply: $100 • **Tier 5 (Specialty)** 31-day Supply: 33%	• **Tier 1 (Preferred Generics)** 31-day Supply: $0 • **Tier 2 (Generics)** 31-day Supply: $0 • **Tier 3 (Preferred Brands)** 31-day Supply: $47 • **Tier 4 (Non-Preferred Drugs)** 31-day Supply: $100 • **Tier 5 (Specialty)** 31-day Supply: 33%	

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PART D	Alterwood Advantage Select	Alterwood Advantage Choice	Alterwood Advantage Choice Plus	Alterwood Advantage Freedom
Coverage Gap	During this stage, you pay 25% of the cost for all your drugs. You stay in this stage until your year-to-date "out-of-pocket costs" (your payments) reach a total of $7,400. This amount and the rules for counting costs toward this amount have been set by Medicare.			Not Covered
Catastrophic Coverage	Your share of the costs for a coverage drug will be either a copayment or coinsurance, whichever is the larger amount: • -either- the coinsurance of 5% of the total cost • -or- $4.15 for a generic drug or $10.35 for all other drugs			
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.			
Vaccines	Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible.			

BENEFITS	Alterwood Advantage Select	Alterwood Advantage Choice	Alterwood Advantage Choice Plus	Alterwood Advantage Freedom
Outpatient Rehabilitation[1]	• Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions over a period of up to 36 weeks): **deductible, then** $40 copay • Occupational therapy visit: $40 copay • Speech and language therapy visit: $40 copay	• Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions over a period of up to 36 weeks): $40 copay • Occupational therapy visit: $30 copay • Speech and language therapy visit: $30 copay	• Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions over a period of up to 36 weeks): $40 copay • Occupational therapy visit: $20 copay • Speech and language therapy visit: $20 copay	• Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions over a period of up to 36 weeks): $40 copay • Occupational therapy visit: $35 copay • Speech and language therapy visit: $40 copay
Dialysis Services[1]	**Deductible, then:** 20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Durable Medical Equipment[1]	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Diabetic Supplies, Shoes, or Inserts[1]	• Diabetic Supplies: 0% - 20% coinsurance • Diabetic Shoes or Inserts: 20% coinsurance	• Diabetic Supplies: 0% - 20% coinsurance • Diabetic Shoes or Inserts: 20% coinsurance	• Diabetic Supplies: 0% - 20% coinsurance • Diabetic Shoes or Inserts: 20% coinsurance	• Diabetic Supplies: 0% - 20% coinsurance • Diabetic Shoes or Inserts: 20% coinsurance

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BENEFITS	Alterwood Advantage Select	Alterwood Advantage Choice	Alterwood Advantage Choice Plus	Alterwood Advantage Freedom
Home Health Care[1]	$0 copay	$0 copay	$0 copay	$0 copay
Telehealth	$0 copay for eligible Primary Care Physician, Specialist, Mental Health individual and group, and Urgent Care services.			
Health & Wellness Program	$150 annual reimbursement towards the purchase of a fitness tracker, at-home fitness equipment, participation in a fitness class, or gym membership.			
Home Delivered Meals	Receive 14 healthy meals delivered to your home after discharge from an inpatient hospital stay or skilled nursing facility stay - Limited to 8 times per year.			
Chiropractic Care[1]	• Medicare-covered visit: $20 copay • Routine visit: $20 copay - Limited to 4 visits per year • Routine Chiropractic Evaluation: $0 copay - Limited to 1 visit per year	• Medicare-covered visit: $20 copay • Routine visit: $20 copay - Limited to 4 visits per year • Routine Chiropractic Evaluation: $0 copay - Limited to 1 visit per year	• Medicare-covered visit: $20 copay • Routine visit: $20 copay - Limited to 4 visits per year • Routine Chiropractic Evaluation: $0 copay - Limited to 1 visit per year	• Medicare-covered visit: $20 copay • Routine visit: $20 copay - Limited to 4 visits per year • Routine Chiropractic Evaluation: $0 copay - Limited to 1 visit per year
Acupuncture[1]	• Medicare-covered visit: $20 copay • Routine visit: Not Covered	• Medicare-covered visit: $20 copay • Routine visit: Not Covered	• Medicare-covered visit: $20 copay • Routine visit: Not Covered	• Medicare-covered visit: $20 copay • Routine visit: Not Covered
Foot Care (Podiatry Services)	• Medicare-covered services: $35 copay • Routine visit: $35 copay - Limited to 4 visits per year	• Medicare-covered services: $35 copay • Routine visit: $35 copay - Limited to 4 visits per year	• Medicare-covered services: $35 copay • Routine visit: $0 copay - Limited to 4 visits per year	• Medicare-covered services: $30 copay • Routine visit: $30 copay - Limited to 4 visits per year
Over-the-Counter (OTC) Products & Essential Food Pantry Items	$35 quarterly allowance, items ordered through the plan's catalog	$35 quarterly allowance, items ordered through the plan's catalog	$35 quarterly allowance, items ordered through the plan's catalog	$35 quarterly allowance, items ordered through the plan's catalog
Lifestyle Medication	Not Covered	Not Covered	$10 copay per monthly supply of generic erectile dysfunction medication - Limited to 4 pills per month	Not Covered

[1] May require prior authorization

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-866-550-1011 (TTY: 711).

Understanding the Benefits:

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit www.AlterwoodAdvantage.com or call 1-866-550-1011 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:

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/coinsurance may change on January 1, 2024.
- ☐ 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).

ALTERWOOD ADVANTAGE
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You can access the Evidence of Coverage (EOC), which provides a full listing of our plan's benefits and services, on our website at www.AlterwoodAdvantage.com, or by calling the telephone number listed below.

You may view our plan's Provider & Pharmacy Directory, complete plan formulary (list of Part D prescription drugs) and any restrictions on our website at www.AlterwoodAdvantage.com

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Hours of Operation:
October 1 – March 31
8 am – 8 pm ET | 7 days a week
April 1 – September 30
8 am – 8 pm ET | Monday - Friday

www.AlterwoodAdvantage.com

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 1-866-675-3944. 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 1-866-675-3944. 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 1-866-675-3944。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 1-866-675-3944。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 1-866-675-3944. 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 1-866-675-3944. 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 1-866-675-3944 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 1-866-675-3944. 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 1-866-675-3944 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 1-866-675-3944. 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 1-866-675-3944. 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 1-866-675-3944 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 1-866-675-3944. 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 1-866-675-3944. 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 1-866-675-3944. 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 1-866-675-3944. Ta usługa jest bezpłatna.

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