2024 SUMMARY OF BENEFITS

January 1, 2024 – December 31, 2024

The Health Plan SecureChoice Optimum (PPO)

H8604-014-1

A Medicare Advantage Plan with Prescription Drugs

Our service area includes the following counties in **Ohio:**

Adams, Allen, Ashland, Ashtabula, Athens, Auglaize, Belmont, Brown, Butler, Carroll, Champaign, Clark, Clermont, Clinton, Columbiana, Coshocton, Crawford, Cuyahoga, Darke, Delaware, Fairfield, Fayette, Franklin, Fulton, Gallia, Geauga, Greene, Guernsey, Hamilton, Hardin, Harrison, Henry, Highland, Hocking, Holmes, Jackson, Jefferson, Knox, Lake, Lawrence, Licking, Logan, Lorain, Madison, Mahoning, Medina, Meigs, Mercer, Miami, Monroe, Montgomery, Morgan, Morrow, Muskingum, Noble, Ottawa, Paulding, Perry, Pickaway, Pike, Portage, Preble, Putnam, Richland, Ross, Scioto, Seneca, Shelby, Stark, Summit, Trumbull, Tuscarawas, Van Wert, Vinton, Warren, Washington, Wayne, Wyandot

This document is available in other formats such as braille, large print and audio CD. For additional information on available formats, call us at **1.877.847.7915 (TTY: 711)**.

INTRODUCTION

The benefit information provided in this booklet is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, access our Evidence of Coverage online at healthplan.org/medicare. Or call us to request a copy.

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 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.

The Health Plan SecureChoice Optimum(PPO) is a PPO plan with a Medicare contract. Enrollment in The Health Plan SecureChoice – OptimumPPO depends on contract renewal.

ELIGIBILITY

To join The Health Plan SecureChoice Optimum(PPO) you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

WHICH DOCTORS, HOSPITALS AND PHARMACIES CAN I USE?

This is a Preferred Provider Organization (PPO) plan. This means that even though we have a network of doctors, hospitals, pharmacies and other providers, you may use providers that are not in our network. However, if you use providers outside of our network, your costs may be higher. No referral is needed, but some services do require prior authorization from the plan.

Out-of-network/non-contracted providers are under no obligation to treat SecureChoice (PPO) members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

You can see current provider lists on our website at healthplan.org/medicare. Or call us and we will send you a copy.

HOW TO REACH US

If you are a member, call toll-free: 1.877.847.7907 (TTY: 711)

If you are not a member, call toll-free: 1.877.847.7915 (TTY: 711)

Hours of operation:

- October 1 to March 31, 8:00 a.m. to 8:00 p.m. Eastern, 7 days a week.
- April 1 to September 30, 8:00 a.m. to 8:00 p.m. Eastern, Monday through Friday.

Or visit our website: healthplan.org/medicare.

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 **1.877.847.7915 (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 healthplan.org/medicare or call **1.877.847.7915 (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 medicines 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

- ☐ **Effect on Current Coverage**. Your current health care coverage will end once your new Medicare coverage starts. For example, if you are in Tricare or a Medicare plan, you will no longer receive benefits from that plan once your new coverage starts.
- ☐ 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/co-insurance may change on January 1, 2025.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.

PREMIUMS & BENEFITS	THE HEALTH PLAN SECURECHOICE OPTIMUM(PPO) H8604-014-1	
Monthly Plan Premium	**$0** You must continue to pay your Medicare Part B premium.	
Annual Medical Deductible	This plan does not have a medical deductible.	
Maximum Out-of-Pocket Responsibility (Does not include prescription drugs)	$4,900 for services you receive from in-network providers $9,550 for services you receive from any provider. Your out-of-pocket costs for services received from in-network providers will count towards this combined limit This is the most that you will pay out-of-pocket for covered Medicare Part A and Part B services in 2024. The amounts you pay for copayments and coinsurance for these covered services count towards the maximum out-of-pocket amount(s)	
Inpatient Hospital Coverage* **(Per admission or stay)**	In-Network: Days 1-5: $325 copay per day Days 6-90: $0 copay Days 91 and beyond: $0 copay	Out-of-Network: 30% co-insurance per stay
	Our plan covers an unlimited number of days for an inpatient hospital stay	
Outpatient Hospital Coverage*	In-Network: $285 copay for outpatient surgeries. $0 copay for diagnostic colonoscopies. $200 copay for observation visits	Out-of-Network: 30% co-insurance
Ambulatory Surgical Center*	In-Network: $285 copay	Out-of-Network: 30% co-insurance
Doctor Visit: Primary Care Provider	In-Network: $0 copay	Out-of-Network: $25 copay
Doctor Visit: Specialist*	In-Network: $40 copay No referral needed. However, organizational authorization may be required for tertiary specialists.	Out-of-Network: $60 copay

Preventive Care (Medicare-covered zero cost sharing preventive services)	Medicare–covered zero cost sharing preventive services
	$0 copay for the following*:
	
	• Abdominal aortic aneurysm screenings
	• Alcohol misuse screenings & counseling
	• Blood-based biomarker tests
	• Cardiovascular disease screenings
	• Cardiovascular disease (behavioral therapy)
	• Cervical & vaginal cancer screenings
	• Colorectal cancer screenings
	  o Multi-target stool DNA tests
	  o Screening barium enemas
	  o Screening colonoscopies
	  o Screening fecal occult blood tests
	  o Screening flexible sigmoidoscopies
	• Depression screenings
	• Diabetes screenings
	• Diabetes self-management training
	• Flu shots
	• Glaucoma tests
	• Hepatitis B shots
	• Hepatitis B Virus (HBV) infection screenings
	• Hepatitis C screening tests
	• HIV screenings
	• Lung cancer screenings
	• Mammograms (screening)
	• Medicare Diabetes Prevention Program
	• Nutrition therapy services
	• Obesity screenings & counseling
	• One-time "Welcome to Medicare" preventive visit
	• Pneumococcal shots
	• Prostate cancer screenings
	• Sexually transmitted infections screenings & counseling
	• Shots:
	  o COVID-19 vaccines
	  o Flu shots
	  o Hepatitis B shots
	  o Pneumococcal shots
	• Tobacco use cessation counseling
	• Yearly "Wellness" visit
	
	Any other preventive services approved by Medicare during the contract year will be covered
		Out-of-Network:
		30% co-insurance

	Annual Physical Exam $0 copay/1 per year	Out-of-Network: $25 copay

Emergency Care (Worldwide)	In-Network: $110 copay If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care Covered emergency services outside of the U.S. have a $25,000 annual plan max	Out-of-Network: $110 copay
Urgently Needed Services	In-Network: $40 copay If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgently needed services	Out-of-Network: $40 copay
Diagnostic Radiological Service* (such as MRIs, CT scans)	In-Network: $0 or $150 copay $150 for CT scans, MRI, MRA, PET and SPECT scans $0 copay for all diagnostic mammograms and diagnostic bone density exams	Out-of-Network: 30% co-insurance
Therapeutic Radiological Services* (such as radiation treatment for cancer)	In-Network: 20% co-insurance	Out-of-Network: 30% co-insurance
Lab Services	In-Network: $0 copay	Out-of-Network: 30% co-insurance
Diagnostic Tests and Procedures*	In-Network: $50 copay	Out-of-Network: 30% co-insurance
Outpatient X-rays*	In-Network: $50 copay	Out-of-Network: 30% co-insurance

Hearing Services	Medicare-covered hearing exam to diagnose and treat hearing and balance issues In-Network: $40 copay	Out-of-Network: $60 copay
	Hearing exam In-Network: $0 copay for one exam every year	Out-of-Network: $60 copay for one exam every year
	Hearing aids: Hearing aids are covered up to one per ear, every two years - $599 copayment for Advanced level hearing aid - $899 copayment for Premium level hearing aid - Includes 2-year supply of batteries per aid (non-rechargeable models only) after purchase - $0 copay for provider visits for fittings and adjustments, covered for 12 months after hearing aid purchase A TruHearing provider must be used.	Out-of-Network: A TruHearing provider must be used. There is no coverage for hearing aids through out-of-network providers.
Medicare-covered Dental Services*	In-Network: $40 copay	Out-of-Network: $60 copay
	This does not include services in connection with care, treatment, filling,removal, or replacement of teeth	

Routine Dental Services	This plan covers preventive and comprehensive dental services <u>Preventive Dental</u> You pay a $0 copay for: • 2 oral exams every year • 2 cleanings and 1 set of bitewing X-rays every year • 1 full mouth X-ray every 3 years <u>Comprehensive Dental</u>***** This plan also covers up to a $1,500 allowance for covered comprehensive dental services every year. You pay $0 for covered in network dental services through Liberty Dental providers, and $0-50% for covered out of network dental services through non-Liberty Dental providers. This includes but is not limited to: • Fillings • Root canal • Periodontal scaling and root planing • Extractions • Crowns • Dentures Not every covered dental service is listed here. Also, most services have limits that are not included above. Contact us for more details. Liberty Dental providers are considered in-network for this plan. You can find the dental directory on our website at healthplan.org/medicare, or by calling us at 1.877.847.7915 (TTY: 711).	
Optional Supplemental Dental	Comprehensive dental benefits are available with a separate monthly premium. See the "Optional Supplemental Benefits" section in the back of this book	
Vision Services: Medicare-covered exam to diagnose and treat conditions of the eye	In-Network: $0 copay	Out-of-Network: $25-60 copay

Vision Services: Medicare-covered eyewear	In-Network: $0 copay Limited coverage of eyewear related to cataract surgery.	Out-of-Network: 30% co-insurance
Vision Services: Routine eye exam	In-Network: $0 copay for one exam every year Routine vision services are provided through plan participating providers.Contact the plan for more details.	Out-of-Network: $60 copay for one exam every year
Vision Services: Routine Eyewear	In-Network: $0 copay This plan has a coverage limit for routine eyewear. We will cover up to $200 toward glasses (lens and frames) or contacts (including fitting exam) every year if purchased at a participating provider	Out-of-Network: $15 copay
Inpatient Mental Health Services* (Per admission or stay)	In-Network: Days 1-5: $325 copay per day Days 6-90: $0 copay	Out-of-Network: 30% co-insurance
Outpatient Individual or Group Mental Health Therapy Visit*	In-Network: $40 copay	Out-of-Network: $60 copay
Skilled Nursing Facility* (Per benefit period,as defined by Original Medicare)	In-Network: Days 1-20: $0 copay Days 21-100 $150 copay per day This plan covers up to 100 days in a skilled nursing facility during each benefit period.	Out-of-Network: 20% co-insurance
Physical Therapy*	In-Network: $40 copay	Out-of-Network: $60 copay

Ambulance Authorization required for non- emergency Medicare services.	In-Network: $250 copay for all other ambulance services $500 copay for air ambulance services The above cost shares are for Medicare-covered ambulance services only Emergency transportation is covered worldwide. Covered emergency transportation services outside of the U.S. have a $25,000 annual plan maximum	Out-of-Network: $250 copay for all other ambulance services $500 copay for air ambulance services
Transportation* (Routine)	Not covered	Not covered
Medicare Part B Drugs* Part B drugs may be subject to step therapy. See Evidence of Coverage for details	In-Network: Most Part B drugs and biologicals will have a 20% coinsurance. However, Medicare publishes a list of certain Part B drugs and biologicals with prices that have increased faster than the rate of inflation. For these drugs and biologicals, the coinsurance will be 20% of the inflation-adjusted payment amount, which will be less than what they would pay in coinsurance otherwise. The amount could change throughout the year depending on the rate of inflation.	Out-of-Network: Most Part B drugs and biologicals will have a 30% coinsurance. However, Medicare publishes a list of certain Part B drugs and biologicals with prices that have increased faster than the rate of inflation. For these drugs and biologicals, the coinsurance will be 30% of the inflation-adjusted payment amount, which will be less than what they would pay in coinsurance otherwise. The amount could change throughout the year depending on the rate of inflation.
ADDITIONAL BENEFITS		
Medicare-covered Foot Exams and Treatment* (Podiatry)	In-Network: $40 copay	Out-of-Network: $60 copay
Routine Foot Care* (Podiatry)	In-Network: $40 copay Routine foot care covered for up to 2 visits every year	Out-of-Network: $60 copay

Durable Medical Equipment* (like wheelchairs and oxygen) and Prosthetics* (like braces and artificial limbs)	In-Network: 20% co-insurance Must meet certain criteria to be covered. Contact the plan for more details	Out-of-Network: 40% co-insurance
Diabetic Monitoring Supplies*	In-Network: 0-20% coinsurance for each Medicare-covered supply to monitor blood glucose. • 0% coinsurance for OneTouch/LifeScan or Abbot supplies including test strips, glucose monitors, solutions, lancets, and lancing devices at a network pharmacy. • 20% coinsurance for non-OneTouch/LifeScan or Abbot supplies including test strips, glucose monitors, solutions, lancets, and lancing devices, with a medical exception, at a network pharmacy. • 20% coinsurance for supplies including test strips, glucose monitors, solutions, lancets, and lancing devices when obtained through a contracted DME Provider. Coverage is limited to 100 strips for a 30-day supply. Additional quantities require coverage review.	Out-of-Network: 40% co-insurance
Diabetic Therapeutic Shoes or Inserts*	In-Network: 20% co-insurance	Out-of-Network: 40% co-insurance
Health/Wellness Programs (e.g., fitness, tobacco cessation, etc.)	In-Network: $0 copay SilverSneakers is the fitness program covered by this plan	Out-of-Network: 30% co-insurance
Home Health Services*	In-Network: $0 copay	Out-of-Network: 30% co-insurance

Cardiac/Pulmonary Rehabilitation Services*	In-Network: $0 copay	Out-of-Network: 30% co-insurance
Chiropractic Services*	In-Network: $20 copay	Out-of-Network: $60 copay
	Medicare-covered chiropractic services only	
Over-the-Counter Items (OTC)	$125 allowance per quarter The unused quarterly allowance amount will not carry over to the next quarter. Unused amounts will not carry over to the next calendar year. Members can shop in-store or online through our contracted vendor.	
Telehealth Services	$0 copay This applies to: • Primary Care Physician Services • Physician Specialist Services • Individual Sessions for Mental Health Specialty Services • Individual Sessions for Psychiatric Services Individual Sessions for Outpatient Substance Abuse Services must be accessed through our contracted vendor.	
Wellness Incentive Program	Earn $25 on your InComm card after receiving any of these services: • Breast Cancer Screening • Colorectal Cancer Screening • Annual Wellness Visit Limit one incentive reward per service per year.	

Services with an * may require your provider to obtain prior authorization from the plan.

Prescription Coverage

Costs may differ based on pharmacy type and status. For example, preferred/standard retail, mail order, long term care or home infusion pharmacies. For more information, please call us or access our Evidence of Coverage online at healthplan.org/medicare.

THE HEALTH PLAN SECURECHOICE OPTIMUM(PPO) H8604-014-1				
Outpatient Prescription Drugs				
Stage 1: **Annual Prescription (Part D) Deductible**	$0			
Stage 2: **Initial Coverage**	After you pay your yearly deductible, you pay the amount listed in the table(s) 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. There are preferred and standard retail pharmacies in our network. You will generally pay a lower copay at a preferred pharmacy.			
	Preferred Retail Pharmacy 30-day supply	**Standard Retail Pharmacy 30-day supply**	**Preferred Mail Order Pharmacy 30-day supply**	**Standard Mail Order Pharmacy 30-day supply**
Tier 1: Preferred Generic	$0	$13	$0	$13
Tier 2: Generic	$0	$20	$0	$20
Tier 3: Preferred Brand	$47	$47	$47	$47
Tier 4: Non-Preferred Drug	$100	$100	$100	$100
Tier 5: Specialty Tier (Extended day supply not available in this Tier)	33%	33%	33%	33%

	Preferred Retail Pharmacy 90-day supply	Standard Retail Pharmacy 90-day supply	Preferred Mail Order Pharmacy 90-day supply	Standard Mail Order Pharmacy 90-day supply
Tier 1: Preferred Generic	$0	$39	$0	$39
Tier 2: Generic	$0	$60	$0	$60
Tier 3: Preferred Brand	$141	$141	$125	$141
Tier 4: Non-Preferred Drug	$300	$300	$275	$300
Tier 5: Specialty Tier (Extended day supply not available in this Tier)	N/A	N/A	N/A	N/A

THE HEALTH PLAN SECURECHOICE OPTIMUM(PPO) H8604-014-1	
Stage 3: **Coverage Gap**	Most Medicare drug plans have a coverage gap. 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 price for brand name drugs plus a portion of the drug dispensing fee, and 25% of the price for generic drugs until your costs total $8,000
Stage 4: **Catastrophic Coverage**	Beginning in 2024, if you reach the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs.

IMPORTANT MESSAGE ABOUT WHAT YOU PAY FOR INSULIN AND VACCINES
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.
Our plan covers most Part D vaccines at no cost to you. Call member services for more information.

Optional Supplemental Benefits - Dental

This coverage is available to you for an additional monthly cost of **$17.50**. This will be in addition to your The Health Plan SecureChoice PPO monthly premium.

Our plan will cover up to $1,500 for dental services per plan year. You will be responsible for a portion of the cost for services, as indicated below. The benefit is administered through Liberty Dental providers.

This is not a complete description of benefits. There are covered services that are not listed here. In addition, some of the following services have limitations, exclusions, and maximums. Please contact the plan for complete details.

Monthly Premium	**$17.50**	
Maximum Benefit – Plan Coverage Limit	**$1,500 per year**	
Covered Dental Benefits	**In-Network: You Pay**	**Out-of-Network: You Pay**
Basic Benefits		
Fillings	20%	50%
Resin-based Composite	20%	50%
Endodontics	50%	75%
Scaling and Root Planing	50%	75%
Periodontal Maintenance	50%	75%
General Anesthesia/Intravenous Sedation	50%	75%
Major Benefits		
Crown	50%	75%
Extractions	50%	75%
Complete and Partial Dentures	50%	75%
Denture Adjustment	50%	75%
Denture Repair	50%	75%
Denture Reline/Rebase	50%	75%

How to add this additional Optional Supplemental dental coverage to your plan: Mark the appropriate section on your initial Medicare Advantage plan enrollment form. You can also add this coverage: Up to 60 days after your effective date or during the Annual Enrollment Period (AEP). This coverage will have an additional monthly cost. Your options are listed on the enrollment form. Please contact the plan for complete details.

Nondiscrimination Notice

Discrimination is Against the Law

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

- 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 The Health Plan Customer Service Department. If you believe that The Plan has failed to provide these services or discriminated in another way on the basis of race, religion, color, national origin, age, disability, or sex, you can file a grievance with: The Health Plan Appeals Coordinator, 1110 Main Street, Wheeling, WV 26003, Phone: 1.877.847.7907, TTY: 711, Fax 740.699.6163, Email: info@healthplan.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance The Health Plan Customer Service Department 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:

Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1.800.368.1019, 1.800.537.7697 (TDD).

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

English:
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1.877.847.7907 (TTY: 711).

Spanish:
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.877.847.7907 (TTY: 711).

Chinese:
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1.877.847.7907（TTY：711）。

Tagalog:
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1.877.847.7907 (TTY: 711).

French:
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1.877.847.7907 (ATS : 711).

Vietnamese:
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1.877.847.7907 (TTY: 711).

German:
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.877.847.7907 (TTY: 711).

Korean:
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.877.847.7907 (TTY: 711)번으로 전화해 주십시오.

Russian:
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1.877.847.7907 (телетайп: 711).

Arabic:
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1.877.847.7907 (رقم هاتف الصم والبكم: 711).

Hindi:
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1.877.847.7907 (TTY: 711) पर कॉल करें।

Italian:
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1.877.847.7907 (TTY: 711).

Portugues:
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1.877.847.7907 (TTY: 711).

French Creole:
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1.877.847.7907 (TTY: 711).

Polish:
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1.877.847.7907 (TTY: 711).

Japanese:
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1.877.847.7907（TTY: 711）まで、お電話にてご連絡ください。

Dutch:
MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: 1.877.847.7907 (TTY: 711).

Pennsylvania Dutch:
Wann du (Deitsch (Pennsylvania German / Dutch)) schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1.877.847.7907 (TTY: 711).

Ukranian:
УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером (1.877.847.7907) (TTY: 711).

Romanian:
ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la (1.877.847.7907) (TTY: 711).

Cushite:
XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa (1.877.847.7907) (TTY: 711).

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 1-877-847-7915. 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 1-877-847-7915. 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 1-877-847-7915。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 1-877-847-7915。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 1-877-847-7915. 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 1-877-847-7915. 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 1-877-847-7915 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 1-877-847-7915. 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 1-877-847-7915번으로 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 1-877-847-7915. 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 على1-877-847-7915 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 1-877-847-7915 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 1-877-847-7915. 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 1-877-847-7915. 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 1-877-847-7915. 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 1-877-847-7915. 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、1-877-847-7915 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。


TheHealthPlan