DOCTORS
HEALTHCARE PLANS, INC.

2024

Summary of Benefits

BROWARD COUNTY

DrMax-B

(HMO) H4140-009

H4140_SBDRMAXB2024_M

Doctors HealthCare Plans, Inc. is an HMO with a Medicare contract. Enrollment in Doctors HealthCare Plans, Inc. depends on contract renewal.

Eligibility for Prepaid Card - Special Supplemental Benefits for the Chronically Ill (SSBCI) Benefit under the VBID Model is not assured and will be determined by Doctors HealthCare Plans, Inc. after enrollment, based on relevant criteria (e.g., clinical diagnoses, eligibility criteria, participation in a disease state management program).

This information is not a complete description of benefits. Call (786) 460-3427 or (833) 342-7463 (TTY:711) from 8AM to 8PM, 7 days a week, for more information.

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 with a member services representative at (786) 460-3427 or toll-free (833) 342-7463 (TTY:711), 7 days a week, 8AM to 8PM.

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.doctorshcp.com/2024Plans/ or call (786) 460-3427 or toll-free (833) 342-7463 (TTY:711) to view or request 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 Provider 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 or "Drug List" to make sure your prescription medications are included.

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. If you have Medicaid, your Part B premium may be paid by the state.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2025.
- ☐ **DrPlus-B (HMO D-SNP) H4140-010:** These plans are dual eligible special needs plans (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid.
- ☐ **Effect on Current Coverage:** If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.

2024 Summary of Benefits

DrMax-B (HMO) H4140-009

This is a summary of drug and health services covered by Doctors HealthCare Plans, Inc., beginning January 1, 2024, through December 31, 2024. The Summary of Benefits does not list every service covered by the plan or list every limitation or exclusion. For a complete list of covered services, please call us and ask for the Evidence of Coverage (EOC), or you can view on our website at www.doctorshcp.com/2024Plans/.

WHO CAN JOIN

To join Doctors HealthCare Plans, Inc., you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area. The service area for DrMax-B is Broward County.

HOW YOU CAN COMPARE MEDICARE PLANS

For coverage and cost of original Medicare, look in your current "Medicare & You" handbook. You can order a handbook, find, and compare health plans online at www.medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Hours of operation: 24 hours a day, 7 days a week.

WHAT WE COVER

Everything that Original Medicare covers and much more including Medicare Part D drugs, Part B drugs (such as chemotherapy and some drugs administered by your provider). For more information, please refer to the Evidence of Coverage (EOC).

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.

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

For a complete plan formulary (list of Part D drugs) and information on any restrictions or limitations, visit our website at: www.doctorshcp.com/2024druglist/, or call us to obtain a copy of the drug formulary.

With just a few easy steps, you can find out what your covered drugs will cost. Our plan groups medications into 6 tiers. The amount you pay for the drug will depend on what tier your drug is in. You will need to use your formulary to determine the tier. Then, go to the Summary of Benefits Prescription Drug section and match your drug to the tier to determine the cost.

Generally speaking, members must use a pharmacy in our network. You may get your covered drugs from pharmacies not in our plan only when you are unable to get your prescription drugs from a pharmacy that is in our plan.

To find a pharmacy in our plan, see our online Provider Directory on our website at www.doctorshcp.com/2024Providers/ or call us to obtain a copy.

WHICH DOCTORS, HOSPITALS AND PHARMACIES CAN YOU USE?

Doctors HealthCare Plans, Inc., has a network of doctors, hospital, pharmacies, and other providers. Depending on your plan, you may need a referral to visit a specialist. Except for emergency, urgent, and preventive services, certain services require prior authorization and/or referral.

To get detailed information about your covered services, please see the Evidence of Coverage (EOC).

DO YOU HAVE MEDICARE AND MEDICAID?

Certain levels of Medicaid (Qualified Medicare Beneficiary – QMB) are cost share protected and have a zero cost-sharing liability. Please make sure to discuss Medicaid status with your agent or call the plan for more details.

ARE PRIOR AUTHORIZATIONS OR REFERRALS REQUIRED?

For certain procedures, services and drugs, you may need advanced approval. Please note that services that may require a prior authorization are noted with a "[1]" and services that may require a referral are noted with a "[2]" in the benefit titles listed in this booklet. For more information, you may refer to your Evidence of Coverage.

To request a prior authorization and/or referral, please contact your physician.

HOW TO REACH US

If you have any questions and would like to reach us, please call the phone numbers listed below or visit us at www.doctorshcp.com.

If you are a member of this plan, call Member Services at our local number (786) 460-3427 or toll-free at (833) 342-7463 (TTY:711).

Hours of operation:
7 days a week, 8AM to 8PM EST.

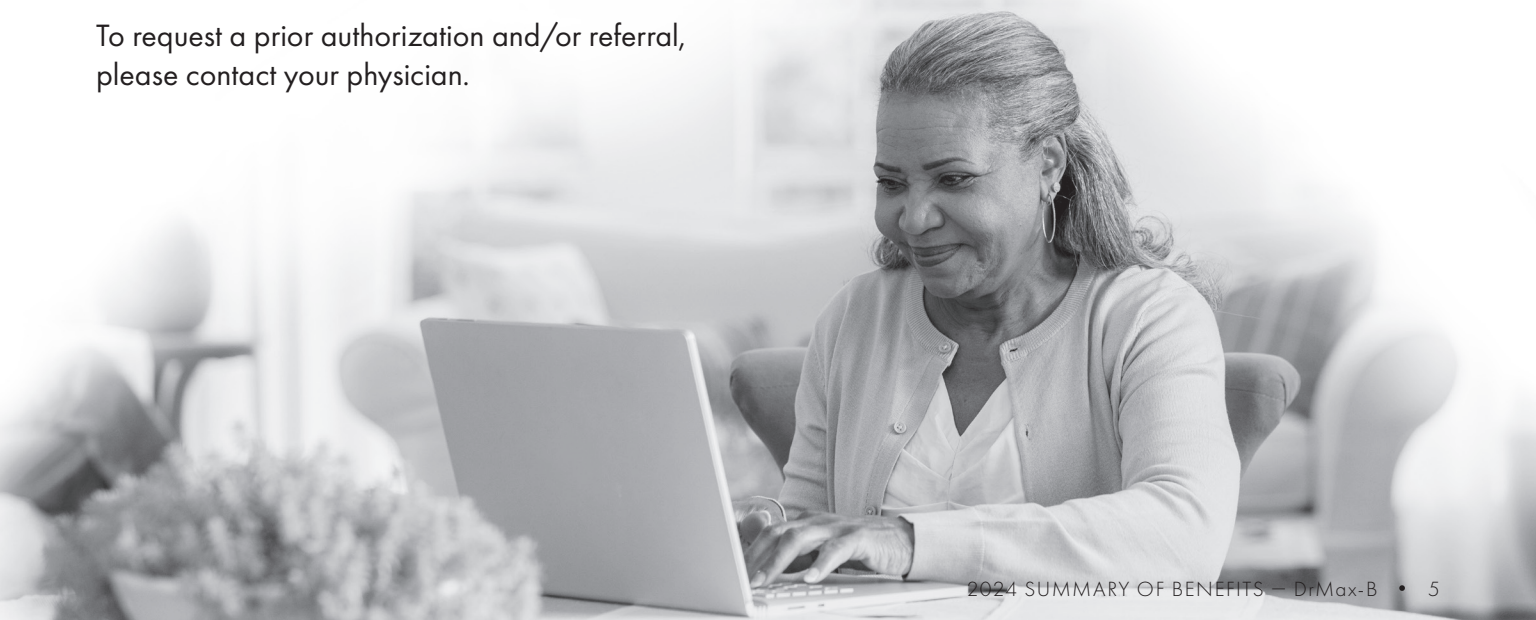
If you are NOT a member of this plan, you can call a licensed sales agent at our local number (786) 420-3427 or toll-free at (833) 639-3427 (TTY:711).

Hours of operation:
7 days a week, 8AM to 8PM EST.

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

@DoctorsHealthCarePlans

@DoctorsHCP



2024 Summary of Benefits

PREMIUMS AND BENEFITS	DrMax-B (HMO) H4140-009
Monthly Plan Premium	**$0:** You must continue to pay your Medicare Part B premium.
Deductible	This plan does not have a deductible for medical services.
Maximum Out-of-Pocket (MOOP)	**$3,400 per year:** This amount is the most you will pay during the plan year for in-network approved medical services under our plan. Once you have paid this amount, we pay **100%** of your covered services for the rest of the year, excluding any prescription drug costs, health expenses incurred during foreign travel, or supplemental benefit costs.

COVERED MEDICAL AND HOSPITAL SERVICES	DrMax-B (HMO) H4140-009
Inpatient Hospital Care[1]	**$0 per admission:** Our plan covers an unlimited number of days for an inpatient hospital stay.
Outpatient Hospital Care	**$0 copay** for: • Lab services[2] • Mental health care group and individual therapy visits[1,2] • Physical therapy, occupational therapy, speech and language therapy[1,2] • Cardiac and pulmonary rehabilitation services[1,2] • Diagnostic procedures and test[2] • Basic radiology (x-ray) services[1,2] **$50 copay** for surgery at a hospital facility.[1,2] **$50 copay** for observation services.[1,2]
Outpatient Surgery — Ambulatory Surgical Center (ASC)[1,2]	**$50 copay**
Primary Care Physician (PCP)	**$0 copay** for primary care physician visits. You must select a PCP from the network.
Specialist[1,2]	**$0 copay** for specialist visits. A referral is required for specialist office visits.

Services with a "1" may need prior authorization from the plan. Services with a "2" may need a referral from your primary care physician (PCP).

COVERED MEDICAL AND HOSPITAL SERVICES	DrMax-B (HMO) H4140-009
Preventive Care Services	**$0 copay** for the following supplemental preventative services: • Abdominal aortic aneurysm screening • Alcohol misuse screening and counseling • Annual "wellness" visit • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease risk reduction (therapy for cardiovascular disease) • Cardiovascular disease testing (screening) • Cervical and vaginal cancer screening • Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) • Depression screening • Diabetes screenings and monitoring • Diabetes self-management training, diabetic services and supplies • Health and wellness education programs • HIV screening • Lung cancer screenings • Medical nutrition therapy services • Obesity screenings and therapy • Prostate cancer screenings (PSA) • Sexually transmitted infections screenings and counseling • Smoking and tobacco use cessation counseling • Vaccines, including vaccines for the flu, hepatitis B, COVID-19 and pneumococcal • Vision care: Glaucoma screening • "Welcome to Medicare" preventive visit (one-time) Any extra preventive services approved by Medicare during the contract year will be covered. When you use doctors in this plan, **100%** of the cost of preventive care screenings are covered.
Emergency Care	**$90 copay**, waived if admitted within 24 hours.
Urgent Care	**$0 copay**
Worldwide Emergency and Urgent Care Services	**$125 copay** for emergency services obtained outside the U.S. **$25 copay** for urgent care services obtained outside the U.S. This plan may cover emergency care, urgent care and transportation up to a **$50,000** limit. The plan will reimburse you for our share of the cost up to the Medicare allowable charge. If the cost of the service is more than $50,000 you will have to pay the difference.

Services with a "1" may need prior authorization from the plan. Services with a "2" may need a referral from your primary care physician (PCP).

2024 Summary of Benefits *(continued)*

COVERED MEDICAL AND HOSPITAL SERVICES	DrMax-B (HMO) H4140-009
Diagnostic Services	Diagnostic procedures and tests: • **$0 copay** at your primary care physician's office • **$0 copay** at a specialist's office[2] • **$0 copay** at a hospital facility as an outpatient[2] Basic radiology (X-ray) services: • **$0 copay** at your primary care physician's office • **$0 copay** at a specialist's office[1,2] • **$0 copay** at a freestanding radiological facility[1,2] • **$0 copay** at a hospital facility as an outpatient[1,2] Diagnostic radiology services (includes advanced imaging services such as MRI, MRA and CT Scans): • **$0 copay** at your primary care physician's office • **$0 copay** at a specialist's office[1,2] • **$0 copay** at a freestanding radiological facility[1,2] • **$50 copay** at a hospital facility as an outpatient[1,2] Therapeutic radiology (radiation therapy) services:[1,2] • **$50 copay** Lab services:[2] • **$0 copay**
Hearing Services	**$0 copay** for routine hearing exam. **$0 copay** for hearing aid fitting/evaluation every 2 calendar years. Up to **$1,000** for hearing aids every 2 calendar years.
Dental Services — Preventive	**$0 copay** for the following preventive dental services: • Periodic oral evaluation(s), up to **4** per calendar year • Comprehensive oral evaluation, up to **2** per calendar year • Prophylaxis cleaning(s), up to **2** per calendar year • Fluoride, up to **2** per calendar year • Bitewing x-rays, up to **2** per calendar year • Panoramic x-ray, up to **1** per 3 calendar years
Dental Services — Comprehensive[1]	**$0 copay** for the following comprehensive dental services: • Fillings (amalgam or resin), up to **4** per calendar year • Extractions, up to **4** per calendar year • Root canal, up to **1** per calendar year • Crowns, up to **2** per calendar year • Implant, up to **1** per calendar year • Scaling and root planing (deep cleaning), up to **1** per quadrant per 2 years • Dentures, up to **1** full upper and **1** full lower denture per 5 years or 1 partial upper and 1 partial lower denture per 5 calendar years You must visit a participating dental network provider to receive dental benefits. Please refer to the plans website www.doctorshcp.com/2024Providers/ for participating dental providers.

Services with a "1" may need prior authorization from the plan. Services with a "2" may need a referral from your primary care physician (PCP).

COVERED MEDICAL AND HOSPITAL SERVICES	DrMax-B (HMO) H4140-009
Vision Services	**$0 copay** for eye exams. Up to **$200** for eyeglasses and/or contact lenses per calendar year.
Mental Health Care — InPatient[1]	**$0 copay per stay:** Our plan has a lifetime limit of 190 days for inpatient mental health care in a psychiatric hospital. This limit does not apply to inpatient mental health services provided in a general hospital. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.
Mental Health Care Services — Outpatient[1,2]	**$0 copay:** Group **$0 copay:** Individual Includes outpatient treatment for mental illness and/or substance abuse.
Skilled Nursing Facility (SNF)[1]	**$0 copay** per day for days 1 through 20. **$60 copay** per day for days 21 through 100. Our plan covers up to 100 days in a SNF per benefit period. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient hospital care or skilled care in a SNF for 60 days in a row. If you go into a hospital or SNF after one benefit period has ended, a new benefit period begins. There's no limit to the number of benefit periods.
Physical Therapy[1,2]	**$0 copay**
Ambulance	**$200 copay** per trip for emergency ground ambulance services. **20% coinsurance** per trip for emergency air ambulance services.
Transportation	**$0 copay** for **unlimited** trips to plan approved locations per calendar year. You must call our contracted transportation vendor to schedule an appointment.

Services with a "1" may need prior authorization from the plan. Services with a "2" may need a referral from your primary care physician (PCP).

2024 Summary of Benefits *(continued)*

MEDICARE PART B DRUGS	
Part B Drugs[1]	**0% coinsurance** for select Nebulized Medications. These include: Albuterol Sulfate, Budesonide, Cromolyn Sodium, Ipratropium Bromide, Ipratropium-Albuterol and Levalbuterol HCL **0%-20% coinsurance** for: • Chemotherapy/radiation drugs • Other Part B Drugs • Part B Insulins (not to exceed $35 monthly) **$0 copay** for administration of Part B Drugs.

PART D PRESCRIPTION DRUG BENEFITS		
Deductible	This plan has no deductible.	
Initial Coverage Limit	You pay the following until your yearly drug costs reach **$5,030**.	
TIERS	**RETAIL COST-SHARING**	**MAIL-ORDER COST-SHARING**
Tier 1: Preferred Generics	**$0 copay** for 30-day supply **$0 copay** for 90-day supply*	**$0 copay** for 30-day supply **$0 copay** for 90-day supply*
Tier 2: Generics	**$0 copay** for 30-day supply **$0 copay** for 90-day supply*	**$0 copay** for 30-day supply **$0 copay** for 90-day supply*
Tier 3: Preferred Brands	**$45 copay** for 30-day supply **$135 copay** for 90-day supply* *(You pay $35 per month supply of each covered insulin product on this tier.)*	**$45 copay** for 30-day supply **$135 copay** for 90-day supply* *(You pay $35 per month supply of each covered insulin product on this tier.)*
Tier 4: Non-Preferred Drugs	**$100 copay** for 30-day supply **$300 copay** for 90-day supply* *(You pay $35 per month supply of each covered insulin product on this tier.)*	**$100 copay** for 30-day supply **$300 copay** for 90-day supply* *(You pay $35 per month supply of each covered insulin product on this tier.)*
Tier 5: Specialty	**33% coinsurance** for 30-day supply	**33% coinsurance** for 30-day supply
	A long-term supply (also called an "extended supply") is not available for drugs in the Specialty Tier.	
Tier 6: Supplemental Drugs	**$0 copay** for 30 day-supply **$0 copay** for 90-day supply*	**$0 copay** for 30 day-supply **$0 copay** for 90-day supply*

* Any medication being filled for the FIRST TIME is subject to a 30-day supply limit.

Tier 6 Drugs are covered at **$0 copayment** throughout all your benefit stages.

VACCINES

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

INSULIN

Important Message About What You Pay for Insulin: You won't pay more than **$35** for a one-month supply (no more than $70 for a two-month supply and $105 for a three-month supply) of each insulin product covered by our plan, no matter what cost-sharing tier it's on and this is applicable throughout all coverage stages.

COVERAGE GAP

After your total yearly drug costs (what you pay plus what the plan pays) reach **$5,030**, you enter the Coverage Gap.

- You pay **$0 copay** for all drugs in Tiers 1, 2 and 6 through the Coverage Gap.
- You pay only **25%** of the cost and portion of the dispensing fee for Brand Name drugs in Tiers 3, 4 and 5.
- You pay only **25%** of the plan's negotiated retail price for Generic Drugs in Tiers 3, 4 & 5.
- You remain in this stage until you reach your yearly out-of-pocket drug cost of **$8,000**, at which time you move on to the Catastrophic Coverage Stage.

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 and this is applicable throughout all stages of your benefit. Your cost may be less if you receive "Extra Help" from Medicare.

Our plan covers most Part D vaccines at no cost to you. Call Member Services for more information.

Coverage Gap Stage coinsurance requirements do not apply to Part D covered insulin products and most adult Part D vaccines, including shingles, tetanus, and travel vaccines.

CATASTROPHIC COVERAGE

You will stay in this payment stage until the end of the calendar year. During this stage, the plan pays the full cost for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit. **You pay nothing.**

SUPPLEMENTAL DRUG COVERAGE AND VITAMINS

Our plan offers additional coverage of some prescription drugs not normally covered in a Medicare prescription drug plan under our enhanced benefit (Tier 6 – Supplemental Drugs). Covered drugs include:

- Some drugs used for the relief of cough and cold symptoms, such as benzonatate.
- Some prescription vitamins, such as ergocalciferol (Vitamin D2) oral with a limit of four (4) capsules per 28 days and cyanocobalamin (Vitamin B12) injectable with a limit of 10mLs per month.
- Some erectile dysfunction drugs, such as sildenafil (generic for Viagra®) and tadalafil (generic for Cialis®), with a limit of four (4) tablets per month.

Your Plan's Formulary includes additional information about all drugs covered under this benefit.

ADDITIONAL PRESCRIPTION DRUG INFORMATION

If you receive "Extra Help", you pay whichever is less: your plan cost-share or the Low Income Subsidy (LIS) cost-share. *Please refer to your LIS Rider for the specific amount you pay.*

2024 Summary of Benefits *(continued)*

ADDITIONAL BENEFITS	DrMax-B (HMO) H4140-009
Outpatient Rehabilitation[1,2]	**$0 copay** per visit for: • Cardiac rehabilitation services • Pulmonary rehabilitation services • Occupational therapy services • Supervised Exercise Therapy (SET) services
Podiatry Services	**$0 copay:** Medicare-covered foot care **$0 copay:** Routine foot care, up to **6** visits per year
Renal Dialysis[1,2]	**20% coinsurance**
Additional Telehealth Benefit for Part B Services[1,2]	**$0 copay** per telehealth visit for: • Primary Care Physician Services • Occupational Therapy Services • Physician Specialists Services • Individual Sessions for Mental Health Specialty • Group Sessions for Mental Health Specialty • Podiatry Services • Other Health Care Professional Services • Individual Sessions for Psychiatric Services • Group Sessions for Psychiatric Services • Physical Therapy and Speech-Language Pathology Services • Opioid Treatment Program Services • Individual Sessions for Outpatient Substance Abuse • Group Sessions for Outpatient Substance Abuse • Kidney Disease Educational Services • Diabetes Self-Management Training

Services with a "1" may need prior authorization from the plan. Services with a "2" may need a referral from your primary care physician (PCP).

MEDICAL EQUIPMENT AND SUPPLIES	DrMax-B (HMO) H4140-009
Durable Medical Equipment (DME)[1]	**20% coinsurance** for covered items, including but not limited to powered wheelchairs, powered mattress systems, continuous glucose monitors (CGMs), and other electric devices. **0% coinsurance** for the total cost of CPAP machines. **0% coinsurance** for all other medical equipment. The list of preferred vendors and manufacturers for durable medical equipment (DME) can be found in your EOC and online at www.doctorshcp.com/2024Plans/.
Prosthetic Devices[1]	**20% coinsurance** for braces/artificial limbs. **0% coinsurance** for all other prosthetic devices.
Diabetic Supplies[1]	**0% coinsurance** for preferred glucometers, test strips, lancets, lancet devices and control solutions. The Plan's Preferred Diabetic Supplies include **Abbott products: FreeStyle® Lite, FreeStyle® Freedom Lite, Freestyle® Precision Neo, Precision Xtra (does not include Freestyle® Libre).** **20% coinsurance** for non-preferred glucometers, lancets, test strips and other diabetic supplies. A prior authorization is required for non-preferred glucometers and test strips.
Therapeutic Shoes or Inserts; Medicare-covered[1]	**0% coinsurance**

WELLNESS PROGRAMS	DrMax-B (HMO) H4140-009
Prepaid Card	**$107 monthly** on a prepaid card to be used at approved locations to purchase groceries and over-the-counter (OTC) products. Amounts do not roll over from month to month. Funds will be available every 1st of the month. The prepaid card is only available to members with certain chronic health conditions. Refer to your Evidence of Coverage (EOC) for details.
Health Education	Interactive sessions with a certified health educator for members who qualify.
Fitness Benefit	**$0 copay:** Membership and access to fitness facilities, healthy aging coaching, home fitness kits and fitness education materials.
Meals Benefit[1,2]	**$0 copay** for up to **16** meals per calendar year following discharge from hospital.
Over-the-Counter (OTC) Benefit	*Please refer to your benefit labeled "Prepaid Card."*
Chiropractor Care	**$0 copay** Medicare-covered chiropractic services. **$0 copay** routine chiropractic care, up to **12** visits per year.
Acupuncture[1]	**$0 copay** Medicare-covered acupuncture treatments. **$0 copay** supplemental acupuncture treatments, up to **20** visits per year.
Home Health Services[1,2]	**$0 copay** for limited skilled nursing care and certain other health services you get in your home for the treatment of an illness or injury. Number of covered visits is based on medical need as determined by your physician and authorized by the plan.

Services with a "1" may need prior authorization from the plan. Services with a "2" may need a referral from your primary care physician (PCP).

Discrimination Is Against The Law

Doctors HealthCare Plans, Inc. complies with applicable civil rights laws and does not discriminate or exclude individuals on the basis of race, color, national origin, age disability, sex, sexual orientation, pregnancy, gender, gender identity, or religion.

Doctors HealthCare Plans, Inc. provides: (1) free aids and services to people with disabilities to communicate effectively with us, such as, qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats); and, (2) free language services to individuals whose primary language is not English, such as, qualified interpreters and information written in other languages.

If you need these services, contact the number on the back of your ID Card. If you believe that Doctors HealthCare Plans, Inc., has failed to provide these services or discriminated in any way, you can file a grievance with: **Doctors HealthCare Plans, Inc.**, *Attention: Member Services Department,* 2020 Ponce de Leon Blvd., PH 1, Coral Gables, FL 33134 or call (786) 460-3427 or (833) 342-7463, TTY:711; 7 days a week; 8AM to 8PM EST.

You can file a grievance by calling, in person, by mail, or by fax. If you need help filing a grievance, our Member Services Representatives are available to help you at the number listed above. You can also file a civil rights complaint electronically through the U.S. Department of Health and Human Services, 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 or call (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 833-342-7463 (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 833-342-7463 (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 833-342-7463 (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 833-342-7463 (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 833-342-7463 (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 833-342-7463 (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 833-342-7463 (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 833-342-7463 (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 833-342-7463 (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 833-342-7463 (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 (TTY:711) 833-342-7463 . سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स ्वास ्थ ्य या दवा की योजना के बारे में आपके ककसी भी प ्रश ्न के जवाब देने के कए हमारे पास मुफ ्त दुभाकयिा सेवाएँ उपबि ्ध हैं. एक दुभाकयिा प ्राप ्त करने के कए, बस हमें 833-342-7463 (TTY:711) पर फोन करें. कोई व ्यक ्त जिो कहन ्दी बोिता है आपकी मदद कर सकता है. यह एक मुफ ्त 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 833-342-7463 (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 833-342-7463 (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 833-342-7463 (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 833-342-7463 (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、833-342-7463 (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。