CareFirst Medicare Advantage

2024 Summary of Benefits

CareFirst BlueCross BlueShield Medicare Advantage

January 1, 2024–December 31, 2024

Service area: Anne Arundel, Frederick, Carroll, Harford and Howard Counties.

CareFirst BlueCross BlueShield Advantage Core (HMO)
H6067-001-001

CareFirst BlueCross BlueShield Advantage Enhanced (HMO)
H6067-002-001

2024 Summary of Benefits

CareFirst BlueCross BlueShield Medicare Advantage

This document summarizes the benefits of our plans and what you can expect to pay when you seek care. Every plan is required to create a Summary of Benefits document (like the one you're reading now). For additional information, including a complete list of benefits, call us and request an "Evidence of Coverage" document or find a copy online at **carefirst.com/medicareadvantage.**

Who is eligible for our plans?

Anyone qualified for Medicare Part A, enrolled in Medicare Part B and living in our service area. The CareFirst BlueCross BlueShield Medicare Advantage service area includes the following counties in Maryland: Anne Arundel, Carroll, Frederick, Harford, and Howard. Understanding your options Medicare benefits are available through Original Medicare, which is run by the Federal government. Another option is to enroll in Medicare benefits through a Medicare Advantage health plan with CareFirst BlueCross BlueShield Medicare Advantage. A Medicare Plan Finder tool is available at **medicare.gov**. Additionally, you can view the free "Medicare & You" handbook at that same website. Printed handbooks are available by request—for your copy, call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users can call 1-877-486-2048.

Pharmacy

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 on our website (**carefirst.com/medicareadvantage**). Or, call us and we will send you a copy of the provider and pharmacy directories.

Provider Networks

CareFirst BlueCross BlueShield Medicare Advantage members are generally not covered for out-of-network services except for emergent or urgent situations, dialysis, and other special circumstances approved in advance by the plan. Please call our member services number or see your Evidence of Coverage for more information. Referrals may be required for specialty care only.

Want more information?

Call 855-290-5744 (TTY:711) 8 a.m.–8 p.m. ET, 7 days a week from October 1 through March 31. From April 1 through September 30, our hours are 8 a.m.–8 p.m. ET, Monday through Friday. Visit **carefirst.com/medicareadvantage.**

Premiums and Benefits	CareFirst BlueCross BlueShield Advantage Core (HMO)	CareFirst BlueCross BlueShield Advantage Enhanced (HMO)
Monthly Plan Premium	$14 You must continue to pay your Part B premium each month.	$72 You must continue to pay your Part B premium each month.
Deductible	No Deductible	No Deductible
Maximum Out-of-Pocket Responsibility (Does not include prescription drugs)	Your yearly limit(s) in this plan is $8,300 for services you receive from in-network providers for Medicare-covered services. 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 still need to pay your monthly premiums.	Your yearly limit(s) in this plan is $7,300 for services you receive from in-network providers for Medicare-covered services. 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 still need to pay your monthly premiums.
Inpatient Hospital Coverage*	You pay a $350 copay per day for days 1 through 5. You pay a $0 copay per day for days 6 through 90. Our plan covers 90 days for each Medicare-covered inpatient hospital stay. Lifetime reserve applies.	You pay a $350 copay per day for days 1 through 5. You pay a $0 copay per day for days 6 through 90. Our plan covers 90 days for each Medicare-covered inpatient hospital stay. Lifetime reserve applies.
Outpatient Hospital Coverage*		
Outpatient Hospital, including surgery	You pay a $250 copay for each Medicare-covered outpatient hospital visit.	You pay a $150 copay for each Medicare-covered outpatient hospital visit.
Outpatient Hospital Observation Services	You pay a $330 copay for each Medicare-covered outpatient observation service.	You pay a $250 copay for each Medicare-covered outpatient observation service.

Premiums and Benefits	CareFirst BlueCross BlueShield Advantage Core (HMO)	CareFirst BlueCross BlueShield Advantage Enhanced (HMO)
Ambulatory Surgical Center (ASC)*	You pay a $200 copay for each Medicare-covered ambulatory surgical center visit.	You pay a $100 copay for each Medicare-covered ambulatory surgical center visit.
Doctor Visits		
Primary Care Provider (PCP)	You pay a $5 copay per Medicare-covered PCP visit.	You pay a $0 copay per Medicare-covered PCP visit.
Specialist* (Referral may be required)	You pay a $50 copay per Medicare-covered Specialist visit.	You pay a $40 copay per Medicare-covered Specialist visit.
Preventive Care	Our plan covers Medicare-covered preventive services at no cost when you see an in-network provider. Any additional preventive services approved by Medicare during the contract year will be covered.	Our plan covers Medicare-covered preventive services at no cost when you see an in-network provider. Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency Care	You pay a $100 copay for each Medicare-covered emergency care visit. Copay waived if admitted to the hospital within 24 hours.	You pay a $100 copay for each Medicare-covered emergency care visit. Copay waived if admitted to the hospital within 24 hours.
Urgently Needed Services	You pay a $30 copay for each Medicare-covered urgent care visit. Copay is waived if you are admitted to the hospital within 48 hours. Worldwide (outside the U.S.) urgently needed care coverage also covered. There is a $25,000 combined maximum for Worldwide Emergency/ Urgently Needed Services. You pay a $30 copay. Copay is not waived if admitted to the hospital.	You pay a $20 copay for each Medicare-covered urgent care visit. Copay is waived if you are admitted to the hospital within 48 hours. Worldwide (outside the U.S.) urgently needed care coverage also covered There is a $50,000 combined maximum for Worldwide Emergency/Urgently Needed Services. You pay a $0 copay.

Premiums and Benefits	CareFirst BlueCross BlueShield Advantage Core (HMO)	CareFirst BlueCross BlueShield Advantage Enhanced (HMO)
Diagnostic Services*		
Tests and Procedures	You pay a $50 copay for each Medicare-covered diagnostic test and procedure.	You pay a $40 copay for each Medicare-covered diagnostic test and procedure.
Lab Services	You pay $0 for Medicare-covered lab services.	You pay $0 for Medicare-covered lab services.
Diagnostic Radiology Services (e.g. CT, MRI)	You pay a $200 copay for Medicare-covered diagnostic radiology.	You pay a $150 copay for Medicare-covered diagnostic radiology.
Therapeutic Radiology Services	You pay a 20% coinsurance for Medicare-covered therapeutic radiological services.	You pay a 20% coinsurance for Medicare-covered therapeutic radiological services.
X-Rays	You pay a $20 copay for Medicare-covered x-rays.	You pay a $10 copay for Medicare-covered x-rays.
Hearing Services		
Exam to diagnose and treat hearing and balance issues	You pay a $40 copay for each Medicare-covered hearing exam.	You pay a $20 copay for each Medicare-covered hearing exam.
Routine hearing exams	You pay a $0 copay for one routine hearing exam annually and for one fitting and evaluation for hearing aids annually. Coverage through in-network vendor.	You pay a $0 copay for one routine hearing exam annually and for one fitting and evaluation for hearing aids annually. Coverage through in-network vendor.
Hearing aids	You pay a $475 to $1,950 copay per hearing aid based on technology level. Coverage through in-network vendor.	You pay a $400 to $1,875 copay per hearing aid based on technology level. Coverage through in-network vendor.

Premiums and Benefits	CareFirst BlueCross BlueShield Advantage Core (HMO)	CareFirst BlueCross BlueShield Advantage Enhanced (HMO)
Dental Services		
Comprehensive*	You pay a $40 copay for each Medicare-covered dental service.	You pay a $20 copay for each Medicare-covered dental service.
Preventive services (frequencies vary based on services)	You pay a $10 copay for oral exams. You pay a $10 copay for prophylaxis (cleaning). You pay a $10 copay for fluoride treatment. You pay a $10 copay for dental x-rays.	You pay a $5 copay for oral exams. You pay a $5 copay for prophylaxis (cleaning). You pay a $5 copay for fluoride treatment. You pay a $5 copay for dental x-rays.
Additional comprehensive dental services	There are no additional comprehensive dental services covered in this plan.	The maximum allowance for comprehensive dental is $800.00 each year. You pay a $15 to $30 copay for non-routine services, including caries-arresting medicament (treatment to help stop active decay) and emergency dental pain treatment. You pay a $15 to $500 copay for basic restorative services, including amalgam and composite fillings. You pay a $50 to $300 copay for non-surgical periodontics. You pay a $40 to $100 copay for non-surgical extractions.

Premiums and Benefits	CareFirst BlueCross BlueShield Advantage Core (HMO)	CareFirst BlueCross BlueShield Advantage Enhanced (HMO)
Vision Services		
Exam to diagnose and treat diseases and conditions of the eye	You pay a $40 copay for Medicare covered eye exam	You pay a $20 copay for Medicare covered eye exam.
Preventive Glaucoma screening	You pay a $0 copay.	You pay a $0 copay.
Eyeglasses or contact lenses after cataract surgery	You pay a $0 copay.	You pay a $0 copay.
Diabetic eye exam	You pay a $0 copay.	You pay a $0 copay.
Routine eye exam	You pay a $20 copay for a routine eye exam every year (includes dilation and refraction) through our in-network vendor.	You pay a $10 copay for a routine eye exam every year (includes dilation and refraction) through our in-network vendor.
Eyewear allowance	Select frames purchased from our in-network vendor's exclusive collection will be covered in full through our vision services partner. Any frames outside the collection will have a $75 allowance annually. You pay a $20 copay for eyeglass lenses. If contact lenses are medically necessary, they will be covered in full through our in-network vendor. The elective contact lenses allowance is $100 each year. Contact lens fitting and evaluation is not covered.	Select frames purchased from our in-network vendor's exclusive collection will be covered in full through our vision services partner. Any frames outside the collection will have a $150 allowance annually. You pay a $10 copay for eyeglass lenses. If contact lenses are medically necessary, they will be covered in full through our in-network vendor. The elective contact lenses allowance is $200 each year. Contact lens evaluation allowance is $60 each year.

Premiums and Benefits	CareFirst BlueCross BlueShield Advantage Core (HMO)	CareFirst BlueCross BlueShield Advantage Enhanced (HMO)
Mental Health Services		
Inpatient*	You pay a $330 copay for Days 1 to 5. You pay $0 copay for Days 6 to 90.	You pay a $250 for Days 1 to 5. You pay $0 copay for Days 6 to 90.
Outpatient	You pay a $40 copay for each outpatient individual therapy visit and $20 copay for each outpatient group therapy visit.	You pay a $20 copay for each outpatient individual therapy visit and $10 copay for each outpatient group therapy visit.
Skilled Nursing Facility (SNF)*	Our plan covers up to 100 days in a Skilled Nursing Facility. You pay a $0 copay per day for days 1 through 20. You pay a $180 copay per day for days 21 through 100.	Our plan covers up to 100 days in a Skilled Nursing Facility. You pay a $0 copay per day for days 1 through 20. You pay a $160 copay per day for days 21 through 100.
Physical Therapy*	You pay a $35 copay for each Medicare-covered visit.	You pay a $18 copay for each Medicare-covered visit.
Ambulance*		
Ground	You pay a $240 copay for ground services.	You pay a $200 copay for ground services.
Air	You pay a 20% coinsurance for air services.	You pay a 20% coinsurance for air services.
Routine Transportation	No coverage.	No coverage.
Medicare Part B Prescription Drugs*	You pay 0%-20% coinsurance of the total cost for Medicare-covered Part B insulin, chemotherapy, or other Part B drugs. Insulin cost sharing is subject to a coinsurance cap of $35 for a one-month supply.	You pay 0%-20% coinsurance of the total cost for Medicare-covered Part B insulin, chemotherapy, or other Part B drugs. Insulin cost sharing is subject to a coinsurance cap of $35 for a one-month supply.

**Prior authorization may be required*

Additional Benefits	CareFirst BlueCross BlueShield Advantage Core (HMO)	CareFirst BlueCross BlueShield Advantage Enhanced (HMO)
Chiropractic Care*		
Medicare Covered	You pay a $15 copay for each Medicare-covered chiropractic visit.	You pay a $10 copay for each Medicare-covered chiropractic visit.
Routine	Not covered.	You pay a $10 copay for each non-Medicare-covered routine chiropractic service (12 visits a calendar year).
Diabetes Management: Onduo	Members with diabetes who are enrolled in our Onduo care management program will have access to the following no-cost benefits: ■ Virtual clinics with primary care providers and specialists, ■ Continuous glucose monitors (CGMs) for eligible members ■ Blood pressure cuffs for eligible members ■ Additional diabetic supplies such as test strips and lancets, ■ Health and lifestyle coaching, support, and services and access to an app.	Members with diabetes who are enrolled in our Onduo care management program will have access to the following no-cost benefits: ■ Virtual clinics with primary care providers and specialists, ■ Continuous glucose monitors (CGMs) for eligible members ■ Blood pressure cuffs for eligible members ■ Additional diabetic supplies such as test strips and lancets, ■ Health and lifestyle coaching, support, and services and access to an app.
In Home Assessment	The In-Home Assessment is an annual in-home clinical assessment, like a physical. We have created an easy and effective way for you to gain a more complete picture of your health. You pay a $0 copay.	The In-Home Assessment is an annual in-home clinical assessment, like a physical. We have created an easy and effective way for you to gain a more complete picture of your health. You pay a $0 copay.

Additional Benefits	CareFirst BlueCross BlueShield Advantage Core (HMO)	CareFirst BlueCross BlueShield Advantage Enhanced (HMO)
Foot Care (Podiatry Services)*		
Foot exams and treatment	You pay a $40 copay for each Medicare-covered podiatry visit.	You pay a $30 copay for each Medicare-covered podiatry visit.
Routine foot care	Not covered.	You pay a $10 copay for each non-Medicare-covered routine podiatry service (12 visits a calendar year).
24-Hour Nurse Advice Hotline	You pay a $0 copay for services provided by the 24-Hour Nurse Advice Line.	You pay a $0 copay for services provided by the 24-Hour Nurse Advice Line.
Fitness (SilverSneakers)	You're automatically enrolled in the SilverSneakers® Fitness Program at no additional cost. SilverSneakers can help you live a healthier, more active life through fitness and social connection. Enjoy SilverSneakers On-Demand workout videos from home, LIVE Classes and Workshops and more through SilverSneakers. com and the SilverSneakers GO app. You can also sign up for a home fitness kit. You'll have access to thousands of gym locations nationwide with use of basic amenities. SilverSneakers offers specially designed, signature exercise classes for all fitness levels plus group exercise classes for all levels at select locations.	You're automatically enrolled in the SilverSneakers® Fitness Program at no additional cost. SilverSneakers can help you live a healthier, more active life through fitness and social connection. Enjoy SilverSneakers On-Demand workout videos from home, LIVE Classes and Workshops and more through SilverSneakers. com and the SilverSneakers GO app. You can also sign up for a home fitness kit. You'll have access to thousands of gym locations nationwide with use of basic amenities. SilverSneakers offers specially designed, signature exercise classes for all fitness levels plus group exercise classes for all levels at select locations.

Additional Benefits	CareFirst BlueCross BlueShield Advantage Core (HMO)	CareFirst BlueCross BlueShield Advantage Enhanced (HMO)
Acupuncture*		
Medicare-covered	You pay a $50 copay for Medicare covered acupuncture.	You pay a $40 copay for Medicare covered acupuncture.
Routine	Routine acupuncture is not covered on this plan	You pay a $20 copay for each non-Medicare-covered routine acupuncture visit (12 visits a calendar year).

**Prior authorization may apply.*

Part D

Premiums and Benefits	CareFirst BlueCross BlueShield Advantage Core (HMO) CareFirst BlueCross BlueShield Advantage Enhanced (HMO)
Initial Coverage Stage	You pay the copays in the tables below until your total yearly drug costs reach $5,030 in 2024. 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, specialty pharmacies and mail order pharmacies. Cost-sharing is based upon the Tier the drug is on 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 **Prescription drugs cost-sharing tier descriptions:** ■ **Tier 1—Preferred Generic:** is the lowest tier and includes preferred generic drugs and may include some brand drugs. ■ **Tier 2—Generic:** includes generic drugs and may include some brand drugs. ■ **Tier 3—Preferred Brand:** includes preferred brand drugs and non-preferred generic drugs. ■ **Tier 4—Non-Preferred Drug:** includes non-preferred brand and generic drugs. ■ **Tier 5—Specialty:** is the highest tier and includes high-cost brand and generic drugs.
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 in 2024. 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. CareFirst BlueCross BlueShield Advantage Enhanced (HMO) has additional gap coverage.

Premiums and Benefits	CareFirst BlueCross BlueShield Advantage Core (HMO) CareFirst BlueCross BlueShield Advantage Enhanced (HMO)
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy, specialty pharmacies and through mail order) reach $8,000 in 2024, your plan will cover all costs.
Long Term Care Facility Resident Coverage	If you live in a long-term care facility and get your drugs from their pharmacy, you pay the same as copays as a 30-day retail pharmacy prescriptions for both Core and Enhanced plans.

You pay $35 or less for a one-month supply of the cost-sharing tier for insulins covered under this product.

Medicare Part D Drugs	CareFirst BlueCross BlueShield Advantage Core (HMO)	CareFirst BlueCross BlueShield Advantage Enhanced (HMO)
Retail Pharmacy—one-month supply	Copay	Copay
Tier 1—Preferred Generic	$4	$2
Tier 2—Generic	$20	$15
Tier 3—Preferred Brand	$47	$47
Tier 4—Non-Preferred Drug	40% of the total cost	40% of the total cost
Tier 5—Specialty	33% of the total cost	33% of the total cost
Retail Pharmacy—two-month supply	Copay	Copay
Tier 1—Preferred Generic	$4	$2
Tier 2—Generic	$20	$15
Tier 3—Preferred Brand	$94	$94
Tier 4—Non-Preferred Drug	40% of the total cost	40% of the total cost
Tier 5—Specialty	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.
Retail Pharmacy—three-month supply	Copay	Copay
Tier 1—Preferred Generic*	$4	$2
Tier 2—Generic	$20	$15
Tier 3—Preferred Brand	$141	$141
Tier 4—Non-Preferred Drug	40% of the total cost	40% of the total cost
Tier 5—Specialty	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.
Mail Order—one-month supply	Copay	Copay
Tier 1—Preferred Generic	$4	$2
Tier 2—Generic	$20	$15
Tier 3—Preferred Brand	$47	$47
Tier 4—Non-Preferred Drug	40% of the total cost	40% of the total cost
Tier 5—Specialty	33% of the total cost	33% of the total cost

Medicare Part D Drugs	CareFirst BlueCross BlueShield Advantage Core (HMO)	CareFirst BlueCross BlueShield Advantage Enhanced (HMO)
Mail Order—two-month supply	Copay	Copay
Tier 1—Preferred Generic	$7	$5
Tier 2—Generic	$20	$15
Tier 3—Preferred Brand	$94	$94
Tier 4—Non-Preferred Drug	40% of the total cost	40% of the total cost
Tier 5—Specialty	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.
Mail Order—three-month supply	Copay	Copay
Tier 1—Preferred Generic*	$4	$2
Tier 2—Generic	$20	$15
Tier 3—Preferred Brand	$94	$94
Tier 4—Non-Preferred Drug	40% of the total cost	40% of the total cost
Tier 5—Specialty	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.
Enhanced Gap Coverage	Gap coverage is not available for this plan.	Enhanced plan members entering the coverage gap stage (donut hole) will pay the copay listed below for Tier 1—Preferred Generic drugs. ■ One-month Retail Supply: $2 ■ Two-month Retail Supply: $2 ■ Three-month Retail Supply: $2 ■ One-month Mail Order: $2 ■ Two-month Mail Order: $2 ■ Three-month Mail Order: $2 $2 for a one-month supply OON (Out-of-network) and for LTC (Long-Term Care drugs)

You pay $35 or less depending for a one-month supply on the cost-sharing tier for insulins covered under this product.

CareFirst Medicare Advantage

CONNECT WITH US:

Notice of Nondiscrimination and Multi-Language Insert

(Updated 8/5/19)

CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc., CareFirst Diversified Benefits and all of their corporate affiliates (CareFirst) comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. CareFirst does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

CareFirst:

- Provides free aid 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, please call 1-855-290-5744.

If you believe CareFirst 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 our CareFirst Civil Rights Coordinator by mail, fax or email. If you need help filing a grievance, our CareFirst Civil Rights Coordinator is available to help you.

To file a grievance regarding a violation of federal civil rights, please contact the Civil Rights Coordinator as indicated below. Please do not send payments, claims issues, or other documentation to this office.

Civil Rights Coordinator, Corporate Office of Civil Rights

Mailing Address	P.O. Box 8894 Baltimore, Maryland 21224
Email Address	**civilrightscoordinator@carefirst.com**
Telephone Number	410-528-7820
Fax Number	410-505-2011

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf** or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/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 1-855-290-5744. 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 1-855-290-5744. 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 1-855-290-5744。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 1-855-290-5744。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 1-855-290-5744. 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 1-855-290-5744. 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 1-855-290-5744 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 1-855-290-5744. 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 1-855-290-5744 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 1-855-290-5744. 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 1-855-290-5744 . 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 1-855-290-5744 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 1-855-290-5744. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

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