2024 Summary of Benefits

commonwealth care alliance® MASSACHUSETTS

Commonwealth Care Alliance® Massachusetts

CCA Medicare Preferred (PPO) H9414-001
CCA Medicare Value (PPO) H9414-002

This is a summary of drug and health services covered by CCA Massachusetts from January 1, 2024 to December 31, 2024.

30 Winter Street
Boston, MA 02108

INTRODUCTION TO SUMMARY OF BENEFITS

WHO CAN JOIN?

You must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes these counties in Massachusetts: Bristol, Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester.

WHICH DOCTORS, HOSPITALS, AND PHARMACIES CAN I USE?

This plan has a network of doctors, hospitals, pharmacies, and other providers. Using in-network providers can cost less than using out-of-network services, except in emergency situations.
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 7 days a week, 24 hours a day. TTY users should call 1-877-486-2048.

IMPORTANT INFORMATION

For more information, please call us at 866-610-2273. TTY users should call 711. The hours are 8 am to 8 pm, seven days a week from October 1 through March 31 and 8 am to 8 pm, Monday through Friday from April 1 through September 30. You can also visit us at www.ccama.org.

- CCA Medicare Preferred (PPO) and CCA Medicare Value (PPO) are Medicare Advantage PPO plans with a Medicare contract. Enrollment in this plan depends on contract renewal.
- 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 call 866-610-2273 (TTY 711) and request the "Evidence of Coverage" or access it at ccama.org.
- When this document says "we," "us," or "our," it means Commonwealth Care Alliance Massachusetts, LLC. When it says "plan" or "our plan," it means CCA Medicare Preferred and CCA Medicare Value.
- This information is not a complete description of benefits. Contact Member Services for more information.
- Benefits may change on January 1, 2025. The List of Covered Drugs (formulary), pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.
- Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our member service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

You can get this document for free in other formats, such as large print, braille or audio. Call 866-610-2273 (TTY 711).

Premiums and Deductibles

	CCA MEDICARE PREFERRED (PPO) H9414-001	CCA MEDICARE VALUE (PPO) H9414-002
Monthly Plan Premium (includes both medical and drugs)	$0 You must continue to pay your Medicare Part B premium.	$20 You must continue to pay your Medicare Part B premium.
Medical Deductible	$0	$0
Maximum Out-of-Pocket Responsibility (does not include Part D prescription drugs)	In-network: $5,950 annually $9,550 combined annually for Medicare-covered services you receive from in-network and out-of-network providers	In-network: $5,000 annually $8,950 combined annually for Medicare- covered services you receive from in-network and out-of-network
	If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services, and we will pay the full cost for the rest of the year. Please note that you will still need to pay your share of the cost for your Part D prescription drugs.	

List of Covered Services

The following table is a quick overview of in-network services you may need, your costs, and rules about the benefits.

Benefits		CCA MEDICARE PREFERRED (PPO) H9414-001	CCA MEDICARE VALUE (PPO) H9414-002
Inpatient Hospital	Acute	In-Network: You pay the following per day, per admission: Days 1 – 5: $370 copay Days 6 – beyond: $0 copay Prior authorization required Out-of-Network: You pay 30% of the total cost	In-Network: You pay the following per day, per admission: Days 1 – 7: $275 copay Days 8 – beyond: $0 copay Prior authorization required Out-of-Network: You pay 30% of the total cost
	Psychiatric	In-Network: You pay the following per day, per admission: Days 1 – 5: $370 copay Days 6 – 90: $0 copay Prior authorization required Out-of-Network: You pay 30% of the total cost	In-Network: You pay the following per day, per admission: Days 1 – 7: $275 copay Days 8 – 90: $0 copay Prior authorization required Out-of-Network: You pay 30% of the total cost
Outpatient Hospital	Hospital, including surgery	In-Network: $370 copayment per visit Diagnostic Colonoscopy: $0 Prior authorization required Out-of-Network: You pay 40% of the total cost	In-Network: $300 copayment per visit Diagnostic Colonoscopy: $0 Prior authorization required Out-of-Network: You pay 40% of the total cost
	Observation services	In-Network: $370 copayment per day Out-of-Network: You pay 40% of the total cost	In-Network: $370 copayment per day Out-of-Network: You pay 40% of the total cost
Ambulatory Surgical Center (ASC)		In-Network: $270 copayment per visit Diagnostic Colonoscopy: $0 Prior authorization required Out-of-Network: You pay 40% of the total cost	In-Network: $270 copayment per visit Diagnostic Colonoscopy: $0 Prior authorization required Out-of-Network: You pay 40% of the total cost

Benefits		CCA MEDICARE PREFERRED (PPO) H9414-001	CCA MEDICARE VALUE (PPO) H9414-002
Doctor Visits	Primary Care Provider (PCP)	In-Network: $0 copayment per visit Out-of-Network: $0 copayment per visit	In-Network: $0 copayment per visit Out-of-Network: $0 copayment per visit
	Specialists	In-Network: $40 copayment per visit Out-of-Network: $65 copayment per visit	In-Network: $35 copayment per visit Out-of-Network: $65 copayment per visit
Preventive Care (e.g., flu vaccine, diabetic screenings)		In-Network: $0 copayment per visit Out-of-Network: $0 copayment per visit Other preventive services available	In-Network: $0 copayment per visit Out-of-Network: $0 copayment per visit Other preventive services available
Emergency Care		$90 copayment per visit Waived if admitted to the hospital within 24 hours	$90 copayment per visit Waived if admitted to the hospital within 1 day
Urgently Needed Services		In- and Out-of-Network: $30 copayment per visit	In- and Out-of-Network: $30 copayment per visit
Diagnostic Services/ Labs/ Imaging (This section is continued on the next page)	Diagnostic radiology services (e.g., MRI)	In-Network: $130 copayment per visit Diagnostic Mammogram: $0 Prior authorization required Out-of-Network: You pay 40% of the total cost	In-Network: $130 copayment per visit Diagnostic Mammogram: $0 Prior authorization required Out-of-Network: You pay 40% of the total cost
	Lab services	In-Network: $0 copayment per visit Prior authorization required Out-of-Network: $0 copayment per visit	In-Network: $0 copayment per visit Prior authorization required Out-of-Network: $0 copayment per visit

Benefits		CCA MEDICARE PREFERRED (PPO) H9414-001	CCA MEDICARE VALUE (PPO) H9414-002
Diagnostic Services/ Labs/ Imaging (continued)	Diagnostic tests and procedures	In-Network: $30 copayment per visit Prior authorization required Out-of-Network: You pay 40% of the total cost	In-Network: $30 copayment per visit Prior authorization required Out-of-Network: You pay 40% of the total cost
	Therapeutic radiology	In-Network: $60 copayment per visit Prior authorization required Out-of-Network: You pay 40% of the total cost	In-Network: $60 copayment per visit Prior authorization required Out-of-Network: You pay 40% of the total cost
	Outpatient X-rays	In-Network: $0 copayment per visit Prior authorization required Out-of-Network: $20 copayment per visit	In-Network: $0 copayment per visit Prior authorization required Out-of-Network: $20 copayment per visit
Hearing Services	Hearing exam (Medicare covered)	In-Network: $0 copayment per visit Out-of-Network: $65 per visit	In-Network: $0 copayment per visit Out-of-Network: $65 per visit
	Routine hearing exam (Non-Medicare)	In-Network: $0 copayment per visit One (1) per year Out-of-Network: Not covered	In-Network: $0 copayment per visit One (1) per year Out-of-Network: Not covered
	Hearing aid	In-Network: $200 - $1,150 copayment dependent upon the aid selected Two (2) aids per year Out-of-Network: 50% of the total cost Covered up to $300 per ear, One (1) aid per ear, per year	In-Network: $0 copayment up to annual combined benefit maximum of $2,000 One (1) aid per ear, per year *Out-of-Network:* 50% of the total cost covered up to annual combined benefit maximum of $2,000 towards the purchase of hearing aids One (1) aid per ear, per year

Benefits		CCA MEDICARE PREFERRED (PPO) H9414-001	CCA MEDICARE VALUE (PPO) H9414-002
Dental Services	Preventive services (Non-Medicare)	In-Network and Out-of-Network: $0 copayment per visit, up to the annual combined maximum	In-Network and Out-of-Network: $0 copayment per visit, up to the annual combined maximum
	Comprehensive Services (Medicare)	In-Network: 20% coinsurance Prior authorization required Out-of-Network: You pay 40% of the total cost	In-Network: $0 copayment Prior authorization required Out-of-Network: You pay 40% of the total cost
	Comprehensive services (Non-Medicare)	In-Network: $0 copay up to the annual combined maximum Prior authorization required for certain services Out-of-Network: $0 copay up to the annual combined maximum Please refer to your Evidence of Coverage for a full list of benefit cost shares and limitations.	In-Network: $0 copay up to the annual combined maximum Prior authorization required for certain services Out-of-Network: $0 copay up to the annual combined maximum Please refer to your Evidence of Coverage for a full list of benefit cost shares and limitations.
	Annual Combined Maximum (Non-Medicare)	$2,300 for preventive and comprehensive services (Non-Medicare)	$2,300 for preventive and comprehensive services (Non-Medicare)
Vision Services (This section is continued on the next page)	Eye exam (Medicare covered)	In-Network: $0 copayment per visit Out-of-Network: $65 copayment per visit	In-Network: $0 copayment per visit Out-of-Network: $65 copayment per visit
	Routine eye exam (Non-Medicare)	In-Network: $0 copayment per visit One (1) exam per year *Out-of-Network:* 50% of the total cost up to max benefit of $150 One (1) exam per year	In-Network: $0 copayment per visit One (1) exam per year *Out-of-Network:* 50% of the total cost up to max benefit of $150 One (1) exam per year

Benefits		CCA MEDICARE PREFERRED (PPO) H9414-001	CCA MEDICARE VALUE (PPO) H9414-002
Vision Services (continued)	Eyewear	In-Network: Up to $350 annually for frames, lenses, visually needed contact lenses, and upgrades Out-of-Network: 0% up to $350 for frames and visually necessary contact lenses 50% of the total cost for lenses up to $150	In-Network: Up to $350 annually for frames, lenses, visually needed contact lenses, and upgrades Out-of-Network: 0% up to $350 for frames and visually necessary contact lenses 50% of the total cost for lenses up to $150
Mental Health Services Individual and Group Sessions		In-Network: $0 copayment per visit Prior authorization required Out-of-Network: $30 copayment per visit for Group Sessions $40 copayment per visit for Individual Sessions	In-Network: $0 copayment per visit Prior authorization required Out-of-Network: $30 copayment per visit for Group Sessions $40 copayment per visit for Individual Sessions
Skilled Nursing Facility		In-Network: You pay the following per day, per admission: Days 1 – 20: $0 copay Days 21 – 57: $184 copay Days 58 – 100: $0 copay Prior authorization required Out-of-Network: You pay the following per day, per admission: Days 1 – 45: $225 copay Days 46 – 100: $0 copay	In-Network: You pay the following per day, per admission: Days 1 – 20: $0 copay Days 21 – 57: $184 copay Days 58 – 100: $0 copay Prior authorization required Out-of-Network: You pay the following per day, per admission: Days 1 – 45: $225 copay Days 46 – 100: $0 copay

Benefits	CCA MEDICARE PREFERRED (PPO) H9414-001	CCA MEDICARE VALUE (PPO) H9414-002
Physical Therapy (PT), Occupational Therapy (OT), and Speech and Language Therapy (ST)	In-Network: $0 copayment per visit in-home $30 copayment per visit at an office or facility Prior authorization required Out-of-Network: $65 copayment per visit	In-Network: $0 copayment per visit in-home $35 copayment per visit at an office or facility for PT and ST $40 copayment per visit at an office or facility for OT Prior authorization required Out-of-Network: $65 copayment per visit
Ambulance Ground and Air services	$290 copayment per transport via ground ambulance $350 copayment per transport via air ambulance Prior authorization required for non-emergent transport	$300 copayment per transport via ground ambulance $350 copayment per transport via air ambulance Prior authorization required for non-emergent transport
Transportation	Not Covered	$0 copayment per one-way for medical trips up to 24 per year to plan approved locations, maximum of 50 miles Out-of-Network: You pay 50% of the total cost for 24 one-way trips per year up to $32 to plan approved locations, maximum of 50 miles
Medicare Part B Drugs	In-Network: $35 copayment for Part B Insulin You pay 0%-20% of the total cost for Part B Chemotherapy/Radiation and Other Drugs. Prior Authorization is required Out-of-Network: 40% of the total cost	In-Network: $30 copayment for Part B Insulin You pay 0%-20% of the total cost for Part B Chemotherapy/Radiation and Other Drugs. Prior Authorization is required Out-of-Network: 40% of the total cost

Prescription Drugs

Drug Coverage	CCA MEDICARE PREFERRED (PPO) H9414-001	CCA MEDICARE VALUE (PPO) H9414-002
Annual Prescription Drug (Part D) Deductible	$0 for all Tiers	$200 for Tiers 3,4, and 5 Deductible does not apply to insulin

Initial Coverage	You will pay the following until your total yearly drug costs reach $5,030. Total yearly drug costs are the total drugs costs paid by both you and our Part D plan. You pay $35 for insulin for a one-month supply.

Standard Retail				
	CCA MEDICARE PREFERRED (PPO)		**CCA MEDICARE VALUE (PPO)**	
Drug Tier	**One-month supply**	**Three-month supply**	**One-month supply**	**Three-month supply**
Tier 1 (Preferred Generic)	$0	$0	$0	$0
Tier 2 (Generic)	$0	$0	$0	$0
Tier 3 (Preferred Brand)	$47	$131	$47	$141
Tier 4 (Non-Preferred Brand)	$100	$290	$100	$300
Tier 5 (Specialty Drugs)	33%	N/A*	30%	N/A*
Mail Order				
Drug Tier	**One-month supply**	**Three-month supply**	**One-month supply**	**Three-month supply**
Tier 1 (Preferred Generic)	$0	$0	$0	$0
Tier 2 (Generic)	$0	$0	$0	$0
Tier 3 (Preferred Brand)	$47	$131	$47	$141
Tier 4 (Non-Preferred Brand)	$100	$290	$100	$300
Tier 5 (Specialty Drugs)	33%	N/A*	30%	N/A*

Coverage Gap Stage	After your total drug costs reach $5,030, you will enter the Coverage Gap stage. You will pay no more than 25% for generic and brand name drugs, for any drug Tier during the coverage gap. You pay $35 for insulin for a one-month supply
Catastrophic Coverage	After your total drug costs reach $8,000, you will enter the Catastrophic Coverage stage. You pay $0 for insulin for a one-month supply Your drug costs will be $0.

***N/A – Three-month supplies of Tier 5 drugs are not available.**

Additional Benefits

The following table are additional benefits you get through our plan at a network provider or facility.

Additional Benefits		CCA MEDICARE PREFERRED (PPO) H9414-001	CCA MEDICARE VALUE (PPO) H9414-002
Acupuncture (Medicare-covered)		In-Network: $40 per visit for up to 20 visits per year for Medicare-covered acupuncture for chronic back pain Out-of-Network: $65 copayment	In-Network: $35 per visit for up to 20 visits per year for Medicare-covered acupuncture for chronic back pain Out-of-Network: $65 copayment
Chiropractic Services (Medicare-covered)		In-Network: $15 copayment Prior authorization is required Out-of-Network: $65 copayment	In-Network: $20 copayment Prior authorization is required Out-of-Network: $65 copayment
Annual Wellness Visit and Physical Exam Reward		$25 reward for an annual wellness visit or physical exam	$25 reward for an annual wellness visit or physical exam
Disease Management (This section is continued on the next page)	Diabetes monitoring supplies	In-Network: $0 copayment Prior authorization required Out-of-Network: 40% of the total cost	In-Network: $0 copayment Prior authorization required Out-of-Network: 40% of the total cost
		Our plan contracts with Abbott Diabetes Care and LifeScan, preferred vendors to supply glucometers and test strips to our diabetic members.	
	Diabetes Self-Management Training	In-Network: $0 copayment Out-of-Network: 40% of the total cost	In-Network: $0 copayment Out-of-Network: 40% of the total cost

Additional Benefits		CCA MEDICARE PREFERRED (PPO) H9414-001	CCA MEDICARE VALUE (PPO) H9414-002
Disease Management (Continued)	Therapeutic shoes or inserts	In-Network: 20% of the total cost Prior authorization required Out-of-Network: 40% of the total cost	In-Network: 20% of the total cost Prior authorization required Out-of-Network: 40% of the total cost
Durable Medical Equipment and Related Supplies	Durable Medical Equipment (e.g., wheelchairs, oxygen)	In-Network: 20% coinsurance Prior authorization required Out-of-Network: 50% of the total cost	In-Network: 20% coinsurance Prior authorization required Out-of-Network: 50% of the total cost
	Prosthetics (e.g., braces, artificial limbs)	In-Network: 20% coinsurance Prior authorization required Out-of-Network: 40% of the total cost	In-Network: 20% coinsurance Prior authorization required Out-of-Network: 40% of the total cost
Fitness Benefit		Silver&Fit® includes a fitness membership with access to a single in-network fitness center of your choosing per month, Fit at Home programming for at-home fitness, one (1) home fitness kit per year, and more.[1]	Silver&Fit® includes a fitness membership with access to a single in-network fitness center of your choosing per month, Fit at Home programming for at-home fitness, one (1) home fitness kit per year, and more.[1]

[1] The Silver&Fit® program is provided by American Specialty Health Fitness, Inc. (ASH Fitness), a subsidiary of American Specialty Health Incorporated (ASH). Silver&Fit are trademarks of ASH and used with permission herein. Only at participating locations. Contact the plan for more information.

Additional Benefits		CCA MEDICARE PREFERRED (PPO) H9414-001	CCA MEDICARE VALUE (PPO) H9414-002
Podiatry Services	Foot exams and treatment (Medicare-Covered)	In-Network: $40 copayment Prior authorization required Out-of-Network: $65 copayment	In-Network: $35 copayment Prior authorization required Out-of-Network: $65 copayment
	Routine foot care (Non-Medicare)	In-Network: $40 copayment Six (6) visits per year Prior authorization required Out-of-Network: $65 copayment Six (6) visits per year	In-Network: $40 copayment Six (6) visits per year Prior authorization required Out-of-Network: $65 copayment Six (6) visits per year
Home Health Care		In-Network: $0 copayment Prior authorization required Out-of-Network: 50% of the total cost	In-Network: $0 copayment Prior authorization required Out-of-Network: 50% of the total cost
Hospice		$0 You pay nothing for hospice care from any Medicare-approved hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered by Original Medicare, outside of our plan.	$0 You pay nothing for hospice care from any Medicare-approved hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered by Original Medicare, outside of our plan.
Identity Theft Insurance		$0 You pay nothing for free identity monitoring for members with qualifying chronic conditions. Not all members qualify.[2]	$0 You pay nothing for free identity monitoring for members with qualifying chronic conditions. Not all members qualify.[2]

[2] The identity theft, sneaker, and food benefits mentioned are part of a special supplemental program for people with qualifying chronic conditions. Certain restrictions may apply. Call Member Services at 866-610-2273 (TYY 711) to see if you qualify. Not all members qualify.

Additional Benefits	CCA MEDICARE PREFERRED (PPO) H9414-001	CCA MEDICARE VALUE (PPO) H9414-002
Nurse Advice Line (24/7)	In-Network: You pay nothing to speak with a registered nurse or behavioral health clinician 24 hours a day, 7 days a week Out-of-Network: 40% of the total cost	In-Network: You pay nothing to speak with a registered nurse or behavioral health clinician 24 hours a day, 7 days a week Out-of-Network: 40% of the total cost
Opioid Treatment Services	In-Network and Out-of-Network: $0 copayment	In-Network and Out-of-Network: $0 copayment
Over the Counter (OTC) Items	You receive a CCA Healthy Savings card with an allowance of $220 loaded every calendar quarter (3 months) to purchase CCA-approved over the counter (OTC) items without a prescription at in-network retailers. Use your card to purchase OTC items including: first aid supplies, COVID-19 tests, body wash, dental care, and cold and flu remedies at in-network retailers.	You receive a CCA Healthy Savings card with an allowance of $335 loaded every calendar quarter (3 months) to purchase CCA-approved over the counter (OTC) items without a prescription at in-network retailers. Use your card to purchase OTC items including: first aid supplies, COVID-19 tests, body wash, dental care, and cold and flu remedies at in-network retailers. For members with a qualifying chronic condition, you may use the quarterly allowance on the Healthy Savings card for the purchase of CCA approved food at in-network retailers. Not all members qualify.[2]
Renal Dialysis	In- and Out-of-Network: 20% of the total cost	In- and Out-of-Network: 20% of the total cost

[2] The identity theft, sneaker, and food benefits mentioned are part of a special supplemental program for people with qualifying chronic conditions. Certain restrictions may apply. Call Member Services at 866-610-2273 (TYY 711) to see if you qualify. Not all members qualify.

Additional Benefits	CCA MEDICARE PREFERRED (PPO) H9414-001	CCA MEDICARE VALUE (PPO) H9414-002
Sneaker Allowance	$50 annual maximum for the purchase of sneakers at registered shoe stores that accept Visa for members with a qualifying chronic condition. Not all members qualify.[2]	$100 annual maximum for the purchase of sneakers at registered shoe stores that accept Visa for members with a qualifying chronic condition. Not all members qualify.[2]
Worldwide Coverage	$90 copayment for emergency services $90 copayment for urgent care services $90 copayment for emergency transportation Covered for emergency department, urgent care and emergency transportation up to $100,000 per year	$0 copayment for emergency services $0 copayment for urgent care services $0 copayment for emergency transportation Covered for emergency department, urgent care and emergency transportation up to $100,000 per year

[2] The identity theft, sneaker, and food benefits mentioned are part of a special supplemental program for people with qualifying chronic conditions. Certain restrictions may apply. Call Member Services at 866-610-2273 (TYY 711) to see if you qualify. Not all members qualify.

Notice of Nondiscrimination

Commonwealth Care Alliance, Inc.® complies with applicable Federal civil rights laws and does not discriminate on the basis of, or exclude people or treat them differently because of, medical condition, health status, receipt of health services, claims experience, medical history, disability (including mental impairment), marital status, age, sex (including sex stereotypes and gender identity), sexual orientation, national origin, race, color, religion, creed, public assistance, or place of residence. Commonwealth Care Alliance, Inc.:

- 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 Member Services.

If you believe that Commonwealth Care Alliance, Inc. has failed to provide these services or discriminated in another way based on medical condition, health status, receipt of health services, claims experience, medical history, disability (including mental impairment), marital status, age, sex (including sex stereotypes and gender identity), sexual orientation, national origin, race, color, religion, creed, public assistance, or place of residence, you can file a grievance with:

Commonwealth Care Alliance, Inc.
Civil Rights Coordinator
30 Winter Street
Boston, MA 02108
Phone: 617-960-0474, ext. 3932 (TTY 711) Fax: 857-453-4517
Email: civilrightscoordinator@commonwealthcare.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at 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
Phone: 800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at 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 1-866-610-2273 (TTY 711). Someone who speaks English 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 1-866-610-2273 (TTY 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-866-610-2273 (TTY 711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-866-610-2273 (TTY 711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-866-610-2273 (TTY 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-866-610-2273 (TTY 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-866-610-2273 (TTY 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-866-610-2273 (TTY 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-866-610-2273 (TTY 711) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-866-610-2273 (телетайп 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-866-610-2273 (رقم هاتف الصم والبكم 711). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-866-610-2273 (TTY 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-866-610-2273 (TTY 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-866-610-2273 (TTY 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-866-610-2273 (TTY 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-866-610-2273 (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、1-866-610-2273 (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。

Gujarati: અમારી આરોગ્ય અથવા દવાની યોજના વિશે તમને હોય તેવા કોઈપણ પ્રશ્નોના જવાબ આપવા માટે અમારી પાસે મફત દુભાષિયા સેવાઓ છે. દુભાષિયા મેળવવા માટે, અમને ફક્ત 1-866-610-2273 (TTY 711) પર કૉલ કરો. અંગ્રેજી/ગુજરાતી બોલતી વ્યક્તિ તમને મદદ કરી શકે છે. આ એક મફત સેવા છે.

Lao/Laotian: ພວກເຮົາມີບໍລິການລ່າມແປພາສາໂດຍບໍ່ເສຍຄ່າເພື່ອຕອບທຸກຄຳຖາມທີ່ທ່ານອາດມີກ່ຽວກັບແຜນສຸຂະພາບ ຫຼື ແຜນຢາຂອງພວກເຮົາ. ເພື່ອຂໍລ່າມແປພາສາ, ພຽງໂທຫາພວກເຮົາທີ່ເບີ 1-866-610-2273 (TTY 711). ຈະມີຜູ້ທີ່ເວົ້າພາສາອັງກິດ/ລາວຊ່ວຍທ່ານໄດ້. ນີ້ແມ່ນການບໍລິການບໍ່ເສັຍຄ່າ.

Cambodian: យើងមានសេវាបកប្រែផ្តាល់មាត់ដោយឥតគិតថ្លៃដើម្បីឆ្លើយសំនួរណាមួយដែលអ្នកអាចមានអំពីគម្រោងសុខភាព ឬថ្នាំរបស់យើង។ ដើម្បីទទួលបានអ្នកបកប្រែផ្តាល់មាត់ សូមហៅទូរសព្ទមកយើងតាមរយៈលេខ 1-866-610-2273 (TTY 711) ។ នរណាម្នាក់ដែលនិយាយភាសាអង់គ្លេស/ភាសាខ្មែរអាចជួយអ្នកបាន។ នេះគឺជាសេវាកម្មដែលឥតគិតថ្លៃ។