

2027 Summary of Benefits

eternalHealth Harmony (HMO)

The Next Generation of Medicare Advantage

H3551-004_SB27_HAR_M

This booklet gives you a summary of drug and health services covered by eternalHealth Horizon (HMO), and what you pay.

This information is not a complete description of benefits. Call 1-800-680-4568 (TTY 711) for more information. To get a complete list of services covered by eternalHealth, call our Member Service department and ask for the Evidence of Coverage (EOC). You can also access the EOC online at our website, eternalhealth.com/for-members/forms-and-documents.

What does this document contain?

This summary of benefits serves as a resource to understand the coverage and costs associated with eternalHealth's Harmony HMO plan. The information in this document is for the plan year beginning January 1, 2027, and ending December 31, 2027.

What are the eligibility requirements for this plan?

To be eligible for this plan, you must

- be enrolled in both Medicare Parts A & B and
- live in Maricopa, Graham, or Pinal counties in Arizona.

Does this plan cover my current healthcare needs?

To find out if this plan covers your current prescription drugs, doctors, and pharmacies, please visit us at www.eternalhealth.com to view our online drug list and directory. If you have questions or would like a paper copy mailed to you, please call us at 1-800-680-4568 (TTY 711).

Where can I learn more about Medicare?

The ***Medicare & You*** **handbook** is a great resource and can be found at www.medicare.gov. You can also request a paper copy to be mailed to you by calling 1-800-MEDICARE (1-800-633-4227). TTY users can dial 1-877-486-2048, 24 hours a day, 7 days a week.

What is a deductible?

A deductible is the amount of money you pay out of pocket before your health plan begins to pay. Once you reach the defined threshold, you will only have to pay coinsurance or a copayment.

What is a copayment?

A copayment (also known as copay) is a fixed amount of money you pay out of pocket when you receive care.

What is coinsurance?

Coinsurance is a percentage you pay out of pocket for the cost of your care.

Where can I find more information?

If you would like more information, please see eternalHealth's Evidence of Coverage at www.eternalhealth.com under Member Resources.

You can call customer service at 1-800-680-4568 (TTY 711) from:

October 1 to March 31, 8am to 8pm, 7 days a week.

April 1 to September 30, 8am to 8pm, Monday to Friday.

eternalHealth of Arizona is an HMO plan with a Medicare contract for HMO and HMO-POS offerings. Enrollment in eternalHealth of Arizona 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 1-800-680-4568 (TTY 711) and request the "Evidence of Coverage" or access it online at www.eternalHealth.com.

My Monthly Premium, Deductible, and Maximum Out of Pocket

	eternalHealth Harmony (HMO) H3551-004
	In-Network
Monthly Premium	$0.00
Medicare Part B Buy Down (Give Back)	This plan does not have a Give Back.
Medical Deductible	This plan does not have a deductible.
Pharmacy (Part D) Deductible	**Tier 3, Tier 4, and Tier 5** $250 deductible.
Maximum Out-of-Pocket Responsibility This is the maximum amount you will pay during the plan year for copays, coinsurance, medical services, supplies, and Part B-covered medication. Any out-of-pocket expenses for prescription drugs and other benefits do not apply.	$4,000

My Covered Hospital and Medical Benefits and Services

	eternalHealth Harmony (HMO) H3551-004
	In-Network
Inpatient Hospital Coverage Prior Authorization is required.	$225 copay per day for days 1-7; $0 copay per day for days 8-90. $0 copay per day for days 91+.
Outpatient Hospital Coverage Prior Authorization is required.	**Diagnostic Colonoscopy** $0 copay at any in-network location. **Outpatient Hospital** $175 copay for surgery performed at an outpatient hospital. **Observation Stays** $150 copay per stay.

Ambulatory Surgical Center (ASC) Services Prior Authorization is required.	**Diagnostic Colonoscopy** $0 copay if performed at an ASC. **ASC** $100 copay for surgery performed at an ASC.
Outpatient Hospital Clinic Visit	$20 copay per visit.
Doctor Visits	**Primary Care Provider (PCP) Visits:** $0 copay per visit. **Specialist Visits:** $0 copay per visit.
Preventive Care	$0 copay per service. **Our plans cover many preventive services, including:** • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy) * • Depression screening • Diabetes screenings • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screening (PSA) • Sexually transmitted infection screening and counseling • Lung cancer screening (low dose computed tomography [LDCT]) • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Flu shots, pneumococcal shots, Hepatitis B shots (limitations may apply) • "Welcome to Medicare" preventive visit (one-time) Any additional preventive services approved by Medicare during the calendar year will be covered.
Emergency Care	$130 copay per visit.
	Your copay is waived if you are admitted to the hospital within 24 hours. Your plan also includes worldwide coverage for emergency care up to $25,000 per calendar year. You must pay the cost

	out-of-pocket and then submit to plan for reimbursement. Please see the Evidence of Coverage for more information.
Urgently Needed Services	$25 copay for urgently needed services from an urgent care center or walk-in center.
	Your plan includes coverage for Worldwide Urgent Care. You must pay the cost out-of-pocket and then submit to plan for reimbursement. Please see the Evidence of Coverage for more information.
Diagnostic Services/Labs/Imaging	
Diagnostic Radiology (Such as MRIs, CT scans) Prior Authorization may be required. Please contact Member Services for more information.	$0 copay for Ultrasounds. $160 for all other outpatient diagnostic radiology, such as CT, MRI and PET scans.
Therapeutic Radiology Prior Authorization is required.	$60 copay per service.
Diagnostic Tests and Procedures Prior Authorization may be required. Please contact Member Services for more information.	$0 copay per service in an office setting. $60 copay per service at a free-standing lab facility.
Lab Services Prior Authorization may be required. Please contact Member Services for more information.	$0 copay per service.
Outpatient X-ray .	$10 copay per service.
Hearing Services	
Medicare-Covered Hearing Exam	$30 copay per exam.
Routine Hearing Exam *One (1) Visit Per Year.*	$0 copay per exam with a NationsHearing provider.
Hearing Aids *Up to two (2) aids per year. One (1) Hearing Aid Per Ear, Per Year.* You must use a NationsHearing Provider for all routine hearing exams and the purchase of hearing aids. There is no coverage for out-of-network providers.	$595 copay based on your selection through NationsHearing. $895 copay based on your selection through NationsHearing.
Dental services	
Medicare-Covered Dental Services	$30 copay per service.
Non-Medicare Covered Dental Services	Preventive and comprehensive services: $1,000 Annual Allowance

	eternalHealth will pay as much as $1,000 per year for comprehensive and preventive services, with no required network. With this plan, you receive an eternalPlus Benefits Card that will include this benefit and may be used at any dental provider who accepts Mastercard. Please see the Evidence of Coverage for more information.
Vision services	
Medicare-Covered Eye Exam	$30 copay per exam.
Eyewear After Cataract Surgery (Medicare-Covered Standard Eyewear)	$0 copay for one pair of standard eyewear after cataract surgery.
Routine Eye Exams	$0 copay per exam with an EyeMed provider.
Eyewear Benefit (for covered eyewear you pay any balance more than the annual limit)	Up to $200 per calendar year for prescription eyewear or contact lenses purchased from an EyeMed provider. You must use an EyeMed provider to receive a routine eye exam and the eyewear allowance. There is no coverage for out-of-network providers.
Mental Health Services	
Inpatient Mental Health Care in a Psychiatric hospital Prior Authorization is Required, except in an emergency.	$225 copay per day for days 1-7; $0 copay per day for days 8-90. $0 copay per day for days 91+. There is a Medicare 190-day lifetime limit for care in a free-standing psychiatric hospital. Please see the Evidence of Coverage for additional important information.
Outpatient Mental Health Care	$0-$30 copay per visit. $0 copay for brief office visits for the sole purpose of monitoring or changing medications. $30 copay for individual or group therapy visits.
Opioid Treatment Program Services	$30 copay per service.
Additional Services	
Skilled Nursing Facility (SNF) Prior Authorization is Required. No Prior Hospital Stay Required.	$0 copay per day for days 1-20. $203 copay per day for days 21-100.
Occupational, Physical and Speech Therapy	$30 copay per visit.

Ambulance Services Prior Authorization is required for non-emergent ambulance services.	$250 copay per service for ground/air ambulance. This plan also covers you for emergency transportation Worldwide. You must pay out-of-pocket and submit to plan for reimbursement. Please see the Evidence of Coverage for more information.
Transportation	You pay a $0 copayment for 36 one-way trips with a maximum of 60 miles per trip to and from healthcare-related locations, such as your doctor appointments, dentist appointments, or the pharmacy Rides must be scheduled through the plan's approved vendor to be covered. Please see the Evidence of Coverage for more information.
Part B Prescription Drugs Prior Authorization is required for certain Part B medications. Medicare Part B drugs may be subject to Step Therapy requirements. You may find the list of Part B medications subject to Step therapy on our website at Step Therapy Criteria - eternalHealth These prescription drugs are covered under Part B and not covered under the Medicare Prescription Drug Program.	0% - 20% Coinsurance. 20% coinsurance with a maximum copay per month of $35 for Part B insulins. Lesser copays will be applied as required by the Inflation Reduction Act (IRA).

My Prescription Drug Benefits

There are three drug payment stages for your prescription drug coverage under eternalHealth Harmony (HMO) plan. How much you pay depends on what stage you are in when you get a prescription filled or refilled. The stages are:
Stage 1: Yearly Deductible Stage
Stage 2: Initial Coverage Stage
Stage 3: Catastrophic Coverage Stage

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deducible. Call Pharmacy Member Services for more information at 1-800-891-6989 (TTY users call 711).

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 even if you haven't paid your deductible.

Deductible Stage

After you pay your yearly deductible (for certain tiers), our plan starts to cover some of your costs. There are no deductibles on Tiers 1 and 2 so you will pay those copays. Tiers 3, 4, and 5 have the deductible listed below.

	eternalHealth Harmony (HMO) H3551-004
Deductible Tiers 3, 4, and 5	$250

Initial Coverage Stage

You will stay in the Initial Coverage Stage until the total amount for the prescription drugs you and your plan pay reaches $2,400.

	eternalHealth Harmony (HMO) H3551-004	
Supply	**Retail**	**Mail Order**
Tier 1 (Preferred Generic)	**30-Day Supply** $0 copay. **100-Day Supply** $0 copay.	**30-Day Supply** $0 copay. **100-Day Supply** $0 copay.
Tier 2 (Generic)	**30-Day Supply** $5 copay. **100-Day Supply** $15 copay.	**30-Day Supply** $5 copay. **100-Day Supply** $10 copay.
Tier 3 (Preferred Brand)	**30-Day Supply** 25% of the total cost	**30-Day Supply** 25% of the total cost

You pay $35 per month supply of each covered insulin product on this tier.	**100-Day Supply** 25% of the total cost	**100-Day Supply** 25% of the total cost
Tier 4 **(Non-Preferred Drug)** You pay $35 per month supply of each covered insulin product on this tier.	**30-Day Supply** 35% of the total cost **100-Day Supply** 35% of the total cost	**30-Day Supply** 35% of the total cost **100-Day Supply** 35% of the total cost
Tier 5 **(Specialty)** You pay $35 per month supply of each covered insulin product on this tier.	**30-Day Supply** 30% of the total cost **100-Day Supply** Not covered.	**30-Day Supply** 30% of the total cost **100-Day Supply** Not covered.

Note: Costs may differ based on pharmacy type such as mail order, long-term care (LTC) or home infusion, and 30-day, 60-day or 100-day supply.

Catastrophic Coverage Stage

You qualify for the Catastrophic Coverage Stage when your out-of-pocket costs have reached $2,400. Once you are in the Catastrophic Coverage Stage, you will pay nothing for a covered Part D drug for the remainder of the calendar year.

My Additional Covered Benefits and Services

	eternalHealth Harmony (HMO) H3551-004
	In-Network
Telehealth Services *This benefit may not be offered by all providers.*	$0 copay per service.
Medicare-Covered Acupuncture Visits	$20 copay per visit.
Medicare-Covered Chiropractic Care	$15 copay per visit.
Kidney Disease Treatment Services	**Dialysis Treatment (both facility and clinic visits):** 20% coinsurance per service. **Kidney Disease Education Services:** $0 copay per service.
Foot Care (Podiatry services)	$40 copay per service.
Durable Medical Equipment (DME) and Prosthetic Devices Prior Authorization may be required. Please contact Member Services for more information.	20% coinsurance.
Diabetes self-management training, Diabetic services, and Diabetic Supplies Prior Authorization is required for Diabetic Supplies and Quantity Limits apply. **Preferred Products through the Pharmacy Benefit:** **Test Strips:** Roche (Accu-Chek) and Ascencia (Contour) are covered with Prior Authorization and Quantity Limits. All other brands are excluded and would need an approved exception. **Continuous Glucose Monitors (CGM):** Abbott (Freestyle Libre) and Dexcom are covered with Prior Authorization and Quantity Limits. All other brands are excluded and would need an approved exception.	**Test Strips:** You pay 0% coinsurance for preferred brands. You pay 20% coinsurance for non-preferred brands. Non-preferred brands require an exception submission and approval and 20% coinsurance. **Continuous Glucose Monitors:** You pay 0% coinsurance for preferred brand Medicare Covered Continuous Glucose Monitors (CGM) when ordered by a physician and filled at a network pharmacy. If obtained through a Durable Medical Equipment (DME) provider, your cost-share will be 20%. **Testing Supplies** You pay 20% for blood glucose testing supplies including lancets and glucose control solutions. **Medicare-covered Diabetic Therapeutic Shoes or Inserts** 20% coinsurance. **Medicare-covered Diabetic Therapeutic Shoes or Inserts** 20% coinsurance.

	Diabetes Self-Management Training There is no coinsurance, copayment or deductible for Medicare-covered diabetes self-management training.
Cardiac & Pulmonary Rehabilitation Services	**Cardiac & Pulmonary Rehabilitation Services:** $20 copay. **Supervised Exercise Therapy for Peripheral Arterial Disease (SET-PAD)** $20 copay.
Annual Physical Exams	$0 copay per exam.
Alternative Therapies - Myndstream	$0 copayment for this benefit. This benefit provides members with personalized, on-demand therapeutic music experiences designed to support symptom management, functional status, and overall health and wellbeing.
Over the Counter (OTC) items	$110 Per calendar quarter (every three months). This amount does not roll over from quarter to quarter. Eligible items are listed in the OTC Catalog. To purchase eligible items, you can order online through your portal, over the phone, via mail order, or by visiting participating retail stores. With this plan, you receive an eternalPlus Benefits Card that will include this benefit. Please see the Evidence of Coverage for more information.
SSBCI Grocery* Members having Diabetes, Cancer, Cardiovascular disorders, Chronic and disabling mental health conditions & Chronic kidney disease (CKD) are eligible to use their standard $110 OTC benefit combined with an additional $115 benefit every three months towards a food and produce benefit or OTC. ***This benefit is for members who qualify. Not all members will qualify for this benefit.*	$115 Per calendar quarter (every three months). This amount does not roll over from quarter to quarter. Eligible items are listed in the OTC Catalog. To purchase eligible items, you can order online through your portal, over the phone, via mail order, or by visiting participating stores. With this plan, you receive an eternalPlus Benefits Card that will include this benefit if eligible. For more information, please see the Evidence of Coverage.

Meals – Post hospitalization	You pay a $0 copayment for this benefit. After a discharge from an inpatient stay at a hospital, you may be eligible to have up to two weeks (28 meals) of fully prepared, nutritious meals delivered to your home to help you recover from your illness/injuries and or manage your health conditions. Upon your discharge, our care management team will coordinate your meal benefit. (Meals must be ordered by an eternalHealth care manager). If the criteria are met, meals are prepared and delivered to your home by a plan approved vendor at no cost to you.
Wellness Wallet	Our plan offers a bi-annual Wellness Allowance to give you flexibility and choice while achieving and maintaining health and wellness. It is intended to supplement and complement your medical benefits. You will receive a $500 allowance every six months. You will receive an eternalPlus Benefits Card that will be funded every 6 months – unused funds do not roll over. You may use your Wellness Allowance to cover the cost of any one – or any combination – of the following services approved by the plan: 1. Acupuncture visits not covered by your medical benefit (Must be provided by a licensed Acupuncturist.) 2. Routine chiropractic visits not covered by your medical benefit (Must be provided by a licensed Chiropractor) 3. Naturopath medicine practitioner visits that integrate conventional and alternative therapies to prevent and treat disease and, most importantly, promote optimal health. Naturopathic doctors (NDs) are trained as primary care providers who diagnose, treat, and manage patients with both acute and chronic conditions, addressing health at the levels of body, mind, and spirit. Coverage is for practitioner visits only.

Health and Wellness Programs - Fitness	You pay a $0 copay for this benefit. OnePass offers a robust and flexible fitness benefit, which gives members access to various gyms, boutique fitness studios, online fitness videos, and a personalized online brain training program for improved cognitive health. Members may also choose to receive a home kit if they prefer working out at home. Members receive $150 annually on their eternalPlus Benefits Card which can be used to pay for home fitness equipment, such as stationary bikes and weights, golf green fees, tennis and pickleball court fees and bowling fees. Please see the Evidence of Coverage for more information.

Pre-Enrollment Checklist

Prior to making an enrollment decision, it is important that you fully understand the coverage you are going to be receiving. If you have any questions regarding your coverage options, you can call to speak to us at 1 (800) 893-9457 (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 that are important to you before enrolling. Visit www.eternalHealth.com/Forms-Documents or call 1 (800) 893-9457 (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 medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

☐Review the formulary to make sure your drugs are covered.

Understanding Important Rules

☐You must continue to pay your Medicare Part B premium. This premium is typically taken out of your social security check each month.

☐Benefits, premiums and/or copayments/co-insurance may change on January 1, 2028

☐Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).

☐Select benefits and services may require a prior authorization.

Notice of Non-Discrimination: Discrimination is Against the Law

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

eternalHealth:

- 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 eternalHealth Member Services at **1-800-680-4568 (TTY 711)**

If you believe that eternalHealth 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:

eternalHealth (Mail)
eternalHealth, Inc.
eH Privacy Officer
C/O Appeals & Grievances
PO Box 1377
Westborough, MA 01581

eternalHealth (Phone/Fax)
Local Phone Number: 617-684-2348 (TTY 711)
Toll Free Phone Number: 1-800-680-4568 (TTY 711)
Fax: 1-866-326-1073

eternalHealth (In Person)
eternalHealth, Inc.
31 St. James Ave, Suite 950
Boston, MA 02116

You can file a grievance in person, by mail, or fax. If you need help filing a grievance, eternalHealth Member Services 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:

U.S. Department of Health and Human Services

200 Independence Avenue, SW Room 509F, HHH Building

Washington, D.C. 20201

Phone: 1-800-368-1019, 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 1-800-680-4568 (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 1-800-680-4568 (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 1-800-680-4568 (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 1-800-680-4568 (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 1-800-680-4568 (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 1-800-680-4568 (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 1-800-680-4568 (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 1-800-680-4568 (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 1-800-680-4568 (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 1-800-680-4568 (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 بمساعدتك. هذه خدمة فوري، ليس عليك سوى الاتصال بنا على (T1-800-680-4568, TTY:711. سيقوم شخص ما يتحدث العربية 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 1-800-680-4568 (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 1-800-680-4568 (TTY:711). 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 1-800-680-4568 (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 1-800-680-4568 (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 1-800-680-4568 (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、1-800-680-4568 (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。