Banner Medicare Advantage Dual (HMO D-SNP) offered by Banner Medicare Advantage (dba Banner Medicare Advantage Dual)

Annual Notice of Changes for 2025

You are currently enrolled as a member of Banner Medicare Advantage Dual. Next year, there will be changes to the plan's costs and benefits. ***Please see page 4 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which is located on our website at www.BannerHealth.com/MA. You may also call our Customer Care Center to ask us to mail you an *Evidence of Coverage*.

What to do now

1. **ASK:** Which changes apply to you

- Check the changes to our benefits and costs to see if they affect you.
  - Review the changes to medical care costs (doctor, hospital).
  - Review the changes to our drug coverage, including coverage restrictions and cost sharing.
  - Think about how much you will spend on premiums, deductibles, and cost sharing.
  - Check the changes in the 2025 "Drug List" to make sure the drugs you currently take are still covered.
  - Compare the 2024 and 2025 plan information to see if any of these drugs are moving to a different cost-sharing tier or will be subject to different restrictions, such as prior authorization, step therapy, or a quantity limit, for 2025.
- Check to see if your primary care doctors, specialists, hospitals and other providers, including pharmacies will be in our network next year.
- Check if you qualify for help paying for prescription drugs. People with limited incomes may qualify for "Extra Help" from Medicare.
- Think about whether you are happy with our plan.

2. **COMPARE:** Learn about other plan choices

- Check coverage and costs of plans in your area. Use the Medicare Plan Finder at www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2025* handbook. For additional support, contact your State Health Insurance Assistance Program (SHIP) to speak with a trained counselor.
- Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. **CHOOSE:** Decide whether you want to change your plan

- If you don't join another plan by December 7, 2024, you will stay in Banner Medicare Advantage Dual.
- To **change to a different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2025.** This will end your enrollment with Banner Medicare Advantage Dual.
- Look in section 3, page 13 to learn more about your choices.
- If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

Additional Resources

- This document is available for free in Spanish.
- Please contact our Customer Care Center number at 877-874-3930 for additional information. (TTY users should call 711.) Hours are 8 a.m. to 8 p.m., seven days a week. This call is free.
- This document may be available in other formats such as braille, large print, or other alternate formats. For additional information, call our Customer Care Center at the phone number listed above.
- **Coverage under this plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Banner Medicare Advantage Dual

- Banner Medicare Advantage Dual HMO D-SNP has a contract with Medicare and Medicaid. Enrollment depends on contract renewal. The plan also has a written agreement with the Arizona Medicaid program to coordinate your Medicaid benefits.
- When this document says "we," "us," or "our," it means Banner Medicare Advantage (dba Banner Medicare Advantage Dual). When it says "plan" or "our plan," it means Banner Medicare Advantage Dual.

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Annual Notice of Changes for 2025
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Summary of Important Costs for 2025

The table below compares the 2024 costs and 2025 costs for Banner Medicare Advantage Dual in several important areas. **Please note this is only a summary of costs**. If you are eligible for Medicare cost-sharing assistance under AHCCCS (Medicaid), you pay $0 for your deductible, premium, and cost share.

Cost	2024 (this year)	2025 (next year)
Monthly plan premium* * Your premium may be higher than this amount. See Section 1.1 for details.	$0	$0
Doctor office visits	Primary care visits: 0% coinsurance per visit Specialist visits: 0% coinsurance per visit	Primary care visits: 0% coinsurance per visit Specialist visits: 0% coinsurance per visit
Inpatient hospital stays	$0 copayment.	$0 copayment
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: $0 Copayment during the Initial Coverage Stage: • All covered drugs: $0 copayment Catastrophic Coverage: • During this payment stage, you pay nothing for your covered Part D drugs.	Deductible: $0 Copayment during the Initial Coverage Stage: • All covered drugs: $0 copayment Catastrophic Coverage: • During this payment stage, you pay nothing for your covered Part D drugs.

Cost	2024 (this year)	2025 (next year)
Maximum out-of-pocket amount This is the most you will pay out of pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	$8,850 If you are eligible for Medicare cost-sharing assistance under AHCCCS (Medicaid), you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.	$9,350 If you are eligible for Medicare cost-sharing assistance under AHCCCS (Medicaid), you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2024 (this year)	2025 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.)	$0	$0

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amount

Medicare requires all health plans to limit how much you pay out of pocket for the year. This limit is called the maximum out-of-pocket amount. Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2024 (this year)	2025 (next year)
Maximum out-of-pocket amount **Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum.** If you are eligible for Medicare cost-sharing assistance under AHCCCS (Medicaid), you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$8,850	$9,350 Once you have paid $9,350 out of pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 1.3 – Changes to the Provider and Pharmacy Networks

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Updated directories are located on our website at www.BannerHealth.com/MA. You may also call our Customer Care Center for updated provider and/or pharmacy information or to ask us to mail you a directory, which we will mail within three business days.

There are changes to our network of providers for next year. **Please review the 2025 *Provider Directory* www.BannerHealth.com/MA to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

There are changes to our network of pharmacies for next year. **Please review the 2025 *Pharmacy Directory* www.BannerHealth.com/MA to see which pharmacies are in our network**.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers), and pharmacies that are a part of your plan during the year. If a mid-year change in our providers affects you, please contact our Customer Care Center so we may assist.

Section 1.4 – Changes to Benefits and Costs for Medical Services

Please note that the *Annual Notice of Changes* tells you about changes to your Medicare benefits and costs.

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2024 (this year)	2025 (next year)
Dental Services	**In-Network** You pay $0 copayment for each fluoride treatment (1 fluoride treatment every year).	**In-Network** You pay $0 copayment for each fluoride treatment (2 fluoride treatments per calendar year).
Meal Benefit	**In-Network** You pay $0 copayment for up to 12 meals immediately following surgery or after each inpatient stay in a hospital or skilled nursing facility.	**In-Network** You pay $0 copayment for up to 14 meals immediately following surgery or after each inpatient stay in a hospital or skilled nursing facility.
Outpatient Mental Health Care	Prior authorization is required for Medicare-covered individual and group therapy sessions with a psychiatrist or other mental health care professional (non-psychiatrist).	Prior authorization is not required for Medicare-covered individual and group therapy sessions with a psychiatrist or other mental health care professional (non-psychiatrist).
Over-the-Counter Items	Naloxone is not covered. You receive $250 every 3 months to purchase eligible OTC drugs and health-related products. Unused portion carries over to the next quarter.	Naloxone is covered. You receive $200 every 3 months to purchase eligible OTC drugs and health-related products. Unused portion does not carry over to the next quarter.

Cost	2024 (this year)	2025 (next year)
Special Supplemental Benefits for the Chronically Ill	Enrollees with chronic condition(s) and meet certain criteria will have $75 per quarter added to their Healthy Benefits card to be used for healthy, nutritious food and produce from participating providers. Unused portion carries over to the next period.	Special Supplemental Benefits for the chronically ill is not covered.
Transportation Services (routine)	**In-Network** You pay $0 copayment for routine transportation services (36 one-way trips every year to plan-approved health-related locations) using rideshare services, van and medical transport.	**In-Network** You pay $0 copayment for routine transportation services (36 one-way trips during current benefit year to plan-approved medically necessary health-related locations) using rideshare services, van and medical transport. 36 one-way trip limit is shared with VBID transportation services to plan approved non-medically necessary health-related locations.
Value-Based Insurance Design (VBID) Model Benefits	Members who enroll in the Dial into Diabetes (DID) program will have a reduced cost share for telephonic access to the Exercise Physiologist. You will pay a $0 copayment for this benefit.	Reduced cost share for telephonic access to the Exercise Physiologist is not covered.

Cost	2024 (this year)	2025 (next year)
Value-Based Insurance Design (VBID) Model Benefits (continued)	Routine transportation services for members who qualify for the low-income subsidy (LIS) to any health-related locations are not covered.	Members who qualify for the low-income subsidy (LIS) pay $0 copayment for routine transportation services (36 one-way trips during current benefit year to plan-approved non-medically necessary health-related locations) using rideshare services, van and medical transport. 36 one-way trip limit is shared with transportation services (routine) to plan-approved medically necessary health related locations. Eligibility for plan approved non-medically necessary transportation is not assured and will be determined by Banner Medicare Advantage Dual after enrollment, based on eligibility criteria.
	Food and Produce benefit for members who qualify for the low-income subsidy (LIS) is not covered.	Members who qualify for the low-income subsidy (LIS) will receive a $60 quarterly allowance funded to your &more Benefits Prepaid Mastercard® that can be only used through our contracted vendor to purchase approved items. Unused portion rolls over to the next quarter but must be used in the current benefit year. Eligibility for the Food and Produce benefit is not assured and will be determined by Banner Medicare Advantage Dual after enrollment, based on eligibility criteria.

Cost	2024 (this year)	2025 (next year)
Vision Care - Routine (exams and eyewear)	Routine Eye Exam: $0 copayment - covered every year. Routine Eyewear: $400 annual allowance towards eyeglasses (frames and lenses) or contact lenses (fitting). Eyeglasses: $0 copayment Contacts: $0 copayment	Routine Eye Exam: $0 copayment - covered every year. Routine Eyewear: $200 annual allowance towards frames or contact lenses (fitting). Eyeglasses: $0 copayment • Single vision, lined bifocal, lined trifocals covered every year. • Standard progressive lenses covered every year. • Average savings of 20-25% on additional lens upgrades Contacts: $0 copayment

Section 1.5 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or Drug List. A copy of our Drug List is provided electronically.

We made changes to our Drug List, which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs or moving them to a different cost-sharing tier. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

Most of the changes in the Drug List are new for the beginning of each year. However, we might make other changes that are allowed by Medicare rules that will affect you during the plan year. We update our online Drug List at least monthly to provide the most up-to-date list of drugs. If we make a change that will affect your access to a drug you are taking, we will send you a notice about the change.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your *Evidence of Coverage* and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. You can also contact our Customer Care Center for more information.

We currently can immediately remove a brand name drug on our Drug List if we replace it with a new generic drug version with the same or fewer restrictions as the brand name drug it replaces. Also, when adding a new generic, we may also decide to keep the brand name drug on our Drug List, but immediately add new restrictions.

Starting in 2025, we can immediately replace original biological products with certain biosimilars. This means, for instance, if you are taking an original biological product that is being replaced by a biosimilar, you may not get notice of the change 30 days before we make it or get a month's supply of your original biological product at a network pharmacy. If you are taking the original biological product at the time we make the change, you will still get information on the specific change we made, but it may arrive after we make the change.

Some of these drug types may be new to you. For definitions of the drug types, please see Chapter 12 of your *Evidence of Coverage*. The Food and Drug Administration (FDA) also provides consumer information on drugs. See FDA website: www.fda.gov/drugs/biosimilars/multimedia-education-materials-biosimilars#For%20Patients. You may also contact our Customer Care Center or ask your health care provider, prescriber, or pharmacist for more information.

Changes to Prescription Drug Benefits and Costs

Beginning in 2025, there are three **drug payment stages**: the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage. The Coverage Gap Stage and the Coverage Gap Discount Program will no longer exist in the Part D benefit.

The Coverage Gap Discount Program will also be replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Initial Coverage Stage and the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

Changes to the Deductible Stage

Stage	2024 (this year)	2025 (next year)
Stage 1: Yearly Deductible Stage	The deductible is $0.	The deductible is $0.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2024 (this year)	2025 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs, and **you pay your share of the cost.**	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing is:	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing is:
The costs in this row are for a one-month (31-day) supply when you fill your prescription at a network pharmacy. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6 of your *Evidence of Coverage*. Most adult Part D vaccines are covered at no cost to you.	**All covered drugs:** You pay $0 copayment per prescription.	**All covered drugs:** You pay $0 copayment per prescription. Eligibility for the $0 Part D cost share is not assured and will be determined by Banner Medicare Advantage Dual after enrollment, based on eligibility criteria.
	Once you have paid $8,000 out of pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).	Once you have paid $2,000 out of pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).

Changes to the Catastrophic Coverage Stage

The Catastrophic Coverage Stage is the third and final stage. Beginning in 2025, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

If you reach the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs.

For specific information about your costs in the Catastrophic Coverage Stage, look at Chapter 6, in your *Evidence of Coverage*.

SECTION 2 Administrative Changes

Description	2024 (this year)	2025 (next year)
Over the Counter (OTC) Benefit Administrator	Healthy Benefits by Solutran is contracted to administer the OTC benefit.	&more by Soda Health is contracted to administer the OTC benefit.
Vision (Routine) Benefit Administrator	Administered by Banner Medicare Advantage Dual.	Administered by VSP Vision Care.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Banner Medicare Advantage Dual

To stay in our plan, you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our Banner Medicare Advantage Dual.

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2025 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- *OR* – You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2025* handbook, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Banner Medicare Advantage Dual.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Banner Medicare Advantage Dual.
- To **change to Original Medicare without a prescription drug plan,** you must either:
    - Send us a written request to disenroll. Contact our Customer Care Center if you need more information on how to do so.

- – *OR* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

If you switch to Original Medicare and do **not** enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan unless you have opted out of automatic enrollment.

SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2025.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. Examples include people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area.

Because you have Arizona Health Care Cost Containment System (AHCCCS), you can end your membership in our plan any month of the year. You also have options to enroll in another Medicare plan any month including:

- Original Medicare *with* a separate Medicare prescription drug plan,
- Original Medicare without a separate Medicare prescription drug plan (If you choose this option, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.), or
- If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan.

If you enrolled in a Medicare Advantage plan for January 1, 2025, and don't like your plan choice, you can also switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2025.

If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

SECTION 5 Programs That Offer Free Counseling about Medicare and Medicaid

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In Arizona, the SHIP is called Arizona State Health Insurance Assistance Program.

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. Arizona State Health Insurance Assistance Program counselors can help you with your Medicare questions or problems. They can help you

understand your Medicare plan choices and answer questions about switching plans. You can call Arizona State Health Insurance Assistance Program at 800-432-4040. You can learn more about Arizona State Health Insurance Assistance Program by visiting their website (des.az.gov).

For questions about your Arizona Health Care Cost Containment System (AHCCCS) benefits, contact Arizona Health Care Cost Containment System (AHCCCS) at 855-432-7587 (TTY: 800-842-6520) Monday through Friday, 8 a.m. to 5 p.m. Ask how joining another plan or returning to Original Medicare affects how you get your Arizona Health Care Cost Containment System (AHCCCS) coverage.

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"Extra Help" from Medicare.** Because you have Medicaid, you are already enrolled in "Extra Help," also called the Low-Income Subsidy. "Extra Help" pays some of your prescription drug premiums, yearly deductibles and coinsurance. Because you qualify, you do not have a late enrollment penalty. If you have questions about "Extra Help," call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
    - Your State Medicaid Office.

SECTION 7 Questions?

Section 7.1 – Getting Help from Banner Medicare Advantage Dual

Questions? We're here to help. Please call our Customer Care Center at 877-874-3930. (TTY only, call 711.) We are available for phone calls 8 a.m. to 8 p.m., seven days a week. Calls to these numbers are free.

Read your *2025 Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2025. For details, look in the *2025 Evidence of Coverage* for Banner Medicare Advantage Dual. The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at www.BannerHealth.com/MA. You may also call our Customer Care Center to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at www.BannerHealth.com/MA. As a reminder, our website has the most up-to-date information about our provider network (*Provider Directory*) and our *List of Covered Drugs* (*Formulary/Drug List*).

Section 7.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2025*

Read the *Medicare & You 2025* handbook. Every fall, this document is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this document, you can get it at the Medicare website (www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 7.3 – Getting Help from Medicaid

To get information from Medicaid, you can call Arizona Health Care Cost Containment System (AHCCCS) at 855-432-7587. TTY users should call 800-842-6520.

Form Approved
OMB# 0938-1421

Banner Medicare Advantage Dual HMO D-SNP

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-877-874-3930, 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 1-877-874-3930, 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 1-877-874-3930, 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 1-877-874-3930, 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 1-877-874-3930, 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 1-877-874-3930, 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 1-877-874-3930, 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 1-877-874-3930, 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 1-877-874-3930, 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 1-877-874-3930, 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 1-877-874-3930, TTY 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 1-877-874-3930, 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 1-877-874-3930, 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 1-877-874-3930, 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 1-877-874-3930, 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 1-877-874-3930, TTY 711. Ta usługa jest bezpłatna.

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