PruittHealth Premier (HMO I-SNP)
offered by PruittHealth Premier North Carolina, LLC
Annual Notice of Changes for 2024

You are currently enrolled as a member of PruittHealth Premier (HMO I-SNP). 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 PruittHealthPremier.com. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

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 authorization requirements and costs.
- Think about how much you will spend on premiums, deductibles, and cost sharing.

☐ Check the changes in the 2024 "Drug List" to make sure the drugs you currently take are still covered.

☐ Check to see if your primary care doctors, specialists, hospitals, and other providers, including pharmacies will be in our network next year.

☐ 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 2024* handbook.

- ☐ 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, 2023, you will stay in PruittHealth Premier (HMO I-SNP).
    - To change to a **different plan**, you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

Additional Resources

- Please contact our Member Services number at 1-855-855-0759 for additional information. (TTY users should call 711.) Hours are 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. This call is free.
- This document is also available in braille and in large print.
- **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 PruittHealth Premier (HMO I-SNP)

- PruittHealth Premier is an HMO I-SNP plan with a Medicare contract. Enrollment in PruittHealth Premier depends on contract renewal. PruittHealth Premier complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
- When this document says "we," "us," or "our", it means PruittHealth Premier North Carolina, LLC. When it says "plan" or "our plan," it means PruittHealth Premier (HMO I-SNP).

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Summary of Important Costs for 2024

The table below compares the 2023 costs and 2024 costs for PruittHealth Premier (HMO I-SNP) in several important areas. **Please note this is only a summary of costs**.

Cost	2023 (this year)	2024 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$37.80	$45.70
Deductible	The Part B deductible is $226 The Part A deductible is $1,600	The Part B deductible is $240. The Part A deductible is $1,632.
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.)	$8,300	$8,850
Doctor office visits	Primary care visits: $0 copayment per visit Specialist visits: 20% coinsurance per visit	Primary care visits: $0 copayment per visit Specialist visits: 20% coinsurance per visit

Cost	2023 (this year)	2024 (next year)
Inpatient hospital stays	You pay the 2023 Original Medicare cost-sharing amounts. $1,600 deductible; $0 copayment each day for days 1 to 60; $400 copayment each day for days 61 to 90; $800 copayment each day for days 91 to 150 (lifetime reserve days). Medicare hospital benefit periods apply.	You pay the 2024 Original Medicare cost-sharing amounts. $1,632 deductible; $0 copayment each day for days 1 to 60; $408 copayment each day for days 61 to 90; $816 copayment each day for days 91 to 150 (lifetime reserve days). Medicare hospital benefit periods apply.
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: $505 except for covered insulin products and most adult Part D vaccines Coinsurance during the Initial Coverage Stage: Drug Tier 1: 25% coinsurance Catastrophic Coverage: • During this payment stage, the plan pays most of the cost for your covered drugs. • Beginning in 2024, there will be a $0 cost share for members in the catastrophic stage.	Deductible: $545 except for covered insulin products and most adult Part D vaccines Coinsurance during the Initial Coverage Stage: Drug Tier 1: 25% coinsurance Catastrophic Coverage: • During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2023 (this year)	2024 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$37.80	$45.70

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as creditable coverage) for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be *less* if you are receiving "Extra Help" with your prescription drug costs. Please see Section 5 regarding "Extra Help" from Medicare.

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	2023 (this year)	2024 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays and deductibles) count toward your maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$8,300	$8,850 Once you have paid $8,850 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

Updated directories are also located on our website at PruittHealthPremier.com. You may also call Member

Services 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 2024 *Provider Directory* 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 2024 *Pharmacy Directory* 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 part of your plan during the year. If a mid-year change in our providers affects you, please contact Member Services so we may assist.

Section 1.4 – Changes to Benefits and Costs for Medical Services

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

Cost	2023 (this year)	2024 (next year)
Prior Authorization	Prior authorization is not required for Occupational Therapy Services. Prior authorization is not required for Physical and Speech Therapy Services. Prior authorization is required for Hearing Aids.	Prior authorization is required for Occupational Therapy Services. Prior authorization is required for Physical and Speech Therapy Services. Prior authorization is no longer required for Hearing aids.
Referral	Additional Telehealth Services is required.	Additional Telehealth Services is not required.
Chiropractic services - Routine chiropractic care	Not covered	You pay a $30 copayment. Limited to 12 visit(s) every year.

Cost	2023 (this year)	2024 (next year)
Hearing services *Supplemental benefits* Hearing aids	$0 copayment Up to a $1,250 credit for both ears combined every two years for hearing aids.	$0 copayment Up to a $2,500 credit for both ears combined every two years for hearing aids.
Inpatient hospital care	You pay the 2023 Original Medicare cost-sharing amounts. $1,600 deductible; $0 copayment each day for days 1 to 60; $400 copayment each day for days 61 to 90; $800 copayment each day for days 91 to 150 (lifetime reserve days). Medicare hospital benefit periods apply.	You pay the 2024 Original Medicare cost-sharing amounts. $1,632 deductible; $0 copayment each day for days 1 to 60; $408 copayment each day for days 61 to 90; $816 copayment each day for days 91 to 150 (lifetime reserve days). Medicare hospital benefit periods apply.
Inpatient services in a psychiatric hospital	You pay the 2023 Original Medicare cost-sharing amounts. $1,600 deductible; $0 copayment each day for days 1 to 60; $400 copayment each day for days 61 to 90; $800 copayment each day for days 91 to 150 (lifetime reserve days). Medicare hospital benefit periods apply.	You pay the 2024 Original Medicare cost-sharing amounts. $1,632 deductible; $0 copayment each day for days 1 to 60; $408 copayment each day for days 61 to 90; $816 copayment each day for days 91 to 150 (lifetime reserve days). Medicare hospital benefit periods apply.
Medicare Part B prescription drugs - Chemotherapy/Radiation drugs	You pay a 20% coinsurance for each Medicare-covered service.	You pay a 0% - 20% coinsurance depending on the Medicare-covered service.

Cost	2023 (this year)	2024 (next year)
Medicare Part B prescription drugs- Part B drugs	You pay a 20% coinsurance for each Medicare-covered service. The plan offers step therapy for Part B to Part B.	You pay a 0% - 20% coinsurance depending on the Medicare-covered service. The plan offers step therapy for Part B to Part B.
Medicare Part B prescription drugs - Insulin drugs	You pay a 20% coinsurance for each Medicare-covered service.	You pay a 0% - 20% coinsurance depending on the Medicare-covered service. You pay a maximum of $35.
Occupational therapy	You pay a 20% coinsurance for each Medicare-covered service.	You pay a 10% coinsurance for each Medicare-covered service.
Physical therapy and speech-language pathology	You pay a 20% coinsurance for each Medicare-covered service.	You pay a 10% coinsurance for each Medicare-covered service.
Over-the-counter benefit	A maximum of $45 credit every month to be used toward the purchase of over-the-counter (OTC) health and wellness products. OTC benefit list of approved items provided by the Plan. Unused credits do not roll over to the next period.	$40 every month for over-the-counter (OTC) medications filled through your PruittHealth Pharmacy. $45 every month for OTC health and wellness supplies selected from a plan-approved Health catalog. Unused credits do not roll over to the next period.
Urgently needed services	You pay a 20% coinsurance for each Medicare-covered service. Up to a maximum of $60 per visit. Coinsurance is waived if you are admitted to a hospital within 3 days.	You pay a 20% coinsurance for each Medicare-covered service. Up to a maximum of $55 per visit. Coinsurance is waived if you are admitted to a hospital within 3 days.
Vision care - Additional routine eyewear - Maximum plan amount	Up to a $225 credit every year for all additional eyewear.	Up to a $300 credit every year for all additional eyewear.

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, during the year, we might make other changes that are allowed by Medicare rules. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online Drug List to provide the most up to date list of drugs.

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 Member Services for more information.

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs (“Extra Help”), **the information about costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (also called the Low-Income Subsidy Rider or the LIS Rider), which tells you about your drug costs. If you receive “Extra Help” and you haven’t received this insert by September 30th, 2023, please call Member Services and ask for the LIS Rider.

There are four **drug payment stages**. The information below shows the changes to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage.)

Changes to the Deductible Stage

Stage	2023 (this year)	2024 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Part D drugs until you have reached the yearly deductible. The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus and travel vaccines.	The deductible is $505.	The deductible is $545.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2023 (this year)	2024 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the 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.** Most adult Part D vaccines are covered at no cost to you. The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost sharing. For information about the costs, look in Chapter 6, Section 5 of your *Evidence of Coverage*.	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: 25% coinsurance _____ Once your total drug costs have reached $4,660, you will move to the next stage (the Coverage Gap Stage).	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: 25% coinsurance _____ Once your total drug costs have reached $5,030, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage.**

Beginning in 2024, if you reach the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs.

For specific information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

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 deductible. Call Member Services for more information.

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.

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in PruittHealth Premier (HMO I-SNP)

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 PruittHealth Premier (HMO I-SNP).

Section 2.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2024 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. If you do not enroll in a Medicare drug plan, please see Section 1.1 regarding a potential Part D late enrollment penalty.

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 2024* handbook, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2). As a reminder, PruittHealth Premier North Carolina, LLC offers other Medicare health plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from PruittHealth Premier (HMO I-SNP).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from PruittHealth Premier (HMO I-SNP).
- To **change to Original Medicare without a prescription drug plan**, you must either:
  - Send us a written request to disenroll. Contact Member Services 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.

SECTION 3 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, 2024.

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.

If you enrolled in a Medicare Advantage plan for January 1, 2024, and don't like your plan choice, you can 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, 2024.

If you recently moved into, currently live in, or just moved out of 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.

SECTION 4 Programs That Offer Free Counseling about Medicare

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

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. South Carolina Senior Health Insurance Assistance Program (SHIP) 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 South Carolina Senior Health Insurance Assistance Program (SHIP) at 1-800-868-9095. You can learn more about South Carolina Senior Health Insurance Assistance Program (SHIP) by visiting their website (https://aging.sc.gov/programs-initiatives/medicare-and-medicare-fraud).

SECTION 5 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. To see if you qualify, 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 (applications).

- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through South Carolina AIDS Drug Assistance Program (ADAP). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-800-856-9954.

SECTION 6 Questions?

Section 6.1 – Getting Help from PruittHealth Premier (HMO I-SNP)

Questions? We're here to help. Please call Member Services at 1-855-855-0759. (TTY only, call 711.) We are available for phone calls 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.

Read your *2024 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 2024. For details, look in the *2024 Evidence of Coverage* for PruittHealth Premier (HMO I-SNP). 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 PruittHealthPremier.com. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at PruittHealthPremier.com. 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 6.2 – 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 2024*

Read the *Medicare & You 2024* 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 (https://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.

Form Approved
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PruittHealth PREMIER

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 1-855-855-0759. 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 1-855-855-0759. 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 1-855-855-0759。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 1-855-855-0759。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 1-855-855-0759. 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 1-855-855-0759. 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 1-855-855-0759 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 1-855-855-0759. 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 1-855-855-0759 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 1-855-855-0759. 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 1-855-855-0759 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 1-855-855-0759 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

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