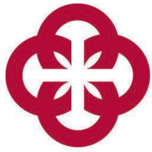
2025 Summary of Benefits for Saint Alphonsus Health Plan Choice (PPO)



Saint Alphonsus
Health Plan
A Member of Trinity Health

2025 Summary of Benefits

Saint Alphonsus Health Plan Choice (PPO)

This is a summary of Medicare health care and prescription drug coverage for Saint Alphonsus Health Plan Choice (PPO).

January 1 – December 31, 2025

Saint Alphonsus Health Plan Choice (PPO) is a Medicare Advantage Local PPO plan with a Medicare contract. Enrollment in the 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 1-800-240-3851 (TTY 711) and request the "Evidence of Coverage" or access it online at www.thpmedicare.org/saint-alphonsus/.

To join **Saint Alphonsus Health Plan Choice (PPO),** 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 Idaho: Ada, Adams, Boise, Canyon, Elmore, Gem, Owyhee, Payette, Valley and Washington.

Except in emergency situations, if you use the providers that are not in our network, we may not pay for these services.

Find a provider at this link www.thpmedicare.org/saint-alphonsus/find-a-provider.

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

This document is available in other formats such as Braille, large print or audio.

For more information, please call us at 1-800-240-3851 (TTY users should call 711), 8 a.m. to 8 p.m., 7 days a week, or visit us at www.thpmedicare.org/saint-alphonsus/.

Premiums and Benefits

This is a short list of benefits and cost sharing for our plan. For a complete list, see the *Evidence of Coverage* on our website at www.thpmedicare.org/saint-alphonsus/.

Premiums and Benefits	Saint Alphonsus Health Plan Choice (PPO)
Monthly Plan Premium (includes both medical and drugs)	You pay $0 each month. You must continue to pay your Medicare Part B premium.
Part B Premium Buy-down	Our plan will reduce your monthly Medicare Part B premium by $14.80.
Deductible	You pay $0 for in- and out-of-network medical benefits. You pay $150 for Part D prescription drugs on Tiers 3, 4, and 5.
Maximum Out-of-Pocket Responsibility (does not include Part D prescription drugs)	You pay no more than $6,100 for in- and out-of-network combined annually. Includes copays and other costs for in-and out-of-network medical services for the year.
Inpatient Hospital	For in-network inpatient hospital stays, you pay: $300 copay per day for days 1-5; $0 copay per day for days 6-90. For out-of-network stays, you pay: 30% of the total cost per stay. May require prior authorization.
Outpatient Hospital	For services at an in-network outpatient hospital, you pay $275 copay. For services at an out-of-network outpatient hospital, you pay 30% of the total cost.
Ambulatory Surgical Center (ASC)	You pay $275 copay in-network. You pay 30% of the total cost out-of-network.

Premiums and Benefits	Saint Alphonsus Health Plan Choice (PPO)
Doctor Visits • Primary care provider • Specialists	 You pay $0 copay in-network. You pay $30 copay out-of-network. You pay $35 copay in-network. You pay $60 copay out-of-network.
Preventive Care (e.g., flu vaccine, diabetic screenings)	You pay $0 copay in- and out-of-network.
Emergency Care	You pay $110 copay per visit. ER cost sharing is waived if you are admitted to the hospital within 48 hours for the same condition. $110 copay for each emergency care visit outside of the United States and its territories. Worldwide ER services cost sharing is waived if you are admitted to the hospital within 24 hours for the same condition.
Urgently Needed Services	You pay $35 copay per visit. $110 copay for each urgently needed care visit outside of the United States and its territories. $250 to $300 copay for each emergency/urgently needed care transportation service outside of the United States and its territories.
Diagnostic Services /Labs /Imaging /Radiology • Diagnostic tests and procedures • Lab services • MRIs, CAT scans	 You pay $30 copay in-network. You pay 30% of the total cost out-of-network. You pay $5 copay in-network. You pay $15 copay out-of-network. You pay $150 copay in-network. You pay 30% of the total cost out-of-network.

Premiums and Benefits	Saint Alphonsus Health Plan Choice (PPO)
• X-rays	You pay $20 copay in-network. You pay 30% of the total cost out-of-network.
• Therapeutic radiology services	You pay 20% of the total cost in-network. You pay 30% of the total cost out-of-network. May require prior authorization.
Hearing Services	
• Medicare-covered hearing exam	You pay $35 copay in-network. You pay $60 copay out-of-network.
• Routine hearing exam	You pay $0 copay in-network (1 exam every year). You pay $60 copay out-of-network.
• Fitting and evaluation for hearing aids	You pay $0 copay in-network (unlimited visits every year). You pay $60 copay out-of-network.
• Hearing aids	You pay $599 to $899 copay in-network for prescription hearing aids – all types (2 hearing aids every year). No out-of-network coverage. Must use TruHearing® provider to access this benefit.
Dental Services	
• Medicare-covered dental services	You pay $35 copay in-network. You pay 30% of the total cost out-of-network.

Premiums and Benefits	Saint Alphonsus Health Plan Choice (PPO)
• Preventive dental services ○ 2 oral exams every year ○ 2 cleanings every year ○ 2 fluoride treatments every year ○ 1 X-ray; x-ray benefit is for bitewing x-rays two to eight per calendar year, vertical bitewing x-rays one per consecutive 36 months, or one full mouth x-ray every 36 consecutive months. ○ 1 visit for other diagnostic dental services; intraoral tomosynthesis benefit is for two to eight x-rays per calendar year for bitewing and periapical, or 1 per consecutive 36 months for comprehensive series. ○ 1 visit for other preventive dental services; space maintainer benefit is for 1 per consecutive 60 months, re-cement or re-bond of space maintainer is for 1 per consecutive 6 months, or removal of fixed space maintainer is unlimited.	$1,000 maximum plan coverage amount every year for in- and out-of-network diagnostic and preventive dental services. This amount is combined with the non-Medicare-covered comprehensive dental services benefit. You pay $0 copay in-network for an office visit. Services include exams, X-rays, other diagnostic dental services, cleanings, fluoride treatments, other preventive dental services.

Premiums and Benefits	Saint Alphonsus Health Plan Choice (PPO)
• Comprehensive dental services: • 1 visit; frequencies include unlimited, one per consecutive 6 months, one per consecutive 12 months, or one per consecutive 60 months depending on service code. • 1 visit; frequencies include one per tooth per lifetime, two per tooth per lifetime, or unlimited depending on service code. • 1 visit; frequencies include unlimited, two per calendar year, two per consecutive 12 months, one per consecutive 36 months, or one per quadrant per consecutive 24 or 36 months depending on service code. • 1 visit; frequency includes unlimited, 1 per site per visit, consecutive 36 months, or lifetime, 1 per tooth per lifetime, 1 per consecutive 36 months, or 1 biopsy per site per visit depending on service code. • 1 visit; frequency is unlimited, 1 per consecutive 6 months, or 2 per calendar year depending on the service code.	$1,000 maximum plan coverage amount every year for in- and out-of-network non-Medicare-covered comprehensive dental services. This amount is combined with the diagnostic and preventive dental services benefit. You pay 50% of the total cost in- and out-of-network for restorative services. You pay 70% of the total cost in and out-of-network for endodontics services. You pay 70% of the total cost in and out-of-network for periodontics services. You pay 50% of the total cost in and out-of-network for oral and maxillofacial surgery services. You pay $0 copay in and out-of-network for adjunctive general services.

Premiums and Benefits	Saint Alphonsus Health Plan Choice (PPO)
Vision Services	
• Medicare-covered benefits	You pay $0 to $35 copay in-network for an eye exam to diagnose and treat diseases and conditions of the eye. You pay $50 copay out-of-network. You pay $0 copay in-network for one pair of eyeglasses or contact lenses after cataract surgery. You pay 30% of the total cost out-of-network.
• Routine eye exams	You pay $0 copay in-network (1 exam every year). You pay $50 copay out-of-network.
• Routine eyewear	$125 maximum plan coverage amount every year for all in- and out-of-network non-Medicare-covered eyewear. No out-of-network coverage. Must use Spectera, Inc. provider to access this benefit.
Mental Health Services	
• Outpatient therapy with a psychiatrist	You pay $35 copay in-network for individual sessions. You pay $60 copay out-of-network. You pay $35 copay in-network for group sessions. You pay $60 copay out-of-network.
• Outpatient therapy with a mental health care professional (non-psychiatrist)	You pay $35 copay in-network for individual sessions. You pay $60 copay out-of-network. You pay $35 copay in-network for group sessions. You pay $60 copay out-of-network.
Skilled Nursing Facility (SNF)	For in-network SNF stays, you pay: $0 copay per day for days 1-20; $214 copay per day for days 21-55; $0 copay per day for days 56-100. For out-of-network stays, you pay: 30% of the total cost per stay.
Physical Therapy	You pay $35 copay in-network. You pay $60 copay out-of-network.

Premiums and Benefits	Saint Alphonsus Health Plan Choice (PPO)
Ambulance	You pay $250 copay in- and out-of-network for ground ambulance services. You pay $300 copay in- and out-of-network for air ambulance services. May require prior authorization.
Transportation	Not covered.
Medicare Part B Drugs	You pay $35 copay in- and out-of-network for Medicare Part B insulin drugs. You pay 0% to 20% of the total cost in-network for Medicare Part B chemotherapy and radiation drugs. You pay 0% to 30% of the total cost out-of-network. You pay 0% to 20% of the total cost in-network for other Medicare Part B drugs. You pay 0% to 30% of the total cost out-of-network. May require prior authorization.
Podiatry Services	You pay $35 copay in-network for Medicare podiatry services. You pay $60 copay out-of-network for Medicare podiatry services.
Durable Medical Equipment	You pay 20% of the total cost of the total cost in-network durable medical equipment. You pay 30% of the total cost of the total cost out-of-network durable medical equipment. May require prior authorization.

Premiums and Benefits	Saint Alphonsus Health Plan Choice (PPO)
Prosthetic Devices (braces, artificial limbs, etc.)	Prosthetic devices: You pay 20% of the total cost of the total cost for in-network devices. You pay 30% of the total cost of the total cost for out-of-network devices. Related medical supplies: You pay 20% of the total cost of the total cost for in-network supplies. You pay 30% of the total cost of the total cost for out-of-network supplies. May require prior authorization.
Diabetic Supplies and Services	Diabetic supplies: You pay $0 copay for in-network supplies. You pay 30% of the total cost for out-of-network supplies. Diabetes self-management training: You pay $0 copay in- and out-of-network. Therapeutic shoes or inserts: You pay 20% of the total cost of the total cost for in-network shoes. You pay 30% of the total cost of the total cost for out-of-network shoes. May require prior authorization.
Fitness Benefit	You pay $0 copay for the fitness benefit.
Meal Benefit	You pay $0 copay for the meal benefit. The benefit consists of 2 meals per day for 7 days, immediately following a qualifying discharge. There is no annual limit on occurrences. Benefit is combined in and out-of-network. GA Foods must be used for in-and out-of-network meals benefit.

Part D Prescription Drugs

This is a summary of Part D prescription drug coverage and cost sharing for our plan. For more information, see the *Evidence of Coverage* on our website at www.thpmedicare.org/saint-alphonsus/.

Part D Prescription Drugs	
Part D Insulin Coverage	You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.
ED Drug Coverage	Included! Call for details.
Deductible	You will pay a yearly deductible of $150 on Tier 3, Tier 4, and Tier 5 drugs. **You must pay the full cost of your Tier 3, Tier 4, Tier 5 drugs** until you reach this amount. For all other drugs, including insulin, you will not have to pay any deductible.

Initial Coverage	You pay the following until your total yearly drug costs reach $2,000. Total yearly drug costs are the drug costs paid by both you and our Part D plan.		
30-Day Supply	**Standard Retail Rx** 30-day supply	**Preferred Retail Rx** 30-day supply	**Mail Order Rx** 30-day supply
Tier 1: Preferred Generic	$10 copay	$0 copay	$0 copay
Tier 2: Generic	$20 copay	$10 copay	$0 copay
Tier 3: Preferred Brand	25% of the total cost	25% of the total cost	25% of the total cost
Tier 4: Non-Preferred Drug	50% of the total cost	50% of the total cost	50% of the total cost
Tier 5: Specialty Tier	31% of the total cost	31% of the total cost	31% of the total cost
90-Day Supply	**Standard Retail Rx** 90-day supply	**Preferred Retail Rx** 90-day supply	**Mail Order Rx** 90-day supply
Tier 1: Preferred Generic	$30 copay	$0 copay	$0 copay
Tier 2: Generic	$60 copay	$30 copay	$0 copay
Tier 3: Preferred Brand	25% of the total cost	25% of the total cost	25% of the total cost
Tier 4: Non-Preferred Drug	50% of the total cost	50% of the total cost	50% of the total cost
Tier 5: Specialty Tier	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.
Catastrophic Coverage	You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $2000 limit for the calendar year. During this payment stage, you pay nothing for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.		

Your cost-sharing may be different if you use a Long-Term Care pharmacy, or an out-of-network pharmacy or if you purchase a long-term supply (up to 90 days) of a drug. Please call us or see the plan’s Evidence of Coverage on our website www.thpmedicare.org/saint-alphonsus/ for complete information about your costs or covered drugs.

Additional Benefits

This plan provides additional benefits. For more information, see the *Evidence of Coverage* on our website at www.thpmedicare.org/saint-alphonsus/.

Additional Benefits	
Flex Card- Including Member Rewards/Incentive and Supplemental Vision/Hearing Allowance	Included! You receive a $500 allowance on your card you
Over the Counter (OTC) Allowance	$0 copay. $100 maximum plan coverage amount every 3 months for OTC items. No out-of-network coverage. Must utilize Over the Counter Health Solutions (OTCHS) to access this benefit. Unused portion does not carry over to the next period.
24 Hour Nurse Advice Line + Virtual Care Visits	$0 copay. No out-of-network coverage. Must call 1-855-638-5842 to access this benefit. The Virtual Clinic Solution combines the traditional nurse advice line with virtual physician consultations. Registered Nurses provide up-front triage to symptoms 24x7x365 and provide a recommendation for care. Some situations qualify for additional consultations, in which case the Registered Nurse will connect the member with the virtual partner whose physicians will address the member's symptoms.
Visitor Travel Allowance	$1,500
Acupuncture	$20 copay, 6 visits every year, for in-network services. $60 copay, for out-of-network services. May require prior authorization.

Optional Supplemental Benefits

This plan offers some extra benefits that are not covered by Original Medicare and not included in its benefits package. These extra benefits are called **Optional Supplemental Benefits**. If you want these optional supplemental benefits, you must sign up for them and you may have to pay an additional premium for them. For more information, see the *Evidence of Coverage* on our website at www.thpmedicare.org/saint-alphonsus/.

Optional Supplemental Benefits	
Optional Dental Silver	The premium for the Dental Silver benefit is $20 per month. You pay this monthly premium in addition to your Medicare Part B premium and plan premium (if applicable). • There is an annual maximum benefit limit of $1,500. • $0 copay for diagnostic and preventive services, emergency palliative treatment and X-rays. • 50% coinsurance for extractions, endodontic services, periodontic services and other oral surgery. • 0% - 50% coinsurance for restorative services.
Optional Dental Gold	The premium for the Dental Gold benefit is $49 per month. You pay this monthly premium in addition to your Medicare Part B premium and plan premium (if applicable). • There is an annual maximum benefit limit of $2,000. • $0 copay for diagnostic and preventive services, emergency palliative treatment and X-rays. • 50% coinsurance for extractions, endodontic services, periodontic services and other oral surgery. • 0% - 50% coinsurance for restorative services. • 50% coinsurance for crowns, bridges and dentures.

This document is available in other alternate formats.

ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call 1-800-240-3851 (TTY: 711).

ATENCIÓN: Si habla español, hay servicios de traducción, libre de cargos, disponibles para usted. Llame al 1-800-964- 4525 (TTY: 711).

Saint Alphonsus Health Plan Choice (PPO) is a local PPO plan with a Medicare contract. Enrollment depends on contract renewal. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year. You must continue to pay your Medicare Part B premium. The 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 Saint Alphonsus Health Plan members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our Member Services number or see your “Evidence of Coverage” for more information, including the cost-sharing that applies to out-of-network services. Health coverage is offered by Mount Carmel Health Plan Of Idaho, Inc..

Notice of Nondiscrimination

Saint Alphonsus Health Plan complies with applicable Federal civil rights laws and does not discriminate on age, racial or ethnic background, national origin, religion, culture, language, physical or mental disability, socioeconomic status, sex (including sex at birth and legal sex), pregnancy, sexual stereotypes, sexual orientation, or gender (which includes gender identity and gender expression), veteran status, or any category protected by law.

Saint Alphonsus Health Plan does not exclude people or treat them differently because of age, racial or ethnic background, national origin, religion, culture, language, physical or mental disability, socioeconomic status, sex (including sex at birth and legal sex), pregnancy, sexual stereotypes, sexual orientation, or gender (which includes gender identity and gender expression), veteran status, or any category protected by law. Saint Alphonsus Health Plan:

- 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 Saint Alphonsus Health Plan has failed to provide these services or discriminated in any other way on the basis of age, racial or ethnic background, national origin, religion, culture, language, physical or mental disability, socioeconomic status, sex (including sex at birth and legal sex), pregnancy, sexual stereotypes, sexual orientation, or gender (which includes gender identity and gender expression), veteran status, or any category protected by law), you can file a grievance with: Daniel Hayes, Member Services Manager, 3100 Easton Square Place, Third Floor - Health Plan, Columbus, OH 43219, 1-800- 240-3851 (TTY 711), 1-833-802-2200 fax, HealthPlanAppeals@trinity-health.org. You can file a grievance in person or by mail, fax, or email.

If you need help filing a grievance, Daniel Hayes, Member Services Manager, 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, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at *www.hhs.gov/ocr/complaints/index.html*

Form Approved
OMB# 0938-1421

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 1-800-240-3851 (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 1-800-240-3851 (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 1-800-240-3851 (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 1-800-240-3851 (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 1-800-240-3851 (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 1-800-240-3851 (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 1-800-240-3851 (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 1-800-240-3851 (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 1-800-240-3851 (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 1-800-240-3851 (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 1-800-240-3851 (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 1-800-240-3851 (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 1-800-240-3851 (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 1-800-240-3851 (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 1-800-240-3851 (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 1-800-240-3851 (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、
1-800-240-3851 (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。