



GlobalHealth

Texas

SUMMARY OF BENEFITS

January 1 – December 31, 2023

Texas LoneStar Medicare Advantage Plan Options:

Texas LoneStar Gold (HMO)

Texas LoneStar Gold (HMO)

Texas LoneStar Gold Rewards (HMO)

Texas LoneStar Valor (HMO-POS)

1-844-200-8167 (TTY: 711)

8 am to 8 pm, 7 days a week, (October 1 – March 31), and
8 am to 8 pm, Monday – Friday, (April 1 – September 30)

www.GlobalHealth.com

H6062_SBCORE_2023_M

GlobalHealth is an HMO with a Medicare contract. Enrollment in GlobalHealth depends on contract renewal.

To join **GlobalHealth**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Except in emergency situations, if you use providers that are not in our network, we may not pay for these services. For Texas LoneStar Valor (HMO-POS) check the *Evidence of Coverage* for out-of-network coverage options.

2023 Service Area

Collin

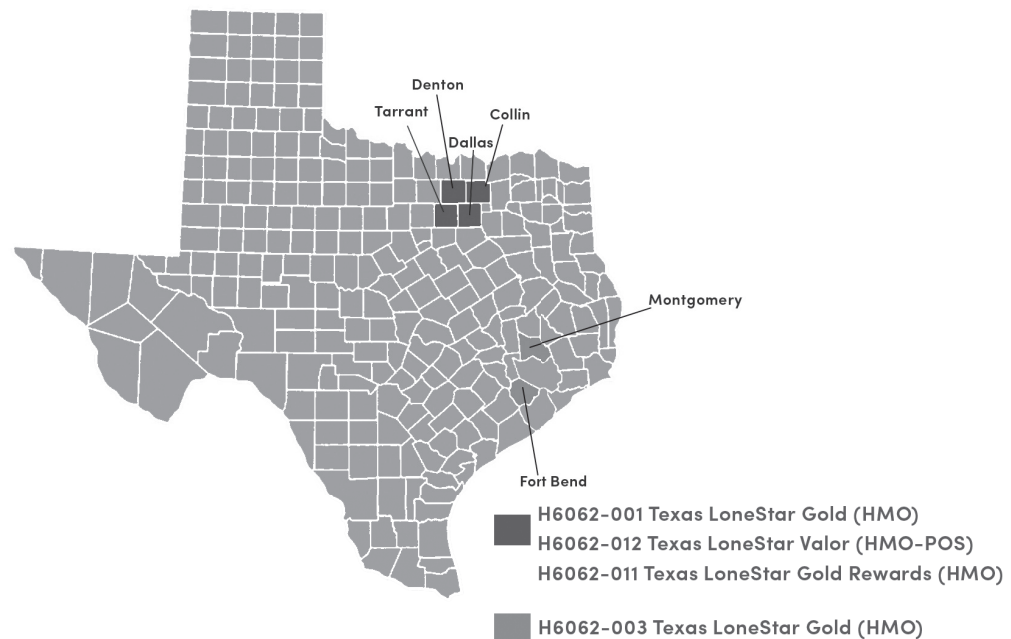
Dallas

Denton

Tarrant

Montgomery

Fort Bend



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 see the “Evidence of Coverage.” The Evidence of Coverage can be found online at www.GlobalHealth.com, or you can request a copy from Customer Care at 1-844-200-8167 (toll-free) (TTY: 711).

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). TTY users should call 1-877-486-2048.

This document is available in other languages and formats such as large print and Spanish.

For more information, please call us at 1-844-200-8167 (TTY: 711), or visit us at www.GlobalHealth.com

A decorative graphic consisting of three overlapping, wavy lines in teal, orange, and a darker orange-brown color, flowing from left to right across the middle of the page.

Texas LoneStar Medicare Advantage Plans Summary of Benefits

Texas LoneStar Medicare Advantage Plans

Summary of Benefits

January 1, 2023 – December 31, 2023

Plans may offer supplemental benefits in addition to Part C benefits.

Important Message About What You Pay for Vaccines and Insulin: Our plan covers most Part D vaccines at no cost to you. 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. Call Customer Care for more information.

	Texas LoneStar Gold (HMO) H6062-001	Texas LoneStar Gold (HMO) H6062-003	Texas LoneStar Gold Rewards (HMO) H6062-011	Texas LoneStar Valor (HMO-POS) H6062-012
Monthly Plan Premium (You must continue to pay your Part B premium)	\$0	\$0	\$0	\$0
Medicare Part B Premium Buydown	\$0 per month	\$0 per month	\$125 per month	\$75 per month
Deductible	\$0	\$0	\$0	\$0
Maximum Out-of-Pocket (MOOP) Responsibility (Does not include supplemental benefits or prescription drugs)	\$3,900	\$4,500	\$5,900	\$3,900 in-network; \$6,900 combined in- and out-of-network
PART C BENEFITS				
Inpatient Hospital Coverage ^{1,2}	\$195 copay per day (Days 1-7); \$0 copay per day (Days 8-90)	\$300 copay per day (Days 1-7); \$0 copay per day (Days 8-90)	\$295 copay per day (Days 1-7); \$0 copay per day (Days 8-90)	\$295 copay per day (Days 1-7) in-network; \$345 copay per day (Days 1-7) out-of-network \$0 copay per day (Days 8-90)

1 = Prior Authorization Required

2 = Referral Required

	Texas LoneStar Gold (HMO) H6062-001	Texas LoneStar Gold (HMO) H6062-003	Texas LoneStar Gold Rewards (HMO) H6062-011	Texas LoneStar Valor (HMO-POS) H6062-012
Outpatient Hospital Surgery ^{1,2}	\$250 copay per visit	\$315 copay per visit	\$250 copay per visit	\$250 copay per visit
Outpatient Hospital Observation Services ^{1,2}	\$250 copay per visit	\$315 copay per visit	\$250 copay per visit	\$250 copay per visit
Ambulatory Surgery Center ^{1,2}	\$200 copay per visit	\$265 copay per visit	\$200 copay per visit	\$200 copay per visit
Doctor Visits	• \$0 copay per visit for PCP • \$30 copay per visit for specialists^{1,2}	• \$0 copay per visit for PCP • \$30 copay per visit for specialists^{1,2}	• \$0 copay per visit for PCP • \$40 copay per visit for specialists^{1,2}	• \$0 copay per visit for PCP • \$35 copay per visit for in-network specialists • \$55 copay per visit for out-of-network specialist visits^{1,2}
Preventive Services	\$0 for Medicare-covered preventive services	\$0 for Medicare-covered preventive services	\$0 for Medicare-covered preventive services	\$0 for Medicare-covered preventive services
Emergency Care	\$90 copay per visit; waived if admitted to acute care	\$90 copay per visit; waived if admitted to acute care	\$90 copay per visit; waived if admitted to acute care	\$90 copay per visit; waived if admitted to acute care
Worldwide Emergency Care (Does not accumulate to MOOP)	• \$90 copay per visit • Limited to \$50,000 benefit combined with urgent care	• \$90 copay per visit • Limited to \$50,000 benefit combined with urgent care	• \$90 copay per visit • Limited to \$50,000 benefit combined with urgent care	• \$90 copay per visit • Limited to \$50,000 benefit combined with urgent care
Urgently Needed Services	\$60 copay per visit	\$60 copay per visit	\$60 copay per visit	\$15 copay per visit
Worldwide Urgent Care (Does not accumulate to MOOP)	• \$90 copay per visit • Limited to \$50,000 benefit combined with emergency care	• \$90 copay per visit • Limited to \$50,000 benefit combined with emergency care	• \$90 copay per visit • Limited to \$50,000 benefit combined with emergency care	• \$90 copay per visit • Limited to \$50,000 benefit combined with emergency care

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Outpatient Labs, X-Rays, Etc.	\$0 copay for labs, x-rays, ultrasounds, EKGs, and similar low-cost diagnostics	\$0 copay for labs, x-rays, ultrasounds, EKGs, and similar low-cost diagnostics	\$0 copay for labs, x-rays, ultrasounds, EKGs, and similar low-cost diagnostics	\$5 copay for labs \$0 copay for x-rays, ultrasounds, EKGs and similar low-cost diagnostics
Outpatient Therapeutic Radiology ^{1,2}	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Outpatient Diagnostic Radiology (MRI, etc.) ^{1,2}	\$175 copay per visit in PCP, specialist, urgent care, freestanding radiological facility \$250 copay per visit in outpatient hospital	\$180 copay per visit in PCP, specialist, urgent care, freestanding radiological facility \$315 copay per visit in outpatient hospital	\$175 copay per visit in PCP, specialist, urgent care, freestanding radiological facility \$250 copay per visit in outpatient hospital	\$180 copay per visit in PCP, specialist, urgent care, freestanding radiological facility \$250 copay per visit in outpatient hospital
Hearing Services	\$0 copay per visit for Medicare-covered services in a PCP office \$30 for Medicare-covered services in a specialist office^{1,2} \$0 copay for routine hearing exam limited to one per year \$0 copay for routine hearing aid evaluation limited to one per year - Our plan pays up to a total of \$750 for hearing aids per year	\$0 copay per visit for Medicare-covered services in a PCP office \$30 for Medicare-covered services in a specialist office^{1,2} \$0 copay for routine hearing exam limited to one per year \$0 copay for routine hearing aid evaluation limited to one per year - Our plan pays up to a total of \$750 for hearing aids per year	\$0 copay per visit for Medicare-covered services in a PCP office \$40 for Medicare-covered services in a specialist office^{1,2} \$0 copay for routine hearing exam limited to one per year \$0 copay for routine hearing aid evaluation limited to one per year - Our plan pays up to a total of \$750 for hearing aids per year	\$0 copay per visit for Medicare-covered services in a PCP office \$35 for Medicare-covered services in a specialist office^{1,2} \$0 copay for routine hearing exam limited to one per year \$0 copay for routine hearing aid evaluation limited to one per year - Our plan pays up to a total of \$1,000 for hearing aids per year

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Dental Services (Coinsurance for comprehensive services does not accumulate to MOOP)	\$30 for Medicare-covered services^{1,2} \$0 copay for preventive services - oral exams, x-rays, cleanings, and fluoride treatments - Our plan pays a total of \$1,500 for comprehensive dental services per year 20% coinsurance for some comprehensive services	\$30 for Medicare-covered services^{1,2} \$0 copay for preventive services - oral exams, x-rays, cleanings, and fluoride treatments	\$40 for Medicare-covered services^{1,2} \$0 copay for preventive services - oral exams, x-rays, cleanings, and fluoride treatments - Our plan pays a total of \$1,500 for comprehensive dental services per year 20% coinsurance for some comprehensive services	\$35 for Medicare-covered services^{1,2} \$0 copay for preventive services - oral exams, x-rays, cleanings, and fluoride treatments - Our plan pays a total of \$1,500 for comprehensive dental services per year 20% coinsurance for some comprehensive services
Vision Services	\$30 per visit for Medicare-covered services^{1,2} \$0 copay for routine eye exam limited to 1 per year - Our plan pays up to a total of \$100 for all supplemental eyewear per year	\$30 per visit for Medicare-covered services^{1,2} \$0 copay for routine eye exam limited to 1 per year - Our plan pays up to a total of \$100 for all supplemental eyewear per year	\$40 per visit for Medicare-covered services^{1,2} \$0 copay for routine eye exam limited to 1 per year - Our plan pays up to a total of \$100 for all supplemental eyewear per year	\$0 copay per visit for Medicare-covered services^{1,2} \$0 copay for routine eye exam limited to 1 per year - Our plan pays up to a total of \$100 for all supplemental eyewear per year
Inpatient Mental Health Care ^{1,2}	\$195 copay per day (Days 1-7); \$0 copay per day (Days 8-90)	\$300 copay per day (Days 1-7); \$0 copay per day (Days 8-90)	\$295 copay per day (Days 1-7); \$0 copay per day (Days 8-90)	\$295 copay per day (Days 1-7) in-network; \$345 copay per day (Days 1-7) out-of-network \$0 copay per day (Days 8-90)
Outpatient Mental Health Visit ^{1,2}	\$30 copay per visit	\$30 copay per visit	\$40 copay per visit	\$35 copay per visit

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Skilled Nursing Facility (SNF) ^{1,2}	\$0 copay per day (Days 1-20); \$184 copay per day (Days 21-100)	\$0 copay per day (Days 1-20); \$184 copay per day (Days 21-100)	\$0 copay per day (Days 1-20); \$184 copay per day (Days 21-100)	\$0 copay per day (Days 1-20); \$184 copay per day (Days 21-100) in-network; \$225 copay per day (Days 1-25); \$0 copay per day (Days 26-100) out-of-network
Outpatient Rehabilitation Services ^{1,2} (Physical, occupational, and/or speech therapy)	\$30 copay per visit	\$30 copay per visit	\$20 copay per visit	\$20 copay per visit
Ambulance (One-way trip)	• \$225 per occurrence for ground • You pay 20% of the cost per occurrence for air	• \$225 per occurrence for ground • You pay 20% of the cost per occurrence for air	• \$225 per occurrence for ground • You pay 20% of the cost per occurrence for air	• \$240 per occurrence for ground • You pay 20% of the cost per occurrence for air
Transportation ¹ (To and from plan-approved locations)	• \$0 copay per trip • Limited to 12 one-way trips per year • Limited to 50 miles per one-way trip	• \$0 copay per trip • Limited to 6 one-way trips per year • Limited to 50 miles per one-way trip	• \$0 copay per trip • Limited to 12 one-way trips per year • Limited to 50 miles per one-way trip	• \$0 copay per trip • Limited to 24 one-way trips per year • Limited to 50 miles per one-way trip

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Medicare Part B Drugs (Includes chemotherapy) ^{1,2,3}	You pay 20% of the cost You will pay no more than the dollar amount of the adjusted coinsurance percentage that applies to the specific Part B rebatable drug (typically a single source drug, e.g., brand drug) based on the date of service beginning April 1, 2023 . This applies to specific Part B drugs and may include chemotherapy drugs.	You pay 20% of the cost You will pay no more than the dollar amount of the adjusted coinsurance percentage that applies to the specific Part B rebatable drug (typically a single source drug, e.g., brand drug) based on the date of service beginning April 1, 2023 . This applies to specific Part B drugs and may include chemotherapy drugs.	You pay 20% of the cost You will pay no more than the dollar amount of the adjusted coinsurance percentage that applies to the specific Part B rebatable drug (typically a single source drug, e.g., brand drug) based on the date of service beginning April 1, 2023 . This applies to specific Part B drugs and may include chemotherapy drugs.	You pay 20% of the cost You will pay no more than the dollar amount of the adjusted coinsurance percentage that applies to the specific Part B rebatable drug (typically a single source drug, e.g., brand drug) based on the date of service beginning April 1, 2023 . This applies to specific Part B drugs and may include chemotherapy drugs.
	You will pay no more than \$35 for a one-month's supply of Part B insulin beginning July 1, 2023 . This applies to insulin used in an insulin pump.	You will pay no more than \$35 for a one-month's supply of Part B insulin beginning July 1, 2023 . This applies to insulin used in an insulin pump.	You will pay no more than \$35 for a one-month's supply of Part B insulin beginning July 1, 2023 . This applies to insulin used in an insulin pump.	You will pay no more than \$35 for a one-month's supply of Part B insulin beginning July 1, 2023 . This applies to insulin used in an insulin pump.
	\$20 copay per visit	\$20 copay per visit	\$20 copay per visit	\$20 copay per visit
	\$30 copay per visit	\$30 copay per visit	\$40 copay per visit	\$35 copay per visit
	\$30 copay per visit	\$30 copay per visit	\$40 copay per visit	\$35 copay per visit
Home Health Services ^{1,2}	\$0 copay per visit	\$0 copay per visit	\$0 copay per visit	\$0 copay per visit
Durable Medical Equipment ¹ (e.g., Continuous glucose monitors (CGM), wheelchairs, oxygen)	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance

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3 = May be subject to Part B step therapy

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Standard Diabetic Testing Supplies ¹	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Prosthetics and Related Supplies ¹ (e.g., Braces, artificial limbs)	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
PART D DRUGS				
Phase 1: Deductible	\$0	\$0	\$0	Not covered
Phase 2: Initial Coverage Limit (ICL)	\$4,660	\$4,660	\$4,660	Not covered
Tier 1: Preferred Generics (Preferred Retail 30-Day Supply*)	\$0 copay per fill	\$0 copay per fill	\$0 copay per fill	Not covered
Tier 2: Generic (Preferred Retail 30-Day Supply*)	\$10 copay per fill	\$10 copay per fill	\$10 copay per fill	Not covered
Tier 3: Preferred Brand (Preferred Retail 30-Day Supply*)	• \$42 copay per fill • \$35 copay per fill for insulins	• \$42 copay per fill • \$35 copay per fill for insulins	• \$42 copay per fill • \$35 copay per fill for insulins	Not covered
Tier 4: Non-Preferred Drug (Preferred Retail 30-Day Supply*)	• \$90 copay per fill • \$35 copay per fill for insulins	• \$90 copay per fill • \$35 copay per fill for insulins	• \$90 copay per fill • \$35 copay per fill for insulins	Not covered

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*Cost-sharing may differ depending on the pharmacy's status (e.g., preferred, non-preferred, mail-order, Long Term Care (LTC), or home infusion) or the supply (e.g., 30 or 100 days supply). For more information on the additional pharmacies specific cost-sharing and the phases of the benefit, please call us or access our Evidence of Coverage online. PLEASE NOTE: Please visit our website for the most up-to-date drug formulary. The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

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Tier 5: Specialty Tier (Preferred Retail 30-Day Supply)*	• 33% of the cost per fill • \$35 copay per fill for insulins	• 33% of the cost per fill • \$35 copay per fill for insulins	• 33% of the cost per fill • \$35 copay per fill for insulins	Not covered
Tier 1: (Preferred Retail & Mail Order 100-Day Supply)*	\$0 copay per fill	\$0 copay per fill	\$0 copay per fill	Not covered
Tier 2: (Preferred Retail & Mail Order 100-Day Supply)	\$20 copay per fill	\$20 copay per fill	\$20 copay per fill	Not covered
Tier 3: (Preferred Retail & Mail Order 100-Day Supply)*	• \$84 copay per fill • \$84 copay per fill for insulins	• \$84 copay per fill • \$84 copay per fill for insulins	• \$84 copay per fill • \$84 copay per fill for insulins	Not covered
Tier 4: Non-Preferred Drug (Preferred Retail and Mail Order 100-Day-Supply)*	• \$270 copay per fill • \$105 copay per fill for insulins	• \$270 copay per fill • \$105 copay per fill for insulins	• \$270 copay per fill • \$105 copay per fill for insulins	Not covered

*Cost-sharing may differ depending on the pharmacy's status (e.g., preferred, non-preferred, mail-order, Long Term Care (LTC), or home infusion) or the supply (e.g., 30 or 100 days supply). For more information on the additional pharmacies specific cost-sharing and the phases of the benefit, please call us or access our Evidence of Coverage online. PLEASE NOTE: Please visit our website for the most up-to-date drug formulary. The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

*Cost-sharing may differ depending on the pharmacy's status (e.g., preferred, non-preferred, mail-order, Long Term Care (LTC), or home infusion) or the supply (e.g., 30 or 100 days supply). For more information on the additional pharmacies specific cost-sharing and the phases of the benefit, please call us or access our Evidence of Coverage online. PLEASE NOTE: Please visit our website for the most up-to-date drug formulary. The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

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Phase 3 Coverage Gap Stage ⁴ (After your prescription costs reach \$4,660)	Generic Drugs: - GlobalHealth members continue to pay the same amount as in the initial coverage stage for Tier 1 generic drugs. - Members pay 25% of the cost for other generic drugs.	Generic Drugs: - GlobalHealth members continue to pay the same amount as in the initial coverage stage for Tier 1 generic drugs. - Members pay 25% of the cost for other generic drugs.	Generic Drugs: - GlobalHealth members continue to pay the same amount as in the initial coverage stage for Tier 1 generic drugs. - Members pay 25% of the cost for other generic drugs.	Not covered
	Brand Name Drugs: - The Medicare Coverage Gap Discount Program of 70% is applied to the initial coverage stage copayment for Tier 1 brand drugs or for Tier 3 oral antidiabetics. - Members pay 25% of the cost of the drug plus a portion of the dispensing fee for other brand name drugs.	Brand Name Drugs: - The Medicare Coverage Gap Discount Program of 70% is applied to the initial coverage stage copayment for Tier 1 brand drugs or for Tier 3 oral antidiabetics. - Members pay 25% of the cost of the drug plus a portion of the dispensing fee for other brand name drugs.	Brand Name Drugs: - The Medicare Coverage Gap Discount Program of 70% is applied to the initial coverage stage copayment for Tier 1 brand drugs or for Tier 3 oral antidiabetics. - Members pay 25% of the cost of the drug plus a portion of the dispensing fee for other brand name drugs.	
	Insulins: Members pay no more than \$35 for a 30-day supply of insulin.	Insulins: Members pay no more than \$35 for a 30-day supply of insulin.	Insulins: Members pay no more than \$35 for a 30-day supply of insulin.	

4 = You stay in this stage until your year-to-date "out-of-pocket costs" (your payments) reach a total of \$7,400. This amount and rules for counting costs toward this amount have been set by Medicare.

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4: Catastrophic Coverage Stage (After you have paid \$7,400 out-of-pocket)	You pay the greater of 5% of the cost of the drug or \$4.15 for generics/\$10.35 for brand names.	You pay the greater of 5% of the cost of the drug or \$4.15 for generics/\$10.35 for brand names.	You pay the greater of 5% of the cost of the drug or \$4.15 for generics/\$10.35 for brand names.	Not covered
SUPPLEMENTAL BENEFITS				
Smart Wallet	\$500 per year for Hearing, Dental and/or Vision \$75 per quarter for Over-the-Counter	\$50 per quarter for Over-the-Counter	\$500 per year for Hearing, Dental and/or Vision \$75 per quarter for Over-the-Counter	\$500 per year for Hearing, Dental and/or Vision \$75 per quarter for Over-the-Counter
Over-the-Counter Benefit (Includes nicotine replacement therapy)	\$75 per quarter	\$50 per quarter	\$75 per quarter	\$75 per quarter
Fitness	\$0 copay per visit	\$0 copay per visit	\$0 copay per visit	\$0 copay per visit
24/7 Nurse Line	\$0 copay per visit	\$0 copay per visit	\$0 copay per visit	\$0 copay per visit
Post-Discharge Meal Delivery ¹	\$0 copay per meal - Limited to 10 meals following discharge - Limited to 4 times per year	\$0 copay per meal - Limited to 10 meals following discharge - Limited to 4 times per year	\$0 copay per meal - Limited to 10 meals following discharge - Limited to 4 times per year	\$0 copay per meal - Limited to 10 meals following discharge - Limited to 4 times per year
In-Home Support Services	60 hours per year	Not covered	60 hours per year	60 hours per year

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Notes

[illegible]

Notes

[illegible]

Notes

[illegible]



Customer Care: 1-844-200-8167 (TTY: 711)

8 am to 8 pm, 7 days a week, (October 1 – March 31), and 8 am to 8 pm, Monday – Friday, (April 1 – September 30)

www.GlobalHealth.com

Provider Directory: www.GlobalHealth.com

Pharmacy Directory: www.GlobalHealth.com

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website at www.GlobalHealth.com.

Fraud, Waste and Abuse: GlobalHealth is committed to fighting healthcare fraud, waste and abuse. If you suspect Medicare fraud, waste or abuse, call our hotline – 1-877-280-5852.

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 1-844-200-8167 (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 1-844-200-8167 (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 1-844-200-8167 (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 1-844-200-8167 (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 1-844-200-8167 (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 1-844-200-8167 (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 quý vị cần thông dịch viên xin gọi 1-844-200-8167 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-844-200-8167 (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 1-844-200-8167 (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 1-844-200-8167 (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 1-844-200-8167 (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 1-844-200-8167 (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 1-844-200-8167 (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 1-844-200-8167 (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 1-844-200-8167 (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 1-844-200-8167 (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。通訳をご用命になるには、1-844-200-8167 (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。

2023 Service Area

Collin

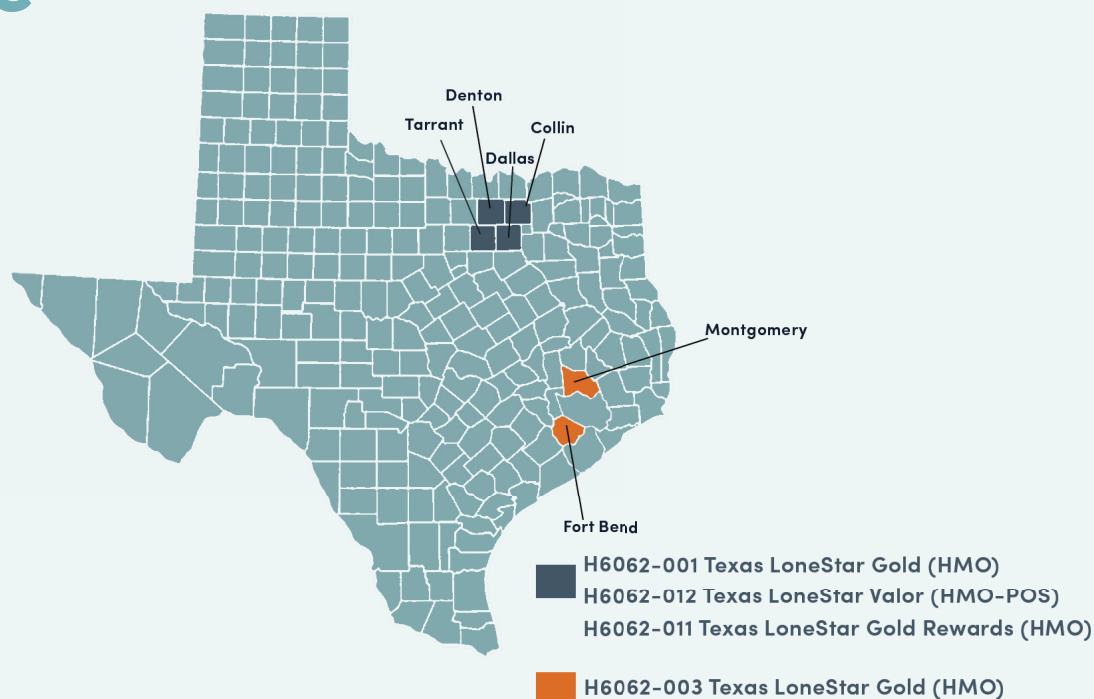
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Limitations, copayments and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year.