Pennsylvania Public School
Employees' Retirement System (PSERS)

Health Options Program

2025

Managed Care Plans for Medicare-Eligible and Non-Medicare-Eligible Members

Southeast
PENNSYLVANIA

Bucks • Chester • Delaware • Montgomery • Philadelphia

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2025 Monthly Costs if You Are Eligible for Medicare *(Excluding Premium Assistance)*

	SINGLE COVERAGE	2-PERSON COVERAGE
Highmark Freedom Blue PPO	$351	$702
Capital Blue Cross PPO	$260	$520
Aetna Medicare P01 PPO	$546	$1,092
UPMC PSERS HOP Custom PPO	$262	$524
Independence Blue Cross Personal Choice 65 PPO	$307	$614

2025 Monthly Costs if You Are NOT Eligible for Medicare *(Excluding Premium Assistance)*

	SINGLE COVERAGE	2-PERSON COVERAGE
Highmark PPOBlue (80-70 Plan)	$2,017	$4,034
Capital Blue Cross PPO	$1,697	$3,394
Aetna Premier Open Choice PPO	$2,112	$4,224
UPMC Business Advantage	$2,068	$4,136
Independence Blue Cross POS $20-$40/$250	$3,938	$7,876

2025 Plan Options if You Are Eligible for Medicare

HOW MUCH YOU WILL PAY IN 2025	HIGHMARK FREEDOM BLUE PPO	
MEDICAL PLAN	**In-Network**	**Out-of-Network**
Annual Deductible	$0	$0
Annual Out-of-Pocket Maximum	$1,000 (combined)	
Hospitalization	$0	$0
Doctor Visits	$5 PCP; $15 specialist	$5 PCP; $15 specialist
Preventive Care	$0	$0
Emergency Room	$40 (waived if admitted)	$40 (waived if admitted)
Urgent Care Facility	$25	$25
Outpatient Surgery	$0	$0
Diagnostic Testing	$0	$0
Outpatient Therapy	$15	$15
Durable Medical Equipment	15%	20%
Outpatient Mental Health	$15	$15
Inpatient Mental Health	$0	$0
Physical Exams	$0 (office visit copay may apply)	$0 (office visit copay may apply)
Ob/Gyn Exams	$0 (office visit copay may apply)	$0 (office visit copay may apply)
Mammograms	$0	$0
Skilled Nursing Facility	$0 up to 100 days per Medicare Benefit Period	$0 up to 100 days per Medicare Benefit Period
Hearing Aids (once every 12 months)	Per year $499 copay per aid for TruHearing Advanced; $799 per aid for TruHearing Premium; $500 allowance per year for other aids through TruHearing	$500 allowance for hearing aids every three years from any other provider or TruHearing
Dental Care (subject to frequency limitations)	$20 for exam & cleaning and $20 for X-rays every 6 months; 50% for restorative services and dentures	50% for periodic exams, cleanings, X-rays, fillings as needed and dentures
Vision Exam/Hearing Exams	$0 vision; $15 hearing	$50 vision; $15 hearing
Prescription Lenses (once every 12 months)	$150 benefit maximum per calendar year for standard eyeglass frames, eyeglass lenses or contact lenses; Davis Vision Fashion Collection frames and standard lenses covered in full	$150 benefit maximum per calendar year for standard eyeglass frames, eyeglass lenses or contact lenses; Davis Vision Fashion Collection frames and standard lenses covered in full
PRESCRIPTION DRUGS	**Retail Pharmacy (31-day supply)**	**Mail Order***
Annual Deductible	$0	$0
Initial Coverage Up to an Out-of-Pocket Threshold of $2,000**		
Preferred generic drugs (Tier 1)	$5 preferred pharmacy; $10 standard pharmacy	$12.50 preferred pharmacy; $25 standard pharmacy
Non-preferred generic drugs (Tier 2)	$5 preferred pharmacy; $10 standard pharmacy	$12.50 preferred pharmacy; $25 standard pharmacy
Preferred brand-name drugs (Tier 3)	$25 preferred pharmacy; $30 standard pharmacy	$62.50 preferred pharmacy; $75 standard pharmacy
Non-preferred brand-name drugs (Tier 4)	$55 preferred pharmacy; $60 standard pharmacy	$137.50 preferred pharmacy; $150 standard pharmacy
Specialty drugs (Tier 5)	33%	33% (31-day supply)
Catastrophic Coverage		
Generic drugs	$0	
Brand-name drugs	$0	

* Must obtain mail order supply using Express Scripts/ESI. In Initial Coverage and the Coverage Gap: 100-day supply for Tier 1 and Tier 2 drugs; 90-day supply for Tier 3 and Tier 4 drugs.

** Includes total costs for covered drugs paid by the participant.

HOW MUCH YOU WILL PAY IN 2025	CAPITAL BLUE CROSS PPO	
MEDICAL PLAN	**In-Network**	**Out-of-Network**
Annual Deductible	$0	$0
Annual Out-of-Pocket Maximum	$3,400 combined	
Hospitalization	$0	$0
Doctor Visits	$5 PCP; $15 specialist	$5 PCP; $15 specialist
Preventive Care	$0	$0
Emergency Room	$50 (waived if admitted)	$50 (waived if admitted)
Urgent Care Facility	$35	$35
Outpatient Surgery	$0	30%
Diagnostic Testing	$0 lab services; $0 - $25 high-tech imaging; 15% therapeutic radiology; all other $0	30%
Outpatient Therapy	$15	$15
Durable Medical Equipment	20%	20%
Outpatient Mental Health	$15	$15
Inpatient Mental Health	$0	$0
Physical Exams	$0 (annual wellness exam)	$0 (annual wellness exam)
Ob/Gyn Exams	$0 preventive screenings	$0 preventive screenings
Mammograms	$0 preventive screenings	$0 preventive screenings
Skilled Nursing Facility	$0 days 1-20; $30 days 21-100	20% days 1-100
Hearing Aids (once every 12 months)	$499/$699/$999 copay per aid, per year	Not covered
Dental Care	$0 office visit, cleaning and X-rays covered twice per year; $1,500 max per calendar year (in- and out-of-network combined)	50% office visit, cleaning and X-rays covered twice per year; $1,500 max per calendar year (in- and out-of-network combined)
Vision Exam/Hearing Exams (once every calendar year)	Vision: $0 for routine vision exam Hearing: $0 for routine hearing exam	Vision: 50% for routine vision exam Hearing: $0 for routine hearing exam
Prescription Lenses (once every 12 months)	100% after $150 allowance for frames and lenses or contacts	
PRESCRIPTION DRUGS	**Retail Pharmacy (30-day supply)**	**Mail Order (100-day supply)**
Annual Deductible	$0	$0
Initial Coverage Up to an Out-of-Pocket Threshold of $2,000*		
Preferred generic drugs (Tier 1)	$0	$0
Non-preferred generic drugs (Tier 2)	$4	$12
Preferred brand-name drugs (Tier 3)	$30	$90
Non-preferred brand-name drugs (Tier 4)	33%	33%
Specialty drugs (Tier 5)	33% (30-day supply)	Not covered
Catastrophic Coverage		
Generic drugs	$0	
Brand-name drugs	$0	

* Includes total costs for covered drugs paid by the participant.

HOW MUCH YOU WILL PAY IN 2025	AETNA MEDICARE P01 PPO*	
MEDICAL PLAN	**In-Network**	**Out-of-Network**
Annual Deductible	$0	$0
Annual Out-of-Pocket Maximum	$3,500	$5,000
Hospitalization	$0	15%
Doctor Visits	$15	15%
Preventive Care	$0	15%
Emergency Room	$50 (waived if admitted)	$50 (waived if admitted)
Urgent Care Facility	$15	$15
Outpatient Surgery	$0	15%
Diagnostic Testing	$15	15%
Outpatient Therapy	$15	15%
Durable Medical Equipment	15%	15%
Outpatient Mental Health	$15	15%
Inpatient Mental Health	$0	15%
Physical Exams	$0	15%
Ob/Gyn Exams	$0	15%
Mammograms	$0	15%
Skilled Nursing Facility	$0 copay per day, day(s) 1-20; $75 per day, day(s) 21-100	15%
Hearing Aids	$500 allowance once every 36 months	
Dental Care	$15 (if covered by Medicare)	15% (if covered by Medicare)
Vision Exam/Hearing Exams	$0 (once every 12 months)	15% (once every 12 months)
Prescription Lenses (once every 24 months)	$100 allowance	
PRESCRIPTION DRUGS	**Retail Pharmacy (30-day supply)**	**Mail Order (90-day supply)**
Annual Deductible	$0	$0
Initial Coverage Up to an Out-of-Pocket Threshold of $2,000**		
Generic drugs (Tier 1)	$4 preferred pharmacy; $5 standard pharmacy	$8 preferred pharmacy; $10 standard pharmacy
Preferred brand-name drugs (Tier 2)	$25***	$50***
Non-preferred brand-name drugs (Tier 3)	$50***	$100***
Specialty drugs (Tier 4)	33%***	33%*** (limited to one-month supply)
Catastrophic Coverage		
Generic drugs	$0	
Brand-name drugs	$0	

* Aetna is only available in Pennsylvania, New Jersey, and some counties in Florida, Maryland, New York, and Delaware.
** Includes total costs for covered drugs paid by the participant.
*** Includes some high-cost generics.

HOW MUCH YOU WILL PAY IN 2025	UPMC PSERS HOP CUSTOM PPO*	
MEDICAL PLAN	**In-Network**	**Out-of-Network**
Annual Deductible	$0	$500
Annual Out-of-Pocket Maximum	$3,400	$5,100
Hospitalization	$0	20%
Doctor Visits	$0 PCP; $20 specialist	20%
Preventive Care	$0	20%, no deductible
Emergency Room	$120 (waived if admitted within 3 days)	$120 (waived if admitted within 3 days), no deductible
Urgent Care Facility	$20	$20 copay, no deductible
Outpatient Surgery	$0	20%
Diagnostic Testing	$0 labs; $10 X-rays; $30 advanced imaging	20%
Outpatient Therapy	$20	20%
Durable Medical Equipment	15%	50%
Outpatient Mental Health	$20	20%
Inpatient Mental Health	$0	20%
Physical Exams	$0 Annual Wellness Exams; Annual physical exams - not covered	20% Annual Wellness Exams, no deductible; Annual physical exams - not covered
Ob/Gyn Exams	$0 routine	20%, no deductible
Mammograms	$0 routine	20%, no deductible
Skilled Nursing Facility	$0 per day days 1-15; $50 per day days 16-100	20%
Hearing Aids (once every 12 months)	$690 - $1,890	$690 - $1,890, no deductible
Dental Care	Dental exams: $20	Dental exams: 50%, no deductible
Vision Exam/Hearing Exams (once every year)	$0 routine vision; $20 routine hearing	$50 routine vision, no deductible; 50% routine hearing, no deductible
Prescription Lenses (once every 12 months)	$175 allowance (combined in- and out-of-network)	
PRESCRIPTION DRUGS	**Retail Pharmacy (30-day supply)****	**Retail/Mail Order (100-day supply)****
Annual Deductible	$0	$0
Initial Coverage Up to an Out-of-Pocket Threshold of $2,000***		
Preferred generic drugs (Tier 1)	$0 preferred pharmacy; $15 standard pharmacy	$0 preferred pharmacy; $30 standard pharmacy
Non-preferred generic drugs (Tier 2)	$10 preferred pharmacy; $20 standard pharmacy	$20 preferred pharmacy; $40 standard pharmacy
Preferred brand-name drugs (Tier 3)	$47 preferred or standard pharmacy	$117.50 preferred pharmacy; $141 standard pharmacy
Non-preferred drugs (Tier 4)	50% preferred or standard pharmacy	50% preferred or standard pharmacy
Specialty drugs (Tier 5)	33% preferred or standard pharmacy	33% preferred or standard pharmacy (limited to a 30-day supply)
Catastrophic Coverage		
Generic drugs	$0	
Brand-name drugs	$0	

* UPMC is available in all South East, South West Pennsylvania counties and some North Central Pennsylvania counties.
** 60-day supply is also available.
*** Includes total costs for covered drugs paid by the participant.

HOW MUCH YOU WILL PAY IN 2025	INDEPENDENCE BLUE CROSS–PERSONAL CHOICE 65 PPO	
MEDICAL PLAN	**In-Network**	**Out-of-Network**
Annual Deductible	$0	$0
Annual Out-of-Pocket Maximum	$3,400	$10,000 (in- and out-of-network combined)
Hospitalization	$50/stay (days 1–6)	30%
Doctor Visits	$0 PCP; $15 specialist	30%
Preventive Care	$0	30%
Emergency Room	$90 (waived if admitted)	$90 (waived if admitted)
Urgent Care Facility	$40	$40
Outpatient Surgery	$75	30%
Diagnostic Testing	$0	30%
Outpatient Therapy	$15; $5 pulmonary/cardiac rehab	30%
Durable Medical Equipment	20%; $0 diabetic supplies	30%
Outpatient Mental Health	$15	30%
Inpatient Mental Health (190-day combined lifetime max)	$50/stay (days 1-6); 190-day lifetime max in a Medicare-approved facility	30%
Physical Exams	$0	30%
Ob/Gyn Exams	$0 (routine every two years)	30%
Mammograms	$0	30%
Skilled Nursing Facility	$0 days 1-20; $188 days 21-100	30%
Hearing Aids (once every 12 months)	$0 after annual $499 copay per aid for TruHearing Advanced; $799 per aid for TruHearing Premium	$0 after annual $499 copay per aid for TruHearing Advanced; $799 per aid for TruHearing Premium
Dental Care	Not covered	Not covered
Vision Exam/Hearing Exams	$15	30%
Prescription Lenses (once every 24 months)	$0 for standard lenses and frames or contacts; 100% after $100 allowance for nonstandard frames and specialty contacts	30%
PRESCRIPTION DRUGS	**Retail Pharmacy (30-day supply)**	**Mail Order (90-day supply)**
Annual Deductible	$0	$0
Initial Coverage Up to an Out-of-Pocket Threshold of $2,000*		
Preferred generic drugs (Tier 1)	$2 preferred pharmacy; $10 standard pharmacy	$4 preferred pharmacy
Non-preferred generic drugs (Tier 2)	$10 preferred pharmacy; $20 standard pharmacy	$20 preferred pharmacy
Preferred brand-name drugs (Tier 3)	$30	$60 preferred pharmacy
Non-preferred brand-name drugs (Tier 4)	$60	$120 preferred pharmacy
Specialty drugs (Tier 5)	33%	33% preferred pharmacy
Catastrophic Coverage		
Generic drugs	$0	
Brand-name drugs	$0	

* Includes total costs for covered drugs paid by the participant.

2025 Plan Options if You Are NOT Eligible for Medicare

HOW MUCH YOU WILL PAY IN 2025	HIGHMARK PPOBLUE (80-70 PLAN)	
MEDICAL	**In-Network**	**Out-of-Network**
Annual Deductible	$100/individual $300/family	$500/individual $1,500/family
Annual Out-of-Pocket Maximum	$10,000	No maximum
Hospitalization	20%	30%
Doctor Visits	$20/visit PCP; $40/visit specialist; no deductible	30%
Preventive Care	$20/visit; no deductible	Routine physicals not covered; 30% for routine gynecological and mammograms
Emergency Room	$100 (waived if admitted); no deductible	$100 (waived if admitted); no deductible
Urgent Care Facility	$40; no deductible	30%
Outpatient Surgery	20%	30%
Diagnostic Testing	20%	30%
Outpatient Therapy	$40/visit; 60-visit maximum*; no deductible	30%; 60-visit maximum*
Durable Medical Equipment	20%	30%
Outpatient Mental Health	0%; no deductible	30%
Inpatient Mental Health	20%	30%
Physical Exams	$20/visit PCP; $40/visit specialist; no deductible	Not covered
Ob/Gyn Exams	$40/visit; no deductible	30% routine; no deductible
Mammograms	20%	30%
Skilled Nursing Facility	20%; 100 visits per calendar year	30%; 100 visits per calendar year
Hearing Aids	Not covered	Not covered
Dental Care	Not covered	Not covered
Vision Exam/Hearing Exams	Not covered	Not covered
Prescription Lenses	Not covered	Not covered
PRESCRIPTION DRUGS		
Annual Deductible	$0	Not covered
Annual Maximum	No maximum	Not covered
Retail Pharmacy (34-day supply)		
Generic drugs	30% (mandatory generic)	Not covered
Brand-name drugs	50%	Not covered
Mail Order (90-day supply)		
Generic drugs	30% (mandatory generic)	Not covered
Brand-name drugs	50%	Not covered

* Combined in- and out-of-network maximum

HOW MUCH YOU WILL PAY IN 2025	CAPITAL BLUE CROSS PPO	
MEDICAL	**In-Network**	**Out-of-Network**
Annual Deductible	$100/individual $300/family	$500/individual $1,500/family
Annual Out-of-Pocket Maximum	$3,000/individual $6,000/family	No maximum
Hospitalization	20%; no deductible	30%; no deductible
Doctor Visits	$10/PCP visit; $25/specialist visit; no deductible	30%; no deductible
Preventive Care	$10/visit; no deductible	20%
Emergency Room	$100; no deductible (waived if admitted)	$100; no deductible (waived if admitted)
Urgent Care Facility	$40; no deductible	30%
Outpatient Surgery	20%	30%
Diagnostic Testing	20%	30%
Outpatient Therapy	$40/visit; no deductible	30%
Durable Medical Equipment	20%	30%
Outpatient Mental Health	$40/visit; no deductible	30%; no deductible
Inpatient Mental Health	20%	30%
Physical Exams	$10/PCP visit; $25/specialist visit; no deductible	20%; no deductible
Ob/Gyn Exams	$0; no deductible	30%, no deductible
Mammograms	$0; no deductible	30%, no deductible
Skilled Nursing Facility	$0; limit 100 days	50%; limit 100 days
Hearing Aids	Not covered	Not covered
Dental Care	Not covered	Not covered
Vision Exam/Hearing Exams	Not covered	Not covered
Prescription Lenses	Not covered	Not covered
PRESCRIPTION DRUGS		
Annual Deductible	$300/individual $600/family	Not covered
Annual Maximum	$2,500 benefit period maximum on lifestyle drugs	Not covered
Retail Pharmacy		
Generic drugs	30%*	Not covered
Brand-name drugs	30%/preferred;* 50%/non-preferred	Not covered
Mail Order (90-day supply)		
Generic drugs	50%	Not covered
Brand-name drugs	50%	Not covered

* Specialty generic drugs and brand preferred drugs are covered at 50%, and Specialty brand non-preferred drugs are not covered.

HOW MUCH YOU WILL PAY IN 2025	AETNA PREMIER OPEN CHOICE PPO*	
MEDICAL	**In-Network**	**Out-of-Network**
Annual Deductible	$300/individual $600/family	$500/individual $1,000/family
Annual Out-of-Pocket Maximum	$6,600/individual $13,200/family	$10,000/individual $20,000/family
Hospitalization	$200/day for 5 days; then $0	30%
Doctor Visits	$15/visit PCP; $40/visit specialist	30%
Preventive Care	$0; no deductible	30%
Emergency Room	$75; no deductible (waived if admitted)	$75; no deductible (waived if admitted)
Urgent Care Facility	$50; no deductible	30%
Outpatient Surgery	$150	30%
Diagnostic Testing	$35 X-ray/lab; $150 complex imaging	30%
Outpatient Therapy	$40; coverage is subject to change based on type of therapy received	30%
Durable Medical Equipment	20%	30%
Outpatient Mental Health	$40; all other mental health $0	30%
Inpatient Mental Health	$200/day for 5 days; then $0	30%
Physical Exams	0%; no deductible; routine	30%
Ob/Gyn Exams	0%; no deductible; routine	30%
Mammograms	0%; no deductible; routine	30%
Skilled Nursing Facility	$200/day for 5 days; then $0; 100-day limit	30%
Hearing Aids (once every 36 months; $1,000 maximum benefit)	100% after $1,000 allowance	30%
Dental Care	Not covered	Not covered
Vision Exam/Hearing Exams	Vision: $0; no deductible; 1 exam/12 months; Hearing: $40; 1 exam/24 months	30%
Prescription Lenses (once every 24 months)	100% after $100 allowance	100% after $100 allowance
PRESCRIPTION DRUGS		
Annual Deductible	$200/individual $600/family	$200/individual $600/family
Annual Maximum	Combined with medical	Combined with medical
Retail Pharmacy		
Generic drugs	30%	50% after applicable copay
Brand-name drugs	30%-formulary 50%-non-formulary	50% after applicable copay
Mail Order (90-day supply)		
Generic drugs	30%	Not covered
Brand-name drugs	30%-formulary 50%-non-formulary	Not covered

* Aetna is available only in New Jersey, Pennsylvania and some counties in Florida, Delaware, Maryland and New York.

HOW MUCH YOU WILL PAY IN 2025	UPMC BUSINESS ADVANTAGE*
MEDICAL	**In-Network Only**
Annual Deductible	$500/individual $1,000/family
Annual Out-of-Pocket Maximum	$4,000/individual $8,000/family
Hospitalization	20%
Doctor Visits	$20/visit PCP; $40/visit specialist; no deductible
Preventive Care	$0; no deductible
Emergency Room	$100 copay (waived if admitted); no deductible
Urgent Care Facility	$40; no deductible
Outpatient Surgery	20%
Diagnostic Testing	20%
Outpatient Therapy	$40/visit; 30-visit maximum; no deductible
Durable Medical Equipment	20%
Outpatient Mental Health	$20/visit; no deductible
Inpatient Mental Health	20%
Physical Exams	$0 routine; no deductible
Ob/Gyn Exams	$0 routine; no deductible
Mammograms	$0 routine; no deductible
Skilled Nursing Facility	20%; 120 days per benefit period
Hearing Aids	Not covered
Dental Care	Not covered
Vision Exam/Hearing Exams	Not covered
Prescription Lenses	Not covered
PRESCRIPTION DRUGS	
Annual Deductible	$0
Annual Maximum	No maximum
Retail Pharmacy	
Generic drugs	$8 (mandatory generic)
Brand-name drugs	$38/preferred; $76/non-preferred and specialty
Mail Order (90-day supply)	
Generic drugs	$16 (mandatory generic)
Brand-name drugs	$76/preferred; $152/non-preferred

* UPMC is not available in all counties.

HOW MUCH YOU WILL PAY IN 2025	INDEPENDENCE BLUE CROSS POS $20-$40/$250	
MEDICAL	**In-Network**	**Out-of-Network**
Annual Deductible	$0	$5,000/individual $10,000/family
Annual Out-of-Pocket Maximum	$7,900/individual $15,800/family	$30,000/individual $60,000/family
Hospitalization	$250/day to $1,250/admission maximum	50%
Doctor Visits	$20/visit PCP; $40/visit specialist	50%
Preventive Care	$0	50%; no deductible
Emergency Room	$250 (not waived if admitted)	$250 (not waived if admitted); no deductible
Urgent Care Facility	$85	50%
Outpatient Surgery	$250	50%
Diagnostic Testing	$0 outpatient lab/pathology; $40 outpatient X-ray and routine/diagnostic radiology; $80 complex radiology	50%
Outpatient Therapy	$40 (30 visits per year)	50%
Durable Medical Equipment	50%	50%
Outpatient Mental Health	$40	50%
Inpatient Mental Health	$250/day to $1,250/admission maximum	50%
Physical Exams	$20/visit PCP; $40/visit specialist	50%; no deductible
Ob/Gyn Exams	$0	50%
Mammograms	$0	50%; no deductible
Skilled Nursing Facility	$125/day maximum $625 copay; 120 days per calendar year	50%; 120 days per calendar year
Hearing Aids	Not covered	Not covered
Dental Care	Not covered	Not covered
Vision Exam/Hearing Exams	$35 for vision, once every 24 months; Hearing not covered	Not covered
Prescription Lenses	Not covered	Not covered
PRESCRIPTION DRUGS		
Annual Deductible	$0	$0
Annual Maximum	No maximum	No maximum
Retail Pharmacy		
Generic drugs	$20	70% of drug retail cost
Brand-name drugs	$40	70% of drug retail cost
Mail Order (90-day supply)		
Generic drugs	$40	70% of drug retail cost
Brand-name drugs	$80	70% of drug retail cost

Notes

This brochure provides only a summary of benefits under these plans. It does not provide details about what is covered or limitations that may apply. More information is included in the Evidence of Coverage (for a Medicare Advantage plan) or the Benefit Description (for a plan for non-Medicare-eligible members). In addition, you can call the HOP Administration Unit at 1-800-773-7725 and request an information packet for any of these plans.

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Pennsylvania Public School Employees' Retirement System (PSERS)

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 1-800-773-7725. 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 1-800-773-7725. 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 1-800-773-7725。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 1-800-773-7725。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 1-800-773-7725. 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 1-800-773-7725. 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 1-800-773-7725 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 1-800-773-7725. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

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(Expires 12/31/25)

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-773-7725 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 1-800-773-7725. 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 1-800-773-7725. 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 1-800-773-7725 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 1-800-773-7725. 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 1-800-773-7725. 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 1-800-773-7725. 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 1-800-773-7725. Ta usługa jest bezpłatna.

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