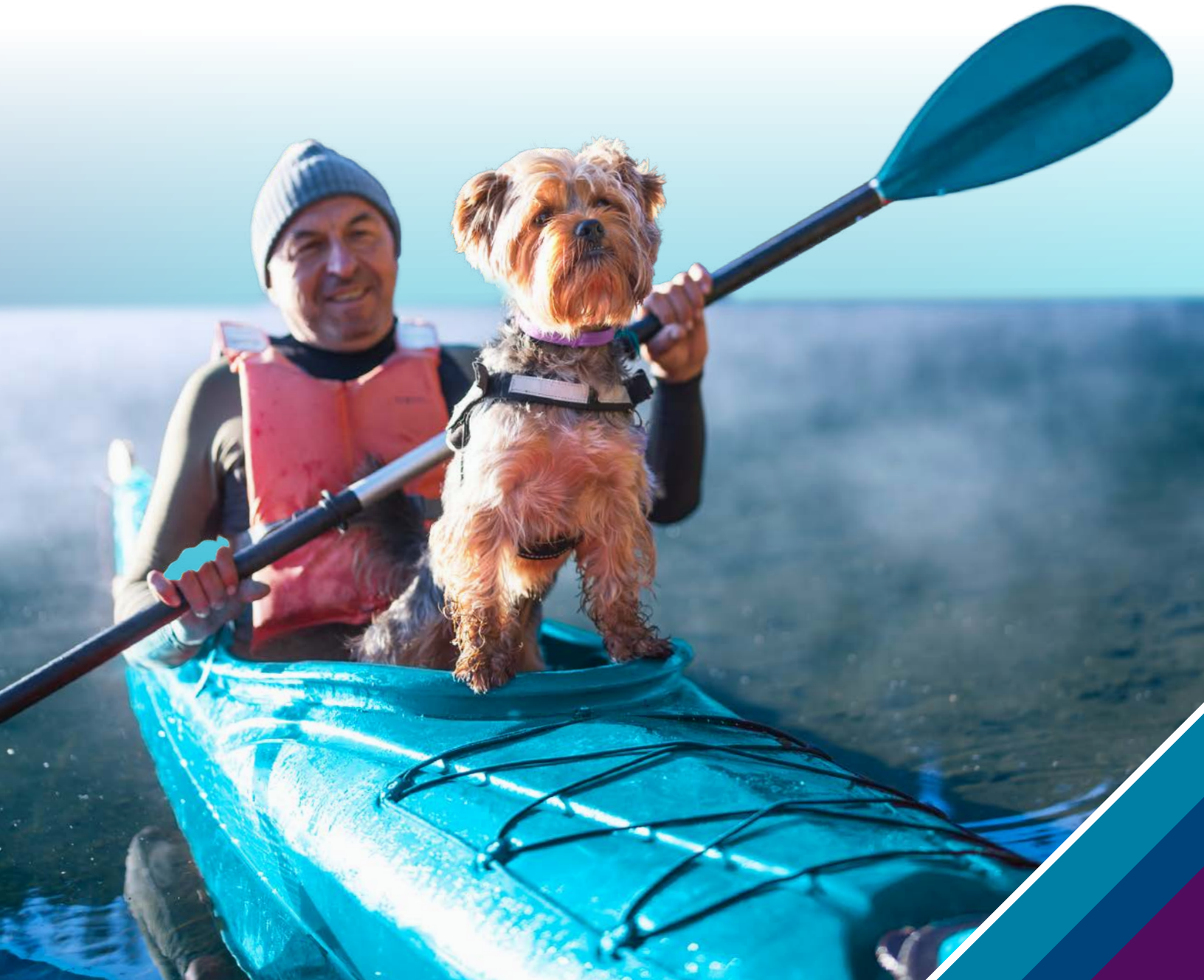
healthteam advantage℠

2025

Summary of Benefits

HealthTeam Advantage Vitality Plan (PPO) H9808-010



2025
Summary of Benefits

HealthTeam Advantage Vitality Plan (PPO)

January 1, 2025 - December 31, 2025.

The benefit information provided is a summary of what we cover and what you pay. It doesn't list every service we cover or every limitation or exclusion. For a complete list of covered services refer to our Evidence of Coverage booklet. You can request a copy from HealthTeam Advantage or view it on the website at www.htanc.com/members/2025-plan-documents/.

To join HealthTeam Advantage Vitality (PPO) Health Plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in North Carolina: **Alamance, Alexander, Alleghany, Anson, Bladen, Brunswick, Cabarrus, Caswell, Chatham, Columbus, Davidson, Davie, Durham, Forsyth, Gaston, Guilford, Iredell, Lincoln, Mecklenburg, Montgomery, New Hanover, Orange, Pender, Person, Randolph, Richmond, Rockingham, Rowan, Scotland, Stokes, Union, Wilkes, and Yadkin**.

HealthTeam Advantage has a network of doctors, hospitals, pharmacies and other providers. If you use the providers in our network, you may pay less for your covered services. You also have the option of using providers outside the network, however you will have higher costs associated with those visits and services.

For more information, contact HealthTeam Advantage at 1-888-965-1965 (TTY 711) from 8 a.m. to 8 p.m. Eastern, 7 days a week from October 1 – March 31, and 8 a.m. to 8 p.m. Eastern, Monday through Friday, April 1 – September 30, or visit online at www.htanc.com.

Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our customer service number or see the Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

HealthTeam Advantage, a product of Care N' Care Insurance Company of North Carolina, Inc., is a PPO and HMO Medicare Advantage plan with a Medicare contract. Enrollment in HealthTeam Advantage depends on contract renewal. H9808-2517_M

Premiums and Benefits	HealthTeam Advantage Vitality Plan (PPO)
Monthly Plan Premium	**$0** You must continue to pay your Medicare Part B premium. Part B Premium Reduction: **$3**
Deductible	**$0** This plan does not have a deductible for medical services.
Maximum Out-of-Pocket Responsibility *(does not include prescription drugs)*	**In-Network: $4,150** annually **Out-of-Network: $6,200** annually The most you pay for copays, coinsurance and other costs for Medicare-covered medical services, supplies, and Part B-covered medication for the plan year you receive from in- and out-of-network providers. What you pay out-of-pocket for Part D prescription drugs and certain supplemental benefits (e.g., dental, vision, and hearing aids) does not apply to this amount.
Inpatient Hospital Coverage	
	In-Network: **$335** copay per day for days 1 through 6 **$0** copay per day for days 7 through 90 **$0** copay for days 91 and beyond **Out-of-Network:** **40%** coinsurance per day per stay Our plan covers an unlimited number of days for an inpatient hospital stay. Prior authorization may be required.
Outpatient Hospital Coverage	
• Outpatient Hospital Facility	**In-Network: $300** copay **Out-of-Network: 40%** coinsurance Prior authorization may be required for some services. Please contact the plan for more information.

Premiums and Benefits *(continued)*	HealthTeam Advantage Vitality Plan (PPO)
Ambulatory Surgical Center (ASC)	
	In-Network: $200 copay per day **Out-of-Network: 40%** coinsurance Prior authorization may be required for some services. Please contact the plan for more information.
Doctor Visits	
• Primary Care Provider (PCP)	**In-Network: $0** copay **Out-of-Network: $50** copay
• Specialist	**In-Network: $30** copay **Out-of-Network: $75** copay
Preventive Care (e.g., flu vaccine, diabetic screenings)	
	In-Network: $0 copay **Out-of-Network: $30** copay Any additional preventive services approved by Medicare during the contract year will be covered. There are some items not covered at **$0** cost.
Emergency Care	
	In- and Out-of-Network: $140 copay If you are admitted to the hospital for the same condition within 3 days, the emergency copay is waived.
Urgently Needed Services	
	In- and Out-of-Network: $35 copay Copay is not waived if you are admitted to the hospital.

Premiums and Benefits *(continued)*	HealthTeam Advantage Vitality Plan (PPO)
Diagnostic Services/Imaging	
(Copay varies based on type of service)	
EKG Testing	**$0** copay
Ultrasound	**$75** copay
CT Scan	**$150** copay
MRI / MRA	**$225** copay
PET Scan	**$300** copay
Nuclear Stress Testing	**$225** copay
Echocardiography	**$75 - $150** copay
Therapeutic Radiological Services	**20%** coinsurance
Diagnostic Services/Labs	
• Diagnostic Radiology Services (such as Ultrasounds, MRIs, CT scans, and PET scans)	**In-Network: $0-$300** copay (Copay varies based on type of service.) **Out-of-Network: 40%** coinsurance
• Lab Services	**In-Network: $0** copay at a lab facility **In-Network: $10** copay at an outpatient hospital facility **Out-of-Network: 40%** coinsurance
• Diagnostic Tests and Procedures	**In-Network: $0** copay at a stand-alone facility **In-Network: $10** copay at an outpatient hospital facility **Out-of-Network: 40%** coinsurance Prior authorization may be required for some services. Please contact the plan for more information.
• Outpatient X-rays	**In-Network: $10** copay **Out-of-Network: 40%** coinsurance

Premiums and Benefits *(continued)*	HealthTeam Advantage Vitality Plan (PPO)
Hearing Services	
• Medicare-covered Diagnostic Hearing Exam	**In-Network: $30** copay **Out-of-Network: 40%** coinsurance
• Routine Assessment for Hearing Aids	**In-Network: $25** copay **Out-of-Network:** not covered 1 per year A TruHearing provider must be used for routine hearing benefits.
• Fitting and Evaluation for Hearing Aid	**In-Network: $0** copay **Out-of-Network:** not covered Unlimited visits A TruHearing provider must be used for routine hearing benefits.
• Hearing Aid	**In-Network:** **$299-$799** per hearing aid. Advanced and premium hearing aids are available in rechargeable style options for an additional **$50** per aid. **Out-of-Network:** Not covered Up to two TruHearing hearing aids every year (one per ear per year). A TruHearing provider must be used for hearing aid benefit.

Premiums and Benefits *(continued)*	**HealthTeam Advantage Vitality Plan (PPO)**
Dental Services (Dominion Dental Services, Inc.)	
Diagnostic and Preventive Services	**Office Visit Copay: $20** copay **Annual Deductible: $0** Deductible **Annual Benefit Maximum: Unlimited**
• Oral examinations (periodic and comprehensive) / 2 per year • Prophylaxis (cleanings) / 2 per year	Periodic and comprehensive oral exams, cleanings, and dental X-rays are covered. After the office visit copay, you pay **0%** coinsurance (in-network) and **50%** coinsurance (out-of-network). Diagnostic and Preventive dental services are not subject to a deductible or annual benefit maximum amount.
• Dental X-rays	Frequency and visit limits apply.
Optional Supplemental Comprehensive Dental Rider - $40/monthly premiium	
Diagnostic and Preventive Services	**Monthly Premium: $40** **Deductible: $0** Deductible **Annual Benefit Maximum: Unlimited** **Office Visit Copay: $0** copay
• Periodic oral evaluations • Prophylaxis (cleanings) • Bitewing X-rays • Comprehensive series of radiographic images • Periapical radiographic images • Extra-oral - 2D projection radiographics image	**In-Network: 0%** coinsurance **Out-of-Network: 50%** coinsurance
Comprehensive Dental Services	**Deductible: $50** Deductible **Annual Benefit Maximum: $2,000** (combined in- and out-of-network) **Office Visit Copay: $0** copay
• Other Diagnostic Services	**In-Network: 0%-20%** coinsurance **Out-of-Network: 50%** coinsurance
• Restorative Services • Periodontics (deep cleanings) • Oral and Maxillofacial Surgery (extractions)	**In-Network: 20%-50%** coinsurance **Out-of-Network: 50%** coinsurance
• Endodontics (root canals) • Prosthodontics (removeable and fixed) • Implants*	**In-Network: 50%** coinsurance **Out-of-Network: 50%** coinsurance
• Adjunctive General Services	**In-Network: 0%-50%** coinsurance **Out-of-Network: 50%** coinsurance
	Frequency and visit limits apply.

Implant coverage is limited to abutment supported porcelain and cast metal crowns and implant supported crowns.* ***The surgical placement of implant body is NOT a covered service.*

Premiums and Benefits *(continued)*	HealthTeam Advantage Vitality Plan (PPO)
Vision Services (VSP® Vision Care)	
• Medicare-covered Diagnostic Eye Exam	**In-Network: $30** copay **Out-of-Network: 40%** coinsurance
• Medicare-covered Eyewear	**In-Network:** **$0** copay for Medicare-covered frames or contact lenses after cataract surgery. **Out-of-Network:** **$50** copay for Medicare-covered eyeglasses or contact lenses after cataract surgery. Materials covered up to Medicare-approved limits.
• Routine Eye Exam (non-Medicare covered)	**In-Network: $25** copay **Out-of-Network: 40%** coinsurance (One routine eye exam per year) 1 Routine eye exam per year (refraction included)
• Eyeglasses (lenses and frames)	**In- and Out-of-Network:** Reimbursed up to **$150** towards eyewear, including contact lenses. Single vision, lined bifocals, lined trifocals, and lenticular lenses are covered in full.
• Contact Lenses	**$60** copay for contact lens fitting/evaluation
• Lens Upgrades	Standard progressive lenses, scratch-resistant coating, polycarbonate lenses, and UV protection are covered in full upgrades. Members can use their eyewear allowance amount towards non-prescription sunglasses or non-prescription blue light filtering glasses.

Premiums and Benefits *(continued)*	HealthTeam Advantage Vitality Plan (PPO)
Mental Health Services	
Inpatient Hospital	**In-Network:** **$300** copay per day for days 1 through 8 **$0** copay per day for days 9 through 90 **Out-of-Network:** **40%** coinsurance Services require prior authorization.
Outpatient Individual Therapy Visit	**In-Network: $30** copay **Out-of-Network: 40%** coinsurance
Outpatient Group Therapy Visit	**In-Network: $30** copay **Out-of-Network: 40%** coinsurance
Skilled Nursing Facility	
	In-Network: **$0** copay per day for days 1 through 20 **$214** copay per day for days 21 through 100 **Out-of-Network:** **40%** coinsurance Our plan covers up to 100 days in a SNF. Services require prior authorization.

Premiums and Benefits *(continued)*	HealthTeam Advantage Vitality Plan (PPO)
Rehabilitation Services	
• Physical Therapy Visit	**In-Network: $10** copay **Out-of-Network: 40%** coinsurance
• Speech and Language Therapy Visit	**In-Network: $30** copay **Out-of-Network: 40%** coinsurance
• Occupational Therapy Visit	**In-Network: $30** copay **Out-of-Network: 40%** coinsurance
• Cardiac/Intensive Cardiac Rehab Services	**In-Network: $30** copay **Out-of-Network: 40%** coinsurance
• Pulmonary Rehab Services	**In-Network: $30** copay **Out-of-Network: 40%** coinsurance
Ambulance	
	In- and Out-of-Network: **$300** copay for Medicare-covered ground ambulance benefits per one-way trip. **$350** copay for Medicare-covered air ambulance benefits per one-way trip. Prior authorization required for non-emergency transportation.
Transportation	
	Not covered.
Medicare Part B Drugs	
	In-Network: 0%-20% coinsurance **Out-of-Network: 40%** coinsurance Prior authorization may be required.

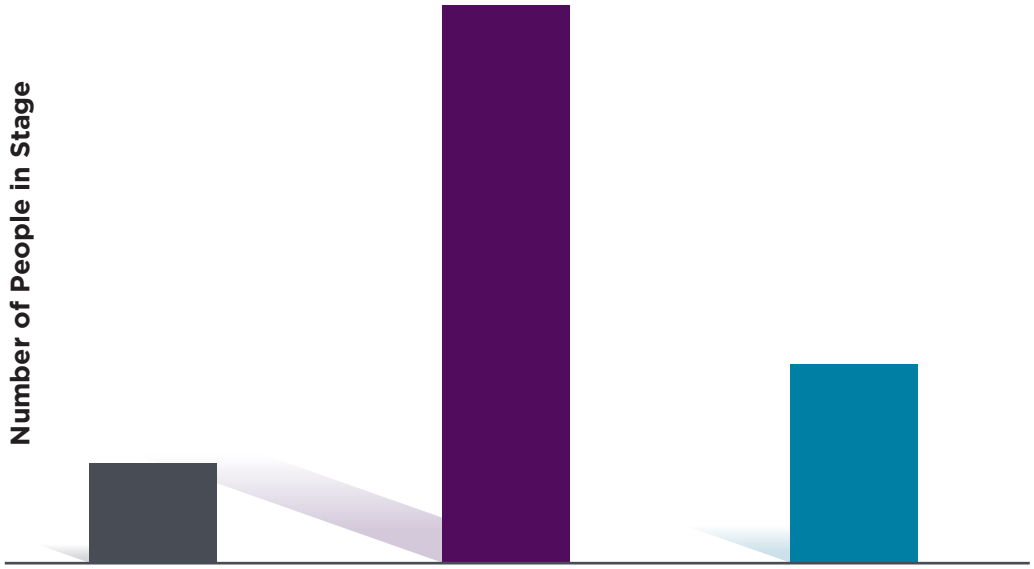
Premiums and Benefits *(continued)*	**HealthTeam Advantage Vitality Plan (PPO)**			
Outpatient Prescription Drugs				
Phase 1: Deductible	**$150** Deductible applies to Tiers 4 and 5 only.			
Phase 2: Initial Coverage	**In-Network Retail** (After you pay your deductible, if applicable)			
	Preferred Pharmacies		**Other Retail Pharmacies**	
	30-day supply	**100-day supply**	**30-day supply**	**100-day supply**
Tier 1 - Preferred Generics	**$0** copay	**$0** copay	**$10** copay	**$25** copay
Tier 2 - Generics	**$5** copay	**$12.50** copay	**$20** copay	**$50** copay
Tier 3 - Preferred Brands	**$47** copay	**$117.50** copay	**$47** copay	**$ 117.50** copay
Tier 4 - Non-Preferred Drugs	**40%** coinsurance	**40%** coinsurance	**50%** coinsurance	**50%** coinsurance
Tier 5 - Specialty Drugs	**30%** coinsurance	**30%** coinsurance	**30%** coinsurance	**30%** coinsurance
	In-Network Mail Order (After you pay your deductible, if applicable)			
	Mail Order			
	30-day supply		**100-day supply**	
Tier 1 - Preferred Generics	**$0** copay		**$0** copay	
Tier 2 - Generics	**$5** copay		**$12.50** copay	
Tier 3 - Preferred Brands	**$47** copay		**$117.50** copay	
Tier 4 - Non-Preferred Drugs	**40%** coinsurance		**40%** coinsurance	
Tier 5 - Specialty Drugs	**30%** coinsurance		**30%** coinsurance	
	You won't pay more than **$35** for a one-month supply of each covered insulin product regardless of the cost-sharing tier. **Once your out-of-pocket costs reach $2,000 (2025), you move to catastrophic coverage.**			
Phase 3: Catastrophic Coverage (After your out-of- pocket costs have reached the **$2,000** limit for the calendar year)	In this stage, the plan pays the full cost for your covered Part D drugs. You pay nothing. (See the EOC for details). **The plan and Medicare pay the rest until the end of the calendar year.**			

** For more information regarding our 2025 preferred pharmacy locations, please see your Evidence of Coverage.*

Premiums and Benefits *(continued)*	HealthTeam Advantage Vitality Plan (PPO)
Over-the-Counter (OTC) Items	
	$60/Quarter Allowance per quarter for OTC items. Any unused portion can be carried forward to the next quarter. This benefit ends on 12/31/25. Any unused funds cannot be carried forward to the new plan year.
Foot Care (podiatry services)	
• Foot Exams and Treatment	**In-Network: $30** copay **Out-of-Network: 40%** coinsurance
• Routine Foot Care	**In-Network: $30** copay **Out-of-Network: 40%** coinsurance Limited to 2 visits per year
Medical Equipment/Supplies	
• Durable Medical Equipment (e.g., wheelchairs, oxygen, braces)	**In-Network: 20%** coinsurance **Out-of-Network: 40%** coinsurance Services require prior authorization.
• Prosthetics (e.g., artificial limbs)	**In-Network: 20%** coinsurance **Out-of-Network: 40%** coinsurance Services require prior authorization.
• Diabetes Supplies	**In-Network:** **$0** copay for preferred and **20%** coinsurance for non-preferred **Out-of-Network: 40%** coinsurance Diabetic Supplies and Services limited to those from the following preferred manufacturers: - Blood Glucose Meter and testing supplies - One Touch - Continuous Glucose Monitor and supplies - FreeStyle Libre Systems Prior authorization required for non-preferred. **In-Network:** **$0** copay for one pair of Medicare-covered therapeutic shoes and up to two pairs of inserts. **Out-of-Network: 40%** coinsurance

Premiums and Benefits *(continued)*	HealthTeam Advantage Vitality Plan (PPO)
Fitness Benefit	
• Physical Fitness (SilverSneakers)	**SilverSneakers: $0** copay HealthTeam Advantage covers the full cost of this benefit through participating SilverSneakers fitness locations. SilverSneakers fitness program offers access to thousands of fitness locations nationwide. SilverSneakers also provides virtual resources and a mobile app.
• Memory Fitness (BrainHQ)	**BrainHQ: $0** copay Online program offered through BrainHQ with dozens of exercises to improve focus and memory.
• Fitness Allowance	**Fitness allowance:** You receive a **$75** quarterly fitness benefit allowance in addition to the SilverSneakers physical fitness benefit. This allowance is designed to help offset out-of-pocket fitness expenses. Eligible fitness items and services include: • Weights, exercise bands, exercise peddlers, yoga mats, and yoga balls • Wearable items such as fitness tracking devices • Personal trainers in a fitness facility • Fitness fees for activities such as pickleball, yoga, dance, or cycling Unused allowance amounts can be carried forward to the next quarter. Any used benefit dollars will expire at the end of the year.
Routine Chiropractic Care	
• Routine chiropractic manipulations, including maintenance and other services for indications other than subluxation.	**In-Network: $10** copay **Out-of-Network: 40%** coinsurance Limited to 18 visits per year.
Custodial Care	
• Home-Based Palliative and Custodial Care	**In-Network and Out-of-Network: $0** copay Up to 20 hours post-inpatient discharge or qualifying outpatient procedure, maximum of 60 hours annually. Prior authorization is required for some services. Please contact the plan for more information.
In-Home Support/Companion Services	
	Not covered.
Additional Telehealth Services	
	$0-$30 copay (copay based on provider type) If you choose to receive services via telehealth, you must use an in-network provider that currently offers the service via telehealth. This benefit may not be offered by all providers. Check directly with your providers about the availability of telehealth services.

Understanding Medicare Drug Payment Stages



DEDUCTIBLE $150 Tiers 4 & 5	INITIAL Up to $2,000	CATASTROPHIC through the end of the year
Annual Deductible Stage During this stage, **you pay the full cost** of your Tier 4 Non-Preferred Drug and Tier 5 Specialty Drug. You stay in this stage until you have paid $150 for your Tier 4 Non-Preferred Drug and Tier 5 Specialty Drug deductible. During this stage, you pay no more than $35 per month for each insulin product.	**Initial Coverage Stage** During this stage, you pay a flat fee (copay) or a percentage of a drug's total cost (coinsurance) for each prescription you fill. During this stage, you pay no more than $35 per month for each insulin product. **Once your out-of-pocket costs reach $2,000 (2025) you move to catastrophic stage.**	**Catastrophic Coverage Stage** In this stage, the plan pays the full cost for your covered Part D drugs. You pay nothing. (See the EOC for details). **The plan and Medicare pay the rest until the end of the calendar year.**

HealthTeam Advantage, a product of Care N' Care Insurance Company of North Carolina, Inc., is a PPO and HMO Medicare Advantage plan with a Medicare contract. Enrollment in HealthTeam Advantage depends on contract renewal.

Non-Discrimination Notice

HealthTeam Advantage complies with applicable federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex. HealthTeam Advantage does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

HealthTeam Advantage:

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 your Healthcare Concierge at 888-965-1965 (TTY: 711) October 1-March 31, 8 a.m. to 8 p.m. ET, 7 days a week; April 1-September 30, 8 a.m. to 8 p.m. ET, Monday through Friday.

If you believe that HealthTeam Advantage has failed to provide these services or discriminated in another way based on race, color, national origin, age, disability, or sex, you can file a grievance with:

HealthTeam Advantage
Attn: Appeals and Grievances
300 East Wendover Avenue, Suite 121
Greensboro, NC 27401
888-965-1965, (TTY 711), or via fax at 800-845-4104

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Appeals and Grievances Department 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 https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf, by email OCRMail@hhs.gov, by phone 1-888-368-1019, TDD: 1-800-537-7697, or by mail U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201.

Get Help in Other Languages

If you need help or speak a non-English language, call 888-965-1965 TTY: 711, and you will be connected to an interpreter who will assist you at no cost.

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MULTI-PLAN_25110_C

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 1-888-965-1965. 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 1-888-965-1965. 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 1-888-965-1965 。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 1-888-965-1965 。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 1-888-965-1965. 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 1-888-965-1965. 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 1-888-965-1965 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 1-888-965-1965. 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 1-888-965-1965 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 1-888-965-1965 . 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 1-888-965-1965 . 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 1-888-965-1965 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 1-888-965-1965. 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 1-888-965-1965. 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 1-888-965-1965. 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 1-888-965-1965. Ta usługa jest bezpłatna.

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