WVU MEDICINE | MARSHALL HEALTH

Peak Advantage
MEDICARE PLANS

2024 MEDICARE COVERAGE GUIDE

Peak Advantage PPO Plans | West Virginia North Central

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Peak Advantage

MEDICARE PLANS

2024 SUMMARY OF BENEFITS

West Virginia:
North Central

Peak Advantage Vista (PPO)

H8947.2024.04.0021_C Accepted 9/18/23

Peak Advantage Vista (PPO) Medical Benefits

Premiums and Benefits	Coverage Details
Premiums How much do I need to pay monthly?	Part C Premium: You pay $0 per month. Part D Premium: You pay $0 per month. You must continue to pay your Medicare Part B premium.
Deductible How much do I need to pay before the plan pays?	This plan does not have a Part C deductible.
Maximum Out-of-Pocket costs What's the limit on how much I will pay for in-network or out-of-network services?	$7,000 per year for services from in-network providers $10,500 per year for in and out of network services combined
Inpatient Hospital Coverage[1] How long will my plan cover? How much do I pay?	In-network: ▪ After the Medicare-covered stay, $200 copay per day for days 1-3 ▪ $0 copay per day for days 4 - 90 ▪ $800 copay for 60 Lifetime Reserve days Out-of-Network: 35% of the total cost
Outpatient Hospital Coverage[1]	In-network: ▪ $275 per stay for covered hospital services. ▪ $175 per stay for covered observation services Out-of-Network: 35% of the total cost
Ambulatory Surgery Center[1]	In-network: $225 copay per visit Out-of-Network: 35% of the total cost
Doctor visits Primary Care Specialists[1]	 In-network: You pay $0 Out-of-network: 35% of the total cost In-network: You pay $25 per visit Out-of-network: 35% of the total cost
Preventive Care	In-network: You pay $0 Out-of-network: 35% of the total cost
Emergency Care	You pay $80 per visit. Your copay is waived if you are admitted to the hospital within 24 hours.
Urgently Needed Services	You pay $30 per visit

Services within this summary of benefits with a [1] may require prior authorization from our plan. Services with a [2] may require a referral from your doctor.

Premiums and Benefits	Coverage Details
Diagnostic Services / Labs / Imaging[1]	In-network: ▪ $0 copay for diagnostic tests and X-rays at your primary care provider's office. $25 copay if provided elsewhere ▪ $0 copay for some diagnostic ultrasound, mammography, and diagnostic bone density imaging ▪ $225 copay for all other Diagnostic Radiological Services (e.g., CT, MRI) Out-of-Network: 35% of the total cost
Hearing Services How much do I pay for Hearing Services or Hearing Aids?	In-network: ▪ $0 copay for diagnostic and routine exams ▪ $599 copay for advanced, 32-channel models ▪ $899 copay for premium, 48-channel models Out-of-Network: 35% of the total cost
Dental Services	Medicare-covered dental services & preventative dental: ▪ In-network: $0 copay per visit ▪ Out-of-Network: 35% of the total cost Comprehensive dental (e.g. fillings, dentures, oral surgery): 50% of the total cost in-network or out-of-network The plan covers up to $3,000 in dental services per year.

Vision Services	The plan covers up to $200 per year for vision services and eyewear.
	In-network:
	▪ You pay $0 for Medicare-covered vision services.
	▪ You pay $0 for routine eye exams.
	▪ You pay $0 every year for either:
	  ▪ One pair of eyeglasses (lenses and frames)
	  ▪ One pair of contact lenses
	Out-of-Network: 35% of the total cost

Mental Health Services[1] Inpatient Visit	In-network: ▪ After the Medicare-covered stay, $425 copay per day for days 1-3 ▪ $0 copay per day for days 4 - 90 ▪ $800 copay for 60 Lifetime Reserve days Out-of-Network: 35% of the total cost
Outpatient Visit	In-network: ▪ $40 copay for each individual or group therapy visit Out-of-Network: 35% of the total cost

Premiums and Benefits	Coverage Details
Skilled Nursing Facility[1] (SNF)	In-network: We cover up to 100 days in a SNF per benefit period. ▪ You pay $0 per day for days 1 – 20. ▪ You pay $196 per days for days 21 - 100. Out-of-Network: 35% of the total cost
Physical Therapy[1]	In-network: ▪ $10 copay for cardiac (heart) rehab services[2] ▪ $30 copay for: ▪ Occupational therapy ▪ Physical therapy ▪ Speech and language therapy Out-of-network: 35% of the total cost
Ambulance[1]	In-network: $290 copay per one-way trip by ground or air Out-of-network: 35% of the total cost Prior authorization required for non-emergency trips.
Transportation[1]	In-network: $0 copay for up to 24 one-way trips to plan approved locations per year
Medicare Part B Drugs[1]	In-network: ▪ $0 copay for Part B insulins and certain other Part B drugs ▪ 20% of the total cost for chemotherapy drugs Out-of-network: 35% of the total cost

Need to Know

The amount you pay for prescriptions may change depending on the pharmacy you choose and Part D benefit stage. For more information, please call us or visit www.medicare.peakhealth.org to find:

- The Provider & Pharmacy Directories
- The Formulary (list of covered drugs)
- The EOC - a complete list of benefits

Part D Prescription Drugs		
Part D Premium	You pay $0.	
Out-of-Pocket Cost Threshold What's the limit on how much I will pay?	Your yearly limit for Part D drugs in this plan is $8,000.	
Deductible Stage	No deductible (Your coverage begins on the effective date of your enrollment).	
Initial Coverage Stage	**You pay the following costs until your total yearly drug costs reach $5,030**	
	30 Day Supply at a Preferred Retailer	**Mail Order 90 Day Supply**
Tier 1 - Preferred Generic Drugs	$0.00	$0.00
Tier 2 - Generic Drugs	$0.00	$0.00
Tier 3 - Preferred Brand Drugs	$42.00	$126.00
Tier 4 – Non-Preferred Drugs	$95.00	$285.00
Tier 5 – Specialty Tier Drugs	33%	Mail order supply not available for Tier 5
Coverage Gap Stage	**You pay the following costs until your yearly out-of- pocket drug costs reach $8,000**	
	30 Day Supply at a Preferred Retailer	**Mail Order 90 Day Supply**
Tier 1 - Preferred Generic Drugs	$0.00	$0.00
Tier 2 - Generic Drugs	$0.00	$0.00
Tier 3 - Preferred Brand Drugs	You pay 25% of the cost for all other drugs and a portion of the dispensing fee.	
Tier 4 - Non-Preferred Drugs		
Tier 5 – Specialty Tier Drugs		
Catastrophic Coverage Stage	**Once your yearly out-of-pocket drug costs reach $8,000, you pay $0**	

Important Message About What You Pay for Insulin - You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

Bonus Benefits	Coverage Details
Acupuncture[1]	$25 copay per visit for up to 20 treatments per year
Chiropractic Care[1]	In-Network: $25 copay per visit for up to 10 routine chiropractic visits per year Out-of-network: 35% of the total cost
Flexible Spending Debit Card	$250 per year to use on healthcare expenses like copays at doctors, dentists or pharmacy
Over-the-Counter (OTC) Drugs and Supplies	$75 allowance every three months through our OTC mail order catalog
Routine Foot Care[1]	In-network: $25 copay per visit for up to 10 routine foot care visits per year Out-of-network: 35% of the total cost
Wellness Programs	You pay $0 for fitness center membership and classes at over 100 gyms across West Virginia through the One Pass® program.
Worldwide Coverage for Emergency Care	$95 copay per emergency care visit received outside of the United States

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-855-962-7325.

Understanding the Benefits

- ❒ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit www.medicare.peakhealth.org or call 1-855-962-7325 to view a copy of the EOC.
- ❒ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ❒ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ❒ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- ❒ You must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ❒ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2025.
- ❒ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services, the provider must agree to treat you. Except in an emergency or urgent situation, non- contracted providers may deny care. In addition, you will pay a higher copay for services received by non- contracted providers.

Verify Your Eligibility

In order to join Peak Advantage Vista (PPO) you must:

- ❒ Have both Medicare Part A and B
- ❒ Be a U.S. citizen or lawfully present in the country
- ❒ Continue to pay your Medicare Part B premium
- ❒ Live in the West Virgina counties of Barbour, Boone, Braxton, Calhoun, Doddridge, Gilmer, Grant, Harrison, Lewis, Marion, Marshall, Monongalia, Ohio, Pendleton, Pleasants, Pocahontas, Preston, Ritchie, Roane, Taylor, Tucker, Tyler, Upshur, Wetzel, or Wirt.

Peak Advantage
MEDICARE PLANS

www.medicare.peakhealth.org

Member Services:
1-855-962-7325 / TTY 711

Hours:
October 1 - March 31: 8am - 8pm, 7 days a week
April 1 - September 30: 8am - 8pm Monday - Friday

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook, or view it online at www.medicare.gov. This information is not a complete description of benefits. Call 1-855-962-7325/TTY 711 for more information. Out-of-network/non-contracted providers are under no obligation to treat Peak Advantage Plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost- sharing that applies to out-of-network services.

Peak Advantage Vista is a PPO with a Medicare contract. Enrollment in Peak Advantage Vista (PPO) depends on contract renewal. Peak Advantage Vista (PPO) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

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Peak Advantage

MEDICARE PLANS

2024 SUMMARY OF BENEFITS

West Virginia:
North Central

Peak Advantage Summit (PPO)

H8947.2024.04.0022_C Accepted 9/18/23

Peak Advantage Summit (PPO) Medical Benefits

Premiums and Benefits	Coverage Details
Premiums How much do I need to pay monthly?	Part C Premium: You pay $0 per month. Part D Premium: You pay $18.00 per month. You must continue to pay your Medicare Part B premium.
Deductible How much do I need to pay before the plan pays?	This plan does not have a Part C deductible.
Maximum Out-of-Pocket costs What's the limit on how much I will pay for in-network or out-of-network services?	$6,250 per year for services from in-network providers $9,550 per year for in and out of network services combined
Inpatient Hospital Coverage[1] How long will my plan cover? How much do I pay?	In-network: ▪ $350 per hospital stay up to 90 days ▪ $800 copay for 60 Lifetime Reserve days Out-of-Network: 35% of the total cost
Outpatient Hospital Coverage[1]	In-network: ▪ $250 per stay for covered hospital services. ▪ $200 per stay for covered observation services Out-of-Network: 35% of the total cost
Ambulatory Surgery Center[1]	In-network: $200 copay per visit Out-of-Network: 35% of the total cost
Doctor visits Primary Care Specialists[1]	 In-network: You pay $0. Out-of-network: 35% of the total cost In-network: You pay $20 per visit. Out-of-network: 35% of the total cost
Preventive Care	In-network: You pay $0. Out-of-network: 35% of the total cost
Emergency Care	You pay $75 per visit. Your copay is waived if you are admitted to the hospital within 24 hours.
Urgently Needed Services	You pay $25 per visit.

Services within this summary of benefits with a [1] may require prior authorization from our plan. Services with a [2] may require a referral from your doctor.

Premiums and Benefits	Coverage Details
Diagnostic Services / Labs / Imaging[1]	In-network: ▪ $0 copay for diagnostic tests and X-rays at your primary care provider's office. $20 copay if provided elsewhere ▪ $0 copay for some diagnostic ultrasound, mammography, and diagnostic bone density imaging ▪ $200 copay for all other Diagnostic Radiological Services (e.g., CT, MRI) Out-of-Network: 35% of the total cost
Hearing Services How much do I pay for Hearing Services or Hearing Aids?	In-network: ▪ $0 copay for diagnostic and routine exams ▪ $599 copay for advanced, 32-channel models ▪ $899 copay for premium, 48-channel models Out-of-Network: 35% of the total cost
Dental Services	Medicare-covered dental services & preventative dental: ▪ In-network: $0 copay per visit ▪ Out-of-Network: 35% of the total cost Comprehensive dental (e.g. fillings, dentures, oral surgery): 50% of the total cost in-network or out-of-network The plan covers up to $3,500 in dental services per year.
Vision Services	The plan covers up to $200 per year for vision services and eyewear. In-network: ▪ You pay $0 for Medicare-covered vision services. ▪ You pay $0 for routine eye exams. ▪ You pay $0 every year for either: ▪ One pair of eyeglasses (lenses and frames) ▪ One pair of contact lenses Out-of-Network: 35% of the total cost
Mental Health Services[1] Inpatient Visit	In-network: ▪ After the Medicare-covered stay, $400 copay per day for days 1-3 ▪ $0 copay per day for days 4 - 90 ▪ $800 copay for 60 Lifetime Reserve days Out-of-Network: 35% of the total cost
Outpatient Visit	In-network: ▪ $30 copay for each individual or group therapy visit Out-of-Network: 35% of the total cost

Premiums and Benefits	Coverage Details
Skilled Nursing Facility[1] (SNF)	In-network: We cover up to 100 days in a SNF per benefit period. ▪ You pay $0 per day for days 1 – 20. ▪ You pay $196 per days for days 21 - 100. Out-of-Network: 35% of the total cost
Physical Therapy[1]	In-network: ▪ $10 copay for cardiac (heart) rehab services[2] ▪ $20 copay for: ▪ Occupational therapy ▪ Physical therapy ▪ Speech and language therapy Out-of-network: 35% of the total cost
Ambulance[1]	In-network: $250 copay per one-way trip by ground or air Out-of-network: 35% of the total cost Prior authorization required for non-emergency trips.
Transportation[1]	In-network: $0 copay for up to 36 one-way trips to plan approved locations per year
Medicare Part B Drugs[1]	In-network: ▪ $0 copay for Part B insulins and certain other Part B drugs ▪ 20% of the total cost for chemotherapy drugs Out-of-network: 35% of the total cost

Need to Know

The amount you pay for prescriptions may change depending on the pharmacy you choose and Part D benefit stage. For more information, please call us or visit www.medicare.peakhealth.org to find:

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- The Formulary (list of covered drugs)
- The EOC - a complete list of benefits

Part D Prescription Drugs		
Part D Premium	You pay $18.	
Out-of-Pocket Cost Threshold What's the limit on how much I will pay?	Your yearly limit for Part D drugs in this plan is $8,000.	
Deductible Stage	No deductible (Your coverage begins on the effective date of your enrollment).	
Initial Coverage Stage	**You pay the following costs until your total yearly drug costs reach $5,030**	
	30 Day Supply at a Preferred Retailer	**Mail Order 90 Day Supply**
Tier 1 - Preferred Generic Drugs	$0.00	$0.00
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Tier 4 - Non-Preferred Drugs		
Tier 5 – Specialty Tier Drugs		
Catastrophic Coverage Stage	**Once your yearly out-of-pocket drug costs reach $8,000, you pay $0**	

Important Message About What You Pay for Insulin - You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

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Flexible Spending Debit Card	$300 per year to use on healthcare expenses like copays at doctors, dentists or pharmacy
Over-the-Counter (OTC) Drugs and Supplies	$120 allowance every three months through our OTC mail order catalog
Routine Foot Care[1]	In-network: $20 copay per visit for up to 10 routine foot care visits per year Out-of-network: 35% of the total cost
Wellness Programs	You pay $0 for fitness center membership and classes at over 100 gyms across West Virginia through the One Pass® program.
Worldwide Coverage for Emergency Care	$95 copay per emergency care visit received outside of the United States

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- ❒ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ❒ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ❒ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- ❒ You must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ❒ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2025.
- ❒ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services, the provider must agree to treat you. Except in an emergency or urgent situation, non- contracted providers may deny care. In addition, you will pay a higher copay for services received by non- contracted providers.

Verify Your Eligibility

In order to join Peak Advantage Summit (PPO) you must:

- ❒ Have both Medicare Part A and B
- ❒ Be a U.S. citizen or lawfully present in the country
- ❒ Continue to pay your Medicare Part B premium
- ❒ Live in the West Virgina counties of Barbour, Boone, Braxton, Calhoun, Doddridge, Gilmer, Grant, Harrison, Lewis, Marion, Marshall, Monongalia, Ohio, Pendleton, Pleasants, Pocahontas, Preston, Ritchie, Roane, Taylor, Tucker, Tyler, Upshur, Wetzel, or Wirt.

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MEDICARE PLANS

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April 1 - September 30: 8am - 8pm Monday - Friday

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook, or view it online at www.medicare.gov. This information is not a complete description of benefits. Call 1-855-962-7325/TTY 711 for more information. Out-of-network/non-contracted providers are under no obligation to treat Peak Advantage Plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost- sharing that applies to out-of-network services.

Peak Advantage Summit is a PPO with a Medicare contract. Enrollment in Peak Advantage Summit (PPO) depends on contract renewal. Peak Advantage Summit (PPO) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

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Peak Advantage
MEDICARE PLANS

Peak Advantage Covers Many of the Most Commonly Used Drugs

ALBUTEROL SULFATE HFA
ALENDRONATE
ALLOPURINOL
ALPRAZOLAM
AMLODIPINE
AMOXICILLIN
AMOXICILLIN/CLAVULANATE
ATENOLOL
ATORVASTATIN
AZITHROMYCIN
BACLOFEN
BUPROPION ER
CARVEDILOL
CELECOXIB
CEPHALEXIN
CIPROFLOXACIN
CITALOPRAM
CLONAZEPAM
CLONIDINE
CLOPIDOGREL
CYCLOBENZAPRINE
DICLOFENAC
DILTIAZEM ER
DONEPEZIL
DOXYCYCLINE HYCLATE
DULOXETINE
ELIQUIS
ENALAPRIL
ESCITALOPRAM
ESOMEPRAZOLE DR
ESTRADIOL
EZETIMIBE
FAMOTIDINE
FENOFIBRATE
FINASTERIDE
FLUOXETINE
FLUTICASONE PROPIONATE
FOLIC ACID
FUROSEMIDE
GABAPENTIN
GLIMEPIRIDE
GLIPIZIDE
GLIPIZIDE ER
GLYBURIDE
HYDRALAZINE
HYDROCHLOROTHIAZIDE
IBUPROFEN
IRBESARTAN
ISOSORBIDE MONONITRATE ER
JANUVIA
JARDIANCE
KETOCONAZOLE
LANTUS SOLOSTAR
LATANOPROST
LEVOTHYROXINE
LISINOPRIL
LISINOPRIL/HCTZ
LORAZEPAM
LOSARTAN
LOSARTAN/HCTZ
LOVASTATIN
MELOXICAM
MEMANTINE
METFORMIN
METFORMIN ER
METOPROLOL SUCCINATE ER
METOPROLOL TARTRATE
MIRTAZAPINE
MODERNA COVID-19 VACCINE
MONTELUKAST
NIFEDIPINE ER
OMEPRAZOLE
OXYBUTYNIN CHLORIDE ER
PANTOPRAZOLE
PFIZER-BIONTECH COVID-19
POTASSIUM CHLORIDE ER
PRAMIPEXOLE
PRAVASTATIN
PREDNISOLONE ACETATE
PREDNISONE
PREGABALIN
PROPRANOLOL
QUETIAPINE
ROSUVASTATIN
SERTRALINE
SHINGRIX
SIMVASTATIN
SMZ/TMP
SPIRONOLACTONE
TAMSULOSIN
TRAMADOL
TRAZODONE
TRELEGY ELLIPTA
TRIAMCINOLONE ACETONIDE
TRIAMTERENE/HCTZ
TRULICITY
VENTOLIN HFA
WARFARIN
XARELTO
ZOLPIDEM

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Scope of Sales Appointment Confirmation Form

The Centers for Medicare and Medicaid Services (CMS) requires agents to document the scope of a marketing appointment prior to any face-to-face sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his/her authorized representative.

Please mark beside the type of product(s) you want the agent to discuss.

Medicare Advantage Prescription Drug Plans (Part C)

☐ Medicare Preferred Provider Organization (PPO) Plan — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and includes Part D prescription drug coverage. PPOs have network doctors and hospitals but you can also use out-of-network providers, usually at a higher cost.

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above. Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the Federal government. This individual may also be paid based on your enrollment in a plan. Signing this form does NOT obligate you to enroll in a plan, affect your current or future enrollment, or automatically enroll you in a Medicare plan.

Beneficiary or Authorized Representative Signature and Signature Date:	
Signature:	Date:
If you are the authorized representative, please sign above and print below:	
Representative Name:	Your Relationship to the Beneficiary:

To be completed by Agent:	
Agent Name:	Agent Phone:
Beneficiary Name:	Beneficiary Phone:
Beneficiary Address:	
Initial Method of Contact: (Indicate here if beneficiary was a walk-in.)	
Agent Signature:	Date Appointment Completed:
Plan(s) Represented During this Meeting:	
Agent, if the form was signed by the beneficiary at time of appointment, provide explanation why SOA was not documented prior to meeting:	

We are not connected with or endorsed by the United States government or the federal Medicare program. We do not offer every plan available in your area. Please contact Medicare.gov, 1-800-MEDICARE, or your local State Health Insurance Program (SHIP) to get information on all of your options. Scope of Appointment (SOA) documentation is subject to CMS record retention requirements. Peak Health Insurance Corporation is a PPO plan with a Medicare Contract. Enrollment in Peak Health Insurance depends on contract renewal.

H8947.2024.04.0016_C

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit Medicare.gov to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional — you can't be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:
Peak Advantage Vista (PPO)
1085 Van Voorhis Rd
Suite 300
Morgantown, WV 26505

Once they process your request to join, they'll contact you.

How do I get help with this form?

Call Peak Advantage Vista (PPO) at 1-855-962-7325. TTY users can call 711.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a Peak Advantage Vista (PPO) al 1-855-962-7325/TTY 711 o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

Individuals experiencing homelessness

- If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

Section 1 – All fields on this page are required (unless marked optional)

Select the plan you want to join:

☐ Peak Advantage Vista (PPO) North Central West Virginia – $0 per month

FIRST name:	LAST name:	Optional: Middle Initial:
Birth date: (MM/DD/YYYY) (/ /)	Sex: ☐ Male ☐ Female	Phone number: ( )

Permanent Residence street address (Don't enter a PO Box):

City:	County:	State:	ZIP Code:

Mailing address, if different from your permanent address (PO Box allowed):
Street address: City: State: ZIP Code:

Your Medicare information:

Medicare Number: _ _ _ _ - _ _ _ - _ _ _ _

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Peak Advantage Vista (PPO)? ☐ Yes ☐ No

Name of other coverage: _____ Member number for this coverage: _____ Group number for this coverage _____

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Peak Advantage Vista (PPO).
- By joining this Medicare Advantage, I acknowledge that Peak Advantage Vista (PPO) will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my Peak Advantage Vista (PPO) coverage begins, I must get all of my medical and prescription drug benefits from Peak Advantage Vista (PPO). Benefits and services provided by Peak Advantage Vista (PPO) and contained in my Peak Advantage Vista (PPO) "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Peak Advantage Vista (PPO) will pay for benefits or services that are not covered.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
  1) This person is authorized under State law to complete this enrollment, and
  2) Documentation of this authority is available upon request by Medicare.

Signature:	**Today's date:**
If you're the authorized representative, sign above and fill out these fields:	
Name:	Address:
Phone number:	Relationship to enrollee:

Section 2 – All fields on this page are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ **I choose not to answer.**

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Black or African American
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian or Chamorro
- ☐ Japanese
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ Vietnamese
- ☐ White
- ☐ **I choose not to answer.**

Select one if you want us to send you information in an accessible format.

☐ Braille ☐ Large print ☐ Audio CD

Please contact Peak Advantage Vista (PPO) at 1-855-962-7325 if you need information in an accessible format other than what's listed above. Our office hours are 10/1-3/31 8am-8pm EST, 7 days a week. 4/1-9/30 Monday - Friday from 8am-8pm EST. TTY users can call 711.

Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No

List your Primary Care Physician (PCP), clinic, or health center:

I want to get the following materials via email. Select one or more.

- ☐ Authorization of Representative Form
- ☐ HIPAA Personal Representative Designation Form
- ☐ Member Claim Form
- ☐ Member Complaint and Appeal Form

E-mail address:

Section 3 Attestation

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- ☐ I am new to Medicare.
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date) _____
- ☐ I recently was released from incarceration. I was released on (insert date) _____
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____
- ☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) _____
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) _____
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) _____
- ☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- ☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on (insert date) _____
- ☐ I recently left a PACE program on (insert date) _____
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____
- ☐ I am leaving employer or union coverage on (insert date). _____
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) _____
- ☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) _____
- ☐ I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

If none of these statements applies to you or you're not sure, please contact Peak Health at 1-866-434-1530 (TTY users should call 711) to see if you are eligible to enroll. We are open 8 AM – 8 PM EST 7 days a week 10/1/23 to 3/31/24 and 8 AM to 8 PM EST Monday – Friday 4/1/24 to 9/30/24.

Office Use Only	
Name of staff member/agent/broker (if assisted in enrollment): _____ Plan ID #: H8947-001-001 Effective Date of Coverage: _____ ICEP/IEP _____ AEP _____ SEP (type) _____ Not Eligible _____	
Note to Agents: Paper applications must be keyed into our enrollment portal or submitted to the managing or general agency within 24 hours of accepting the paper enrollment.	
Date Application Received by Agent:	Date Application Received by FMO/MGA/GA:
Producer 4 Digit ID	Producer NPN
Producer Phone Number:	Producer Email:
I helped the applicant by partially or completely filling out this application: • Yes • No	
This app was written in the following setting: □ In-Home □ Telesales □ Clinic □ Marketing Event □ Phone	
Producing Agent Signature:	Date:

PRIVACY ACT STATMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit Medicare.gov to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional — you can't be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:
Peak Advantage Summit (PPO)
1085 Van Voorhis Rd
Suite 300
Morgantown, WV 26505

Once they process your request to join, they'll contact you.

How do I get help with this form?

Call Peak Advantage Summit (PPO) at 1-855-962-7325. TTY users can call 711.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a Peak Advantage Summit (PPO) al 1-855-962-7325/TTY 711 o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

Individuals experiencing homelessness

- If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

Section 1 – All fields on this page are required (unless marked optional)

Select the plan you want to join:

Peak Advantage Summit (PPO) North Central West Virginia – $18 per month

FIRST name:	LAST name:	Optional: Middle Initial:

Birth date: (MM/DD/YYYY) (/ /)	Sex: ☐ Male ☐ Female	Phone number: ( )

Permanent Residence street address (Don't enter a PO Box):

City:	County:	State:	ZIP Code:

Mailing address, if different from your permanent address (PO Box allowed):
Street address: City: State: ZIP Code:

Your Medicare information:

Medicare Number: _ _ _ _ - _ _ _ - _ _ _ _

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Peak Advantage Summit (PPO)? ☐ Yes ☐ No

Name of other coverage: _____ Member number for this coverage: _____ Group number for this coverage _____

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Peak Advantage Summit (PPO).
- By joining this Medicare Advantage, I acknowledge that Peak Advantage Summit (PPO) will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my Peak Advantage Summit (PPO) coverage begins, I must get all of my medical and prescription drug benefits from Peak Advantage Summit (PPO). Benefits and services provided by Peak Advantage Summit (PPO) and contained in my Peak Advantage Summit (PPO) "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Peak Advantage Summit (PPO) will pay for benefits or services that are not covered.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
  1) This person is authorized under State law to complete this enrollment, and
  2) Documentation of this authority is available upon request by Medicare.

Signature:	**Today's date:**
If you're the authorized representative, sign above and fill out these fields:	
Name:	Address:
Phone number:	Relationship to enrollee:

Section 2 – All fields on this page are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ **I choose not to answer.**

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Black or African American
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian or Chamorro
- ☐ Japanese
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ Vietnamese
- ☐ White
- ☐ **I choose not to answer.**

Select one if you want us to send you information in an accessible format.

☐ Braille ☐ Large print ☐ Audio CD

Please contact Peak Advantage Summit (PPO) at 1-855-962-7325 if you need information in an accessible format other than what's listed above. Our office hours are 10/1-3/31 8am-8pm EST, 7 days a week. 4/1-9/30 Monday - Friday from 8am-8pm EST. TTY users can call 711.

Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No

List your Primary Care Physician (PCP), clinic, or health center:

I want to get the following materials via email. Select one or more.

- ☐ Authorization of Representative Form
- ☐ HIPAA Personal Representative Designation Form
- ☐ Member Claim Form
- ☐ Member Complaint and Appeal Form

E-mail address:

Section 3 Attestation

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- ☐ I recently was released from incarceration. I was released on (insert date) _____
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____
- ☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) _____
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) _____
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- ☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- ☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on (insert date) _____
- ☐ I recently left a PACE program on (insert date) _____
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____
- ☐ I am leaving employer or union coverage on (insert date). _____
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) _____
- ☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) _____
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Office Use Only	
Name of staff member/agent/broker (if assisted in enrollment): _____ Plan ID #: H8947-002-001 Effective Date of Coverage: _____ ICEP/IEP _____ AEP _____ SEP (type) _____ Not Eligible _____	
Note to Agents: Paper applications must be keyed into our enrollment portal or submitted to the managing or general agency within 24 hours of accepting the paper enrollment.	
Date Application Received by Agent:	Date Application Received by FMO/MGA/GA:
Producer 4 Digit ID	Producer NPN
Producer Phone Number:	Producer Email:
I helped the applicant by partially or completely filling out this application: • Yes • No	
This app was written in the following setting: □ In-Home □ Telesales □ Clinic □ Marketing Event □ Phone	
Producing Agent Signature:	Date:

PRIVACY ACT STATMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

Discrimination is Against the Law

Peak Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Peak Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Peak Health:

- 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 Service Phone Number on the front of you Member ID.

If you believe that Peak Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Peak Health
ATTN: Appeals and Grievances Department
1085 Van Voorhis Rd, Suite 300
Morgantown, WV 26505

1.855.962.7325
TTY Users Call: 711
Fax: (304) 974-3191

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Member Service Phone Number on the front of you Member ID.

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/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, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-855-962-7325. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-855-962-7325. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-855-962-7325。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-855-962-7325。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-855-962-7325. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-855-962-7325. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-855-962-7325 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-855-962-7325. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-855-962-7325번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-855-962-7325. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic[1]:
إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-855-962-7325 . سيقوم شخص بمساعدتك. هذه خدمة مجانية ما يتحدث العربية

Hindi[1]: हमारे स्वा य या दवा की योजना केबारे मेंआपकेकिसी भी पर न केजवाब देने केलिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलबध हैं. एक दुभाषिया पराफ्त करने केलिए, बस हमें1-855-962-7325 पर फोन करें. कोई वयिक्त 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 1-855-962-7325. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Português: 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 1-855-962-7325. 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 1-855-962-7325. 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 1-855-962-7325. 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、1-855-962-7325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。