

# SUMMARY OF BENEFITS

CAPITAL HEALTH PLAN

**Silver Advantage (HMO),  
Advantage Plus (HMO),  
Preferred Advantage (HMO) &  
Giveback Advantage (HMO)  
2027**

**LOCAL. TRUSTED.**



## 2027 Summary of Benefits

**Capital Health Plan Silver Advantage (008) (HMO)**

**Capital Health Plan Advantage Plus (001) (HMO)**

**Capital Health Plan Preferred Advantage (006) (HMO)**

**Capital Health Plan Giveback Advantage (009) (HMO)**

This is a summary of drug and health services covered by Capital Health Plan Silver Advantage (HMO), Capital Health Plan Advantage Plus (HMO), Capital Health Plan Preferred Advantage (HMO), and Capital Health Plan Giveback Advantage (HMO) January 1, 2027 – December 31, 2027.

Capital Health Plan is an HMO with a Medicare contract. Enrollment depends on contract renewal.

Capital Health Plan Silver Advantage (HMO), Capital Health Plan Advantage Plus (HMO), Capital Health Plan Preferred Advantage (HMO), and Capital Health Plan Giveback Advantage (HMO) are Medicare Advantage HMO plans (HMO stands for Health Maintenance Organization) approved by Medicare and run by a private company.

The benefit information provided is a summary of what we cover and what you pay when enrolled in one of these plans. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please request an “Evidence of Coverage” by calling Member Services at 1-877-247-6512 (TTY 711) Oct-Mar: seven days a week, 8am-8pm. Apr-Sept: Monday-Friday, 8am-8pm. Or you can view the Evidence of Coverage on our website at [www.capitalhealth.com/Medicare](http://www.capitalhealth.com/Medicare).

To join Capital Health Plan Silver Advantage (HMO), Capital Health Plan Advantage Plus (HMO), Capital Health Plan Preferred Advantage (HMO), and Capital Health Plan Giveback Advantage (HMO), you

- must be entitled to Medicare Part A;
- must be enrolled in Medicare Part B; and
- must live in our service area

Our service area includes the following counties in Florida: Calhoun, Franklin, Gadsden, Jefferson, Leon, Liberty, Madison, Taylor, and Wakulla.

Capital Health Plan has a large stable network of doctors, hospitals, pharmacies, and other providers. If you use providers that are not in our network, the plan may not pay for those services unless you receive prior authorization.

Urgently needed care and emergencies are covered anywhere in the world. You are not required to use Capital Health Plan providers or receive prior authorization in these circumstances.

Covered medical and hospital benefits may require prior authorization or a referral from your doctor. Services with a <sup>1</sup> may require prior authorization and services with a <sup>2</sup> may require a referral from your doctor.

## Premiums and Benefits

|                                                                                     | Capital Health Plan Silver Advantage (HMO) (008)                                                | Capital Health Plan Advantage Plus (HMO) (001)                                                  | Capital Health Plan Preferred Advantage (HMO) (006)                                             | Capital Health Plan Giveback Advantage (HMO) (009)                                              | What You Should Know                                                                |
|-------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|
| <b>Monthly Premium, Deductible and Limits</b>                                       |                                                                                                 |                                                                                                 |                                                                                                 |                                                                                                 |                                                                                     |
| <b>Monthly Plan Premium</b>                                                         | \$0                                                                                             | \$39                                                                                            | \$105                                                                                           | \$0                                                                                             |                                                                                     |
| <b>Part B Give Back</b>                                                             | Capital Health Plan will reduce your Medicare Part B premium by \$25                            |                                                                                                 |                                                                                                 | Capital Health Plan will reduce your Medicare Part B premium by \$100                           | You must continue to pay your Medicare Part B premium.                              |
| <b>Deductible</b>                                                                   | No deductible                                                                                   | No deductible                                                                                   | No deductible                                                                                   | No deductible                                                                                   |                                                                                     |
| <b>Maximum Out-of-Pocket Amount</b><br><i>(does not include prescription drugs)</i> | \$6,500                                                                                         | \$6,000                                                                                         | \$6,000                                                                                         | \$7,000                                                                                         | Includes copayments, coinsurance and other costs for medical services for the year. |
| <b>Hospital</b>                                                                     |                                                                                                 |                                                                                                 |                                                                                                 |                                                                                                 |                                                                                     |
| <b>Inpatient hospital coverage</b> <sup>1, 2</sup>                                  | \$300 copayment per day for days 1 through 7<br><br>\$0 copayment per day for days 8 through 92 | \$275 copayment per day for days 1 through 7<br><br>\$0 copayment per day for days 8 through 92 | \$200 copayment per day for days 1 through 5<br><br>\$0 copayment per day for days 6 through 92 | \$400 copayment per day for days 1 through 7<br><br>\$0 copayment per day for days 8 through 92 | You are covered for up to 2 days additional and 60 Lifetime Reverse Days.           |

|                                                                 | Capital Health Plan Silver Advantage (HMO) (008)                         | Capital Health Plan Advantage Plus (HMO) (001)                           | Capital Health Plan Preferred Advantage (HMO) (006)                      | Capital Health Plan Giveback Advantage (HMO) (009)                       | What You Should Know                                                                       |
|-----------------------------------------------------------------|--------------------------------------------------------------------------|--------------------------------------------------------------------------|--------------------------------------------------------------------------|--------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|
|                                                                 | \$2,100 out-of-pocket limit every stay                                   | \$1,925 out-of-pocket limit every stay                                   | \$1,000 out-of-pocket limit every stay                                   | \$2,800 out-of-pocket limit every stay                                   |                                                                                            |
| <b>Outpatient hospital coverage</b> <sup>2</sup>                | \$350 copayment                                                          | \$300 copayment                                                          | \$200 copayment                                                          | \$350 copayment                                                          |                                                                                            |
| <b>Ambulatory surgery center</b> <sup>2</sup>                   | \$275 copayment                                                          | \$200 copayment                                                          | \$150 copayment                                                          | \$275 copayment                                                          |                                                                                            |
| <b>Doctor Visits and Preventive Care</b>                        |                                                                          |                                                                          |                                                                          |                                                                          |                                                                                            |
| <b>Doctor visits</b>                                            |                                                                          |                                                                          |                                                                          |                                                                          |                                                                                            |
| Primary care provider                                           | \$0 copayment                                                            | \$0 copayment                                                            | \$0 copayment                                                            | \$0 copayment                                                            | You pay same copayment for PCP or select Specialist visits via Telehealth                  |
| Specialists <sup>2</sup>                                        | \$50 copayment                                                           | \$45 copayment                                                           | \$35 copayment                                                           | \$60 copayment                                                           |                                                                                            |
| <b>Preventive care</b> (e.g., flu vaccine, diabetic screenings) | There is no coinsurance, copayment, or deductible for preventative care. | There is no coinsurance, copayment, or deductible for preventative care. | There is no coinsurance, copayment, or deductible for preventative care. | There is no coinsurance, copayment, or deductible for preventative care. | Other preventive services are available. There are some covered services that have a cost. |
| <b>Emergency and Urgent Care</b>                                |                                                                          |                                                                          |                                                                          |                                                                          |                                                                                            |
| <b>Emergency care</b>                                           | \$130 copayment                                                          | \$130 copayment                                                          | \$130 copayment                                                          | \$130 copayment                                                          | If you are admitted to the hospital within 24 hours, the copayment is waived.              |
| <b>Urgently needed services</b>                                 | \$30 copayment                                                           | \$30 copayment                                                           | \$30 copayment                                                           | \$30 copayment                                                           |                                                                                            |

|                                                                                                      | Capital Health Plan Silver Advantage (HMO) (008)               | Capital Health Plan Advantage Plus (HMO) (001)                 | Capital Health Plan Preferred Advantage (HMO) (006)            | Capital Health Plan Giveback Advantage (HMO) (009)  | What You Should Know                                                             |
|------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|----------------------------------------------------------------|----------------------------------------------------------------|-----------------------------------------------------|----------------------------------------------------------------------------------|
| <b>Outpatient Diagnostic Tests, Radiation Therapy, X-rays and Labs</b>                               |                                                                |                                                                |                                                                |                                                     |                                                                                  |
| <b>Diagnostic services/labs/imaging</b>                                                              |                                                                |                                                                |                                                                |                                                     | You pay nothing for Medicare-covered diagnostic mammograms.                      |
| Diagnostic radiology services <sup>1,2</sup> (e.g. MRI, CT, PET, thallium, nuclear cardiology scans) | \$0 - \$150 copayment                                          | \$0 - \$150 copayment                                          | \$0 - \$150 copayment                                          | \$0 - \$150 copayment                               |                                                                                  |
| Lab services                                                                                         | You pay nothing for lab services                               | You pay nothing for lab services                               | You pay nothing for lab services                               | You pay nothing for lab services                    |                                                                                  |
| Diagnostic tests and procedures <sup>2</sup>                                                         | You pay nothing for diagnostic tests and procedures            | You pay nothing for diagnostic tests and procedures            | You pay nothing for diagnostic tests and procedures            | You pay nothing for diagnostic tests and procedures |                                                                                  |
| Outpatient X-rays <sup>2</sup>                                                                       | You pay nothing for outpatient x-rays                          | You pay nothing for outpatient x-rays                          | You pay nothing for outpatient x-rays                          | You pay nothing for outpatient x-rays               |                                                                                  |
| Therapeutic radiology <sup>2</sup>                                                                   | 20% coinsurance                                                | 20% coinsurance                                                | 20% coinsurance                                                | 20% coinsurance                                     |                                                                                  |
| <b>Hearing / Dental / Vision</b>                                                                     |                                                                |                                                                |                                                                |                                                     |                                                                                  |
| <b>Hearing services</b>                                                                              |                                                                |                                                                |                                                                |                                                     | One Medicare-covered hearing exam and one routine hearing exam allowed annually. |
| Routine hearing exam                                                                                 | \$50 copayment                                                 | \$45 copayment                                                 | \$35 copayment                                                 | \$60 copayment                                      |                                                                                  |
| Diagnostic exam                                                                                      | \$50 copayment                                                 | \$45 copayment                                                 | \$35 copayment                                                 | \$60 copayment                                      |                                                                                  |
| Hearing aids                                                                                         | Hearing aid coverage may be provided through your Choice Card. | Hearing aid coverage may be provided through your Choice Card. | Hearing aid coverage may be provided through your Choice Card. | Hearing aids are <u>not</u> covered                 |                                                                                  |

|                                                                                                                                    | Capital Health Plan Silver Advantage (HMO) (008)                                                                                                                                                             | Capital Health Plan Advantage Plus (HMO) (001)                                                                                                                                                               | Capital Health Plan Preferred Advantage (HMO) (006)                                                                                                                                                          | Capital Health Plan Giveback Advantage (HMO) (009)                                                                                                                                                           | What You Should Know                                                                                    |
|------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|
| <b>Hearing services (continued)</b>                                                                                                | (See CHP Choice Card for details).                                                                                                                                                                           | (See CHP Choice Card for details).                                                                                                                                                                           | (See CHP Choice Card for details).                                                                                                                                                                           |                                                                                                                                                                                                              |                                                                                                         |
| <b>Dental services</b> (limited dental services) <sup>1,2</sup>                                                                    | <p>\$50 copayment for Medicare-covered dental services.</p> <p>Additional coverage may be provided through your Choice Card. (See CHP Choice Card for details).</p>                                          | <p>\$45 copayment for Medicare-covered dental services.</p> <p>Additional coverage may be provided through your Choice Card. (See CHP Choice Card for details).</p>                                          | <p>\$35 copayment for Medicare-covered dental services.</p> <p>Additional coverage may be provided through your Choice Card. (See CHP Choice Card for details).</p>                                          | \$60 copayment for Medicare-covered dental services.                                                                                                                                                         | Does not include services in connection with care, treatment, filling, removal or replacement of teeth. |
| <b>Vision services</b><br><br>Diagnostic exam<br><br>Eyewear after cataract surgery<br><br>Routine eye exam<br><br>Routine eyewear | <p>\$10 or \$50 copayment</p> <p>You pay nothing for eyeglasses or contacts after cataract surgery (some limitations apply)</p> <p>\$10 or \$50 copayment</p> <p>Our plan pays up to \$200 reimbursement</p> | <p>\$10 or \$45 copayment</p> <p>You pay nothing for eyeglasses or contacts after cataract surgery (some limitations apply)</p> <p>\$10 or \$45 copayment</p> <p>Our plan pays up to \$200 reimbursement</p> | <p>\$10 or \$35 copayment</p> <p>You pay nothing for eyeglasses or contacts after cataract surgery (some limitations apply)</p> <p>\$10 or \$35 copayment</p> <p>Our plan pays up to \$200 reimbursement</p> | <p>\$10 or \$60 copayment</p> <p>You pay nothing for eyeglasses or contacts after cataract surgery (some limitations apply)</p> <p>\$10 or \$60 copayment</p> <p>Our plan pays up to \$200 reimbursement</p> | Copayments may vary depending on the place of service.                                                  |

|                                                           | Capital Health Plan Silver Advantage (HMO) (008)                                                                                                | Capital Health Plan Advantage Plus (HMO) (001)                                                                                                  | Capital Health Plan Preferred Advantage (HMO) (006)                                                                                             | Capital Health Plan Giveback Advantage (HMO) (009)                                                                                              | What You Should Know                                         |
|-----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|
| <b>Vision services (continued)</b>                        | every year for contact lenses or eyeglasses                                                                                                     | every year for contact lenses or eyeglasses                                                                                                     | every year for contact lenses or eyeglasses                                                                                                     | every year for contact lenses or eyeglasses                                                                                                     |                                                              |
| <b>Mental Health Services</b>                             |                                                                                                                                                 |                                                                                                                                                 |                                                                                                                                                 |                                                                                                                                                 |                                                              |
| <b>Outpatient group therapy/ individual therapy visit</b> | \$50 copayment                                                                                                                                  | \$45 copayment                                                                                                                                  | \$35 copayment                                                                                                                                  | \$60 copayment                                                                                                                                  |                                                              |
| <b>Skilled Nursing Facility (SNF)</b>                     |                                                                                                                                                 |                                                                                                                                                 |                                                                                                                                                 |                                                                                                                                                 |                                                              |
| <b>Skilled nursing facility (SNF) <sup>1,2</sup></b>      | \$10 copayment per day for days 1 through 20<br>\$200 copayment per day for days 21 through 100<br><br>Your plan covers up to 100 days in a SNF | \$10 copayment per day for days 1 through 20<br>\$200 copayment per day for days 21 through 100<br><br>Your plan covers up to 100 days in a SNF | \$10 copayment per day for days 1 through 20<br>\$200 copayment per day for days 21 through 100<br><br>Your plan covers up to 100 days in a SNF | \$10 copayment per day for days 1 through 20<br>\$200 copayment per day for days 21 through 100<br><br>Your plan covers up to 100 days in a SNF | Our plan covers up to 100 days in a SNF each benefit period. |
| <b>Outpatient Rehabilitation Services</b>                 |                                                                                                                                                 |                                                                                                                                                 |                                                                                                                                                 |                                                                                                                                                 |                                                              |
| <b>Physical therapy <sup>2</sup></b>                      | \$30 copayment                                                                                                                                  | \$20 copayment                                                                                                                                  | \$20 copayment                                                                                                                                  | \$30 copayment                                                                                                                                  |                                                              |
| <b>Medical Transportation</b>                             |                                                                                                                                                 |                                                                                                                                                 |                                                                                                                                                 |                                                                                                                                                 |                                                              |
| <b>Ambulance <sup>1</sup></b>                             | \$290 copayment                                                                                                                                 | \$290 copayment                                                                                                                                 | \$290 copayment                                                                                                                                 | \$290 copayment                                                                                                                                 | Our plan covers worldwide emergency transportation.          |

|                       | Capital Health<br>Plan Silver<br>Advantage<br>(HMO) (008)                                                                                                       | Capital Health<br>Plan Advantage<br>Plus (HMO) (001)                                                                                                            | Capital Health<br>Plan Preferred<br>Advantage<br>(HMO) (006)                                                                                                    | Capital Health<br>Plan Giveback<br>Advantage<br>(HMO) (009) | What You Should<br>Know |
|-----------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|-------------------------|
| <b>Transportation</b> | Transportation coverage may be provided through your CHP Choice Card where members can utilize their allowance to cover rides to and from medical appointments. | Transportation coverage may be provided through your CHP Choice Card where members can utilize their allowance to cover rides to and from medical appointments. | Transportation coverage may be provided through your CHP Choice Card where members can utilize their allowance to cover rides to and from medical appointments. | Not covered                                                 |                         |

|                              | Capital Health<br>Plan Silver<br>Advantage<br>(HMO) (008) | Capital Health<br>Plan Advantage<br>Plus (HMO) (001) | Capital Health<br>Plan Preferred<br>Advantage<br>(HMO) (006) | Capital Health<br>Plan Giveback<br>Advantage<br>(HMO) (009) | What You Should<br>Know |
|------------------------------|-----------------------------------------------------------|------------------------------------------------------|--------------------------------------------------------------|-------------------------------------------------------------|-------------------------|
| <b>Medicare Part B Drugs</b> |                                                           |                                                      |                                                              |                                                             |                         |
| Chemotherapy drugs           | 0% - 20%<br>coinsurance                                   | 0% - 20%<br>coinsurance                              | 0% - 20%<br>coinsurance                                      | 0% - 20%<br>coinsurance                                     |                         |
| Other Part B drugs           | 0% - 20%<br>coinsurance                                   | 0% - 20%<br>coinsurance                              | 0% - 20%<br>coinsurance                                      | 0% - 20%<br>coinsurance                                     |                         |
| Insulin                      | \$35 copayment                                            | \$35 copayment                                       | \$35 copayment                                               | \$35 copayment                                              |                         |

## Prescription Drug Benefits

**Important Message About What You Pay for Vaccines** - Our plan covers most Part D vaccines at no cost to you, no matter what cost-sharing tier it's on.

**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.

|                                                                            | Capital Health Plan Silver Advantage (HMO) (008)                                                                                                                           |               | Capital Health Plan Advantage Plus (HMO) (001)                                                                                                                             |               | Capital Health Plan Preferred Advantage (HMO) (006)                                                                                                                        |               | Capital Health Plan Giveback Advantage (HMO) (009)                                                                                                                         |               | What You Should Know                                                                                                        |
|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|-----------------------------------------------------------------------------------------------------------------------------|
| Stage 1: Deductible                                                        | You will pay a yearly deductible of \$550 on Tier 3, 4 and 5 drugs. You must pay the full cost of your Tier 3, 4 and 5 drugs until you reach the plan's deductible amount. |               | You will pay a yearly deductible of \$400 on Tier 3, 4 and 5 drugs. You must pay the full cost of your Tier 3, 4 and 5 drugs until you reach the plan's deductible amount. |               | You will pay a yearly deductible of \$300 on Tier 3, 4 and 5 drugs. You must pay the full cost of your Tier 3, 4 and 5 drugs until you reach the plan's deductible amount. |               | You will pay a yearly deductible of \$550 on Tier 3, 4 and 5 drugs. You must pay the full cost of your Tier 3, 4 and 5 drugs until you reach the plan's deductible amount. |               |                                                                                                                             |
| Stage 2: Initial coverage – Prior to total cost of drugs reaching \$2,400. |                                                                                                                                                                            |               |                                                                                                                                                                            |               |                                                                                                                                                                            |               |                                                                                                                                                                            |               |                                                                                                                             |
| Retail                                                                     | 30-day supply                                                                                                                                                              | 90-day supply | 30-day supply                                                                                                                                                              | 90-day supply | 30-day supply                                                                                                                                                              | 90-day supply | 30-day supply                                                                                                                                                              | 90-day supply |                                                                                                                             |
| Tier 1: Preferred Generic                                                  |                                                                                                                                                                            |               |                                                                                                                                                                            |               |                                                                                                                                                                            |               |                                                                                                                                                                            |               | <b>*Silver Advantage and Giveback Advantage have non-preferred and preferred pharmacies.</b><br><br>Cost sharing may change |
| Preferred cost-share                                                       | You pay \$0                                                                                                                                                                | You pay \$0   |                                                                                                                                                                            |               |                                                                                                                                                                            |               | You pay \$0                                                                                                                                                                | You pay \$0   |                                                                                                                             |
| Standard cost-share                                                        | You pay \$10                                                                                                                                                               | You pay \$30  | You pay \$0                                                                                                                                                                | You pay \$0   | You pay \$0                                                                                                                                                                | You pay \$0   | You pay \$10                                                                                                                                                               | You pay \$30  |                                                                                                                             |

|                               | Capital Health Plan<br>Silver Advantage<br>(HMO) (008) |                  | Capital Health Plan<br>Advantage Plus<br>(HMO) (001) |                  | Capital Health Plan<br>Preferred Advantage<br>(HMO) (006) |                  | Capital Health Plan<br>Giveback Advantage<br>(HMO) (009) |                  | What You<br>Should Know                                                                                                                                                                                                                                                                                                                                                                     |
|-------------------------------|--------------------------------------------------------|------------------|------------------------------------------------------|------------------|-----------------------------------------------------------|------------------|----------------------------------------------------------|------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Tier 2:<br>Generic            | You pay<br>\$0                                         | You pay<br>\$0   |                                                      |                  |                                                           |                  | You pay<br>\$0                                           | You pay<br>\$0   | when you enter<br>another phase of<br>the Part D<br>benefit.<br><br>For more<br>information on<br>the additional<br>pharmacy<br>specific cost-<br>sharing and the<br>phases of the<br>benefit, please<br>call us or see the<br>Evidence of<br>Coverage. Your<br>cost sharing may<br>differ for mail<br>order, Long Term<br>Care (LTC) or<br>home infusion,<br>and 60 or 90-day<br>supplies. |
| Preferred cost-share          |                                                        |                  |                                                      |                  |                                                           |                  |                                                          |                  |                                                                                                                                                                                                                                                                                                                                                                                             |
| Standard cost-share           | You pay<br>\$14                                        | You pay<br>\$42  | You pay<br>\$7                                       | You pay<br>\$21  | You pay<br>\$7                                            | You pay<br>\$21  | You pay<br>\$14                                          | You pay<br>\$42  |                                                                                                                                                                                                                                                                                                                                                                                             |
| Tier 3:<br>Preferred Brand    | You pay<br>25%                                         | You pay<br>25%   | You pay<br>\$45                                      | You pay<br>\$135 | You pay<br>\$45                                           | You pay<br>\$135 | You pay<br>25%                                           | You pay<br>25%   |                                                                                                                                                                                                                                                                                                                                                                                             |
| Tier 4:<br>Non-Preferred Drug | You pay<br>25%                                         | You pay<br>25%   | You pay<br>25%                                       | You pay<br>25%   | You pay<br>25%                                            | You pay<br>25%   | You pay<br>25%                                           | You pay<br>25%   |                                                                                                                                                                                                                                                                                                                                                                                             |
| Tier 5:<br>Specialty Tier     | You pay<br>25%                                         | Not<br>available | You pay<br>25%                                       | Not<br>available | You pay<br>25%                                            | Not<br>available | You pay<br>25%                                           | Not<br>available |                                                                                                                                                                                                                                                                                                                                                                                             |
| Tier 6:<br>Select Care Drugs  | You pay<br>\$0                                         | You pay<br>\$0   | You pay<br>\$0                                       | You pay<br>\$0   | You pay<br>\$0                                            | You pay<br>\$0   | You pay<br>\$0                                           | You pay<br>\$0   |                                                                                                                                                                                                                                                                                                                                                                                             |

|                               | Capital Health Plan<br>Silver Advantage<br>(HMO) (008) |                   | Capital Health Plan<br>Advantage Plus<br>(HMO) (001) |                     | Capital Health Plan<br>Preferred Advantage<br>(HMO) (006) |                     | Capital Health Plan<br>Giveback Advantage<br>(HMO) (009) |                   | What You<br>Should Know                                                                                                                         |
|-------------------------------|--------------------------------------------------------|-------------------|------------------------------------------------------|---------------------|-----------------------------------------------------------|---------------------|----------------------------------------------------------|-------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|
| Mail Order                    | 30-day<br>supply                                       | 90-day<br>supply  | 30-day<br>supply                                     | 90-day<br>supply    | 30-day<br>supply                                          | 90-day<br>supply    | 30-day<br>supply                                         | 90-day<br>supply  |                                                                                                                                                 |
| Tier 1:<br>Preferred Generic  | You pay<br>\$0                                         | You pay<br>\$0    | You pay<br>\$0                                       | You pay<br>\$0      | You pay<br>\$0                                            | You pay<br>\$0      | You pay<br>\$0                                           | You pay<br>\$0    | 30-day and 60-<br>day mail order<br>supplies are<br>available for all<br>but Tier 5 drugs.<br>A cost savings<br>applies to a 90-<br>day supply. |
| Tier 2:<br>Generic            | You pay<br>\$0                                         | You pay<br>\$0    | You pay<br>\$7                                       | You pay<br>\$17.50  | You pay<br>\$7                                            | You pay<br>\$17.50  | You pay<br>\$0                                           | You pay<br>\$0    |                                                                                                                                                 |
| Tier 3:<br>Preferred Brand    | You pay<br>25%                                         | You pay<br>25%    | You pay<br>\$45                                      | You pay<br>\$112.50 | You pay<br>\$45                                           | You pay<br>\$112.50 | You pay<br>25%                                           | You pay<br>25%    |                                                                                                                                                 |
| Tier 4:<br>Non-Preferred Drug | You pay<br>25%                                         | You pay<br>25%    | You pay<br>25%                                       | You pay<br>25%      | You pay<br>25%                                            | You pay<br>25%      | You pay<br>25%                                           | You pay<br>25%    |                                                                                                                                                 |
| Tier 5:<br>Specialty Tier     | Not<br>available                                       | Not<br>available  | Not<br>available                                     | Not<br>available    | Not<br>available                                          | Not<br>available    | Not<br>available                                         | Not<br>available  |                                                                                                                                                 |
|                               | 30-day<br>supply                                       | 100-day<br>supply | 30-day<br>supply                                     | 100-day<br>supply   | 30-day<br>supply                                          | 100-day<br>supply   | 30-day<br>supply                                         | 100-day<br>supply |                                                                                                                                                 |
| Tier 6:<br>Select Care Drugs  | You pay<br>\$0                                         | You pay<br>\$0    | You pay<br>\$0                                       | You pay<br>\$0      | You pay<br>\$0                                            | You pay<br>\$0      | You pay<br>\$0                                           | You pay<br>\$0    |                                                                                                                                                 |

|                                                                                                  | Capital Health Plan<br>Silver Advantage<br>(HMO) (008)                                                 | Capital Health Plan<br>Advantage Plus<br>(HMO) (001)                                                   | Capital Health Plan<br>Preferred Advantage<br>(HMO) (006)                                              | Capital Health Plan<br>Giveback Advantage<br>(HMO) (009)                                               | What You Should<br>Know |
|--------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|-------------------------|
| <b>Stage 3: Catastrophic Coverage</b> – After yearly total of out-of-pocket costs reach \$2,400. |                                                                                                        |                                                                                                        |                                                                                                        |                                                                                                        |                         |
|                                                                                                  | 30-day supply                                                                                          | 30-day supply                                                                                          | 30-day supply                                                                                          | 30-day supply                                                                                          |                         |
| All Tiers                                                                                        | During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing. | During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing. | During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing. | During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing. |                         |

#### Additional Benefits

|                            | Capital Health<br>Plan Silver<br>Advantage<br>(HMO) (008)                                                                                                                                   | Capital Health<br>Plan Advantage<br>Plus (HMO) (001)                                                                                                                                        | Capital Health<br>Plan Preferred<br>Advantage<br>(HMO) (006)                                                                                                                                | Capital Health<br>Plan Giveback<br>Advantage<br>(HMO) (009) | What You Should<br>Know                                                                                                  |
|----------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|
| <b>Additional Benefits</b> |                                                                                                                                                                                             |                                                                                                                                                                                             |                                                                                                                                                                                             |                                                             |                                                                                                                          |
| <b>CHP Choice Card</b>     | A supplemental spend debit card in the amount of <b>\$525</b> per year to help pay towards Dental Expenses, Over the Counter Items, Hearing Aids, Member Food Allowance, Personal Emergency | A supplemental spend debit card in the amount of <b>\$625</b> per year to help pay towards Dental Expenses, Over the Counter Items, Hearing Aids, Member Food Allowance, Personal Emergency | A supplemental spend debit card in the amount of <b>\$725</b> per year to help pay towards Dental Expenses, Over the Counter Items, Hearing Aids, Member Food Allowance, Personal Emergency | <u>Not</u> covered                                          | Some restrictions apply.<br><br>The food allowance benefit is only available to members who meet the SSBCI requirements. |

|                                                                                                                                                                                                                                                                  | Capital Health Plan Silver Advantage (HMO) (008)                                                                                                                                                                                                                                                                  | Capital Health Plan Advantage Plus (HMO) (001)                                                                                                                                                                                                                                                                    | Capital Health Plan Preferred Advantage (HMO) (006)                                                                                                                                                                                                                                                               | Capital Health Plan Giveback Advantage (HMO) (009)            | What You Should Know |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|----------------------|
| <b>CHP Choice Card (continued)</b>                                                                                                                                                                                                                               | <p>Response System (PERS), and Transportation Services.</p> <p>For over-the-counter items you can use your CHP Choice Card at Wal-Mart, CVS, Walgreens, Kroger, Rite Aid, Publix, and Albertson's. Participation is subject to change, please call 1-877-210-6729 for a full list of participating retailers.</p> | <p>Response System (PERS), and Transportation Services.</p> <p>For over-the-counter items you can use your CHP Choice Card at Wal-Mart, CVS, Walgreens, Kroger, Rite Aid, Publix, and Albertson's. Participation is subject to change, please call 1-877-210-6729 for a full list of participating retailers.</p> | <p>Response System (PERS), and Transportation Services.</p> <p>For over-the-counter items you can use your CHP Choice Card at Wal-Mart, CVS, Walgreens, Kroger, Rite Aid, Publix, and Albertson's. Participation is subject to change, please call 1-877-210-6729 for a full list of participating retailers.</p> |                                                               |                      |
| <b>Durable medical equipment, prosthetic devices and medical supplies</b><br><br>Durable medical equipment (e.g., wheelchairs, oxygen) <sup>1</sup><br><br>Medical supplies <sup>1</sup><br><br>Prosthetic devices (e.g., braces, artificial limbs) <sup>1</sup> | 20% coinsurance<br><br>20% coinsurance<br><br>20% coinsurance                                                                                                                                                                                                                                                     | 20% coinsurance<br><br>20% coinsurance<br><br>20% coinsurance                                                                                                                                                                                                                                                     | 20% coinsurance<br><br>20% coinsurance<br><br>20% coinsurance                                                                                                                                                                                                                                                     | 20% coinsurance<br><br>20% coinsurance<br><br>20% coinsurance |                      |

|                                                                                                                                                                                                                                                  | Capital Health Plan Silver Advantage (HMO) (008)                                                                                                                                                                                                                            | Capital Health Plan Advantage Plus (HMO) (001)                                                                                                                                                                                                                              | Capital Health Plan Preferred Advantage (HMO) (006)                                                                                                                                                                                                                         | Capital Health Plan Giveback Advantage (HMO) (009)                                                                                                                                                                                                                          | What You Should Know                                                                                                                                                  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Durable medical equipment, prosthetic devices and medical supplies (continued)</b><br><br>Diabetic supplies and monitors                                                                                                                      | \$0 copayment for preferred brand<br><br><br><br><br><br><br><br><br><br>20% coinsurance for non-preferred brand                                                                                                                                                            | \$0 copayment for preferred brand<br><br><br><br><br><br><br><br><br><br>20% coinsurance for non-preferred brand                                                                                                                                                            | \$0 copayment for preferred brand<br><br><br><br><br><br><br><br><br><br>20% coinsurance for non-preferred brand                                                                                                                                                            | \$0 copayment for preferred brand<br><br><br><br><br><br><br><br><br><br>20% coinsurance for non-preferred brand                                                                                                                                                            | Preferred brand diabetic supplies include Ascensia and Abbott. Some restrictions apply.<br><br><br><br><br><br><br><br><br><br>Non-preferred brands require approval. |
| <b>Health and Wellness Education Programs</b><br><br>Health Education<br><br>Additional Sessions of Smoking and Tobacco Use Cessation Counseling<br><br>Wellness Benefit<br><br>Nursing Hotline<br><br>Personal Emergency Response System (PERS) | Generally there are no copayments for health and wellness programs.<br><br><br><br><br><br><br><br><br><br>Our plan pays up to a \$150 Health and Wellness reimbursement each calendar year for exercise programs and memberships at approved health or fitness facilities. | Generally there are no copayments for health and wellness programs.<br><br><br><br><br><br><br><br><br><br>Our plan pays up to a \$150 Health and Wellness reimbursement each calendar year for exercise programs and memberships at approved health or fitness facilities. | Generally there are no copayments for health and wellness programs.<br><br><br><br><br><br><br><br><br><br>Our plan pays up to a \$150 Health and Wellness reimbursement each calendar year for exercise programs and memberships at approved health or fitness facilities. | Generally there are no copayments for health and wellness programs.<br><br><br><br><br><br><br><br><br><br>Our plan pays up to a \$150 Health and Wellness reimbursement each calendar year for exercise programs and memberships at approved health or fitness facilities. | Some restrictions apply.                                                                                                                                              |
| <b>Home health care <sup>2</sup></b>                                                                                                                                                                                                             | \$0 copayment                                                                                                                                                                                                                                                               | \$0 copayment                                                                                                                                                                                                                                                               | \$0 copayment                                                                                                                                                                                                                                                               | \$0 copayment                                                                                                                                                                                                                                                               |                                                                                                                                                                       |

|                                                                                              | Capital Health Plan Silver Advantage (HMO) (008) | Capital Health Plan Advantage Plus (HMO) (001) | Capital Health Plan Preferred Advantage (HMO) (006) | Capital Health Plan Giveback Advantage (HMO) (009) | What You Should Know                                                                                          |
|----------------------------------------------------------------------------------------------|--------------------------------------------------|------------------------------------------------|-----------------------------------------------------|----------------------------------------------------|---------------------------------------------------------------------------------------------------------------|
| <b>Hospice</b>                                                                               | \$0 copayment                                    | \$0 copayment                                  | \$0 copayment                                       | \$0 copayment                                      |                                                                                                               |
| <b>Other rehabilitation services</b> <sup>1, 2</sup>                                         |                                                  |                                                |                                                     |                                                    |                                                                                                               |
| Cardiac and Intensive Cardiac rehabilitation services                                        | \$40 copayment                                   | \$40 copayment                                 | \$25 copayment                                      | \$40 copayment                                     |                                                                                                               |
| Pulmonary rehabilitation services <sup>1, 2</sup>                                            | \$20 copayment                                   | \$20 copayment                                 | \$20 copayment                                      | \$20 copayment                                     |                                                                                                               |
| Occupational therapy visit <sup>2</sup>                                                      | \$30 copayment                                   | \$20 copayment                                 | \$20 copayment                                      | \$30 copayment                                     |                                                                                                               |
| Speech and language therapy visit <sup>2</sup>                                               | \$30 copayment                                   | \$20 copayment                                 | \$20 copayment                                      | \$30 copayment                                     |                                                                                                               |
| <b>Foot Care (Podiatry services)</b>                                                         | \$50 copayment                                   | \$45 copayment                                 | \$35 copayment                                      | \$60 copayment                                     | Foot exams and treatment if you have diabetes related nerve damage and/or meet certain conditions.            |
| <b>Supervised Exercise Therapy (SET) for Peripheral Artery Disease (PAD)</b> <sup>1, 2</sup> | \$10 copayment                                   | \$10 copayment                                 | \$10 copayment                                      | \$10 copayment                                     |                                                                                                               |
| <b>Telehealth</b>                                                                            |                                                  |                                                |                                                     |                                                    | Members have access to telehealth services provided by a primary care physician, specialist, and urgent care. |
| Primary Care Physician Telehealth visit                                                      | \$0 copayment                                    | \$0 copayment                                  | \$0 copayment                                       | \$0 copayment                                      |                                                                                                               |
| Specialist Telehealth visit                                                                  | \$50 copayment                                   | \$45 copayment                                 | \$35 copayment                                      | \$60 copayment                                     |                                                                                                               |
| Urgent Care Telehealth (CHP) visit                                                           | \$30 copayment                                   | \$30 copayment                                 | \$30 copayment                                      | \$30 copayment                                     |                                                                                                               |
| Urgent Care Telehealth (Amwell) visit                                                        | \$15 copayment                                   | \$15 copayment                                 | \$15 copayment                                      | \$15 copayment                                     |                                                                                                               |

|                                            | Capital Health Plan Silver Advantage (HMO) (008) | Capital Health Plan Advantage Plus (HMO) (001) | Capital Health Plan Preferred Advantage (HMO) (006) | Capital Health Plan Giveback Advantage (HMO) (009) | What You Should Know                                                          |
|--------------------------------------------|--------------------------------------------------|------------------------------------------------|-----------------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------|
| <b>Worldwide emergency/urgent coverage</b> |                                                  |                                                |                                                     |                                                    | If you are admitted to the hospital within 24 hours, the copayment is waived. |
| Emergency care                             | \$130 copayment                                  | \$130 copayment                                | \$130 copayment                                     | \$130 copayment                                    |                                                                               |
| Urgently needed services                   | \$30 copayment                                   | \$30 copayment                                 | \$30 copayment                                      | \$30 copayment                                     |                                                                               |
| Worldwide transportation                   | \$290 copayment                                  | \$290 copayment                                | \$290 copayment                                     | \$290 copayment                                    |                                                                               |

The food and produce grocery benefit mentioned is part of a special supplemental benefit for the chronically ill. Eligible members must have a documented diagnosis of diabetes. Even if you meet this condition, you will not automatically receive this benefit because other plan coverage and eligibility criteria must also be met.

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## 2027 Summary of Benefits

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Capital Health Plan is offering a new online enrollment tool for our Medicare Advantage (HMO) plans! You will now be able to research our plans and enroll online. Visit [www.capitalhealth.com/Medicare](http://www.capitalhealth.com/Medicare) for more information.

### 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 Member Service representative at 850-523-7441 or 1-877-247-6512 (TTY 711) Oct-Mar: seven days a week, 8am-8pm. Apr-Sept: Monday-Friday, 8am-8pm.

### 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.capitalhealth.com/Medicare](http://www.capitalhealth.com/Medicare) or call 850-523-7441 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 medicines 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

- ☐ In addition to your monthly plan premium, 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, deductibles and/or copayments/co-insurance may change on January 1, 2028.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory) unless prior authorization by the plan.
- ☐ If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.

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## CONTACT US

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We are available for phone calls Oct-Mar: seven days a week, 8am-8pm. Apr-Sept: Monday-Friday, 8am-8pm.

Call toll-free **1-877-247-6512**. TTY users should call **711**.

This is a summary of what we cover. It doesn't list every service that we cover or list every limitation or exclusion. For a full list of covered services, check the Evidence of Coverage (EOC) at [www.capitalhealth.com/Medicare](http://www.capitalhealth.com/Medicare) or call us at the number above.

This document is available in a non-English language. For additional information call us at the number above.

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

Out-of-network/non-contracted providers are under no obligation to treat Capital Health Plan Silver Advantage (008), Capital Health Plan Advantage Plus (001), Capital Health Plan Preferred Advantage (006), and Capital Health Plan Giveback Advantage (009) plan members, except in emergency situations. Please call Member Services or see the Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

To find out more about the coverage and costs of Original Medicare, look in the current “Medicare & You” handbook. View it online at [medicare.gov](http://medicare.gov) or get a copy by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, seven days a week. TTY users should call **1-877-486-2048**.



## **Nondiscrimination and Accessibility Notice (ACA §1557)**

We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, sex, age, or disability. We do not exclude people or treat them differently because of race, color, national origin, sex, age, or disability. We provide:

**Free auxiliary aids, reasonable modifications, 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, and accessible electronic formats)

**Free language assistance services to people whose primary language is not English, such as:**

- Qualified interpreters
- Information written in other languages

If you need these services, contact Member Services at one of the numbers listed below. If you believe we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, sex, age, or disability, you can file a grievance with Capital Health Plan's Section 1557 Coordinator at:

Capital Health Plan  
c/o Compliance and Privacy Officer  
2140 Centerville Place  
Tallahassee, FL 32308.

Phone: Member Services 850-383-3311, 1-877-247-6512, TTY 850-383-3534 or 1-877-870-8943, Fax: 850-523-7419, Email: [memberservices@chp.org](mailto:memberservices@chp.org). Medicare members or prospective members call 850-518-6679 or 1-877-247-6512 (TTY 850-383-3534 or 1-877-870-8943) 8:00 a.m. - 8:00 p.m., seven days a week, October 1 - March 31; 8:00 a.m. - 8:00 p.m., Monday - Friday, April 1 - September 30. State of Florida members call 1-877-392-1532, 7:00 a.m. - 7:00 p.m.

You can file a grievance in person or by mail, fax or email.

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

If you need help filing a grievance, our Member Services 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/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201  
Phone: 800-368-1019, 800-537-7697 (TDD)

**English:** If you speak any of the following languages, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-850-383-3311 or 1-877-247-6512 (TTY: 850-383-3534 or 1-877-870-8943) or speak to your provider.

**Spanish:** Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-877-247-6512 (TTY: 1-877-870-8943) o hable con su proveedor.

**Haitian Creole:** Si w pale kreyòl ayisyen, gen sèvis èd ki disponib pou ou gratis pou lang ou pale a. Gen èd ak sèvis siplemantè apwopriye pou bay enfòmasyon nan fòm aksesib yo ki disponib gratis tou. Rele nan 1-877-247-6512 (TTY: 1-877-870-8943) oswa pale avèk founisè w la.

**Vietnamese:** Nếu quý vị nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ trợ giúp ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Xin vui lòng gọi theo số 1-877-247-6512 (TTY: 1-877-870-8943) hoặc trao đổi với người cung cấp dịch vụ của quý vị.

**Portuguese:** Se você fala Português, serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-877-247-6512 (TTY: 1-877-870-8943) ou fale com seu provedor.

**Simplified Chinese:** 如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-877-247-6512 (文本电话: 1-877-870-8943) 或咨询您的服务提供商。

**French:** Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires

appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-877-247-6512 (TTY: 1-877-870-8943) ou parlez à votre fournisseur.

**Tagalog:** Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga

naa-access na format. Tumawag sa 1-877-247-6512 (TTY: 1-877-870-8943) o makipag-usap sa iyong provider.

**Russian:** Если Вы говорите по-русски, Вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно.

Позвоните по телефону 1-877-247-6512 (TTY: 1-877-870-8943) или обратитесь к своему поставщику услуг.

**Arabic:** إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-877-870-8943 (TTY: 1-877-247-6512) أو تحدث إلى مقدم الخدمة الخاص بك.

**Italian:** se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l' 1-877-247-6512 (TTY: 1-877-870-8943) o parla con il tuo fornitore.

**German:** Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzen zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-877-247-6512 (TTY: 1-877-870-8943) an oder sprechen Sie mit Ihrem Provider.

**Korean:** 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-877-247-6512 (TTY: 1-877-870-8943) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

**Polish:** Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-877-247-6512 (TTY: 1-877-870-8943) lub porozmawiaj ze swoim dostawcą.

**Gujarati:** જો તમે નીચેની કોઈપણ ભાષા બોલતા છો, તો તમારા માટે મફત ભાષા સહાય સેવાઓ ઉપલબ્ધ છે. સુવલ ફોર્મેટમાં માહિતી પ્રદાન કરવા માટે યોગ્ય સહાયક સહાય અને સેવાઓ પણ મફતમાં ઉપલબ્ધ છે. 1-877-247-6512 (TTY: 1-877-870-8943) પર કોલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.

**Thai:** หากคุณพูดภาษาใดภาษาหนึ่งต่อไปนี้ คุณสามารถใช้บริการช่วยเหลือด้านภาษาได้ฟรี นอกจากนี้

ยังมีบริการช่วยเหลือและบริการเสริมที่เหมาะสมเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่ายอีกด้วย โทร 1-877-247-6512 (TTY: 1-877-870-8943)

หรือพูดคุยกับผู้ให้บริการของคุณ



An Independent Licensee of the Blue Cross and Blue Shield Association

## Notice of Availability

### Notice of Availability of Language Assistance Services and Auxiliary Aids and Services (§ 92.11)

**English:** If you speak any of the following languages, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-850-383-3311 or 1-877-247-6512 (TTY: 850-383-3534 or 1-877-870-8943) or speak to your provider.

**Spanish:** Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-877-247-6512 (TTY: 1-877-870-8943) o hable con su proveedor.

**Haitian Creole:** Si w pale kreyòl ayisyen, gen sèvis èd ki disponib pou ou gratis pou lang ou pale a. Gen èd ak sèvis siplemantè apwopriye pou bay enfòmasyon nan fòm aksesib yo ki disponib gratis tou. Rele nan 1-877-247-6512 (TTY: 1-877-870-8943) oswa pale avèk founisè w la.

**Vietnamese:** Nếu quý vị nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ trợ giúp ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Xin vui lòng gọi theo số 1-877-247-6512 (TTY: 1-877-870-8943) hoặc trao đổi với người cung cấp dịch vụ của quý vị.

**Portuguese:** Se você fala Português, serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-877-247-6512 (TTY: 1-877-870-8943) ou fale com seu provedor.

**Simplified Chinese:** 如果您说中文, 我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务, 以无障碍格式提供信息。致电 1-877-247-6512 (文本电话: 1-877-870-8943) 或咨询您的服务提供商。

**French:** Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles

gratuitement. Appelez le 1-877-247-6512 (TTY: 1-877-870-8943) ou parlez à votre fournisseur.

**Tagalog:** Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyonang tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-877-247-6512 (TTY: 1-877-870-8943) o makipag-usap sa iyong provider.

**Russian:** Если Вы говорите по-русски, Вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-877-247-6512 (TTY: 1-877-870-8943) или обратитесь к своему поставщику услуг.

**Arabic:** إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-877-870-8943 (TTY: 1-877-247-6512) أو تحدث إلى مقدم الخدمة الخاص بك.

**Italian:** se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l' 1-877-247-6512 (TTY: 1-877-870-8943) o parla con il tuo fornitore.

**German:** Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzen zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-877-247-6512 (TTY: 1-877-870-8943) an oder sprechen Sie mit Ihrem Provider.

**Korean:** 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-877-247-6512 (TTY: 1-877-870-8943) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

**Polish:** Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-877-247-6512 (TTY: 1-877-870-8943) lub porozmawiaj ze swoim dostawcą.

**Gujarati:** જો તમે નીચેની કોઈપણ ભાષા બોલતા હો, તો તમારા માટે મફત ભાષા સહાય સેવાઓ ઉપલબ્ધ છે. સુલભ ફોર્મેટમાં માહિતી પ્રદાન કરવા માટે યોગ્ય સહાયક સહાય અને સેવાઓ પણ મફતમાં ઉપલબ્ધ છે. 1-877-247-6512 (TTY: 1-877-870-8943) પર કોલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.

**Thai:** หากคุณพูดภาษาใดภาษาหนึ่งต่อไปนี้ คุณสามารถใช้บริการช่วยเหลือด้านภาษาได้ฟรี นอกจากนี้ ยังมีบริการช่วยเหลือและบริการเสริมที่เหมาะสมเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่ายอีกด้วย โทร 1-877-247-6512 (TTY: 1-877-870-8943) หรือพูดคุยกับผู้ให้บริการของคุณ