

2023

SUMMARY OF BENEFITS

**SCAN Classic (HMO)
SCAN Prime (HMO)
Orange County**

January 1, 2023 - December 31, 2023

SCAN Classic (HMO) and SCAN Prime (HMO) are HMO plans with Medicare contracts. Enrollment in SCAN Health Plan depends on contract renewal. You must continue to pay your Medicare Part B premium.

The benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please request the “Evidence of Coverage” by calling our Member Services Department at the phone number listed in this document or online at www.scanhealthplan.com.

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08/22 23C-CASMB3001



SUMMARY OF BENEFITS

JANUARY 1, 2023 – DECEMBER 31, 2023

PREMIUM AND BENEFITS	SCAN CLASSIC	SCAN PRIME	WHAT YOU SHOULD KNOW
Monthly Health Plan Premium	You pay \$0 per month	You pay \$26 per month	You must continue to pay your Medicare Part B premium.
Deductible	You pay \$0	You pay \$0	This plan does not have a deductible.
Maximum Out-of-Pocket Responsibility (this does not include prescription drugs)	\$499 annually	\$299 annually	The most you pay for copays and coinsurance for Medicare-covered medical services for the year.
Inpatient Hospital Coverage	You pay \$0	You pay \$0	Our plan covers an unlimited number of days for an inpatient hospital stay. Prior authorization rules apply.
Outpatient Hospital Services			Prior authorization rules apply for outpatient hospital services.
<ul style="list-style-type: none"> • Ambulatory Surgical Center • Outpatient Hospital 	You pay \$0	You pay \$0	
Doctor Visits			
<ul style="list-style-type: none"> • Primary Care • Specialists 	You pay \$0	You pay \$0	Prior authorization rules apply for specialist visits.
Preventive Care	You pay \$0	You pay \$0	Any additional preventive services approved by Medicare during the contract year will be covered. Prior authorization rules apply.
Emergency Care	You pay \$90 copay per visit	You pay \$90 copay per visit	The emergency room copay will be waived if you are immediately admitted to the hospital. You are covered for worldwide emergency services.
Urgently Needed Services	You pay \$0	You pay \$0	You are covered for worldwide urgent care services.

PREMIUM AND BENEFITS	SCAN CLASSIC	SCAN PRIME	WHAT YOU SHOULD KNOW
<p>Diagnostic Services/Labs/Imaging</p> <ul style="list-style-type: none"> • Lab services • Diagnostic tests and procedures • Outpatient X-rays • Therapeutic radiology • Diagnostic radiology (e.g., MRI, CT) 	<p>You pay \$0</p> <p>You pay \$0</p> <p>You pay \$0</p> <p>You pay \$50 copay per visit</p> <p>You pay \$0</p>	<p>You pay \$0</p> <p>You pay \$0</p> <p>You pay \$0</p> <p>You pay \$50 copay per visit</p> <p>You pay \$0</p>	<p>Prior authorization rules apply for diagnostic, lab, and imaging services.</p>
<p>Hearing Services</p> <ul style="list-style-type: none"> • Medicare-covered diagnostic hearing and balance exam • Non-Medicare-covered (routine) hearing exam • Non-Medicare-covered (routine) hearing aids 	<p>You pay \$0</p> <p>You pay \$0 for up to 1 visit every 12 months</p> <p>You pay \$450 copay per aid for a TruHearing Advanced hearing aid or \$750 copay per aid for a TruHearing Premium hearing aid</p> <p>You are covered for up to 2 hearing aids every 12 months</p>	<p>You pay \$0</p> <p>You pay \$0 for up to 1 visit every 12 months</p> <p>Your benefit includes 3 options: 1) A \$200 copay per aid for TruHearing Advanced Hearing aids, or 2) a \$400 copay per aid for TruHearing Premium hearing aids, or 3) a \$3,000 allowance toward the purchase of any hearing aid from the TruHearing Choice product line.</p> <p>You are covered for up to 2 hearing aids every 12 months</p>	<p>Prior authorization rules apply for Medicare-covered diagnostic hearing and balance exams.</p> <p>You must go to a SCAN-contracted provider to obtain a routine hearing exam and hearing aids.</p>

PREMIUM AND BENEFITS	SCAN CLASSIC	SCAN PRIME	WHAT YOU SHOULD KNOW
<p>Dental Services</p> <ul style="list-style-type: none"> • Medicare-covered dental services • Non-Medicare-covered (routine) oral exam • Non-Medicare-covered (routine) dental cleaning • Non-Medicare-covered (routine) dental X-rays 	<p>You pay \$0</p> <p>You pay \$0 for up to 2 visits every 12 months</p> <p>You pay \$0 for up to 2 visits every 12 months</p> <p>You pay \$0 for up to 2 series every 12 months</p>	<p>You pay \$0</p> <p>You pay \$0 for up to 2 visits every 12 months</p> <p>You pay \$0 for up to 2 visits every 12 months</p> <p>You pay \$0 for up to 2 series every 12 months</p>	<p>Prior authorization rules apply for Medicare-covered dental services.</p> <p>Routine dental benefits are also available with an additional premium.</p> <p>See the “Optional Supplemental Benefits” chart at the end of this document.</p>
<p>Vision Services</p> <ul style="list-style-type: none"> • Medicare-covered vision exam to diagnose/treat diseases of the eye • Medicare-covered glasses after cataract surgery • Non-Medicare-covered (routine) vision exam • Non-Medicare-covered (routine) vision coverage limit 	<p>You pay \$0</p> <p>You pay \$0</p> <p>You pay \$0 for up to 1 visit every 12 months</p> <p>You are covered for up to \$250 for frames, lenses, and lens options or contact lenses every 12 months</p>	<p>You pay \$0</p> <p>You pay \$0</p> <p>You pay \$0 for up to 1 visit every 12 months</p> <p>You are covered for up to \$345 for frames, lenses, and lens options or contact lenses every 12 months</p>	<p>Prior authorization rules apply for Medicare-covered vision exam and glasses after cataract surgery.</p> <p>Routine vision services do not require prior authorization.</p> <p>You must go to a SCAN-contracted vision provider to obtain routine vision services.</p>

PREMIUM AND BENEFITS	SCAN CLASSIC	SCAN PRIME	WHAT YOU SHOULD KNOW
Mental Health Services <ul style="list-style-type: none"> Inpatient visit Outpatient individual/group therapy visit Outpatient individual/group therapy visit with a psychiatrist 	<p>You pay \$0 for days 1-90</p> <p>You pay \$0</p> <p>You pay \$0</p>	<p>You pay \$0 for days 1-90</p> <p>You pay \$0</p> <p>You pay \$0</p>	<p>Prior authorization rules apply for inpatient mental health hospitalization. You are covered for up to 90 days per benefit period.*</p> <p>Prior authorization rules apply for outpatient mental health services.</p>
Skilled Nursing Facility	<p>You pay \$0 for days 1-100</p>	<p>You pay \$0 for days 1-100</p>	<p>Prior authorization rules apply for skilled nursing facility services. You are covered for up to 100 days per benefit period.*</p> <p>No prior hospitalization is required.</p>
Physical Therapy	<p>You pay \$0</p>	<p>You pay \$0</p>	<p>Prior authorization rules apply for outpatient physical therapy services.</p>
Ambulance	<p>You pay \$100 copay per one-way trip</p>	<p>You pay \$100 copay per one-way trip</p>	
Transportation (Non-Medicare-covered — routine)	<p>You pay \$0 for up to 32 one-way trips per year</p> <p>75-mile limit applies to each one-way trip</p>	<p>You pay \$0 for up to 44 one-way trips per year</p> <p>75-mile limit applies to each one-way trip</p>	<p>Prior authorization rules apply for routine transportation services.</p> <p>You must use a SCAN-contracted provider to obtain routine transportation services.</p>
Medicare Part B Drugs	<p>You pay 20% of the total cost for chemotherapy and other Part B drugs</p>	<p>You pay 20% of the total cost for chemotherapy and other Part B drugs</p>	<p>Prior authorization rules apply to select drugs.</p>

*A benefit period begins the day you go into a hospital or SNF. The benefit period ends when you haven't received any inpatient hospital or SNF care for 60 days in a row.

OUTPATIENT PRESCRIPTION DRUGS (PART D DRUGS):

SCAN CLASSIC — You pay the following:

Drug Tier	Retail				Mail-Order	
	Preferred		Standard		Preferred	Standard
	30-day supply	100-day supply	30-day supply	100-day supply	100-day supply	100-day supply

Part D Deductible — You pay \$0

Initial Coverage Stage

Tier 1 (Preferred Generic)		You pay \$0	You pay \$0	You pay \$7	You pay \$14	You pay \$0	You pay \$14
Tier 2 (Generic)		You pay \$0	You pay \$0	You pay \$15	You pay \$30	You pay \$0	You pay \$30
Tier 3 (Preferred Brand)	Select Insulins	You pay \$25	You pay \$55	You pay \$35	You pay \$85	You pay \$55	You pay \$85
	Other Drugs	You pay \$25	You pay \$55	You pay \$47	You pay \$121	You pay \$55	You pay \$121
Tier 4 (Non-Preferred Drug)		You pay \$95	You pay \$265	You pay \$100	You pay \$280	You pay \$265	You pay \$280
Tier 5 (Specialty Tier)		You pay 33%	Not available	You pay 33%	Not available	Not available	Not available

Coverage Gap Stage

Begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches \$4,660.

You pay the same copays as in the Initial Coverage Stage for medications in Tier 1, Tier 2 and Tier 3 (select insulins only). For drugs in other tiers, you pay 25% of the negotiated price (and a portion of the dispensing fee) for your brand name drugs and 25% of the cost for your generic drugs.

Catastrophic Coverage Stage

After your yearly out-of-pocket drug costs reach \$7,400, you pay the greater of:

- 5% of the cost, or
- \$4.15 copay for generic (including drugs that are treated like a generic) and \$10.35 copay for all other drugs.

These copays for select insulins apply to members who do not qualify for a program that helps pay for your drugs (“Extra Help”). Select insulins are all insulin pens and vials in Tier 3 covered on our most recent Drug List we provided electronically. If you have questions about the Drug List, you can call Member Services.

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.

Important Message About What You Pay for Vaccines – Our plan covers most Part D vaccines at no cost to you. Call Member Services for more information.

Some of our network pharmacies have preferred cost-sharing. You may pay less for certain drugs if you use these pharmacies. Your cost-sharing may vary depending on the pharmacy you choose (e.g., Preferred Retail, Standard Retail, Preferred Mail-Order, Standard Mail-Order, Long Term Care (LTC), Home infusion, etc.) or whether you receive a one-month or a three-month supply or when you enter another phase of the Part D benefit or if you receive "Extra Help." For more information, please call our Member Services Department at the number provided in this document or access your Evidence of Coverage online. If you reside in a long-term care facility, your cost-sharing for a 31-day supply is the same as at a standard retail pharmacy for a 30-day supply. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.

OUTPATIENT PRESCRIPTION DRUGS (PART D DRUGS):

SCAN PRIME — You pay the following:

Drug Tier	Retail				Mail-Order	
	Preferred		Standard		Preferred	Standard
	30-day supply	100-day supply	30-day supply	100-day supply	100-day supply	100-day supply

Part D Deductible — You pay \$0

Initial Coverage Stage

Tier 1 (Preferred Generic)		You pay \$0	You pay \$0	You pay \$5	You pay \$10	You pay \$0	You pay \$10
Tier 2 (Generic)		You pay \$0	You pay \$0	You pay \$12	You pay \$24	You pay \$0	You pay \$24
Tier 3 (Preferred Brand)	Select Insulins	You pay \$25	You pay \$55	You pay \$35	You pay \$85	You pay \$55	You pay \$85
	Other Drugs	You pay \$25	You pay \$55	You pay \$47	You pay \$121	You pay \$55	You pay \$121
Tier 4 (Non-Preferred Drug)		You pay \$95	You pay \$265	You pay \$100	You pay \$280	You pay \$265	You pay \$280
Tier 5 (Specialty Tier)		You pay 33%	Not available	You pay 33%	Not available	Not available	Not available

Coverage Gap Stage

Begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches \$4,660.

You pay the same copays as in the Initial Coverage Stage for medications in Tier 1, Tier 2 and Tier 3 (select insulins only). For drugs in other tiers, you pay 25% of the negotiated price (and a portion of the dispensing fee) for your brand name drugs and 25% of the cost for your generic drugs.

Catastrophic Coverage Stage

After your yearly out-of-pocket drug costs reach \$7,400, you pay the greater of:

- 5% of the cost, or
- \$4.15 copay for generic (including drugs that are treated like a generic) and \$10.35 copay for all other drugs.

These copays for select insulins apply to members who do not qualify for a program that helps pay for your drugs (“Extra Help”). Select insulins are all insulin pens and vials in Tier 3 covered on our most recent Drug List we provided electronically. If you have questions about the Drug List, you can call Member Services.

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.

Important Message About What You Pay for Vaccines – Our plan covers most Part D vaccines at no cost to you. Call Member Services for more information.

Some of our network pharmacies have preferred cost-sharing. You may pay less for certain drugs if you use these pharmacies. Your cost-sharing may vary depending on the pharmacy you choose (e.g., Preferred Retail, Standard Retail, Preferred Mail-Order, Standard Mail-Order, Long Term Care (LTC), Home infusion, etc.) or whether you receive a one-month or a three-month supply or when you enter another phase of the Part D benefit or if you receive "Extra Help." For more information, please call our Member Services Department at the number provided in this document or access your Evidence of Coverage online. If you reside in a long-term care facility, your cost-sharing for a 31-day supply is the same as at a standard retail pharmacy for a 30-day supply. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.

ADDITIONAL BENEFITS

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

BENEFITS	SCAN CLASSIC	SCAN PRIME	WHAT YOU SHOULD KNOW
<p>Acupuncture Services</p> <ul style="list-style-type: none"> • Medicare-covered acupuncture care • Routine acupuncture care 	<p>You pay \$0</p> <p>You pay \$0 copay per visit for up to 30 visits per year combined with routine chiropractic services</p>	<p>You pay \$0</p> <p>You pay \$0 for up to 20 visits per year combined with routine chiropractic services</p>	<p>Prior authorization rules apply</p> <p>You do not need a referral for an initial routine acupuncture visit. Any subsequent visits require prior authorization.</p>
<p>Chiropractic Services</p> <ul style="list-style-type: none"> • Medicare-covered chiropractic care • Routine chiropractic care 	<p>You pay \$0</p> <p>You pay \$0 copay per visit for up to 30 visits per year combined with acupuncture services</p>	<p>You pay \$0</p> <p>You pay \$0 for up to 20 visits per year combined with acupuncture services</p>	<p>Prior authorization rules apply</p> <p>You do not need a referral for an initial routine chiropractor visit. Any subsequent visits require prior authorization.</p>
<p>Home Health Care (Medicare-covered)</p>	<p>You pay \$0</p>	<p>You pay \$0</p>	<p>Prior authorization rules apply</p>

BENEFITS	SCAN CLASSIC	SCAN PRIME	WHAT YOU SHOULD KNOW
<p>Medical Equipment/Supplies</p> <ul style="list-style-type: none"> • Durable Medical Equipment (e.g., wheelchairs, oxygen) • Prosthetics (e.g., braces, artificial limbs) • Diabetic supplies 	<p>You pay \$0 for items that have a purchase cost of \$0 to \$99 based on the Medicare-approved amount.</p> <p>You pay 20% of the total cost for items with a purchase cost of \$100 or more.</p> <p>You pay \$0 for items that have a purchase cost of \$0 to \$99 based on the Medicare-approved amount.</p> <p>You pay 20% of the total cost for items with a purchase cost of \$100 or more.</p> <p>You pay \$0</p>	<p>You pay \$0 for items that have a purchase cost of \$0 to \$99 based on the Medicare-approved amount.</p> <p>You pay 20% of the total cost for items with a purchase cost of \$100 or more.</p> <p>You pay \$0 for items that have a purchase cost of \$0 to \$99 based on the Medicare-approved amount.</p> <p>You pay 20% of the total cost for items with a purchase cost of \$100 or more.</p> <p>You pay \$0</p>	<p>Prior authorization rules apply for covered durable medical equipment, prosthetic devices, and certain diabetic supplies.</p> <p>SCAN covers diabetic supplies such as glucose monitors, test strips, and control solution from a select manufacturer. Lancets are also covered and are available from all manufacturers.</p>
<p>Telehealth Services</p>	<p>You pay \$0</p>	<p>You pay \$0</p>	<p>A visit with a licensed doctor in the comfort of your own home. This benefit is for non-life-threatening conditions such as, but not limited to, cough, flu, nausea, sore throat, fever, and allergies.</p> <p>Visits with doctors can be conducted either by telephone or secure video capabilities from your computer or smart phone.</p>

BENEFITS	SCAN CLASSIC	SCAN PRIME	WHAT YOU SHOULD KNOW
Over-the-Counter (OTC) Products	You are covered for up to \$75 per quarter	You are covered for up to \$100 per quarter	You are covered up to 2 shipments per quarter and any remaining balance is carried over to the next quarter. The benefit does not carry over to the next calendar year.

OPTIONAL SUPPLEMENTAL BENEFITS

DENTAL SERVICES – SCAN CLASSIC AND SCAN PRIME

PPO Dental Plan California

Monthly Premium	\$42 per month
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- Access to a large network of Delta Dental DPPO providers
- Over 300 dental procedures included
- Comprehensive dental coverage
- Dental services available at in-network and out-of-network dentists
- Services with in-network dentists will have predictable copayments
- Maximum coverage of \$2,000 for non-Delta Dental Medicare PPO dentists

SCAN Classic and **SCAN Prime** have a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

ABOUT SCAN CLASSIC AND SCAN PRIME

Who can join?	<p>You must:</p> <ul style="list-style-type: none"> – have both Medicare Part A and Part B – live in the plan service area (Orange County, California) – be a United States citizen or be lawfully present in the United States
<p>Phone Number (Members)</p> <p>Phone Number (Non-Members)</p> <p>TTY</p>	<p>1-800-559-3500</p> <p>1-877-870-4867</p> <p>Calling this number will direct you to a licensed insurance agent.</p> <p>711</p>
Hours of Operation	<p>October 1 to March 31: 8 a.m. to 8 p.m., 7 days a week</p> <p>April 1 to September 30: 8 a.m. to 8 p.m., Monday through Friday</p> <p>Messages received on holidays and outside of our business hours will be returned within one business day.</p>
Website	http://www.scanhealthplan.com

To get more information about the coverage and costs of Original Medicare, look in your current **“Medicare & You”** handbook. View it online at <https://www.medicare.gov> or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

This information is not a complete description of benefits. Call 1-800-559-3500 (TTY: 711) for more information.

You can get prescription drugs shipped to your home through our network mail-order delivery program. Express Scripts PharmacySM is our Preferred mail-order pharmacy. While you can fill your prescription medications at any of our network mail-order pharmacies, you may pay less at the Preferred mail-order pharmacy. Typically, you should expect to receive your prescription drugs within 14 days from the time that Express Scripts mail-order pharmacy receives the order. If you do not receive your prescription drug(s) within this time, please contact SCAN Health Plan’s Member Services at 1-800-559-3500, 8 a.m. to 8 p.m., 7 days a week from October 1 to March 31. From April 1 to September 30, hours are 8 a.m. to 8 p.m. Monday through Friday (messages received on holidays and outside of our business hours will be returned within one business day). TTY: 711. For your mail-order prescriptions, you have the option to sign up for an automatic refill program by contacting Express Scripts Pharmacy at 1-866-553-4125, 24 hours a day, 7 days a week. TTY users call 711. You may opt out of automatic deliveries at any time. Other pharmacies are available in our network.

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-877-870-4867 (TTY users call 711) Hours are 8 a.m. to 8 p.m., seven days a week from October 1 to March 31. From April 1 to September 30 hours are 8 a.m. to 8 p.m., Monday through Friday. Messages received on holidays and outside of our business hours will be returned within one business day.

Understanding the Benefits

- Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. Visit www.scanhealthplan.com or call 1-877-870-4867 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.

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 and/or copayments/co-insurance may change on January 1, 2024.
- 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).

SCAN Health Plan and SCAN Desert Health Plan comply with applicable federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of, or because of, race, color, national origin, age, disability, or sex. SCAN Health Plan and SCAN Desert Health Plan provide free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats). SCAN Health Plan and SCAN Desert Health Plan provide free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact SCAN Member Services.

If you believe that SCAN Health Plan or SCAN Desert Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by phone, mail, or fax, at:

SCAN Member Services

Attention: Grievance and Appeals Department

P.O. Box 22616, Long Beach, CA 90801-5616

SCAN Health Plan, California 1-800-559-3500 FAX: 1-562-989-0958

SCAN Health Plan, Nevada 1-855-827-7226 FAX: 1-562-989-0958

SCAN Health Plan, Texas 1-855-844-7226 FAX: 1-562-989-0958

SCAN Desert Health Plan, Arizona 1-855-650-7226 FAX: 1-562-989-0958

TTY: 711

Or by filling out the “File a Grievance” form on our website at:

<https://www.scanhealthplan.com/contact-us/file-a-grievance>

If you need help filing a grievance, SCAN Member Services 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 Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019 (TTY: 1-800-537-7697)

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

You can also file a civil rights complaint with the California Department of Health Care Services, Office of Civil Rights by phone, in writing, or electronically:

- By phone: Call 1-916-440-7370. If you cannot speak or hear well, please call 711 (Telecommunications Relay Services).
- In writing: Fill out a complaint form or send a letter to:
Deputy Director, Office of Civil Rights
Department of Health Care Services
Office of Civil Rights
P.O. Box 997413, MS 0009
Sacramento, CA 95899-7413
Complaint forms are available at http://www.dhcs.ca.gov/Pages/Language_Access.aspx.
- Electronically: Send an email to CivilRights@dhcs.ca.gov

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at (CA: 1-800-559-3500) (AZ: 1-855-650-7226)(NV: 1-855-827-7226)(TX: 1-855-844-7226). Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, llame al (CA: 1-800-559-3500)(AZ: 1-855-650-7226)(NV: 1-855-827-7226)(TX: 1-855-844-7226). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Traditional: 我們提供免費的口譯服務，以解答您對我們的健康或藥物計劃可能有的任何問題。如需獲得口譯服務，請致電 (CA: 1-800-559-3500)(AZ: 1-855-650-7226) (NV: 1-855-827-7226)(TX: 1-855-844-7226) 聯絡我們。我們有會說中文的工作人員可以為您提供幫助。這是一項免費服務。

Chinese Simplified: 我们提供免费的口译服务，以解答您对我们的健康或药物计划可能有的任何问题。如需获得口译服务，请致电 (CA: 1-800-559-3500)(AZ: 1-855-650-7226) (NV: 1-855-827-7226)(TX: 1-855-844-7226) 联系我们。我们有会说中文的工作人员可以为您提供帮助。这是一项免费服务。

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời bất kỳ câu hỏi quý vị có thể có về chương sức khỏe và chương trình thuốc men. Để được thông dịch, chỉ cần gọi theo số (CA: 1-800-559-3500)(AZ: 1-855-650-7226)(NV: 1-855-827-7226)(TX: 1-855-844-7226). Người nói Tiếng Việt có thể trợ giúp quý vị. Đây là dịch vụ miễn phí.

Tagalog: Mayroon kaming mga libreng serbisyo ng interpreter upang masagot ang anumang katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng interpreter, tawagan lamang kami sa (CA: 1-800-559-3500)(AZ: 1-855-650-7226) (NV: 1-855-827-7226)(TX: 1-855-844-7226). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 (CA: 1-800-559-3500)(AZ: 1-855-650-7226) (NV: 1-855-827-7226)(TX: 1-855-844-7226)번으로 문의해 주십시오. 한국어를 하는 담당자가 도와드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Armenian: Առողջության կամ դեղերի ծրագրի վերաբերյալ որևէ հարց առաջանալու դեպքում կարող եք օգտվել անվճար թարգմանչական ծառայությունից: Թարգմանչի ծառայությունից օգտվելու համար զանգահարե՛ք (CA: 1-800-559-3500)(AZ: 1-855-650-7226)(NV: 1-855-827-7226) (TX: 1-855-844-7226) հեռախոսահամարով: Ձեզ կօգնի հայերենին տիրապետող մեր աշխատակիցը: Ծառայությունն անվճար է:

Persian: توجه: ما خدمات مترجم رایگان داریم تا به هر سوالی که ممکن است در مورد برنامه بهداشتی یا داروهای ما داشته باشید پاسخ دهیم. برای آن که مترجم دریافت کنید فقط کافیست با شماره (CA: 1-800-559-3500)(AZ: 1-855-650-7226) (NV: 1-855-827-7226)(TX: 1-855-844-7226) تماس بگیرید. شخصی که به زبان فارسی صحبت می کند، می تواند به شما کمک کند. این یک سرویس رایگان است.

Russian: Если у вас возникнут вопросы относительно плана медицинского обслуживания или обеспечения лекарственными препаратами, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по номеру (CA: 1-800-559-3500)(AZ: 1-855-650-7226)(NV: 1-855-827-7226) (TX: 1-855-844-7226). Вам окажет помощь сотрудник, который говорит на русском языке. Данная услуга бесплатная.

Japanese: 当社の健康保険と処方薬プランに関するご質問にお答えするために、無料の通訳サービスをご用意しています。通訳をご利用になるには、(CA: 1-800-559-3500)(AZ: 1-855-650-7226)(NV: 1-855-827-7226)(TX: 1-855-844-7226)にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة لديك تتعلق بخطتنا الصحية أو جدول الدواء. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على الرقم (CA: 1-800-559-3500)(AZ: 1-855-650-7226)(NV: 1-855-827-7226)(TX: 1-855-844-7226). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه الخدمة المجانية.

Punjabi: ਸਾਡੀ ਸਿਹਤ ਜਾਂ ਦਵਾਈ ਯੋਜਨਾ ਬਾਰੇ ਤੁਹਾਡੇ ਕਿਸੇ ਵੀ ਸਵਾਲਾਂ ਦਾ ਜਵਾਬ ਦੇਣ ਲਈ ਸਾਡੇ ਕੋਲ ਮੁਫਤ ਦੁਬਾਸ਼ੀਆ ਸੇਵਾਵਾਂ ਹਨ। ਕੋਈ ਦੁਬਾਸ਼ੀਆ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ, ਬੱਸ ਸਾਨੂੰ (CA: 1-800-559-3500)(AZ: 1-855-650-7226)(NV: 1-855-827-7226)(TX: 1-855-844-7226) 'ਤੇ ਕਾਲ ਕਰੋ। ਕੋਈ ਵਿਅਕਤੀ ਜੋ ਪੰਜਾਬੀ ਬੋਲਦਾ ਹੈ, ਉਹ ਤੁਹਾਡੀ ਮਦਦ ਕਰ ਸਕਦਾ ਹੈ। ਇਹ ਇੱਕ ਮੁਫਤ ਸੇਵਾ ਹੈ।

Mon-Khmer, Cambodian: យើងខ្ញុំមានសេវាអ្នកបកប្រែផ្តល់មាត់ដោយមិនគិតថ្លៃចាំឆ្លើយរាល់សំណួរដែលអ្នកអាចមានអំពីសុខភាព ឬផែនការឱសថរបស់យើងខ្ញុំ។ ដើម្បីទទួលបានអ្នកបកប្រែ គ្រាន់តែហៅទូរស័ព្ទមកយើងខ្ញុំតាមរយៈលេខ (CA: 1-800-559-3500)(AZ: 1-855-650-7226)(NV: 1-855-827-7226)(TX: 1-855-844-7226)។ មានគេដែលនិយាយភាសាខ្មែរអាចជួយលោកអ្នកបាន។ សេវាកម្មនេះមិនគិតថ្លៃទេ។

Hmong: Peb muaj cov kev pab cuam txhais lus los teb koj cov lus nug uas koj muaj txog ntawm peb lub phiaj xwm kho mob thiab tshuaj kho mob. Kom tau txais tus kws txhais lus, tsuas yog hu peb ntawm (CA: 1-800-559-3500)(AZ: 1-855-650-7226)(NV: 1-855-827-7226)(TX: 1-855-844-7226). Muaj qee tus neeg hais lus Hmoob tuaj yeem pab tau koj. Qhov no yog kev pab cuam pab dawb.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं। एक दुभाषिया प्राप्त करने के लिए, बस हमें (CA: 1-800-559-3500)(AZ: 1-855-650-7226)(NV: 1-855-827-7226)(TX: 1-855-844-7226) पर फोन करें। कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है। यह एक मुफ्त सेवा है।

Thai: เรามีบริการล่ามฟรีเพื่อตอบข้อสงสัยต่าง ๆ ที่คุณอาจมีเกี่ยวกับแผนสุขภาพและด้านเภสัชกรรมของเรา ขอความช่วยเหลือจากล่ามโดยโทรติดต่อเราที่หมายเลข (CA: 1-800-559-3500)(AZ: 1-855-650-7226)(NV: 1-855-827-7226)(TX: 1-855-844-7226) เจ้าหน้าที่ในภาษาไทยจะเป็นผู้ให้บริการโดยไม่มีค่าใช้จ่ายใด ๆ

Lao: ພວກເຮົາມີການບໍລິການນາຍພາສາຟຣີ ເພື່ອຕອບຄໍາຖາມທີ່ທ່ານອາດຈະມີກ່ຽວກັບສຸຂະພາບ ຫຼື ແຜນການຢາຂອງພວກເຮົາ. ເພື່ອຮັບເອົານາຍພາສາ, ພາກແຕ່ໂທຫາພວກເຮົາທີ່ເບີ (CA: 1-800-559-3500)(AZ: 1-855-650-7226)(NV: 1-855-827-7226)(TX: 1-855-844-7226). ບາງຄົນທີ່ເວົ້າພາສາລາວ ສາມາດຊ່ວຍທ່ານໄດ້. ນີ້ແມ່ນການບໍລິການຟຣີ.