

2024

SUMMARY OF BENEFITS

SCAN Strive (HMO C-SNP) Clark County

January 1, 2024 - December 31, 2024

SCAN Strive (HMO C-SNP) is an HMO plan with a Medicare contract. 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.

Y0057_SCAN_20578_2024_M

8/23 24C-NVSMB0010

SUMMARY OF BENEFITS

JANUARY 1, 2024 – DECEMBER 31, 2024

PREMIUM AND BENEFITS	SCAN STRIVE	WHAT YOU SHOULD KNOW
Monthly Health Plan Premium	You pay \$32 per month	You must continue to pay your Medicare Part B premium.
Deductible	You pay a \$226 deductible per year for in-network services in 2023. These amounts may change for 2024. See outpatient prescription drugs section for Part D deductible.	This plan has deductibles for some hospital and medical services, and Part D prescription drugs. See outpatient prescription drugs section for Part D deductible.
Maximum Out-of-Pocket Responsibility (this does not include prescription drugs)	\$8,850 annually	The most you pay for copays and coinsurance for Medicare-covered medical services for the year.
Inpatient Hospital Coverage	In 2023, the amounts for each benefit period* were: <ul style="list-style-type: none"> • \$1,600 deductible per benefit period • \$0 for days 1-60 • \$400 copay per day for days 61-90 • \$800 copay per day for each “lifetime reserve day” 1-60 These amounts may change for 2024.	You are covered for up to 90 days per benefit period.* You are also covered up to 60 additional days for days 91 and beyond per lifetime. Prior authorization rules apply.
Outpatient Hospital Services <ul style="list-style-type: none"> • Ambulatory Surgical Center • Outpatient Hospital 	You pay 20% of the total cost You pay 20% of the total cost	Prior authorization rules apply for outpatient hospital services.
Doctor Visits <ul style="list-style-type: none"> • Primary Care • Specialists 	You pay \$0 You pay \$0	Prior authorization rules apply for specialist visits.

*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.

PREMIUM AND BENEFITS	SCAN STRIVE	WHAT YOU SHOULD KNOW
Preventive Care	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 20% of the total cost for up to \$100 per visit	You are covered for worldwide emergency services.
Urgently Needed Services	You pay 20% of the total cost for up to \$55 copay per visit	You are covered for worldwide urgent care services.
Diagnostic Services/Labs/Imaging <ul style="list-style-type: none"> • Lab services • Diagnostic tests and procedures • Outpatient X-rays • Therapeutic radiology • Diagnostic radiology (e.g., MRI, CT) 	You pay \$0 You pay 20% of the total cost You pay 20% of the total cost You pay 20% of the total cost You pay 20% of the total cost	Prior authorization rules apply for diagnostic, lab, and imaging services.
Hearing Services <ul style="list-style-type: none"> • Medicare-covered diagnostic hearing and balance exam • Non-Medicare-covered (routine) hearing exam 	You pay 20% of the total cost per visit You pay \$0	Prior authorization rules apply for Medicare-covered diagnostic hearing and balance exams. You must go to a SCAN-contracted provider to obtain a routine hearing exam.
Dental Services <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 	You pay 20% of the total cost per visit You pay \$0 for up to 2 visits every 12 months You pay \$0 for up to 2 visits every 12 months You pay \$0 for up to 2 visits every 12 months	Prior authorization rules apply for Medicare-covered dental services.

PREMIUM AND BENEFITS	SCAN STRIVE	WHAT YOU SHOULD KNOW
<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 20% of the total cost</p> <p>You pay 20% of the total cost</p> <p>You pay \$0 for up to 1 visit every 12 months</p> <p>You are covered for up to \$300 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>
<p>Mental Health Services</p> <ul style="list-style-type: none"> • Inpatient visit • Outpatient individual/group therapy visit • Outpatient individual/group therapy visit with a psychiatrist 	<p>In 2023, the amounts for each benefit period* were:</p> <ul style="list-style-type: none"> • \$1,600 deductible per benefit period • \$0 for days 1-60 • \$400 copay per day for days 61-90 • \$800 copay per day for each “lifetime reserve day” 1-60 <p>These amounts may change for 2024.</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>

*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.

PREMIUM AND BENEFITS	SCAN STRIVE	WHAT YOU SHOULD KNOW
Skilled Nursing Facility	<p>In 2023, the amounts for each benefit period* were:</p> <ul style="list-style-type: none"> • \$0 for days 1-20 • \$200 copay per day for days 21-100 <p>These amounts may change for 2024.</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	You pay 20% of the total cost	Prior authorization rules apply for outpatient physical therapy services.
Ambulance	You pay 20% of the total cost	
Transportation (Non-Medicare-covered — routine)	<p>You pay \$0 for up to 48 one-way trips per year</p> <p>You may use up to 24 of your 48 one-way trips to non-medical destinations (grocery store, health club, or senior center) per year. Specific criteria apply.</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>

PREMIUM AND BENEFITS	SCAN STRIVE	WHAT YOU SHOULD KNOW
<p>Medicare Part B Drugs</p>	<p>You pay \$0 for Part B chemotherapy and other Part B drugs received at a pharmacy</p> <p>You pay \$0-20% of the Medicare-approved amount for Part B chemotherapy and other Part B drugs received in any other setting</p> <p>You pay \$0 of a Part B insulin received at a pharmacy and furnished through an item of durable medical equipment, such as a medically necessary insulin pump</p> <p>You pay no more than \$35 for a one-month supply of a Part B insulin received in any other setting and furnished through an item of durable medical equipment, such as a medically necessary insulin pump</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 STRIVE — You pay the following:

	Members with No “Extra Help”	Members with “Extra Help”
	Retail & Mail Order Pharmacies (one-, two- or three-month supply)	Retail & Mail Order Pharmacies (one-, two- or three-month supply)
Part D Deductible	The deductible is \$545. You pay the full cost of your Part D drugs until you have reached your deductible. The deductible doesn't apply to covered insulin products and most adult Part D vaccines.	You pay \$0
Initial Coverage Stage	You pay 25% coinsurance. You won't pay more than \$35 for a one-month supply of each insulin product covered by our plan, even if you haven't paid your deductible. Most adult Part D vaccines are covered at no cost to you, even if you haven't paid your deductible.	You pay \$0 for all covered Part D prescription drugs. You pay \$0 for each insulin product covered by our plan. Most adult Part D vaccines are covered at no cost to you.
Coverage Gap Stage	<p>Begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches \$5,030.</p> <p>You pay the same copays as in the Initial Coverage Stage for each insulin covered by our plan. 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.</p> <p>Coverage Gap Stage coinsurance requirements do not apply to Part D covered insulin products and most adult Part D vaccines. You won't pay more than \$35 for a one-month supply of each insulin covered by our plan. Most adult Part D vaccines are covered at no cost to you.</p>	<p>You pay \$0 for all covered Part D prescription drugs.</p> <p>You pay \$0 for each insulin product covered by our plan.</p> <p>Most adult Part D vaccines are covered at no cost to you.</p>
Catastrophic Coverage Stage	After your yearly out-of-pocket drug costs reach \$8,000, you pay \$0 for all covered prescription drugs for the remainder of the year.	<p>You pay \$0 for all covered Part D prescription drugs.</p> <p>You pay \$0 for each insulin product covered by our plan.</p> <p>Most adult Part D vaccines are covered at no cost to you.</p>

	Members with No “Extra Help”	Members with “Extra Help”
	Retail & Mail Order Pharmacies (one-, two- or three-month supply)	Retail & Mail Order Pharmacies (one-, two- or three-month supply)

Your cost-sharing may vary when you enter another phase of the Part D benefit or if you receive “Extra Help.” If you reside in a long-term care facility, your cost-sharing for a one-month supply is the same as at a retail pharmacy for a one-month supply. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy. Some medications (e.g., Specialty medications) are available up to a one-month supply. 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, you pay \$0 for all covered Part D prescription drugs. You may get drugs from an out-of-network pharmacy, but you may pay more than you pay at an in-network pharmacy. Some medications (e.g., Specialty medications) are available up to a one-month supply. For more information, please call our Member Services Department at the number provided in this document or access your Evidence of Coverage online.

ADDITIONAL BENEFITS

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

BENEFITS	SCAN STRIVE	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 for up to 30 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>Care Navigation</p> <ul style="list-style-type: none"> • Dedicated care professional to answer your questions and find the right clinical and social resources to ensure you get the care you need 	<p>You pay \$0</p>	
<p>Chiropractic Services</p> <ul style="list-style-type: none"> • Medicare-covered chiropractic care • Routine chiropractic care 	<p>You pay 20% of the total cost</p> <p>You pay \$0 for up to 30 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>Prior authorization rules apply</p>

BENEFITS	SCAN STRIVE	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 20% of the total cost</p> <p>You pay 20% of the total cost</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>

BENEFITS	SCAN STRIVE	WHAT YOU SHOULD KNOW
<p>Telehealth Services</p>	<p>You pay \$0</p>	<p>Urgent Care:</p> <p>A licensed health care professional in the comfort of your own home. This benefit is non-life threatening conditions such as, but not limited to, cough, flu, nausea, sore throat, fever and allergies.</p> <p>Visits with providers can be conducted by telephone or secure video capabilities from your computer or smart phone.</p> <p>Behavioral Health:</p> <p>This benefit allows you to connect with licensed Psychologists, Master’s level therapists, or Psychiatrists via video visits 7 days a week by appointment.</p> <p>Behavioral telehealth visits with practitioners can be conducted by secure video capabilities from your computer, tablet, or smart phone. Behavioral telehealth is not intended to replace your primary care doctor or specialist.</p>
<p>Over-the-Counter (OTC) Products</p>	<p>You are covered for up to \$100 per quarter</p>	<p>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.</p>

SCAN Strive has 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 STRIVE

Who can join?	You must: <ul style="list-style-type: none"> – have both Medicare Part A and Part B – live in the plan service area (Clark County, Nevada) – be a United States citizen or be lawfully present in the United States
Phone Number (Members)	1-855-827-7226
Phone Number (Non-Members)	1-877-212-7647
	Calling this number will direct you to a licensed insurance agent.
TTY	711
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 1-855-827-7226 (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 one of our mail order pharmacies. You can fill your prescription medications at any of our network mail order pharmacies. 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 1-855-827-7226, 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 1-877-212-7647 (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 1-877-212-7647 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, 2025.
- 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).
- This plan is a chronic condition special needs plan (C-SNP). Your ability to enroll will be based on verification that you have a qualifying specific severe or disabling chronic condition.

SCAN Health Plan complies 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 provides 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 provides 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 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 Health Plan, Nevada
Attention: Grievance and Appeals Department
P.O. Box 22616
Long Beach, CA 90801-5616

SCAN Member Services
PHONE: 1-855-827-7226
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 <https://www.hhs.gov/civil-rights/filing-a-complaint/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 1-855-827-7226. 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 1-855-827-7226. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Cantonese (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 1-855-827-7226 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 Mandarin (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 1-855-827-7226 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 1-855-827-7226. 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 1-855-827-7226. 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 1-855-827-7226 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

w

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 کافیسیت با شماره 1-855-827-7226 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 1-855-827-7226. 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、1-855-827-7226 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 1-855-827-7226. 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 ਦੁਭਾਸ਼ੀਆ ਸੇਵਾਵਾਂ ਹਨ। ਕੋਈ ਦੁਭਾਸ਼ੀਆ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ, ਬੱਸ ਸਾਨੂੰ 1-855-827-7226 'ਤੇ ਕਾਲ ਕਰੋ। ਕੋਈ ਵਿਅਕਤੀ ਜੋ ਪੰਜਾਬੀ ਬੋਲਦਾ ਹੈ, ਉਹ ਤੁਹਾਡੀ ਮਦਦ ਕਰ ਸਕਦਾ ਹੈ। ਇਹ ਇੱਕ ਮੁਫਤ ਸੇਵਾ ਹੈ।

Mon-Khmer, Cambodian:

យើងខ្ញុំមានសេវាកម្មបកប្រែផ្ទាល់មាត់ដោយមិនគិតថ្លៃចាំឆ្លើយរាល់សំណួរដែលអ្នកអាចមានអំពីសុខភាព ឬផែនការឱសថរបស់យើងខ្ញុំ។ ដើម្បីទទួលបានអ្នកបកប្រែ គ្រាន់តែហៅទូរស័ព្ទមកយើងខ្ញុំតាមរយៈលេខ 1-855-827-7226។ មានគេដែលនិយាយភាសាខ្មែរអាចជួយលោកអ្នកបាន។ សេវាកម្មនេះមិនគិតថ្លៃទេ។

Hmong: Peb muaj cov kev pab cuam txhais lus los teb koj cov lus nug uas koj muaj txog ntawm pib lub phiaj xwm kho mob thiab tshuaj kho mob. Kom tau txais tus kws txhais lus, tsuas yog hu pib ntawm 1-855-827-7226. 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 1-855-827-7226 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Thai: เรามีบริการล่ามฟรีเพื่อตอบข้อสงสัยต่าง ๆ ที่คุณอาจมีเกี่ยวกับแผนสุขภาพและด้านเภสัชกรรมของเรา ขอความช่วยเหลือจากล่ามโดยโทรติดต่อเราที่หมายเลข 1-855-827-7226 เจ้าหน้าที่ในภาษาไทยจะเป็นผู้ให้บริการโดยไม่มีค่าใช้จ่ายใด ๆ

Lao: ພວກເຮົາມີການບໍລິການນາຍພາສາພາສາ ເພື່ອຕອບຄໍາຖາມທີ່ທ່ານອາດຈະມີກ່ຽວກັບສຸຂະພາບ ຫຼື ແຜນການຢາຂອງ ພວກເຮົາ. ເພື່ອຮັບເອົານາຍພາສາ, ພຽງແຕ່ໂທຫາພວກເຮົາທີ່ເບີ 1-855-827-7226. ບາງຄົນທີ່ເວົ້າພາສາລາວ ສາມາດຊ່ວຍທ່ານໄດ້. ນີ້ແມ່ນການບໍລິການພາສາ.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-855-827-7226. Quelqu'un parlant français pourra vous aider. Ce service est gratuit.

German: Unser kostenloser Dolmetscherservice beantwortet Ihre Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-855-827-7226. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per usufruire di un interprete, contattare il numero 1-855-827-7226. Un nostro incaricato che parla Italiano Le fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-855-827-7226. Irá encontrar alguém que fale português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan sante oswa medikaman nou yo. Pou w jwenn yon entèprèt, jis rele nou nan 1-855-827-7226. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-855-827-7226. Ta usługa jest bezpłatna.

Hmong-Mien: Peb muaj kev pab cuam txhais lus pub dawb los teb cov lus nug uas koj muaj txog ntawm pib lub phiaj xwm kev noj qab haus huv los sis phiaj xwm tshuaj kho mob. Kom tau txais tus kws txhais lus, tsuas yog hu pib ntawm 1-855-827-7226. Muaj tus neeg hais lus Hmoob tuaj yeem pab tau koj. Qhov kev pab cuam no yog pab dawb xwb.

Ukrainian: Ми надаємо безкоштовні послуги усного перекладача, який відповість на будь-які ваші запитання щодо нашого плану медичного обслуговування або лікарського забезпечення. Щоб отримати послуги перекладача, просто зателефонуйте нам за номером 1-855-827-7226. Вам може допомогти людина, яка володіє українською мовою. Ця послуга безкоштовна.