2024

SUMMARY OF BENEFITS

SCAN Balance (HMO C-SNP)
SCAN Heart First (HMO C-SNP)
San Francisco County

January 1, 2024 - December 31, 2024

SCAN Balance (HMO C-SNP) and SCAN Heart First (HMO C-SNP) 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.

Y0057_SCAN_20558_2024_M 8/23 24C-CASMB0105

scan | medicare advantage

SUMMARY OF BENEFITS JANUARY 1, 2024 – DECEMBER 31, 2024

PREMIUM AND BENEFITS	SCAN BALANCE	SCAN HEART FIRST	WHAT YOU SHOULD KNOW
Monthly Health Plan Premium	You pay $29 per month	You pay $29 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)	$2,900 annually	$2,900 annually	The most you pay for copays and coinsurance for **Medicare-covered medical services** for the year.
Inpatient Hospital Coverage	You pay $150 copay per day for days 1-7 You pay $0 for days 8-90 and beyond	You pay $150 copay per day for days 1-7 You pay $0 for days 8-90 and beyond	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.
• Ambulatory Surgical Center	You pay $0-$175 copay per visit	You pay $0-$175 copay per visit	
• Outpatient Hospital	You pay $0-$200 copay per visit	You pay $0-$200 copay per visit	
Doctor Visits			
• Primary Care	You pay $0	You pay $0	
• 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.

PREMIUM AND BENEFITS	SCAN BALANCE	SCAN HEART FIRST	WHAT YOU SHOULD KNOW
Urgently Needed Services	You pay $0	You pay $0	You are covered for worldwide urgent care services.
Diagnostic Services/Labs/ Imaging			**Prior authorization** rules apply for diagnostic, lab, and imaging services.
• Lab services	You pay $0	You pay $0	
• Diagnostic tests and procedures	You pay $0	You pay $0	
• Outpatient X-rays	You pay $0	You pay $0	
• Therapeutic radiology	You pay 20% of the total cost	You pay 20% of the total cost	
• Diagnostic radiology (e.g., MRI, CT)	You pay $60 copay per procedure	You pay $60 copay per procedure	
Hearing Services			
• Medicare-covered diagnostic hearing and balance exam	You pay $0	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 and hearing aids.
• Non-Medicare-covered (routine) hearing exam	You pay $0 for up to 1 visit every 12 months	You pay $0 for up to 1 visit every 12 months	
• Non-Medicare-covered (routine) hearing aids	You pay $450 copay per aid for a TruHearing Advanced hearing aid or $750 copay per aid for a TruHearing Premium hearing aid You are covered for up to 2 hearing aids every 12 months	You pay $450 copay per aid for a TruHearing Advanced hearing aid or $750 copay per aid for a TruHearing Premium hearing aid You are covered for up to 2 hearing aids every 12 months	

PREMIUM AND BENEFITS	SCAN BALANCE	SCAN HEART FIRST	WHAT YOU SHOULD KNOW
Dental Services			
• Medicare-covered dental services	You pay $0	You pay $0	**Prior authorization** rules apply for Medicare-covered dental services. Routine dental benefits are available with an additional premium. See the "Optional Supplemental Benefits" chart at the end of this document.
• Non-Medicare-covered (routine) oral exam	Not covered	Not covered	
• Non-Medicare-covered (routine) dental cleaning	Not covered	Not covered	
• Non-Medicare-covered (routine) dental X-rays	Not covered	Not covered	
Vision Services			
• Medicare-covered vision exam to diagnose/treat diseases of the eye	You pay $0	You pay $0	**Prior authorization** rules apply for Medicare-covered vision exam and glasses after cataract surgery.
• Medicare-covered glasses after cataract surgery	You pay $0	You pay $0	
• Non-Medicare-covered (routine) vision exam	You pay $0 for up to 1 visit every 12 months	You pay $0 for up to 1 visit every 12 months	Routine vision services do not require prior authorization.
• Non-Medicare-covered (routine) vision coverage limit	You are covered for up to $150 for frames, lenses, and lens options or contact lenses every 24 months	You are covered for up to $150 for frames, lenses, and lens options or contact lenses every 24 months	You must go to a SCAN-contracted vision provider to obtain routine vision services.
Mental Health Services			
• Inpatient visit	You pay $900 per stay	You pay $900 per stay	**Prior authorization** rules apply for inpatient mental health hospitalization. You are covered for up to 90 days per benefit period.*
• Outpatient individual/ group therapy visit	You pay $25 copay per visit	You pay $25 copay per visit	No prior authorization is required for outpatient individual/group therapy visits.
• Outpatient individual/ group therapy visit with a psychiatrist	You pay $15 copay per visit	You pay $15 copay per visit	

*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 BALANCE	SCAN HEART FIRST	WHAT YOU SHOULD KNOW
Skilled Nursing Facility	You pay $0 for days 1-20 You pay $125 copay per day for days 21-100	You pay $0 for days 1-20 You pay $125 copay per day for days 21-100	**Prior authorization** rules apply for skilled nursing facility services. You are covered for up to 100 days per benefit period.* No prior hospitalization is required.
Physical Therapy	You pay $15 copay per visit	You pay $15 copay per visit	**Prior authorization** rules apply for outpatient physical therapy services.
Ambulance	You pay $175 copay per one-way trip	You pay $175 copay per one-way trip	
Transportation (Non-Medicare-covered — routine)	You pay $0 for up to 36 one-way trips per year You may use up to 18 of your 36 one-way trips to non-medical destinations (grocery store, health club, or senior center) per year. Specific criteria apply. 75-mile limit applies to each one-way trip	You pay $0 for up to 36 one-way trips per year You may use up to 18 of your 36 one-way trips to non-medical destinations (grocery store, health club, or senior center) per year. Specific criteria apply. 75-mile limit applies to each one-way trip	**Prior authorization** rules apply for routine transportation services. You must use a SCAN-contracted provider to obtain routine transportation services.

*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 BALANCE	SCAN HEART FIRST	WHAT YOU SHOULD KNOW
Medicare Part B Drugs	You pay $0-20% of the Medicare-approved amount for Part B chemotherapy and other Part B drugs You pay no more than $35 for a one-month supply of a Part B insulin furnished through an item of durable medical equipment, such as a medically necessary insulin pump	You pay $0-20% of the Medicare-approved amount for Part B chemotherapy and other Part B drugs You pay no more than $35 for a one-month supply of a Part B insulin furnished through an item of durable medical equipment, such as a medically necessary insulin pump	**Prior authorization** rules apply to select drugs.

OUTPATIENT PRESCRIPTION DRUGS (PART D DRUGS):

SCAN BALANCE — 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 $15	You pay $30	You pay $0	You pay $30
Tier 3 (Preferred Brand)	Insulin	You pay $0	You pay $0	You pay $0	You pay $0	You pay $0	You pay $0
	Other Drugs	You pay $35	You pay $85	You pay $45	You pay $115	You pay $85	You pay $115
Tier 4 (Non-Preferred Drug)		You pay $85	You pay $235	You pay $95	You pay $265	You pay $235	You pay $265
Tier 5 (Specialty Tier)		You pay 33%	Not available	You pay 33%	Not available	Not available	Not available
Tier 6 (Select Care Drugs)		You pay $0	You pay $0	You pay $0	You pay $0	You pay $0	You pay $0

Coverage Gap Stage	Begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $5,030. You pay the same copays as in the Initial Coverage Stage for medications in Tiers 1 and 2. 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. Coverage Gap Stage coinsurance requirements do not apply to Part D covered insulin products and most adult Part D vaccines, including shingles, tetanus, and travel vaccines.
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.

During the Initial Coverage Stage and the Coverage Gap Stage, you won't pay more than $0 for a one-month supply of each insulin product covered by our plan on our "Drug List" (Formulary), regardless of the cost-sharing tier. You won't pay more than $35 for a one-month supply of each insulin product covered through a coverage determination, appeal, or transition. During the Catastrophic Coverage Stage, you pay $0 for all covered insulin products.

Most adult Part D vaccines, including shingles, tetanus and travel vaccines, are covered by our plan at no cost to you across all Part D benefit stages, even if you haven't paid your deductible. Refer to your plan's "Drug List" (Formulary) or contact Member Services for coverage and cost-sharing details about specific vaccines.

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 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 HEART FIRST — 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 $15	You pay $30	You pay $0	You pay $30
Tier 3 (Preferred Brand)	Insulin	You pay $25	You pay $55	You pay $35	You pay $85	You pay $55	You pay $85
	Other Drugs	You pay $40	You pay $100	You pay $47	You pay $121	You pay $100	You pay $121
Tier 4 (Non-Preferred Drug)		You pay $90	You pay $250	You pay $100	You pay $280	You pay $250	You pay $280
Tier 5 (Specialty Tier)		You pay 33%	Not available	You pay 33%	Not available	Not available	Not available
Tier 6 (Select Care Drugs)		You pay $0	You pay $0	You pay $0	You pay $0	You pay $0	You pay $0

Coverage Gap Stage	Begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $5,030. You pay the same copays as in the Initial Coverage Stage for medications in Tiers 1 and 2. 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. Coverage Gap Stage coinsurance requirements do not apply to Part D covered insulin products and most adult Part D vaccines, including shingles, tetanus, and travel vaccines.
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.

During the Initial Coverage Stage and the Coverage Gap Stage, 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, even if you haven't paid your deductible. During the Catastrophic Coverage Stage, you pay $0 for all covered insulin products.

Most adult Part D vaccines, including shingles, tetanus and travel vaccines, are covered by our plan at no cost to you across all Part D benefit stages, even if you haven't paid your deductible. Refer to your plan's "Drug List" (Formulary) or contact Member Services for coverage and cost-sharing details about specific vaccines.

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 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 BALANCE	SCAN HEART FIRST	WHAT YOU SHOULD KNOW
Acupuncture Services			
• Medicare-covered acupuncture care	You pay $0	You pay $0	**Prior authorization** rules apply.
• Routine acupuncture care	You pay $5 copay per visit	You pay $5 copay per visit	You do not need a referral for an initial routine acupuncture visit. Any subsequent visits require **prior authorization**.
Chiropractic Services			
• Medicare-covered chiropractic care	You pay $0	You pay $0	**Prior authorization** rules apply
• Routine chiropractic care	You pay $5 copay per visit	You pay $5 copay per visit	You do not need a referral for an initial routine chiropractor visit. Any subsequent visits require **prior authorization**.
Home Health Care (Medicare-covered)	You pay $0	You pay $0	**Prior authorization** rules apply

BENEFITS	SCAN BALANCE	SCAN HEART FIRST	WHAT YOU SHOULD KNOW
Medical Equipment/Supplies			
• Durable Medical Equipment (e.g., wheelchairs, oxygen)	You pay $0 for items that have a purchase cost of $0 to $99 based on the Medicare-approved amount. You pay 20% of the total cost for items with a purchase cost of $100 or more.	You pay $0 for items that have a purchase cost of $0 to $99 based on the Medicare-approved amount. You pay 20% of the total cost for items with a purchase cost of $100 or more.	**Prior authorization** rules apply for covered durable medical equipment, prosthetic devices, and certain diabetic supplies.
• Prosthetics (e.g., braces, artificial limbs)	You pay $0 for items that have a purchase cost of $0 to $99 based on the Medicare-approved amount. You pay 20% of the total cost for items with a purchase cost of $100 or more.	You pay $0 for items that have a purchase cost of $0 to $99 based on the Medicare-approved amount. You pay 20% of the total cost for items with a purchase cost of $100 or more.	
• Diabetic supplies	You pay $0	You pay $0	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.

BENEFITS	SCAN BALANCE	SCAN HEART FIRST	WHAT YOU SHOULD KNOW
Telehealth Services	You pay $0	You pay $0	**Urgent Care:** 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. Visits with providers can be conducted by telephone or secure video capabilities from your computer or smart phone. **Behavioral Health:** This benefit allows you to connect with licensed Psychologists, Master's level therapists, or Psychiatrists via video visits 7 days a week by appointment. 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.

OPTIONAL SUPPLEMENTAL BENEFITS

DENTAL SERVICES – SCAN BALANCE AND SCAN HEART FIRST

Basic Dental Plan

Monthly Premium	$6 per month

- Access to a large network of Delta Dental DHMO providers
- Over 290 dental procedures included
- Predictable copayments
- Low monthly premium/higher copayments for certain procedures

Enhanced Dental Plan

Monthly Premium	$16 per month

- Access to a large network of Delta Dental DHMO providers
- Over 300 dental procedures included
- Predictable copayments
- Monthly premium/lower copayments for many procedures

SCAN Balance and **SCAN Heart First** 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 BALANCE AND SCAN HEART FIRST

Who can join?	**SCAN Balance** **You must:** – have both Medicare Part A and Part B – live in the plan service area (San Francisco County, California) – be a United States citizen or be lawfully present in the United States – be diagnosed with diabetes mellitus **SCAN Heart First** **You must:** – have both Medicare Part A and Part B – live in the plan service area (San Francisco County, California) – be a United States citizen or be lawfully present in the United States – be diagnosed with cardiovascular disorders and/or chronic heart failure
Phone Number (Members) **Phone Number (Non-Members)** **TTY**	**1-800-559-3500** **1-877-870-4867** Calling this number will direct you to a licensed insurance agent. **711**
Hours of Operation	**October 1 to March 31:** 8 a.m. to 8 p.m., 7 days a week **April 1 to September 30:** 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.
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 Pharmacy℠ 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, 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
Attention: Grievance and Appeals Department
P.O. Box 22616
Long Beach, CA 90801-5616

SCAN Member Services
PHONE: 1-800-559-3500
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 1-800-559-3500. 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 1-800-559-3500. 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 1-800-559-3500 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 1-800-559-3500 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 1-800-559-3500. 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 1-800-559-3500. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-559-3500 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Armenian: Առողջության կամ դեղերի ծրագրի վերաբերյալ որևէ հարց առաջանալու դեպքում կարող եք օգտվել անվճար թարգմանչական ծառայությունից: Թարգմանչի ծառայություններից օգտվելու համար զանգահարե՛ք 1-800-559-3500 հեռախոսահամարով: Ձեզ կօգնի հայերենին տիրապետող մեր աշխատակիցը: Ծառայությունն անվճար է:

Persian: توجه: ما خدمات مترجم رایگان داریم تا به هر سؤالی که ممکن است در مورد برنامه بهداشتی یا داروهای ما داشته باشید پاسخ دهیم. برای آن که مترجم دریافت کنید فقط کافیست با شماره1-800-559-3500 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 1-800-559-3500. 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、1-800-559-3500 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 الرقم1-800-559-3500. 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 ਮੁਫ਼ਤ ਦੁਭਾਸ਼ੀਆ ਸੇਵਾਵਾਂ ਹਨ। ਕੋਈ ਦੁਭਾਸ਼ੀਆ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ, ਬੱਸ ਸਾਨੂੰ 1-800-559-3500 'ਤੇ ਕਾਲ ਕਰੋ। ਕੋਈ ਵਿਅਕਤੀ ਜੋ ਪੰਜਾਬੀ ਬੋਲਦਾ ਹੈ, ਉਹ ਤੁਹਾਡੀ ਮਦਦ ਕਰ ਸਕਦਾ ਹੈ। ਇਹ ਇੱਕ ਮੁਫ਼ਤ ਸੇਵਾ ਹੈ।

Mon-Khmer, Cambodian:
យើងខ្ញុំមានសេវាអ្នកបកប្រែផ្តាល់មាត់ដោយមិនគិតថ្លៃចាំឆ្លើយរាល់សំណួរដែលអ្នកអាចមានអំពីសុខភាព ឬផែនការឱសថរបស់យើងខ្ញុំ។ ដើម្បីទទួលបានអ្នកបកប្រែ គ្រាន់តែហៅទូរស័ព្ទមកយើងខ្ញុំតាមរយៈលេខ 1-800-559-3500។ 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 1-800-559-3500. 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 1-800-559-3500 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Thai: เรามีบริการล่ามฟรีเพื่อตอบข้อสงสัยต่าง ๆ ที่คุณอาจมีเกี่ยวกับแผนสุขภาพและด้านเภสัชกรรมของเรา ขอความช่วยเหลือจากล่ามโดยโทรติดต่อเราที่หมายเลข 1-800-559-3500 เจ้าหน้าที่ในภาษาไทยจะเป็นผู้ให้บริการโดยไม่มีค่าใช้จ่ายใด ๆ

Lao: ພວກເຮົາມີການບໍລິການນາຍພາສາຟຣີ ເພື່ອຕອບຄຳຖາມທີ່ທ່ານອາດຈະມີກ່ຽວກັບສຸຂະພາບ ຫຼື ແຜນການຢາຂອງ ພວກເຮົາ. ເພື່ອຮັບເອົານາຍພາສາ, ພຽງແຕ່ໂທຫາພວກເຮົາທີ່ເບີ 1-800-559-3500. ບາງຄົນທີ່ເວົ້າພາສາລາວ ສາມາດຊ່ວຍທ່ານໄດ້. ນີ້ແມ່ນການບໍລິການຟຣີ.

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 1-800-559-3500. 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 1-800-559-3500. 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 1-800-559-3500. 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 1-800-559-3500. 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 1-800-559-3500. 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 1-800-559-3500. 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 peb 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 peb ntawm 1-800-559-3500. 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 1-800-559-3500. Вам може допомогти людина, яка володіє українською мовою. Ця послуга безкоштовна.