

2023

SUMMARY OF BENEFITS

VillageHealth (HMO-POS SNP) Los Angeles County

January 1, 2023 - December 31, 2023

VillageHealth (HMO-POS SNP) is an HMO plan and is a Point of Service (POS) 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.villagehealthca.com.

Y0057_SCAN_20039_2023_M

08/22 23C-SMBVH2



SUMMARY OF BENEFITS

JANUARY 1, 2023 – DECEMBER 31, 2023

PREMIUM AND BENEFITS	VILLAGEHEALTH		WHAT YOU SHOULD KNOW
	In-Network Services	Out-of-Network Services	
Monthly Health Plan Premium	You pay \$31.20 per month	You pay \$31.20 per month	You must continue to pay your Medicare Part B premium.
Deductible	<p>You pay \$233 deductible per year for in-network services in 2022. This amount may change for 2023.</p> <p>You pay \$505 deductible per year for Part D prescription drugs for Tiers 2-5.</p>	<p>You pay \$233 deductible per year for in-network services in 2022. This amount may change for 2023.</p> <p>You pay \$505 deductible per year for Part D prescription drugs for Tiers 2-5.</p>	This plan has deductibles for some hospital and medical services, and Part D prescription drugs.
Maximum Out-of-Pocket Responsibility (this does not include prescription drugs)	\$8,300 annually	\$8,300 annually	The most you pay for copays and coinsurance for Medicare-covered medical services for the year.
Inpatient Hospital Coverage	<p>In 2022, the amounts for each benefit period* were:</p> <ul style="list-style-type: none"> • \$1,556 deductible per benefit period • \$0 per day for days 1-60 • \$389 copay per day for days 61-90 • \$778 copay per day for each “lifetime reserve day” 1-60 <p>These amounts may change for 2023.</p>	<p>In 2022, the amounts for each benefit period* were:</p> <ul style="list-style-type: none"> • \$1,556 deductible per benefit period • \$0 per day for days 1-60 • \$389 copay per day for days 61-90 • \$778 copay per day for each “lifetime reserve day” 1-60 <p>These amounts may change for 2023.</p>	<p>Prior authorization rules apply for inpatient hospital services.</p> <p>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.</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	VILLAGEHEALTH		WHAT YOU SHOULD KNOW
	In-Network Services	Out-of-Network Services	
Outpatient Hospital Services <ul style="list-style-type: none"> • Ambulatory Surgical Center • Outpatient Hospital 	<p>You pay 20% of the total cost</p> <p>You pay 20% of the total cost</p>	<p>You pay 20% of the total cost</p> <p>You pay 20% of the total cost</p>	
Doctor Visits <ul style="list-style-type: none"> • Primary Care • Specialists 	<p>You pay \$0</p> <p>\$0 Nephrologist</p> <p>You pay 20% of the total cost for all other specialists</p>	<p>You pay \$0</p> <p>\$0 Nephrologist</p> <p>You pay 20% of the total cost for all other specialists</p>	
Preventive Care	<p>You pay \$0</p>	<p>You pay \$0</p>	<p>Any additional preventive services approved by Medicare during the contract year will be covered.</p>
Emergency Care	<p>You pay 20% of the total cost for up to \$90 per visit</p>	<p>You pay 20% of the total cost for up to \$90 per visit</p>	<p>The emergency room copay will be waived if you are immediately admitted to the hospital.</p> <p>Not covered outside of the U.S. except under limited circumstances as defined by Medicare.</p>
Urgently Needed Services	<p>You pay \$0</p>	<p>You pay \$0</p>	<p>Not covered outside of the U.S. except under limited circumstances as defined by Medicare.</p>

PREMIUM AND BENEFITS	VILLAGEHEALTH		WHAT YOU SHOULD KNOW
	In-Network Services	Out-of-Network 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) 	<p>You pay \$0</p> <p>You pay 20% of the total cost</p> <p>You pay 20% of the total cost</p> <p>You pay 20% of the total cost</p> <p>You pay 20% of the total cost</p>	<p>You pay \$0</p> <p>You pay 20% of the total cost</p> <p>You pay 20% of the total cost</p> <p>You pay 20% of the total cost</p> <p>You pay 20% of the total cost</p>	
Hearing Services <ul style="list-style-type: none"> • Medicare-covered diagnostic hearing and balance exam 	<p>You pay 20% of the total cost</p>	<p>You pay 20% of the total cost</p>	
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 	<p>You pay 20% of the total cost per visit</p> <p>You pay \$0 for up to 2 visits every 12 months</p> <p>You pay \$0 for up to 2 visit every 12 months</p> <p>You pay \$0 for up to 1 series every 6 months</p>	<p>You pay 20% of the total cost per visit</p> <p>Not covered</p> <p>Not covered</p> <p>Not covered</p>	<p>Routine dental services do not require a prior authorization.</p> <p>You must go to a VillageHealth-contracted dentist to obtain routine dental services.</p>
Vision Services <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 coverage limit 	<p>You pay 20% of the total cost</p> <p>You pay 20% of the total cost</p> <p>You are covered for up to \$400 for frames, lenses, and lens options or contact lenses every 12 months</p>	<p>You pay 20% of the total cost</p> <p>You pay 20% of the total cost</p> <p>Not covered</p>	<p>Routine vision services do not require prior authorization.</p> <p>You must go to a VillageHealth-contracted vision provider to obtain routine vision services.</p>

PREMIUM AND BENEFITS	VILLAGEHEALTH		WHAT YOU SHOULD KNOW
	In-Network Services	Out-of-Network Services	
<p>Mental Health Services</p> <ul style="list-style-type: none"> Inpatient visit <ul style="list-style-type: none"> Outpatient individual/group therapy visit Outpatient individual/group therapy visit with a psychiatrist 	<p>In 2022, the amounts for each benefit period* were:</p> <ul style="list-style-type: none"> \$1,556 deductible per benefit period \$0 per day for days 1-60 \$389 copay per day for days 61-90 \$778 copay per day for each "lifetime reserve day" 1-60 <p>These amounts may change for 2023.</p> <p>You pay \$0</p> <p>You pay \$0</p>	<p>In 2022, the amounts for each benefit period* were:</p> <ul style="list-style-type: none"> \$1,556 deductible per benefit period \$0 per day for days 1-60 \$389 copay per day for days 61-90 \$778 copay per day for each "lifetime reserve day" 1-60 <p>These amounts may change for 2023.</p> <p>You pay \$0</p> <p>You pay \$0</p>	<p>Prior authorization rules apply for inpatient mental hospitalization.</p> <p>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.</p>
<p>Skilled Nursing Facility</p>	<p>In 2022, the amounts for each benefit period* were:</p> <ul style="list-style-type: none"> \$0 for days 1-20 \$194.50 copay per day for days 21-100 <p>These amounts may change for 2023.</p>	<p>Not covered</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>
<p>Physical Therapy</p>	<p>You pay 20% of the total cost</p>	<p>You pay 20% of the total cost</p>	
<p>Ambulance</p>	<p>You pay 20% of the total cost</p>	<p>You pay 20% of the total cost</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	VILLAGEHEALTH		WHAT YOU SHOULD KNOW
	In-Network Services	Out-of-Network Services	
Transportation (Non-Medicare-covered — routine)	<p>You pay \$0 for up to 38 one-way trips per year</p> <p>75-mile limit applies to each one-way trip</p>	<p>Not covered</p>	<p>Prior authorization rules apply for routine transportation services.</p> <p>You must use a VillageHealth-contracted provider to obtain routine transportation services.</p>
Medicare Part B Drugs	<p>You pay \$0 for chemotherapy and other Part B drugs received at a pharmacy</p> <p>You pay 20% of the total cost for chemotherapy and other Part B drugs received at any other setting</p>	<p>You pay \$0 for chemotherapy and other Part B drugs received at a pharmacy</p> <p>You pay 20% of the total cost for chemotherapy and other Part B drugs received at any other setting</p>	<p>Prior authorization rules apply to select drugs.</p>

OUTPATIENT PRESCRIPTION DRUGS (PART D DRUGS):

You pay the following:

VILLAGEHEALTH

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 the full cost of your Tier 2 through Tier 5 drugs until you have paid \$505.					
Initial Coverage Stage						
Tier 1 (Preferred Generic)	You pay \$0	You pay \$0	You pay \$3	You pay \$9	You pay \$0	You pay \$9
Tier 2 (Generic)	You pay 25%	You pay 25%	You pay 25%	You pay 25%	You pay 25%	You pay 25%
Tier 3 (Preferred Brand)	You pay 25%	You pay 25%	You pay 25%	You pay 25%	You pay 25%	You pay 25%
Tier 4 (Non-Preferred Drug)	You pay 25%	You pay 25%	You pay 25%	You pay 25%	You pay 25%	You pay 25%
Tier 5 (Specialty Tier)	You pay 25%	Not available	You pay 25%	Not available	Not available	Not available
Coverage Gap Stage		<p>Begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches \$4,660.</p> <p>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>				
Catastrophic Coverage Stage		<p>After your yearly out-of-pocket drug costs reach \$7,400, you pay the greater of:</p> <ul style="list-style-type: none"> – 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. 				

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.

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, even if you haven't paid your deductible.

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. Call Member Services for more information.

ADDITIONAL BENEFITS

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

BENEFITS	VILLAGEHEALTH		WHAT YOU SHOULD KNOW
	In-Network Services	Out-of-Network Services	
Home Health Care (Medicare-covered)	You pay \$0	Not covered	Prior authorization rules apply
Medical Equipment/Supplies <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 is only required for certain items including, but not limited to, power chairs, air mattresses, continuous glucose monitors, home ventilators, Hoyer lifts, and bone stimulators. Contact Member Services for more information.</p> <p>VillageHealth 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	VILLAGEHEALTH		WHAT YOU SHOULD KNOW
	In-Network Services	Out-of-Network Services	
Over-the-Counter (OTC) Products	You are covered for up to \$150 per quarter	Not covered	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.
Special Support Benefits for Chronically Ill (SSBCI) <ul style="list-style-type: none"> • Grocery card 	Coverage up to \$50 per quarter	Not covered	Prior authorization rules apply For members who qualify for home peritoneal dialysis (PD) as these are requirements for PD.

ABOUT VILLAGEHEALTH

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 (Los Angeles County, California) – be a United States citizen or be lawfully present in the United States – be diagnosed with end-stage renal disease (ESRD) or be a post-transplant patient
Phone Number (Members) Phone Number (Non-Members) TTY	1-800-399-7226 1-877-916-1234 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.villagehealthca.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 1-800-399-7226 (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 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 VillageHealth Member Services at 1-800-399-7226, 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 1-877-916-1234 (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.villagehealthca.com or call 1-877-916-1234 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).
- Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care.

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.