2024-2025

SUMMARY OF BENEFITS

SCAN Retiree Group
Newport-Mesa Unified School District (N-MUSD) (HMO)

October 1, 2024 - September 30, 2025

SCAN Retiree Group - N-MUSD (HMO) is an HMO plan with a Medicare contract. Enrollment in SCAN Health Plan depends on contract renewal.

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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scan HEALTH PLAN®

SUMMARY OF BENEFITS

OCTOBER 1, 2024 - SEPTEMBER 30, 2025

PREMIUM AND BENEFITS	BASIC PLAN	ENHANCED PLAN	WHAT YOU SHOULD KNOW
Monthly Health Plan Premium	For premium information, please contact your plan sponsor's benefit administrator.	For premium information, please contact your plan sponsor's benefit administrator.	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)	$3,400 annually	$3,400 annually	The most you pay for copays and coinsurance for **Medicare-covered medical services** for the year.
Inpatient Hospital Coverage	You pay $100 copay per admission	You pay $0	Our plan covers an unlimited number of days for an inpatient hospital stay. **Prior authorization** rules may apply.
Outpatient Hospital Coverage			**Prior authorization** rules may apply for outpatient hospital services.
• Ambulatory Surgical Center	You pay $0	You pay $0	
• Outpatient Hospital	You pay $0	You pay $0	
Doctor Visits			**Prior authorization** rules may apply for specialist visits.
• Primary Care	You pay $15 copay per visit	You pay $10 copay per visit	
• Specialists	You pay $15 copay per visit	You pay $10 copay per visit	

PREMIUM AND BENEFITS	BASIC PLAN	ENHANCED PLAN	WHAT YOU SHOULD KNOW
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 may apply.
Emergency Care	You pay $25 copay per visit	You pay $50 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 $25 copay per visit	You pay $10 copay per visit	You are covered for worldwide urgent care services.
Diagnostic Services/ Labs/Imaging			**Prior authorization** rules may 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 $0	You pay $0	
• Diagnostic radiology (e.g., MRI, CT)	You pay $0	You pay $0	

PREMIUM AND BENEFITS	BASIC PLAN	ENHANCED PLAN	WHAT YOU SHOULD KNOW
Hearing Services			**Prior authorization** rules may apply for Medicare-covered diagnostic hearing and balance exams.
• Medicare-covered diagnostic hearing and balance exam	You pay $15 copay per visit	You pay $10 copay per visit	
• Non-Medicare-covered (routine) hearing exam	You pay $15 copay for up to 1 visit per year	You pay $10 copay for up to 1 visit per year	Routine hearing services do not require a prior authorization.
• Non-Medicare-covered (routine) hearing aid fitting/ evaluation	You pay $15 copay per visit within the first year of purchase	You pay $10 copay per visit within the first year of purchase	You must go to a SCAN-contracted provider to obtain a routine hearing exam and hearing aids.
• Non-Medicare-covered (routine) hearing aids	You are covered up to $2,000 for up to 2 hearing aids every 2 years	You are covered up to $4,000 for up to 2 hearing aids every 2 years	
Dental Services			**Prior authorization** rules may apply for Medicare-covered dental services.
• Medicare-covered dental services	You pay $15 copay per visit	You pay $10 copay per visit	
• Non-Medicare-covered (routine) oral exam	You pay $8 copay per visit	You pay $0	Routine dental services do not require a prior authorization.
• Non-Medicare-covered (routine) dental cleanings	You pay $0 for up to 2 visits every 12 months	You pay $0 for up to 2 visits every 12 months	You must go to a SCAN-contracted dental provider to obtain routine dental services.
• Non-Medicare-covered (routine) dental X-rays	You pay $0 for up to 1 series every 6 months	You pay $0 for up to 1 series every 6 months	

PREMIUM AND BENEFITS	BASIC PLAN	ENHANCED PLAN	WHAT YOU SHOULD KNOW
Vision Services			**Prior authorization** rules may apply for Medicare-covered vision exams and glasses after cataract surgery. Routine vision services do not require a prior authorization. You must go to a SCAN-contracted vision provider to obtain routine vision services.
• Medicare-covered vision exam to diagnose/treat diseases of the eye	You pay $15 copay per visit	You pay $10 copay per visit	
• Medicare-covered glasses after cataract surgery	You pay $15 copay per pair	You pay $10 copay per visit	
• Non-Medicare-covered (routine) vision exam	You pay $15 copay for up to 1 visit per year	You pay $10 copay for up to 1 visit per year	
• Non-Medicare-covered (routine) lenses	You pay $20 every 2 years	You pay $20 every 2 years	
• Non-Medicare-covered (routine) vision coverage limit	You are covered for up to $100 for frames or up to $130 for contact lenses every 2 years	You are covered for up to $100 for frames or up to $130 for contact lenses every 2 years	
Mental Health Services			**Prior authorization** rules may apply for inpatient mental health hospitalization. You are covered for up to 90 days per benefit period.*
• Inpatient visit	You pay $100 copay per admission for days 1-90	You pay $0 for days 1-90	
• Outpatient individual/group therapy visit	You pay $15 copay per visit	You pay $10 copay per visit	**Prior authorization** rules may apply for outpatient mental health services.
• Outpatient individual/group therapy visit with a psychiatrist	You pay $15 copay per visit	You pay $10 copay per visit	

PREMIUM AND BENEFITS	BASIC PLAN	ENHANCED PLAN	WHAT YOU SHOULD KNOW
Skilled Nursing Facility	You pay $100 copay per admission for days 1-100	You pay $0 for days 1-100	**Prior authorization** rules may 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 $5 copay per visit	You pay $0	**Prior authorization** rules may apply for outpatient physical therapy services.
Ambulance	You pay $0 per one-way trip	You pay $0 per one-way trip	
Transportation (Non-Medicare-covered - routine)	You pay $0 for unlimited one-way trips per year 75-mile limit applies to each one-way trip	You pay $0 for unlimited one-way trips per year 75-mile limit applies to each one-way trip	**Prior authorization** rules may apply for routine transportation services. You must use a SCAN-contracted provider to obtain routine transportation services.
Medicare 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 $40 copay for chemotherapy and other Part B drugs	You pay no more than $30 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 $30 copay for chemotherapy and other Part B drugs	**Prior authorization** rules apply to select drugs.

* 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):

You pay the following:

N-MUSD BASIC PLAN AND ENHANCED PLAN

		Preferred Retail & Mail-Order (in-network) (30-day supply)	Standard Retail & Mail-Order (in-network) (30-day supply)	Preferred Retail (in-network) (100-day supply)	Standard Retail & Mail-Order (in-network) (100-day supply)	Preferred Mail-Order (in-network) (100-day supply)
Part D Deductible — You pay $0						
Initial Coverage Stage						
Tier 1 (Preferred Generic)		You pay $5	You pay $10	You pay $10	You pay $20	You pay $10
Tier 2 (Generic)		You pay $5	You pay $10	You pay $10	You pay $20	You pay $10
Tier 3 (Preferred Brand)	Insulin	You pay $20	You pay $20	You pay $40	You pay $40	You pay $40
	Other Drugs	You pay $20	You pay $20	You pay $40	You pay $40	You pay $40
Tier 4 (Non-Preferred Drug)		You pay $20	You pay $20	You pay $40	You pay $40	You pay $40
Tier 5 (Specialty Tier)		You pay 25%	You pay 25%	Not available	Not available	Not available
Tier 6 (Select Care Drugs)		You pay $11	You pay $11	You pay $33	You pay $33	You pay $33

Catastrophic Coverage Stage	**Effective 10/01/2024 to 12/31/2024:** You stay in the Initial Coverage Stage until your yearly out-of-pocket costs reach $8,000. 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. **Effective 01/01/2025 to 09/30/2025:** You stay in the Initial Coverage Stage until your yearly out-of-pocket costs reach $2,000. After your yearly out-of-pocket drug costs reach $2,000, you pay $0 for all covered prescription drugs for the remainder of the year.

Effective January 1st, 2025, there are important changes that may help you manage your drug costs and keep them lower:

You will never pay more than $2,000 in out-of-pocket for your prescription drugs, but you may pay even less.

Some members may benefit from the new Medicare Prescription Payment Plan option that helps spread out your out-of-pocket cost for a drug if it is too high. And SCAN is always here to help find solutions like patient assistance programs or apply for "Extra Help" from Medicare.

You won't pay more than $20 for a one-month supply of each insulin product covered by our plan on our "Drug List" (Formulary), no matter what cost-sharing tier it's on. 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. 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 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

PREMIUM AND BENEFITS	BASIC PLAN	ENHANCED PLAN	WHAT YOU SHOULD KNOW
Medical Equipment/ Supplies			**Prior authorization** rules may apply for covered durable medical equipment, prosthetic devices, and certain diabetic supplies. 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.
• Durable medical equipment (e.g., wheelchairs, oxygen)	You pay $0	You pay $0	
• Prosthetics (e.g., braces, artificial limbs)	You pay $0	You pay $0	
• Diabetic supplies	You pay $0	You pay $0	
• Continuous Glucose Monitors	You pay $0 at the pharmacy or DME provider	You pay $0 at the pharmacy or DME provider	Freestyle Libre and Dexcom CGMs are covered at contracted pharmacies. Other CGM manufacturers are available at contracted DME providers. **Prior authorization** rules apply.
Telehealth Services	You pay $0	You pay $0	A visit with a 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. Visits with doctors can be conducted by secure video capabilities from your computer, tablet, or smart phone.
Health Club Membership	You pay $0	You pay $0	You are covered for SCAN-contracted health clubs in your area.

PREMIUM AND BENEFITS	BASIC PLAN	ENHANCED PLAN	WHAT YOU SHOULD KNOW
HEALTH*tech*	You pay $0	You pay $0	A technology support line to provide education and training on how to use your computer, tablet or smartphone to access health care and health care related information.
Nurse Advice Line	You pay $0	You pay $0	The Nurse Advice Line benefit allows you to seek advice from a nurse based on current symptoms, 24 hours a day, 7 days a week. Qualified nurses can help manage your symptoms and help you decide where and how to seek medical care. The Nurse Advice Line can be accessed by telephone or smart phone.
Home-delivered meals	You pay $0	You pay $0	Up to 28 days/84 meals of home-delivered meals are available to members with chronic conditions.

INDEPENDENT LIVING POWER/LONG TERM SERVICES AND SUPPORTS (ILP/LTSS)*

SCAN offers unique home and community-based services designed to keep you healthy and independent. These services are offered under the Independent Living Power/Long Term Services and Supports (ILP/LTSS) program.

Qualifying members are eligible for up to $850 per month of these additional services. ILP/LTSS Services are only available in Los Angeles, Orange, Riverside, San Bernardino, and San Diego counties, California. Contact Independent Living Power Call Center at 1-800-887-8695 for an assessment request.

Please Note: You must be eligible to qualify for ILP/LTSS. An initial assessment is required. Once you are enrolled with ILP/LTSS, you must agree to receive your personal care and related homemaking services from SCAN. Contact SCAN Member Services for details.

Homemaker Service You are eligible to receive assistance with light cleaning, grocery shopping, laundry and meal preparation.	You pay $15 per visit
Home Delivered Meals You are covered for home delivery of meals to meet nutritional needs.	You pay $0
Personal Care Services You are covered for in-home assistance for tasks such as bathing, dressing, eating, getting in and out of bed, moving about/walking, and grooming.	You pay $15 per visit
Emergency Response System You are covered for the installation of a personal emergency response device that alerts emergency medical personnel to provide immediate help. There is no cost for installation.	You pay $0
Transportation Escort Services You are eligible to receive an escort to assist you during transportation to and from medical appointments.	You pay $15 per visit
Personal Care Coordinator SCAN staff will provide personal assistance to coordinate your Independent Living Power/Long Term Support Services.	You pay $0

*Members who qualify for Independent Living Power/Long Term Services and Supports must meet state criteria for Nursing Home Certifiable as determined by a SCAN Specialist after enrollment in the plan. Copayments apply for most services. Limits also apply. ILP/LTSS Services available only in Los Angeles, Orange, Riverside, San Bernardino, and San Diego counties, California.

INDEPENDENT LIVING POWER/LONG TERM SERVICES AND SUPPORTS (ILP/LTSS)*

Inpatient Custodial Care You are covered for up to 5 days per year for post-acute or respite support in a skilled nursing facility. You may use this service following a hospital discharge, ER visit, or for respite care purposes.	You pay $0
In-Home Caregiver Relief SCAN provides alternative caregiver services in your home when a regular caregiver can't be there.	You pay $15 per visit
Community-Based Adult Services (CBAS)-Adult Day Care SCAN covers adult day care services to provide relief for your regular caregiver while addressing the individual needs of the member for physical, social or intellectual exercises and stimulation. Criteria applies.	You pay $15 per visit
Incontinence Supplies Members who qualify may be eligible to receive selected incontinence supplies, such as diapers, briefs, and pads to maintain skin integrity.	You pay $0
Select Bathroom Safety Equipment Members may be eligible to receive selected bathroom safety equipment to assist you in performing certain daily activities. Please contact your Care Manager for further information.	You pay $0

*Members who qualify for Independent Living Power/Long Term Services and Supports must meet state criteria for Nursing Home Certifiable as determined by a SCAN Specialist after enrollment in the plan. Copayments apply for most services. Limits also apply. ILP/LTSS Services available only in Los Angeles, Orange, Riverside, San Bernardino, and San Diego counties, California.

SCAN Retiree Group - N-MUSD 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

Who can join?	**You must:** - have both Medicare Part A and Part B - live in the plan service areas (Los Angeles, Orange, Riverside, San Bernardino, San Diego, Ventura, Alameda, Fresno, Madera, Santa Clara, San Francisco, San Mateo and Stanislaus counties, California) - be a United States citizen or be lawfully present in the United States
Phone Number (Members)	**1-800-559-3500**
Phone Number (Non-Members)	**1-877-791-7226** Calling this number will direct you to a licensed insurance agent.
TTY	**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	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 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 1-877-791-7226 (TTY: 711). Hours are 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.

Understanding the Benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor. Visit www.scanhealthplan.com or call 1-877-791-7226 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 October 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).

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 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

- **Arabic:** إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة لديك تتعلق بخطتنا الصحية أو جدول الدواء. سيقوم شخص ما يتحدث العربية 1-866-722-6725للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على الرقم . بمساعدتك.هذه الخدمة المجانية.

- **Armenian:** Առողջության կամ դեղերի ծրագրի վերաբերյալ որևէ հարց առաջանալու դեպքում կարող եք օգտվել անվճար թարգմանչական ծառայությունից: Թարգմանչի ծառայությունից օգտվելու համար զանգահարե՛ք 1-866-722-6725 հեռախոսահամարով: Ձեզ կօգնի հայերենին տիրապետող մեր աշխատակիցը: Ծառայությունն անվճար է:

- **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 1-866-722-6725 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 1-866-722-6725 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。

- **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 1-866-722-6725. Someone who speaks English can help you. This is a free service.

- **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 1-866-722-6725. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

- **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 1-866-722-6725. 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 1-866-722-6725. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

- **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 1-866-722-6725 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

- **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 1-866-722-6725. Muaj qee tus neeg hais lus Hmoob tuaj yeem pab tau koj. Qhov no yog kev pab cuam pab dawb.

- **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 1-866-722-6725. Muaj tus neeg hais lus Hmoob tuaj yeem pab tau koj. Qhov kev pab cuam no yog pab dawb xwb.

- **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 1-866-722-6725. Un nostro incaricato che parla Italiano Le fornirà l'assistenza necessaria. È un servizio gratuito.
- **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 1-866-722-6725 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。
- **Korean:** 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-866-722-6725번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.
- **Lao:** ພວກເຮົາມີການບໍລິການນາຍພາສາຟຣີ ເພື່ອຕອບຄຳຖາມທີ່ທ່ານອາດຈະມີກ່ຽວກັບສຸຂະພາບ ຫຼື ແຜນການຢາ ຂອງພວກເຮົາ. ເພື່ອຮັບເອົານາຍພາສາ, ພຽງແຕ່ໂທຫາພວກເຮົາທີ່ເບີ 1-866-722-6725. ບາງຄົນທີ່ເວົ້າພາສາລາວ ສາມາດຊ່ວຍທ່ານໄດ້. ນີ້ແມ່ນການບໍລິການຟຣີ.
- **Mon-Khmer, Cambodian:**
  យើងខ្ញុំមានសេវាអ្នកបកប្រែផ្តាល់មាត់ដោយមិនគិតថ្លៃចាំឆ្លើយរាល់សំណួរដែលអ្នកអាចមានអំពីសុខភាព ឬផែនការឱសថរបស់យើងខ្ញុំ។ ដើម្បីទទួលបានអ្នកបកប្រែ គ្រាន់តែហៅទូរស័ព្ទមកយើងខ្ញុំតាមរយៈលេខ 1-866-722-6725។ មានគេដែលនិយាយភាសាខ្មែរអាចជួយលោកអ្នកបាន។ សេវាកម្មនេះមិនគិតថ្លៃទេ។
- **Persian:**
  ما خدمات مترجم رایگان داریم تا به هر سؤالی که ممکن است در مورد برنامه بهداشتی یا داروهای ما داشته باشید پاسخ دهیم. توجه: شخصی که به زبان فارسی صحبت می کند، تماس بگیرید.1-866-722-6725برای آن که مترجم دریافت کنید فقط کافیست با شماره می تواند به شما کمک کند. این یک سرویس رایگان است.
- **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 1-866-722-6725. Ta usługa jest bezpłatna.
- **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 1-866-722-6725. Irá encontrar alguém que fale português para o ajudar. Este serviço é gratuito.
- **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 1-866-722-6725 'ਤੇ ਕਾਲ ਕਰੋ। ਕੋਈ ਵਿਅਕਤੀ ਜੋ ਪੰਜਾਬੀ ਬੋਲਦਾ ਹੈ, ਉਹ ਤੁਹਾਡੀ ਮਦਦ ਕਰ ਸਕਦਾ ਹੈ। ਇਹ ਇੱਕ ਮੁਫ਼ਤ ਸੇਵਾ ਹੈ।
- **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 1-866-722-6725. Вам окажет помощь сотрудник, который говорит на русском языке. Данная услуга бесплатная.
- **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 1-866-722-6725. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

- **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 1-866-722-6725. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.
- **Thai:** เรามีบริการล่ามฟรีเพื่อตอบข้อสงสัยต่าง ๆ ที่คุณอาจมีเกี่ยวกับแผนสุขภาพและด้านเภสัชกรรมของเรา ขอความช่วยเหลือจากล่ามโดยโทรติดต่อเราที่หมายเลข 1-866-722-6725 เจ้าหน้าที่ในภาษาไทยจะเป็นผู้ให้บริการโดยไม่มีค่าใช้จ่ายใด ๆ
- **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 1-866-722-6725. Вам може допомогти людина, яка володіє українською мовою. Ця послуга безкоштовна.
- **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 1-866-722-6725. Người nói Tiếng Việt có thể trợ giúp quý vị. Đây là dịch vụ miễn phí.