2025

Summary of Benefits

SCAN Embrace (HMO-POS I-SNP)

Maricopa and Pima Counties

January 1, 2025 – December 31, 2025

SCAN Embrace (HMO-POS I-SNP) is an HMO plan and is a Point of Service (POS) plan with a Medicare contract. Enrollment in SCAN Desert Health Plan depends on contract renewal. You must continue to pay your Medicare Part B premium.

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

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scan™

SUMMARY OF BENEFITS

JANUARY 1, 2025 – DECEMBER 31, 2025

PREMIUM AND BENEFITS	SCAN EMBRACE		WHAT YOU SHOULD KNOW
	In-Network Services	Out-of-Network Services	
Monthly Health Plan Premium	$0	$0	You must continue to pay your Medicare Part B premium.
Plan Deductible	$0	$0	This plan does not have a deductible.
Maximum Out-of-Pocket Responsibility (this does not include prescription drugs)	$1,500	$1,500	The most you pay for copays and coinsurance for **Medicare-covered medical services** for the year.
Inpatient Hospital Coverage	$150 copay per day for days 1-5 $0 for days 6-90. Unlimited days per admission	Not covered	**Prior authorization** rules may apply.
Outpatient Hospital Services			**Prior authorization** rules apply for outpatient hospital services.
• Ambulatory Surgical Center	$0-$50 copay per visit	Not covered	
• Outpatient Hospital	$0-$100 copay per visit	Not covered	
• Observation services	$0	Not covered	
Doctor Visits			
• Primary Care	$0	Not covered	
• Specialists	$0	$10 copay per visit	**Prior authorization** rules apply for specialist visits.
Preventive Care	$0	Not covered	**Prior authorization** rules apply.

PREMIUM AND BENEFITS	SCAN EMBRACE		WHAT YOU SHOULD KNOW
	In-Network Services	Out-of-Network Services	
Emergency Care	$120 copay per visit	Not covered	The emergency room copay will be waived if you are immediately admitted to the hospital. You are covered for worldwide emergency services at Original Medicare reimbursable rates.
Urgently Needed Services	$0	Not covered	You are covered for worldwide urgent care services at Original Medicare reimbursable rates.
Diagnostic Services/ Labs/Imaging			**Prior authorization** rules apply for diagnostic, lab, and imaging services.
• Lab services	$0	$0	
• Diagnostic tests and procedures	$0	$0	
• Outpatient X-rays	$0	$0	
• Therapeutic radiology	$60 copay per visit	$60 copay per visit	
• Diagnostic radiology (e.g., MRI, CT)	$0-$125 copay per visit	$0-$125 copay per visit	

PREMIUM AND BENEFITS	SCAN EMBRACE		WHAT YOU SHOULD KNOW
	In-Network Services	Out-of-Network Services	
Hearing Services			
• Medicare-covered diagnostic hearing and balance exam	$0	$0	**Prior authorization** rules apply for Medicare-covered diagnostic hearing and balance exams.
• Non-Medicare-covered (routine) hearing exam	$0 for up to 1 visit every 12 months	Not covered	You must go to a SCAN-contracted provider to obtain a routine hearing exam and hearing aids.
• Non-Medicare-covered (routine) hearing aids	$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	Not covered	
Dental Services			
• Medicare-covered dental services	$0	$0	**Prior authorization** rules apply for Medicare-covered dental services.

PREMIUM AND BENEFITS	SCAN EMBRACE		WHAT YOU SHOULD KNOW
	In-Network Services	Out-of-Network Services	
• Non-Medicare-covered (routine) dental services	Dental Plan AZC73+EPO		You must go to a SCAN-contracted dental provider to obtain covered services. Once you have reached your coverage limit, you will be responsible for any remaining costs.
– Dental exams	$0 up to 2 visits every 12 months	Not covered	
– Dental cleanings	$0 up to 2 visits every 12 months	Not covered	
– Dental X-rays	$0 up to 2 visits every 12 months	Not covered	
– Diagnostic services	$0-$5 copay	Not covered	
– Preventive services	$0-$80 copay	Not covered	
– Restorative services	$8-$395 copay	Not covered	
– Endodontic services	$5-$395 copay	Not covered	
– Periodontics	$0-$380 copay	Not covered	
– Prosthodontics fixed	$25-$395 copay	Not covered	
– Prosthodontics removable	$13-$395 copay	Not covered	
– Oral and maxillofacial surgery	$0-$140 copay	Not covered	
– Adjunctive services	$0-$125 copay	Not covered	

PREMIUM AND BENEFITS	SCAN EMBRACE		WHAT YOU SHOULD KNOW
	In-Network Services	Out-of-Network Services	
Vision Services			
• Medicare-covered vision exam to diagnose/treat diseases of the eye	$0	$0	**Prior authorization** rules apply for Medicare-covered vision exam and glasses after cataract surgery.
• Medicare-covered glasses after cataract surgery	$0	$0	
• Non-Medicare-covered (routine) vision exam	$0 for up to 1 visit every 12 months	Not covered	Routine vision services do not require prior authorization.
• Non-Medicare-covered (routine) vision coverage limit	You are covered for up to $375 for frames, lenses, and lens options or contact lenses every 12 months	Not covered	You must go to a SCAN-contracted vision provider to obtain routine vision services.
Mental Health Services			
• Inpatient visit	$150 copay per day for days 1-5 $0 for days 6-90	Not covered	**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	$0	$10 copay per visit	**Prior authorization** rules apply for outpatient individual/group therapy visits.
• Outpatient individual/group therapy visit with a psychiatrist	$0	$10 copay per visit	
Skilled Nursing Facility	$0 for days 1-100	Not covered	**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.

*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 EMBRACE		WHAT YOU SHOULD KNOW
	In-Network Services	Out-of-Network Services	
Physical Therapy	$0	Not covered	**Prior authorization** rules apply for outpatient physical therapy services.
Ambulance	$200 copay per one-way trip	Not covered	**Prior authorization** rules apply for non-emergency and air ambulance services.
Transportation (Non-Medicare-covered — routine)	$0 for up to 56 one-way trips per year You may use up to 28 of your 56 one-way trips to non-medical destinations (grocery store, health club, or senior center) per year. This is an SSBCI benefit. Members must meet qualifying conditions.† 50-mile limit applies to each one-way trip	Not covered	**Prior authorization** rules apply for routine transportation services. You must use a SCAN-contracted provider to obtain routine transportation services.
Medicare Part B Drugs	$0 for select nebulized medications and $0-20% of the Medicare-approved amount for Part B chemotherapy and other Part B drugs 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	Not covered	**Prior authorization** rules apply to select drugs.

OUTPATIENT PRESCRIPTION DRUGS (PART D DRUGS):

SCAN EMBRACE

You pay the following:

Part D Deductible	$0

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
Initial Coverage Stage							
Tier 1 (Preferred Generic)		$0	$0	$0	$0	$0	$0
Tier 2 (Generic)		$0	$0	$0	$0	$0	$0
Tier 3 (Preferred Brand)	Insulin	$0	$0	$0	$0	$0	$0
	Other Drugs	$42	$126	$43	$129	$126	$129
Tier 4 (Non-Preferred Drug)		50%	50%	50%	50%	50%	50%
Tier 5 (Specialty Tier)		33%	Not available	33%	Not available	Not available	Not available

Catastrophic Coverage Stage

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.

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), 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 across all Part D benefit stages. 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.

PREMIUM AND BENEFITS	SCAN EMBRACE		WHAT YOU SHOULD KNOW
	In-Network Services	Out-of-Network Services	
Acupuncture Services • Medicare-covered acupuncture care	$0	$10 copay	**Prior authorization** rules apply.
Chiropractic Services • Medicare-covered chiropractic care	$0	Not covered	**Prior authorization** rules apply.
HEALTH*tech* • Technology support to help you access your health care information	$0	Not covered	
Home Health Care (Medicare-covered)	$0	Not covered	**Prior authorization** rules apply.
In-Home Support Services	$0 120 hours for personal in-home care after a hospitalization	Not covered	**Prior authorization** rules apply.

PREMIUM AND BENEFITS	SCAN EMBRACE		WHAT YOU SHOULD KNOW
	In-Network Services	Out-of-Network Services	
Medical Equipment/ Supplies			
• Durable Medical Equipment (e.g., wheelchairs, oxygen)	$0 for items $0-$499 20% of the total cost for items $500 or more	Not covered	**Prior authorization** rules apply for covered durable medical equipment, prosthetic devices, and certain diabetic supplies.
• Prosthetics (e.g., braces, artificial limbs)	$0 for items $0-$499 20% of the total cost for items $500 or more	Not covered	
• Diabetic supplies	$0	Not covered	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.
• Continuous Glucose Monitors	$0 at the pharmacy or DME provider	Not covered	Freestyle Libre and Dexcom CGMs are covered at contracted pharmacies. Other CGM manufacturers are available at contracted DME providers. **Prior authorization** rules apply.

PREMIUM AND BENEFITS	SCAN EMBRACE		WHAT YOU SHOULD KNOW
	In-Network Services	Out-of-Network Services	
Telehealth Services • Urgent Care and Mental Health	$0	Not covered	**Urgent Care:** A licensed health care professional 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 providers can be conducted by telephone or secure video capabilities from your computer or smart phone. Telehealth is not intended to replace your primary care doctor or specialist. **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 medical groups mental health provider.

PREMIUM AND BENEFITS	SCAN EMBRACE		WHAT YOU SHOULD KNOW
	In-Network Services	Out-of-Network Services	
Over-the-Counter (OTC) Products	$200 per quarter	Not covered	You receive a quarterly allowance to be used for eligible OTC items in-store at CVS retailers or home delivery. Unused balances will be carried over to the next quarter, but will **not** roll over to the following year.
Dental, Vision, Hearing Allowance	$150 per year	Not covered	You receive a $150 allowance annually for your dental, vision, and/or hearing needs. You can choose to spend it on out-of-pocket costs or additional services.

ADDITIONAL DETAILS AND CONTACT INFORMATION

SCAN EMBRACE	
Who can join?	**You must:** – have both Medicare Part A and Part B – live in the plan service area (Maricopa and Pima Counties, Arizona) – be a United States citizen or be lawfully present in the United States
Phone Number (Members)	**1-855-650-7226**
Phone Number (Non-Members)	**1-877-814-7226** Calling this number will direct you to a licensed insurance agent.
TTY	**711**
Hours of Operation	**October 1 to March 31:** 8 am to 8 pm, 7 days a week **April 1 to September 30:** 8 am to 8 pm, Monday through Friday Messages received on holidays and outside of our business hours will be returned within one business day.
Website	www.scanhealthplan.com

SCAN Embrace 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.

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 1-855-650-7226 (TTY: 711) for more information.

†Eligibility for this benefit is not based solely on chronic conditions. All applicable eligibility requirements must be met before the benefit is provided. Qualifying chronic condition(s) required to be eligible for the SSBCI benefit include cardiovascular disorders, chronic heart failure, diabetes, cancer, chronic lung disorders. Other chronic conditions may apply. Medical records will be used to establish qualifications for the benefit.

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 Desert Health Plan's Member Services at 1-855-650-7226, 8 am to 8 pm, 7 days a week from October 1 to March 31. From April 1 to September 30, hours are 8 am to 8 pm 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:

1-877-814-7226

TTY users call 711

October 1 to March 31
8 am to 8 pm, 7 days a week

April 1 to September 30
8 am to 8 pm, Monday through Friday

Messages received on holidays and outside of our business hours will be returned within one business day.

Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit www.scanhealthplan.com or call 1-877-814-7226 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.
- ☐ Review the Formulary to make sure your drugs are covered.

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, 2026.
- ☐ 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 Desert 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 Desert 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 Desert 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 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 Desert Health Plan
Attention: Grievance and Appeals Department
P.O. Box 22616
Long Beach, CA 90801-5616

SCAN Member Services
PHONE: 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 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 1-855-650-7226. 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 1-855-650-7226. 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 1-855-650-7226 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 1-855-650-7226 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 1-855-650-7226. 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 1-855-650-7226. 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 1-855-650-7226 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 ծառայությունից օգտվելու համար զանգահարե՛ք 1-855-650-7226 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 شماره1-855-650-7226 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 1-855-650-7226. 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、1-855-650-7226 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 الرقم1-855-650-7226. 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 ਮੁਫ਼ਤ ਦੁਭਾਸ਼ੀਆ ਸੇਵਾਵਾਂ ਹਨ। ਕੋਈ ਦੁਭਾਸ਼ੀਆ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ, ਬੱਸ ਸਾਨੂੰ 1-855-650-7226 '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 1-855-650-7226។ 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 1-855-650-7226. 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 1-855-650-7226 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Thai: เรามีบริการล่ามฟรีเพื่อตอบข้อสงสัยต่าง ๆ ที่คุณอาจมีเกี่ยวกับแผนสุขภาพและด้านเภสัชกรรมของเรา ขอความช่วยเหลือจากล่ามโดยโทรติดต่อเราที่หมายเลข 1-855-650-7226 เจ้าหน้าที่ในภาษาไทยจะเป็นผู้ให้บริการโดยไม่มีค่าใช้จ่ายใด ๆ

Lao: ພວກເຮົາມີການບໍລິການນາຍພາສາຟຣີ ເພື່ອຕອບຄຳຖາມທີ່ທ່ານອາດຈະມີກ່ຽວກັບສຸຂະພາບ ຫຼື ແຜນການຢາຂອງ ພວກເຮົາ. ເພື່ອຮັບເອົານາຍພາສາ, ພຽງແຕ່ໂທຫາພວກເຮົາທີ່ເບີ 1-855-650-7226. 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 1-855-650-7226. 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 1-855-650-7226. 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 1-855-650-7226. 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 1-855-650-7226. 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 1-855-650-7226. 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 1-855-650-7226. 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 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 1-855-650-7226. 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 1-855-650-7226. Вам може допомогти людина, яка володіє українською мовою. Ця послуга безкоштовна.