Regence

2023 Summary of Benefits

Regence MedAdvantage + Rx Classic (PPO)
For residents of the following counties in Oregon: Clackamas, Deschutes, Lane, Multnomah, and Washington.

H3817-008-001

January 1, 2023 – December 31, 2023

Regence BlueCross BlueShield of Oregon
is an Independent Licensee of the Blue Cross and Blue Shield Association

SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "**Evidence of Coverage**." You can also see the Evidence of Coverage on our website, www.regence.com/medicare.

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **Regence MedAdvantage + Rx Classic (PPO)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Regence MedAdvantage + Rx Classic (PPO)** covers and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on www.medicare.gov.
- If you want to know more 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 should call 1-877-486-2048.

Sections in this booklet

- Things to Know About **Regence MedAdvantage + Rx Classic (PPO).**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services.
- Covered Medical and Hospital Benefits.
- Prescription Drug Benefits.

This document is available in other formats such as Braille and large print.

This document may be available in a non-English language. For additional information, call us at 1-800-541-8981 (TTY: 711).

Things to Know About Regence MedAdvantage + Rx Classic (PPO)

Hours of Operation & Contact Information

- From October 1 to March 31, we're open 8 a.m. – 8 p.m., 7 days a week.
- From April 1 to September 30, we're open 8 a.m. – 8 p.m., Monday through Friday.
- If you are a member of this plan, call us at 1-800-541-8981, TTY: 711.
- If you are not a member of this plan, call us at 1-844-734-3623, TTY: 711, 8 a.m. to 5 p.m., Monday through Friday.
- Our website: www.regence.com/medicare.

SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

Who can join?

To join **Regence MedAdvantage + Rx Classic (PPO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and you must live in our service area. Our service area includes these counties in Oregon: Clackamas, Deschutes, Lane, Multnomah and Washington.

Which doctors, hospitals, and pharmacies can I use?

Regence MedAdvantage + Rx Classic (PPO) has a network of doctors, hospitals, pharmacies, and other providers. If you use providers that are not in our network, your costs may be more (except in emergency or urgent situations).

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

You can see our plan's provider and pharmacy directory at our website (www.regence.com/medicare).

Or, call us and we will send you a copy of the provider and pharmacy directories.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers – and *more*. Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs including chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, www.regence.com/medicare.
- Or, call us and we will send you a copy of the formulary.

How will I determine my drug costs?

Our plan groups each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Deductible, Initial Coverage, Coverage Gap and Catastrophic Coverage.

If you have any questions about this plan's benefits or costs, please contact
Regence BlueCross BlueShield of Oregon

SECTION II - SUMMARY OF BENEFITS Regence MedAdvantage + Rx Classic (PPO)	
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES	
Monthly Plan Premium	$47 per month. In addition, you must keep paying your Medicare Part B premiums.
Deductible	Medical Deductible: There is no deductible for this plan.
Maximum Out-of-Pocket Responsibility	Annual limit(s) on your out-of-pocket costs for Part A (hospital) and Part B (medical) services: • $5,700 for services you receive from in-network providers. • $8,950 for services you receive from in- and out-of-network providers combined. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.
COVERED MEDICAL AND HOSPITAL BENEFITS	
Inpatient Hospital	**In-Network:** Days 1-4: $395 Copay per day for each admission. Days 5+: $0 Copay per day. Our plan covers an unlimited number of days for an inpatient hospital stay. May require prior authorization. **Out-of-Network:** Days 1-999: 30% Coinsurance per day.
Outpatient Hospital	**In-Network:** Outpatient Hospital: $35 - $350 Copay. May require prior authorization. **Out-of-Network:** Outpatient Hospital: 30% Coinsurance.
Ambulatory Surgical Center	**In-Network:** Ambulatory Surgical Center: $35 - $300 Copay. May require prior authorization. **Out-of-Network:** Ambulatory Surgical Center: 30% Coinsurance.

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Doctor's Office Visits	**In-Network:** Primary care physician visit: $5 Copay. Specialist visit: $35 Copay. **Out-of-Network:** Primary care physician visit: 30% Coinsurance. Specialist visit: 30% Coinsurance.
Preventive Care *(e.g., flu vaccine, diabetic screenings)*	**In-Network:** $0 Copay for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare during the contract year will be covered. **Out-of-Network:** 30% Coinsurance for all preventive services covered under Original Medicare.
Emergency Care	**In-Network and Out-of-Network:** $90 Copay per visit. If you are admitted to the hospital within 48 hours, you do not have to pay your share of the cost for emergency care. Worldwide Emergency Coverage: $90 Copay.
Urgently Needed Services	**In-Network and Out-of-Network:** $40 Copay per visit. Worldwide Urgent Coverage: $90 Copay.
Diagnostic Services / Labs/ Imaging	**In-Network:** Diagnostic tests and procedures: $10 Copay. Lab services: $0 - $10 Copay. Diagnostic Radiology Services (such as MRI, CAT Scan): $0 - $250 Copay. X-rays: $10 Copay. Therapeutic radiology services (such as radiation treatment for cancer): 20% Coinsurance. May require prior authorization. **Out-of-Network:** Diagnostic tests and procedures: 30% Coinsurance. Lab services: 30% Coinsurance. Diagnostic Radiology Services (such as MRI, CAT Scan): 30% Coinsurance. X-rays: 30% Coinsurance. Therapeutic radiology services (such as radiation treatment for cancer): 30% Coinsurance.

SECTION II - SUMMARY OF BENEFITS Regence MedAdvantage + Rx Classic (PPO)	
Hearing Services	**In-Network:** Exam to diagnose and treat hearing and balance issues: $35 Copay. Routine hearing exam (up to 1 visit(s) every year): $0 Copay. Hearing Aid (up to 2 hearing aids every year): $699 - $999 Copay. **Out-of-Network:** Exam to diagnose and treat hearing and balance issues: 30% Coinsurance. Routine hearing exam (up to 1 visit(s) every year): $150 Copay.
Dental Services	**In-Network:** Medicare Covered: $35 Copay. Preventive dental services: • Oral exam (up to 2 visit(s) every year): $0 Copay. • Cleaning (up to 2 visit(s) every year): $0 Copay. • Fluoride treatment (up to 2 visit(s) every year): $0 Copay. • Dental X-rays (up to 2 visit(s) every year): $0 Copay. Comprehensive dental services: • Diagnostic Services: $0 Copay. **Out-of-Network:** Medicare Covered: 30% Coinsurance. Preventive dental services: • Oral exam (up to 2 visit(s) every year): 50% Coinsurance. • Cleaning (up to 2 visit(s) every year): 50% Coinsurance. • Fluoride treatment (up to 2 visit(s) every year): 50% Coinsurance. • Dental X-rays (up to 2 visit(s) every year): 50% Coinsurance. Comprehensive Dental Services: • Diagnostic Services: 50% Coinsurance.
OPTIONAL SUPPLEMENTAL DENTAL SERVICES	
Covered Comprehensive Dental Services	Comprehensive Dental Services: • Restorative Services: 50% Coinsurance. • Endodontics: 50% Coinsurance.

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	• Periodontics: 50% Coinsurance. • Extractions: 50% Coinsurance. • Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: 50% Coinsurance. Cost share is the same for In-network and Out-of-network providers.
How much is the monthly premium?	If you elect this optional supplemental benefit, you will pay an additional $24 per month. You must also keep paying your Medicare Part B premium and your plan monthly premium.
How much is the deductible?	There is no deductible.
What is the maximum payment that this plan will pay per calendar year?	This dental plan will pay up to $1,000 maximum per calendar year for optional supplemental dental services.
COVERED MEDICAL AND HOSPITAL BENEFITS (Continued)	
Vision Services	**In-Network:** Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $0 Copay. Routine eye exam (up to 1 visit(s) every year): $0 Copay. Eyeglasses or contact lenses after cataract surgery: $0 Copay. Contact lenses: $0 Copay. Eyeglasses (frames and lenses): $0 Copay. Frames or contact lenses: $100 allowance per year. **Out-of-Network:** Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): 30% Coinsurance. Routine eye exam (up to 1 visit(s) every year): 30% Coinsurance. Eyeglasses or contact lenses after cataract surgery: 30% Coinsurance. Contact lenses: 0% Coinsurance. Eyeglasses (frames and lenses): 0% - 50% Coinsurance. Frames or contact lenses: $100 allowance per year.

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Mental Health Care	**In-Network:** Outpatient group therapy visit: $25 Copay. Individual therapy visit: $25 Copay. Inpatient Mental Health Care: Days 1-4: $395 Copay per day for each admission. Days 5-190: $0 Copay per day. May require prior authorization. **Out-of-Network:** Outpatient group therapy visit: 30% Coinsurance. Individual therapy visit: 30% Coinsurance. Inpatient Mental Health Care: Days 1-190: 30% Coinsurance per day.
Skilled Nursing Facility (SNF)	**In-Network:** Days 1-20: $0 Copay per day. Days 21-51: $188 Copay per day. Days 52-100: $0 Copay per day. May require prior authorization. **Out-of-Network:** Days 1-100: 30% Coinsurance per day.
Outpatient Rehabilitation	**In-Network:** Occupational therapy visit: $30 Copay. Physical therapy and speech and language therapy visit: $30 Copay. May require prior authorization. **Out-of-Network:** Occupational therapy visit: 30% Coinsurance. Physical therapy and speech and language therapy visit: 30% Coinsurance.
Ambulance	**In-Network:** Ground Ambulance: $300 Copay. Air Ambulance: $300 Copay. May require prior authorization.

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	Out-of-Network: Ground Ambulance: $300 Copay. Air Ambulance: $300 Copay.
Transportation	**In-Network:** Not covered. **Out-of-Network:** Not covered.
Medicare Part B Drugs	**In-Network:** For Part B drugs such as chemotherapy drugs: 0% - 20% Coinsurance (depending on the drug). Other Part B drugs: 0% - 20% Coinsurance (depending on the drug). Part B insulin drugs: 20% up to $35 Copay for a one-month supply. May require prior authorization. **Out-of-Network:** For Part B drugs such as chemotherapy drugs: 30% Coinsurance. Other Part B drugs: 30% Coinsurance. Part B insulin drugs: 30% Coinsurance.
Acupuncture – Medicare-Covered Services	**In-Network:** $20 Copay. **Out-of-Network:** 30% Coinsurance. Limited to treatment of chronic low back pain.
Acupuncture – Additional Covered Services	**In-Network:** $20 Copay. **Out-of-Network:** 30% Coinsurance. Limited to 18 visits per year combined with additional chiropractic.
Chiropractic – Medicare-Covered Services	**In-Network:** $20 Copay. **Out-of-Network:** 30% Coinsurance. Limited to manipulation of the spine to correct a subluxation.

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Chiropractic – Additional-Covered Services	**In-Network:** $20 Copay. **Out-of-Network:** 30% Coinsurance. Limited to 18 visits per year combined with additional acupuncture.
Massage Therapy	**In-Network:** $20 Copay. **Out-of-Network:** 30% Coinsurance. Limit of 6 visits per year, up to 60 minutes per visit.
Naturopathy	**In-Network:** $20 Copay. **Out-of-Network:** 30% Coinsurance. Limit of 6 visits per year.
Additional Telehealth/Virtual Care	**In-Network:** $5 Copay. **Out-of-Network:** 30% Coinsurance. Includes urgent care and mental health services by phone or video.
Bathroom Safety Devices	$100 allowance every year.
Diabetic Routine Footcare	**In-Network:** $0 Copay. **Out-of-Network:** 30% Coinsurance. Limit of 6 visits per year.
Durable Medical Equipment (DME)	**In-Network:** 20% Coinsurance. **Out-of-Network:** 50% Coinsurance. May require prior authorization.

<table>
<tr><th colspan="2">SECTION II - SUMMARY OF BENEFITS
Regence MedAdvantage + Rx Classic (PPO)</th></tr>
<tr><td>Fitness Program</td><td>$0 Copay.
Flexible fitness options that support physical activity, well-being, community building, and healthy aging.</td></tr>
<tr><td>Home Delivered Meals – Post Discharge</td><td>$0 Copay.
2 meals per day, up to 28 days, 56-meal limit.</td></tr>
<tr><td>Home Delivered Meals – Chronic Health Needs</td><td>$0 Copay.
2 meals per day, up to 56 days, 112-meal limit.
Requires enrollment in care management program.
The benefits mentioned are a part of special supplemental program for the chronically ill. Not all members qualify.</td></tr>
<tr><td>In-home support services</td><td>$0 Copay.
In-person and virtual support services. Limited to 48 hours per year; up to 1 hour per visit.</td></tr>
<tr><td>Over The Counter (OTC) Items</td><td>$20 every three months.</td></tr>
<tr><td>Palliative Care and Support</td><td><u>In-Network:</u>
$0 Copay.
<u>Out-of-Network:</u>
30% Coinsurance.</td></tr>
<tr><td>Personal Emergency Response System (PERS)</td><td>$0 Copay.
Benefit includes device and monthly monitoring services.</td></tr>
<tr><td colspan="2">PRESCRIPTION DRUG BENEFITS</td></tr>
<tr><td>Deductible</td><td>Prescription Drug Deductible: $0 for Tiers 1 & 2, for Tiers 3 & 4 insulins and most vaccines; $150 for Tiers 3, 4 and 5.</td></tr>
<tr><td>Initial Coverage</td><td>You pay the following until your total yearly drug costs reach $4,660. Total yearly drug costs are the drug costs paid by both you and our Part D plan.
Standard Retail Cost-Sharing
<table>
<tr><th>Tier</th><th>One-month supply</th><th>Two-month supply</th><th>Three-month supply</th></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>$10 Copay</td><td>$20 Copay</td><td>$20 Copay</td></tr>
</table></td></tr>
</table>

Tier 2 (Generic)	$20 Copay	$40 Copay	$40 Copay
Tier 3 (Preferred Brand) Insulin drugs Most vaccines	$47 Copay $35 Copay $0 Copay	$94 Copay $70 Copay $0 Copay	$117.50 Copay $87.50 Copay $0 Copay
Tier 4 (Non-Preferred Drug) Insulin drugs	$100 Copay $35 Copay	$200 Copay $70 Copay	$250 Copay $87.50 Copay
Tier 5 (Specialty Tier)	30% Coinsurance	Not Applicable	Not Applicable

Preferred Retail Cost-Sharing

Tier	One-month supply	Two-month supply	Three-month supply
Tier 1 (Preferred Generic)	$0 Copay	$0 Copay	$0 Copay
Tier 2 (Generic)	$13 Copay	$26 Copay	$26 Copay
Tier 3 (Preferred Brand) Insulin drugs Most vaccines	$40 Copay $35 Copay $0 Copay	$80 Copay $70 Copay $0 Copay	$100 Copay $87.50 Copay $0 Copay
Tier 4 (Non-Preferred Drug) Insulin drugs	$100 Copay $35 Copay	$200 Copay $70 Copay	$250 Copay $87.50 Copay
Tier 5 (Specialty Tier)	30% Coinsurance	Not Applicable	Not Applicable

Standard Mail Order

Tier	One-month supply	Two-month supply	Three-month supply
Tier 1 (Preferred Generic)	$0 Copay	$0 Copay	$0 Copay
Tier 2 (Generic)	$13 Copay	$26 Copay	$26 Copay
Tier 3 (Preferred Brand) Insulin drugs Most vaccines	$40 Copay $35 Copay $0 Copay	$80 Copay $70 Copay $0 Copay	$100 Copay $87.50 Copay $0 Copay
Tier 4 (Non-Preferred Drug) Insulin drugs	$100 Copay $35 Copay	$200 Copay $70 Copay	$250 Copay $87.50 Copay

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	Tier 5 (Specialty Tier)	30% Coinsurance	Not Applicable	Not Applicable
	Your cost-sharing may be different if you use a Long-Term Care pharmacy, or an out-of-network pharmacy, or if you purchase a long-term supply (up to 100 days) of a drug. Please call us or see the plan's **"Evidence of Coverage"** on our website (www.regence.com/medicare) for complete information about your costs for covered drugs.			
Coverage Gap	The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,660. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $7,400, which is the end of the coverage gap. Our plan covers Tier 3 and Tier 4 Insulins and most vaccines at the Initial Coverage cost share during the Coverage Gap.			
Catastrophic Amount	After your yearly out-of-pocket drug costs reach $7,400, you pay the greater of: • $4.15 Copay for generic (including brand drugs treated as generic) and a $10.35 Copay for all other drugs, or • 5% of the cost. Our plan covers most vaccines at $0 in the Catastrophic Coverage stage.			

DISCLAIMERS

This document is available in other alternate formats.

ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call 1-800-541-8981 (TTY: 711).

ATENCIÓN: Si habla español, hay servicios de traducción, libre de cargos, disponibles para usted. Llame al 1-800-541-8981 (TTY: 711)..

Regence is an HMO/PPO/PDP plan with a Medicare contract. Enrollment in Regence depends on contract renewal.

Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our Customer Service number or see your "Evidence of Coverage" for more information, including the cost-sharing that applies to out-of-network services.

Utilization Management (UM) is the way we review the type and amount of care you're getting. This involves looking at the setting for your care and its medical necessity. Clinical professionals make decisions based on our clinical review criteria, guidelines, and medical policies. Examples of UM procedures include pre-service review (prior authorization), concurrent review (including urgent concurrent review) and post-service review. Find more information in our Member FAQ on regence.com/medicare/resources/faq.

Health coverage is offered by Regence BlueCross BlueShield of Oregon.

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 1-800-541-8981 (TTY 711).

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.regence.com/medicare or call 1-800-541-8981 (TTY 711) 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 medicine 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, 2024.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.

Multi-Language Insert

Multi-language Interpreter Services

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 1-800-541-8981. Someone who speaks English/Language 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, por favor llame al 1-800-541-8981. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-800-541-8981。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-800-541-8981。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-541-8981. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

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 1-800-541-8981. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-541-8981 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-541-8981. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-541-8981 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-541-8981. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على متر جم فوري، ليس عليك سوى الاتصال بنا على 1-800-541-8981. سيقوم شخص ما يتحدث العربية بمساعدتك.هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके ककसी भी पर्श्न के जवाब देने के किए हमारे पास मुफ्त दुभाकिया सेवाएँ उपिब्ध हैं. एक दुभाकिया पर्ाप्त करने के किए, बस हमें 1-800-541-8981 पर फोन करें. कोई व्यकि्त जो कहन्दी बोिता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-541-8981. Un nostro incaricato che parla Italianovi 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 1-800-541-8981. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-541-8981. 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 1-800-541-8981. Ta usługa jest bezpłatna.

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