ATRIO™
HEALTH PLANS

2023 Summary of Benefits

Oregon

Jackson & Josephine Counties

ATRIO Freedom (PPO) ATRIO Choice Rx (PPO)
ATRIO Prime Rx (PPO)

January 1, 2023 - December 31, 2023

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Out-of-network/non-contracted providers are under no obligation to treat ATRIO Health Plans members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. 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.

2023 Summary of Benefits

January 1, 2023 – December 31, 2023

About the Summary of Benefits and Who Can Join

This is a summary of drug and health services covered by **ATRIO Freedom (PPO), ATRIO Choice Rx (PPO),** and **ATRIO Prime Rx (PPO)**. 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 view the Evidence of Coverage at **atriohp.com**. To join an ATRIO Health Plans Medicare Advantage Plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Our service area for these plans includes the following counties in **Oregon: Jackson and Josephine Counties**.

Which Doctors, Hospitals and Pharmacies Can I Use?

ATRIO Health Plans has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers in our network, you may pay less for your covered services. If you use providers that are not in our network, you may pay a higher out-of-pocket cost. You must generally use network pharmacies to fill your prescription drugs (if you choose a plan that includes drug coverage). You can see our plan's Formulary (Part D prescription drug list), Provider Directory and Pharmacy Directory at our website, **atriohp.com**.

Tips for Comparing Your Medicare Choices

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 **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.

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 **1-877-672-8620** (TTY 711), daily from 8 a.m. to 8 p.m. local time.

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 **atriohp.com** or call **1-877-672-8620** (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.
☐	If you choose a plan that includes drug coverage, 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.
☐	If you choose a plan that includes drug coverage, review the formulary to make sure your drugs are covered.
Understanding Important Rules	
☐	In addition to your monthly plan premium (if applicable), 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 copay for services received by non-contracted providers.

ATRIO Health Plans is a PPO and HMO D-SNP with Medicare and Oregon Health Plan contracts. Enrollment in ATRIO Health Plans depends on contract renewal.

H6743_SB_OR_JAJO_2023_M
H6743-024-002, H6743-025, H6743-023-002

Summary of Benefits: January 1, 2023 – December 31, 2023

Plan Premium, Deductibles, and Limits on How Much You Pay for Covered Services

	ATRIO Freedom H6743-024-002	ATRIO Choice Rx H6743-025	ATRIO Prime Rx H6743-023-002
Plan Premium	$0 per month. In addition, you must keep paying your Medicare Part B premium.	$0 per month. In addition, you must keep paying your Medicare Part B premium.	$99 per month. In addition, you must keep paying your Medicare Part B premium.
Plan Deductible	$0 per year	$0 per year	$0 per year
Out-of-Pocket Limits	$4,500 for services you receive from in-network providers. $6,500 for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit.	$4,500 for services you receive from in-network providers. $6,500 for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit.	$2,500 for services you receive from in-network providers. $5,000 for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit.

Covered Medical and Hospital Benefits

Note: Services marked with * may require prior authorization.

	ATRIO Freedom H6743-024-002	ATRIO Choice Rx H6743-025	ATRIO Prime Rx H6743-023-002
Inpatient Hospital Care (Acute) *	**In-network:** $275 copay per day for days 1-7; $0 copay per day for days 8 and beyond **Out-of-network:** $375 copay per day for days 1-7; $0 copay per day for days 8-90 No maximum out-of-pocket	**In-network:** $400 copay per day for days 1-5; $0 copay per day for days 6 and beyond **Out-of-network:** $500 copay per day for days 1-5; $0 copay per day for days 6-90 No maximum out-of-pocket	**In-network:** $225 copay per day for days 1-8; $0 copay per day for days 9 and beyond **Out-of-network:** $350 copay per day for days 1-7; $0 copay per day for days 8-90 No maximum out-of-pocket
Outpatient Hospital*	**In-network:** 20% coinsurance **Out-of-network:** 30% coinsurance	**In-network:** $300 copay **Out-of-network:** 50% coinsurance	**In-network:** $275 copay **Out-of-network:** $375 copay
Ambulatory Surgery Center *	**In-network:** 20% coinsurance **Out-of-network:** 30% coinsurance	**In-network:** $225 copay **Out-of-network:** $325 copay	**In-network:** $225 copay **Out-of-network:** $325 copay

	ATRIO Freedom H6743-024-002	**ATRIO Choice Rx H6743-025**	**ATRIO Prime Rx H6743-023-002**
Doctor's Office Visits	Primary care physician: **In-network:** $0 copay **Out-of-network:** $50 copay Specialist: **In-network:** $25 copay **Out-of-network:** $65 copay	Primary care physician: **In-network:** $0 copay **Out-of-network:** $50 copay Specialist: **In-network:** $40 copay **Out-of-network:** $65 copay	Primary care physician: **In-network:** $0 copay **Out-of-network:** $30 copay Specialist: **In-network:** $25 copay **Out-of-network:** $50 copay
Preventive Care	You pay nothing for Medicare covered preventive services. Any additional preventive services approved by Medicare during the plan year will be covered. Our plan also covers a supplemental Annual Physical Exam at no cost.		
Emergency Care Worldwide emergency/urgent coverage.	$110 copay (waived if admitted within 24 hours for the same condition)	$110 copay (waived if admitted within 24 hours for the same condition)	$125 copay (waived if admitted within 24 hours for the same condition)
Urgent Care See "Emergency Care" for worldwide copay.	$35 copay (waived if admitted within 24 hours for the same condition)	$35 copay (waived if admitted within 24 hours for the same condition)	$25 copay (waived if admitted within 24 hours for the same condition)
Diagnostic Tests, Lab, X-rays, and Radiology Services * (such as MRIs, CT scans)	Diagnostic radiology services: **In-network:** 20% coinsurance **Out-of-network:** 30% coinsurance Other diagnostic tests and procedures: **In-network:** $20 copay **Out-of-network:** 30% coinsurance Lab services **In-network:** $20 copay **Out-of-network:** 15% coinsurance Therapeutic radiology services (such as radiation treatment for cancer): **In-network:** 20% coinsurance **Out-of-network:** 30% coinsurance Outpatient x-rays: **In-network:** $20 copay **Out-of-network:** 30% coinsurance	Diagnostic radiology services: **In-network:** $0 to $150 copay **Out-of-network:** 30% coinsurance Other diagnostic tests and procedures: **In-network:** $20 copay **Out-of-network:** 30% coinsurance Lab services **In-network:** $0 copay **Out-of-network:** $20 copay Therapeutic radiology services (such as radiation treatment for cancer): **In-network:** $60 copay **Out-of-network:** 30% coinsurance Outpatient x-rays: **In-network:** $20 copay **Out-of-network:** $20 copay	Diagnostic radiology services: **In-network:** $100 copay **Out-of-network:** 30% coinsurance Other diagnostic tests and procedures: **In-network:** $10 copay **Out-of-network:** 30% coinsurance Lab services **In-network:** $0 copay **Out-of-network:** $0 copay Therapeutic radiology services (such as radiation treatment for cancer): **In-network:** $60 copay **Out-of-network:** 30% coinsurance Outpatient x-rays: **In-network:** $15 copay **Out-of-network:** $15 copay

	ATRIO Freedom H6743-024-002	ATRIO Choice Rx H6743-025	ATRIO Prime Rx H6743-023-002
Hearing Services Medicare-covered: Exams to diagnose and treat hearing and balance issues.	Medicare-covered: **In-network:** $45 copay **Out-of-network:** $50 copay Additional hearing services (not covered by Medicare): Routine hearing exam – **In-network:** $0 copay Hearing aids - $699 to $999 copay per aid, up to 2 per year (one per ear) **Out-of-network:** $0 copay (Amplifon provider must be used to receive hearing aid benefits)	Medicare-covered: **In-network:** $45 copay **Out-of-network:** $65 copay Additional hearing services (not covered by Medicare): Routine hearing exam – **In-network:** $0 copay Hearing aids - $699 to $999 copay per aid, up to 2 per year (one per ear) **Out-of-network:** $0 copay (Amplifon provider must be used to receive hearing aid benefits)	Medicare-covered: **In-network:** $25 copay **Out-of-network:** $50 copay Additional hearing services (not covered by Medicare): Routine hearing exam – **In-network:** $0 copay Hearing aids - $699 to $999 copay per aid, up to 2 per year (one per ear) **Out-of-network:** $0 copay (Amplifon provider must be used to receive hearing aid benefits)
Dental Services * Medicare-covered: Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth).	Medicare-covered: **In-network:** $45 copay **Out-of-network:** $45 copay Additional dental services (not covered by Medicare): **In & Out-of-network:** $0 copay up to allowance Annual allowance of $1,000 towards preventive and comprehensive dental services at any provider through a Flex Card.	Medicare-covered: **In-network:** $45 copay **Out-of-network:** $65 copay Additional dental services (not covered by Medicare): **In & Out-of-network:** $0 copay up to allowance Annual allowance of $1,400 towards preventive and comprehensive dental services at any provider through a Flex Card.	Medicare-covered: **In-network:** $25 copay **Out-of-network:** $45 copay Additional dental services (not covered by Medicare): **In & Out-of-network:** $0 copay up to allowance Annual allowance of $1,750 towards preventive and comprehensive dental services at any provider through a Flex Card.
Vision Services Medicare-covered: Exams to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening).	Medicare-covered exams: **In-network:** $45 copay **Out-of-network:** $45 copay Medicare-covered glaucoma screening: **In & Out-of-network:** $0 copay Additional vision services (not covered by Medicare): Routine eye exam – **In-network:** $0 copay **Out-of-network:** 50% coinsurance	Medicare-covered exams: **In-network:** $45 copay **Out-of-network:** $65 copay Medicare-covered glaucoma screening: **In & Out-of-network:** $0 copay Additional vision services (not covered by Medicare): Routine eye exam – **In-network:** $0 copay	Medicare-covered exams: **In-network:** $15 copay **Out-of-network:** $15 copay Medicare-covered glaucoma screening: **In & Out-of-network:** $0 copay Additional vision services (not covered by Medicare): Routine eye exam – **In-network:** $0 copay

	ATRIO Freedom H6743-024-002	ATRIO Choice Rx H6743-025	ATRIO Prime Rx H6743-023-002
	Routine eyewear – **In-network:** $0 copay **Out-of-Network:** 50% coinsurance $150 allowance for frames every year; $100 allowance towards contact lenses, fitting and evaluation every year	**Out-of-network:** 50% coinsurance Routine eyewear – **In-network:** $0 copay **Out-of-Network:** 50% coinsurance $150 allowance for frames every year; $100 allowance towards contact lenses, fitting and evaluation every year	**Out-of-network:** 50% coinsurance Routine eyewear – **In-network:** $0 copay **Out-of-Network:** 50% coinsurance $200 allowance for frames every year; $100 allowance towards contact lenses, fitting and evaluation every year
Mental Health Services *	Inpatient mental health care: **In-network:** $225 copay per day for days 1-7; $0 copay per day for days 8-90 **Out-of-network:** $375 copay per day for days 1-7; $0 copay per day for days 8-90 Outpatient group and individual therapy visit: **In-network:** $25 copay **Out-of-network:** 50% coinsurance	Inpatient mental health care: **In-network:** $370 copay per day for days 1-5; $0 copay per day for days 6-90 **Out-of-network:** $500 copay per day for days 1-5; $0 copay per day for days 6-90 Outpatient group and individual therapy visit: **In-network:** $40 copay **Out-of-network:** 50% coinsurance	Inpatient mental health care: **In-network:** $200 copay per day for days 1-8; $0 copay per day for days 9-90 **Out-of-network:** $325 copay per day for days 1-7; $0 copay per day for days 8-90 Outpatient group and individual therapy visit: **In-network:** $25 copay **Out-of-network:** 50% coinsurance
Skilled Nursing Facility (SNF) *	**In-network:** $0 copay per day for days 1-20; $150 copay per day for days 21-100 **Out-of-network:** $150 copay per day for days 1-100	**In-network:** $0 copay per day for days 1-20; $150 copay per day for days 21-100 **Out-of-network:** $150 copay per day for days 1-100	**In-network:** $0 copay per day for days 1-20; $125 copay per day for days 21-100 **Out-of-network:** $125 copay per day for days 1-100
Physical Therapy *	Physical & Speech therapy visit: **In-network:** $25 copay **Out-of-network:** 50% coinsurance Occupational therapy visit: **In-network:** $25 copay **Out-of-network:** 50% coinsurance	Physical & Speech therapy visit: **In-network:** $40 copay **Out-of-network:** 50% coinsurance Occupational therapy visit: **In-network:** $40 copay **Out-of-network:** 50% coinsurance	Physical & Speech therapy visit: **In-network:** $30 copay **Out-of-network:** 50% coinsurance Occupational therapy visit: **In-network:** $30 copay **Out-of-network:** 50% coinsurance

	ATRIO Freedom H6743-024-002	ATRIO Choice Rx H6743-025	ATRIO Prime Rx H6743-023-002
Ambulance *	**In-network:** $275 copay **Out-of-network:** $275 copay	**In-network:** $250 copay **Out-of-network:** $250 copay	**In-network:** $225 copay **Out-of-network:** $225 copay
Transportation	$0 copay for up to 24 one-way non-emergent medical transportation trips to any plan-approved health-related location every year (SafeRide must be used to receive routine transportation benefits)	$0 copay for up to 24 one-way non-emergent medical transportation trips to any plan-approved health-related location every year (SafeRide must be used to receive routine transportation benefits)	$0 copay for up to 24 one-way non-emergent medical transportation trips to any plan-approved health-related location every year (SafeRide must be used to receive routine transportation benefits)
Medicare Part B Drugs *	**In-network:** 20% coinsurance **Out-of-network:** 50% coinsurance	**In-network:** 20% coinsurance **Out-of-network:** 50% coinsurance	**In-network:** 20% coinsurance **Out-of-network:** 50% coinsurance
Telehealth (Non-Medicare covered)	**In-network:** $0 copay **Out-of-network:** Not covered (Teladoc provider must be used to receive additional telehealth benefits)	**In-network:** $0 copay **Out-of-network:** Not covered (Teladoc provider must be used to receive additional telehealth benefits)	**In-network:** $0 copay **Out-of-network:** Not covered (Teladoc provider must be used to receive additional telehealth benefits)
Foot Care Medicare-covered: Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions.	Medicare-covered: **In-network:** $25 copay **Out-of-network:** 50% coinsurance	Medicare-covered: **In-network:** $45 copay **Out-of-network:** 50% coinsurance	Medicare-covered: **In-network:** $25 copay **Out-of-network:** 50% coinsurance
Medical Equipment and Supplies *	DME, prosthetic devices, medical supplies: **In-network:** 20% coinsurance **Out-of-network:** 30% coinsurance Diabetic supplies and services: **In-network:** $0 copay **Out-of-network:** 20% coinsurance	DME, prosthetic devices, medical supplies: **In-network:** 20% coinsurance **Out-of-network:** 50% coinsurance Diabetic supplies and services: **In-network:** $0 copay **Out-of-network:** 50% coinsurance	DME, prosthetic devices, medical supplies: **In-network:** 20% coinsurance **Out-of-network:** 30% coinsurance Diabetic supplies and services: **In-network:** $0 copay **Out-of-network:** 20% coinsurance
Fitness	$250 annual allowance towards gym membership fees provided through a Flex Card.	$250 annual allowance towards gym membership fees provided through a Flex Card.	$550 annual allowance towards gym membership fees provided through a Flex Card.

	ATRIO Freedom H6743-024-002	ATRIO Choice Rx H6743-025	ATRIO Prime Rx H6743-023-002
Chiropractic Services Medicare-covered: Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position).	Medicare-covered: **In-network:** $20 copay **Out-of-network:** $65 copay	Medicare-covered: **In-network:** $20 copay **Out-of-network:** $65 copay	Medicare-covered: **In-network:** $20 copay **Out-of-network:** $50 copay
Chiropractic/ Acupuncture/ Naturopathy Services (Non-Medicare covered)	**In-network:** $20 copay **Out-of-network:** $65 copay Up to 30 combined visits for routine chiropractic, routine acupuncture, and naturopathy services every year	**In-network:** $20 copay **Out-of-network:** $65 copay Up to 30 combined visits for routine chiropractic, routine acupuncture, and naturopathy services every year	**In-network:** $20 copay **Out-of-network:** $50 copay Up to 30 combined visits for routine chiropractic, routine acupuncture, and naturopathy services every year
Over-The-Counter Items	You receive an allowance of $50 per quarter	You receive an allowance of $50 per quarter	You receive an allowance of $75 per quarter
Meals*	$0 copay for 2 meals per day for 14 days after an inpatient or skilled nursing facility stay or while receiving home health services	$0 copay for 2 meals per day for 14 days after an inpatient or skilled nursing facility stay or while receiving home health services	$0 copay for 2 meals per day for 14 days after an inpatient or skilled nursing facility stay or while receiving home health services

Medicare Part D Prescription Drug Benefits

There is **no** Part D Prescription Drug Benefit for **ATRIO Freedom (PPO)**.

Deductible Stage

The Part D Deductible applies only to drugs in tiers 3, 4 and 5.

ATRIO Choice Rx H6743-025	ATRIO Prime Rx H6743-023-002
$100 per year	$0 per year

Initial Coverage Stage

You pay the following until your total yearly drug costs reach $4,660.

If you reside in a long-term facility, you pay the same as at a standard retail pharmacy. If you choose mail-order, you pay the same as a retail 90-day supply at an in-network pharmacy. You may get drugs from an out-of-network pharmacy but may pay more than you pay at an in-network pharmacy.

ATRIO Choice Rx			ATRIO Prime Rx		
Standard Retail Cost Sharing			**Standard Retail Cost Sharing**		
Tier	**30-day supply**	**90-day supply**	**Tier**	**30-day supply**	**90-day supply**
Tier 1 (Preferred Generic)	$0 copay	$0 copay	Tier 1 (Preferred Generic)	$0 copay	$0 copay
Tier 2 (Generic)	$8 copay	$16 copay	Tier 2 (Generic)	$8 copay	$16 copay
Tier 3 (Preferred Brand)	$47 copay	$94 copay	Tier 3 (Preferred Brand)	$47 copay	$94 copay
Tier 4 (Non-Preferred Drug)	$100 copay	$200 copay	Tier 4 (Non-Preferred Drug)	$100 copay	$200 copay
Tier 5 (Specialty Tier)	30% coinsurance	A long-term supply is not available	Tier 5 (Specialty Tier)	33% coinsurance	A long-term supply is not available
Tier 6 (Select Care Drugs)	$0 copay	$0 copay	Tier 6 (Select Care Drugs)	$0 copay	$0 copay

Coverage Gap Stage

Most Medicare drug plans have a coverage gap (also called the "donut hole"). The coverage gap begins once your total yearly drug costs reach $4,660.

Once you have entered the coverage gap, you pay 25% of the plan's cost for covered generic and brand name drugs until your yearly out-of-pockets costs reach $7,400, then you enter the Catastrophic Coverage Stage. This amount and rules for counting costs toward this amount have been set by Medicare.

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.

Important Message About What You Pay for Insulin (Part D) - You won't pay more than $35, while you **are in** the Coverage Gap, 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.

Catastrophic Coverage Stage

Once your yearly out-of-pocket drug costs have reached $7,400, you will pay the greater of:

- 5% of the cost, or
- $4.15 copay for generic and a $10.35 copayment for all other drugs.

Notice about Nondiscrimination and Accessibility Requirements

Discrimination is Against the Law

ATRIO Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATRIO Health Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

ATRIO Health Plans:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need any of the services listed above, contact ATRIO Customer Service toll free at 1-877-672-8620, daily from 8 a.m. to 8 p.m. TTY users should call 711.

If you believe that ATRIO Health Plans 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 with:

ATRIO Compliance Officer
2965 Ryan Drive SE
Salem, OR 97301
1-877-672-8620
File a compliant with ATRIO Compliance Hotline: 1-877-309-9952
compliance@atriohp.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, contact Customer Service toll free at 1-877-672-8620, daily from 8 a.m. to 8 p.m. TTY users should call 711.

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, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Español (Spanish) - ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-672-8620 (TTY: 711).

Tiếng Việt (Vietnamese) - CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Hãy gọi số 1-877-672-8620 (TTY: 711)

繁體中文 (Chinese) - 注意：如果您講國語，您可以免費獲得語言援助服務。請致電 1-877-672-8620（TTY：711）。

Русский (Russian) - ВНИМАНИЕ! Если Вы говорите по-русски, Вы можете бесплатно воспользоваться услугами перевода. Телефон: 1-877-672-8620 (телетайп: 711).

한국어 (Korean) - 유의사항: 무료 한국어 지원 서비스를 이용하실 수 있습니다. 전화번호는 1-877-672-8620 (TTY: 711) 번입니다.

Українська (Ukrainian) - УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-877-672-8620 (телетайп: 711).

日本語 (Japanese) - 注意事項：日本語でのサービスをご希望の場合、1-877-672-8620（TTY:711）までご連絡ください。このサービスは無料です。

"إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-672-8620 (رقم هاتف الصم والبكم: 1-800-735-2900)."

فارسی (Farsi) – توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما موجود است. با شماره 1-877-672-8620 تماس بگیرید (TTY: 1-800-735-2900).

Română (Romanian) - ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-877-672-8620 (TTY: 711).

ខ្មែរ (Cambodian) - ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរទូរស័ព្ទ 1-877-672-8620 (TTY: 711)។

Oroomiffa (Oromo) - XIYYEEFFANNAA: Afaandubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, niargama. 1-877-672-8620 (TTY: 711) Bilbilaa.

Deutsch (German) - ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-672-8620 (TTY: 711).

فارسی (Farsi) – توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما موجود است. با شماره 1-877-672-8620 تماس بگیرید (TTY: 1-800-735-2900).

Français (French) - ATTENTION : Si vous parlez français, des services d'aide linguistique sont disponibles gratuitement. Appelez le 1-877-672-8620 (ATS : 711).

ภาษาไทย (Thai) - โปรดทราบ: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-877-672-8620 (TTY: 711)

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 1-877-672-8620. 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 1-877-672-8620. 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 1-877-672-8620。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 1-877-672-8620。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 1-877-672-8620. 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 1-877-672-8620. 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 1-877-672-8620 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 1-877-672-8620. 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 1-877-672-8620번으로 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 1-877-672-8620. 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 مترجم فوري، ليس عليك سوى الاتصال بنا على 1-877-672-8620. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

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 1-877-672-8620 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता 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 1-877-672-8620. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: 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 1-877-672-8620. 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 1-877-672-8620. 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 1-877-672-8620. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 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がありますございます。通訳をご用命になるには、1-877-672-8620 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。