ATRIO™ HEALTH PLANS

2024 Medicare Advantage

SUMMARY OF BENEFITS

ATRIO Choice Rx, Select Rx, Prime Rx, and Freedom (PPO)

Service area coverage for Oregon Counties:

Clackamas, Lane, Multnomah, Washington, and Yamhill

Plan IDs include: H7006-018, H7006-019, H7006-020, H7006-021

January 1, 2024 - December 31, 2024

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*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.

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About the Summary of Benefits and Who Can Join

This is a summary of ATRIO Health Plans' health and drug services covered by **ATRIO Choice Rx (PPO), ATRIO Select Rx (PPO), ATRIO Prime Rx (PPO), and ATRIO Freedom (PPO)**. The benefit information provided does not show every service that we cover or every limitation or exclusion. For 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 Clackamas, Lane, Multnomah, Washington, and Yamhill Counties in Oregon.**

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.
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, 2025.
☐	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.

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	ATRIO Choice Rx (PPO) H7006-018	ATRIO Select Rx (PPO) H7006-019	ATRIO Prime Rx (PPO) H7006-020	ATRIO Freedom (PPO) H7006-021
Plan Premium	$0 per month	$40.60 per month	$125 per month	$0 per month
	You must also continue to pay your Medicare Part B premium			
Plan Deductible	$0 per year	$0 per year	$0 per year	$0 per year
Out-of-Pocket Maximums What you pay for in-network services also applies to any out-of-pocket limits	**In-network**: • $3,600 for services received from in-network providers **Combined**: • $3,600 for services received from any provider	**In-network**: • $3,400 for services received from in-network providers **Combined**: • $4,950 for services received from any provider	**In-network**: • $2,950 for services received from in-network providers **Combined**: • $2,950 for services received from any provider	**In-network**: • $3,400 for services received from in-network providers **Combined**: • $3,400 for services received from any provider
Covered Medical and Hospital Benefits *(Services marked with * may require prior authorization)*				
Inpatient Hospital Care (Acute) *	**In- and Out-of-network:** • $375 copay per day for days 1-4; $0 days 5-90	**In- and Out-of-network:** • $325 copay per day for days 1–4; $0 days 5–90	**In-network**: • $275 copay day 1; $0 days 2–90 **Out-of-network**: • $1,000 copay day 1; $0 days 2-90	**In-network**: • $100 copay per day for days 1–5; $0 days 6–90 **Out-of-network**: • 50% per stay
Outpatient Hospital Services *	**In-network**: • $0-$350 copay **Out-of-network**: • 50% coinsurance	**In-network**: • $0-$350 copay **Out-of-network**: • 50% coinsurance	**In-network**: • $0-$100 copay **Out-of-network**: • $100 copay	**In-network**: • $0-$350 copay **Out-of-network**: • 50% coinsurance
Ambulatory Surgery Center Services *	**In-network**: • $250 copay **Out-of-network**: • 50% coinsurance	**In-network**: • $250 copay **Out-of-network**: • 50% coinsurance	**In-network**: • $250 copay **Out-of-network**: • 50% coinsurance	**In-network**: • $25 copay **Out-of-network**: • 50% coinsurance
Doctor's Office Visits	**Primary Care Physician (PCP)**			
	In-network: • $0 copay **Out-of-network**: • $50 copay	**In-network**: • $0 copay **Out-of-network**: • $50 copay	**In-network**: • $0 copay **Out-of-network**: • $50 copay	**In-network**: • $0 copay **Out-of-network**: • $50 copay
	Specialists			
	In-network: • $25 copay **Out-of-network**: • $25 copay	**In-network**: • $30 copay **Out-of-network**: • $30 copay	**In-network**: • $15 copay **Out-of-network**: • $20 copay	**In-network**: • $25 copay **Out-of-network**: • $50 copay

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Preventive Care	• You pay nothing for Medicare covered preventive services • Our plan also covers a supplemental Annual Physical Exam at no cost			
Emergency Care Worldwide emergent / urgent care coverage	**In- and Out-of-network:** • $90 copay (waived if admitted within 24 hours for the same condition)	**In- and Out-of-network:** • $90 copay (waived if admitted within 24 hours for the same condition)	**In-network:** • $0 copay **Out-of-network:** • $90 copay	**In- and Out-of-network:** • $125 copay (waived if admitted within 24 hours for the same condition)
Urgent Care	**In- and Out-of-network:** • $60 copay (waived if admitted within 24 hours for the same condition)	**In- and Out-of-network:** • $60 copay (waived if admitted within 24 hours for the same condition)	**In-network:** • $0 copay **Out-of-network:** • $90 copay	**In- and Out-of-network:** • $30 copay (waived if admitted within 24 hours for the same condition)
Diagnostic Tests, Lab, X-Rays, and Diagnostic / Therapeutic Radiology Services *	**Diagnostic Radiology Services *** *(such as MRIs, CT scans)*			
	In-network: • $0-$300 copay **Out-of-network:** • 50% coinsurance	**In-network:** • $0-$250 copay **Out-of-network:** • 50% coinsurance	**In-network:** • $0-$200 copay **Out-of-network:** • $0 copay	**In-network:** • $0-$60 copay **Out-of-network:** • 50% coinsurance
	Other Diagnostic Tests and Procedures *			
	In-network: • $0 copay **Out-of-network:** • 50% coinsurance	**In-network:** • 0%-20% coinsurance **Out-of-network:** • 50% coinsurance	**In-network:** • $0 copay **Out-of-network:** • $0 copay	**In-network:** • $0 copay **Out-of-network:** • 50% coinsurance
	Lab Services *			
	In-network: • $0 copay **Out-of-network:** • $15 copay	**In-network:** • $0 copay **Out-of-network:** • $15 copay	**In-network:** • $0 copay **Out-of-network:** • $0 copay	**In-network:** • $0 copay **Out-of-network:** • 50% coinsurance
	Therapeutic Radiology Services * *(such as radiation treatment for cancer)*			
	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	**In-network:** • $20 copay **Out-of-network:** • 50% coinsurance
	Outpatient X-Rays			
	In-network: • $0 copay **Out-of-network:** • 50% coinsurance	**In-network:** • $0 copay **Out-of-network:** • $15 copay	**In-network:** • $0 copay **Out-of-network:** • $0 copay	**In-network:** • $0 copay **Out-of-network:** • 50% coinsurance

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Hearing Services Exams to diagnose and treat hearing and balance issues, and an annual routine exam	**Hearing Exams** (*Medicare-covered and supplemental hearing care*)			
	In-network: • $0 copay **Out-of-network**: • 50% coinsurance **In- and Out-of-network:** • $0 copay for one routine exam per year	**In-network**: • $0 copay **Out-of-network**: • 50% coinsurance **In- and Out-of-network:** • $0 copay for one routine exam per year	**In-network**: • $0 copay **Out-of-network**: • 50% coinsurance **In- and Out-of-network:** • $0 copay for one routine exam per year	**In-network**: • $0 copay **Out-of-network**: • 50% coinsurance **In- and Out-of-network:** • $0 copay for one routine exam per year
Amplifon provider must be used for hearing aid benefits	**Hearing Aids**			
	In-network: • Up to $1,500 allowance per year	**In-network**: • Up to $1,500 allowance per year	**In-network**: • Up to $1,500 allowance per year	**In-network**: • Up to $1,500 allowance per year
Dental Services Limited dental services (does not include services in connection with care, treatment, filling, removal, or replacement of teeth)	**Dental Care** (*Medicare-covered and supplemental dental care*)			
	In-network: • $0 copay **Out-of-network**: • $50% coinsurance **In- and Out-of-network:** • Up to $4,000 allowance per year on Flex Card for preventive and comprehensive services at any dental provider	**In-network:** • $0 copay **Out-of-network**: • $50% coinsurance **In- and Out-of-network:** • Up to $4,000 allowance per year on Flex Card for preventive and comprehensive services at any dental provider	**In-network:** • $0 copay **Out-of-network**: • $50% coinsurance **In- and Out-of-network:** • Up to $3,000 allowance per year on Flex Card for preventive and comprehensive services at any dental provider	**In-network:** • $0 copay **Out-of-network**: • $50% coinsurance **In- and Out-of-network:** • Up to $2,500 allowance per year on Flex Card for preventive and comprehensive services at any dental provider
Vision Services Exams to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening)	**Vision Exams** (*Medicare-covered and supplemental vision care*)			
	In-network: • $0 copay **Out-of-network**: • 50% coinsurance **In-network**: • $0 copay for annual exam **Out-of-network**: • 50% coinsurance for annual exam	**In-network**: • $0 copay **Out-of-network**: • 50% coinsurance **In-network**: • $0 copay for annual exam **Out-of-network**: • 50% coinsurance for annual exam	**In-network**: • $0 copay **Out-of-network**: • 50% coinsurance **In-network**: • $0 copay for annual exam **Out-of-network**: • 50% coinsurance for annual exam	**In-network**: • $0 copay **Out-of-network**: • 50% coinsurance **In-network**: • $0 copay for annual exam **Out-of-network**: • 50% coinsurance for annual exam

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Vision Services (Continued) *Eyeglasses includes lenses and frames*	**Eyewear**			
	In- and Out-of-network: • Up to $150 allowance for eyeglasses *or* $100 for contact lenses, per year	**In- and Out-of-network:** • Up to $150 allowance for eyeglasses *or* $100 for contact lenses, per year	**In- and Out-of-network:** • Up to $250 allowance for eyeglasses *or* $100 for contact lenses, per year	**In- and Out-of-network:** • Up to $200 allowance for eyeglasses *or* $100 for contact lenses, per year
Mental Health Services * *No cost for individual virtual visit / telehealth sessions in-network with Teladoc*	**Inpatient Mental Health Care ***			
	In-network: • $375 copay per day for days 1–4; $0 days 5–90 **Out-of-network**: • 50% per stay	**In- and Out-of-Network**: • $325 copay per day for days 1–4; $0 days 5–90	**In-network**: • $275 copay for day 1; $0 days 2–90 **Out-of-network**: • $1,000 copay for day 1; $0 days 2-90	**In-network**: • $100 copay per day for days 1–5; $0 days 6–90 **Out-of-network**: • 50% per stay
	Outpatient Group and Individual Therapy Visits			
	In-network: • $20 copay **Out-of-network**: • 50% coinsurance	**In-network**: • $20 copay **Out-of-network**: • 50% coinsurance	**In- and Out-of-network:** • $0 copay	**In-network**: • $10 copay **Out-of-network**: • 50% coinsurance
Skilled Nursing Facility (SNF)*	**In-network**: • $10 copay per day for days 1–20; $200 per day 21-100 **Out-of-network**: • 50% per stay	**In-network**: • $20 copay per day for days 1–20; $200 per day 21-100 **Out-of-network**: • 50% per stay	**In-network**: • $0 per stay **Out-of-network**: • $200 copay per day for days 1–40; $200 per day 41-100	**In-network**: • $0 days 1–20; $100 per day 21-100 **Out-of-network**: • 50% per stay
Occupational, Physical, and Speech Therapy *	**In-network**: • $0 copay **Out-of-network**: • $20 copay	**In-network**: • $0 copay **Out-of-network**: • $20 copay	**In-network**: • $0 copay **Out-of-network**: • $0 copay	**In-network**: • $0 copay **Out-of-network**: • 50% coinsurance

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Ambulance * *Authorization required for non-emergent transportation*	**In- and Out-of-network:** • $250 copay	**In- and Out-of-network:** • $250 copay	**In- and Out-of-network:** • $0 copay	**In- and Out-of-network:** • $300 copay
Transport * *Must use SafeRide for covered trips*	12 one-way trips per year to plan-approved, health-related locations	12 one-way trips per year to plan-approved, health-related locations	Not Covered	24 one-way trips per year to plan-approved, health-related locations
Medicare Part B Drugs*	**In-network**: • 0%-20% coinsurance **Out-of-network**: • 50% coinsurance	**In-network**: • 0%-20% coinsurance **Out-of-network**: • 50% coinsurance	**In-network**: • 0%-20% coinsurance **Out-of-network**: • 50% coinsurance	**In-network**: • 0%-20% coinsurance **Out-of-network**: • 50% coinsurance
Virtual Visits / Telehealth *Must use Teladoc for covered visits*	**In-network**: • $0 copay **Out-of-network**: • Not covered	**In-network**: • $0 copay **Out-of-network**: • Not covered	**In-network**: • $0 copay **Out-of-network**: • Not covered	**In-network**: • $0 copay **Out-of-network**: • Not covered
Durable Medical Equipment (DME) and Supplies, and Diabetic Supplies *	**Medical Equipment, Prosthetic Devices, and Medical Supplies**			
	In-network: • 20% coinsurance **Out-of-network**: • 50% coinsurance	**In-network**: • 20% coinsurance **Out-of-network**: • 50% coinsurance	**In- and Out-of-network:** • $0 copay	**In-network**: • 20% coinsurance **Out-of-network**: • 50% coinsurance
	Diabetes Supplies			
	In-network: • $0 copay **Out-of-network**: • 50% coinsurance	**In-network**: • $0 copay **Out-of-network**: • 50% coinsurance	**In- and Out-of-network:** • $0 copay	**In-network**: • $0 copay **Out-of-network**: • 50% coinsurance
Fitness Covers gym membership fees / classes	$300 annual allowance on Flex Card	$600 annual allowance on Flex Card	$600 annual allowance on Flex Card	$550 annual allowance on Flex Card
Over the Counter (OTC) Items	$50 quarterly allowance on Flex Card for select OTC items	$170 quarterly allowance on Flex Card for select OTC items	$100 quarterly allowance on Flex Card for select OTC items	$150 quarterly allowance on Flex Card for select OTC items

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Meals After inpatient stay and some Home Health services	Up to 2 meals per day for 14 days (28 meals total) per stay	Up to 2 meals per day for 14 days (28 meals total per stay)	Up to 2 meals per day for 14 days (28 meals total per stay)	Up to 2 meals per day for 14 days (28 meals total per stay)
Personal Emergency Response System (PERS) *Must use LifeStation for PERS benefit*	**In-network:** • $0 for wearable alert, including wristwatch option with heart monitor and step counter	**In-network:** • $0 for wearable alert, including wristwatch option with heart monitor and step counter	**In-network:** • $0 for wearable alert, including wristwatch option with heart monitor and step counter	**In-network:** • $0 for wearable alert, including wristwatch option with heart monitor and step counter
Chiropractic Services Manipulation of the spine to correct subluxation *Must use ASH for in-network benefits*	**In-network:** • $20 copay **Out-of-network:** • 50% coinsurance	**In-network:** • $20 copay **Out-of-network:** • 50% coinsurance	**In- and Out-of-network:** • $0 copay	**In-network:** • $10 copay **Out-of-network:** • 50% coinsurance
Alternative Therapies (Chiropractic and Acupuncture Services) *Must use ASH for in-network benefits*	Not Covered	Not Covered	Not Covered	**In-network:** • $20 copay **Out-of-network:** • 50% coinsurance Up to 30 combined visits for routine chiropractic and acupuncture services, per year

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Medicare Part D Prescription Drug Benefits							
Drug Deductible	$0		$0		$0		*This plan does not cover prescription drugs*
Drug Tiers	**30-day supply**	**90-day supply**	**30-day supply**	**90-day supply**	**30-day supply**	**90-day supply**	
Tier 1 Preferred Generic	$0	$0	$0	$0	$0	$0	
Tier 2 Generic	$0	$0	$0	$0	$0	$0	
Tier 3* Preferred Brand	$47	$94	$47	$94	$47	$94	
Tier 4* Non-Preferred Drugs	$100	$200	$100	$200	$100	$200	
Tier 5* Specialty Drugs	33%	Not Available	33%	Not Available	33%	Not Available	
Tier 6 Select Care Drugs	$0	$0	$0	$0	$0	$0	
Coverage Gap Stage							
When the total paid by you and the plan reaches $5,030, you move to the Coverage Gap Stage. There is a 75% discount for most brand name and generic drugs in this stage.							
Catastrophic Coverage Stage							
After you have paid $8,000 out of pocket, you move to the Catastrophic Coverage Stage. You pay nothing through the end of the year.							

*The Part D deductible applies to drugs in this tier

- Save one month's copay by switching to a 90-day supply at a network retail or mail order pharmacy. Ask your doctor about a 100-day supply and save even more (restrictions may apply).
- If you reside in a long-term facility, you pay the same as at a 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.
- **What you pay for vaccines** – our plan covers most Part D vaccines at no cost to you, even if you haven't met your deductible or have reached the coverage gap. Please call Customer Service for more information
- **What you pay for insulin** – our plan covers select insulin products, for which you will pay no more than $35 for a one-month supply no matter what tier it is on, and even if you haven't met your deductible or have reached the coverage gap

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 (TTY 711)
File a compliant with ATRIO Compliance Hotline:
1-877-309-9952 or 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 1-877-672-8620 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Multi-Language Insert

Multi-language Interpreter Services

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.

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 1-877-672-8620. 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。