2023 Summary of Benefits

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PREMERA | BLUE CROSS
An Independent Licensee of the Blue Cross Blue Shield Association

2023 Summary of Benefits

PREMERA BLUE CROSS MEDICARE ADVANTAGE (HMO) H7245-001
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This is a summary of drug and health services covered by Premera Blue Cross Medicare Advantage (HMO), Premera Blue Cross Medicare Advantage Classic (HMO), Premera Blue Cross Medicare Advantage Total Health (HMO), Premera Blue Cross Medicare Advantage Peak + Rx (HMO), Premera Blue Cross Medicare Advantage Sound + Rx (HMO) and Premera Blue Cross Medicare Advantage Alpine (HMO) from January 1, 2023 to December 31, 2023.

Premera Blue Cross Medicare Advantage (HMO), Premera Blue Cross Medicare Advantage Classic (HMO), Premera Blue Cross Medicare Advantage Total Health (HMO), Premera Blue Cross Medicare Advantage Peak + Rx (HMO), Premera Blue Cross Medicare Advantage Sound + Rx (HMO) and **Premera Blue Cross Medicare Advantage Alpine (HMO)** are plans with a Medicare contract. Enrollment in these plans depends on contract renewal.

The benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please request the "Evidence of Coverage" by calling customer service or accessing it on our website: **premera.com/ma**.

To join **Premera Blue Cross Medicare Advantage (HMO), Premera Blue Cross Medicare Advantage Classic (HMO), Premera Blue Cross Medicare Advantage Total Health (HMO), Premera Blue Cross Medicare Advantage Peak + Rx (HMO), Premera Blue Cross Medicare Advantage Sound + Rx (HMO)** or **Premera Blue Cross Medicare Advantage Alpine (HMO),** you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in Washington: Cowlitz, Island, King, Kitsap, Lewis, Pierce, San Juan, Skagit, Snohomish, Spokane, Stevens, Thurston, Walla Walla, and Whatcom.

If you use providers that are not in our network, we may not pay for these services.

For 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). TTY/TDD users should call 1-877-486-2048.

This document is available in other formats, including Braille and Spanish.

For more information, please call us at 888-850-8526 (TTY/TDD: 711), or visit us at **premera.com/ma**.

Representatives are available:
October 1 – March 31, 8 a.m. to 8 p.m., 7 days a week
April 1 – September 30, 8 a.m. to 8 p.m., Monday through Friday.

Counties	Cowlitz, Island, King, Kitsap, Lewis, Pierce, San Juan, Skagit, Snohomish, Spokane, Thurston, Walla Walla, and Whatcom	Cowlitz, Island, King, Kitsap, Lewis, Pierce, San Juan, Skagit, Snohomish, Thurston, Walla Walla, and Whatcom	Spokane, Stevens, and Walla Walla
Premium and Benefits	**Premera Blue Cross Medicare Advantage (HMO)**	**Premera Blue Cross Medicare Advantage Classic (HMO)**	**Premera Blue Cross Medicare Advantage Total Health (HMO)**
Monthly Plan Premium	You pay $0 per month. You must continue to pay your Medicare Part B premium.	You pay $54 per month. You must continue to pay your Medicare Part B premium.	You pay $23 per month. You must continue to pay your Medicare Part B premium.
Part C Deductible	No deductible.	No deductible.	No deductible.
Part D Deductible	$160 per year for Part D prescription drugs except for drugs listed on Tier 1 and Tier 2, which are excluded from the deductible.	No deductible.	No deductible.
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	You pay no more than $6,500 annually. Includes copays and other costs for medical services for the year.	You pay no more than $5,000 annually. Includes copays and other costs for medical services for the year.	You pay no more than $5,000 annually. Includes copays and other costs for medical services for the year.
Inpatient Hospital Coverage*	You pay a $450 copay per day for days 1–4. You pay a $0 copay per day for days 5 and beyond.	You pay a $350 copay per day for days 1–4. You pay a $0 copay per day for days 5 and beyond.	You pay a $350 copay per day for days 1–4. You pay a $0 copay per day for days 5 and beyond.
Outpatient Hospital Coverage*	$350	$300	$275
Outpatient Hospital Observation Coverage*	$90	$90	$90
Ambulatory Surgery Center*	You pay a $250 copay for each Medicare-covered ambulatory surgical center visit.	You pay a $250 copay for each Medicare-covered ambulatory surgical center visit.	You pay a $250 copay for each Medicare-covered ambulatory surgical center visit.

^ PCP referral may be required.

* Prior authorization is required.

Counties	Cowlitz, Island, King, Kitsap, Lewis, Pierce, San Juan, Skagit, Snohomish, Spokane, Thurston, Walla Walla, and Whatcom	Cowlitz, Island, King, Kitsap, Lewis, Pierce, San Juan, Skagit, Snohomish, Thurston, Walla Walla, and Whatcom	Spokane, Stevens, and Walla Walla
Premium and Benefits	**Premera Blue Cross Medicare Advantage (HMO)**	**Premera Blue Cross Medicare Advantage Classic (HMO)**	**Premera Blue Cross Medicare Advantage Total Health (HMO)**
Doctor Visits			
Primary care providers	You pay a $5 copay per office visit. You pay a $0 copay per telehealth visit.	You pay a $0 copay per office visit. You pay a $0 copay per telehealth visit.	You pay a $0 copay per office visit. You pay a $0 copay per telehealth visit.
Specialists^	You pay a $40 copay per office visit. You pay a $35 copay per telehealth visit.	You pay a $30 copay per office visit. You pay a $25 copay per telehealth visit.	You pay a $30 copay per office visit. You pay a $25 copay per telehealth visit.
Preventive Care (such as flu vaccine, diabetic screenings)	You pay $0. Other preventive services are available. There are some covered services that have a cost.	You pay $0. Other preventive services are available. There are some covered services that have a cost.	You pay $0. Other preventive services are available. There are some covered services that have a cost.
Emergency Care	You pay a $90 copay per visit. Waived, if you are admitted to the hospital within 24 hours. Includes worldwide coverage.	You pay a $90 copay per visit. Waived, if you are admitted to the hospital within 24 hours. Includes worldwide coverage.	You pay a $90 copay per visit. Waived, if you are admitted to the hospital within 24 hours. Includes worldwide coverage.
Urgently Needed Services	You pay a $35 copay per visit. Includes worldwide coverage with a $50 copay.	You pay a $35 copay per visit. Includes worldwide coverage with a $50 copay.	You pay a $35 copay per visit. Includes worldwide coverage with a $50 copay.

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Counties	Cowlitz, Island, King, Kitsap, Lewis, Pierce, San Juan, Skagit, Snohomish, Spokane, Thurston, Walla Walla, and Whatcom	Cowlitz, Island, King, Kitsap, Lewis, Pierce, San Juan, Skagit, Snohomish, Thurston, Walla Walla, and Whatcom	Spokane, Stevens, and Walla Walla
Premium and Benefits	**Premera Blue Cross Medicare Advantage (HMO)**	**Premera Blue Cross Medicare Advantage Classic (HMO)**	**Premera Blue Cross Medicare Advantage Total Health (HMO)**
Diagnostic Services/Labs/ Imaging			
Diagnostic tests and procedures*	You pay a $60 copay per service location per day.	You pay a $30 copay per service location per day.	You pay a $30 copay per service location per day.
Lab services	You pay a $10 copay per service location per day.	You pay a $0 copay per service location per day.	You pay a $0 copay per service location per day.
Outpatient X-rays	You pay a $15 copay per service location per day.	You pay a $10 copay per service location per day.	You pay a $10 copay per service location per day.
Therapeutic radiology services (such as radiation treatment for cancer)*	You pay 20% of the cost. If your doctor provides additional services, a separate cost sharing amount may apply.	You pay 20% of the cost. If your doctor provides additional services, a separate cost sharing amount may apply.	You pay 20% of the cost. If your doctor provides additional services, a separate cost sharing amount may apply.
Diagnostic radiology services*	$180 copay per service location per day.	$160 copay per service location per day.	$160 copay per service location per day.
Hearing Services			
Medicare-covered hearing exam	You pay a $35 copay per visit.	You pay a $30 copay per visit.	You pay a $30 copay per visit.
Routine hearing exam	You pay a $0–$35 copay for one routine hearing exam per calendar year. $0 copay through Hearing Care Solutions provider; higher copay applies to exams by all other providers.	You pay a $0–$30 copay for one routine hearing exam per calendar year. $0 copay through Hearing Care Solutions provider; higher copay applies to exams by all other providers.	You pay a $0–$30 copay for one routine hearing exam per calendar year. $0 copay through Hearing Care Solutions provider; higher copay applies to exams by all other providers.
Hearing aid	You pay a $0 copay. There is a $1,000 annual allowance per ear toward the purchase of hearing aids through Hearing Care Solutions.	You pay a $0 copay. There is a $1,000 annual allowance per ear toward the purchase of hearing aids through Hearing Care Solutions.	You pay a $0 copay. There is a $1,000 annual allowance per ear toward the purchase of hearing aids through Hearing Care Solutions.

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Premium and Benefits	**Premera Blue Cross Medicare Advantage (HMO)**	**Premera Blue Cross Medicare Advantage Classic (HMO)**	**Premera Blue Cross Medicare Advantage Total Health (HMO)**
Dental Services			
Medicare-covered dental services	You pay a $45 copay per visit.	You pay a $30 copay per visit.	You pay a $30 copay per visit.
Annual maximum	$1,000	$1,500	$1,500
Dental services	You pay a $0 copay for preventive and comprehensive dental services.		
Preventive services	• Prophylaxis (cleaning) – Two per calendar year OR Periodontal maintenance – Three per calendar year • Fluoride – Two per calendar year • Periodic oral exam – Up to two periodic oral evaluations per calendar year • Limited oral evaluation (problem-focused) – One evaluation per 12 months • Comprehensive oral exam – One comprehensive exam per 36 months • Detailed and extensive oral evaluation – (problem-focused, by report) – One per lifetime • Re-evaluation – (limited, problem-focused established patient) – One per lifetime • Comprehensive periodontal exam – One per calendar year • Bitewing X-rays – One set per calendar year • Full-mouth complete set – One procedure every 60 months • Panoramic film X-ray for evaluation of the teeth and mouth – One procedure every 60 months		
Annual Comprehensive Deductible (in-network and out-of-network)	You pay a one-time annual Comprehensive Services deductible of $75. Deductible is waived for preventive and Medicare-covered dental services.		

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Premium and Benefits	**Premera Blue Cross Medicare Advantage (HMO)**	**Premera Blue Cross Medicare Advantage Classic (HMO)**	**Premera Blue Cross Medicare Advantage Total Health (HMO)**
Comprehensive services	• Periodontal scaling and root planing – One every two years, per quadrant • Scaling in presence of generalized moderate or severe gingival inflammation, full mouth – Once per two years • Occlusal adjustment performed with covered surgery – No limit • Gingivectomy or gingivoplasty – One surgical procedure per lifetime • Osseous surgery including flap entry and closure – One per lifetime • Pedicle or free soft tissue graft – One per lifetime • Full mouth debridement – One per lifetime • Intraoral X-rays: Periapical X-rays or Occlusal X-rays – One procedure code per calendar year • Restorations (fillings): Amalgam (silver) and/or composite – One per tooth per 24 months • Recementing a crown that has fallen off – One per 12 months • Recementing bridges, inlays, onlays and crowns – After 12 months of insertion and per 12 months per tooth thereafter • Pins when preparing a tooth for a crown – Bundle with crown code and pins (when required) • Buildup of filling around a post to prepare the tooth for a crown – One combo per tooth every five years • Crowns – One per tooth every five years • Oral surgery, including postoperative care for coronectomy, intentional partial tooth removal – One per tooth per lifetime • Root canal – One initial root canal procedure and one retreatment procedure per tooth per lifetime • Pulpotomy – No Limit • Apicoectomy – No Limit • Retrograde fillings – One per root per lifetime • Medicine placed under fillings to promote pulp healing – Unlimited per plan year to plan annual maximum • Complete denture – Maxillary (upper) or mandibular (lower) – One upper complete and/or one lower complete denture every seven years, including routine post-delivery care • Partial dentures: Resin or metal, maxillary (upper) or mandibular (lower) or maxillary (upper) or mandibular (lower) – One upper and/or one lower partial denture every seven years		

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Premium and Benefits	**Premera Blue Cross Medicare Advantage (HMO)**	**Premera Blue Cross Medicare Advantage Classic (HMO)**	**Premera Blue Cross Medicare Advantage Total Health (HMO)**
Comprehensive services	• Complete denture and partial denture adjustment – Two per denture per year • Complete or partial denture reline or rebase – One relining or rebasing of existing removable dentures per 24 months (only after 24 months from date of last placement, unless an immediate prosthesis replacing at least 3 teeth). • Recementation – One procedure per calendar year • Repair of dentures or fixed bridgework – One per denture/bridgework per 24 months • Teledentistry – Two per calendar year • Pain Management – Unlimited per plan year to plan annual maximum. Only if no services other than exam and X-rays were performed on the same date of service. • Deep sedation/general anesthesia – Unlimited per plan year to plan annual maximum. In conjunction with covered oral surgery or periodontal surgery. • Local anesthesia – Unlimited per plan year to plan annual maximum. In conjunction with covered oral surgery or periodontal surgery. • Intravenous moderate (conscious) sedation/analgesia – Unlimited per plan year to plan annual maximum. In conjunction with covered oral surgery or periodontal surgery.		

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Premium and Benefits	**Premera Blue Cross Medicare Advantage (HMO)**	**Premera Blue Cross Medicare Advantage Classic (HMO)**	**Premera Blue Cross Medicare Advantage Total Health (HMO)**
Vision Services			
Medicare-covered vision exam	You pay a $0 copay for each Medicare-covered diabetic retinopathy and glaucoma screenings once per calendar year. You pay a $20 copay for each Medicare-covered exam to diagnose and treat diseases and conditions of the eye.	You pay a $0 copay for each Medicare-covered diabetic retinopathy and glaucoma screenings once per calendar year. You pay a $30 copay for each Medicare-covered exam to diagnose and treat diseases and conditions of the eye.	You pay a $0 copay for each Medicare-covered diabetic retinopathy and glaucoma screenings once per calendar year. You pay a $30 copay for each Medicare-covered exam to diagnose and treat diseases and conditions of the eye.
Medicare-covered vision hardware	You pay a $0 copay for one pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery.	You pay a $0 copay for one pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery.	You pay $0 copay for one pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery.
Routine vision exam	You pay a $20 copay for one routine vision exam per calendar year for the purposes of obtaining eyeglasses or contact lenses.	You pay a $0 copay for one routine vision exam per calendar year for the purposes of obtaining eyeglasses or contact lenses.	You pay a $0 copay for one routine vision exam per calendar year for the purposes of obtaining eyeglasses or contact lenses.
Routine vision hardware	There is a $150 benefit limit for routine eyeglasses (lenses and frames) or contact lenses per calendar year.	There is a $250 benefit limit for routine eyeglasses (lenses and frames) or contact lenses per calendar year.	There is a $200 benefit limit for routine eyeglasses (lenses and frames) or contact lenses per calendar year.

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Premium and Benefits	**Premera Blue Cross Medicare Advantage (HMO)**	**Premera Blue Cross Medicare Advantage Classic (HMO)**	**Premera Blue Cross Medicare Advantage Total Health (HMO)**
Mental Health Services			
Inpatient mental health care*	You pay a $390 copay per day for days 1–4. You pay a $0 copay per day for days 5–90.	You pay a $390 copay per day for days 1–4. You pay a $0 copay per day for days 5–90.	You pay a $390 copay per day for days 1–4. You pay a $0 copay per day for days 5–90.
Outpatient mental health care	You pay a $30 copay for each Medicare-covered individual or group therapy visit. You pay a $20 copay for each telemental health visit.	You pay a $30 copay for each Medicare-covered individual or group therapy visit. You pay a $20 copay for each telemental health visit.	You pay a $30 copay for each Medicare-covered individual or group therapy visit. You pay a $20 copay for each telemental health visit.
Skilled Nursing Facility*	You pay a $0 copay per day for days 1–20. You pay a $160 copay per day for days 21–60. You pay a $0 copay per day for days 61–100.	You pay a $0 copay per day for days 1–20. You pay a $160 copay per day for days 21–60. You pay a $0 copay per day for days 61–100.	You pay a $0 copay per day for days 1–20. You pay a $160 copay per day for days 21–60. You pay a $0 copay per day for days 61–100.
Physical Therapy	You pay a $20 copay per visit.	You pay a $10 copay per visit.	You pay a $10 copay per visit.
Ambulance* No prior authorization required for emergencies	You pay a $300 copay each way for Medicare-covered ambulance transport.	You pay a $330 copay each way for Medicare-covered ambulance transport.	You pay a $370 copay each way for Medicare-covered ambulance transport.

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Premium and Benefits	**Premera Blue Cross Medicare Advantage (HMO)**	**Premera Blue Cross Medicare Advantage Classic (HMO)**	**Premera Blue Cross Medicare Advantage Total Health (HMO)**
Transportation	Not covered.	Not covered.	Not covered.
Medicare Part B Drugs*	You pay 20% of the cost for Medicare-covered Part B chemotherapy drugs and other Part B drugs.	You pay 20% of the cost for Medicare-covered Part B chemotherapy drugs and other Part B drugs.	You pay 20% of the cost for Medicare-covered Part B chemotherapy drugs and other Part B drugs.
Over the Counter (OTC)	Receive a $25 quarterly benefit for over-the-counter health and wellness products available through OTC Health Solutions.	Receive a $50 quarterly benefit for over-the-counter health and wellness products available through OTC Health Solutions.	Receive a $50 quarterly benefit for over-the-counter health and wellness products available through OTC Health Solutions.
Chiropractic Services	Medicare-covered copay: $20. Routine Chiropractic Services: 6 visits/ $20 copay.	Medicare-covered copay: $20. Routine Chiropractic Services: 10 visits/ $20 copay.	Medicare-covered copay: $20. Routine Chiropractic Services: 10 visits/ $20 copay.
Acupuncture*	Medicare-covered copay: $40. Routine Acupuncture: 6 visits/ $20 copay.	Medicare-covered copay: $30. Routine Acupuncture: 10 visits/ $20 copay.	Medicare-covered copay: $30. Routine Acupuncture: 10 visits/ $20 copay.
Routine Naturopathic Services	Not covered.	6 visits/ $30 copay.	6 visits/ $30 copay.

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Premera Blue Cross Medicare Advantage (HMO)		**Premera Blue Cross Medicare Advantage Classic (HMO)**		**Premera Blue Cross Medicare Advantage Total Health (HMO)**	
PRESCRIPTION DRUG BENEFITS (PART D)		**PRESCRIPTION DRUG BENEFITS (PART D)**		**PRESCRIPTION DRUG BENEFITS (PART D)**	
Deductible Phase	During this stage, you pay the full cost of your Tier 3, 4, and 5 drugs. You stay in this stage until you have paid $160 for your Tier 3, 4, and 5 drugs. During this stage, your out-of-pocket costs for Select Insulins will be $35, if eligible.	**Deductible Phase**	Because there is no deductible for the plan, this payment stage does not apply to you.	**Deductible Phase**	Because there is no deductible for the plan, this payment stage does not apply to you.
Initial Coverage Phase - You begin in this stage when you fill your first prescription of the year. You stay in the Initial Coverage Stage until your total drug costs for the year reach $4,660. During this stage, your out-of-pocket costs for Select Insulins will be $35, if eligible.					
	Standard Retail Cost sharing (in-network)(up to 30-day supply)		Standard Retail Cost sharing (in-network)(up to 30-day supply)		Standard Retail Cost Sharing (in-network)(up to 30-day supply)
Tier 1: Preferred Generic	You pay a $4 copay.	**Tier 1: Preferred Generic**	You pay a $2 copay.	**Tier 1: Preferred Generic**	You pay a $2 copay.
Tier 2: Generic	You pay a $12 copay.	**Tier 2: Generic**	You pay a $10 copay.	**Tier 2: Generic**	You pay a $10 copay.
Tier 3: Preferred Brand	You pay a $42 copay $35 copay for Select Insulins, if eligible.	**Tier 3: Preferred Brand**	You pay a $40 copay. $35 copay for Select Insulins, if eligible.	**Tier 3: Preferred Brand**	You pay a $40 copay. $35 copay for Select Insulins, if eligible.
Tier 4: Non-Preferred Drugs	You pay a $100 copay.	**Tier 4: Non-Preferred Drugs**	You pay a $100 copay.	**Tier 4: Non-Preferred Drugs**	You pay a $100 copay.
Tier 5: Specialty	You pay 30% of the cost.	**Tier 5: Specialty**	You pay 33% of the cost.	**Tier 5: Specialty**	You pay 33% of the cost.

Counties: Cowlitz, Island, King, Kitsap, Lewis, Pierce, San Juan, Skagit, Snohomish, Spokane, Thurston, Walla Walla, and Whatcom		
Premera Blue Cross Medicare Advantage (HMO)		
	Mail Order Cost Sharing (90-day supply)	Long-Term Care Cost Sharing (up to a 31-day supply)
Tier 1: Preferred Generic	You pay a $0 copay.	You pay a $4 copay.
Tier 2: Generic	You pay a $36 copay.	You pay a $12 copay.
Tier 3: Preferred Brand	You pay a $126 copay. $105 copay for Select Insulins, if eligible.	You pay a $42 copay. $35 copay for Select Insulins, if eligible.
Tier 4: Non-Preferred Drugs	You pay a $300 copay.	You pay a $100 copay.
Tier 5: Specialty	Not offered.	You pay 30% of the cost.
Cost sharing may change when you enter another of the four phases of the Part D benefit.		

Counties: Cowlitz, Island, King, Kitsap, Lewis, Pierce, San Juan, Skagit, Snohomish, Thurston, Walla Walla, and Whatcom		
Premera Blue Cross Medicare Advantage Classic (HMO)		
	Mail Order Cost Sharing (90-day supply)	Long-Term Care Cost Sharing (up to a 31-day supply)
Tier 1: Preferred Generic	You pay a $0 copay.	You pay a $2 copay.
Tier 2: Generic	You pay a $30 copay.	You pay a $10 copay.
Tier 3: Preferred Brand	You pay a $120 copay. $105 copay for Select Insulins, if eligible.	You pay a $40 copay. $35 copay for Select Insulins, if eligible.
Tier 4: Non-Preferred Drugs	You pay a $300 copay.	You pay a $100 copay.
Tier 5: Specialty	Not offered.	You pay 33% of the cost.
Cost sharing may change when you enter another of the four phases of the Part D benefit.		

Counties: Spokane, Stevens, and Walla Walla		
Premera Blue Cross Medicare Advantage Total Health (HMO)		
	Mail Order Cost Sharing (90-day supply)	Long-Term Care Cost Sharing (up to a 31-day supply)
Tier 1: Preferred Generic	You pay a $0 copay.	You pay a $2 copay.
Tier 2: Generic	You pay a $30 copay.	You pay a $10 copay.
Tier 3: Preferred Brand	You pay a $120 copay. $105 copay for Select Insulins, if eligible.	You pay a $40 copay. $35 copay for Select Insulins, if eligible.
Tier 4: Non-Preferred Drugs	You pay a $300 copay.	You pay a $100 copay.
Tier 5: Specialty	Not offered.	You pay 33% of the cost.
Cost sharing may change when you enter another of the four phases of the Part D benefit.		

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Premium and Benefits	**Premera Blue Cross Medicare Advantage (HMO)**	**Premera Blue Cross Medicare Advantage Classic (HMO)**	**Premera Blue Cross Medicare Advantage Total Health (HMO)**
Coverage Gap	After you enter the Coverage Gap, you pay 25% of the costs of brand name drugs and 25% of the costs of generic drugs until your out-of-pocket costs reach $7,400, which is the end of the Coverage Gap. During this stage, your out-of-pocket costs for Select Insulins will be $35, if eligible. Not everyone will reach the Coverage Gap.		
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $7,400, you pay whichever of these is larger: • 5% of the cost of the drug, or • $4.15 copay for a generic drug, or a drug that is treated like a generic and $10.35 copay for all other drugs.		

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 Customer Service for more information.

Important Message About What You Pay for Insulin – You won't pay more than $35 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.

Counties	King, Pierce, Snohomish, Thurston, and Whatcom		
Premium and Benefits	**Premera Blue Cross Medicare Advantage Peak + Rx (HMO)**	**Premera Blue Cross Medicare Advantage Sound + Rx (HMO)**	**Premera Blue Cross Medicare Advantage Alpine (HMO)**
Monthly Plan Premium	You pay $0 per month. You must continue to pay your Medicare Part B premium.	You pay $34 per month. You must continue to pay your Medicare Part B premium.	You pay $24 per month. You must continue to pay your Medicare Part B premium.
Part C Deductible	No deductible.	No deductible.	No deductible.
Part D Deductible	$160 per year for Part D prescription drugs except for drugs listed on Tier 1 and Tier 2, which are excluded from the deductible.	No deductible.	Not applicable.
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	You pay no more than $6,700 annually. Includes copays and other costs for medical services for the year.	You pay no more than $6,500 annually. Includes copays and other costs for medical services for the year.	You pay no more than $6,500 annually. Includes copays and other costs for medical services for the year.
Inpatient Hospital Coverage*	You pay a $450 copay per day for days 1-4. You pay a $0 copay per day for days 5 and beyond.	You pay a $450 copay per day for days 1-4. You pay a $0 copay per day for days 5 and beyond.	You pay a $350 copay per day for days 1-4 You pay a $0 copay per day for days 5 and beyond.
Outpatient Hospital Coverage*	$350	$350	$350
Outpatient Hospital Observation Coverage*	$90	$90	$90
Ambulatory Surgery Center*	You pay a $250 copay for each Medicare-covered ambulatory surgical center visit.	You pay a $275 copay for each Medicare-covered ambulatory surgical center visit.	You pay a $250 copay for each Medicare-covered ambulatory surgical center visit.
Doctor Visits			
Primary care providers	You pay a $5 copay per office visit. You pay a $0 copay per telehealth visit.	You pay a $0 copay per office visit. You pay a $0 copay per telehealth visit.	You pay a $0 copay per office visit. You pay a $0 copay per telehealth visit.

^ PCP referral may be required.

* Prior authorization is required.

Counties	King, Pierce, Snohomish, Thurston, and Whatcom		
Premium and Benefits	**Premera Blue Cross Medicare Advantage Peak + Rx (HMO)**	**Premera Blue Cross Medicare Advantage Sound + Rx (HMO)**	**Premera Blue Cross Medicare Advantage Alpine (HMO)**
Specialists^	You pay a $40 copay per office visit. You pay a $35 copay per telehealth visit.	You pay a $45 copay per office visit. You pay a $40 copay per telehealth visit.	You pay a $45 copay per office visit. You pay a $40 copay per telehealth visit.
Preventive Care (such as flu vaccine, diabetic screenings)	You pay $0. Other preventive services are available. There are some covered services that have a cost.	You pay $0. Other preventive services are available. There are some covered services that have a cost.	You pay $0. Other preventive services are available. There are some covered services that have a cost.
Emergency Care	You pay a $90 copay per visit. Waived, if admitted to the hospital within 24 hours. Includes worldwide coverage.	You pay a $90 copay per visit. Waived, if admitted to the hospital within 24 hours. Includes worldwide coverage.	You pay a $90 copay per visit. Waived, if you are admitted to the hospital within 24 hours. Includes worldwide coverage.
Urgently Needed Services	You pay a $35 copay per visit. Includes worldwide coverage with a $50 copay.	You pay a $40 copay per visit. Includes worldwide coverage with a $50 copay.	You pay a $40 copay per visit. Includes worldwide coverage with a $50 copay.
Diagnostic Services/Labs/ Imaging			
Diagnostic tests and procedures*	You pay a $60 copay per service location per day.	You pay a $25 copay per service location per day.	You pay a $25 copay per service location per day.
Lab services	You pay a $10 copay per service location per day.	You pay a $5 copay per service location per day.	You pay a $5 copay per service location per day.
Outpatient X-rays	You pay a $15 copay per service location per day.	You pay a $10 copay per service location per day.	You pay a $10 copay per service location per day.
Therapeutic radiology services (such as radiation treatment for cancer)*	You pay 20% of the cost. If your doctor provides additional services, a separate cost sharing amount may apply.	You pay 20% of the cost. If your doctor provides additional services, a separate cost sharing amount may apply.	You pay 20% of the cost. If your doctor provides additional services, a separate cost sharing amount may apply.
Diagnostic radiology services*	$180 copay per service location per day.	$170 copay per service location per day.	$170 copay per service location per day.

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* Prior authorization is required.

Counties	King, Pierce, Snohomish, Thurston, and Whatcom		
Premium and Benefits	**Premera Blue Cross Medicare Advantage Peak + Rx (HMO)**	**Premera Blue Cross Medicare Advantage Sound + Rx (HMO)**	**Premera Blue Cross Medicare Advantage Alpine (HMO)**
Hearing Services			
Medicare-covered hearing exam	You pay a $35 copay per visit.	You pay a $45 copay per visit.	You pay a $50 copay per visit.
Routine hearing exam	You pay a $0–$35 copay for one routine hearing exam per calendar year. $0 copay through Hearing Care Solutions provider; higher copay applies to exams performed by all other providers.	You pay a $0–$45 copay for one routine hearing exam per calendar year. $0 copay through Hearing Care Solutions provider; higher copay applies to exams performed by all other providers.	You pay a $0–$50 copay for one routine hearing exam per calendar year. $0 copay through Hearing Care Solutions provider; higher copay applies to exams by all other providers.
Hearing aid	You pay a $0 copay. There is a $1,000 annual allowance per ear toward the purchase of hearing aids through Hearing Care Solutions provider.		
Dental Services			
Medicare-covered dental services	You pay a $50 copay per visit.		
Annual maximum	$1,000	$1,300	$1,500
Dental services	You pay a $0 copay for routine preventive and comprehensive dental services.		
Preventive services	• Prophylaxis (cleaning) – Two per calendar year OR Periodontal maintenance – Three per calendar year • Fluoride – Two per calendar year • Periodic oral exam – Up to two periodic oral evaluations per calendar year • Limited oral evaluation (problem-focused) – One evaluation per 12 months • Comprehensive oral exam – One comprehensive exam per 36 months • Detailed and extensive oral evaluation – (problem-focused, by report) – One per lifetime • Re-evaluation – (limited, problem-focused, established patient) – One per lifetime • Comprehensive periodontal exam – One per calendar year • Bitewing X-rays – One set per calendar year • Full-mouth complete set – One procedure every 60 months • Panoramic film X-ray for evaluation of the teeth and mouth – One procedure every 60 months		

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* Prior authorization is required.

Counties	King, Pierce, Snohomish, Thurston, and Whatcom		
Premium and Benefits	**Premera Blue Cross Medicare Advantage Peak + Rx (HMO)**	**Premera Blue Cross Medicare Advantage Sound + Rx (HMO)**	**Premera Blue Cross Medicare Advantage Alpine (HMO)**
Annual Comprehensive Deductible (in-network and out-of-network)	You pay a one-time annual Comprehensive Services deductible of $75. Deductible is waived for preventive and Medicare-covered dental services.		You pay a one-time annual Comprehensive Services deductible of $25. Deductible is waived for preventive and Medicare-covered dental services.
Comprehensive services	• Periodontal scaling and root planing – One every two years, per quadrant • Scaling in presence of generalized moderate or severe gingival inflammation, full mouth – Once per two years • Occlusal adjustment performed with covered surgery – No limit • Gingivectomy or gingivoplasty – One surgical procedure per lifetime • Osseous surgery including flap entry and closure – One per lifetime • Pedicle or free soft tissue graft – One per lifetime • Full mouth debridement – One per lifetime • Intraoral X-rays: Periapical X-rays or Occlusal X-rays – One procedure code per calendar year • Restorations (fillings): Amalgam (silver) and/or composite – One per tooth per 24 months • Recementing a crown that has fallen off – One per 12 months • Recementing bridges, inlays, onlays and crowns – After 12 months of insertion and per 12 months per tooth thereafter • Pins when preparing a tooth for a crown – Bundle with crown code and pins (when required) • Buildup of filling around a post to prepare the tooth for a crown – One combo per tooth every five years • Crowns – One per tooth every five years • Oral surgery, including postoperative care for coronectomy, intentional partial tooth removal – One per tooth per lifetime • Root canal – One initial root canal procedure and one retreatment procedure per tooth per lifetime • Pulpotomy – No Limit • Apicoectomy – No Limit • Retrograde fillings – One per root per lifetime		

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* Prior authorization is required.

Counties	King, Pierce, Snohomish, Thurston, and Whatcom		
Premium and Benefits	**Premera Blue Cross Medicare Advantage Peak + Rx (HMO)**	**Premera Blue Cross Medicare Advantage Sound + Rx (HMO)**	**Premera Blue Cross Medicare Advantage Alpine (HMO)**
Comprehensive services	• Medicine placed under fillings to promote pulp healing – Unlimited per plan year to plan annual maximum • Complete denture – Maxillary (upper) or mandibular (lower) – One upper complete and/or one lower complete denture every seven years, including routine post-delivery care • Partial dentures: Resin or metal, maxillary (upper) or mandibular (lower) or maxillary (upper) or mandibular (lower) – One upper and/or one lower partial denture every seven years • Complete denture and partial denture adjustment – Two per denture per year • Complete or partial denture reline or rebase – One relining or rebasing of existing removable dentures per 24 months (only after 24 months from date of last placement, unless an immediate prosthesis replacing at least 3 teeth). • Recementation – One procedure per calendar year • Repair of dentures or fixed bridgework – One per denture/bridgework per 24 months • Teledentistry – Two per calendar year • Pain Management – Unlimited per plan year to plan annual maximum. Only if no services other than exam and X-rays were performed on the same date of service. • Deep sedation/general anesthesia – Unlimited per plan year to plan annual maximum. In conjunction with covered oral surgery or periodontal surgery. • Local anesthesia – Unlimited per plan year to plan annual maximum. In conjunction with covered oral surgery or periodontal surgery. • Intravenous moderate (conscious) sedation/analgesia – Unlimited per plan year to plan annual maximum. In conjunction with covered oral surgery or periodontal surgery.		

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Counties	King, Pierce, Snohomish, Thurston, and Whatcom		
Premium and Benefits	**Premera Blue Cross Medicare Advantage Peak + Rx (HMO)**	**Premera Blue Cross Medicare Advantage Sound + Rx (HMO)**	**Premera Blue Cross Medicare Advantage Alpine (HMO)**
Vision Services			
Medicare-covered vision exam	You pay a $0 copay for each Medicare-covered diabetic retinopathy and glaucoma screenings once per calendar year. You pay a $50 copay for each Medicare-covered exam to diagnose and treat diseases and conditions of the eye.	You pay a $0 copay for each Medicare-covered diabetic retinopathy and glaucoma screenings once per calendar year. You pay a $50 copay for each Medicare-covered exam to diagnose and treat diseases and conditions of the eye.	You pay a $0 copay for each Medicare-covered diabetic retinopathy and glaucoma screenings once per calendar year. You pay a $45 copay for each Medicare-covered exam to diagnose and treat diseases and conditions of the eye.
Medicare-covered vision hardware	You pay $0 copay for one pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery.	You pay $0 copay for one pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery.	You pay a $0 copay for one pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery.
Routine vision exam	You pay a $20 copay for one routine vision exam per calendar year for the purposes of obtaining eyeglasses or contact lenses.	You pay a $20 copay for one routine vision exam per calendar year for the purposes of obtaining eyeglasses or contact lenses.	You pay a $20 copay for one routine vision exam per calendar year for the purposes of obtaining eyeglasses or contact lenses.
Routine vision hardware	There is a $150 benefit limit for routine eyeglasses (lenses and frames) or contact lenses per calendar year.	There is a $150 benefit limit for routine eyeglasses (lenses and frames) or contact lenses per calendar year.	There is a $300 benefit limit for routine eyeglasses (lenses and frames) or contact lenses per calendar year.

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Counties	King, Pierce, Snohomish, Thurston, and Whatcom		
Premium and Benefits	**Premera Blue Cross Medicare Advantage Peak + Rx (HMO)**	**Premera Blue Cross Medicare Advantage Sound + Rx (HMO)**	**Premera Blue Cross Medicare Advantage Alpine (HMO)**
Mental Health Services			
Inpatient mental health care*	You pay a $595 copay per day for days 1–2. You pay $0 copay per day for days 3–90.	You pay a $595 copay per day for days 1–2. You pay $0 copay per day for days 3–90.	You pay a $595 copay per day for days 1–2. You pay a $0 copay per day for days 3–90.
Outpatient mental health care	You pay a $30 copay for each Medicare-covered individual or group therapy visit. You pay a $20 copay for each telemental health visit.	You pay a $35 copay for each Medicare-covered individual or group therapy visit. You pay a $20 copay for each telemental health visit.	You pay a $35 copay for each Medicare-covered individual or group therapy visit. You pay a $20 copay for each telemental health visit.
Skilled Nursing Facility*	You pay a $0 copay per day for days 1–20. You pay a $160 copay per day for days 21–60. You pay a $0 copay per day for days 61–100.	You pay a $0 copay per day for days 1–20. You pay a $160 copay per day for days 21–60. You pay a $0 copay per day for days 61–100.	You pay a $0 copay per day for days 1–20. You pay a $160 copay per day for days 21–60. You pay a $0 copay per day for days 61–100.
Physical Therapy	You pay a $20 copay per visit.	You pay a $35 copay per visit.	You pay a $35 copay per visit.
Ambulance* No prior authorization required for emergencies	You pay a $280 copay each way for Medicare-covered ambulance transport.	You pay a $285 copay each way for Medicare-covered ambulance transport.	You pay a $255 copay each way for Medicare-covered ambulance transport.
Transportation	Not covered.	Not covered.	Not covered.
Medicare Part B Drugs*	You pay 20% of the cost for Medicare-covered Part B chemotherapy drugs and other Part B drugs.	You pay 20% of the cost for Medicare-covered Part B chemotherapy drugs and other Part B drugs.	You pay 20% of the cost for Medicare-covered Part B chemotherapy drugs and other Part B drugs.

^ PCP referral may be required.

* Prior authorization is required.

Counties	King, Pierce, Snohomish, Thurston, and Whatcom		
Premium and Benefits	**Premera Blue Cross Medicare Advantage Peak + Rx (HMO)**	**Premera Blue Cross Medicare Advantage Sound + Rx (HMO)**	**Premera Blue Cross Medicare Advantage Alpine (HMO)**
Over the Counter (OTC)	Receive a $25 quarterly benefit for over-the-counter health and wellness products available through OTC Health Solutions.	Receive a $50 quarterly benefit for over-the-counter health and wellness products available through OTC Health Solutions.	Receive a $50 quarterly benefit for over-the-counter health and wellness products available through OTC Health Solutions.
Chiropractic Services	Medicare-covered copay: $20. Routine Chiropractic Services: 6 visits/ $20 copay.	Medicare-covered copay: $20. Routine Chiropractic Services: 6 visits/ $20 copay.	Medicare-covered copay: $20. Routine Chiropractic Services: 12 visits/ $20 copay.
Acupuncture*	Medicare-covered copay: $40. Routine Acupuncture: 6 visits/ $20 copay.	Medicare-covered copay: $45. Routine Acupuncture: 6 visits/ $20 copay.	Medicare-covered copay: $45. Routine Acupuncture: 12 visits/ $20 copay.
Routine Naturopathic Services	Not covered.	Not covered.	25 visits/ $30 copay.

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Counties: King, Pierce, Snohomish, Thurston, and Whatcom				
Premera Blue Cross Medicare Advantage Peak + Rx (HMO)		**Premera Blue Cross Medicare Advantage Sound + Rx (HMO)**		**Premera Blue Cross Medicare Advantage Alpine (HMO)**
PRESCRIPTION DRUG BENEFITS (PART D)		**PRESCRIPTION DRUG BENEFITS (PART D)**		**PRESCRIPTION DRUG BENEFITS (PART D)**
Deductible Phase	During this stage, you pay the full cost of your Tier 3, 4, and 5 drugs. You stay in this stage until you have paid $160 for your Tier 3, 4, and 5 drugs. During this stage, your out-of-pocket costs for Select Insulins will be $35, if eligible.	**Deductible Phase**	Because there is no deductible for the plan, this payment stage does not apply to you.	**Not applicable.**
Initial Coverage Phase - You begin in this stage when you fill your first prescription of the year. You stay in the Initial Coverage Stage until your total drug costs for the year reach $4,660. During this stage, your out-of-pocket costs for Select Insulins will be $35, if eligible.				
	Standard Retail Cost Sharing (in-network)(up to 30-day supply)		Standard Retail Cost Sharing (in-network)(up to 30-day supply)	
Tier 1: Preferred Generic	You pay a $3 copay.	**Tier 1: Preferred Generic**	You pay a $2 copay.	
Tier 2: Generic	You pay a $12 copay.	**Tier 2: Generic**	You pay a $12 copay.	
Tier 3: Preferred Brand	You pay a $42 copay. $35 copay for Select Insulins, if eligible.	**Tier 3: Preferred Brand**	You pay a $42 copay. $35 copay for Select Insulins, if eligible.	
Tier 4: Non-Preferred Drugs	You pay $100.	**Tier 4: Non-Preferred Drugs**	You pay $100.	
Tier 5: Specialty	You pay 30% of the cost.	**Tier 5: Specialty**	You pay 33% of the cost.	

Counties: King, Pierce, Snohomish, Thurston, and Whatcom						
Premera Blue Cross Medicare Advantage Peak + Rx (HMO)			**Premera Blue Cross Medicare Advantage Sound + Rx (HMO)**			**Premera Blue Cross Medicare Advantage Alpine (HMO)**
	Mail Order Cost Sharing (90-day supply)	Long-Term Care Cost Sharing (up to a 31-day supply)		Mail Order Cost Sharing (90-day supply)	Long-Term Care Cost Sharing (up to a 31-day supply)	**Not applicable.**
Tier 1: Preferred Generic	You pay a $0 copay.	You pay a $3 copay.	**Tier 1: Preferred Generic**	You pay a $0 copay.	You pay a $2 copay.	
Tier 2: Generic	You pay a $36 copay.	You pay a $12 copay.	**Tier 2: Generic**	You pay a $36 copay.	You pay a $12 copay.	
Tier 3: Preferred Brand	You pay a $126 copay. $105 copay for Select Insulins, if eligible.	You pay a $42 copay. $35 copay for Select Insulins, if eligible.	**Tier 3: Preferred Brand**	You pay a $126 copay. $105 copay for Select Insulins, if eligible.	You pay a $42 copay. $35 copay for Select Insulins, if eligible.	
Tier 4: Non-Preferred Drugs	You pay $300.	You pay $100.	**Tier 4: Non-Preferred Drugs**	You pay $300.	You pay $100.	
Tier 5: Specialty	Not offered.	You pay 30% of the cost.	**Tier 5: Specialty**	Not offered.	You pay 33% of the cost.	
Cost sharing may change when you enter another of the four phases of the Part D benefit.			Cost sharing may change when you enter another of the four phases of the Part D benefit.			

Counties	King, Pierce, Snohomish, Thurston, and Whatcom		
Premium and Benefits	**Premera Blue Cross Medicare Advantage Peak + Rx (HMO)**	**Premera Blue Cross Medicare Advantage Sound + Rx (HMO)**	**Premera Blue Cross Medicare Advantage Alpine (HMO)**
Coverage Gap	After you enter the Coverage Gap, you pay 25% of the costs of brand name drugs and 25% of the costs of generic drugs until your out-of-pocket costs reach $7,400, which is the end of the Coverage Gap. During this stage, your out-of-pocket costs for Select Insulins will be $35, if eligible. Not everyone will reach the Coverage Gap.		**Not applicable.**
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $7,400, you pay whichever of these is larger: • 5% of the cost of the drug, or • $4.15 copay for a generic drug, or a drug that is treated like a generic and $10.35 copay for all other drugs.	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $7,400, you pay whichever of these is larger: • 5% of the cost of the drug, or • $4.15 copay for a generic drug, or a drug that is treated like a generic and $10.35 copay for all other drugs.	**Not applicable.**

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 Customer Service for more information.

Important Message About What You Pay for Insulin – You won't pay more than $35 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.

Form Approved
OMB# 0938-1421

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 1-888-850-8526 (TTY/TDD: 711). 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 1-888-850-8526 (TTY/TDD: 711). 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 1-888-850-8526 (TTY/TDD: 711)。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 1-888-850-8526 (TTY/TDD: 711)。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 1-888-850-8526 (TTY/TDD: 711). 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 1-888-850-8526 (TTY/TDD: 711). 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 1-888-850-8526 (TTY/TDD: 711) 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 1-888-850-8526 (TTY/TDD: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Form Approved
OMB# 0938-1421

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-888-850-8526 (TTY/TDD: 711) 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 1-888-850-8526 (TTY/TDD: 711). 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 (TTY/TDD: 711) 1-888-850-8526. 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 1-888-850-8526 (TTY/TDD: 711) 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 1-888-850-8526 (TTY/TDD: 711). 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 1-888-850-8526 (TTY/TDD: 711). 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 1-888-850-8526 (TTY/TDD: 711). 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 1-888-850-8526 (TTY/TDD: 711). Ta usługa jest bezpłatna.

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