

Premera Blue Cross Medicare Advantage Peak + Rx (HMO) offered by Premera Blue Cross

Annual Notice of Changes for 2023

You are currently enrolled as a member of Premera Blue Cross Medicare Advantage Peak + Rx (HMO). Next year, there will be changes to the plan's costs and benefits. ***Please see page 4 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which is located on our website at **premera.com/ma**. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**
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What to do now

1. ASK: Which changes apply to you

- Check the changes to our benefits and costs to see if they affect you.
 - Review the changes to Medical care costs (doctor, hospital).
 - Review the changes to our drug coverage, including authorization requirements and costs.
 - Think about how much you will spend on premiums, deductibles, and cost sharing.
- Check the changes in the 2023 Drug List to make sure the drugs you currently take are still covered.
- Check to see if your primary care doctors, specialists, hospitals and other providers, including pharmacies will be in our network next year.
- Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

- Check coverage and costs of plans in your area. Use the Medicare Plan Finder at **www.medicare.gov/plan-compare** website or review the list in the back of your *Medicare & You 2023* handbook.

- Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. CHOOSE: Decide whether you want to change your plan

- If you don't join another plan by December 7, 2022, you will stay in Premera Blue Cross Medicare Advantage Peak + Rx (HMO).
- To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2023**. This will end your enrollment with Premera Blue Cross Medicare Advantage Peak + Rx (HMO).
- If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

Additional Resources

- Please contact our Customer Service number at 888-850-8526 for additional information. (TTY users should call 711.) October 1 - March 31, hours are 8:00 a.m. - 8:00 p.m. (Pacific Time), seven days a week.

April 1 - September 30, hours are 8:00 a.m. - 8:00 p.m. (Pacific Time), Monday through Friday.

- This information is available in a different format, including braille and large print.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Premera Blue Cross Medicare Advantage Peak + Rx (HMO)

- Premera Blue Cross is an HMO plan with a Medicare contract. Enrollment in Premera Blue Cross depends on contract renewal.
- When this document says "we," "us," or "our," it means Premera Blue Cross. When it says "plan" or "our plan," it means Premera Blue Cross Medicare Advantage Peak + Rx (HMO).

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Summary of Important Costs for 2023

The table below compares the 2022 costs and 2023 costs for Premera Blue Cross Medicare Advantage Peak + Rx (HMO) in several important areas. **Please note this is only a summary of costs.**

Cost	2022 (this year)	2023 (next year)
<p>Monthly plan premium*</p> <p>* Your premium may be higher than this amount. See Section 1.1 for details.</p>	\$0	\$0
<p>Maximum out-of-pocket amount</p> <p>This is the <u>most</u> you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)</p>	\$6,700	\$6,700
<p>Doctor office visits</p>	<p>Primary care visits: \$5 per in-person visit. \$0 per virtual visit.</p> <p>Specialist visits: \$40 per in-person visit. \$35 per virtual visit.</p>	<p>Primary care visits: \$5 per in-person visit. \$0 per virtual visit.</p> <p>Specialist visits: \$40 per in-person visit. \$35 per virtual visit.</p>
<p>Inpatient hospital stays</p>	<p>For Medicare-covered hospital stays: \$450 copay per day for days 1 through 4 \$0 copay per day for days 5 through 90.</p>	<p>For Medicare-covered hospital stays: \$450 copay per day for days 1 through 4 \$0 copay per day for days 5 through 90.</p>

Cost	2022 (this year)	2023 (next year)
<p>Part D prescription drug coverage (See Section 1.5 for details.) To find out which drugs are Select Insulins, review the most recent Drug List we provided electronically. You can identify Select Insulins by SI. If you have questions about the Drug List, you can also call Customer Service (phone numbers for Customer Service are printed on the back cover of this document).</p>	<p>Deductible: \$160 Copayment/Coinsurance during the Initial Coverage Stage:</p> <ul style="list-style-type: none"> • Drug Tier 1 Preferred Generic: <i>Standard cost sharing: \$12 Preferred cost sharing: \$3</i> • Drug Tier 2 Generic: <i>Standard cost sharing: \$20 Preferred cost sharing: \$12</i> • Drug Tier 3 Preferred Brand: <i>Standard cost sharing: \$47 Preferred cost sharing: \$42</i> • Drug Tier 4 Non-Preferred Drug: <i>Standard cost sharing: \$100 Preferred cost sharing: \$100</i> • Drug Tier 5 Specialty: <i>Standard cost sharing: 30% Preferred cost sharing: 30%</i> 	<p>Deductible: \$160 Copayment/Coinsurance during the Initial Coverage Stage:</p> <ul style="list-style-type: none"> • Drug Tier 1 Preferred Generic: \$3 • Drug Tier 2 Generic: \$12 • Drug Tier 3 Preferred Brand: \$42 • Drug Tier 4 Non-Preferred Drug: \$100 • Drug Tier 5 Specialty: 30%

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2022 (this year)	2023 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	\$0	\$0

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as “creditable coverage”) for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amount

Medicare requires all health plans to limit how much you pay “out-of-pocket” for the year. This limit is called the “maximum out-of-pocket amount.” Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2022 (this year)	2023 (next year)
Maximum out-of-pocket amount	\$6,700	\$6,700
Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.		Once you have paid \$6,700 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 1.3 – Changes to the Provider and Pharmacy Networks

Updated directories are also located on our website at premera.com/ma. You may also call Customer Service for updated provider and/or pharmacy information or to ask us to mail you a directory.

There are changes to our network of providers for next year. **Please review the 2023 Provider and Pharmacy Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

There are changes to our network of pharmacies for next year. **Please review the 2023 Provider and Pharmacy Directory to see which pharmacies are in our network.**

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers), and pharmacies that are part of your plan during the year. If a mid-year change in our providers affects you, please contact Customer Service so we may assist.

Section 1.4 – Changes to Benefits and Costs for Medical Services

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2022 (this year)	2023 (next year)
Colorectal cancer screening	For people age 50 and older, the following are covered: <ul style="list-style-type: none"> • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months 	For people age 45 and older, the following are covered: <ul style="list-style-type: none"> • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months
Diabetes self-management training, diabetic services, and supplies	You pay 5% of the approved amount (limited to specific manufacturers) for Medicare-covered diabetic supplies (e.g. test strips).	You pay 0% of the approved amount (limited to specific manufacturers) for Medicare-covered diabetic supplies (e.g. test strips).
Opioid treatment program services	You pay a \$35 copay for opioid treatment services, if offered by Medicare-enrolled Opioid Treatment Program providers.	You pay a \$30 copay for opioid treatment services, if offered by Medicare-enrolled Opioid Treatment Program providers.
Outpatient diagnostic tests and therapeutic services and supplies	You pay a \$15 copay for Medicare-covered lab services.	You pay a \$10 copay for Medicare-covered lab services.

Cost	2022 (this year)	2023 (next year)
Outpatient mental health care	<p>You pay a \$35 copay for each Medicare-covered individual or group therapy visit (in-person).</p> <p>You pay a \$20 copay for each Medicare-covered individual therapy visit (virtual), if offered by a contracted provider.</p> <p>You pay a \$35 copay for Medicare-covered psychiatrist services (in-person).</p> <p>You pay a \$20 copay for Medicare-covered psychiatrist services (virtual), if offered by a contracted provider.</p>	<p>You pay a \$30 copay for each Medicare-covered individual or group therapy visit (in-person).</p> <p>You pay a \$20 copay for each Medicare-covered individual therapy visit (virtual), if offered by a contracted provider.</p> <p>You pay a \$30 copay for Medicare-covered psychiatrist services (in-person).</p> <p>You pay a \$20 copay for Medicare-covered psychiatrist services (virtual), if offered by a contracted provider.</p>

Section 1.5 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or “Drug List.” A copy of our Drug List is provided electronically.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online Drug List to provide the most up to date list of drugs.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your *Evidence of Coverage* and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. You can also contact Customer Service for more information.

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs (“Extra Help”), **the information about costs for Part D prescription drugs may not apply to you.** We have included a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (also called the “Low Income Subsidy Rider” or the “LIS Rider”), which tells you about your drug costs. If you receive “Extra Help” and didn’t receive this insert with this packet, please call Customer Service and ask for the “LIS Rider.”

There are four “drug payment stages.” The information below shows the changes to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage.)

Changes to the Deductible Stage

Stage	2022 (this year)	2023 (next year)
<p>Stage 1: Yearly Deductible Stage</p> <p>During this stage, you pay the full cost of your Tier 3, Tier 4 and Tier 5 drugs until you have reached the yearly deductible.</p>	<p>The deductible is \$160.</p> <p>During this stage, you pay \$12 for Standard cost sharing and \$3 for Preferred cost sharing for drugs on Tier 1.</p> <p>You pay \$20 for Standard cost sharing and \$12 for Preferred cost sharing for drugs on Tier 2.</p> <p>You pay the full cost of drugs on Tier 3, Tier 4 and Tier 5 until you have reached the yearly deductible.</p> <p>There is no deductible for Premera Blue Cross Medicare Advantage Peak + Rx (HMO) for Select Insulins. You pay \$35 for a 30-day supply for Select Insulins.</p>	<p>The deductible is \$160.</p> <p>During this stage, you pay \$3 for drugs on Tier 1.</p> <p>You pay \$12 for drugs on Tier 2.</p> <p>You pay the full cost of drugs on Tier 3, Tier 4 and Tier 5 until you have reached the yearly deductible.</p> <p>There is no deductible for Premera Blue Cross Medicare Advantage Peak + Rx (HMO) for Select Insulins. You pay \$35 for a 30-day supply for Select Insulins.</p>

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2022 (this year)	2023 (next year)
<p>Stage 2: Initial Coverage Stage</p> <p>Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs, and you pay your share of the cost.</p> <p>The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your <i>Evidence of Coverage</i>.</p> <p>We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.</p>	<p>Your cost for a one-month supply at a network pharmacy:</p> <p>Tier 1 Preferred Generic:</p> <p><i>Standard cost sharing:</i> You pay \$12 per prescription.</p> <p><i>Preferred cost sharing:</i> You pay \$3 per prescription.</p> <p>Tier 2 Generic:</p> <p><i>Standard cost sharing:</i> You pay \$20 per prescription.</p> <p><i>Preferred cost sharing:</i> You pay \$12 per prescription.</p> <p>Tier 3 Preferred Brand:</p> <p><i>Standard cost sharing:</i> You pay \$47 per prescription.</p> <p>You pay \$35 for Select Insulins.</p> <p><i>Preferred cost sharing:</i> You pay \$42 per prescription.</p> <p>You pay \$35 for Select Insulins.</p>	<p>Your cost for a one-month supply at a network pharmacy:</p> <p>Tier 1 Preferred Generic:</p> <p><i>In-Network cost sharing:</i> You pay \$3 per prescription.</p> <p>Tier 2 Generic:</p> <p><i>In-Network cost sharing:</i> You pay \$12 per prescription.</p> <p>Tier 3 Preferred Brand:</p> <p><i>In-Network cost sharing:</i> You pay \$42 per prescription.</p> <p>You pay \$35 for Select Insulins.</p>

Stage	2022 (this year)	2023 (next year)
Stage 2: Initial Coverage Stage (continued)	<p>Tier 4 Non-Preferred Drug:</p> <p><i>Standard cost sharing:</i> You pay \$100 per prescription.</p> <p><i>Preferred cost sharing:</i> You pay \$100 per prescription.</p> <p>Tier 5 Specialty:</p> <p><i>Standard cost sharing:</i> You pay 30% of the total cost.</p> <p><i>Preferred cost sharing:</i> You pay 30% of the total cost.</p> <hr/> <p>Once your total drug costs have reached \$4,430, you will move to the next stage (the Coverage Gap Stage).</p>	<p>Tier 4 Non-Preferred Drug:</p> <p><i>In-Network cost sharing:</i> You pay \$100 per prescription.</p> <p>Tier 5 Specialty:</p> <p><i>In-Network cost sharing:</i> You pay 30% of the total cost.</p> <hr/> <p>Once your total drug costs have reached \$4,660, you will move to the next stage (the Coverage Gap Stage).</p>

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.

Getting Help from Medicare - If you choose this plan because you were looking for insulin coverage at \$35 a month or less, it is important to know that you may have other options available to you for 2023 at even lower costs because of changes to the Medicare Part D program. Contact Medicare, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week for help comparing your options. TTY users should call 1-877-486-2048.

Additional Resources to Help - Please contact our Customer Service number at 888-850-8526 for additional information (TTY users should call 711.) October 1 - March 31, hours are

8:00 a.m. - 8:00 p.m. (Pacific Time), seven days a week. April 1 - September 30, hours are 8:00 a.m. - 8:00 p.m. (Pacific Time), Monday through Friday.

SECTION 2 Administrative Changes

Description	2022 (this year)	2023 (next year)
Cost sharing at network pharmacies	Our network includes pharmacies that offer standard cost sharing and pharmacies that offer preferred cost sharing. You may go to either type of network pharmacy to receive your covered prescription drugs. Your cost sharing may be less at pharmacies with preferred cost sharing.	A network pharmacy is a pharmacy that has a contract with the plan to provide your covered prescription drugs. The term “covered drugs” means all of the Part D prescription drugs that are on the plan’s Drug List. Your cost sharing is the same at any network pharmacy.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Premera Blue Cross Medicare Advantage Peak + Rx (HMO)

To stay in our plan, you don’t need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our Premera Blue Cross Medicare Advantage Peak + Rx (HMO).

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2023 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- *OR* -- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 1.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2023* handbook, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

As a reminder, Premera Blue Cross offers other Medicare health plans and Medicare prescription drug plans. These other plans may differ in coverage, monthly premiums, and cost sharing amounts.

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Premera Blue Cross Medicare Advantage Peak + Rx (HMO).
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from Premera Blue Cross Medicare Advantage Peak + Rx (HMO).
- To **change to Original Medicare without a prescription drug plan**, you must either:
 - Send us a written request to disenroll or visit our website to disenroll online. Contact Customer Service if you need more information on how to do so.
 - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on January 1, 2023.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. Examples include people with Medicaid, those who get “Extra Help” paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area.

If you enrolled in a Medicare Advantage plan for January 1, 2023, and don’t like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2023.

If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

SECTION 5 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In Washington, the SHIP is called Statewide Health Insurance Benefits Advisors (SHIBA).

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. Statewide Health Insurance Benefits Advisors (SHIBA) counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call Statewide Health Insurance Benefits Advisors (SHIBA) at 800-562-6900 (TTY 360-586-0241). You can learn more about Statewide Health Insurance Benefits Advisors (SHIBA) by visiting their website (www.insurance.wa.gov/shiba).

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **“Extra Help” from Medicare.** People with limited incomes may qualify for “Extra Help” to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. To see if you qualify, call:
 - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
 - The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
 - Your State Medicaid Office (applications).
- **Help from your state’s pharmaceutical assistance program.** Washington state has a program called Washington Prescription Drug Program (WPDP) that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program.
- **Prescription Cost sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost sharing assistance through the Washington State’s ADAP known as the Early Intervention Program (EIP). The EIP provides services to help eligible persons with HIV get the medications and assistance with insurance premium payments they need to improve and maintain their health. For information on

eligibility criteria, covered drugs, or how to enroll in the program, please call 877-376-9316.

SECTION 7 Questions?

Section 7.1 – Getting Help from Premera Blue Cross Medicare Advantage Peak + Rx (HMO)

Questions? We're here to help. Please call Customer Service at 888-850-8526. (TTY only, call 711.) We are available for phone calls. October 1 - March 31, hours are 8:00 a.m. - 8:00 p.m. (Pacific Time), seven days a week.

April 1 - September 30, hours are 8:00 a.m. - 8:00 p.m. (Pacific Time), Monday through Friday. Calls to these numbers are free.

Read your 2023 Evidence of Coverage (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2023. For details, look in the 2023 *Evidence of Coverage* for Premera Blue Cross Medicare Advantage Peak + Rx (HMO). The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at premera.com/ma. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at premera.com/ma. As a reminder, our website has the most up-to-date information about our provider network (*Provider and Pharmacy Directory*) and our list of covered drugs (Formulary/Drug List).

Section 7.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2023*

Read the *Medicare & You 2023* handbook. Every fall, this document is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this document, you can get it at the Medicare website (<https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf>) or 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.

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 quý vị cần thông dịch viên xin gọi 1-888-850-8526 (TTY/TDD: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quý 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.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 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 (1-888-850-8526 (TTY/TDD: 711)). 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.

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。通訳をご用命になるには、1-888-850-8526 (TTY/TDD: 711) 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。