Medicare Advantage Group Plan

Enrollment Guide

Plan overview | Benefit highlights | Brand perks | How to enroll

Anthem

County of San Joaquin
Anthem Medicare Preferred (PPO) with Senior Rx Plus
07/01/2024 - 12/31/2024

Get to know your group plan

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Common health plan terms

Here is a list with definitions of frequent terms found throughout this guide

Care

Facility - A location for receiving care. Examples: hospital, skilled nursing facility (SNF), imaging center.

Inpatient care - Medical treatment for someone formally admitted to a facility with a doctor's order. Without a doctor's order it may be considered outpatient care, even if you stay overnight.

Outpatient care - Medical treatment for someone not admitted to a facility. May take place in a doctor's office, clinic, or hospital outpatient department.

Preventive care - Services and treatment to prevent illness or injury. Examples: annual wellness visit, screenings, diet or exercise counseling.

Primary care provider (PCP) - A general practice doctor, nurse practitioner, or physician assistant who treats basic medical conditions and is often the first person you'll see for health concerns.

PCPs provide checkups, vaccinations, and screenings. They help diagnose conditions and refer to specialists when needed.

You are not required to select a PCP.

Provider - A medical professional who provides care. Examples: doctor, specialist, physician assistant, nurse practitioner, nurse.

*Not all medical costs or services are included in or subject to the annual out-of-pocket maximum.

Cost

Allowed amount - The maximum amount the plan pays for each covered service.

Annual out-of-pocket maximum (or max OOP) - The maximum amount you pay for medical costs each plan year. After paying the max OOP, you pay nothing for covered services until the next plan year. Copays, coinsurance, and deductibles count toward the max OOP, but not all costs do.*

Summary of Benefits - A summarized list of medical care and drugs the plan covers.

Coinsurance - A percentage you may be required to pay for covered services or drugs after paying your deductible. The plan pays the rest.

Copay - A fixed dollar amount you may be required to pay for covered services or drugs after paying your deductible. The plan pays the rest.

Cost share - Also called "cost-sharing amount" or "your share of the costs." Usually a deductible, copay, or coinsurance. This is the amount you pay for covered services or drugs, while the plan pays the rest.

Covered services and drugs - Medical care and drugs your plan pays for under the plan terms.

Deductible - If applicable, the fixed dollar amount you pay for medical care or drugs before the plan begins to pay.

Plan highlights

PPO stands for Preferred Provider Organization.

PPOs use a network of hospitals and doctors. As long as your care provider accepts Medicare, you can see any doctor you wish.

County of San Joaquin offers you this Anthem Medicare Preferred (PPO) with Senior Rx Plus plan. It's both a Medicare Advantage plan and a PPO plan from Anthem BC Health Insurance Company. This plan includes:

Medical benefits

- A $0 copay for an annual wellness visit
- Access to emergency care both inside and outside of the United States

Prescription drug benefits

- Coverage on commonly prescribed drugs, plus extra covered drugs
- $0 copays on Select generics
- Plan pharmacies nationwide
- Savings on prescriptions with home delivery

Additional benefits

- SilverSneakers®
- LiveHealth Online®
- Discounted rates on health products and services

Questions?

Call our **First Impressions Welcome Team** for answers or plan details, and provide them with this group specific code CA061GRS.

1-833-848-8729 (TTY: **711**) **Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays**

Medical benefit highlights

Health and wellness

- Preventive care services
- Flu and pneumonia vaccines and most health screenings
- Inpatient hospital care and ambulance services
- Emergency and urgent care
- Skilled nursing facility benefits
- Complex radiology services and radiation therapy
- Diagnostic procedures and testing services received in a doctor's office
- Lab services and outpatient X-rays
- Home health agency care
- Tobacco-cessation counseling
- Routine hearing exams and hearing aid coverage

Nutrition

- Diabetes services and supplies
- Healthy Meals

Devices

- Durable medical equipment and related supplies
- Prosthetic devices

Programs and services

- 24/7 NurseLine
- Outpatient surgery and rehabilitation
- SilverSneakers® fitness program
- Medicare Community Resource Support
- Doctors available anytime, anywhere with LiveHealth® Online
- Foreign travel emergency and urgently needed services
- Anthem Health Guide

See your *Summary of Benefits* located in the appendix for more details.

Prescription drug benefit highlights

You'll save money on prescription drugs with:

Covered medications

We cover generic, brand name, and specialty drugs that Medicare Part D allows us to cover, plus even more than Medicare allows called "extra covered drugs".

Choosing covered generic drugs may save you money without sacrificing effectiveness. Generics have the same active ingredients and effects as brand name drugs, generally without the higher cost share. Generic drugs on our select generics list have a $0 copay.

Network pharmacies

Save by filling your prescriptions at any of our nearly 65,000 network pharmacies. Most national chains and many local pharmacies are in our National Discount Network.

Choose home delivery through CarelonRx pharmacy for convenience and savings. You'll get up to 90 days of supplies — often at a lower cost than if you were to fill the same amount at a regular pharmacy. It saves time as well.

See your *Summary of Benefits* located in the appendix for more details or call our First Impressions Welcome Team if you have questions about County of San Joaquin Anthem Medicare Preferred (PPO) with Senior Rx Plus plan benefits, and provide them with this group specific code CA061GRS. **1-833-848-8729** (TTY: **711**) **Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays**

Access to care

Nationwide access for peace of mind

Choose the doctors you want

- See any doctor, care provider, or specialist in or out of your plan's network who accepts both Medicare and your plan.
- Your copay or coinsurance is the same if you see a care provider in or out of your plan's network.
- Your benefits and coverage stay the same, no matter where you travel in the country.

What if a doctor or other provider says they don't accept this plan?

Have the doctor or care provider call the phone number on the back of your plan membership card. We'll explain to them how they can submit a claim for your visit.

Enroll

If you're ready to enroll, please go to page 19 to get started.

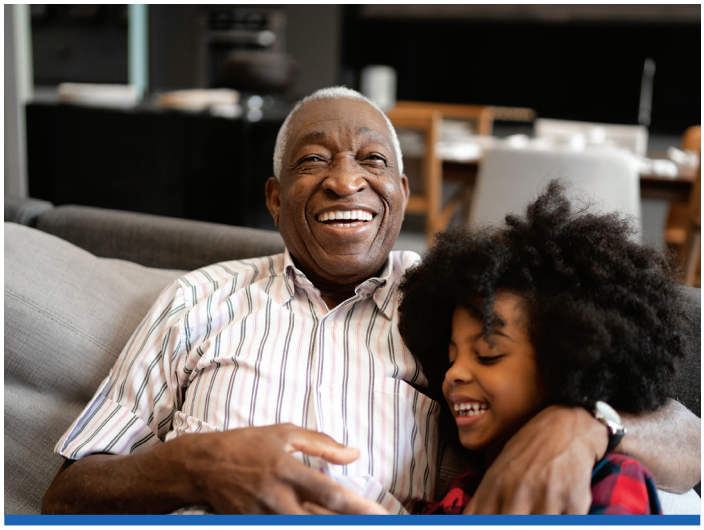
What is Medicare?

This plan is a PPO Medicare Advantage prescription drug plan

Medicare is a federal government health insurance program for people:

- Over age 65.
- Under age 65 with certain disabilities.
- With end-stage renal disease (ESRD).
- With amyotrophic lateral sclerosis (ALS), also called Lou Gehrig's disease.

More information is available at **www.medicare.gov** or 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**.



Medicare is available as follows:

Original Medicare

- Part A provides coverage for hospital benefits.
- Part B provides medical benefits.

Medicare Advantage

- Also called Part C.
- Bundles Parts A and B.
- Offers supplemental benefits and a first class member service experience.
- Can include Part D, the prescription drug plan.

Medicare Advantage is a Medicare-approved plan available only through private insurance companies. The added benefits it offers are listed throughout this guide.

Original Medicare = government program		Offered by private insurance companies	
Medicare Part A	Medicare Part B	Medicare Part C	Medicare Part D

Original Medicare + Part C = Medicare Advantage

Medicare Advantage + Part D = MAPD plan

Medicare Advantage vs. Original Medicare

Traveling outside the US?

Medicare Advantage members have emergency care coverage

Compare coverage

The good thing about Medicare Advantage is that it limits how much you'll spend each year on treatment. Plus, the prices are often fixed, so you'll have a better idea of any costs beforehand.

Medicare Advantage can include prescription drug coverage (Part D) — something Original Medicare doesn't offer.

Medicare Advantage	Original Medicare
Plan pays 100% of covered medical costs for rest of plan year after annual out-of-pocket maximum is met*	No limit to medical costs you will pay annually — no annual out-of-pocket maximum
You will often pay copays (fixed dollar amounts)	You will pay percentage of cost (20% of the cost for common services like outpatient surgery and doctor visits)
Emergency care is covered outside of U.S.	No emergency care coverage outside of U.S.
Can include Part D prescription drug coverage	No Part D prescription drug coverage

* Not all medical costs and services are included in or are subject to the annual out-of-pocket maximum, see the benefits chart for details. Call our First Impressions Welcome Team to request a benefits chart and ask any questions about County of San Joaquin Anthem Medicare Preferred (PPO) with Senior Rx Plus plan benefits, and provide them with this group specific code CA061GRS. **1-833-848-8729 (TTY: 711) Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays**

Medicare Part D

The prescription drug plan described in this guide is also known as a Medicare Part D plan. All of our covered drugs appear on a drug list called the Part D formulary. This plan also covers drugs beyond those that Original Medicare covers, which appear on a separate list called extra covered drugs, located in your *Evidence of Coverage* (EOC).

If you take a medicine that is not covered, you have three options:

- Ask your doctor to switch you to a covered drug
- Request an exception
- Request a temporary supply while discussing other drug options

Drug type	Description	Possible tier coverage[2]	Cost
Generic[1]	Same active ingredients and effects as brand-name drug without the brand-name	Tier 1	$
Preferred brand-name	Safe and effective brand-name drugs that may not have a generic alternative	Tier 2	$$
Non-preferred brand-name	Less commonly used brand-name drugs that usually have a generic alternative	Tier 3	$$$
Specialty	Cost $950 or more for a 30-day supply. May require special handling.	Highest tier	$$$$

Covered drugs are divided into levels or tiers. Drugs on the lowest-numbered tier generally cost less, while drugs on the highest-numbered tier generally cost the most. Each tier contains drugs that we cover based on their safety and effectiveness. This chart provides an overview of how the tiers and pricing generally work.

1 High-cost generic medications may also appear on the same tiers as brand-name medications. Please consult the formulary for specific tier details.

2 Some drug lists divide generic drugs into two tiers. For those lists, the tier number increases by one for all tiers after the first. For example, Tier 1 becomes Tier 1 and Tier 2, and the numbering continues up the tiers.

$0 copay for select generics

These select generics have the same active ingredients and effects as brand name drugs for a $0 copay. If you don't see one of your drugs here, you can call us to check the full drug list for you.[1]

Use	Name	
Cardiovascular	Amlodipine/benazepril capsule	Irbesartan tablet
	Atenolol tablet	Irbesartan/hydrochlorothiazide tablet
	Atenolol/chlorthalidone tablet	Lisinopril tablet
	Benazepril tablet	Lisinopril/hydrochlorothiazide tablet
	Benazepril/hydrochlorothiazide tablet	Losartan potassium tablet
	Bisoprolol fumarate tablet	Losartan potassium/ hydrochlorothiazide tablet
	Bisoprolol/hydrochlorothiazide tablet	Metoprolol tartrate tablet
	Carvedilol tablet	Olmesartan tablet
	Chlorthalidone tablet	Quinapril tablet
	Enalapril maleate tablet	Ramipril tablet
	Enalapril/hydrochlorothiazide tablet	Trandolapril tablet
	Fosinopril tablet	Valsartan tablet
	Furosemide tablet	Valsartan/hydrochlorothiazide tablet
	Hydrochlorothiazide capsule/tablet	
Cholesterol	Atorvastatin tablet	Rosuvastatin tablet
	Lovastatin tablet	Simvastatin tablet[2]
	Pravastatin sodium tablet	
Diabetes	Glimepiride tablet	Metformin ER tablet[2]
	Glipizide ER tablet	Metformin tablet
	Glipizide tablet	Pioglitazone tablet
	Glipizide/metformin hcl tablet	
Osteoporosis	Alendronate sodium tablet	

1 This list is current as of May 2023 and is subject to change. It is not a complete list of covered drugs.

2 Not all dosages are covered at the select generics cost share.

Top 50 most prescribed drugs we cover

If you don't see one of your drugs here, you can call us to check the full drug list for you.[1]

amlodipine besylate
atorvastatin calcium
amlodipine besylate
levothyroxine sodium
losartan potassium
lisinopril
metoprolol succinate
rosuvastatin calcium
gabapentin
ELIQUIS[2]
omeprazole
pantoprazole sodium
tamsulosin
furosemide
hydrochlorothiazide
metformin
hydrocodone-acetaminophen
simvastatin[2]
metoprolol tartrate
prednisone
carvedilol[2]
tramadol
albuterol sulfate HFA
SYNTHROID
sertraline
potassium chloride
clopidogrel
escitalopram oxalate
trazodone
montelukast sodium
pravastatin sodium
amoxicillin
famotidine
alprazolam
meloxicam
allopurinol
fluticasone propionate
latanoprost
azithromycin
duloxetine
zolpidem tartrate
ezetimibe
metformin ER
cephalexin
finasteride
atenolol
diclofenac sodium
XARELTO
lorazepam
donepezil
oxycodone-acetaminophen

Generic drugs appear in lowercase (lisinopril, for example), while brand-name drugs are in uppercase (ELIQUIS, for example).

1 This list is current as of May 2023 and is subject to change. It is not a complete list of covered drugs.
2 Not all dosages are covered at the select generics cost share.

Perks and programs

This plan includes useful and valuable programs to help you stay healthy and support your well-being. You will have access to the following services at no additional cost:

Annual health exams and preventive care

- Annual wellness visit
- Preventive care services
- Flu and pneumonia shots
- Tobacco cessation counseling

The House Call program[1]

A personalized visit to your home that can lead to a care plan tailored just for you.

24/7 NurseLine[2]

24/7 NurseLine puts you in touch with a registered nurse anytime of the day or night. Call **1-800-700-9184** (TTY: **711**) to have your questions answered.

MyHealth Advantage

This program gives you personalized reminders about preventive care, medical tests, and ways to stay healthy. It also offers access to health specialists who can answer your questions.

Healthy Meals

Have healthy, balanced meals delivered to your home after a hospital stay or if you have a chronic illness.

Questions?

Call our First Impressions Welcome Team for answers or plan details, and provide them with this group specific code CA061GRS. **1-833-848-8729** (TTY: **711**) Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays

1 The House Call program is administered by an independent contracted vendor.

2 The information contained in this program is for general guidance only. Your doctor will be specific regarding recommendations for your individual circumstances. Recommended treatments may not be covered under your health plan.

Perks and programs

LiveHealth Online®[1]

Visit with a doctor, therapist, or psychiatrist through live video on your phone, tablet, or computer with a camera. It's a great way to:

- Access a board-certified doctor in the comfort of your home, 24/7.
- Find help with common conditions like the flu, colds, sinus infections, pink eye, and skin rashes — and even have prescriptions sent to the pharmacy[2] if needed.
- Set up a 45-minute counseling session with a licensed therapist to find help when you feel depressed, anxious, or stressed. You can also meet with a board-certified psychiatrist to get medication management support if talk therapy alone isn't enough.[3]

With the Anthem plan, video visits using LiveHealth Online are $0.

1 LiveHealth Online is offered through an arrangement with Amwell, a separate company, providing telehealth services on behalf of your health plan.

2 Prescription availability is defined by physician judgment.

3 Prescriptions determined to be a "controlled substance" (as defined by the Controlled Substances Act under federal law) cannot be prescribed using LiveHealth Online. Psychiatrists on LiveHealth Online will not offer counseling or talk therapy.

Online counseling is not appropriate for all kinds of problems. If you are in crisis or have suicidal thoughts, it's important that you seek help immediately. Please call 988 (National Suicide Prevention Lifeline) or 911 and ask for help.

If your issue is an emergency, call 911 or go to your nearest emergency room. LiveHealth Online does not offer emergency services.

Perks and programs

Care and support with Carelon Health[1]

Carelon Health is a community-based program that specializes in providing an extra layer of support to patients facing serious illness and their families. This support is provided by a team of doctors, nurse practitioners, nurses, and social workers who work closely with a patient's primary care provider and other providers to coordinate care and improve communication. The Carelon Health clinical team is available 24/7 to provide extra care and attention, as well as education about illness, the plan of care, and medications. Carelon Health services are provided through a combination of home-based visits and telehealth support.

Anthem Health Guide

Whatever questions you might have, our Anthem Health Guide concierge service has answers.

Once you enroll, you can contact us by calling the number on the back of your plan membership card, logging into **www.anthem.com/ca**, or on the Sydney Health app.

1 Carelon Health is a separate company providing coordination of care through home-based visits and telehealth services on behalf of this plan.

Perks and programs

SilverSneakers®

SilverSneakers is a fitness and lifestyle benefit that offers the opportunity to connect with your community, make friends, and stay active. Your membership gives you:[1]

- Access to thousands of participating locations with use of basic amenities,[2] plus group exercise classes[3] for all levels at select locations.
- The SilverSneakers GO™ app so you can find locations near you, participate in live classes from your phone, and tailor workouts to your fitness level.
- Access to SilverSneakers LIVE virtual classes and the On-Demand library with hundreds of online videos so you can work out at home.

To find a location near you or join virtual classes, visit **www.silversneakers.com/starthere** or call **1-855-741-4985**, TTY: **711**, Monday to Friday, 8 a.m. to 8 p.m. ET.

1 Always talk with your doctor before starting an exercise program.

2 Participating locations ("PL") are not owned or operated by Tivity Health, Inc. or its affiliates. Use of PL facilities and amenities is limited to terms and conditions of PL basic membership. Facilities and amenities vary by PL.

3 Membership includes SilverSneakers instructor-led group fitness classes. Some locations offer members additional classes. Classes vary by location.

The SilverSneakers fitness program is provided by Tivity Health, an independent company. SilverSneakers and the SilverSneakers shoe logotype are registered trademarks of Tivity Health, Inc. SilverSneakers On-Demand and SilverSneakers GO are trademarks of Tivity Health, Inc. © 2019 Tivity Health, Inc. All rights reserved.

Health and savings with SpecialOffers

Our members receive discounts on these products and services:

Fitness and healthy living

The ChooseHealthy® program*

- Discounts on services such as acupuncture, chiropractic care, and therapeutic massage, from a nationwide network of healthcare providers.
- Discounts on fitness and wellness products such as activity trackers and equipment, with access to online health and wellness classes at no additional cost.

Fitbit®
Save up to 22% on select Fitbit trackers and smartwatches.

Garmin®
20% off select Garmin wellness devices.

GlobalFit™
Discounts on gym memberships, fitness equipment, and coaching.

Puritan's Pride®
10% off vitamins, supplements, and minerals.

SelfHelpWorks
Choose one of the online living programs and save 15% on coaching to help you lose weight, stop smoking, manage stress or diabetes, restore sound sleep, or address an alcohol problem.

* The ChooseHealthy program is provided by ChooseHealthy, Inc. ChooseHealthy, Inc. is a subsidiary of American Specialty Health Incorporated (ASH). ChooseHealthy is a trademark of ASH and used with permission herein. The ChooseHealthy program is a discount program; it is not insurance. You can access services from any ChooseHealthy participating provider; referral from a primary care physician is not required. You are responsible for paying the discounted fee directly to the contacted provider.

Health and savings with SpecialOffers

Family and home offerings

Allergy Control and National Allergy

- Save up to 25% on select products.
- Free shipping on all orders over $59 when shipping ground within the United States.

23andMe

- $40 off each Health + Ancestry Service kit
- 20% off one 23andMe kit — learn about your wellness, ancestry, and more

Vision

1-800 CONTACTS® or Glasses.com™

- $20 off orders of $100 or more for the latest contact lenses or brand name frames
- Free shipping

Premier LASIK

- Save $800 on LASIK when you choose any featured Premier LASIK Network provider.
- Save 15% with all other vision providers in your plan's network

TruVision

- Save up to 40% on LASIK eye surgery at more than 1,000+ locations
- 6.5 million procedures performed in the network

SpecialOffers is a discount program that is not part of your health plan coverage. It is a value-added online service we provide to give our Medicare Advantage members access to discounts offered by different vendors. Vendors and offers are subject to change without prior notice. Anthem does not endorse and is not responsible for the products, services, or information provided by SpecialOffers vendors. Arrangements and discounts were negotiated between vendors and Anthem for the benefit of our members. The products and services described are not part of our contract with Medicare. They are not subject to the Medicare appeals process. Any disputes about these products or services may be subject to the Anthem grievance process.

IMPORTANT: SpecialOffers vendors and discounts are subject to change without notice.

Sydney℠ Health app

The Sydney℠ Health app offers online tools to help you stay healthy and manage your health plan.*

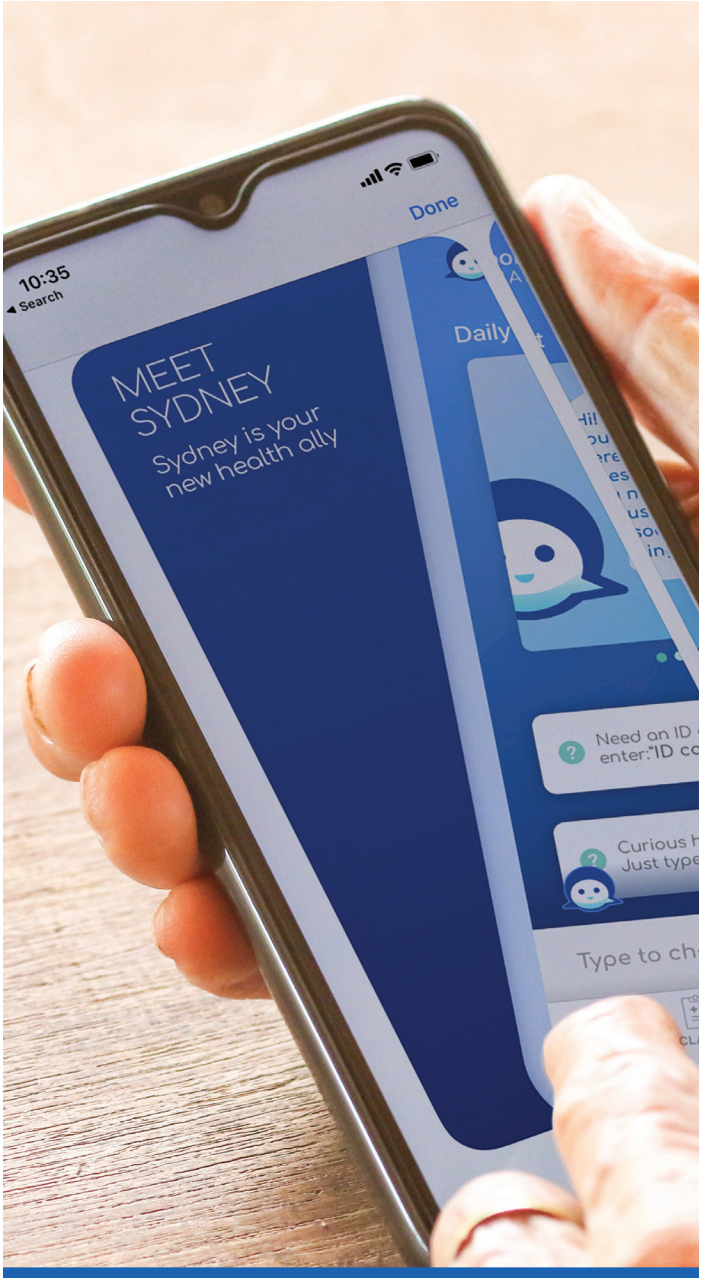
After we send you your plan membership card, use the information on the card to set up your account. It only takes a few minutes to register.

When you're done, you can use the app to:

- See a live doctor with virtual visits.
- Access plan and health resources.
- Check the status of claims.
- Request a replacement membership card or print a temporary one.
- Use home delivery for prescription drugs.

You can also:

- Use your device's GPS to find nearby doctors, hospitals, and urgent care centers in your plan's network.
- Use the chat feature to quickly find answers to your health questions.
- Set health reminders and wellness goals.
- Store and share health records with My Family Health Record (myFHR), which gives you the ability to share your health information with doctors, family members, and caregivers.



Download the Sydney Health app today from the App Store®, Google Play™, or www.anthem.com/ca.

* Online tools are offered to Anthem plan members as extra services. They are not part of the contract and can change or stop.

How to qualify and enroll

Qualifications for enrolling in Anthem Medicare Preferred (PPO) with Senior Rx Plus:

- You are a United States (U.S.) citizen or are lawfully present in the U.S.
- You live in the plan's service area.
- You are now entitled to Medicare Part A and enrolled in Part B.
- You keep paying your Medicare Part B premiums, unless they are paid by Medicaid or through another third party.
- You qualify for coverage under your or your spouse's group-sponsored health plan.

▷ Your membership will automatically transfer to this Anthem Medicare Preferred (PPO) plan unless you opt out by contacting San Joaquin County Employees' Retirement Association at 209-468-2163.

What to expect after you enroll

After your enrollment is processed, you will receive:

- Proof of your enrollment request with your membership start date listed.
- A plan membership card. Begin using this card on your membership start date.
- A health survey to help us understand and address your needs. We'll call you within 90 days to talk about your experience to understand how we can better take care of you.

We will also send you a plan Welcome Guide with ways to:

- Make the most of your benefits.
- Find plan doctors and facilities.
- Access information online.

IMPORTANT INFORMATION:

Official U.S. Government Medicare Information

2024 Medicare Star Ratings

Anthem BC Health Insurance Company - H4036

For 2024, Anthem BC Health Insurance Company - H4036 received the following Star Ratings from Medicare:

Overall Star Rating: ★★★★☆
Health Services Rating: ★★★½☆
Drug Services Rating: ★★★★★

Every year, Medicare evaluates plans based on a 5-star rating system.

Why Star Ratings are important

Medicare rates plans on their health and drug services.

This lets you easily compare plans based on quality and performance.

Star Ratings are based on factors that include:

- Feedback from members about the plan's service and care.
- The number of members who left or stayed with the plan.
- The number of complaints Medicare got about the plan.
- Data from doctors and hospitals that work with the plan.

More stars mean a better plan – for example, members may get better care and better, faster customer service.

The number of stars show how well a plan performs.

★★★★★ EXCELLENT
★★★★☆ ABOVE AVERAGE
★★★☆☆ AVERAGE
★★☆☆☆ BELOW AVERAGE
★☆☆☆☆ POOR

Get more information on Star Ratings online

Compare Star Ratings for this and other plans online at **www.medicare.gov/plan-compare**.

Questions about this plan?

Contact Anthem BC Health Insurance Company Monday through Friday, 8 a.m. to 9 p.m. ET at **1-833-848-8729** (toll free) or **711** (TTY). Current members please call **1-833-848-8730** or **711** (TTY).

Anthem BC Health Insurance Company is an LPPO plan with a Medicare contract. Enrollment in Anthem BC Health Insurance Company depends on contract renewal.

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Summary of Benefits

We've provided a *Summary of Benefits* so you can have a better understanding of what's covered and what's not, including:

- Costs you are responsible for
- What we cover under the plan
- Any copays or percentage of the cost
- Any out-of-pocket costs

Questions?

Call our First Impressions Welcome Team for answers or plan details, and provide them with this group specific code CA061GRS. **1-833-848-8729** (TTY: **711**) Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays

Anthem

County of San Joaquin
2024 Summary of Benefits

PPO Plan 0PH

www.anthem.com/CA

About this plan:

Anthem BC Health Insurance Company gives you the tools and resources to make the best decisions for your health, like this summary of benefits. It's a snapshot of your plan's covered benefits and services and what they cost. This Summary of Benefits doesn't list every service we cover or every limitation or exclusion. For more details about your benefits and services, please review your *Evidence of Coverage* (EOC). You can access your EOC online by logging into the member portal, or you can call Member Services with any questions you may have.

Doctor and hospital choice: You may go to doctors, specialists, and hospitals in or out of the network. You do not need a referral.

This plan offers coverage in our Centers for Medicare & Medicaid Services (CMS) defined geographic service area of all 50 states, Washington, DC, and all United States territories.

How much is the monthly premium? Contact your group plan benefit administrator to determine your actual premium amount, if applicable.

	In-network:	Out-of-network:
Annual medical deductible:	$0 Combined in-network and out-of-network	
Maximum out-of-pocket responsibility: (Does not include Part D prescription drugs)	$0 Combined in-network and out-of-network	

Covered medical benefits	In-network, members pay:	Out-of-network, members pay:
Inpatient hospital care*	For Medicare-covered hospital stays: $0 copay per admission	For Medicare-covered hospital stays: $0 copay per admission
Outpatient hospital facility or ambulatory surgical center visit for surgery*	$0 copay per visit	$0 copay per visit
Outpatient hospital services observation room	$0 copay per visit	$0 copay per visit
Primary care office visit	$0 copay per visit	$0 copay per visit
Specialty care office visit	$0 copay per visit	$0 copay per visit
Preventive care, screenings, and tests	$0 copay per visit	$0 copay per visit
Emergency care	$0 copay for each Medicare-covered emergency room visit	
Urgently needed services	$0 copay for each Medicare-covered urgently needed care visit	
X-ray visit and/or simple diagnostic test*	$0 copay per visit	$0 copay per visit
Complex diagnostic test and/or radiology visit*	$0 copay per visit	$0 copay per visit
Radiation therapy treatment*	$0 copay per visit	$0 copay per visit
Clinical/diagnostic lab test*	$0 copay per visit	$0 copay per visit
Medicare-covered basic hearing and balance exams performed by your specialist*	$0 copay per visit	$0 copay per visit

Covered medical benefits	In-network, members pay:	Out-of-network, members pay:
Routine hearing services	Must use a Hearing Care Solutions participating provider. $0 copay for routine hearing exams, one exam every calendar year combined in-network and out-of-network. $0 copay for hearing aid fitting evaluations, one evaluation per covered hearing aid combined in-network and out-of-network. Routine hearing exams and fitting evaluations are limited to a $70 maximum benefit every calendar year combined in-network and out-of-network. $0 copay for hearing aids Hearing aids are limited to a $500 benefit per ear with a $1,000 maximum benefit every three calendar years.	Out-of-network providers must order hearing aids through Hearing Care Solutions. $0 copay for routine hearing exams, one exam every calendar year combined in-network and out-of-network. $0 copay for hearing aid fitting evaluations, one evaluation per covered hearing aid combined in-network and out-of-network. Routine hearing exams and fitting evaluations are limited to a $70 maximum benefit every calendar year combined in-network and out-of-network. $0 copay for hearing aids through Hearing Care Solutions Hearing aids are limited to a $500 benefit per ear with a $1,000 maximum benefit every three calendar years through Hearing Care Solutions.
Medicare-covered dental is non-routine care performed by your specialist*	$0 copay per visit	$0 copay per visit
Medicare-covered exams performed by your specialist to diagnose and treat eye diseases and conditions	$0 copay per visit	$0 copay per visit
Medicare-covered glaucoma screening	$0 copay per visit	$0 copay per visit
Medicare-covered eyewear following cataract surgery	$0 copay per surgery	$0 copay per surgery

Covered medical benefits	In-network, members pay:	Out-of-network, members pay:
Routine vision eye exam	Must use a Blue View Vision provider. $0 copay for routine vision exams, one exam every calendar year, $70 maximum benefit every calendar year combined in-network and out-of-network.	$0 copay for routine vision exams, one exam every calendar year, $70 maximum benefit every calendar year combined in-network and out-of-network.
Routine vision eyewear	Must use a Blue View Vision provider. $0 copay for eyewear Eyewear is limited to a $100 maximum benefit every two calendar years combined in-network and out-of-network.	$0 copay for eyewear Eyewear is limited to a $100 maximum benefit every two calendar years combined in-network and out-of-network.
Inpatient services in a psychiatric hospital*	For Medicare-covered hospital stays: $0 copay per admission	For Medicare-covered hospital stays: $0 copay per admission
Mental health professional individual therapy visit	$0 copay per visit	$0 copay per visit
Substance abuse professional individual therapy visit	$0 copay per visit	$0 copay per visit
Skilled nursing facility (SNF) care*	For Medicare-covered SNF stays: $0 copay for days 1-100 per benefit period 100-day limit per benefit period	For Medicare-covered SNF stays: $0 copay for days 1-100 per benefit period 100-day limit per benefit period
Outpatient rehabilitation services*	$0 copay per visit	$0 copay per visit
Ambulance services	Your provider must get an approval from the plan before you get ground, air, or water transportation that is not an emergency. $0 copay per one-way trip for Medicare-covered ambulance services	
Medicare Part B prescription drugs*	$0 copay for Medicare-covered Part B drugs	$0 copay for Medicare-covered Part B drugs
Chiropractic services* Medicare-covered	$0 copay per visit	$0 copay per visit

Covered medical benefits	In-network, members pay:	Out-of-network, members pay:
Acupuncture for chronic low back pain* Medicare-covered	$0 copay per visit	$0 copay per visit
Cardiac rehabilitation services*	$0 copay per visit	$0 copay per visit
Pulmonary rehabilitation services*	$0 copay per visit	$0 copay per visit
Blood glucose test strips, lancets, lancet devices, and glucose control solutions	$0 copay for a 30-day supply on each Medicare-covered purchase of blood glucose test strips, lancets, lancet devices, and glucose control solutions	$0 copay for a 30-day supply on each Medicare-covered purchase of blood glucose test strips, lancets, lancet devices, and glucose control solutions
Blood glucose monitors	$0 copay for Medicare-covered blood glucose monitors	$0 copay for Medicare-covered blood glucose monitors
Therapeutic shoes	$0 copay per purchase	$0 copay per purchase
Diabetes self-management training	$0 copay per visit	$0 copay per visit
Continuous glucose monitors (CGMs)*	$0 copay per purchase	$0 copay per purchase
Durable medical equipment (DME) and related supplies*	$0 copay per purchase	$0 copay per purchase
Opioid treatment program services*	$0 copay per visit	$0 copay per visit
Podiatry services*	$0 copay per visit	$0 copay per visit
Routine foot care	$0 copay per visit 12 visits per year combined in-network and out-of-network	$0 copay per visit 12 visits per year combined in-network and out-of-network
Home health agency care*	$0 copay per visit	$0 copay per visit
Hospice care When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and B services are paid for by Original Medicare, not this plan.	$0 copay for the one time only hospice consultation One visit per lifetime	$0 copay for the one time only hospice consultation One visit per lifetime

Additional covered benefits and services	Members pay:
Video doctor visits LiveHealth Online†	$0 copay for video doctor visits using LiveHealth Online
Health and wellness programs SilverSneakers® Membership† Take fitness classes virtually or visit a participating location.	$0 copay for the SilverSneakers fitness benefit
24/7 NurseLine†	$0 copay for 24/7 NurseLine
Foreign travel emergency (outside U.S. territories) Emergency care Emergency or urgently needed care services while traveling outside the United States or its territories during a temporary absence of less than six months	$0 copay for emergency care
Foreign Travel - Urgently Needed Services	$0 copay for urgently needed services
Foreign Travel - Inpatient Care	$0 copay per admission for emergency inpatient care 60 days per lifetime
Healthy Meals†* Meals delivered after being discharged from inpatient hospital visit or for members living with a chronic condition	$0 copay for Healthy Meals Provides up to 14 meals per qualifying event, allows up to four (4) events each year (56 meals in total).
Medicare Community Resource Support	$0 copay for Medicare Community Resource Support

* Some services that fall within this benefit category require prior authorization. Based on the service you are receiving, your provider will know if prior authorization is needed. This means an approval in advance is needed, by your plan, to get covered services. In the network portion of a PPO, some in-network medical services are covered only if your doctor or other in-network provider gets prior authorization from our plan. In a PPO, you do not need prior authorization to obtain out-of-network services. However, we recommend you ask for a pre-visit coverage decision to confirm that the services you are getting are covered and medically necessary. Benefit categories that include services that require prior authorization are marked with an asterisk in the benefits chart.

Note: While you can get your care from an out-of-network provider for Medicare-covered services, the provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If the provider is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Providers that do not contract with us are under no obligation to treat you, except in emergency situations.

This document reflects cost shares only.

†Must use the plan approved provider

Some of the benefits and limitations listed above are combined in-network and out-of-network.

This information is not a complete description of the benefits. Contact the plan for more information. Limitations, copayments, coinsurance, and restrictions may apply. If there is a difference between this document and the *Evidence of Coverage* (EOC), the EOC is considered correct.

Some of the benefits mentioned are part of a special supplement program for the chronically ill. Not all members may qualify for these benefits.

Benefits, premiums and/or copayments/coinsurance may change upon renewal or on January 1 of each year.

Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our member service number or see your *Evidence of Coverage* for more information, including the cost-sharing that applies to out-of-network services. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service.

Medicare & You 2024 resource: For more information, we encourage you to read Medicare & You 2024. This booklet is mailed to people with Medicare every year in the fall. It has a summary of Medicare benefits, rights, and protections. It also includes answers to the most frequently asked questions. If you don't have a copy of this booklet, request one at **www.medicare.gov.** Or call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, seven days a week. TTY users should call **1-877-486-2048**.

LiveHealth Online is the trade name of Carelon Health, Inc., a separate company, providing telehealth services on behalf of the plan.

The SilverSneakers fitness program is provided by Tivity Health, an independent company. SilverSneakers is a registered trademark of Tivity Health, Inc.© 2023 Tivity Health, Inc. All rights reserved

Your 2024 Prescription Drug Benefits Chart
Formulary E3, 10/20/20 (with Senior Rx Plus)
County of San Joaquin
Retirees

Your retiree drug coverage includes Medicare Part D drug benefits and non-Medicare supplemental drug benefits. The cost shown below is what you pay after all benefits under your retiree drug coverage have been provided.

Formulary	E3
Deductible	$0
Covered Services	What you pay
Part D Initial Coverage	

Below is your payment responsibility until the amount paid by you and the Coverage Gap Discount Program for covered Part D prescriptions reaches your True Out of Pocket limit of $4,050.

Retail Pharmacy	per 30-day supply
• Select Generics	$0 copay
• Generics	$10 copay
• Preferred Brands	$20 copay
• Non-Preferred Drugs, including Specialty Drugs and Non-Formulary Drugs	$20 copay
• Diabetic Supplies - Insulin Syringes and Alcohol Swabs up to 90-day supply	$10 copay
Covered Services	What you pay
Retail Pharmacy	per 90-day supply
• Select Generics	$0 copay
• Generics	$30 copay
• Preferred Brands	$60 copay
• Non-Preferred Drugs, including Specialty Drugs and Non-Formulary Drugs	$60 copay
• Diabetic Supplies - Insulin Syringes and Alcohol Swabs up to 90-day supply	$10 copay

Many of our retail pharmacies can dispense more than a 30-day supply of medication. If you purchase more than a 30-day supply at these retail pharmacies, you will need to pay one copay for each full or partial 30-day supply filled. For example, if you order a 90-day supply, you will need to pay three 30-day supply copays. If you get a 45-day or 50-day supply, you will need to pay two 30-day copays.

Covered Services	What you pay
Mail-Order Pharmacy	per 60-day supply
• Select Generics	$0 copay
• Generics	$10 copay
• Preferred Brands	$20 copay
• Non-Preferred Drugs, including Specialty Drugs and Non-Formulary Drugs	$20 copay
• Diabetic Supplies - Insulin Syringes and Alcohol Swabs	$10 copay

Covered Services	What you pay
Part D Catastrophic Coverage	
Your payment responsibility changes after the cost you and the Coverage Gap Discount Program have paid for covered drugs reaches your True Out of Pocket limit of $4,050 up to $7,999.99.	
Retail and Mail-Order Pharmacies Phase 1	Up to a 90-day supply
• Select Generics	$0 copay
• Generics	5% coinsurance with a minimum of $2.25 and a maximum of $10
• Brand-Name Drugs	5% coinsurance with a minimum of $5.60 and a maximum of $20
After you have met your Part D Catastrophic Coverage Phase 1 limit of $7,999.99, your payment responsibility changes after the cost you and the Coverage Gap Discount Program have paid for covered drugs reaches your True Out of Pocket limit of $8,000.	
Covered Services	**What you pay**
Retail and Mail-Order Pharmacies Phase 2	Up to a 90-day supply
• Select Generics	$0 copay
• Generics	$0 copay
• Brand-Name Drugs	$0 copay

- **Important Message About What You Pay for Vaccines:** All Advisory Committee on Immunization Practices (ACIP) recommended Part D vaccines are covered at no cost to you.

- **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 your plan, no matter what cost-sharing tier it is on.

- **Vaccines:** Medicare covers some vaccines under Medicare Part B medical coverage and other vaccines under Medicare Part D drug coverage. Vaccines for Flu, including H1N1, and Pneumonia are covered under Medicare medical coverage. Vaccines for Chicken Pox, Shingles, Tetanus, Diphtheria, Meningitis, Rabies, Polio, Yellow Fever and Hepatitis A are covered under Medicare drug coverage. Hepatitis B is covered under drug coverage unless you fall into a high risk category, then it is covered under medical coverage. All other Advisory Committee on Immunization Practices (ACIP) recommended Part D vaccines are also covered under Medicare drug coverage for Medicare-eligible individuals under 65. You can fill and receive your vaccines at a network pharmacy or they can be administered at a physician's office. However, the physician will only submit a claim for a Part B vaccine. If you want to get a Part D vaccine at your physician's office you will pay for the entire cost of the vaccine and its administration and then ask your drug plan to reimburse you the cost of the vaccine and it's administration. Please see your Evidence of Coverage for complete details on what you pay for vaccines.

- **Senior Rx Plus:** Your supplemental drug benefit is non-Medicare coverage that reduces the amount you pay, after your Group Part D benefits and the Coverage Gap Discount. The copay or coinsurance shown in this benefits chart is the amount you pay for covered drugs filled at network pharmacies.

Your 2024 Extra Covered Drugs Benefits Chart

Covered Services	What you pay
Extra Covered Drugs	
These are prescription drugs that are covered by your retiree drug plan that are often excluded from Part D coverage. These prescription drugs are covered by your Senior Rx Plus benefits. Some of these drugs may be required on your retiree drug plan by state regulations. These drugs do not count towards your True Out of Pocket expenses. They do not qualify for lower Catastrophic copays.	
Retail Pharmacy	per 30-day supply
Cough and Cold **DESI** **Vitamins and Minerals**	See Drug List for complete list of drugs covered
• Generics	$10 copay
• Preferred Brands	$20 copay
• Non-Preferred Drugs	$20 copay
Erectile Dysfunction (ED)	Immediate dose ED drugs Immediate dose formats are limited to 6 per 30 days.
• Generics	$10 copay
• Preferred Brands	$20 copay
• Non-Preferred Drugs	$20 copay
Other Non-Part D Coverage	Copay or coinsurance
• Contraceptive Devices	$20 copay per Covered Device

Covered Services	What you pay
Mail-Order Pharmacy	per 60-day supply
Cough and Cold **DESI** **Vitamins and Minerals**	See Drug List for complete list of drugs covered
• Generics	$10 copay
• Preferred Brands	$20 copay
• Non-Preferred Drugs	$20 copay
Erectile Dysfunction (ED)	Immediate dose ED drugs Immediate dose formats are limited to 6 per 30 days.
• Generics	$10 copay
• Preferred Brands	$20 copay
• Non-Preferred Drugs	$20 copay
Other Non-Part D Coverage	Copay or coinsurance
• Contraceptive Devices	$20 copay per Covered Device

- **Over the Counter Drugs:** To get over the counter drugs listed as covered under your drug plan, you must have a prescription from your provider and have the prescribed drug filled by the pharmacist.

Required information for this plan year

Your rights, protections, and Medicare options

As a Medicare beneficiary, you have many rights and options put in place to protect you as a consumer. You have choices.

As a Medicare beneficiary, you can choose between:

- The Original (Fee-for-Service) Medicare plan.
- A Medicare health plan like the one offered in this guide.

You may have other options

The important thing to remember is that the choice is yours, keeping in mind that you may be able to join or leave a plan only at certain times. Please note that if you do not take your retiree benefits, it may affect other retiree benefits your group sponsor offers. No matter what you decide, you may still be eligible for the Original Medicare program.

Geographic service areas covered by this plan

This plan offers coverage in our Centers for Medicare & Medicaid Services (CMS) defined geographic service area of all 50 states, Washington, DC, and all United States territories.

Your Medicare protection

The plan must offer Medicare benefits to you for a full calendar year at a time, although benefits and cost sharing may change from year to year. The plan provider can decide each year whether to keep offering Medicare Advantage plans, or whether or not to continue offering plans in specific geographic areas like yours.

Also, Medicare may decide to end our contract.

If for some reason this plan is discontinued, we will send you a letter at least 90 days before your coverage ends explaining your options for Medicare coverage in your area.

For more information on the options and rights you have as a Medicare Advantage member with this plan, please contact our First Impressions Welcome Team and ask for a copy of the *Evidence of Coverage (EOC)*.

Extra Help from Medicare

You may be able to find help to pay for your prescription drugs and other Medicare costs. If you qualify for Medicare's Extra Help and are enrolled in a Part D plan like this one, Medicare can pay up to 100% of your prescribed drugs. This can help offset your drug plan's monthly premium, plus coinsurance and copays for covered prescription drugs.

Extra Help can also close any drug coverage gaps and stop late enrollment penalties (LEPs). For more information, visit **www.medicare.gov** or **www.ssa.gov,** or call:

- **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, seven days a week. TTY users should call **1-877-486-2048.**
- The Social Security Administration at **1-800-772-1213**, Monday to Friday, 7 a.m. to 7 p.m. ET. TTY users should call **1-800-325-0778.**
- Your state Medicaid office.

Required information for this plan year

Information about Medicare

To help you make more informed healthcare decisions, we are providing this important information about Medicare to use as a resource. If you have any questions, or you would like to request a benefits chart, please contact our **First Impressions Welcome Team**.

Pay your Medicare Part B premiums

Once you enroll in this plan, you must still pay your Medicare Part B premiums. If you don't, Medicare will terminate your coverage and then you may have to pay a late enrollment penalty if you decide to reenroll.

Enrolling in other plans

If you decide to enroll in other plans, you will be disenrolled from your current plan.

Notifying your group sponsor

To ensure a smooth enrollment, make sure your group sponsor has your most up-to-date information and that it matches your Social Security information.

What to know about a drug list

A drug list is a list of drugs covered by the plan. We choose our list to provide good prescription coverage and a good value to you, as well.

Your full Benefits Chart will tell you if you have an open or closed drug list plan. Open plans cover almost all Medicare Part D eligible drugs, while closed plans cover most.

When new drugs come to market, we conduct a clinical and cost review and may add them to the drug list. To keep plans affordable, every year we may also remove drugs or change the cost you pay for them the following year. But don't worry; we'll notify you first and send you a new drug list when we make these changes.

Important: Check to see if your drug is on the drug list before you go to the pharmacy.

If the drug you take is not on our drug list, you will have to pay the full price of the drug. If that's the case, or if your drug comes with additional requirements or limits, you may be able to receive a temporary supply. We will notify you once the temporary supply is dispensed. You will have to contact your doctor and ask if you can switch to a different drug listed on our drug list.

About IRMAA and your income level

If your modified adjusted gross income on your IRS tax return from two years ago is above a certain limit, you must pay an income-related monthly adjustment amount (IRMAA) in addition to your monthly plan premium.

The Social Security Administration will contact you if you have to pay an IRMAA, which you must pay to them, not us.

High-income surcharges

If you must pay a high-income surcharge on your Medicare Part B or Part D premium to the Social Security Administration, please be sure to do so to avoid a mandatory disenrollment.

Required information for this plan year

Information about Medicare

We do not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age, or disability. For people with disabilities, we offer free aids and services. Our plan has free language interpreter services available to answer questions from non-English-speaking members. Please call the First Impressions Welcome Team at the number listed in this guide to request interpreter services.

Out-of-network/noncontracted providers are under no obligation to treat Anthem BC Health Insurance Company members, except in emergency situations. Please call our First Impressions Welcome Team at **1-833-848-8729, TTY: 711, Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays**, and provide them with this group specific code CA061GRS for more information.

This information is not a complete description of benefits. Contact the plan for more information. Every year, Medicare evaluates plans based on a five-star rating system.

This guide is intended to be a brief outline of coverage and is not intended to be a legal contract. The entire provisions of benefits and exclusions are contained in the *Benefits Chart and Evidence of Coverage (EOC)*, which is received upon enrollment. In the event of a conflict between the *Benefits Chart* and *EOC* and this guide, the terms of the *Benefits Chart* and *EOC* will prevail.

Coordination of Benefits (COB) letter

If we receive Coordination of Benefits (COB) information from CMS, we are required to send a letter to you requesting verification of the other coverage information. The benefit verification letter we send will include information from CMS, including any other coverage that needs to be verified. Separately, we could receive COB information from other reporting sources in addition to CMS.

If the information is not correct in the letter, you can call Member Services or you can fill in the correct information on the letter and return it to the plan for processing.

If a response is not received within 21 days, the information on the letter is considered to be accurate.

If the previous carrier does not notify CMS of the previous plan termination prior to the plan enrollment process, a COB letter could be triggered for the plan that was just terminated.

Required information for this plan year

Information about Medicare

Some of the benefits mentioned are part of a special supplement program for the chronically ill. Not all members may qualify for these benefits.

Anthem BC Health Insurance Company is an LPPO plan with a Medicare contract. Enrollment in Anthem BC Health Insurance Company depends on contract renewal. Anthem BC Health Insurance Company is the trade name of Anthem Insurance Companies, Inc. Independent licensee of the Blue Cross Association.

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.

Medicare Advantage with Part D prescription drug plan

Important information regarding your plan

Release of information: By joining this Medicare Advantage health plan, I acknowledge that the Medicare Advantage health plan will release my information to Medicare and other plans as is necessary for treatment, payment, and healthcare operations.

I understand that the effective date of coverage is when I can begin using the plan services, and the Medicare Advantage plan will send me written notification of the effective date of my enrollment in the plan. I understand that this Medicare Advantage plan is offered under a contract with the Centers for Medicare & Medicaid Services (CMS) and the CMS review of its benefits. I understand that my coverage will come into effect only if this enrollment is approved by the plan and CMS.

I understand that I need to keep my Medicare Parts A and B. I must maintain my Medicare Part B insurance by continuing to pay the Part B premium, if applicable.

I understand that by enrolling in this Medicare Advantage plan, I will automatically be disenrolled by CMS from any other Medicare Advantage plan or Medicare Part D prescription drug plan. **I can only be in one Medicare Advantage plan at a time.** It is my responsibility to inform the plan of any other prescription drug coverage that I have or may obtain in the future.

I understand that when my Anthem Medicare Preferred (PPO) with Senior Rx Plus coverage begins, I must receive all my medical benefits from Anthem BC Health Insurance Company. Benefits and services authorized by Anthem BC Health Insurance Company and contained in my Anthem Medicare Preferred (PPO) with Senior Rx Plus *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. **Without authorization, neither Medicare nor Anthem BC Health Insurance Company will pay for benefits or services.**

I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the United States border.

I understand that as a member of this plan, I have the right to ask about the plan's decision regarding payments or coverage for services I receive. I also have the right to appeal plan decisions about payment or services if I disagree.

Multi-language Interpreter Services

Form Approved
OMB# 0938-1421

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 1-833-848-8729 (TTY: 711). Someone who speaks your 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 número mencionado anteriormente (TTY: **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 上述數字 (TTY: **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 上述數字 (TTY: **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 numero na nakasulat sa itaas (TTY: **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 le numéro écrit ci-dessus (TTY: **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 số được viết ở trên (TTY: **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 die oben genannte Nummer (TTY: **711**). 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 위에 나와있는 번호 (TTY: **711**) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Form Approved
OMB# 0938-1421

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 номер, указанный выше (TTY: **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 سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية. ليس عليك سوى الاتصال بنا على الرقم المكتوب أعلاه (TTY: **711**)

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 ऊपर लिखा हुआ नंबर (TTY: **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 il numero sopraindicato (TTY: **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 o número escrito acima (TTY: **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 medikaman nou an. Pou jwenn yon entèprèt, jis rele nou nan nimewo ki ekri pi wo a (TTY: **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 numer napisany powyżej (TTY: **711**). Ta usługa jest bezpłatna.

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