

2026

Summary of Benefits

**SCAN Classic (HMO)
SCAN Prime (HMO)**

Los Angeles County

January 1, 2026 – December 31, 2026

SCAN Classic (HMO) and SCAN Prime (HMO) are HMO plans with Medicare contracts. Enrollment in SCAN Health Plan depends on contract renewal. You must continue to pay your Medicare Part B premium.

The benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please request the "Evidence of Coverage" by calling our Member Services Department at the phone number listed in this document or online at www.scanhealthplan.com.

SUMMARY OF BENEFITS

JANUARY 1, 2026 – DECEMBER 31, 2026

PREMIUM AND BENEFITS	SCAN CLASSIC	SCAN PRIME	WHAT YOU SHOULD KNOW
Monthly Health Plan Premium	\$0	\$20	You must continue to pay your Medicare Part B premium.
Plan Deductible	No deductible for medical. See outpatient prescription drugs section for Part D deductible.	No deductible for medical. See outpatient prescription drugs section for Part D deductible.	
Maximum Out-of-Pocket Responsibility (this does not include prescription drugs)	\$199	\$2,499	The most you pay for copays and coinsurance for Medicare-covered medical services for the year.
Inpatient Hospital Coverage	\$0 Unlimited days per admission	\$100 copay per day for days 1-3 \$0 for days 4-90. Unlimited days per admission	Prior authorization rules may apply.
Outpatient Hospital Services <ul style="list-style-type: none"> • Ambulatory Surgical Center • Outpatient Hospital • Observation services 	\$0 \$0 \$0	\$0 \$0 \$0	Prior authorization rules apply for outpatient hospital services.
Doctor Visits <ul style="list-style-type: none"> • Primary Care • Specialists 	\$0 \$0	\$0 \$0	Prior authorization rules apply for specialist visits.
Preventive Care	\$0	\$0	Prior authorization rules apply.

PREMIUM AND BENEFITS	SCAN CLASSIC	SCAN PRIME	WHAT YOU SHOULD KNOW
Emergency Care	\$90 copay per visit	\$120 copay per visit	The emergency room copay will be waived if you are immediately admitted to the hospital. You are covered for worldwide emergency services at Original Medicare reimbursable rates.
Urgently Needed Services	\$0	\$0	You are covered for worldwide urgent care services at Original Medicare reimbursable rates.
Diagnostic Services/Labs/Imaging <ul style="list-style-type: none"> • Lab services • Diagnostic tests and procedures • Outpatient X-rays • Therapeutic radiology • Diagnostic radiology (e.g., MRI, CT) 	\$0 \$0 \$0 \$50 copay per visit \$0	\$0 \$0 \$0 \$50 copay per visit \$0	Prior authorization rules apply for diagnostic, lab, and imaging services.
Hearing Services <ul style="list-style-type: none"> • Medicare-covered diagnostic hearing and balance exam • Non-Medicare-covered (routine) hearing exam • Non-Medicare-covered (routine) hearing aids 	\$0 \$0 for up to 1 visit every 12 months \$450 copay per aid for a TruHearing Advanced hearing aid or \$750 copay per aid for a TruHearing Premium hearing aid You are covered for up to 2 hearing aids every 12 months	\$0 \$0 for up to 1 visit every 12 months \$550 copay per aid for a TruHearing Advanced hearing aid or \$850 copay per aid for a TruHearing Premium hearing aid You are covered for up to 2 hearing aids every 12 months	Prior authorization rules apply for Medicare-covered diagnostic hearing and balance exams. You must go to a SCAN-contracted provider to obtain a routine hearing exam and hearing aids. Members don't need a referral from a PCP or other doctor to use their benefit. To locate a contracted provider and to schedule your appointment, please call 1-844-244-9003.

PREMIUM AND BENEFITS	SCAN CLASSIC	SCAN PRIME	WHAT YOU SHOULD KNOW
<p>Dental Services</p> <ul style="list-style-type: none"> • Medicare-covered dental services • Non-Medicare-covered (routine) dental services <ul style="list-style-type: none"> – Dental allowance <p>Preventive Services</p> <ul style="list-style-type: none"> – Dental exams – Dental cleanings – Dental X-rays <p>Comprehensive Services</p> <ul style="list-style-type: none"> – Diagnostic services – Preventive services – Restorative services (fillings and crowns) – Endodontic services (root canals) – Periodontics (deep cleaning, periodontal maintenance, surgical procedures) – Prosthodontics, removable (dentures, adjustments, repairs) – Maxillofacial Prosthetics (facial or jaw prosthetics after surgery or trauma) – Implant Services (implants and associated services) – Prosthodontics, fixed (bridges and fixed dentures) 	<p>\$0</p> <p>Dental Plan CAC73</p> <p>\$0 up to 2 visits every 12 months</p> <p>\$0 up to 2 visits every 12 months</p> <p>\$0 up to 2 visits every 12 months</p> <p>In-network only: \$0-\$5 copay</p> <p>In-network only: \$0-\$80 copay</p> <p>In-network only: \$8-\$395</p> <p>In-network only: \$5-\$395</p> <p>In-network only: \$0-\$380</p> <p>In-network only: \$13-\$395</p> <p>Not covered</p> <p>Not covered</p> <p>In-network only: \$25-\$395</p>	<p>\$0</p> <p>\$4,000 coverage limit per year</p> <p>\$0 up to 2 visits every 12 months</p> <p>\$0 up to 2 visits every 12 months</p> <p>\$0 up to 1 visit every 12 months</p> <p>\$0 In-network 50% Out-of-network</p>	<p>Prior authorization rules apply for Medicare-covered dental services.</p> <p><u>SCAN Classic</u></p> <p>You must go to a SCAN contracted dental provider to obtain covered services.</p> <p>Once you have reached your coverage limit, you will be responsible for any remaining costs.</p> <p>Optional Dental PPO (DPPO) plan is available at an additional premium. See the “Optional Supplemental Benefits” chart at the end of this document.</p> <p><u>SCAN Prime</u></p> <p>If you choose to see a dentist that is out-of-network, you may pay more. Preventive and comprehensive services are covered up to negotiated rates.</p> <p>Preventive services do not count towards allowance maximum.</p> <p>Once you have reached your coverage limit, you will be responsible for any remaining costs.</p>

PREMIUM AND BENEFITS	SCAN CLASSIC	SCAN PRIME	WHAT YOU SHOULD KNOW
<ul style="list-style-type: none"> – Oral and maxillofacial surgery (extractions and surgical procedures) – Adjunctive services (anesthesia, emergency pain treatment) 	<p>In-network only: \$0-\$140</p> <p>In-network only: \$0-\$125</p>	<p>\$0 In-network 50% Out-of-network</p> <p>\$0 In-network 50% Out-of-network</p>	
<p>Vision Services</p> <ul style="list-style-type: none"> • Medicare-covered vision exam to diagnose/treat diseases of the eye • Medicare-covered glasses after cataract surgery • Non-Medicare-covered (routine) vision exam • Non-Medicare-covered (routine) vision coverage limit 	<p>\$0</p> <p>\$0</p> <p>\$0 for up to 1 visit every 12 months</p> <p>You are covered for up to \$300 for frames, lenses, and lens options or contact lenses every 12 months</p>	<p>\$0</p> <p>\$0</p> <p>\$0 for up to 1 visit every 12 months</p> <p>You are covered for up to \$200 for frames, lenses, and lens options or contact lenses every 12 months</p>	<p>Prior authorization rules apply for Medicare-covered vision exam and glasses after cataract surgery.</p> <p>Routine vision services do not require prior authorization.</p> <p>You must go to a SCAN-contracted vision provider to obtain routine vision services.</p>
<p>Mental Health Services</p> <ul style="list-style-type: none"> • Inpatient visit • Outpatient individual/group therapy visit • Outpatient individual/group therapy visit with a psychiatrist 	<p>\$0 per day for days 1-90</p> <p>\$0</p> <p>\$0</p>	<p>\$100 per day for days 1-3 \$0 for days 4-90</p> <p>\$0</p> <p>\$0</p>	<p>Prior authorization rules apply for inpatient mental health hospitalization. You are covered for up to 90 days per benefit period.*</p> <p>Prior authorization rules apply for outpatient individual/group therapy visits.</p>
<p>Skilled Nursing Facility</p>	<p>\$0 for days 1-100</p>	<p>\$0 for days 1-100</p>	<p>Prior authorization rules apply for skilled nursing facility services. You are covered for up to 100 days per benefit period.*</p> <p>No prior hospitalization is required.</p>

*A benefit period begins the day you go into a hospital or SNF. The benefit period ends when you haven't received any inpatient hospital or SNF care for 60 days in a row.

PREMIUM AND BENEFITS	SCAN CLASSIC	SCAN PRIME	WHAT YOU SHOULD KNOW
Physical Therapy	\$0	\$0	Prior authorization rules apply for outpatient physical therapy services.
Ambulance	\$200 copay per one-way trip	\$200 copay per one-way trip	Prior authorization rules apply for non-emergency and air ambulance services.
Transportation (Non-Medicare-covered — routine)	\$0 for up to 32 one-way trips per year 50-mile limit applies to each one-way trip	Not covered	You must use a SCAN-contracted provider to obtain routine transportation services.
Medicare Part B Drugs	\$0-20% of the Medicare-approved amount for Part B chemotherapy and other Part B drugs No more than \$35 for a one-month supply of a Part B insulin furnished through an item of durable medical equipment, such as a medically necessary insulin pump	\$0-20% of the Medicare-approved amount for Part B chemotherapy and other Part B drugs No more than \$35 for a one-month supply of a Part B insulin furnished through an item of durable medical equipment, such as a medically necessary insulin pump	Prior authorization rules apply to select drugs.

OUTPATIENT PRESCRIPTION DRUGS (PART D DRUGS): SCAN CLASSIC

You pay the following:

Part D Deductible	You pay the full cost of your Tier 3 through Tier 5 drugs until you have paid \$250.
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Drug Tier	Retail				Mail-Order	
	Preferred		Standard		Preferred	Standard
	30-day supply	100-day supply	30-day supply	100-day supply	100-day supply	100-day supply

Initial Coverage Stage							
Tier 1 (Preferred Generic)		\$0	\$0	\$7	\$14	\$0	\$14
Tier 2 (Generic)		\$0	\$0	\$15	\$30	\$0	\$30
Tier 3 (Preferred Brand)	Insulin	\$35	\$85	\$35	\$85	\$85	\$85
	Other Drugs	\$42	\$126	\$47	\$141	\$126	\$141
Tier 4 (Non-Preferred Drug)		35%	35%	35%	35%	35%	35%
Tier 5 (Specialty Tier)		30%	Not available	30%	Not available	Not available	Not available

Catastrophic Coverage Stage

After your yearly out-of-pocket drug costs reach \$2,100, you pay \$0 for all covered prescription drugs for the remainder of the year.

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. During the Catastrophic Coverage Stage, you pay \$0 for all covered insulin products.

Most adult Part D vaccines, including shingles, tetanus and travel vaccines, are covered by our plan at no cost to you across all Part D benefit stages, even if you haven't paid your deductible. Refer to your plan's "Drug List" (Formulary) or contact Member Services for coverage and cost-sharing details about specific vaccines.

Some of our network pharmacies have preferred cost-sharing. You may pay less for certain drugs if you use these pharmacies. Your cost-sharing may vary depending on the pharmacy you choose (e.g., Preferred Retail, Standard Retail, Preferred Mail-Order, Standard Mail-Order, Long Term Care (LTC), Home infusion, etc.) or whether you receive a one-month or a three-month supply or when you enter another phase of the Part D benefit or if you receive "Extra Help." For more information, please call our Member Services at the number provided in this document or access your Evidence of Coverage online. If you reside in a long-term care facility, your cost-sharing for a 31-day supply is the same as at a standard retail pharmacy for a 30-day supply. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.

OUTPATIENT PRESCRIPTION DRUGS (PART D DRUGS): SCAN PRIME

You pay the following:

Part D Deductible	You pay the full cost of your Tier 3 through Tier 5 drugs until you have paid \$250.
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Drug Tier	Retail				Mail-Order	
	Preferred		Standard		Preferred	Standard
	30-day supply	100-day supply	30-day supply	100-day supply	100-day supply	100-day supply

Initial Coverage Stage							
Tier 1 (Preferred Generic)		\$0	\$0	\$5	\$10	\$0	\$10
Tier 2 (Generic)		\$0	\$0	\$12	\$24	\$0	\$24
Tier 3 (Preferred Brand)	Insulin	\$35	\$85	\$35	\$85	\$85	\$85
	Other Drugs	\$42	\$126	\$47	\$141	\$126	\$141
Tier 4 (Non-Preferred Drug)		35%	35%	35%	35%	35%	35%
Tier 5 (Specialty Tier)		30%	Not available	30%	Not available	Not available	Not available

Catastrophic Coverage Stage

After your yearly out-of-pocket drug costs reach \$2,100, you pay \$0 for all covered prescription drugs for the remainder of the year.

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. During the Catastrophic Coverage Stage, you pay \$0 for all covered insulin products.

Most adult Part D vaccines, including shingles, tetanus and travel vaccines, are covered by our plan at no cost to you across all Part D benefit stages, even if you haven't paid your deductible. Refer to your plan's "Drug List" (Formulary) or contact Member Services for coverage and cost-sharing details about specific vaccines.

Some of our network pharmacies have preferred cost-sharing. You may pay less for certain drugs if you use these pharmacies. Your cost-sharing may vary depending on the pharmacy you choose (e.g., Preferred Retail, Standard Retail, Preferred Mail-Order, Standard Mail-Order, Long Term Care (LTC), Home infusion, etc.) or whether you receive a one-month or a three-month supply or when you enter another phase of the Part D benefit or if you receive "Extra Help." For more information, please call our Member Services at the number provided in this document or access your Evidence of Coverage online. If you reside in a long-term care facility, your cost-sharing for a 31-day supply is the same as at a standard retail pharmacy for a 30-day supply. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.

ADDITIONAL BENEFITS

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

PREMIUM AND BENEFITS	SCAN CLASSIC	SCAN PRIME	WHAT YOU SHOULD KNOW
<p>Acupuncture Services</p> <ul style="list-style-type: none"> • Medicare-covered acupuncture care • Routine acupuncture care 	<p>\$0</p> <p>\$5 copay per visit for up to 30 visits per year combined with routine chiropractic services</p>	<p>\$0</p> <p>Not covered</p>	<p>Prior authorization rules apply.</p> <p>You do not need a referral for an initial routine acupuncture visit. Any subsequent visits require prior authorization.</p> <p>You must use a SCAN-contracted provider to obtain routine acupuncture services.</p>
<p>At-Home Support</p> <ul style="list-style-type: none"> • In-home care • Meals (home-delivered) • Respite care 	<p>\$0</p> <p>80 hours for personal in-home care after a hospitalization, after a hip or knee replacement, or for assistance with two or more activities of daily living</p> <p>\$0</p> <p>84 meals per year after a hospitalization</p> <p>84 meals per year due to a chronic condition</p> <p>\$0</p> <p>20 hours per year to provide temporary relief to unpaid caregivers of members</p>	<p>\$0</p> <p>80 hours for personal in-home care after a hospitalization, after a hip or knee replacement, or for assistance with two or more activities of daily living</p> <p>\$0</p> <p>84 meals per year after a hospitalization</p> <p>84 meals per year due to a chronic condition</p> <p>\$0</p> <p>20 hours per year to provide temporary relief to unpaid caregivers of members</p>	<p>Prior authorization rules apply.</p>

PREMIUM AND BENEFITS	SCAN CLASSIC	SCAN PRIME	WHAT YOU SHOULD KNOW
<p>Chiropractic Services</p> <ul style="list-style-type: none"> • Medicare-covered chiropractic care • Routine chiropractic care 	<p>\$0</p> <p>\$5 copay per visit for up to 30 visits per year combined with routine acupuncture services</p>	<p>\$0</p> <p>Not covered</p>	<p>Prior authorization rules apply.</p> <p>You do not need a referral for an initial routine chiropractor visit. Any subsequent visits require prior authorization.</p> <p>You must use a SCAN-contracted provider to obtain routine chiropractic services.</p>
<p>FlexEssentials</p> <p>This includes:</p> <ul style="list-style-type: none"> • Over-the-Counter (OTC) Products 	<p>\$150 per quarter with the FlexEssentials card</p>	<p>\$50 per quarter with the FlexEssentials card</p>	<p>You receive a quarterly allowance to be used for eligible OTC items in-store at CVS retailers or home delivery.</p> <p>Unused balances will be carried over to the next quarter, but will not roll over to the following year.</p>
<p>HEALTHtech+</p> <ul style="list-style-type: none"> • Technology support to help you access your health care information 	<p>\$0</p>	<p>\$0</p>	
<p>Home Health Care (Medicare-covered)</p>	<p>\$0</p>	<p>\$0</p>	<p>Prior authorization rules apply.</p>

PREMIUM AND BENEFITS	SCAN CLASSIC	SCAN PRIME	WHAT YOU SHOULD KNOW
<p>Medical Equipment/Supplies</p> <ul style="list-style-type: none"> • Durable Medical Equipment (e.g., wheelchairs, oxygen) • Prosthetics (e.g., braces, artificial limbs) • Diabetic supplies • Continuous Glucose Monitors 	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0 at the pharmacy or DME provider</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0 at the pharmacy or DME provider</p>	<p>Prior authorization rules apply for covered durable medical equipment, prosthetic devices, and certain diabetic supplies.</p> <p>SCAN covers diabetic supplies such as glucose monitors, test strips, and control solution from a select manufacturer. Lancets are also covered and are available from all manufacturers.</p> <p>Freestyle Libre and Dexcom CGMs are covered at contracted pharmacies. Other CGM manufacturers are available at contracted DME providers.</p> <p>Prior authorization rules apply.</p>
<p>OnePass® (Fitness)</p>	<p>\$0 fitness benefit through One Pass, including gym memberships, on-demand workouts, and community classes</p>	<p>\$0 fitness benefit through One Pass, including gym memberships, on-demand workouts, and community classes</p>	
<p>Personal Emergency Response System (PERS)</p>	<p>\$0 for personal emergency response device and monitoring service to help you get assistance quickly during a fall or emergency</p>	<p>\$0 for personal emergency response device and monitoring service to help you get assistance quickly during a fall or emergency</p>	

PREMIUM AND BENEFITS	SCAN CLASSIC	SCAN PRIME	WHAT YOU SHOULD KNOW
<p>Telehealth Services</p> <ul style="list-style-type: none"> • Urgent Care and Mental Health 	\$0	\$0	<p>Urgent Care:</p> <p>This benefit is for non-life threatening conditions such as, but not limited to, cough, flu, nausea, sore throat, fever and allergies.</p> <p>Visits with providers can be conducted by telephone or secure video capabilities from your computer or smart phone. Telehealth is not intended to replace your primary care doctor or specialist.</p> <p>Behavioral Health:</p> <p>This benefit allows you to connect with licensed Psychologists, Master's level therapists, or Psychiatrists via video visits 7 days a week by appointment.</p> <p>Behavioral telehealth visits with practitioners can be conducted by secure video capabilities from your computer, tablet, or smart phone. Behavioral telehealth is not intended to replace your medical groups mental health provider.</p>

OPTIONAL SUPPLEMENTAL BENEFITS

DENTAL SERVICES

SCAN CLASSIC

PPO Dental Plan California	
Monthly Premium	\$55 per month

- Access to a large network of Delta Dental DPPO providers
- Over 300 dental procedures included
- Comprehensive dental coverage
- Dental services available at in-network and out-of-network dentists
- Services with in-network dentists will have predictable copayments
- Services with out-of-network dentists have a maximum coverage of \$2,000
- 50% coinsurance applies to out-of-network services

ADDITIONAL DETAILS AND CONTACT INFORMATION

SCAN CLASSIC AND SCAN PRIME	
Who can join?	<p>You must:</p> <ul style="list-style-type: none"> - have both Medicare Part A and Part B - live in the plan service area (Los Angeles County, California) - be a United States citizen or be lawfully present in the United States
Phone Number (Members)	1-800-559-3500
Phone Number (Non-Members)	1-877-870-4867
	Calling this number will direct you to a licensed insurance agent.
TTY	711
Hours of Operation	<p>October 1 to March 31: 8 am to 8 pm, 7 days a week</p> <p>April 1 to September 30: 8 am to 8 pm, Monday through Friday</p> <p>Messages received on holidays and outside of our business hours will be returned within one business day.</p>
Website	www.scanhealthplan.com

SCAN Classic and **SCAN Prime** have a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

To get more information about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at <https://www.medicare.gov> or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

This information is not a complete description of benefits. Call 1-800-559-3500 (TTY: 711) for more information.

You can get prescription drugs shipped to your home through our network mail-order delivery program. Express Scripts PharmacySM is our Preferred mail-order pharmacy. While you can fill your prescription medications at any of our network mail-order pharmacies, you may pay less at the Preferred mail-order pharmacy. Typically, you should expect to receive your prescription drugs within 14 days from the time that Express Scripts mail-order pharmacy receives the order. If you do not receive your prescription drug(s) within this time, please contact SCAN Health Plan's Member Services at 1-800-559-3500, 8 am to 8 pm, 7 days a week from October 1 to March 31. From April 1 to September 30, hours are 8 am to 8 pm Monday through Friday (messages received on holidays and outside of our business hours will be returned within one business day). TTY: 711. For your mail-order prescriptions, you have the option to sign up for an automatic refill program by contacting Express Scripts Pharmacy at 1-866-553-4125, 24 hours a day, 7 days a week. TTY users call 711. You may opt out of automatic deliveries at any time. Other pharmacies are available in our network.

SCAN Health Plan complies with applicable federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of, or because of, race, color, national origin, age, disability, or sex. SCAN Health Plan provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats). SCAN Health Plan provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact SCAN Member Services.

If you believe that SCAN Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by phone, mail, or fax, at:

SCAN Member Services	
SCAN Health Plan (California)	1-800-559-3500
SCAN Health Plan (Arizona)	1-855-650-7226
SCAN Health Plan (New Mexico)	1-855-826-7226
SCAN Health Plan (Nevada)	1-855-827-7226
SCAN Health Plan (Texas)	1-855-844-7226
SCAN Health Plan (Washington)	1-833-944-7226
TTY: 711	

Attention: Grievance and Appeals Department
P.O. Box 22616,
Long Beach, CA 90801-5616

Or by filling out the "File a Grievance" form on our website at:
www.scanhealthplan.com/Help-Center/Contact-Us/File-A-Grievance

If you need help filing a grievance, SCAN Member Services is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019 (TTY: 1-800-537-7697)

Complaint forms are available at www.hhs.gov/civil-rights/filing-a-complaint/index.html.

You can also file a civil rights complaint with the California Department of Health Care Services, Office of Civil Rights by phone, in writing, or electronically:

- By phone: Call 1-916-440-7370. If you cannot speak or hear well, please call 711 (Telecommunications Relay Services).
- In writing: Fill out a complaint form or send a letter to:
Deputy Director, Office of Civil Rights
Department of Health Care Services
Office of Civil Rights
P.O. Box 997413, MS 0009
Sacramento, CA 95899-7413
Complaint forms are available at www.dhcs.ca.gov/Pages/Language_Access.aspx.
- Electronically: Send an email to CivilRights@dhcs.ca.gov

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 1-800-559-3500. Someone who speaks English 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, llame al 1-800-559-3500. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Cantonese (Traditional): 我們提供免費的口譯服務，以解答您對我們的健康或藥物計劃可能有的任何問題。如需獲得口譯服務，請致電 1-800-559-3500 聯絡我們。我們有會說中文的工作人員可以為您提供幫助。這是一項免費服務。

Chinese Mandarin (Simplified): 我们提供免费的口译服务，以解答您对我们的健康或药物计划可能有的任何问题。如需获得口译服务，请致电 1-800-559-3500 联系我们。我们有会说中文的工作人员可以为您提供帮助。这是一项免费服务。

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời bất kỳ câu hỏi quý vị có thể có về chương sức khỏe và chương trình thuốc men. Để được thông dịch, chỉ cần gọi theo số 1-800-559-3500. Người nói Tiếng Việt có thể trợ giúp quý vị. Đây là dịch vụ miễn phí.

Tagalog: Mayroon kaming mga libreng serbisyo ng interpreter upang masagot ang anumang katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng interpreter, tawagan lamang kami sa 1-800-559-3500. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-559-3500 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Armenian: Առողջութեան կամ դեղերի ծրագրի վերաբերյալ որևէ հարց առաջանալու դեպքում կարող եք օգտվել անվճար թարգմանչական ծառայությունից: Թարգմանչի ծառայությունից օգտվելու համար զանգահարե՛ք 1-800-559-3500 հեռախոսահամարով: Ձեզ կօգնի հայերենին տիրապետող մեր աշխատակիցը: Ծառայությունն անվճար է:

Persian: توجه: ما خدمات مترجم رایگان داریم تا به هر سؤالی که ممکن است در مورد برنامه بهداشتی یا داروهای ما داشته باشید پاسخ دهیم. برای آن که مترجم دریافت کنید فقط کافیست با شماره 1-800-559-3500 تماس بگیرید. شخصی که به زبان فارسی صحبت می کند، می تواند به شما کمک کند. این یک سرویس رایگان است.

Russian: Если у вас возникнут вопросы относительно плана медицинского обслуживания или обеспечения лекарственными препаратами, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по номеру 1-800-559-3500. Вам окажет помощь сотрудник, который говорит на русском языке. Данная услуга бесплатная.

Japanese: 当社の健康保険と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をご用意しています。通訳をご利用になるには、1-800-559-3500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。

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة لديك تتعلق بخططنا الصحية أو جدول الدواء. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على الرقم 1-800-559-3500. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه الخدمة المجانية.

Punjabi: ਸਾਡੀ ਸਿਹਤ ਜਾਂ ਦਵਾਈ ਯੋਜਨਾ ਬਾਰੇ ਤੁਹਾਡੇ ਕਿਸੇ ਵੀ ਸਵਾਲਾਂ ਦਾ ਜਵਾਬ ਦੇਣ ਲਈ ਸਾਡੇ ਕੋਲ ਮੁਫਤ ਦੁਬਾਸ਼ੀਆ ਸੇਵਾਵਾਂ ਹਨ। ਕੋਈ ਦੁਬਾਸ਼ੀਆ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ, ਬੱਸ ਸਾਨੂੰ 1-800-559-3500 'ਤੇ ਕਾਲ ਕਰੋ। ਕੋਈ ਵਿਅਕਤੀ ਜੋ ਪੰਜਾਬੀ ਬੋਲਦਾ ਹੈ, ਉਹ ਤੁਹਾਡੀ ਮਦਦ ਕਰ ਸਕਦਾ ਹੈ। ਇਹ ਇੱਕ ਮੁਫਤ ਸੇਵਾ ਹੈ।

Mon-Khmer, Cambodian:

យើងខ្ញុំមានសេវាអ្នកបកប្រែផ្ទាល់មាត់ដោយមិនគិតថ្លៃចាំឆ្លើយរាល់សំណួរដែលអ្នកអាចមានអំពីសុខភាព ឬផែនការឱសថរបស់យើងខ្ញុំ។ ដើម្បីទទួលបានអ្នកបកប្រែ គ្រាន់តែហៅទូរស័ព្ទមកយើងខ្ញុំតាមរយៈលេខ 1-800-559-3500។ មានគេដែលនិយាយភាសាខ្មែរអាចជួយលោកអ្នកបាន។ សេវាកម្មនេះមិនគិតថ្លៃទេ។

Hmong: Peb muaj cov kev pab cuam txhais lus los teb koj cov lus nug uas koj muaj txog ntawm pab lub phiaj xwm kho mob thiab tshuaj kho mob. Kom tau txais tus kws txhais lus, tsuas yog hu pab ntawm 1-800-559-3500. Muaj qee tus neeg hais lus Hmoob tuaj yeem pab tau koj. Qhov no yog kev pab cuam pab dawb.

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 1-800-559-3500 पर फोन करें। कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है। यह एक मुफ्त सेवा है।

Thai: เรามีบริการล่ามฟรีเพื่อตอบข้อสงสัยต่าง ๆ ที่คุณอาจมีเกี่ยวกับแผนสุขภาพและด้านเภสัชกรรมของเรา ขอความช่วยเหลือจากล่ามโดยโทรติดต่อเราที่หมายเลข 1-800-559-3500 เจ้าหน้าที่ในภาษาไทยจะเป็นผู้ให้บริการโดยไม่มีค่าใช้จ่ายใด ๆ

Lao: ພວກເຮົາມີການບໍລິການນາຍພາສາຟຣີ ເພື່ອຕອບຄໍາຖາມທີ່ທ່ານອາດຈະມີກ່ຽວກັບສຸຂະພາບ ຫຼື ແຜນການຢາຂອງ ພວກເຮົາ. ເພື່ອຮັບເອົານາຍພາສາ, ພຽງແຕ່ໂທຫາພວກເຮົາທີ່ເບີ 1-800-559-3500. ບາງຄົນທີ່ເວົ້າພາສາລາວ ສາມາດຊ່ວຍທ່ານໄດ້. ນີ້ແມ່ນການບໍລິການຟຣີ.

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 1-800-559-3500. Quelqu'un parlant français pourra vous aider. Ce service est gratuit.

German: Unser kostenloser Dolmetscherservice beantwortet Ihre Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-559-3500. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per usufruire di un interprete, contattare il numero 1-800-559-3500. Un nostro incaricato che parla Italiano Le 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 1-800-559-3500. Irá encontrar alguém que fale português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan sante oswa medikaman nou yo. Pou w jwenn yon entèprèt, jis rele nou nan 1-800-559-3500. 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 1-800-559-3500. Ta usługa jest bezpłatna.

Hmong-Mien: Peb muaj kev pab cuam txhais lus pub dawb los teb cov lus nug uas koj muaj txog ntawm pab lub phiaj xwm kev noj qab haus huv los sis phiaj xwm tshuaj kho mob. Kom tau txais tus kws txhais lus, tsuas yog hu pab ntawm 1-800-559-3500. Muaj tus neeg hais lus Hmoob tuaj yeem pab tau koj. Qhov kev pab cuam no yog pab dawb xwb.

Ukrainian: Ми надаємо безкоштовні послуги усного перекладача, який відповість на будь-які ваші запитання щодо нашого плану медичного обслуговування або лікарського забезпечення. Щоб отримати послуги перекладача, просто зателефонуйте нам за номером 1-800-559-3500. Вам може допомогти людина, яка володіє українською мовою. Ця послуга безкоштовна.