January 1, 2023 – December 31, 2023

2023 Summary of Benefits
Blue KC Group 25 Retirees

Medicare Advantage Plan with Part D Prescription Drug Coverage

To join Blue KC Group 25 Retirees, you must be entitled to Medicare Part A and be enrolled in Medicare Part B. Our provider network service area is in the following counties:

Kansas: Johnson and Wyandotte.
Missouri: Andrew, Bates, Buchanan, Cass, Clay, Clinton, Henry, Jackson, Johnson (MO), Lafayette, Platte, Ray, St. Clair and Vernon.

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage." You can also see the Evidence of Coverage on our website, www.medicarebluekc.com/bluekcretiree.

If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at 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 should call 1-877-486-2048.

Have Questions?

Call us at 1-888-892-8907, TTY: 711 from 8 a.m. – 8 p.m. Central Time 7 days a week, October 1 to March 31 and from April 1 to September 30, 8 a.m. – 8 p.m. Central Time, Monday through Friday or go online to our website: www.medicarebluekc.com/bluekcretiree.

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, www.medicarebluekc.com/EGWPformulary.

SUMMARY OF BENEFITS Blue KC Group 25 Retirees	
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES	
Monthly Plan Premium	Please refer to your Employer's Benefit department for your premium. In addition, you must keep paying your Medicare Part B premiums.
Deductible	Medical Deductible: $400 All in-network and out-of-network Medicare-covered services, except zero-dollar preventive, primary care physician visits, diagnostic labs, x-rays, and emergency services apply to the deductible. Prescription Drug Deductible: Not Applicable.
Maximum Out-of-Pocket Responsibility	Your yearly limit(s) in this plan: • $1,000 for services you receive from in-network providers. • $1,000 for services you receive from in and out-of-network providers combined. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.
Prior Authorization	Some in-network services may require prior authorization and are indicated with (PA) for your reference.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Acupuncture for Chronic Low Back Pain	You pay a $20 copay for each Medicare-covered acupuncture treatment. Your deductible applies to this service. You pay $20 copay for each supplemental non-Medicare acupuncture treatment up to 12 visits per year.	You pay a 20% co-insurance for each Medicare-covered acupuncture treatment. Your deductible applies to this service. You pay a 20% coinsurance for each supplemental non-Medicare acupuncture treatment up to 12 visits per year.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Ambulance (PA)	Ground Ambulance: $250 copay. Air Ambulance: $250 copay. Worldwide Ambulance Coverage: $250 copay.	Ground Ambulance: $250 copay. Air Ambulance: $250 copay.
Ambulatory Surgical Center (PA)	Ambulatory Surgical Center: $0 copay. Your deductible applies to this service.	Ambulatory Surgical Center: 20% coinsurance. Your deductible applies to this service.
Annual Physical Exam	You pay a $0 copay for the annual physical exam.	You pay a 20% coinsurance for annual physical exam.
Cardiac Rehabilitation Services	You pay a $0 copay for cardiac rehabilitation and intensive cardiac rehabilitation services. Your deductible applies to this service.	You pay a 20% coinsurance for cardiac rehabilitation and intensive cardiac rehabilitation services. Your deductible applies to this service.
Chiropractic Services	You pay a $20 copay for chiropractic services. Your deductible applies to this service.	You pay a 20% coinsurance for chiropractic services. Your deductible applies to this service.
Companion and Caregiver Support	Your benefit is 40 hours per year. A service of non-clinical individuals who provide assistance with light housekeeping, errand running, or assistance with accessing care (setup for telemedicine appointments, downloading phone apps - like Uber or Lyft)	

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Dental Services	Dental services: $20 copay for a Medicare-covered visit. Your deductible applies to Medicare-covered this service. Preventive: $0 copay, limited to 2 visits per year in and out of network combined. Preventive dental services: • Oral exam • Cleaning • Fluoride treatment • Dental X-rays	Dental services: 20% coinsurance for Medicare-covered visit. Your deductible applies to Medicare-covered this service. Preventive: $40 copay, limited to 2 visits per year in and out of network combined. Preventive dental services: • Oral exam • Cleaning • Fluoride treatment • Dental X-rays
Diabetes Self-Management Training, Diabetic Services and Supplies	You pay a $0 copay for each diabetes self-management training Telehealth visit. You pay a $0 copay for Medicare-covered diabetes self-management training. You pay nothing for the Diabetic Care Program or the diabetic device and supplies. Your deductible applies to the following services: You pay a $0 copay for preferred diabetes monitoring devices and supplies, and Continuous Glucose Monitors (CGM) and supplies when obtained at a pharmacy. Non-preferred brand Continuous Glucose Monitors (CGM) are covered only when deemed medically necessary and prior authorized.	You pay 20% coinsurance for each Medicare-covered diabetes self-management training. Your deductible applies to the following services: You pay a $0 copay for preferred diabetes monitoring devices and supplies, and Continuous Glucose Monitors (CGM) and supplies when obtained at a pharmacy. Non-preferred brand Continuous Glucose Monitors (CGM) are covered only when deemed medically necessary and prior authorized. You pay 20% coinsurance for all other brands of diabetes monitoring supplies when obtained at a pharmacy or a DME provider.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
	You pay 0% coinsurance for all other brands of diabetes monitoring supplies when obtained at a pharmacy or a DME provider. You pay 0% coinsurance for therapeutic custom-molded shoes or inserts.	You pay 20% coinsurance for therapeutic custom-molded shoes or inserts. You pay 20% coinsurance for diabetic services and supplies.
Diagnostic Services / Labs/ Imaging (PA)	Diagnostic tests and procedures: $0 copay. Lab services: $0 copay. Diagnostic Radiology Services (such as MRI, CAT Scan): $0 copay. X-rays: $0 copay. Therapeutic radiology services (such as radiation treatment for cancer): $0 copay. Your deductible applies to this service.	Diagnostic tests and procedures: 20% coinsurance. Lab services: 20% coinsurance. Diagnostic Radiology Services (such as MRI, CAT Scan): 20% coinsurance. X-rays: 20% coinsurance. Therapeutic radiology services (such as radiation treatment for cancer): 20% coinsurance. Your deductible applies to these services.
Doctor's Office Visits	Telehealth visit: $0 copay. Primary care physician visit: $0 copay. Specialist visit: $20 copay. Your deductible applies to Specialist visits.	Primary care physician visit: 20% coinsurance. Specialist visit: 20% coinsurance. Your deductible applies to these services.
Durable Medical Equipment (DME) and Related Supplies	You pay a $0 copay for items. Your deductible applies to this service.	You pay a 20% coinsurance for items. Your deductible applies to this service

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Emergency Care	$50 copay per visit. Worldwide Emergency Coverage: $50 copay.	$50 copay per visit.
Health and Wellness Education Programs	You pay a $0 copay for a Mindful Telehealth counseling visit. You pay a $0 copay for Nutritional Counseling. You pay a $0 copay for Fitness programs. You pay a $0 copay for Blue KC Virtual Care services.	You pay 20% coinsurance for nutritional counseling visit. You pay a 20% coinsurance for in-person counseling visit
Hearing Services	Exam to diagnose and treat hearing and balance issues: $20 copay. Your deductible applies to this service. Routine hearing exam (up to 1 visit(s) every year): $0 copay. Fitting and Evaluation for Hearing Aid (up to 3 visit(s) every year): $0 copay. Hearing Aid (up to 2 hearing aids every year): $0 copay, for up to a $500 per year, per ear benefit maximum, when provided by the Plan's partner.	Exam to diagnose and treat hearing and balance issues: 20% coinsurance. Your deductible applies to this service. Routine hearing exam (up to 1 visit(s) every year): $0 copay. Fitting and Evaluation for Hearing Aid (up to 3 visit(s) every year): $0 copay. Hearing Aid (up to 2 hearing aids every year): $0 copay, for up to a $500 per year, per ear benefit maximum, when provided by the Plan's partner.
Home Health Agency Care	There is no coinsurance or copayment for Medicare-covered home health services. Your deductible applies to this service.	You pay 20% coinsurance for Medicare-covered home health visits. Your deductible applies to this service.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Home Infusion Therapy	You pay 0% coinsurance for home infusion therapy. Your deductible applies to this service.	You pay 20% coinsurance for home infusion therapy. Your deductible applies to this service.
Immunizations	You pay $0 copay for the pneumonia, influenza, Hepatitis B, and COVID-19 vaccines.	There is 20% coinsurance for the pneumonia, influenza, Hepatitis B, and COVID-19 vaccines.
Inpatient Hospital (PA)	**Medical Facility:** Days 1-6: $0 copay per day. Days 7 & beyond: $0 copay per day. Your deductible applies to this service. **Mental Health Facility:** Days 1-7: $0 copay per day for each admission. Days 8-90: $0 copay per day. Your deductible applies to this service.	**Medical Facility:** Days 1-90: 20% coinsurance. Your deductible applies to this service. **Mental Health Facility:** Days 1-90: 20% coinsurance. Your deductible applies to this service.
Meals	For members who qualify with certain chronic conditions may receive 2 meals per day, for up to 4 weeks (56 meals total), pre-cooked, pre-packaged meals. Members who qualify with certain chronic conditions may also choose nutritional shakes for up to 4 weeks (24 shakes).	
Medicare Part B Drugs (PA)	For Part B drugs such as chemotherapy drugs: 0% Coinsurance. Other Part B drugs: 0% Coinsurance. Your deductible applies to these services.	For Part B drugs such as chemotherapy drugs: 20% Coinsurance. Other Part B drugs: 20% Coinsurance. Your deductible applies to these services.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Mental Health Care	Outpatient group therapy visits: $20 copay. Individual therapy visits: $20 copay. Telehealth visits: $0 copay. Your deductible applies to these services.	Outpatient group therapy visits: 20% Coinsurance. Individual therapy visits: 20% Coinsurance. Your deductible applies to these services.
Opioid Treatment Program Services	You pay a $0 copay for Medicare-covered Telehealth services. You pay a $20 copay for each covered opioid treatment services. Your deductible applies to these services.	You pay 20% coinsurance for each covered opioid treatment services. Your deductible applies to these services.
Outpatient Hospital (Pa)	Observation: $0 copay. Outpatient Hospital: $0 copay. Outpatient Surgery: $0 copay. Your deductible applies to these services.	Observation: 20% coinsurance. Outpatient Hospital: 20% coinsurance. Outpatient Surgery: 20% coinsurance. Your deductible applies to these services.
Outpatient Substance Abuse Services	You pay a $0 copay for Medicare-covered Telehealth services. You pay a $20 copay for Medicare-covered substance abuse services. Your deductible applies to these services.	You pay a 20% coinsurance for Medicare-covered outpatient substance abuse services. Your deductible applies to this service.
Over-the-Counter Items	You pay nothing for a $25 allowance per month (online, in-store and delivery options)	Not Applicable

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Partial Hospitalization Services	You pay a $20 copay for each Medicare-covered partial hospitalization. Your deductible applies to this service.	You pay a 20% coinsurance for each Medicare-covered partial hospitalization. Your deductible applies to this service.
Personal Emergency Response Service (PERS)	Your benefit is one PERS Device per year. GPS enabled wearable device that provides security for individuals who are prone to isolation or are subject to falling. The device is connected to a 24/7 call center to provide support in emergencies or help with general information needs/requests.	
Physical Therapy	Physical therapy visits: $20 copay. Telehealth Visits: $0 copay. Your deductible applies to these services.	Physical therapy visits: 20% Coinsurance. Your deductible applies to this service
Podiatry Services	You pay a $20 copay for each Medicare-covered podiatry service. Your deductible applies to this service.	You pay a 20% coinsurance for each Medicare-covered podiatry service. Your deductible applies to this service.
Preventive Care	You pay nothing for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare during the contract year will be covered. Below is a list of Medicare-covered preventive services: • Abdominal aortic aneurysm screening • Annual wellness visit	20% Coinsurance for all preventive services covered under Original Medicare, when out of network. Any additional preventive services approved by Medicare during the contract year will be covered. Below is a list of Medicare-covered preventive services: • Abdominal aortic aneurysm screening • Annual wellness visit

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
	• Bone mass measurement • Breast cancer screening (mammograms) • Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) • Cardiovascular disease testing • Cervical and vaginal cancer screening • Colorectal cancer screening • Depression screening • Diabetes screening • HIV screening • Medical nutrition therapy • Medicare Diabetes Prevention Program (MDPP) • Obesity screening and therapy to promote sustained weight loss • Prostate cancer screening exams • Screening and counseling to reduce alcohol misuse • Screening for lung cancer with low dose computed tomography (LDCT) • Screening for sexually transmitted infections (STIs) and counseling to prevent STIs • Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)	• Bone mass measurement • Breast cancer screening (mammograms) • Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) • Cardiovascular disease testing • Cervical and vaginal cancer screening • Colorectal cancer screening • Depression screening • Diabetes screening • HIV screening • Medical nutrition therapy • Medicare Diabetes Prevention Program (MDPP) • Obesity screening and therapy to promote sustained weight loss • Prostate cancer screening exams • Screening and counseling to reduce alcohol misuse • Screening for lung cancer with low dose computed tomography (LDCT) • Screening for sexually transmitted infections (STIs) and counseling to prevent STIs • Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
	• "Welcome to Medicare" preventive	• "Welcome to Medicare" preventive
Prosthetic Devices and Related Supplies	You pay 0% coinsurance for Medicare-covered prosthetic devices, related medical supplies**.** Your deductible applies to this service.	You pay 20% coinsurance for Medicare-covered prosthetic devices, related medical supplies. Your deductible applies to these services.
Pulmonary Rehabilitation Services	You pay a $0 copay for Medicare-covered pulmonary rehabilitation services. Your deductible applies to this service.	You pay a 20% coinsurance for Medicare-covered pulmonary rehabilitation services. Your deductible applies to these services.
Services to Treat Kidney Disease	You pay a $0 copay for Medicare-covered kidney disease education services. You pay a 0% coinsurance for Medicare-covered renal dialysis. You pay a $0 copay for Medicare-covered Telehealth services for kidney disease education. Your deductible applies to these services.	You pay a 20% coinsurance for Medicare-covered renal dialysis. You pay a 20% coinsurance for Medicare-covered kidney disease education. Your deductible applies to these services.
Skilled Nursing Facility (SNF) (PA)	Days 1-100: $0 copay per day. Your deductible applies to this service.	Days 1-100: 20% Coinsurance per day. Your deductible applies to this service.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Supervised Exercise Therapy (SET)	You pay a $0 copay for Medicare-Covered Supervised Exercise Therapy (SET) services. Your deductible applies to this service.	You pay 20% coinsurance for Medicare-covered Supervised Exercise Therapy (SET) services. Your deductible applies to these services.
Transportation	You Pay Nothing. 12 One-way trips every year to Plan-approved Health-related Location and requires a referral for services from the Plan's service provider, in and out of network.	You Pay Nothing. 12 One-way trips every year to Plan-approved Health-related Location and requires a referral for services from the Plan's service provider, in and out of network.
Urgently Needed Services	You pay a $20 copay per visit. You pay a $0 copay for Blue KC Virtual Care services. Worldwide Urgent Coverage: $20 copay.	You pay a $20 copay per visit.
Vision Services	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $20 copay. Eyeglasses or contact lenses after cataract surgery: $0 copay. Your deductible applies to these services. Routine eye exam (up to 1 visit(s) every year): $0 copay. Our plan pays up to $300 every year for eyewear (lens and frames or contact lenses) for	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): 20% Coinsurance. Eyeglasses or contact lenses after cataract surgery: 20% Coinsurance. Your deductible applies to these services. Routine eye exam (up to 1 visit(s) every year): 20% Coinsurance. Our plan pays up to $300 every year for eyewear (lens and frames or contact lenses) for

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
	both In and Out of Network Services.	both In and Out of Network Services.

<table>
<tr><th colspan="2">PRESCRIPTION DRUG BENEFITS</th></tr>
<tr><td>Deductible</td><td>Prescription Drug Deductible: Not Applicable.</td></tr>
<tr><td>Initial Coverage</td><td>You pay the following until your total yearly drug costs reach $4,660. Total yearly drug costs are the drug costs paid by both you and our Part D plan.

Standard Retail Cost-Sharing

<table>
<tr><th>Tier</th><th>One-month supply</th><th>Two-month supply</th><th>Three-month supply</th></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>$0 copay</td><td>$0 copay</td><td>$0 copay</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$5 copay</td><td>$10 copay</td><td>$0 copay</td></tr>
<tr><td>Tier 3 (Preferred Brand)</td><td>$47 copay</td><td>$94 copay</td><td>$141 copay</td></tr>
<tr><td>Tier 4 (Non-Preferred Drug)</td><td>$100 copay</td><td>$200 copay</td><td>$300 copay</td></tr>
<tr><td>Tier 5 (Specialty Tier)</td><td>33% coinsurance</td><td>Not Applicable</td><td>Not Applicable</td></tr>
</table>
Standard Mail Order

<table>
<tr><th>Tier</th><th>One-month supply</th><th>Two-month supply</th><th>Three-month supply</th></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>$0 copay</td><td>$0 copay</td><td>$0 copay</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$5 copay</td><td>$10 copay</td><td>$0 copay</td></tr>
<tr><td>Tier 3 (Preferred Brand)</td><td>$47 copay</td><td>$94 copay</td><td>$141 copay</td></tr>
<tr><td>Tier 4 (Non-Preferred Drug)</td><td>$100 copay</td><td>$200 copay</td><td>$300 copay</td></tr>
<tr><td>Tier 5 (Specialty Tier)</td><td>33% coinsurance</td><td>Not Applicable</td><td>Not Applicable</td></tr>
</table>
Your cost-sharing may be different if you use a Long-Term Care pharmacy, or an out-of-network pharmacy, or if you purchase a long-term supply (up to 100 days) of a drug.</td></tr>
</table>

<table>
<tr><th colspan="2">PRESCRIPTION DRUG BENEFITS</th></tr>
<tr><td></td><td><u>Important Message About What You Pay for Vaccines</u> <u>- Our plan covers most Part D vaccines at no cost to you.</u>

<u>Important Message About What You Pay for Insulin</u> <u>- 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.</u>

Please call us or see the plan’s “Evidence of Coverage” on our website (www.medicarebluekc.com/bluekcretiree) for complete information about your costs for covered drugs.</td></tr>
<tr><td>Coverage Gap</td><td>The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,660.

After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and up to 25% of the plan's cost for covered generic drugs until your costs total $7,400, which is the end of the coverage gap.

Our plan covers Tier 1 Preferred Generic and Tier 2 Generic in the coverage gap.

Standard Retail Cost-Sharing
<table><tr><th>Tier</th><th>One-month supply</th></tr><tr><td>Tier 1 (Preferred Generic)</td><td>$0 copay</td></tr><tr><td>Tier 2 (Generic)</td><td>$5 copay</td></tr></table>
Your cost-sharing may be different if you use a Long-Term Care pharmacy, or an out-of-network pharmacy, or if you purchase a long-term supply (up to 100 days) of a drug.</td></tr>
<tr><td>Catastrophic Amount</td><td>After your yearly out-of-pocket drug costs reach $7,400, you pay the greater of:
$4.15 copay for generic (including brand drugs treated as generic) and a $10.35 copayment for all other drugs, or
5% of the cost.</td></tr>
</table>

Blue Medicare Advantage is a Local PPO plan with a Medicare contract. Enrollment in **Blue Medicare Advantage** depends on contract renewal.

Out-of-network/non-contracted providers are under no obligation to treat Blue Cross and Blue Shield of Kansas City 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.

Blue Cross and Blue Shield of Kansas City is an independent licensee of the Blue Cross and Blue Shield Association. The PPO product is offered by Missouri Valley Life and Health Insurance Company, a wholly-owned subsidiary of Blue Cross and Blue Shield of Kansas City.

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-866-508-7140, TTY 711. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-866-508-7140, 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 1-866-508-7140, 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 1-866-508-7140, 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 1-866-508-7140, 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 1-866-508-7140, 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 1-866-508-7140, 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 1-866-508-7140, 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 1-866-508-7140, TTY: 711번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-866-508-7140, 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، 1-866-508-7140, TTY: 711ليس عليك سوى الاتصال بنا على 1. سيقوم شخص ما يتحدث العربية. هذه خدمة مجانية بمساعدتك.

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 1-866-508-7140, 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 1-866-508-7140, TTY: 711. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: 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 1-866-508-7140, 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 dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-866-508-7140, 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 1-866-508-7140, TTY: 711. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-866-508-7140, TTY: 711にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。