Kansas City | BLUE MEDICARE ADVANTAGE

January 1, 2023 – December 31, 2023

2023 Summary of Benefits
William Jewell PPO

Medicare Advantage Plan with Part D Prescription Drug Coverage

To join William Jewell PPO, 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/wjcretiree.

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/wjcretiree.

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

SUMMARY OF BENEFITS

William Jewell PPO

MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES	
Monthly Plan Premium	Please refer to your former Employer's Benefit department for your premium. In addition, you must keep paying your Medicare Part B premiums.
Deductible	Medical Deductible: Not Applicable. Prescription Drug Deductible: Not Applicable.
Maximum Out-of-Pocket Responsibility	Your yearly limit(s) in this plan: • $3,950 for services you receive from in-network providers. • $6,700 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 $40 copay for each Medicare-covered Acupuncture treatment.	You pay 35% coinsurance for each Medicare-covered Acupuncture treatment.
Ambulance Services (PA)	You pay a $150 copay for ambulance benefits. This copay applies to each one-way trip. You pay a $150 copay for worldwide ambulance benefit.	You pay a $150 copay for ambulance benefits. This copay applies to each one-way trip.
Ambulatory Surgical Services (PA)	You pay a $300 copay for surgery.	You pay a $300 copay for surgery.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Annual Physical Exam	There is no coinsurance, copayment, or deductible for the annual physical exam.	You pay a 35% coinsurance for annual physical exam.
Cardiac Rehabilitation Services	You pay a $5 copay for cardiac rehabilitation and intensive cardiac rehabilitation services.	You pay a 35% coinsurance for cardiac rehabilitation and intensive cardiac rehabilitation services.
Chiropractic Services	You pay a $20 copay for chiropractic services.	You pay a 35% coinsurance for chiropractic services.
Dental Services	You pay a $40 copay for Medicare-covered dental services. Your plan covers up to $500 per year for preventive and comprehensive dental services in and out of network. Preventive dental services: • Oral exam • Cleaning • Fluoride treatment • Dental X-rays Comprehensive dental services: • Non-Routine Services • Diagnostic Services • Restorative Services • Endodontic • Periodontics • Extractions	You pay a 35% coinsurance for Medicare-covered dental services. Your plan covers up to $500 per year for preventive and comprehensive dental services in and out of network. Preventive dental services: • Oral exam • Cleaning • Fluoride treatment • Dental X-rays Comprehensive dental services: • Non-Routine Services • Diagnostic Services • Restorative Services • Endodontic • Periodontics • Extractions

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Diabetes Self-management Training, Diabetic Services, and Supplies	You pay a $0 copay for each Telehealth visit. You pay a $0 copay for diabetes self-management training. You pay a $0 copay for preferred diabetes monitoring devices and supplies, and Continuous Glucose Monitors (CGM) and supplies when obtained at a pharmacy. You pay 0% coinsurance for diabetic supplies when obtained from EdgePark. You pay 20% coinsurance for other diabetic supplies from another DME provider or at a network pharmacy. Non-preferred brand Continuous Glucose Monitors (CGM) are covered only when deemed medically necessary and prior authorized. You pay 20% coinsurance for diabetic, therapeutic custom-molded shoes or inserts. You pay nothing for the Diabetic Care Program or the diabetic device and supplies.	You pay 35% coinsurance for diabetes self-management training. You pay a $0 copay for preferred diabetes monitoring devices and supplies, and Continuous Glucose Monitors (CGM) and supplies when obtained at a pharmacy. 35% coinsurance for all other brands of diabetes monitoring supplies when obtained at a pharmacy or any brand at a DME provider. Non-preferred brand Continuous Glucose Monitors (CGM) are covered only when deemed medically necessary and prior authorized. You pay 35% coinsurance for diabetic, therapeutic custom-molded shoes or inserts.
Durable Medical Equipment (DME) and Related Supplies (PA)	You pay 20% coinsurance for DME items.	You pay 35% coinsurance for DME items.
Emergency Care	You pay a $80 copay for emergency room visits. You pay a $80 copay for worldwide emergency care.	You pay a $80 copay for emergency room visits.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Urgently Needed Services	$40 copay per visit. $0 copay when you use Blue KC Virtual Care. Worldwide Urgent Coverage: $40 copay.	$40 copay per visit.
Health and wellness education programs	You pay a $0 copay for nutritional counseling. You pay a $0 copay for Mindful Telehealth counseling visit. You pay a $0 copay for access to participating fitness facilities and programs.	You pay 35% coinsurance for nutritional counseling and in-person counseling. You pay a $0 copay for access to participating fitness facilities and programs.
Hearing Services	You pay a $40 copay for each Medicare-covered diagnostic hearing exam to diagnose and treat hearing and balance issues. Benefit must be accessed through the plan's partner and includes up to one hearing aid per ear, per year, up to $500 benefit allowance per ear every year. You pay a $0 copay for each routine hearing exam. You pay a $0 copay for each fitting and evaluation for hearing aid visit.	You pay a 35% coinsurance for each Medicare-covered hearing exam to diagnose and treat hearing and balance issues. Benefit must be accessed through the plan's partner and includes up to one hearing aid per ear, per year, up to $500 benefit allowance per ear every year. You pay a $0 copay for each routine hearing exam. You pay a $0 copay for each fitting and evaluation for hearing aid visit.
Home Health Agency Care (PA)	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered home health visits.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered home health visits.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Home Infusion Therapy (PA)	You pay 20% coinsurance for home infusion therapy.	You pay 20% coinsurance for home infusion therapy.
Immunizations	There is no coinsurance, copayment, or deductible for the Medicare-covered pneumonia, influenza, Hepatitis B and COVID-19 vaccines.	There is a 35% coinsurance the Medicare-covered pneumonia, influenza, Hepatitis B and COVID-19 vaccines.
Inpatient Hospital (PA)	**Medical Facility**: You pay a $250 copay per day, days 1-6 and $0 copay per day, per stay, days 7 & beyond. **Mental Health Facility:** You pay a $200 copay per day, days 1-7 and $0 copay per day, per stay, days 8-90.	**Medical Facility**: You pay a $250 copay per day, days 1-6 and $0 copay per day, per stay, days 7-90. **Mental Health Facility:** You pay a 35% coinsurance per day, per stay, days 1-90.
Medicare Part B Drugs (PA)	You pay a 20% coinsurance for Part B-covered chemotherapy drugs. You pay 0% coinsurance for Part B covered vaccines. You pay a 20% coinsurance for other Part B covered drugs.	You pay 20% coinsurance for Part B covered chemotherapy drugs. You pay 20% coinsurance for other Part B covered drugs.
Opioid Treatment Program Services	You pay a $0 copay for Telehealth services. You pay a $40 copay for each covered opioid treatment services.	You pay a 35% coinsurance for opioid treatment services.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Outpatient Diagnostic Tests and Therapeutic Services and Supplies (PA)	You pay a $0 copay for x-rays. You pay 20% coinsurance for Medicare-covered therapeutic radiology services. You pay a $0 copay for lab services. You pay a $300 copay for Medicare-covered Diagnostic Radiology services (CT, MRI, PET). You pay a $0 copay for other diagnostic procedures and tests.	You pay 35% coinsurance for outpatient diagnostic tests and therapeutic services.
Outpatient Hospital Services (PA)	You pay a $300 copay for observation services. You pay 20% coinsurance for all other hospital services. You pay a $300 copay for outpatient hospital surgery.	You pay a $300 copay for observation services. You pay a $300 copay for outpatient hospital surgery. You pay 35% coinsurance for all other hospital services.
Mental Health Care	You pay a $0 copay for Telehealth services. You pay a $40 copay for each individual therapy and counseling visit. You pay a $40 copay for each group therapy and counseling visit.	You pay 35% coinsurance for each individual therapy and counseling visit. You pay 35% coinsurance for each group therapy and counseling visit.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Outpatient Rehabilitation Services	You pay a $0 copay for Telehealth services. You pay a $40 copay for each occupational therapy visit. You pay a $40 copay for each physical therapy and/or speech and language pathology visit.	You pay a 35% coinsurance for outpatient rehabilitation services.
Outpatient Substance Abuse Services	You pay a $0 copay for Telehealth services. You pay a $40 copay for each individual therapy visit. You pay a $40 copay for each group therapy visit.	You pay a 35% coinsurance for outpatient substance abuse services.
Partial Hospitalization Services (PA)	You pay a $40 copay for each partial hospitalization.	You pay a 35% coinsurance for each partial hospitalization.
Physician/Practitioner Services, Including Doctor's Office Visits	You pay a $0 copay for each Telehealth visit. You pay a $5 copay for each primary care provider or other health care provider in a primary care office visit. You pay a $40 copay for each specialist or other health care providers in a specialist office.	You pay a 35% coinsurance for each primary care provider visit. You pay a 35% coinsurance for each specialist visit.
Podiatry Services	You pay a $40 copay for each Medicare-covered podiatry service.	You pay a 35% coinsurance for each Medicare-covered podiatry service.
Prosthetic Devices and Related Supplies (PA)	You pay a 20% coinsurance for prosthetic devices, related supplies.	You pay 35% coinsurance for prosthetic devices, related supplies.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Pulmonary Rehabilitation Services	You pay a $5 copay for pulmonary rehabilitation services.	You pay a 35% coinsurance for pulmonary rehabilitation services.
Services to Treat Kidney Disease	You pay a $0 copay for Telehealth services. You pay a $0 copay for kidney disease education services. You pay a 0% coinsurance for renal dialysis.	You pay a 35% coinsurance for kidney disease education services. You pay a 35% coinsurance for renal dialysis.
Skilled Nursing Facility (SNF) Care (PA)	You pay a $0 copay per day, days 1-20 and a $184 copay per day, days 21-100 for a Medicare-covered stay.	You pay a 35% coinsurance for Days 1-100 for a Medicare-covered skilled nursing facility (SNF) stay.
Supervised Exercise Therapy (SET)	You pay a $5 copay per day for Supervised Exercise Therapy (SET) services.	You pay 35% coinsurance for Supervised Exercise Therapy (SET) services.
Vision Care	You pay a $40 copay for each Medicare-covered eye exam. You pay a $0 copay for one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery (applies to single, bifocal, trifocal or lenticular lenses). You pay a $0 copay for routine eye exam every year. You pay nothing for eyeglass frames, lenses, or contact lenses.	You pay a 35% coinsurance for each Medicare-covered eye exam. You pay a $0 copay for one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery (applies to single, bifocal, trifocal or lenticular lenses). You pay a 35% coinsurance for each routine eye exam. You pay nothing for eyeglass frames, lenses, or contact lenses.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
	Your plan pays up to $150 every year for eyewear in and out-of-network.	Your plan pays up to $150 every year for eyewear in and out-of-network.
Preventive Care *(e.g., flu vaccine, diabetic screenings)*	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 • 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 • Immunizations • Medical nutrition therapy • Medicare Diabetes	35% 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 • 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 • Immunizations • Medical nutrition therapy • Medicare Diabetes Prevention Program (MDPP)

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
	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) • "Welcome to Medicare" preventive visit	• 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) • "Welcome to Medicare" preventive visit
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).	

<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>$2 copay</td><td>$4 copay</td><td>$0 copay</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$6 copay</td><td>$12 copay</td><td>$18 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>$2 copay</td><td>$4 copay</td><td>$0 copay</td></tr>
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<table>
<tr><th colspan="2">PRESCRIPTION DRUG BENEFITS</th></tr>
<tr><td></td><td>
<table>
<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.
Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines 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 our plan, no matter what cost-sharing tier it’s on.
Please call us or see the plan’s “Evidence of Coverage” on our website (www.medicarebluekc.com/wjcretiree) 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>$2 copay</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$6 copay</td></tr>
</table>
</td></tr>
</table>

PRESCRIPTION DRUG BENEFITS	
	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.
Catastrophic Amount	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.

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: 711 سيقوم شخص ما يتحدث العربية. 1 هذه خدمة مجانية. بمساعدتك ليس عليك سوى الاتصال بنا على.

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。