January 1, 2023 – December 31, 2023

City of Kansas City PPO Plan 1
2023 Summary of Benefits

Medicare Advantage Plan with Part D Prescription Drug Coverage

To join City of Kansas City PPO Plan 1, you must be entitled to Medicare Part A and be enrolled in Medicare Part B. Our 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/cityofkcmo.

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/cityofkcmo.

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 City of Kansas City PPO Plan 1	
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES	
Monthly Plan Premium	Please contact your Employer's Benefit Department for your premium information. 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: • $2,000 for services you receive from in-network providers. • $10,000 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 $30 copay for each Medicare-covered Acupuncture treatment.	You pay a $30 copay for each Medicare-covered Acupuncture treatment.
Ambulance (PA)	You pay a $100 copay for ambulance benefits. This copay applies to each one-way trip. You pay a $100 copay for worldwide ambulance services.	You pay a $100 copay for ambulance benefits. This copay applies to each one-way trip. You pay a $100 copay for worldwide ambulance services.
Ambulatory Surgical Center (PA)	Ambulatory Surgical Center: $100 copay.	Ambulatory Surgical Center: $100 copay.

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.	There is no coinsurance, copayment, or deductible for the annual physical exam.
Cardiac Rehabilitation Services	You pay a $30 copay for cardiac rehabilitation and intensive cardiac rehabilitation services.	You pay a $30 copay for cardiac rehabilitation and intensive cardiac rehabilitation services.
Chiropractic Services	You pay a $20 copay for chiropractic services.	You pay a $20 copay for chiropractic services.
Dental Services	You pay a $30 copay for Medicare-covered dental services. Your plan covers up to $125 every year for preventive dental services in and out of network. • Oral Exams & Cleaning • X-ray & Fluoride	You pay a $30 copay for Medicare-covered dental services. Your plan covers up to $125 every year for preventive dental services in and out of network. • Oral Exams & Cleaning • X-ray & Fluoride
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 brand diabetes monitoring devices and supplies, and Continuous Glucose Monitors (CGM) and supplies when obtained at a pharmacy.	You pay 20% coinsurance for each Medicare-covered diabetes self-management training. You pay a $0 copay for preferred brand diabetes monitoring devices and supplies, and Continuous Glucose Monitors (CGM) and supplies when obtained at a pharmacy.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
	Non-preferred brand Continuous Glucose Monitors (CGM) are covered only when deemed medically necessary and prior authorized. You pay 0% coinsurance on diabetic supplies when obtained from EdgePark. You pay 20% coinsurance for all other brands of diabetes monitoring supplies when obtained at a pharmacy or a DME provider. You pay 0% coinsurance for Medicare-covered diabetic, therapeutic custom-molded shoes or inserts. You pay nothing for the Diabetic Care Program or the Medicare-covered diabetic device and supplies.	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. You pay 0% coinsurance for Medicare-covered diabetic, therapeutic custom-molded shoes or inserts.
Diagnostic Services / Labs/ Imaging (PA)	You pay a $0 copay for x-rays. You pay 20% coinsurance for therapeutic radiology services. You pay $0 copay for lab services. You pay a $100 copay for Diagnostic Radiology services (CT, MRI, PET).	You pay a $0 copay for x-rays. You pay 20% coinsurance for therapeutic radiology services. You pay $0 copay for lab services. You pay a $100 copay for Diagnostic Radiology services (CT, MRI, PET).

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
	You pay a $0 copay for other diagnostic procedures and tests.	You pay a $0 copay for other diagnostic procedures and tests.
Durable Medical Equipment (DME) and Related Supplies (PA)	You pay 20% coinsurance for items.	You pay 20% coinsurance for items.
Emergency Care	You pay a $50 copay for emergency room visits. If you are admitted to the same hospital within 24-hours for the same condition, you pay $0 for the emergency room visit. You pay a $50 copay for worldwide emergency care	You pay a $50 copay for emergency room visits. If you are admitted to the same hospital within 24-hours for the same condition, you pay $0 for the emergency room visit. You pay a $50 copay for worldwide emergency care
Health and wellness education programs	You pay a $0 copay for: • Nutritional counseling • Mindful, • Health Club Membership/Fitness Classes through SilverSneakers® • $0 copay for Blue KC Virtual Care services.	You pay a $0 copay for: • Nutritional counseling • Health Club Membership/Fitness Classes through SilverSneakers® You pay a $5 copay for: • In-person counseling visit
Hearing Services	Exam to diagnose and treat Medicare-covered hearing and balance issues: $30 copay. Routine hearing exam (up to 1 visit(s) every year): $0 copay.	Exam to diagnose and treat Medicare-covered hearing and balance issues: $30 copay. Routine hearing exam (up to 1 visit(s) every year): $0 copay.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
	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. 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.	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. 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.
Home Health Agency Care (PA)	You pay $0 copay for members eligible for home health visits.	You pay $0 copay for members eligible for home health visits.
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 no coinsurance, copayment, or deductible for the Medicare-covered pneumonia, influenza, Hepatitis B and COVID-19 vaccines.
Inpatient Hospital (PA)	**Medical Facility:** Days 1-5: $165 copay per day. Days 6-90: $0 copay per day. **Mental Health Facility:** Days 1-5: $165 copay per day. Days 6-90: $0 copay per day.	**Medical Facility:** Days 1-5: $165 copay per day. Days 6-90: $0 copay per day. **Mental Health Facility:** Days 1-5: $165 copay per day. Days 6-90: $0 copay per day.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Meals	You pay nothing for up to 2 meals per day, for up to 4 weeks (56 meals) per year. You pay nothing for nutritional shakes available for up to 4 weeks (24 units) per year.	
Medicare Part B Prescription Drugs (PA)	You pay a 20% coinsurance for Part B-covered chemotherapy drugs. 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.
Mental Health Care	You pay a $0 copay for Telehealth services. You pay a $5 copay for each individual therapy visit. You pay a $30 copay for each group therapy visit.	You pay a $5 copay for each individual therapy visit. You pay a $30 copay for each Medicare-covered group therapy visit.
Opioid Treatment Program Services	You pay a $0 copay for Telehealth services. You pay a $5 copay for each service.	You pay a $5 copay for each service.
Outpatient Hospital (PA)	You pay a $100 copay for observation services. You pay a $100 copay for Surgery. You pay 20% coinsurance for all other hospital services.	You pay a $100 copay for observation services. You pay a $100 copay for Surgery. You pay 20% coinsurance for all other hospital services.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Outpatient Substance Abuse Services	You pay a $0 copay for Telehealth services. You pay a $5 copay for each individual therapy visit. You pay a $30 copay for each group therapy visit.	You pay a $5 copay for each individual therapy visit. You pay a $30 copay for each group therapy visit.
Over-the-Counter Items	Your benefit is a $25 per month for eligible OTC items.	
Partial hospitalization services	You pay a $30 Copay for each Medicare-covered partial hospitalization.	You pay a $30 Copay for each partial hospitalization day.
Physical, Speech and Occupational Therapy	You pay a $0 copay for Telehealth services. You pay a $30 copay for each occupational therapy visit. You pay a $30 copay for each physical therapy and/or speech and language pathology visit.	You pay a $30 copay for outpatient rehabilitation services. You pay a $30 copay for each physical therapy and/or speech and language pathology visit.
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 professional in a primary care office visit. You pay a $30 copay for each specialist or other health care provider in a specialist office 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 $30 copay for each specialist or other health care provider in a specialist office visit.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Podiatry Services	You pay a $30 copay for each Medicare-covered podiatry service.	You pay a $30 copay for each Medicare-covered podiatry service.
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	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

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	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
Prosthetic Devices and Related Supplies (PA)	You pay a 20% coinsurance for prosthetic devices, related supplies.	You pay a 20% coinsurance for prosthetic devices, related supplies.
Pulmonary Rehabilitation Services and Supervised Exercise Therapy (SET)	You pay a $30 copay for each pulmonary rehabilitation services. You pay a $30 copay for each SET visit.	You pay a $30 copay for pulmonary rehabilitation services. You pay a $30 copay for each SET visit.
Services to Treat Kidney Disease	You pay a $0 copay for kidney disease education services.	You pay a $0 copay for kidney disease education services.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
	You pay a 0% coinsurance for renal dialysis. You pay a $0 copay for Telehealth services.	You pay a 0% coinsurance for renal dialysis.
Skilled Nursing Facility (SNF) Care (PA)	You pay a $0 copay per day, Days 1-20 and $125 copay per day, days 21-100 for a Medicare-covered stay.	You pay a 20% coinsurance for Days 1-100 for a Medicare-covered stay.
Urgently Needed Services	You pay a $10 copay per visit. You pay a $10 copay for each worldwide urgently needed care visit. You pay a $0 copay when you use Blue KC Virtual Care.	You pay a $10 copay per visit.
Vision Care	You pay a $30 copay for each Medicare-covered eye exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): You pay a $0 copay for a routine eye exam (up to 1 visit(s) every year): You pay a $0 copay for Medicare-covered Eyeglasses or contact lenses after cataract surgery (applies to single, bifocal, trifocal, or lenticular lenses). Our plan pays up to $150 for Eyewear (lens and frames or	You pay a $30 copay for each Medicare-covered eye exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): You pay a $0 copay for a routine eye exam (up to 1 visit(s) every year). You pay a $0 copay for Medicare-covered Eyeglasses or contact lenses after cataract surgery (applies to single, bifocal, trifocal, or lenticular lenses). Our plan pays up to $150 for Eyewear (lens and frames or

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
	contact lenses) for both in and out-of-network.	contact lenses) for both in and out-of-network.

<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>$5 copay</td><td>$10 copay</td><td>$10 copay</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$10 copay</td><td>$20 copay</td><td>$20 copay</td></tr>
<tr><td>Tier 3 (Preferred Brand)</td><td>$25 copay</td><td>$50 copay</td><td>$50 copay</td></tr>
<tr><td>Tier 4 (Non-Preferred Drug)</td><td>$50 copay</td><td>$100 copay</td><td>$100 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>$5 copay</td><td>$10 copay</td><td>$10 copay</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$10 copay</td><td>$20 copay</td><td>$20 copay</td></tr>
<tr><td>Tier 3 (Preferred Brand)</td><td>$25 copay</td><td>$50 copay</td><td>$50 copay</td></tr>
<tr><td>Tier 4 (Non-Preferred Drug)</td><td>$50 copay</td><td>$100 copay</td><td>$100 copay</td></tr>
<tr><td>Tier 5 (Specialty Tier)</td><td>33% coinsurance</td><td>Not Applicable</td><td>Not Applicable</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><th colspan="2">PRESCRIPTION DRUG BENEFITS</th></tr>
<tr><td></td><td>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/cityofkcmo) 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 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>$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>

City of Kansas City PPO Plan 1 is a Local PPO plan with a Medicare contract. Enrollment in City of Kansas City PPO Plan 1 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 Member Services 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.

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-888-892-8907 (TTY 711).

Understanding the Benefits

- [ ] The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit https://www.medicarebluekc.com/employer-plans or call 1-888-892-8907 (TTY 711) to view a copy of the EOC.
- [ ] Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- [ ] Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- [ ] Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- [ ] In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- [ ] Benefits, premiums and/or copayments/co-insurance may change on January 1, 2024.
- [ ] **For HMO Plans only:** Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).

☐ **For PPO Plans only:** Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.

☐ **For PPO Plans only:** Out-of-network/non-contracted providers are under no obligation to treat Blue Medicare Advantage (PPO) members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information.

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。