Kansas City | BLUE MEDICARE ADVANTAGE

January 1, 2023 – December 31, 2023

# 2023 Summary of Benefits
# IBEW Local 124 Health and Welfare Fund
# Blue Medicare Advantage Plan (PPO)

## Medicare Advantage Plan with Part D Prescription Drug Coverage

To join IBEW Local 124 Health and Welfare Fund Blue Medicare Advantage Plan (PPO), 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, http://www.medicarebluekc.com/ibew-retirees/.

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: http://www.medicarebluekc.com/ibew-retirees/.

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<br>IBEW Local 124 Health and Welfare Fund<br>Blue Medicare Advantage Plan (PPO) | |
|---|---|
| **MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES** | |
| **Monthly Plan Premium** | Please refer to IBEW Local 124 Health and Welfare Trust Office at 816.943.0277. |
| **Deductible** | Medical Deductible: Not Applicable.<br>Prescription Drug Deductible: Not Applicable. |
| **Maximum Out-of-Pocket Responsibility** | Your yearly limit(s) in this plan:<br>• $0 for services you receive from in-network providers.<br>• $0 for services you receive from in and out-of-network providers combined.<br>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.<br>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 $0 copay for each Medicare-covered acupuncture treatment.<br>You pay a $0 copay for each supplemental non-Medicare Acupuncture treatment.<br>Our plan also covers additional non-Medicare acupuncture for any condition. Treatments are limited to up to 20 visits per year. | You pay a $0 copay for each Medicare-covered acupuncture treatment.<br>You pay a $0 copay for each supplemental non-Medicare acupuncture treatment.<br>Our plan also covers additional non-Medicare acupuncture for any condition. Treatments are limited to up to 20 visits per year. |
| **Ambulance (PA)** | Ground Ambulance: $0 copay. | Ground Ambulance: $0 copay. |

| COVERED MEDICAL AND HOSPITAL BENEFITS | | |
|---|---|---|
| | **In-Network** | **Out-of-Network** |
| | Air Ambulance: $0 copay.<br>Worldwide Ambulance Coverage: $0 copay. | Air Ambulance: $0 copay. |
| **Ambulatory Surgical Center (PA)** | Ambulatory Surgical Center: $0 copay. | Ambulatory Surgical Center: $0 copay. |
| **Annual Physical Exam** | You pay a $0 copay for annual physical exam. | You pay a $0 copay for annual physical exam. |
| **Cardiac Rehabilitation Services** | You pay a $0 copay for each visit. | You pay a $0 copay for each visit. |
| **Chiropractic Services** | You pay a $0 copay for each visit. | You pay a $0 copay for each visit. |
| **Dental Services** | $0 copay for Medicare-covered dental services. | $0 copay for Medicare-covered dental services. |
| **Diabetes Self-Management Training, Diabetic Services and Supplies** | You pay a $0 copay for each Medicare-covered diabetes self-management training Telehealth visit.<br>You pay a $0 copay for diabetes self-management training.<br>You pay nothing for the Diabetic Care Program or the Medicare-covered diabetic device and supplies.<br>You pay a $0 copay for preferred diabetes monitoring devices and supplies, and Continuous Glucose Monitors (CGM) and supplies when obtained at a pharmacy.<br>Non-preferred brand Continuous Glucose Monitors (CGM) are covered only when deemed | You pay 0% coinsurance for Medicare-covered diabetes self-management training.<br>You pay a $0 copay for preferred diabetes monitoring devices and supplies, and Continuous Glucose Monitors (CGM) and supplies when obtained at a pharmacy.<br>Non-preferred brand Continuous Glucose Monitors (CGM) are covered only when deemed medically necessary and prior authorized.<br>You pay 0% 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** |
| | medically necessary and prior authorized.<br>You pay 0% coinsurance for all other brands of diabetes monitoring supplies when obtained at a pharmacy or a DME provider.<br>You pay 0% coinsurance for Medicare-covered therapeutic custom-molded shoes or inserts. | You pay 0% coinsurance for Medicare-covered therapeutic custom-molded shoes or inserts.<br>You pay 0% coinsurance for Medicare-covered diabetic services and supplies. |
| **Diagnostic Services / Labs/ Imaging (PA)** | Diagnostic tests and procedures: $0 copay.<br>Lab services: $0 copay.<br>Diagnostic Radiology Services (such as MRI, CAT Scan): $0 copay.<br>X-rays: $0 copay.<br>Therapeutic radiology services (such as radiation treatment for cancer): $0 copay. | Diagnostic tests and procedures: $0 copay.<br>Lab services: $0 copay.<br>Diagnostic Radiology Services (such as MRI, CAT Scan): $0 copay.<br>X-rays: $0 copay.<br>Therapeutic radiology services (such as radiation treatment for cancer): $0 copay. |
| **Doctor's Office Visits** | Telehealth visit: $0 copay.<br>Primary care physician visit: $0 copay.<br>Specialist visit: $0 copay.<br>You pay a $0 copay for nutritional counseling. | Primary care physician visit: $0 copay.<br>Specialist visit: $0 copay.<br>You pay a $0 copay for nutritional counseling. |
| **Durable Medical Equipment (DME) And Related Supplies** | You pay a $0 copay for DME and supplies. | You pay a 0% coinsurance for DME and supplies. |

| COVERED MEDICAL AND HOSPITAL BENEFITS | | |
|---|---|---|
| | **In-Network** | **Out-of-Network** |
| **Emergency Care** | $0 copay per visit.<br>If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care.<br>Worldwide Emergency Coverage: $0 copay. | $0 copay per visit.<br>If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. |
| **Fitness** | You pay a $0 copay for access to participating fitness facilities and programs. | You pay a $0 copay for access to participating fitness facilities and programs. |
| **Health and Wellness Education Programs** | You pay a $0 copay for Nutritional Counseling.<br>You pay a $0 copay for a Mindful Telehealth counseling visit.<br>You pay a $0 copay for Fitness programs. | You pay a $0 copay for Nutritional Counseling.<br>You pay a $0 copay for in-person counseling visit. |
| **Hearing Services** | Exam to diagnose and treat hearing and balance issues: $0 copay.<br>Hearing aid and associated services $0 copay, up to $2,500 benefit allowance. You pay 10% of costs beyond the benefit allowance, every three (3) years. | Exam to diagnose and treat hearing and balance issues: $0 copay. |
| **Home Health Agency Care** | You pay a $0 copay for home health care. | You pay a 0% coinsurance for home health care. |
| **Home Infusion Therapy** | You pay a 0% coinsurance for home infusion. | You pay a 0% coinsurance for home infusion. |
| **Immunizations** | There is no coinsurance, copayment, or deductible for the | You pay a 0% coinsurance for Medicare-covered immunizations. |

| COVERED MEDICAL AND HOSPITAL BENEFITS | | |
|---|---|---|
| | **In-Network** | **Out-of-Network** |
| | pneumonia, influenza, Hepatitis B, and COVID-19 vaccines. | |
| **Inpatient Hospital (PA)** | **<u>Medical Facility:</u>**<br>Days 1 & beyond: $0 copay per day for each admission.<br>**<u>Mental Health Facility:</u>**<br>Days 1-90: $0 copay per day for each admission. | **<u>Medical Facility:</u>**<br>Days 1-90: $0 copay per day.<br>**<u>Mental Health Facility:</u>**<br>Days 1-90: $0 copay per day. |
| **Medicare Part B Drugs (PA)** | For Part B drugs such as chemotherapy drugs: 0% Coinsurance.<br>Other Part B drugs: 0% Coinsurance. | For Part B drugs such as chemotherapy drugs: 0% Coinsurance.<br>Other Part B drugs: 0% Coinsurance. |
| **Mental Health Care** | Outpatient group therapy visits: $0 copay.<br>Individual therapy visits: $0 copay.<br>Telehealth visit: $0 copay. | Outpatient group therapy visits: $0 copay.<br>Individual therapy visits: $0 copay. |
| **Opioid Treatment Program Services** | You pay a $0 copay for Telehealth services.<br>You pay a $0 copay per visit for opioid treatment program services. | You pay a $0 copay for Telehealth services.<br>You pay a $0 copay per visit for opioid treatment program services. |
| **Outpatient Hospital (PA)** | Observation: $0 copay.<br>Outpatient Hospital: $0 copay.<br>Outpatient Surgery: $0 copay. | Observation: $0 copay.<br>Outpatient Hospital: $0 copay.<br>Outpatient Surgery: $0 copay. |
| **Outpatient Rehabilitation Services** | Physical therapy visits: $0 copay.<br>Telehealth visits: $0 copay. | Physical therapy visits: $0 copay. |

| COVERED MEDICAL AND HOSPITAL BENEFITS | | |
|---|---|---|
| | **In-Network** | **Out-of-Network** |
| **Physical Therapy** | | |
| **Outpatient substance abuse services** | You pay a $0 copay for Medicare-covered Telehealth services.<br>You pay a $0 copay for each individual visit.<br>You pay a $0 copay for each group visit. | You pay a 0% coinsurance for each individual therapy visit.<br>You pay a 0% coinsurance for each group therapy visit. |
| **Partial Hospitalization Services (PA)** | You pay a $0 copay for each partial hospitalization. | You pay a 0% coinsurance for each partial hospitalization day. |
| **Podiatry Services** | $0 copay for each Medicare-covered podiatry service.<br>$0 copay up to 6 routine foot care visits a year.<br>For members who qualify due to certain chronic conditions under the Special Supplemental Benefits for the Chronically Ill benefit, you pay $0 copay for an in-home foot evaluation, including a waterless pedicure up to 12 visits a year. | $0 copay for each Medicare-covered podiatry service.<br>$0 copay up to 6 routine foot care visits a year. |
| **Preventive Care** *(e.g., flu vaccine, diabetic screenings)* | You pay nothing for all preventive services covered under Original Medicare at zero cost sharing.<br>Any additional preventive services approved by Medicare during the contract year will be covered. | You pay nothing for all preventive services covered under Original Medicare at zero cost sharing.<br>Any additional preventive services approved by Medicare during the contract year will be covered. |

| COVERED MEDICAL AND HOSPITAL BENEFITS | | |
|---|---|---|
| | **In-Network** | **Out-of-Network** |
| | Below is a list of Medicare-covered preventive services:<br>• Abdominal aortic aneurysm screening<br>• Annual wellness visit<br>• Bone mass measurement<br>• Breast cancer screening (mammograms)<br>• Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)<br>• Cardiovascular disease testing<br>• Cervical and vaginal cancer screening<br>• Colorectal cancer screening<br>• Depression screening<br>• Diabetes screening<br>• HIV screening<br>• Medical nutrition therapy<br>• Medicare Diabetes Prevention Program (MDPP)<br>• Obesity screening and therapy to promote sustained weight loss<br>• Prostate cancer screening exams<br>• Screening and counseling to reduce alcohol misuse<br>• Screening for lung cancer with low dose computed tomography (LDCT)<br>• Screening for sexually transmitted infections (STIs) and counseling to prevent STIs | Below is a list of Medicare-covered preventive services:<br>• Abdominal aortic aneurysm screening<br>• Annual wellness visit<br>• Bone mass measurement<br>• Breast cancer screening (mammograms)<br>• Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)<br>• Cardiovascular disease testing<br>• Cervical and vaginal cancer screening<br>• Colorectal cancer screening<br>• Depression screening<br>• Diabetes screening<br>• HIV screening<br>• Medical nutrition therapy<br>• Medicare Diabetes Prevention Program (MDPP)<br>• Obesity screening and therapy to promote sustained weight loss<br>• Prostate cancer screening exams<br>• Screening and counseling to reduce alcohol misuse<br>• Screening for lung cancer with low dose computed tomography (LDCT)<br>• Screening for sexually transmitted infections (STIs) and counseling to prevent STIs |

| COVERED MEDICAL AND HOSPITAL BENEFITS | | |
|---|---|---|
| | **In-Network** | **Out-of-Network** |
| | • Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)<br>• "Welcome to Medicare" preventive visit | • Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)<br>• "Welcome to Medicare" preventive visit |
| **Prosthetic devices and related supplies** | You pay a 0% coinsurance for devices and supplies. | You pay a 0% coinsurance for devices and supplies. |
| **Pulmonary rehabilitation services** | You pay a $0 copay for each visit. | You pay a 0% coinsurance per visit. |
| **Services to treat kidney disease** | You pay a $0 copay for kidney disease education services.<br>You pay a $0 copay for Telehealth services.<br>You pay a 0% coinsurance for renal dialysis. | You pay a 0% coinsurance for Medicare-covered kidney disease education services.<br>You pay a 0% coinsurance for renal dialysis. |
| **Skilled Nursing Facility (SNF) (PA)** | Days 1-100: $0 copay per day. | Days 1-100: $0 copay per day. |
| **Supervised Exercise Therapy (SET)** | You pay a $0 copay for each visit. | You pay 0% coinsurance per visit. |
| **Urgently Needed Services** | You pay a $0 copay when you use Virtual Care.<br>$0 copay per visit.<br>Worldwide Urgent Coverage: $0 copay. | $0 copay per visit. |
| **Vision Services** | Exam to diagnose and treat diseases and conditions of the | Exam to diagnose and treat diseases and conditions of the |

| COVERED MEDICAL AND HOSPITAL BENEFITS | | |
|---|---|---|
| | **In-Network** | **Out-of-Network** |
| | eye (including yearly glaucoma screening): $0 copay.<br>Routine eye exam (up to 1 visit(s) every year): $0 copay.<br>Eyeglasses or contact lenses after cataract surgery: $0 copay. | eye (including yearly glaucoma screening): $0 copay.<br>Routine eye exam (up to 1 visit(s) every year): $0 copay.<br>Eyeglasses or contact lenses after cataract surgery: $0 copay. |

<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.<br><br>Standard Retail Cost-Sharing<br><br>
<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>$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>$15 copay</td><td>$30 copay</td><td>$25 copay</td></tr>
<tr><td>Tier 4 (Non-Preferred Drug)</td><td>$15 copay</td><td>$30 copay</td><td>$25 copay</td></tr>
<tr><td>Tier 5 (Specialty Tier)</td><td>$75 copay</td><td>Not Applicable</td><td>Not Applicable</td></tr>
</table>
Standard Mail Order<br><br>
<table>
<tr><th>Tier</th><th>One-month supply</th><th>Two-month supply</th><th>Three-month supply</th></tr>
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<tr><td></td><td>
<table>
<tr><td>Tier 5 (Specialty Tier)</td><td>$75 copay</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.<br><br>
Please call us or see the plan's "Evidence of Coverage" on our website (http://www.medicarebluekc.com/ibew-retirees/) 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.<br><br>
After you enter the coverage gap, you pay your copay or coinsurance for covered drugs until your costs total $7,400 which is the end of the coverage gap.
<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>$0 copay</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$5 copay</td><td>$10 copay</td><td>$0 copay</td></tr>
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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>

| PRESCRIPTION DRUG BENEFITS | |
|---|---|
| | **Important Message About What You Pay for Vaccines** - Our plan covers most Part D vaccines at no cost to you.<br><br>**Important Message About What You Pay for Insulin** - You won't pay more than $15 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.<br><br>Please call us or see the plan's **"Evidence of Coverage"** on our website (www.medicarebluekc.com/bopc) for complete information about your costs for covered drugs. |
| **Catastrophic Amount** | After your yearly out-of-pocket drug costs reach $7,400, you pay the lesser of:<br>• $4.15 copay for generic (including brand drugs treated as generic) and a $10.35 copayment for all other drugs, or<br>• 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 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.

# 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.

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