Kansas City | BLUE MEDICARE ADVANTAGE

January 1, 2023 – December 31, 2023

Blue Medicare Advantage (PPO) for Jackson County MO.

2023 Summary of Benefits

Medicare Advantage Plan with Part D Prescription Drug Coverage

To join Blue Medicare Advantage (PPO) for Jackson County MO., 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/JCMO.

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/JCMO.

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 Medicare Advantage (PPO) for Jackson County MO.

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: 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)	Ground Ambulance: $100 copay. Air Ambulance: $100 copay. Worldwide Ambulance Coverage: $100 copay.	Ground Ambulance: $100 copay. Air Ambulance: $100 copay.
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.
Blue Benefit Bucks	Your plan offers $1,000 per year to spend on extra benefits, like dental, hearing services, prescription eyewear, or non-Medical transportation (Uber or Lyft) beyond any covered benefit.	
Cardiac Rehabilitation Services	$30 copay for cardiac rehabilitation and intensive cardiac rehabilitation services.	$30 copay for cardiac rehabilitation and intensive cardiac rehabilitation services.
Chiropractic Services	$20 copay for each visit.	$20 copay for each visit.
Dental Services	Medicare Covered: $30 copay. You may use your Blue Benefit Bucks card to schedule and pay for dental services to any dental provider. There is a $1,000 per year benefit allowance every year for dental, hearing services, transportation and eyewear combined.	Medicare Covered: $30 copay. You may use your Blue Benefit Bucks card to schedule and pay for dental services to any dental provider. There is a $1,000 per year benefit allowance every year for dental, hearing services, transportation and eyewear combined.
Diabetes Self-management Training, Diabetic Services and Supplies	$0 copay for preferred brand diabetes monitoring devices and supplies, and Continuous Glucose Monitors (CGM) and supplies when obtained at a pharmacy.	$0 copay for Medicare-covered 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. 20% coinsurance for all other brands of diabetes monitoring supplies when obtained at a pharmacy or any brand at a DME provider. 20% coinsurance for therapeutic custom-molded shoes or inserts. Our plan covers additional Diabetic services under Uniform Flexibility for individuals with Chronic Conditions.	Non-preferred brand Continuous Glucose Monitors (CGM) are covered only when deemed medically necessary and prior authorized. 20% coinsurance for all other brands of diabetes monitoring supplies when obtained at a pharmacy or any brand at a DME provider. 20% coinsurance for therapeutic custom-molded shoes or inserts.
Diagnostic Services / Labs/ Imaging (PA)	Diagnostic tests and procedures: $0 copay. Lab services: $0 copay. Diagnostic Radiology Services (such as MRI, CAT Scan): $100 copay. X-rays: $0 copay. Therapeutic radiology services (such as radiation treatment for cancer): 20% coinsurance.	Diagnostic tests and procedures: $0 copay. Lab services: $0 copay. Diagnostic Radiology Services (such as MRI, CAT Scan): $100 copay. X-rays: $0 copay. Therapeutic radiology services (such as radiation treatment for cancer): 20% coinsurance.
Durable Medical Equipment (DME),	20% coinsurance for DME and prosthetic items	20% coinsurance for DME and prosthetic items

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Prosthetics, and Related Supplies (PA)		
Emergency Care	$50 copay per visit. If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. Worldwide Emergency Coverage: $50 copay.	$50 copay per visit. If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care.
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 a $0 copay for Blue KC Virtual Care services.	You pay a $0 copay for access to participating fitness facilities and programs.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Hearing Services	Exam to diagnose and treat hearing and balance issues: $30 copay. You may use your Blue Benefit Bucks card to schedule and pay for hearing services. There is a $1,000 per year benefit allowance every year for dental, hearing services, transportation and eyewear combined.	Exam to diagnose and treat hearing and balance issues: $30 copay. You may use your Blue Benefit Bucks card to schedule and pay for hearing services. There is a $1,000 per year benefit allowance every year for dental, hearing services, transportation and eyewear combined.
Home Health Agency Care	$0 copay	$0 copay
Home Infusion Therapy	20% coinsurance	20% coinsurance
Immunizations	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B, and COVID-19 vaccines.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered immunizations.
Inpatient Hospital (PA)	**Medical Facility (per admission):** Days 1-5: $165 copay per day. Days 6 & beyond: $0 copay per day. **Mental Health Facility (per admission):** Days 1-5: $165 copay per day. Days 6-90: $0 copay per day.	**Medical Facility (per admission):** Days 1-5: $165 copay per day. Days 6-90: $0 copay per day. **Mental Health Facility (per admission):** 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	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: 20% coinsurance. Other Part B drugs: 20% coinsurance.	For Part B drugs such as chemotherapy drugs: 20% coinsurance. Other Part B drugs: 20% coinsurance.
Member & 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)	
Mental Health Care	Outpatient group therapy visit: $30 copay. Individual therapy visit: $5 copay. Telehealth visit: $0 copay.	Outpatient group therapy visit: $30 copay. Individual therapy visit: $5 copay.
Opioid Treatment Program Services	Telehealth services: $0 copay Opioid treatment: $5 copay per visit	Opioid treatment: $5 copay per visit
Outpatient Hospital (PA)	Observation: $100 copay. Outpatient hospital for other procedures and services: 20% coinsurance. Outpatient Surgery: $100 copay.	Observation: $100 copay. Outpatient hospital for other procedures and services: 20% coinsurance. Outpatient Surgery: $100 copay.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Outpatient Substance Abuse Services	Telehealth services: $0 copay. Individual therapy visits: $5 copay. Group therapy visit: $30 copay.	Individual therapy visits: $5 copay. Group therapy visit: $30 copay
Over-the-Counter Items	Your benefit is $500 per year for eligible OTC items.	
Partial Hospitalization Services	$30 copay	$30 copay
Personal Emergency Response Service	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, Speech and Occupational Therapy	$30 copay. Telehealth Visit: $0 copay.	$30 copay.
Physician/Practitioner Services, Including Doctor's Office Visits	Telehealth visit: $0 copay. Primary care physician visit: $5 copay. Specialist visit: $30 copay.	Primary care physician visit: $5 copay. Specialist visit: $30 copay.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Podiatry Services	Medicare-covered podiatry service: $30 copay. Routine foot care: $30 copay up to 6 visits a year. For members who qualify due to certain conditions under Special Supplemental Benefits, you pay $0 copay for an in-home foot evaluation, including a waterless pedicure up to 12 visits a year.	Medicare-covered podiatry service: $30 copay. Routine foot care: $30 copay up to 6 visits a year.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**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 • Medical nutrition therapy • Medicare Diabetes Prevention Program (MDPP)	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 • Medical nutrition therapy • Medicare Diabetes Prevention Program (MDPP) • Obesity screening and therapy to promote sustained weight loss

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
	• 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	• 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
Pulmonary Rehabilitation Services	Pulmonary rehabilitation services: $30 copay.	Pulmonary rehabilitation services: $30 copay.
Services to Treat Kidney Disease	Kidney disease education services: $0 copay. Renal dialysis: 0% coinsurance. Telehealth services: $0 copay.	Kidney disease education services: $0 copay Renal dialysis: 0% coinsurance.
Skilled Nursing Facility (SNF) (PA)	Days 1-20: $0 copay per day. Days 21-100: $125 copay per day.	Days 1-100: 20% coinsurance per day.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Supervised Exercise Therapy (SET)	SET services: $30 copay	SET services: $30 copay
Transportation	You may use your Blue Benefit Bucks card to schedule and pay for transportation services to any health location. There is a $1000 per year benefit allowance every year for Hearing, Transportation, Dental and Eyewear combined.	You may use your Blue Benefit Bucks card to schedule and pay for transportation services to any health location. There is a $1000 per year benefit allowance every year for Hearing, Transportation, Dental and Eyewear combined.
Urgently Needed Services	$10 copay per visit. Worldwide Urgent Coverage: $10 copay. Blue KC Virtual Care: $0 copay	$10 copay per visit.
Vision Services	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $0-30 copay. The minimum copay is for diabetic and glaucoma screenings. The maximum copay is for other Medicare covered eye exams. Routine eye exam (up to 1 visit(s) every year): $0 copay. Eyeglasses or contact lenses after cataract surgery: $0 copay. You may use your Blue Benefit Bucks card to	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $0-30 copay. The minimum copay is for diabetic and glaucoma screenings. The maximum copay is for other Medicare covered eye exams. Routine eye exam (up to 1 visit(s) every year): $0 copay. Eyeglasses or contact lenses after cataract surgery: $0 copay. You may use your Blue Benefit Bucks card to

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
	schedule and pay for eyewear (contacts and glasses) services. There is a $1,000 per year benefit allowance every year for dental, hearing services, transportation and eyewear combined.	schedule and pay for eyewear (contacts and glasses) services. There is a $1,000 per year benefit allowance every year for dental, hearing services, transportation and eyewear combined.

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

Blue Medicare Advantage (PPO) for Jackson County MO. is a Local PPO plan with a Medicare contract. Enrollment in **Blue Medicare Advantage (PPO) for Jackson County, MO.** 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.

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。