ILLINOIS & MISSOURI

Medica Advantage® with SSM (HMO-POS) and
Medica Advantage® (HMO-POS) Plans

Summary of Benefits

January 1, 2025 – December 31, 2025

This is a summary of drug and health services covered by **Medica Advantage with SSM Value (HMO-POS)** and **Medica Advantage Salute (HMO-POS) medical only.**

This booklet gives you a summary of what we cover and what you pay. It doesn't 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 have choices about how to get your Medicare benefits

One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.

Another choice is to get your Medicare benefits by joining a Medicare Advantage plan (such as **Medica Advantage with SSM Value (HMO-POS)** and **Medica Advantage Salute (HMO-POS) medical only**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Medica Advantage with SSM** and **Medica Advantage** plans cover and what you pay. If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on www.medicare.gov.

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.

Sections in this booklet

- Things to Know About **Medica Advantage with SSM** and **Medica Advantage Plans**
- Monthly Premium, Deductible, and Maximums on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Part D Prescription Drug Benefits
- Additional Benefits and Services

This document is available in other formats such as braille and large print. This document may be available in a non-English language. For additional information, call us toll-free at 1 (877) 234-0126 (TTY: 711).

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Medica.

Things to Know About Medica Advantage with SSM and Medica Advantage Plans

Hours of Operation

- From Oct. 1 – March 31, you can call us from 8 a.m. – 8 p.m. CT, 7 days a week.
- From April 1 – Sept. 30, you can call us from 8 a.m. – 8 p.m. CT, Monday – Friday.

Medica Advantage with SSM and Medica Advantage Plans Phone Numbers and Website

- If you are a member of this plan, call toll-free 1 (877) 301-3326 (TTY: 711).
- If you are not a member of this plan, call toll-free 1 (877) 234-0126 (TTY: 711).
- Our website: https://central.medica.com/medicare

Who Can Join?

To join **Medica Advantage with SSM** and **Medica Advantage** plans, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Our service area includes the following counties in **Illinois**: Madison and St. Clair.

Our service area includes the following counties in **Missouri**: St. Charles County, St. Louis City, St. Louis, and Warren.

Which doctors, hospitals, and pharmacies can I use?

Medica Advantage with SSM and **Medica Advantage** plans have a network of doctors, hospitals, pharmacies, and other providers. You pay your lowest cost sharing when you visit an in-network provider. You have coverage for most Medicare-covered services at out-of-network providers through the Point-of-Service (POS) benefit, but you may pay more. Coverage for emergency care is the same in network as it is out of network (within the U.S. and its territories) plus you have coverage worldwide. Covered services that need approval in advance are marked by an asterisk (*).

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. Our network includes pharmacies with preferred cost sharing, which may offer you lower cost sharing than the standard cost sharing offered by other network pharmacies for some drugs. You may search for network providers and pharmacies on our website at https://central.medica.com/medicare. Or, call us and we will send you a copy of the provider and pharmacy directories.

What do we cover?

Medica Advantage with SSM Value (HMO-POS) covers everything that Original Medicare covers – plus more. Our plans cover medical and hospital services, Part D outpatient prescription drugs, and protects you from unlimited out-of-pocket costs.

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider. You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, https://central.medica.com/medicare. Or, call us and we will send you a copy of the formulary.

Medica Advantage Salute (HMO-POS) medical only covers everything that Original Medicare covers – plus more. Our plan covers medical and hospital services and protects you from unlimited out-of-pocket costs.

We cover Part B drugs such as chemotherapy and some drugs administered by your provider. You can see the complete plan formulary and any restrictions on our website, https://central.medica.com/medicare. Or, call us and we will send you a copy of the formulary.

SUMMARY OF BENEFITS

January 1, 2025 – December 31, 2025

	Value HMO-POS ($0)	**Salute HMO-POS medical only ($0)**
MONTHLY PREMIUM, DEDUCTIBLE, AND MAXIMUMS ON HOW MUCH YOU PAY FOR COVERED SERVICES		
Monthly Plan Premium	$0	
Part B Premium Buy-Down	$35	$55
Medical Deductible	No deductible	
Maximum Out-Of-Pocket Responsibility *(does not include prescription drugs)*	In-Network: $4,000 In-Network and Out-of-Network combined: $8,000	In-Network: $5,500 In-Network and Out-of-Network combined: $10,000

	Value HMO-POS ($0)	**Salute HMO-POS medical only ($0)**
COVERED MEDICAL AND HOSPITAL BENEFITS		
Inpatient Hospital Coverage		
In-Network	$325 copay each day for days 1 through 7 $0 copay for day 8 to discharge *	$325 copay each day for days 1 through 7 $0 copay for day 8 to discharge *
Out-of-Network	50% of the total cost for days 1 through 7 $0 copay for day 8 to discharge *	40% of the total cost for days 1 through 7 $0 copay for day 8 to discharge *
Outpatient Hospital Coverage	**Outpatient Hospital Services:**	**Outpatient Hospital Services:**
In-Network	$0 - $300 copay *	$0 - $325 copay *
Out-of-Network	50% of the total cost *	40% of the total cost *
	Outpatient Hospital Observation Services:	**Outpatient Hospital Observation Services:**
In-Network	$300 copay per stay	$325 copay per stay
Out-of-Network	50% of the total cost per stay	40% of the total cost per stay

	Value HMO-POS ($0)	Salute HMO-POS medical only ($0)
COVERED MEDICAL AND HOSPITAL BENEFITS		
Ambulatory Surgery Center		
In-Network	$0 - $250 copay *	$0 - $295 copay *
Out-of-Network	50% of the total cost *	40% of the total cost *
Doctor Visits	**Primary Care Provider:**	**Primary Care Provider:**
In-Network	$0 copay	$0 copay
Out-of-Network	50% of the total cost	40% of the total cost
	Specialist:	**Specialist:**
In-Network	$35 copay	$40 copay
Out-of-Network	50% of the total cost	40% of the total cost
Preventive Care (e.g., Flu Vaccine, Diabetic Screenings)		
In-Network	$0 copay	$0 copay
Out-of-Network	50% of the total cost	40% of the total cost
Emergency Care	$140 copay Copay is waived if you are admitted to a hospital within 1 day within the U.S. and its territories.	$125 copay Copay is waived if you are admitted to a hospital within 1 day within the U.S. and its territories.
Urgently Needed Services	$0 - $40 copay	
Diagnostic and Therapeutic Services/Labs/Imaging	**Diagnostic Tests and Procedures:**	**Diagnostic Tests and Procedures:**
In-Network	$10 - $20 copay *	$15 - $20 copay *
Out-of-Network	50% of the total cost *	40% of the total cost *
	Lab Services:	**Lab Services:**
In-Network	$0 - $20 copay *	$0 - $20 copay *
Out-of-Network	50% of the total cost *	40% of the total cost *
	Diagnostic Radiology Services (e.g., MRI, CAT Scan):	**Diagnostic Radiology Services (e.g., MRI, CAT Scan):**
In-Network	$0 - $200 copay *	$0 - $200 copay *

	Value HMO-POS ($0)	Salute HMO-POS medical only ($0)
COVERED MEDICAL AND HOSPITAL BENEFITS		
Out-of-Network	50% of the total cost *	40% of the total cost *
	Therapeutic Radiology Services:	**Therapeutic Radiology Services:**
In-Network	$20 - $75 copay *	$20 - $65 copay *
Out-of-Network	50% of the total cost *	40% of the total cost *
	X-rays:	**X-rays:**
In-Network	$20 - $25 copay	$10 - $20 copay
Out-of-Network	50% of the total cost *	40% of the total cost *
Hearing Services	**Exam to Diagnose and Treat Hearing and Balance Issues:**	**Exam to Diagnose and Treat Hearing and Balance Issues:**
In-Network	$35 copay	$40 copay
Out-of-Network	50% of the total cost	40% of the total cost
	Routine Hearing Exam:	**Routine Hearing Exam:**
	Limited to 1 visit per calendar year.	Limited to 1 visit per calendar year.
In-Network	$0 copay	$0 copay
Out-of-Network	Not covered	Not covered
	Fitting Evaluation(s) for Hearing Aids:	**Fitting Evaluation(s) for Hearing Aids:**
	Limited to 1 visit every year for each hearing aid.	Limited to 1 visit every year for each hearing aid.
In-Network	$0 copay per fitting-evaluation for hearing aid.	$0 copay fitting-evaluation for hearing aid.
Out-of-Network	Not covered	Not covered
	Hearing Aids:	**Hearing Aids:**
In-Network	Included in FlexSpend benefit	$0 copay Our plan pays up to $750 both ears combined every calendar year for hearing aids Additional allowance included in FlexSpend benefit. You are responsible for costs beyond the plan limit
Out-of-Network	Included in FlexSpend benefit	Included in FlexSpend benefit

	Value HMO-POS ($0)	Salute HMO-POS medical only ($0)
COVERED MEDICAL AND HOSPITAL BENEFITS		
Dental Services - Medicare-covered		
In-Network	$40 copay	$40 copay
Out-of-Network	50% of the total cost	40% of the total cost
Dental Services - Preventive	**Preventive exams:** $0 copay for 2 visits every calendar year **Cleanings:** $0 copay for 2 visits every calendar year **Fluoride treatment:** $0 copay for 1 every calendar year **Bitewing x-ray:** $0 copay for 1 every calendar year	
Dental Services - Comprehensive	**Diagnostic services:**	**Diagnostic services:**
In-Network	$0 copay	$0 copay
Out-of-Network	50% of the total cost	50% of the total cost
	Periodontal and denture maintenance:	**Periodontal and denture maintenance:**
In-Network	50% of the total cost	50% of the total cost
Out-of-Network	50% of the total cost	50% of the total cost
	Restorative (including fillings), extractions, and non-surgical periodontics:	**Restorative (including fillings), extractions, and non-surgical periodontics:**
In-Network	50% of the total cost	50% of the total cost
Out-of-Network	50% of the total cost	50% of the total cost
	Endodontics, prosthodontics and oral surgeries:	**Endodontics, prosthodontics and oral surgeries:**
In-Network	50% of the total cost	Not covered
Out-of-Network	50% of the total cost	Not covered
Dental Services - Maximum annual limit for preventive and comprehensive services You are responsible for costs beyond the plan limit.	$300 every calendar year Additional allowance included with the FlexSpend benefit.	$300 every calendar year Additional allowance included with the FlexSpend benefit.

	Value HMO-POS ($0)	Salute HMO-POS medical only ($0)
COVERED MEDICAL AND HOSPITAL BENEFITS		
Vision Services	**Exam to Diagnose and Treat Diseases and Conditions of the Eye:**	**Exam to Diagnose and Treat Diseases and Conditions of the Eye:**
In-Network	$0 copay	$0 copay
Out-of-Network	50% of the total cost	40% of the total cost
	Routine eye exam (1 exam each calendar year):	**Routine eye exam (1 exam each calendar year):**
In-Network	$0 copay	$0 copay
Out-of-Network	Not covered	Not covered
	Eyewear After Cataract Surgery:	**Eyewear After Cataract Surgery:**
In-Network	One pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens.	One pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens.
	$0 copay	$0 copay
Out-of-Network	Not covered	Not covered
	Contact Lenses, Eyeglasses (Lenses and/or Frames), and Upgrades:	**Contact Lenses, Eyeglasses (Lenses and/or Frames), and Upgrades:**
In-Network	Included in FlexSpend benefit	Included in FlexSpend benefit
Out-of-Network	Included in FlexSpend benefit	Included in FlexSpend benefit
Mental Health Services	**Outpatient Individual Therapy:**	**Outpatient Individual Therapy:**
In-Network	$35 copay	$40 copay
Out-of-Network	50% of the total cost *	40% of the total cost *
	Outpatient Group Therapy:	**Outpatient Group Therapy:**
In-Network	$25 copay	$30 copay
Out-of-Network	50% of the total cost *	40% of the total cost *
	Inpatient Hospital:	**Inpatient Hospital:**
In-Network	$310 copay each day for days 1 through 7 and $0 for days 8 through 90 *	$310 copay each day for days 1 through 7 and $0 for days 8 through 90 *
	$0 copay for up to an additional 60 lifetime reserve days.	$0 copay for up to an additional 60 lifetime reserve days.
Out-of-Network	50% of the total cost for days 1 through 7 and $0 copay for days	40% of the total cost for days 1 through 7 and $0 copay for days

	Value HMO-POS ($0)	Salute HMO-POS medical only ($0)
COVERED MEDICAL AND HOSPITAL BENEFITS		
	8 through 90 * $0 copay for up to an additional 60 lifetime reserve days.	8 through 90 * $0 copay for up to an additional 60 lifetime reserve days.
Skilled Nursing Facility (SNF) In-Network Out-of-Network	$10 copay each day for days 1 through 20, and $214 copay each day for days 21 through 100 * 50% of the total cost for days 1 through 100 *	$0 copay for days 1 through 20, and $214 copay each day for days 21 through 100 * 40% of the total cost for days 1 through 100 *
Outpatient Rehabilitation Services In-Network Out-of-Network	**Physical or Speech Therapy Visit:** $40 copay 50% of the total cost * **Occupational Therapy Visit:** $35 copay 50% of the total cost *	 $40 copay 40% of the total cost *
Ambulance Services – Emergency	**Ground and Air Ambulance:** $300 copay	
Transportation In-Network Out-of-Network	$0 copay for 24 one-way rides every calendar year Not covered	
Medicare Part B Drugs Part B rebatable drugs may be subject to a lower coinsurance. For Part B insulin furnished through an external insulin pump, you will pay a $35 copay per a one- month supply.		

	Value HMO-POS ($0)	Salute HMO-POS medical only ($0)
COVERED MEDICAL AND HOSPITAL BENEFITS		
In-Network	20% of the total cost *	20% of the total cost *
Out-of-Network	50% of the total cost *	40% of the total cost *

	Value HMO-POS ($0)	Salute HMO-POS($0)
PART D PRESCRIPTION DRUG BENEFITS		
Deductible Stage	$0 You will not have to pay any deductible and will start receiving coverage immediately.	NA
Initial Coverage Stage	You will stay in this stage until your yearly out-of-pocket drug costs (including what our plan has paid and what you have paid) reach $2,000. In this stage you will pay a $35 copay for a one-month (30-day) supply or a $105 copay for a three-month (90-day) supply for insulin.	NA

	Value HMO-POS ($0)	Salute HMO-POS medical only ($0)
PREFERRED RETAIL COST SHARING		
Tiers	**1-Month (30-day) supply**	**1-Month (30-day) supply**
Tier 1 (Preferred Generic)	$0 copay	NA
Tier 2 (Generic)	$8 copay	NA
Tier 3 (Preferred Brand)	20% coinsurance	NA
Tier 4 (Non-Preferred Drug)	45% coinsurance	NA
Tier 5 (Specialty Tier)	33% coinsurance	NA

	Value HMO-POS ($0)	Salute HMO-POS medical only ($0)
PREFERRED RETAIL COST SHARING		
Tiers	**1-Month (30-day) supply**	**1-Month (30-day) supply**
Tier 6 (Part D Vaccines)	$0 copay	NA
Insulin	You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.	

	Value HMO-POS ($0)	Salute HMO-POS medical only ($0)
STANDARD RETAIL COST SHARING		
Tiers	**1-Month (30-day) supply**	**1-Month (30-day) supply**
Tier 1 (Preferred Generic)	$7 copay	NA
Tier 2 (Generic)	$13 copay	NA
Tier 3 (Preferred Brand)	25% coinsurance	NA
Tier 4 (Non-Preferred Drug)	50% coinsurance	NA
Tier 5 (Specialty Tier)	33% coinsurance	NA
Tier 6 (Vaccines)	$0 copay	NA
Insulin	You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.	

	Value HMO-POS ($0)	Salute HMO-POS medical only ($0)
STANDARD MAIL-ORDER COST SHARING		
Tiers	**3-Month (90-day) supply**	**3-Month (90-day) supply**
Tier 1 (Preferred Generic)	$0 copay	NA
Tier 2 (Generic)	$16 copay	NA
Tier 3 (Preferred Brand)	20% coinsurance	NA

	Value HMO-POS ($0)	Salute HMO-POS medical only ($0)
STANDARD MAIL-ORDER COST SHARING		
Tiers	**3-Month (90-day) supply**	**3-Month (90-day) supply**
Tier 4 (Non-Preferred Drug)	45% coinsurance	NA
Tier 5 (Specialty Tier)	NA	NA
Tier 6 (Vaccines)	NA	NA
Insulin	You won't pay more than $105 for a three-month supply of each covered insulin product regardless of the cost-sharing tier.	

	Value HMO-POS ($0)	Salute HMO-POS medical only ($0)
PART D COVERAGE STAGES		
Catastrophic Stage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $2,000, the plan pays the full cost for your covered Part D drugs. You pay nothing.	NA

	Value HMO-POS ($0)	Salute HMO-POS medical only ($0)
ADDITIONAL BENEFITS AND SERVICES		
Annual Physical Exam		
In-Network	$0 copay	$0 copay
Out-of-Network	50% of the total cost	40% of the total cost
Cardiac Rehabilitation Services		
In-Network	$40 copay	$30 copay
Out-of-Network	50% of the total cost	40% of the total cost

	Value HMO-POS ($0)	Salute HMO-POS medical only ($0)
ADDITIONAL BENEFITS AND SERVICES		
Chiropractic Services 12 additional routine visits every calendar year		
In-Network	$20 copay	$20 copay
Out-of-Network	50% of the total cost	40% of the total cost
Diabetic Testing Supplies		
In-Network	$0 copayment for Dexcom and Freestyle continuous glucose monitors (CGMs) and related supplies received from a retail pharmacy. 20% of the total cost for other CGMs and related supplies at a retail pharmacy. 20% of the total cost for CGMs received from a medical supplier. *	$0 copayment for Dexcom and Freestyle continuous glucose monitors (CGMs) and related supplies received from a retail pharmacy. 20% of the total cost for other CGMs and related supplies at a retail pharmacy. 20% of the total cost for CGMs received from a medical supplier. *
Out-of-Network	$0 copayment for Dexcom or Freestyle (CGMs) and related supplies received from a retail pharmacy. 50% of the total cost for other CGMs and related supplies from a retail pharmacy. 50% of the total cost for CGMs obtained from a medical supplier. *	$0 copayment for Dexcom or Freestyle (CGMs) and related supplies received from a retail pharmacy. 40% of the total cost for other CGMs and related supplies from a retail pharmacy. 40% of the total cost for CGMs obtained from a medical supplier. *
Durable Medical Equipment (DME) and Related Supplies		
In-Network	20% of the total cost	15% of the total cost
Out-of-Network	50% of the total cost	40% of the total cost
eVisits		
In-Network	$0 copay	
Out-of-Network	Not covered	
FlexSpend Benefit Allowance on a prepaid debit card to spend on dental services, vision services, eyewear, hearing services and hearing aids	$740 yearly	$500 yearly

	Value HMO-POS ($0)	Salute HMO-POS medical only ($0)
ADDITIONAL BENEFITS AND SERVICES		
Health+ by Medica Card (formerly your WellFirst Wallet)	Use this card to pay for dental and eyewear benefits at a licensed dentist or eyewear provider that accepts Visa®. This card can also be used to purchase OTC health and wellness products at participating retailers, online, or over the phone. Allowances are added the first month you are enrolled in the plan. All allowance amounts expire as stated in the benefit, at the end of the plan year, or when you leave the plan.	
Health and Wellness Education Programs	**Nurse Advice Line**	
In-Network	$0 copay	
Out-of-Network	Not covered	
	One Pass™ Fitness Program:	
In-Network	$0 annual fee	
Out-of-Network	Not covered	
Home Health Agency Care		
In-Network	$0 copay	$0 copay
Out-of-Network	50% of the total cost	40% of the total cost
Living Healthy Rewards Earn up to $150 of rewards every calendar year for completing healthy activities like receiving a flu shot, going to the dentist and getting an annual physical	Included	
Meals		
In-Network	$0 copay for 2 meals per day for 7 days after an inpatient stay	
Out-of-Network	Not covered	
Over-The-Counter (OTC) Drugs and Supplies		
In-Network	You are eligible for a $50 allowance quarterly by using the Health+ by Medica card at participating retailers, online, or over the phone.	You are eligible for a $40 allowance quarterly by using the Health+ by Medica card at participating retailers, online, or over the phone.
Out-of-Network	Not covered	Not covered

	Value HMO-POS ($0)	Salute HMO-POS medical only ($0)
ADDITIONAL BENEFITS AND SERVICES		
Podiatry Services In-Network Out-of-Network	 $35 copay 50% of the total cost *	 $40 copay 40% of the total cost *
Pulmonary Rehabilitation Services In-Network Out-of-Network	 $35 copay 50% of the total cost	 $15 copay 40% of the total cost
Smoking and Tobacco Use Cessation – Quit for Life Program In-Network Out-of-Network	 $0 copay Not covered	
Welcome to Medicare Preventive Visit In-Network Out-of-Network	 $0 copay 50% of the total cost	 $0 copay 40% of the total cost
Worldwide Emergency Care	$140 copay	$120 copay

Form Approved
OMB# 0938-1421

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 **1-877-317-2410 (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 **1-877-317-2410.** 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 **1-877-317-2410**。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 **1-877-317-2410**。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 **1-877-317-2410.** 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 **1-877-317-2410.** 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 **1-877-317-2410** 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 **1-877-317-2410.** 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 **1-877-317-2410**번으로 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 **1-877-317-2410.** 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 بمساعدتك. هذه خدمة مجانية فوري، ليس عليك سوى الاتصال بنا على **1 877 317-2410**. سيقوم شخص ما يتحدث العربية.

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 **1-877-317-2410**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 **1-877-317-2410.** Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: 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 **1-877-317-2410.** 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 **1-877-317-2410.** 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 **1-877-317-2410.** 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、**1-877-317-2410**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。

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