**Medica Advantage Solution® H8889-004 (PPO) and**
**Medica Advantage Solution® H8889-008 (PPO)**

# Summary of Benefits

January 1, 2023 – December 31, 2023

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 Solution H8889-004 (PPO)** and **Medica Advantage Solution H8889-008 (PPO)**).

## Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Medica Advantage Solution H8889-004 (PPO)** and **H8889-008 (PPO)** 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 Solution H8889-004 (PPO)** and **H8889-008 (PPO)**
- 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 (800) 918-2416 (TTY users should call 711).

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**Things to Know About Medica Advantage Solution H8889-004 (PPO) and H8889-008 (PPO)**

**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 Solution H8889-004 (PPO) and H8889-008 (PPO) Phone Numbers and Website**

- If you are a member of this plan, call toll-free 1 (866) 269-6804 (TTY: 711).
- If you are not a member of this plan, call toll-free 1 (800) 918-2416 (TTY: 711).
- Our website: Medica.com/Medicare

**Who Can Join?**

To join **Medica Advantage Solution H8889-004 (PPO)** and **H8889-008 (PPO)**, 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 **Minnesota:** Big Stone, Blue Earth, Brown, Cottonwood, Dodge, Faribault, Fillmore, Freeborn, Houston, Jackson, Lac Qui Parle, Lincoln, Lyon, Martin, Mower, Murray, Nicollet, Nobles, Olmsted, Redwood, Steele, Wabasha, Waseca, Watonwan, and Winona.

**Which doctors, hospitals, and pharmacies can I use?**

**Medica Advantage Solution H8889-004 (PPO)** and **H8889-008 (PPO)** 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 services at out-of-network providers, 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 to be covered as in-network services 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 Medica.com/MyPlanDocs. Or, call us and we will send you a copy of the provider and pharmacy directories.

**What do we cover?**

**Medica Advantage Solution H8889-004 (PPO)** and **H8889-008 (PPO)** covers everything that Original Medicare covers – plus more. Our plan covers medical and hospital services, Part D outpatient prescription drugs, and protects you from unlimited out-of-pocket costs.

**SUMMARY OF BENEFITS**

January 1, 2023 – December 31, 2023

| | **Medica Advantage Solution H8889-004 (PPO)** | **Medica Advantage Solution H8889-008 (PPO)** |
|---|---|---|
| **MONTHLY PREMIUM, DEDUCTIBLE, AND MAXIMUMS ON HOW MUCH YOU PAY FOR COVERED SERVICES** | | |
| Monthly Plan Premium | $134 | $19 |
| Deductible | No deductible | No deductible |
| Maximum Out-Of-Pocket Responsibility *(does not include prescription drugs)* | In-Network: $4,900<br>In-Network and Out-of-Network combined: $7,500 | In-Network: $5,500<br>In-Network and Out-of-Network combined: $7,900 |

| | **Medica Advantage Solution H8889-004 (PPO)** | **Medica Advantage Solution H8889-008 (PPO)** |
|---|---|---|
| **COVERED MEDICAL AND HOSPITAL BENEFITS** | | |
| Inpatient Hospital Coverage | **In-Network**<br>$225 copay for each Medicare-covered hospital stay<br><br>$0 copay for additional Medicare-covered days.<br>*<br><br>**Out-of-Network**<br>30% of the total cost | **In-Network**<br>$350 copay each day for days 1 through 5 and<br>$0 copay for days 6 through 90<br>$0 copay for up to an additional 60 lifetime reserved days.<br>*<br><br>**Out-of-Network**<br>30% of the total cost |
| Outpatient Hospital Coverage | | |
| Outpatient Hospital Services | **In-Network**<br>$250 copay<br>*<br><br>**Out-of-Network**<br>30% of the total cost | **In-Network**<br>$395 copay<br>*<br><br>**Out-of-Network**<br>30% of the total cost |
| Outpatient Hospital Observation Services | **In-Network**<br>$225 copay per stay<br><br>**Out-of-Network**<br>30% of the total cost | **In-Network**<br>$350 copay per day<br><br>**Out-of-Network**<br>30% of the total cost |

| | Medica Advantage Solution H8889-004 (PPO) | Medica Advantage Solution H8889-008 (PPO) |
|---|---|---|
| Ambulatory Surgery Center | **In-Network**<br>$175 copay<br>* | **In-Network**<br>$320 copay<br>* |
| | **Out-of-Network**<br>30% of the total cost | **Out-of-Network**<br>30% of the total cost |
| Doctor Visits | | |
| Primary Care Providers | **In-Network**<br>$0 copay | **In-Network**<br>$0 copay |
| | **Out-of-Network**<br>30% of the total cost | **Out-of-Network**<br>30% of the total cost |
| Specialists | **In-Network**<br>$30 copay | **In-Network**<br>$45 copay |
| | **Out-of-Network**<br>30% of the total cost | **Out-of-Network**<br>30% of the total cost |
| Preventive Care (e.g., Flu Vaccine, Diabetic Screenings) | **In-Network**<br>$0 copay | **In-Network**<br>$0 copay |
| | **Out-of-Network**<br>30% of the total cost | **Out-of-Network**<br>30% of the total cost |
| Emergency Care | $90 copay<br>Copay is waived if you are admitted to a hospital within 1 day. If you receive emergency care at an out-of-network hospital (within the U.S. and its territories only) and need inpatient care after your emergency condition is stabilized, you must move to a network hospital in order to pay the in-network cost-sharing amount for the part of your stay after you are stabilized. If you stay at the out-of-network hospital, your stay will be covered but you will pay the out-of-network cost-sharing amount for the part of your stay after you are stabilized. | $90 copay<br>Copay is waived if you are admitted to a hospital within 1 day. If you receive emergency care at an out-of-network hospital (within the U.S. and its territories only) and need inpatient care after your emergency condition is stabilized, you must move to a network hospital in order to pay the in-network cost-sharing amount for the part of your stay after you are stabilized. If you stay at the out-of-network hospital, your stay will be covered but you will pay the out-of-network cost-sharing amount for the part of your stay after you are stabilized. |
| Urgently Needed Services | $0 - $30 copay | $30 - $40 copay |

| | Medica Advantage Solution H8889-004 (PPO) | Medica Advantage Solution H8889-008 (PPO) |
|---|---|---|
| Diagnostic and Therapeutic Services/ Labs/Imaging | | |
| Diagnostic Tests and Procedures | **In-Network**<br>15% of the total cost<br>Up to a maximum of $75 each day.<br>$0 copay for home-based sleep studies | **In-Network**<br>20% of the total cost<br>Up to a maximum of $150 each day.<br>$0 copay for home-based sleep studies |
| | **Out-of-Network**<br>30% of the total cost | **Out-of-Network**<br>30% of the total cost |
| Lab Services | **In-Network**<br>$0 copay<br>* | **In-Network**<br>$0 copay<br>* |
| | **Out-of-Network**<br>30% of the total cost | **Out-of-Network**<br>30% of the total cost |
| Diagnostic and Therapeutic Radiology Services (e.g., MRI, CAT Scan) | **In-Network**<br>15% of the total cost<br>Up to a maximum of $75 each day.<br>* | **In-Network**<br>20% of the total cost<br>Up to a maximum of $150 each day.<br>* |
| | **Out-of-Network**<br>30% of the total cost | **Out-of-Network**<br>30% of the total cost |
| X-Rays | **In-Network**<br>15% of the total cost<br>Up to a maximum of $75 each day. | **In-Network**<br>20% of the total cost<br>Up to a maximum of $150 each day. |
| | **Out-of-Network**<br>30% of the total cost | **Out-of-Network**<br>30% of the total cost |
| Hearing Services | | |
| Exam to Diagnose and Treat Hearing and Balance Issues | **In-Network**<br>$0 - $25 copay | **In-Network**<br>$0 - $25 copay |
| | **Out-of-Network**<br>30% of the total cost | **Out-of-Network**<br>30% of the total cost |

| | Medica Advantage Solution H8889-004 (PPO) | Medica Advantage Solution H8889-008 (PPO) |
|---|---|---|
| Routine Hearing Exam Services from **EPIC®** **Hearing** Providers | **In-Network**<br>$0 copay<br>Limited to 1 visit per calendar year.<br><br>**Out-of-Network**<br>Not covered | **In-Network**<br>$0 copay<br>Limited to 1 visit per calendar year.<br><br>**Out-of-Network**<br>Not covered |
| Fitting Evaluation(s) for Hearing Aids Services from **EPIC®** **Hearing** Providers | **In-Network**<br>$0 copay per fitting-evaluation for hearing aid. Limited to 1 visit every year for each Silver level hearing aid, and 3 visits every year for each Gold level hearing aid.<br><br>**Out-of-Network**<br>Not covered | **In-Network**<br>$0 copay per fitting-evaluation for hearing aid. Limited to 1 visit every year for each Silver level hearing aid, and 3 visits every year for each Gold level hearing aid.<br><br>**Out-of-Network**<br>Not covered |
| Hearing Aids | | |
| All Types Hearing Aids from **EPIC®** **Hearing** Providers | **In-Network**<br>$549 copay per Silver level hearing aid and<br>$799 copay per Gold level hearing aid.<br>Unlimited hearing aids every year.<br><br>**Out-of-Network**<br>Not covered | **In-Network**<br>$549 copay per Silver level hearing aid and<br>$799 copay per Gold level hearing aid.<br>Unlimited hearing aids every year.<br><br>**Out-of-Network**<br>Not covered |
| Dental Services | | |
| Medicare-Covered Dental | **In-Network**<br>$0 - $30 copay<br><br>**Out-of-Network**<br>30% of the total cost | **In-Network**<br>$0 - $45<br><br>**Out-of-Network**<br>30% of the total cost |
| Preventive and Comprehensive Dental | Up to $500 reimbursement every calendar year for non-Medica-re-covered preventive and comprehensive dental services from any licensed dentist within the U.S. and its territories. | Up to $400 reimbursement every calendar year for non-Medica-re-covered preventive and comprehensive dental services from any licensed dentist within the U.S. and its territories. |

| | Medica Advantage Solution H8889-004 (PPO) | Medica Advantage Solution H8889-008 (PPO) |
|---|---|---|
| Vision Services | | |
| Exam to Diagnose and Treat Diseases and Conditions of the Eye | **In-Network**<br>$30 copay<br><br>**Out-of-Network**<br>30% of the total cost | **In-Network**<br>$45 copay<br><br>**Out-of-Network**<br>30% of the total cost |
| Routine Eye Exam | **In-Network**<br>$0 copay<br>Limited to 1 visit every calendar year.<br><br>**Out-of-Network**<br>30% of the total cost | **In-Network**<br>$0 copay<br>Limited to 1 visit every calendar year.<br><br>**Out-of-Network**<br>30% of the total cost |
| Eyewear After Cataract Surgery | **In-Network**<br>$0 copay<br><br>**Out-of-Network**<br>30% of the total cost<br><br>One pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. | **In-Network**<br>$0 copay<br><br>**Out-of-Network**<br>30% of the total cost<br><br>One pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. |
| Contact Lenses, Eyeglasses (Lenses and/or Frames), and Upgrades | Up to $100 reimbursement every calendar year for non-Medicare-covered eyewear. | Up to $100 reimbursement every calendar year for non-Medicare-covered eyewear. |
| Mental Health Services | | |
| Outpatient Individual and Group Therapy Visit | **In-Network**<br>$30 copay<br><br>**Out-of-Network**<br>30% of the total cost | **In-Network**<br>$40 copay<br><br>**Out-of-Network**<br>30% of the total cost |
| Inpatient Hospital | **In-Network**<br>$225 copay for each Medicare-covered hospital stay<br><br>$0 copay for up to an additional 60 lifetime reserve days<br>*<br><br>**Out-of-Network**<br>30% of the total cost | **In-Network**<br>$350 copay each day for days 1 through 5 and<br>$0 copay for days 6 through 90<br>$0 copay for up to an additional 60 lifetime reserve days.<br>*<br><br>**Out-of-Network**<br>30% of the total cost |

| | Medica Advantage Solution H8889-004 (PPO) | Medica Advantage Solution H8889-008 (PPO) |
|---|---|---|
| Skilled Nursing Facility (SNF) Care | **In-Network**<br>$0 copay for days 1 through 20, a $196 copay each day for days 21 through 45, and $0 copay for days 46 through 100<br>* | **In-Network**<br>$0 copay for days 1 through 20, a $196 copay each day for days 21 through 49, and $0 copay for days 50 through 100<br>* |
| | **Out-of-Network**<br>30% of the total cost | **Out-of-Network**<br>30% of the total cost |
| Physical Therapy | **In-Network**<br>$30 copay | **In-Network**<br>$40 copay |
| | **Out-of-Network**<br>30% of the total cost | **Out-of-Network**<br>30% of the total cost |
| Ambulance Services | | |
| Ground Ambulance | $265 copay | $265 copay |
| Air Ambulance | 20% of the total cost | 20% of the total cost |
| Transportation | Not covered | Not covered |
| Medicare Part B Prescription Drugs | | |
| Chemotherapy/Radiation Drugs | **In-Network**<br>20% of the total cost<br>* | **In-Network**<br>20% of the total cost<br>* |
| | **Out-of-Network**<br>30% of the total cost | **Out-of-Network**<br>30% of the total cost |
| Other Part B Drugs | **In-Network**<br>20% of the total cost<br>* | **In-Network**<br>20% of the total cost<br>* |
| | **Out-of-Network**<br>30% of the total cost | **Out-of-Network**<br>30% of the total cost |

| | Medica Advantage Solution H8889-004 (PPO) | Medica Advantage Solution H8889-008 (PPO) |
|---|---|---|

**PART D PRESCRIPTION DRUG BENEFITS**

**Deductible** $295 $395

You will pay the full cost of your Tier 3, Tier 4, and Tier 5 Part D prescription drugs until you reach your deductible.
For all other drugs, including Select Insulins, you will not have to pay any deductible and will start receiving coverage immediately.

**Initial Coverage**
You will stay in this stage until your total drug costs (including what our plan has paid and what you have paid) reach $4,660.

| Preferred Retail Cost Sharing | | |
|---|---|---|
| **Tier** | **One-month (30-day) supply** | **One-month (30-day) supply** |
| Tier 1 (Preferred Generic) | $0 copay | $0 copay |
| Tier 2 (Generic) | $10 copay | $14 copay |
| Tier 3 (Preferred Brand) | $47 copay | $47 copay |
| Select Insulins | $35 copay | $35 copay |
| Tier 4 (Non-Preferred Drug) | 50% coinsurance | 50% coinsurance |
| Tier 5 (Specialty Tier) | 28% coinsurance | 26% coinsurance |

| Standard Retail Cost Sharing | | |
|---|---|---|
| **Tier** | **One-month (30-day) supply** | **One-month (30-day) supply** |
| Tier 1 (Preferred Generic) | $10 copay | $15 copay |
| Tier 2 (Generic) | $20 copay | $20 copay |
| Tier 3 (Preferred Brand) | $47 copay | $47 copay |
| Select Insulins | $35 copay | $35 copay |
| Tier 4 (Non-Preferred Drug) | 50% coinsurance | 50% coinsurance |
| Tier 5 (Specialty Tier) | 28% coinsurance | 26% coinsurance |

| Preferred Mail-Order Cost Sharing | | |
|---|---|---|
| **Tier** | **Three-month (90-day) supply** | **Three-month (90-day) supply** |
| Tier 1 (Preferred Generic) | $0 copay | $0 copay |
| Tier 2 (Generic) | $0 copay | $0 copay |
| Tier 3 (Preferred Brand) | $131 copay | $131 copay |
| Select Insulins | $105 copay | $105 copay |
| Tier 4 (Non-Preferred Drug) | 50% coinsurance | 50% coinsurance |
| Tier 5 (Specialty Tier) | A long-term supply is not available for drugs in Tier 5 | |

| Standard Mail-Order Cost Sharing | | |
|---|---|---|
| **Tier** | **Three-month (90-day) supply** | **Three-month (90-day) supply** |
| Tier 1 (Preferred Generic) | $30 copay | $45 copay |
| Tier 2 (Generic) | $60 copay | $60 copay |
| Tier 3 (Preferred Brand) | $141 copay | $141 copay |
| Select Insulins | $105 copay | $105 copay |
| Tier 4 (Non-Preferred Drug) | 50% coinsurance | 50% coinsurance |
| Tier 5 (Specialty Tier) | A long-term supply is not available for drugs in Tier 5 | |

**Coverage Gap**
After your total drug costs (including what our plan has paid and what you have paid) reach $4,660, you will pay no more than 25% coinsurance for generic drugs or 25% coinsurance for brand name drugs, for any drug tier during the coverage gap.

During the Coverage Gap stage, your out-of-pocket costs for Select Insulins will be a $35 copay for a one-month (30-day) supply or a $105 copay for a three-month (90-day) supply.

**Catastrophic Coverage**
After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail-order) reach $7,400, you pay the greater of:

- 5% coinsurance, or
- $4.15 copay for generic (including brand drugs treated as generic) and a $10.35 copay for all other drugs.

Cost sharing may differ based on type of pharmacy (retail, mail-order, long-term care (LTC)), whether the pharmacy is in our preferred or standard network, or whether the prescription is a short-term (one-month) or long-term (three-month) supply.

| | **Medica Advantage Solution H8889-004 (PPO)** | **Medica Advantage Solution H8889-008 (PPO)** |
|---|---|---|
| **ADDITIONAL BENEFITS AND SERVICES** | | |
| Annual Physical Exam | **In-Network**<br>$0 copay<br><br>**Out-of-Network**<br>30% of the total cost | **In-Network**<br>$0 copay<br><br>**Out-of-Network**<br>30% of the total cost |
| Cardiac Rehabilitation Services | **In-Network**<br>$30 copay<br><br>**Out-of-Network**<br>30% of the total cost | **In-Network**<br>$30 copay<br><br>**Out-of-Network**<br>30% of the total cost |
| Chiropractic Services | **In-Network**<br>$20 copay<br><br>**Out-of-Network**<br>30% of the total cost | **In-Network**<br>$20 copay<br><br>**Out-of-Network**<br>30% of the total cost |
| Diabetic Testing Supplies | $0 copay for diabetic testing supplies from specific manufacturers, LifeScan™ (OneTouch®) and Roche (Accu-Chek®) | $0 copay for diabetic testing supplies from specific manufacturers, LifeScan™ (OneTouch®) and Roche (Accu-Chek®) |
| Durable Medical Equipment (DME) and Related Supplies | **In-Network**<br>20% of the total cost<br>*<br><br>**Out-of-Network**<br>30% of the total cost | **In-Network**<br>20% of the total cost<br>*<br><br>**Out-of-Network**<br>30% of the total cost |
| eVisits<br>Services from virtuwell® | **In-Network**<br>$0 copay<br><br>**Out-of-Network**<br>Not covered | **In-Network**<br>$0 copay<br><br>**Out-of-Network**<br>Not covered |

| | Medica Advantage Solution H8889-004 (PPO) | Medica Advantage Solution H8889-008 (PPO) |
|---|---|---|
| Health and Wellness Education Program | | |
| One Pass™ Fitness Program and HealthAdvocate℠ 24-hour NurseLine | **In-Network**<br>$0 copay<br>**Out-of-Network**<br>Not covered | **In-Network**<br>$0 copay<br>**Out-of-Network**<br>Not covered |
| Home Health Agency Care | **In-Network**<br>$0 copay<br>**Out-of-Network**<br>30% of the total cost | **In-Network**<br>$0 copay<br>**Out-of-Network**<br>30% of the total cost |
| Outpatient Rehabilitation Services | **In-Network**<br>$30 copay<br>**Out-of-Network**<br>30% of the total cost | **In-Network**<br>$40 copay<br>**Out-of-Network**<br>30% of the total cost |
| Over-The-Counter (OTC) Drugs and Supplies | You are eligible for a $50 credit every quarter to be used toward the purchase of OTC health and wellness products from the OTC Health Solutions catalog. | You are eligible for a $50 credit every quarter to be used toward the purchase of OTC health and wellness products from the OTC Health Solutions catalog. |
| Podiatry Services | **In-Network**<br>$30 copay<br>**Out-of-Network**<br>30% of the total cost | **In-Network**<br>$45 copay<br>**Out-of-Network**<br>30% of the total cost |
| Pulmonary Rehabilitation Services | **In-Network**<br>$20 copay<br>**Out-of-Network**<br>30% of the total cost | **In-Network**<br>$20 copay<br>**Out-of-Network**<br>30% of the total cost |

| | Medica Advantage Solution H8889-004 (PPO) | Medica Advantage Solution H8889-008 (PPO) |
|---|---|---|
| Special Supplemental Benefits for the Chronically Ill | $0 copay<br>Members with chronic conditions who meet certain criteria may be eligible for supplemental benefits for the chronically ill. Benefit includes: | |
| The benefits mentioned are part of a special supplemental program for the chronically ill. Not all members qualify. | • Healthy Savings®<br>• Bathroom and home safety devices<br>• Meal benefit<br>• Transportation | • Healthy Savings®<br>• Bathroom and home safety devices<br>• Meal benefit<br>• Transportation |
| Visitor/Traveler Benefit | Visitor/Traveler benefit allows you to stay enrolled in the plan while you're temporarily and continuously outside of Minnesota (and within the U.S. and its territories) for not more than 6 consecutive months. You may receive all plan covered services at in-network cost sharing when using the Visitor/Traveler benefit. | |
| "Welcome to Medicare" Preventive Visit | **In-Network**<br>$0 copay<br><br>**Out-of-Network**<br>30% of the total cost | **In-Network**<br>$0 copay<br><br>**Out-of-Network**<br>30% of the total cost |
| Worldwide Emergency Care | 20% of the total cost | 20% of the total cost |
| Worldwide Emergency Transportation | 20% of the total cost | 20% of the total cost |

**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) 745-9919.** 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) 745-9919.** 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) 745-9919**。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) 745-9919**。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) 745-9919.** 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) 745-9919.** 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) 745-9919** 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) 745-9919.** 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) 745-9919** 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 (866) 745-9919.** 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 (866) 745-9919**. 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 (866) 745-9919** 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) 745-9919.** 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) 745-9919.** 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) 745-9919.** 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) 745-9919.** 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) 745-9919** 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。

Medica.

Medica is a PPO plan with a Medicare contract. Enrollment in Medica depends on contract renewal.

Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost sharing that applies to out-of-network services.