Medica

MINNESOTA - NORTH
Medica Advantage Solution® (PPO and HMO-POS) Plans

Summary of Benefits

January 1, 2024 – December 31, 2024

This is a summary of drug and health services covered by **Medica Advantage Solution H8889-005 (PPO w/Rx)**, **H8889-002 (PPO w/Rx)**, **H8889-009 (PPO medical only), and H6154-001 (HMO-POS w/Rx)**.

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 H8889-005 (PPO w/Rx)**, **H8889-002 (PPO w/Rx)**, **H8889-009 (PPO medical only), and H6154-001 (HMO-POS w/Rx)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Medica Advantage Solution** 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 Solution 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 (800) 918-2416 (TTY: 711).

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Things to Know About Medica Advantage Solution 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 Solution 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** plans you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

For PPO plans, our service area includes the following counties in **Minnesota**: Becker, Beltrami, Benton, Cass, Chippewa, Chisago, Clay, Clearwater, Crow Wing, Douglas, Grant, Hubbard, Isanti, Kandiyohi, Kittson, Lake of the Woods, Mahnomen, Marshall, Morrison, Norman, Otter Tail, Pennington, Polk, Pope, Red Lake, Renville, Roseau, Sherburne, Stearns, Swift, Todd, Wadena, Wilkin, and Wright.

For the HMO-POS plan, our service area includes the following counties in **Minnesota**: Becker, Cass, Chippewa, Chisago, Crow Wing, Douglas, Hubbard, Isanti, Kandiyohi, Otter Tail, Pope, Renville, Sherburne, Stearns, Swift, Todd, Wadena, and Wright.

Which doctors, hospitals, and pharmacies can I use?

Medica Advantage Solution plans have a network of doctors, hospitals, pharmacies, and other providers. You pay your lowest cost sharing when you visit an in-network provider. For PPO, you have coverage for services at out-of-network providers, but you may pay more. For HMO-POS, 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 for PPO that need approval in advance to be covered as in-network services are marked by an asterisk (*). Covered services for HMO-POS 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 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 H8889-005 (PPO w/Rx), H8889-002 (PPO w/Rx), and H6154-001 (HMO-POS w/Rx) cover 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, Medica.com/MyPlanDocs. Or, call us and we will send you a copy of the formulary.

Medica Advantage Solution H8889-009 (PPO 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, Medica.com/MyPlanDocs. Or, call us and we will send you a copy of the formulary.

SUMMARY OF BENEFITS

January 1, 2024 – December 31, 2024

	H8889-005 PPO w/Rx ($0)	**H8889-002 PPO w/Rx ($95)**	**H8889-009 PPO medical only ($0)**	**H6154-001 HMO-POS w/Rx ($0)**
MONTHLY PREMIUM, DEDUCTIBLE, AND MAXIMUMS ON HOW MUCH YOU PAY FOR COVERED SERVICES				
Monthly Plan Premium	$0	$95	$0	$0
Part B Premium Buy-Down	Not Applicable	Not Applicable	$60 per month	Not Applicable
Medical Deductible	No deductible			
Maximum Out-Of-Pocket Responsibility *(does not include prescription drugs)*	In-Network: $3,700 In-Network and Out-of-Network combined: $5,700	In-Network: $2,800 In-Network and Out-of-Network combined: $5,100	In-Network: $4,900 In-Network and Out-of-Network combined: $4,900	In-Network: $5,500 Out-of-Network: $7,500

	H8889-005 PPO w/Rx ($0)	**H8889-002 PPO w/Rx ($95)**	**H8889-009 PPO medical only ($0)**	**H6154-001 HMO-POS w/Rx ($0)**
COVERED MEDICAL AND HOSPITAL BENEFITS				
Inpatient Hospital Coverage In-Network	$350 copay each day for days 1 through 5 and $0 copay for days 6 through 90	$200 copay for each Medicare-covered hospital stay.	$245 copay each day for days 1 through 6 and $0 copay for days 7 through 90	$350 copay each day for days 1 through 5 and $0 copay for days 6 through 90

	H8889-005 PPO w/Rx ($0)	H8889-002 PPO w/Rx ($95)	H8889-009 PPO medical only ($0)	H6154-001 HMO-POS w/Rx ($0)
COVERED MEDICAL AND HOSPITAL BENEFITS				
	$0 copay for additional Medicare-covered days. *	$0 copay for additional Medicare-covered days. *	$0 copay for additional Medicare-covered days. *	$0 copay for additional Medicare-covered days. *
Out-of-Network	$425 copay each day for days 1 through 5 and $0 copay for days 6 through 90	$300 copay for each Medicare-covered hospital stay.	$295 copay each day for days 1 through 6 and $0 copay for days 7 through 90	40% of the total cost *
	$0 for additional Medicare-covered days.	$0 copay for additional Medicare-covered days.	$0 copay for additional Medicare-covered days.	
Outpatient Hospital Coverage	**Outpatient Hospital Services:**	**Outpatient Hospital Services:**	**Outpatient Hospital Services:**	**Outpatient Hospital Services:**
In-Network	$0 - $395 copay *	$0 - $250 copay *	$0 - $250 copay *	$395 copay *
Out-of-Network	$0 - $475 copay	$0 - $300 copay	$0 - $300 copay	40% of the total cost *
	Outpatient Hospital Observation Services:	**Outpatient Hospital Observation Services:**	**Outpatient Hospital Observation Services:**	**Outpatient Hospital Observation Services:**
In-Network	$350 copay each day	$200 copay per stay	$245 copay each day	$350 copay each day
Out-of-Network	$425 copay each day	$300 copay per stay	$295 copay each day	40% of the total cost
Ambulatory Surgery Center				
In-Network	$0 - $320 copay *	$0 - $175 copay *	$0 - $175 copay *	$320 copay *
Out-of-Network	$0 - $400 copay	$0 - $225 copay	$0 - $225 copay	40% of the total cost *

	H8889-005 PPO w/Rx ($0)	H8889-002 PPO w/Rx ($95)	H8889-009 PPO medical only ($0)	H6154-001 HMO-POS w/Rx ($0)
COVERED MEDICAL AND HOSPITAL BENEFITS				
Doctor Visits	**Primary Care Provider:**	**Primary Care Provider:**	**Primary Care Provider:**	**Primary Care Provider:**
In-Network	$0 copay	$0 copay	$0 copay	$0 copay
Out-of-Network	$20 copay	$15 copay	$30 copay	40% of the total cost
	Specialist:	**Specialist:**	**Specialist:**	**Specialist:**
In-Network	$35 copay	$25 copay	$30 copay	$45 copay
Out-of-Network	$50 copay	$40 copay	$50 copay	40% of the total cost
Preventive Care (e.g., Flu Vaccine, Diabetic Screenings)				
In-Network	$0 copay	$0 copay	$0 copay	$0 copay
Out-of-Network	$0 copay	$0 copay	$0 copay	40% of the total cost
Emergency Care	$120 copay Copay is waived if you are admitted to a hospital within 1 day within the U.S. and its territories.	$120 copay Copay is waived if you are admitted to a hospital within 1 day within the U.S. and its territories.	$120 copay Copay is waived if you are admitted to a hospital within 1 day within the U.S. and its territories.	$120 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 - $45 copay	$0 - $40 copay	$0 - $45 copay	$0 - $40 copay
Diagnostic and Therapeutic Services/ Labs/Imaging	**Diagnostic Tests and Procedures:**	**Diagnostic Tests and Procedures:**	**Diagnostic Tests and Procedures:**	**Diagnostic Tests and Procedures:**
In-Network	$30 copay for tests other than diagnostic colonoscopies, home-based sleep studies, and facility-based sleep studies. *	$20 copay for tests other than diagnostic colonoscopies, home-based sleep studies, and facility-based sleep studies. *	$20 copay for tests other than diagnostic colonoscopies, home-based sleep studies, and facility-based sleep studies. *	20% of the total cost Up to a maximum of $150 each day. *

	H8889-005 PPO w/Rx ($0)	H8889-002 PPO w/Rx ($95)	H8889-009 PPO medical only ($0)	H6154-001 HMO-POS w/Rx ($0)
COVERED MEDICAL AND HOSPITAL BENEFITS				
Out-of-Network	$30 copay	$20 copay	$20 copay	40% of the total cost *
In-Network	$0 copay for home-based sleep studies. $0 copay for diagnostic colonoscopies.	$0 copay for home-based sleep studies. $0 copay for diagnostic colonoscopies.	$0 copay for home-based sleep studies. $0 copay for diagnostic colonoscopies.	$0 copay for home-based sleep studies. 20% of the total cost for diagnostic colonoscopies. Up to a maximum of $150 each day. *
Out-of-Network	$0 copay	$0 copay	$0 copay	40% of the total cost for home-based sleep studies. 40% of the total cost for diagnostic colonoscopies. *
In-Network	$95 copay for facility-based sleep studies. *	$70 copay for facility-based sleep studies. *	$70 copay for facility-based sleep studies. *	20% of the total cost for facility-based sleep studies. Up to a maximum of $150 each day. *
Out-of-Network	$95 copay	$70 copay	$70 copay	40% of the total cost *
	Lab Services:	**Lab Services:**	**Lab Services:**	**Lab Services:**
In-Network	$0 copay *	$0 copay *	$0 copay *	$0 copay *
Out-of-Network	$0 copay	$0 copay	$0 copay	40% of the total cost *

	H8889-005 PPO w/Rx ($0)	H8889-002 PPO w/Rx ($95)	H8889-009 PPO medical only ($0)	H6154-001 HMO-POS w/Rx ($0)
COVERED MEDICAL AND HOSPITAL BENEFITS				
	Diagnostic Radiology Services (e.g., MRI, CAT Scan):	**Diagnostic Radiology Services (e.g., MRI, CAT Scan):**	**Diagnostic Radiology Services (e.g., MRI, CAT Scan):**	**Diagnostic Radiology Services (e.g., MRI, CAT Scan):**
In-Network	$30 copay for basic imaging	$20 copay for basic imaging	$20 copay for basic imaging	20% of the total cost Up to a maximum of $150 each day. *
Out-of-Network	$30 copay	$20 copay	$20 copay	40% of the total cost *
In-Network	$0 copay for diagnostic mammogram	$0 copay for diagnostic mammogram	$0 copay for diagnostic mammogram	
Out-of-Network	$0 copay	$0 copay	$0 copay	
In-Network	$95 copay for advanced imaging *	$70 copay for advanced imaging *	$70 copay for advanced imaging *	
Out-of-Network	$95 copay	$70 copay	$70 copay	
	Therapeutic Radiology Services:	**Therapeutic Radiology Services:**	**Therapeutic Radiology Services:**	**Therapeutic Radiology Services:**
In-Network	$60 copay *	$60 copay *	$60 copay *	20% of the total cost Up to a maximum of $150 each day. *
Out-of-Network	$60 copay	$60 copay	$60 copay	40% of the total cost *
	X-Rays:	**X-Rays:**	**X-Rays:**	**X-Rays:**
In-Network	$15 copay	$15 copay	$15 copay	20% of the total cost Up to a maximum of $150 each day.
Out-of-Network	$15 copay	$15 copay	$15 copay	40% of the total cost

	H8889-005 PPO w/Rx ($0)	H8889-002 PPO w/Rx ($95)	H8889-009 PPO medical only ($0)	H6154-001 HMO-POS w/Rx ($0)
COVERED MEDICAL AND HOSPITAL BENEFITS				
Hearing Services	**Exam to Diagnose and Treat Hearing and Balance Issues:**	**Exam to Diagnose and Treat Hearing and Balance Issues:**	**Exam to Diagnose and Treat Hearing and Balance Issues:**	**Exam to Diagnose and Treat Hearing and Balance Issues:**
In-Network	$0 - $25 copay	$0 - $25 copay	$0 - $25 copay	$25 copay
Out-of-Network	$20 - $40 copay	$0 - $40 copay	$0 - $40 copay	40% of the total cost
Hearing Services (Continued)	**Routine Hearing Exam – Services from EPIC® Hearing Providers:** Limited to 1 visit per calendar year.			
In-Network	$0 copay			
Out-of-Network	Not covered			
	Fitting Evaluation(s) for Hearing Aids – Services from EPIC® Hearing Providers: Limited to 1 visit every year for each Silver level hearing aid, and 3 visits every year for each Gold level hearing aid.			
In-Network	$0 copay per fitting-evaluation for hearing aid.			
Out-of-Network	Not covered			
	Hearing Aids – All Types Hearing Aids from EPIC® Hearing Providers: Unlimited hearing aids every year.			
In-Network	$549 copay per Silver level hearing aid and $799 copay per Gold level hearing aid.			
Out-of-Network	Not covered			
Dental Services	**Medicare-Covered Dental:**	**Medicare-Covered Dental:**	**Medicare-Covered Dental:**	**Medicare-Covered Dental:**
In-Network	$0 - $35 copay	$0 - $25 copay	$0 - $30 copay	20% of the total cost
Out-of-Network	$20 - $50 copay	$0 - $40 copay	$0 - $50 copay	40% of the total cost
	Preventive and Comprehensive Dental: Up to $750 allowance every calendar year for	**Preventive and Comprehensive Dental:** Up to $1,000 allowance every calendar year for	**Preventive and Comprehensive Dental:** Up to $1,000 allowance every calendar year for	**Preventive and Comprehensive Dental:** Up to $400 allowance every calendar year for

	H8889-005 PPO w/Rx ($0)	H8889-002 PPO w/Rx ($95)	H8889-009 PPO medical only ($0)	H6154-001 HMO-POS w/Rx ($0)
COVERED MEDICAL AND HOSPITAL BENEFITS				
	non-Medicare-covered preventive and comprehensive dental services from a licensed dentist provider that accepts Visa® at time of payment using the Health+ by Medica card.	non-Medicare-covered preventive and comprehensive dental services from a licensed dentist provider that accepts Visa® at time of payment using the Health+ by Medica card.	non-Medicare-covered preventive and comprehensive dental services from a licensed dentist provider that accepts Visa® at time of payment using the Health+ by Medica card.	non-Medicare-covered preventive and comprehensive dental services from a licensed dentist provider that accepts Visa® at time of payment using the Health+ by Medica card.
Vision Services	**Exam to Diagnose and Treat Diseases and Conditions of the Eye:**	**Exam to Diagnose and Treat Diseases and Conditions of the Eye:**	**Exam to Diagnose and Treat Diseases and Conditions of the Eye:**	**Exam to Diagnose and Treat Diseases and Conditions of the Eye:**
In-Network	$35 copay	$25 copay	$30 copay	$45 copay
Out-of-Network	$50 copay	$40 copay	$50 copay	40% of the total cost
	Routine Eye Exam:	**Routine Eye Exam:**	**Routine Eye Exam:**	**Routine Eye Exam:**
	Limited to 1 visit every calendar year and up to 2 refractions per year.	Limited to 1 routine eye exam per year; and up to 2 refractions per year.	Limited to 1 visit every calendar year and up to 2 refractions per year.	Limited to 1 routine eye exam per year; and up to 2 refractions per year.
In-Network	$0 copay	$0 copay	$0 copay	$0 copay
Out-of-Network	$0 copay	$0 copay	$0 copay	Not covered
	Eyewear After Cataract Surgery:	**Eyewear After Cataract Surgery:**	**Eyewear After Cataract Surgery:**	**Eyewear After Cataract Surgery:**
	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.	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.
In-Network	$0 copay	$0 copay	$0 copay	$0 copay
Out-of-Network	$0 copay	$0 copay	$0 copay	40% of the total cost

	H8889-005 PPO w/Rx ($0)	H8889-002 PPO w/Rx ($95)	H8889-009 PPO medical only ($0)	H6154-001 HMO-POS w/Rx ($0)
COVERED MEDICAL AND HOSPITAL BENEFITS				
	Contact Lenses, Eyeglasses (Lenses and/or Frames), and Upgrades: Up to $200 allowance every calendar year for non-Medicare-covered eyewear from an eyewear location or freestanding vision center that accepts Visa® at point of sale using the Health+ by Medica card.	**Contact Lenses, Eyeglasses (Lenses and/or Frames), and Upgrades:** Up to $300 allowance every calendar year for non-Medicare-covered eyewear from an eyewear location or freestanding vision center that accepts Visa® at point of sale using the Health+ by Medica card.	**Contact Lenses, Eyeglasses (Lenses and/or Frames), and Upgrades:** Up to $200 allowance every calendar year for non-Medicare-covered eyewear from an eyewear location or freestanding vision center that accepts Visa® at point of sale using the Health+ by Medica card.	**Contact Lenses, Eyeglasses (Lenses and/or Frames), and Upgrades:** Up to $100 allowance every calendar year for non-Medicare-covered eyewear from an eyewear location or freestanding vision center that accepts Visa® at point of sale using the Health+ by Medica card.
Mental Health Services	**Outpatient Individual and Group Therapy Visit:**	**Outpatient Individual and Group Therapy Visit:**	**Outpatient Individual and Group Therapy Visit:**	**Outpatient Individual and Group Therapy Visit:**
In-Network	$35 copay	$25 copay	$30 copay	$40 copay
Out-of-Network	$50 copay	$40 copay	$50 copay	Not covered
	Inpatient Hospital:	**Inpatient Hospital:**	**Inpatient Hospital:**	**Inpatient Hospital:**
In-Network	$350 copay each day for days 1 through 5 and $0 copay for days 6 through 90 $0 copay for up to an additional 60 lifetime reserve days. *	$200 copay for each Medicare-covered hospital stay. $0 copay for up to an additional 60 lifetime reserve days. *	$245 copay each day for days 1 through 6 and $0 copay for days 7 through 90 $0 copay for up to an additional 60 lifetime reserve days. *	$350 copay each day for days 1 through 5 and $0 copay for days 6 through 90 $0 copay for up to an additional 60 lifetime reserve days. *
Out-of-Network	$425 copay each day for days 1 through 5 and $0 copay for days 6 through 90	$300 copay for each Medicare-covered hospital stay.	$295 copay each day for days 1 through 6 and $0 copay for days 7 through 90	40% of the total cost *

	H8889-005 PPO w/Rx ($0)	H8889-002 PPO w/Rx ($95)	H8889-009 PPO medical only ($0)	H6154-001 HMO-POS w/Rx ($0)
COVERED MEDICAL AND HOSPITAL BENEFITS				
	$0 copay for up to an additional 60 lifetime reserve days.	$0 copay for up to an additional 60 lifetime reserve days.	$0 copay for up to an additional 60 lifetime reserve days.	
Skilled Nursing Facility (SNF)				
In-Network	$0 copay for days 1 through 20, a $203 copay each day for days 21 through 39, and $0 copay for days 40 through 100 *	$0 copay for days 1 through 20, a $203 copay each day for days 21 through 34, and $0 copay for days 35 through 100 *	$0 copay for days 1 through 20, a $203 copay each day for days 21 through 45, and $0 copay for days 46 through 100 *	$0 copay for days 1 through 20, a $203 copay each day for days 21 through 48, and $0 copay for days 49 through 100 *
Out-of-Network	$100 copay each day for days 1 through 20, a $203 copay each day for days 21 through 39, and $0 copay for days 40 through 100	$100 copay each day for days 1 through 20, a $203 copay each day for days 21 through 34, and $0 copay for days 35 through 100	$100 copay each day for days 1 through 20, a $203 copay each day for days 21 through 45, and $0 copay for days 46 through 100	40% of the total cost *
Physical Therapy				
In-Network	$35 copay	$25 copay	$30 copay	$40 copay
Out-of-Network	$50 copay	$40 copay	$50 copay	40% of the total cost
Ambulance Services	**Ground Ambulance:** $265 copay **Air Ambulance:** 20% of the total cost	**Ground Ambulance:** $290 copay **Air Ambulance:** $290 copay	**Ground Ambulance:** $265 copay **Air Ambulance:** 20% of the total cost	**Ground Ambulance:** $265 copay **Air Ambulance:** 20% of the total cost
Transportation	Not covered			

	H8889-005 PPO w/Rx ($0)	H8889-002 PPO w/Rx ($95)	H8889-009 PPO medical only ($0)	H6154-001 HMO-POS w/Rx ($0)
COVERED MEDICAL AND HOSPITAL BENEFITS				
Medicare Part B Drugs Part B rebatable drugs may be subject to a lower coinsurance. For Part B insulin furnished through an external infusion pump, you will pay no more than a $35 copay per a one-month supply.				
In-Network	20% of the total cost *	20% of the total cost *	20% of the total cost *	20% of the total cost *
Out-of-Network	30% of the total cost	30% of the total cost	30% of the total cost	40% of the total cost *

	H8889-005 PPO w/Rx ($0)	H8889-002 PPO w/Rx ($95)	H8889-009 PPO medical only ($0)	H6154-001 HMO-POS w/Rx ($0)
PART D PRESCRIPTION DRUG BENEFITS				
Deductible Stage You pay the full cost of your drugs until you reach this amount. The deductible does not apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus and travel vaccines. You will start receiving coverage immediately.	Tiers 1 & 2 = $0 Tiers 3-5 = $345	Tiers 1-3 = $0 Tiers 4 & 5 = $245	NA	Tiers 1 & 2 = $0 Tiers 3-5 = $545
Initial Coverage Stage	You will stay in this stage until your total drug costs (including what our plan has paid and what you have paid) reach $5,030. In this stage you will pay no more than a $35 copay for a one-month (30-day) supply or a $105 copay for a three-month (90-day) supply for insulin.		NA	You will stay in this stage until your total drug costs (including what our plan has paid and what you have paid) reach $5,030. In this stage you will pay no more than a $35 copay for a one-month (30-day) supply or a $105 copay for a three-month (90-day) supply for insulin.

	H8889-005 PPO w/Rx ($0)	H8889-002 PPO w/Rx ($95)	H8889-009 PPO medical only ($0)	H6154-001 HMO-POS w/Rx ($0)
PREFERRED RETAIL COST SHARING				
Tiers	**1-Month (30-day) supply**	**1-Month (30-day) supply**	**1-Month (30-day) supply**	**1-Month (30-day) supply**
Tier 1 (Preferred Generic)	$0 copay	$0 copay	NA	$0 copay
Tier 2 (Generic)	$14 copay	$10 copay	NA	$14 copay
Tier 3 (Preferred Brand)	$47 copay	$47 copay	NA	$47 copay
Tier 4 (Non-Preferred Drug)	50% coinsurance	46% coinsurance	NA	47% coinsurance
Tier 5 (Specialty Tier)	28% coinsurance	29% coinsurance	NA	25% coinsurance
Insulin	You won’t pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.			

	H8889-005 PPO w/Rx ($0)	H8889-002 PPO w/Rx ($95)	H8889-009 PPO medical only ($0)	H6154-001 HMO-POS w/Rx ($0)
STANDARD RETAIL COST SHARING				
Tiers	**1-Month (30-day) supply**	**1-Month (30-day) supply**	**1-Month (30-day) supply**	**1-Month (30-day) supply**
Tier 1 (Preferred Generic)	$10 copay	$10 copay	NA	$15 copay
Tier 2 (Generic)	$20 copay	$20 copay	NA	$20 copay
Tier 3 (Preferred Brand)	$47 copay	$47 copay	NA	$47 copay
Tier 4 (Non-Preferred Drug)	50% coinsurance	46% coinsurance	NA	47% coinsurance
Tier 5 (Specialty Tier)	28% coinsurance	29% coinsurance	NA	25% coinsurance
Insulin	You won’t pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.			

	H8889-005 PPO w/Rx ($0)	H8889-002 PPO w/Rx ($95)	H8889-009 PPO medical only ($0)	H6154-001 HMO-POS w/Rx ($0)
PREFERRED MAIL-ORDER COST SHARING				
Tiers	**3-Month (90-day) supply**	**3-Month (90-day) supply**	**3-Month (90-day) supply**	**3-Month (90-day) supply**
Tier 1 (Preferred Generic)	$0 copay	$0 copay	NA	$0 copay
Tier 2 (Generic)	$0 copay	$0 copay	NA	$32 copay
Tier 3 (Preferred Brand)	$131 copay	$131 copay	NA	$131 copay
Tier 4 (Non-Preferred Drug)	50% coinsurance	46% coinsurance	NA	47% coinsurance
Tier 5 (Specialty Tier)	NA	NA	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.			

	H8889-005 PPO w/Rx ($0)	H8889-002 PPO w/Rx ($95)	H8889-009 PPO medical only ($0)	H6154-001 HMO-POS w/Rx ($0)
STANDARD MAIL-ORDER COST SHARING				
Tiers	**3-Month (90-day) supply**	**3-Month (90-day) supply**	**3-Month (90-day) supply**	**3-Month (90-day) supply**
Tier 1 (Preferred Generic)	$30 copay	$30 copay	NA	$45 copay
Tier 2 (Generic)	$60 copay	$60 copay	NA	$60 copay
Tier 3 (Preferred Brand)	$141 copay	$141 copay	NA	$141 copay
Tier 4 (Non-Preferred Drug)	50% coinsurance	46% coinsurance	NA	47% coinsurance
Tier 5 (Specialty Tier)	NA	NA	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.			

	H8889-005 PPO w/Rx ($0)	H8889-002 PPO w/Rx ($95)	H8889-009 PPO medical only ($0)	H6154-001 HMO-POS w/Rx ($0)
PART D COVERAGE STAGES				
Coverage Gap Stage	The Coverage Gap begins after your total drug costs (including what our plan has paid and what you have paid) reach $5,030. After you enter the Coverage Gap, you pay 25% of the plan's cost for covered generic or brand name drugs on any tier until your total yearly drug costs reach $8,000, which is the end of the Coverage Gap. Not everyone will enter the Coverage Gap. During the Coverage Gap stage, you will not pay more than a $35 copay for a one-month (30-day) supply or a $105 copay for a three-month (90-day) supply for covered insulin products.		NA	The Coverage Gap begins after your total drug costs (including what our plan has paid and what you have paid) reach $5,030. After you enter the Coverage Gap, you pay 25% of the plan's cost for covered generic or brand name drugs on any tier until your total yearly drug costs reach $8,000, which is the end of the Coverage Gap. Not everyone will enter the Coverage Gap. During the Coverage Gap stage, you will not pay more than a $35 copay for a one-month (30-day) supply or a $105 copay for a three-month (90-day) supply for covered insulin products.
Catastophic Stage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $8,000, the plan pays the full cost for your covered Part D drugs. You pay nothing.		NA	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $8,000, the plan pays the

	H8889-005 PPO w/Rx ($0)	H8889-002 PPO w/Rx ($95)	H8889-009 PPO medical only ($0)	H6154-001 HMO-POS w/Rx ($0)
PART D COVERAGE STAGES				
				full cost for your covered Part D drugs. You pay nothing.

	H8889-005 PPO w/Rx ($0)	H8889-002 PPO w/Rx ($95)	H8889-009 PPO medical only ($0)	H6154-001 HMO-POS w/Rx ($0)
ADDITIONAL BENEFITS AND SERVICES				
Annual Physical Exam				
In-Network	$0 copay	$0 copay	$0 copay	$0 copay
Out-of-Network	$0 copay	$0 copay	$0 copay	Not covered
Cardiac Rehabilitation Services				
In-Network	$30 copay	$25 copay	$30 copay	$30 copay
Out-of-Network	$50 copay	$40 copay	$50 copay	Not covered
Chiropractic Services				
In-Network	$20 copay	$20 copay	$20 copay	$20 copay
Out-of-Network	$40 copay	$40 copay	$40 copay	Not covered
Diabetic Testing Supplies	$0 copay for diabetic testing supplies from specific manufacturers, LifeScan™ (OneTouch®) and Roche (Accu-Chek®)			

	H8889-005 PPO w/Rx ($0)	H8889-002 PPO w/Rx ($95)	H8889-009 PPO medical only ($0)	H6154-001 HMO-POS w/Rx ($0)
ADDITIONAL BENEFITS AND SERVICES				
Durable Medical Equipment (DME) and Related Supplies				
In-Network	20% of the total cost *	20% of the total cost *	20% of the total cost *	20% of the total cost *
Out-of-Network	30% of the total cost	30% of the total cost	30% of the total cost	Not covered
eVisits Services from virtuwell®				
In-Network	$0 copay	$0 copay	Not covered	$0 copay
Out-of-Network	Not covered	Not covered	Not covered	Not covered
Health and Wellness Education Programs	**HealthAdvocate℠ 24-hour NurseLine:** $0 copay **One Pass™ Fitness Program:** $0 annual fee			
Health+ by Medica Card	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.			
Home Health Agency Care				
In-Network	$0 copay	$0 copay	$0 copay	$0 copay
Out-of-Network	30% of the total cost	30% of the total cost	30% of the total cost	40% of the total cost
Outpatient Rehabilitation Services				
In-Network	$35 copay	$25 copay	$30 copay	$40 copay
Out-of-Network	$50 copay	$40 copay	$50 copay	40% of the total cost

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ADDITIONAL BENEFITS AND SERVICES				
Over-The-Counter (OTC) Drugs and Supplies	You are eligible for a $75 allowance every quarter by using the Health+ by Medica card at participating retailers, online, or over the phone.	You are eligible for a $75 allowance every quarter by using the Health+ by Medica card at participating retailers, online, or over the phone.	You are eligible for a $75 allowance every quarter by using the Health+ by Medica card at participating retailers, online, or over the phone.	You are eligible for a $40 allowance every quarter by using the Health+ by Medica card at participating retailers, online, or over the phone.
Podiatry Services				
In-Network	$35 copay	$25 copay	$30 copay	$45 copay
Out-of-Network	$50 copay	$40 copay	$50 copay	40% of the total cost
Pulmonary Rehabilitation Services				
In-Network	$15 copay	$20 copay	$15 copay	$15 copay
Out-of-Network	$50 copay	$40 copay	$50 copay	Not covered
Special Supplemental Benefits for the Chronically Ill The benefits mentioned are part of a special supplemental program for the chronically ill. Not all members qualify.				
In-Network	$0 copay Members with chronic conditions who meet certain criteria may be eligible for supplemental benefits for the	$0 copay Members with chronic conditions who meet certain criteria may be eligible for supplemental benefits for the	$0 copay Members with chronic conditions who meet certain criteria may be eligible for supplemental benefits for the	Not covered

	H8889-005 PPO w/Rx ($0)	H8889-002 PPO w/Rx ($95)	H8889-009 PPO medical only ($0)	H6154-001 HMO-POS w/Rx ($0)
ADDITIONAL BENEFITS AND SERVICES				
	chronically ill. Benefit includes: • Bathroom and home safety devices • Meal benefit • Transportation	chronically ill. Benefit includes: • Bathroom and home safety devices • Meal benefit • Transportation	chronically ill. Benefit includes: • Bathroom and home safety devices • Meal benefit	
Out-of-Network	$0 copay	$0 copay	$0 copay	Not covered
Visitor/Traveler Benefit	Visitor/Traveler benefit allows you to stay enrolled in the plan while you're temporarily and continuously outside of the service area (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	$0 copay	$0 copay	$0 copay	$0 copay
Out-of-Network	$0 copay	$0 copay	$0 copay	40% of the total cost
Worldwide Emergency Care	20% of the total cost			
Worldwide Emergency Transportation	20% of the total cost			

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 (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 الفور ية المجانية للإجابة ع 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.

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 (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。

Discrimination is Against the Law

Medica complies with applicable Federal civil rights laws and will not discriminate against any person based on his or her race, color, creed, religion, national origin, sex, gender, gender identity, health status including mental and physical medical conditions, marital status, familial status, status with regard to public assistance, disability, sexual orientation, age, political beliefs, membership or activity in a local commission, or any other classification protected by law. Medica:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: TTY communication and written information in other formats such as large print, audio, and braille.
- Provides free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact the number on the back of your identification card. If you believe that Medica has failed to provide these services or discriminated in another way on the basis of your race, color, creed, religion, national origin, sex, gender, gender identity, health status including mental and physical medical conditions, marital status, familial status, status with regard to public assistance, disability, sexual orientation, age, political beliefs, membership or activity in a local commission, or any other classification protected by law, you can file a grievance with: Civil Rights Coordinator, Mail Route CP250, PO Box 9310, Minneapolis, MN 55443-9310, 952-992-3422, TTY: 711, civilrightscoordinator@medica.com.

You can file a grievance in person or by mail, fax, or email. You may also contact the Civil Rights Coordinator if you need assistance with filing a complaint. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201 800-368-1019, TTY: 800-537-7697. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Medica.

Medica is a PPO plan and an HMO-POS plan with a Medicare contract. Enrollment in Medica depends on contract renewal.

Health+ by Medica Card: Card can only be used for Qualified Purchases indicated by your plan provider everywhere Visa® debit cards are accepted. Card is issued by Sutton Bank, pursuant to a license from Visa U.S.A. Inc. Please contact your Program Sponsor directly for a full list of Qualified Purchases. Visa is a registered trademark of Visa, U.S.A. Inc. All other trademarks and service marks belong to their respective owners. No Cash or ATM Access. Terms and conditions apply, contact your Plan Provider for details.

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.