WISCONSIN Medical with Part D
Medica Prime Solution® (Cost) Plans

Summary of Benefits

January 1 – December 31, 2024

This is a summary of drug and health services covered by **Medica Prime Solution Thrift w/Rx, Focus w/Rx, and Total 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 Cost plan (such as **Medica Prime Solution Thrift w/Rx**, **Focus w/Rx**, **or Total w/Rx**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Medica Prime 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 Prime 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) 918-2143 (TTY: 711).

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Things to Know About Medica Prime 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 Prime Solution Phone Numbers and Website

- If you are a member of this plan, call toll-free 1 (800) 234-8755 (TTY: 711).
- If you are not a member of this plan, call toll-free 1 (800) 918-2143 (TTY: 711).
- Our website: Medica.com/Medicare

Who Can Join?

To join **Medica Prime Solution** plans, you must be enrolled in Medicare Part B (or have both Medicare Part A and Medicare Part B), and live in our service area.

Our service area includes the following counties in **Wisconsin**: Ashland, Barron, Bayfield, Buffalo, Burnett, Chippewa, Douglas, Dunn, Eau Claire, Iron, Jackson, Pepin, Pierce, Polk, Rusk, Sawyer, St. Croix, and Washburn.

Which doctors, hospitals, and pharmacies can I use?

Medica Prime Solution plans have a network of doctors, hospitals, pharmacies, and other providers. If you use the providers in our network, you may pay less for your covered services. But if you want to, you can also use providers that are not in our network.

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.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. You may search for network providers and pharmacies on our website at Medica.com/GetMyDocs. Or, call us and we will send you a copy of the provider and pharmacy directories.

What do we cover?

Medica Prime Solution plan members get all of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare. For others, you may pay less.

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/GetMyDocs. Or, call us and we will send you a copy of the formulary.

SUMMARY OF BENEFITS

January 1, 2024 – December 31, 2024

	Thrift w/Rx ($79.70)	Focus w/Rx ($141.80)	Total w/Rx ($266.50)
MONTHLY PREMIUM, DEDUCTIBLE, AND MAXIMUMS ON HOW MUCH YOU PAY FOR COVERED SERVICES			
Monthly Plan Premium	$79.70 per month	$141.80 per month	$266.50 per month
Wisconsin Rider	Not applicable	Not applicable	$39.00 per month
Medical Deductible	$50 per year	No deductible	No deductible
Maximum Out-Of-Pocket Responsibility *(does not include prescription drugs)*	You pay no more than $6,700 annually for services you receive from in-network providers.	You pay no more than $4,000 annually for services you receive from in-network providers.	You pay no more than $3,000 annually for services you receive from in-network providers.

	Thrift w/Rx ($79.70)	Focus w/Rx ($141.80)	Total w/Rx ($266.50)
COVERED MEDICAL AND HOSPITAL BENEFITS			
Inpatient Hospital Coverage	$300 copay per day for days 1 through 4 $0 copay per day for days 5 through 90 $0 copay for up to 60 Medicare-covered lifetime reserve days.	$300 copay per stay Our plan covers an unlimited number of days for an inpatient hospital stay.	$250 copay per stay Our plan covers an unlimited number of days for an inpatient hospital stay.
Outpatient Hospital Coverage	20% of the total cost for outpatient surgery 20% of the total cost per stay for observation services	$250 copay for outpatient surgery $250 copay per stay for observation services	$150 copay for outpatient surgery $150 copay per stay for observation services
Ambulatory Surgery Center	20% of the total cost	$150 copay	$100 copay

	Thrift w/Rx ($79.70)	Focus w/Rx ($141.80)	Total w/Rx ($266.50)
COVERED MEDICAL AND HOSPITAL BENEFITS			
Doctor Visits	**Primary Care Physician:** 20% of the total cost **Specialist:** 20% of the total cost	**Primary Care Physician:** $0 copay **Specialist:** $15 copay	**Primary Care Physician:** $0 copay **Specialist:** $10 copay
Preventive Care (e.g., flu and pneumonia vaccines, diabetic screenings, colorectal cancer screenings)	$0 copay Other preventive services are available. There are some covered services that have a cost.	$0 copay Other preventive services are available. There are some covered services that have a cost.	$0 copay Other preventive services are available. There are some covered services that have a cost.
Emergency Care	$50 copay	$75 copay (worldwide) Copay is waived if you are admitted to the hospital within 24 hours (U.S. only).	$75 copay (worldwide) Copay is waived if you are admitted to the hospital within 24 hours (U.S. only).
Urgently Needed Services	$25 copay for convenience care/retail clinic and traditional urgent care clinic.	$0 copay for convenience care/retail clinic $20 copay for traditional urgent care clinic	$0 copay for convenience care/retail clinic $10 copay for traditional urgent care clinic
Diagnostic and Therapeutic Services/ Labs/Imaging	**Diagnostic and Therapeutic Radiology Services:** 20% of the total cost	**Diagnostic Radiology Services:** $30 copay for services received during an office visit. $150 copay for services received at an outpatient facility. **Therapeutic Radiology Services:** $30 copay	**Diagnostic Radiology Services:** $10 copay for services received during an office visit. $50 copay for services received at an outpatient facility. **Therapeutic Radiology Services:** $10 copay

	Thrift w/Rx ($79.70)	Focus w/Rx ($141.80)	Total w/Rx ($266.50)
COVERED MEDICAL AND HOSPITAL BENEFITS			
	Diagnostic Tests and Procedures, and X-rays: 20% of the total cost **Lab Services:** $0 copay	**Diagnostic Tests and Procedures:** $0 copay for services received during a primary care doctor office visit. $15 copay for services received at a specialist's office or outpatient facility. **X-rays:** $10 copay **Lab Services:** $0 copay	**Diagnostic Tests and Procedures:** $0 copay for services received during a primary care doctor office visit. $10 copay for services received at a specialist's office or outpatient facility. **X-rays:** $0 copay **Lab Services:** $0 copay
Hearing Services	**Exam to Diagnose and Treat Hearing and Balance Issues:** 20% of the total cost	**Exam to Diagnose and Treat Hearing and Balance Issues:** $0 copay for primary care doctor visits and $15 copay for specialist visits. **Routine Hearing Exam (Up To 1 Every Year):** $0 copay **Hearing Aid Fitting/ Evaluation and Hearing Aids:** Our plan will reimburse up to $400 every calendar year.	**Exam to Diagnose and Treat Hearing and Balance Issues:** $0 copay for primary care doctor visits and $10 copay for specialist visits. **Routine Hearing Exam (Up To 1 Every Year):** $0 copay **Hearing Aid Fitting/ Evaluation and Hearing Aids:** Our plan will reimburse up to $400 every calendar year.
Dental Services	20% of the total cost for Medicare-covered dental services.	$0 copay for primary care doctor visits and $15 copay for specialist visits for Medicare-covered dental services. Our plan will reimburse up to $300 every	$0 copay for primary care doctor visits and $10 copay for specialist visits for Medicare-covered dental services. Our plan will reimburse up to $400 every

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COVERED MEDICAL AND HOSPITAL BENEFITS			
		calendar year for non-Medicare-covered dental services from any licensed dentist within the U.S. and its territories.	calendar year for non-Medicare-covered dental services from any licensed dentist within the U.S. and its territories.
Vision Services	**Exam to Diagnose and Treat Diseases and Conditions of the Eye:** 20% of the total cost	**Exam to Diagnose and Treat Diseases and Conditions of the Eye:** $0 copay for primary care doctor visits and $15 copay for specialist visits.	**Exam to Diagnose and Treat Diseases and Conditions of the Eye:** $0 copay for primary care doctor visits and $10 copay for specialist visits.
	Medicare-covered Glaucoma and Diabetic Retinopathy Screening: 20% of the total cost	**Medicare-covered Glaucoma and Diabetic Retinopathy Screening:** $0 copay	**Medicare-covered Glaucoma and Diabetic Retinopathy Screening:** $0 copay
		Routine Eye Exam (1 routine eye exam every year; and up to 2 refractions per year): $0 copay	**Routine Eye Exam (1 routine eye exam every year; and up to 2 refractions per year):** $0 copay
	Medicare-covered Eyeglasses or Contact Lenses After Cataract Surgery: 20% of the total cost	**Medicare-covered Eyeglasses or Contact Lenses After Cataract Surgery:** $30 copay	**Medicare-covered Eyeglasses or Contact Lenses After Cataract Surgery:** $30 copay
		Contact Lenses, Eyeglasses (Frames and Lenses): Our plan will reimburse up to $100 for non-Medicare-covered eyewear per calendar year.	**Contact Lenses, Eyeglasses (Frames and Lenses):** Our plan will reimburse up to $200 for non-Medicare-covered eyewear per calendar year.

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COVERED MEDICAL AND HOSPITAL BENEFITS			
Mental Health Services (including inpatient)	**Inpatient Visit:** $300 copay per day for days 1 through 4 $0 copay per day for days 5 through 90 **For Services Provided by a Psychiatrist or Other Mental Health Care Providers:** 20% of the total cost for individual therapy/ group therapy visits.	**Inpatient visit:** $300 copay per Medicare-covered stay Our plan also adds 175 days of coverage to the Medicare lifetime limit of 190 days for inpatient services received in a psychiatric hospital. **For Services Provided by a Psychiatrist:** $15 copay for individual therapy/ group therapy visits. **For Services Provided by Other Mental Health Care Providers:** $0 copay for individual therapy/group therapy visits.	**Inpatient visit:** $250 copay per Medicare-covered stay Our plan also adds 175 days of coverage to the Medicare lifetime limit of 190 days for inpatient services received in a psychiatric hospital. **For Services Provided by a Psychiatrist:** $10 copay for individual therapy/ group therapy visits. **For Services Provided by Other Mental Health Care Providers:** $0 copay for individual therapy/group therapy visits.
Skilled Nursing Facility (SNF)	$0 copay per day for days 1 through 20 $204 copay per day for days 21 through 100 Our plan covers up to 100 days in a SNF	$0 copay per day for days 1 through 20 $50 copay per day for days 21 through 100 Our plan covers up to 100 days in a SNF	$0 copay per day for days 1 through 20 $50 copay per day for days 21 through 100 Our plan covers up to 100 days in a SNF
Physical Therapy	20% of the total cost	$15 copay per visit	$10 copay per visit
Ambulance	20% of the total cost per ground or air trip	$50 copay per ground trip $100 copay per air trip	$0 copay per ground trip $50 copay per air trip
Transportation (non-emergency)	Not covered		

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COVERED MEDICAL AND HOSPITAL BENEFITS			
Medicare Part B Drugs	20% of the total cost Part B rebatable drugs may be subject to a lower coinsurance. For Part B insulin furnished through an external insulin pump, you will pay no more than a $35 copay per a one-month supply. Plan level deductibles do not apply.	20% of the total cost Part B rebatable drugs may be subject to a lower coinsurance. For Part B insulin furnished through an external insulin pump, you will pay no more than a $35 copay per a one-month supply.	20% of the total cost Part B rebatable drugs may be subject to a lower coinsurance. $0 for a one-month supply of insulin administered through an external insulin pump.

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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.	All Tiers = $545 Plan level deductibles do not apply.	Tier 1 & 2 = $0 Tiers 3-5 = $545	Tier 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.		

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PREFERRED RETAIL COST SHARING			
Tiers	**1-Month (30-day) supply**	**1-Month (30-day) supply**	**1-Month (30-day) supply**
Tier 1 (Preferred Generic)	$10 copay	$2 copay	$0 copay
Tier 2 (Generic)	$15 copay	$10 copay	$10 copay
Tier 3 (Preferred Brand)	$47 copay	$40 copay	$40 copay
Tier 4 (Non-Preferred Drug)	50% of the total cost	50% of the total cost	50% of the total cost
Tier 5 (Specialty Tier)	25% of the total cost	25% of the total cost	25% of the total cost
Insulin	You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.		

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STANDARD RETAIL COST SHARING			
Tiers	**1-Month (30-day) supply**	**1-Month (30-day) supply**	**1-Month (30-day) supply**
Tier 1 (Preferred Generic)	$15 copay	$10 copay	$10 copay
Tier 2 (Generic)	$20 copay	$20 copay	$20 copay
Tier 3 (Preferred Brand)	$47 copay	$47 copay	$47 copay
Tier 4 (Non-Preferred Drug)	50% of the total cost	50% of the total cost	50% of the total cost
Tier 5 (Specialty Tier)	25% of the total cost	25% of the total cost	25% of the total cost
Insulin	You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.		

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PREFERRED MAIL-ORDER COST SHARING			
Tiers	**3-Month (90-day) supply**	**3-Month (90-day) supply**	**3-Month (90-day) supply**
Tier 1 (Preferred Generic)	$20 copay	$4 copay	$0 copay
Tier 2 (Generic)	$30 copay	$20 copay	$20 copay
Tier 3 (Preferred Brand)	$94 copay	$80 copay	$80 copay
Tier 4 (Non-Preferred Drug)	50% of the total cost	50% of the total cost	50% of the total cost
Tier 5 (Specialty Tier)	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.		

	Thrift w/Rx ($79.70)	Focus w/Rx ($141.80)	Total w/Rx ($266.50)
STANDARD MAIL-ORDER COST SHARING			
Tiers	**3-Month (90-day) supply**	**3-Month (90-day) supply**	**3-Month (90-day) supply**
Tier 1 (Preferred Generic)	$45 copay	$30 copay	$30 copay
Tier 2 (Generic)	$60 copay	$60 copay	$60 copay
Tier 3 (Preferred Brand)	$141 copay	$141 copay	$141 copay
Tier 4 (Non-Preferred Drug)	50% of the cost	50% of the cost	50% of the cost
Tier 5 (Specialty Tier)	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.		

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PART D COVERAGE STAGES			
Coverage Gap Stage	The Coverage Gap begins after the 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.		
Catastrophic 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.		

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ADDITIONAL BENEFITS AND SERVICES			
Chiropractic Care	20% of the total cost for Medicare-covered chiropractic services.	$15 copay for Medicare-covered chiropractic services.	$10 copay for Medicare-covered chiropractic services.
eVisits by Amwell®	Not covered	$0 copay	$0 copay
Extended Absence Benefit	Extended Absence benefit allows you to stay enrolled in the plan while you're temporarily and continuously outside of your plan's service area (and within the U.S. and its territories) for not more than 9 consecutive months. You may receive all plan covered services at in-network cost sharing	Extended Absence benefit allows you to stay enrolled in the plan while you're temporarily and continuously outside of your plan's service area (and within the U.S. and its territories) for not more than 9 consecutive months. You may receive all plan covered services at in-network cost sharing	Extended Absence benefit allows you to stay enrolled in the plan while you're temporarily and continuously outside of your plan's service area (and within the U.S. and its territories) for not more than 9 consecutive months. You may receive all plan covered services at in-network cost sharing

	Thrift w/Rx ($79.70)	Focus w/Rx ($141.80)	Total w/Rx ($266.50)
ADDITIONAL BENEFITS AND SERVICES			
	when using the Extended Absence benefit.	when using the Extended Absence benefit.	when using the Extended Absence benefit.
Foot Care *(podiatry services)*	20% of the total cost for Medicare-covered podiatry services.	$15 copay for Medicare-covered podiatry services.	$10 copay for Medicare-covered podiatry services.
Health and Wellness Education Programs	**HealthAdvocate℠ 24-hour NurseLine:** $0 copay	**HealthAdvocate℠ 24-hour NurseLine:** $0 copay **One Pass™ Fitness Program:** $0 annual fee	**HealthAdvocate℠ 24-hour NurseLine:** $0 copay **One Pass™ Fitness Program:** $0 annual fee
Home Health Care	$0 copay		
Medical Equipment/ Supplies (Durable medical equipment, diabetes supplies, prosthetic devices and related medical supplies)	20% of the total cost for durable medical equipment, prosthetic devices and related medical supplies, unless noted below. $0 copay for surgical supplies, splints or casts. 20% of the total cost for diabetic testing supplies. 20% of the total cost for Medicare-covered diabetic footwear and inserts. Up to $35 for a one-month supply of insulin administered through an external insulin pump. Plan level deductibles do not apply.	20% of the total cost for durable medical equipment, prosthetic devices and related medical supplies, unless noted below. $0 copay for diabetic testing supplies, surgical supplies, splints or casts. 20% of the total cost for Medicare-covered diabetic footwear and inserts. Up to $35 for a one-month supply of insulin administered through an external insulin pump.	$0 copay for durable medical equipment, prosthetic devices and related medical supplies, unless noted below. $0 copay for diabetic testing supplies, surgical supplies, splints or casts. $0 copay for Medicare-covered diabetic footwear and inserts. $0 for a one-month supply of insulin administered through an external insulin pump.

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ADDITIONAL BENEFITS AND SERVICES			
Outpatient Substance Abuse	**Group/Individual Therapy Visit:** 20% of the total cost	**Group/Individual Therapy Visit:** $15 copay	**Group/Individual Therapy Visit:** $10 copay
Over-The-Counter (OTC) Drugs and Supplies Health and wellness products from OTC item catalog	Not covered	You are eligible for a $50 credit every quarter to be used toward the purchase of OTC health and wellness products from the catalog.	You are eligible for a $50 credit every quarter to be used toward the purchase of OTC health and wellness products from the catalog.
Renal Dialysis	20% of the total cost	$0 copay	$0 copay

Form Approved
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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 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 is a Cost plan with a Medicare contract. Enrollment in Medica depends on contract renewal.