

2018 Summary of Benefits

Medica Advantage Solution Edge[®] (HMO-POS)

H6154-001

This is a summary of drug and health services covered by Medica Advantage Solution Edge

January 1, 2018 – December 31, 2018

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 Edge (HMO-POS)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Medica Advantage Solution Edge (HMO-POS)** covers 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 <https://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 <https://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

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- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
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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 (800) 918-2416; (TTY/TDD 711).

Things to Know About Medica Advantage Solution Edge (HMO-POS)

Hours of Operation

- From October 1 to February 14, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Central time.
- From February 15 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. Central time.

Medica Advantage Solution Edge (HMO-POS) Phone Numbers and Website

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

Who can join?

To join **Medica Advantage Solution Edge (HMO-POS)**, you must be entitled Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Our service area includes the following counties in Minnesota: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, Sherburne, Washington and Wright.

Which doctors, hospitals, and pharmacies can I use?

Medica Advantage Solution Edge (HMO-POS) has a network of doctors, hospitals, pharmacies, and other providers. You pay your lowest cost-sharing when you visit an in-network provider. You have coverage for most services at out-of-network providers through the Point-of-Service (POS) benefit but you will 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.

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/members. Or, call us and we will send you a copy of the provider and pharmacy directories.

What do we cover?

Medica Advantage Solution Edge (HMO-POS) 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.

MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES	
Monthly Plan Premium	\$65.40 per month In addition, you must continue to pay your Medicare Part B premium.
Deductible	\$0 for in-network medical and hospital care \$250 for Part D prescription drugs \$250 for out-of-network medical and hospital care
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	You pay no more than \$5,900 annually for services you receive from in-network providers.
Coverage limit for out-of-network benefits (Point of Service)	We pay up to \$100,000 per year for covered services received from out-of-network providers.
COVERED MEDICAL AND HOSPITAL BENEFITS	
Inpatient Hospital Coverage	In-network: <ul style="list-style-type: none"> • \$320 copay per day for days 1-5 • You pay nothing for days 6 and beyond Out-of-network: <ul style="list-style-type: none"> • 20% of the cost after deductible is met
Outpatient Hospital Coverage	In-network: <ul style="list-style-type: none"> • \$250 copay for surgical procedures • \$320 copay per day for observation Out-of-network: <ul style="list-style-type: none"> • 20% of the cost after deductible is met Prior authorization is required for some surgical procedures.
Doctor Visits (Primary Care Providers and Specialists)	In-network: <ul style="list-style-type: none"> • Primary care physician visit: \$25 copay • Specialist visit: \$50 copay Out-of-network: <ul style="list-style-type: none"> • 20% of the cost after deductible is met
Preventive Care (e.g., flu and pneumonia vaccines, diabetic screenings, colorectal cancer screenings)	In-network: You pay nothing Out-of-network: 20% of the cost after deductible is met

Emergency Care	<p>In-network:</p> <ul style="list-style-type: none"> • \$80 copay Copay is waived if you are admitted to the hospital within 24 hours (U.S. and its territories only) • 20% of the cost for worldwide emergency care outside the U.S. and its territories <p>Out-of-network: Covered same as in-network.</p>
Urgently Needed Services	<p>In-network:</p> <ul style="list-style-type: none"> • \$40 copay <p>Out-of-network:</p> <ul style="list-style-type: none"> • Covered same as in-network
Diagnostic Services/Labs/Imaging	<p>In-network:</p> <ul style="list-style-type: none"> • Diagnostic tests and procedures, diagnostic radiology services, therapeutic radiology services, and outpatient x-rays: 20% of the cost • Lab Services: You pay nothing <p>Out-of-network:</p> <ul style="list-style-type: none"> • Diagnostic tests and procedures, diagnostic radiology services, therapeutic radiology services, and outpatient x-rays: 20% of the cost after deductible is met • Lab Services: 20% of the cost after deductible is met <p>Prior authorization is required for some services.</p>
Hearing Services	<p>In-network:</p> <ul style="list-style-type: none"> • Exam to diagnose and treat hearing and balance issues: \$25 copay • Routine hearing exam (up to 1 every year): \$25 copay <p>Out-of-network:</p> <ul style="list-style-type: none"> • Exam to diagnose and treat hearing and balance issues: 20% of the cost after deductible is met • Routine hearing exam: Not covered
Dental Services	<p>In-network: 20% of the cost for Medicare covered dental services</p> <p>Out-of-network: 20% of the cost after deductible is met for Medicare covered dental services</p>

Vision Services	<p>In-network:</p> <ul style="list-style-type: none"> • Exam to diagnose and treat diseases and conditions of the eye: \$50 copay • Routine eye exam (up to 1 every year): \$25 copay • Glaucoma screening: You pay nothing • Eyeglasses or contact lenses after cataract surgery: \$25 copay <p>Out-of-network:</p> <ul style="list-style-type: none"> • Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): 20% of the cost after deductible is met • Routine eye exam: Not covered • Glaucoma screening: 20% of the cost after deductible is met • Eyeglasses or contact lenses after cataract surgery: 20% of the cost after deductible is met
Mental Health Services	<p>Outpatient group therapy/individual therapy visit:</p> <ul style="list-style-type: none"> • In-network: \$30 copay • Out-of-network: Not covered
Skilled Nursing Facility (SNF)	<p>Our plan covers up to 100 days in a SNF.</p> <p>In-network:</p> <ul style="list-style-type: none"> • You pay nothing for days 1-20 • \$150 copay for days 21-100 • 3-day hospital stay is not required <p>Out-of-network:</p> <ul style="list-style-type: none"> • 20% of the cost for days 1-100 after deductible is met • 3-day hospital stay is not required <p>Prior authorization is required.</p>
Physical Therapy	<p>In-network:</p> <ul style="list-style-type: none"> • \$40 copay <p>Out-of-network:</p> <ul style="list-style-type: none"> • 20% of the cost after deductible is met
Ambulance	<p>In-network:</p> <ul style="list-style-type: none"> • \$250 copay for ground ambulance • 20% of the cost for air ambulance <p>Out-of-network:</p> <ul style="list-style-type: none"> • \$250 copay for ground ambulance • 20% of the cost for air ambulance

Transportation	In-network: Not covered Out-of-network: Not covered
Medicare Part B Drugs	In-network: 20% of the cost Out-of-network: 20% of the cost after deductible is met Prior authorization is required for some Part B drugs

Outpatient Prescription Drugs	
Deductible	\$250

Initial Coverage

Tier	Standard Retail Cost-Sharing	
	One-month supply	Three-month supply
Tier 1 (Preferred Generic)	\$0	\$0
Tier 2 (Generic)	\$4	\$12
Tier 3 (Preferred Brand)	\$40	\$120
Tier 4 (Non-Preferred Drug)	50%	50%
Tier 5 (Specialty Tier)	28%	28%

Tier	Standard Mail Order Cost-Sharing
	Three-month supply
Tier 1 (Preferred Generic)	\$0
Tier 2 (Generic)	\$8
Tier 3 (Preferred Brand)	\$80
Tier 4 (Non-Preferred Drug)	50%
Tier 5 (Specialty Tier)	28%

You will pay these costs until you enter another of the four stages of the Part D benefit. You can see the plan formulary (list of Part D outpatient prescription drugs we cover) on our website, medica.com/Members. Or, call us and we will send you the formulary.

ADDITIONAL BENEFITS AND SERVICES

eVisits	virtuwell [®] eVisit: You pay nothing
Wellness Programs (fitness, nurseline)	SilverSneakers [®] Fitness Program: You pay nothing HealthAdvocate [™] 24 hour NurseLine: You pay nothing
Chiropractic Care	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position) In-network: \$20 copay Out-of-network: Not covered
Diabetes Self-Management Training and Diabetes Supplies	In-network: <ul style="list-style-type: none"> • Diabetes self-management training: You pay nothing • Diabetes supplies: 20% of the cost Out-of-network: <ul style="list-style-type: none"> • Diabetes self-management training: 20% of the cost after deductible is met • Diabetes supplies: 20% of the cost after deductible is met
Durable Medical Equipment (DME), Prosthetic Devices, and Medical Supplies	In-network: <ul style="list-style-type: none"> • Durable Medical Equipment (DME): 20% of the cost • Prosthetic devices and medical supplies: 20% of the cost Out-of-network: <ul style="list-style-type: none"> • Durable Medical Equipment (DME): Not covered • Prosthetic devices and medical supplies: 20% of the cost after deductible is met Prior authorization is required for durable medical equipment, prosthetics and medical supplies over \$1,000
Home Health Care	In-network: You pay nothing Out-of-network: 20% of the cost after deductible is met

This information is not a complete description of benefits. Contact the plan for more information. Limitation, copayments, and restrictions may apply. Benefits, premiums, and/or copayments/coinsurance may change on January 1 of each year. You must continue to pay your Medicare Part B premium. The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

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

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