NORTH DAKOTA & SOUTH DAKOTA - Medical
Medica Prime Solution® (Cost) Plans

Summary of Benefits

January 1, 2027 – December 31, 2027

This is a summary of health services covered by **Medica Prime Solution Standard, Thrift, Core**, and **Premier.**

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 Standard**, **Thrift**, **Core**, or **Premier**).

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
- 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 at 1 (800) 918-2143 (toll-free) (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 1 (800) 234-8755 (toll-free) (TTY: 711).
- If you are not a member of this plan, call 1 (800) 918-2143 (toll-free) (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:

North Dakota: Adams, Barnes, Benson, Billings, Bottineau, Bowman, Burke, Cass, Cavalier, Dickey, Divide, Dunn, Eddy, Emmons, Foster, Golden Valley, Grant, Griggs, Hettinger, Kidder, LaMoure, Logan, McHenry, McIntosh, McKenzie, McLean, Mercer, Montrail, Nelson, Oliver, Pembina, Pierce, Ramsey, Ransom, Renville, Richland, Rolette, Sargent, Sheridan, Sioux, Slope, Stark, Steele, Towner, Trail, Walsh, Ward, Wells, and Williams.

South Dakota: Aurora, Beadle, Bennett, Bon Homme, Brown, Brule, Buffalo, Charles Mix, Clay, Douglas, Edmunds, Faulk, Grant, Gregory, Hand, Hanson, Hughes, Hutchinson, Hyde, Jerauld, Jones, Lake, Lincoln, Lyman, McCook, McPherson, Mellette, Miner, Minnehaha, Moody, Oglala Lakota, Potter, Stanley, Sully, Todd, Tripp, Turner, Union, and Yankton.

Which doctors and hospitals can I use?

Medica Prime Solution plans have a network of doctors, hospitals, 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.

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

SUMMARY OF BENEFITS

January 1, 2027 – December 31, 2027

	Standard ($0.00)	**Thrift ($53.00)**	**Core ($103.00)**	**Premier ($227.00)**
MONTHLY PREMIUM, DEDUCTIBLE, AND MAXIMUMS ON HOW MUCH YOU PAY FOR COVERED SERVICES				
Monthly Plan Premium	$0.00	$53.00	$103.00	$227.00
Medical Deductible	$200 per year	$50 per year	No deductible	No deductible
Maximum Out-Of-Pocket Responsibility *(does not include prescription drugs)*	You pay no more than $7,150 annually for services you receive from in-network providers	You pay no more than $7,150 annually for services you receive from in-network providers	You pay no more than $4,900 annually for services you receive from in-network providers	You pay no more than $3,900 annually for services you receive from in-network providers

	Standard ($0.00)	**Thrift ($53.00)**	**Core ($103.00)**	**Premier ($227.00)**
COVERED MEDICAL AND HOSPITAL BENEFITS				
Inpatient Hospital Coverage	$425 copay per day for days 1 through 5 $0 copay for days 6 through 90 $0 copay for unlimited extra days.	$350 copay per day for days 1 through 5 $0 copay for days 6 through 90 $0 copay for up to 60 Medicare-covered lifetime reserve days.	$200 copay per day for days 1 through 5 $0 copay for days 6 through 90 $0 copay for unlimited extra days.	$150 copay per day for days 1 through 5 $0 copay for days 6 through 90 $0 copay for unlimited extra days.

	Standard ($0.00)	Thrift ($53.00)	Core ($103.00)	Premier ($227.00)
COVERED MEDICAL AND HOSPITAL BENEFITS				
Outpatient Hospital Coverage	$0 - $500 copay for outpatient surgery $500 copay per stay for observation services	$0 copay - 20% of the total cost for outpatient surgery 20% of the total cost per stay for observation services	$0 - $300 copay for outpatient surgery $300 copay per stay for observation services	$0 - $200 copay for outpatient surgery $200 copay per stay for observation services
Ambulatory Surgery Center	$0 - $400 copay	$0 copay - 20% of the total cost	$0 - $200 copay	$0 - $100 copay
Doctor Visits	**Primary Care Provider:** $15 copay **Specialist:** $60 copay	**Primary Care Provider:** 20% of the total cost **Specialist:** 20% of the total cost	**Primary Care Provider:** $0 copay **Specialist:** $15 copay	**Primary Care Provider:** $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.			
Emergency Care	$130 copay (worldwide) Copay is waived if you are admitted to a hospital within 24 hours (U.S. only).	$130 copay (U.S. only)	$130 copay (worldwide) Copay is waived if you are admitted to a hospital within 24 hours (U.S. only).	$130 copay (worldwide) Copay is waived if you are admitted to a hospital within 24 hours (U.S. only).

	Standard ($0.00)	Thrift ($53.00)	Core ($103.00)	Premier ($227.00)
COVERED MEDICAL AND HOSPITAL BENEFITS				
Urgently Needed Services	$50 copay for convenience care/retail clinic and traditional urgent care center	$25 copay for convenience care/retail clinic and traditional urgent care center	$20 copay for convenience care/retail clinic and traditional urgent care center	$0 copay for convenience care/retail clinic and traditional urgent care center
Diagnostic and Therapeutic Services/ Labs/Imaging	**Diagnostic Radiology Services:** $300 copay **Diagnostic Therapeutic Radiology Services:** $80 copay **Diagnostic Tests and Procedures:** $15 copay for services received during a primary care doctor office visit. $60 copay for services received at a specialist's office or outpatient facility. **X-rays:** $60 copay **Lab Services:** $0 copay	**Diagnostic and Therapeutic Radiology Services:** 20% of the total cost **Diagnostic Tests and Procedures, and X-rays:** 20% of the total cost **Lab Services:** $0 copay	**Diagnostic Radiology Services:** $125 copay **Diagnostic Therapeutic Radiology Services:** $30 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 Radiology Services:** $100 copay **Diagnostic Therapeutic Radiology Services:** $30 copay **Diagnostic Tests and Procedures, and X-rays:** $0 copay **Lab Services:** $0 copay

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COVERED MEDICAL AND HOSPITAL BENEFITS				
Hearing Services	**Exam to Diagnose and Treat Hearing and Balance Issues:** $60 copay	**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.	**Exam to Diagnose and Treat Hearing and Balance Issues:** $0 copay
Hearing Services (Continued)	**Routine Hearing Exam – Services from EPIC® Hearing Providers:** Limited to 1 visit per calendar year. $0 copay **Fitting Evaluation(s) for Prescription Hearing Aids – Services from EPIC® Hearing Providers:** One hearing aid fitting-evaluation is available with the purchase of private label Silver, Gold, or Platinum level hearing aids. Additional fitting-evaluation(s) available based on hearing-aid level. $0 copay per fitting-evaluation for hearing aid. **Hearing Aids - All Types of Hearing Aids from EPIC® Hearing Providers:** Unlimited hearing aids every year. $549 copay per Silver level hearing aid, $799 copay per Gold level hearing aid, $1,299 copay per Platinum level hearing aid, and $999 copay per pair of non-prescription (OTC) hearing aids.			
Dental Services – Medicare-Covered	$15 copay for primary care doctor visits and $60 copay for specialist visits for Medicare-covered 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.	$0 copay for Medicare-covered dental services.

	Standard ($0.00)	Thrift ($53.00)	Core ($103.00)	Premier ($227.00)
COVERED MEDICAL AND HOSPITAL BENEFITS				
Dental Services – Preventive (e.g., exams, routine cleanings, and certain x-rays) Orthodontic services are not covered.				
In-network	$0 copay	Not covered	$0 copay	
Out-of-network	50% of the total cost	Not covered	50% of the total cost	
Vision Services	**Exam to Diagnose and Treat Diseases and Conditions of the Eye:** $15 copay for primary care doctor visits and $60 copay for specialist visits. **Refraction related to Medicare-covered eye service (1 each calendar year):** $0 copay **Medicare-covered Glaucoma and Diabetic Retinopathy Screening:** $0 copay	**Exam to Diagnose and Treat Diseases and Conditions of the Eye:** 20% of the total cost **Medicare-covered Glaucoma and Diabetic Retinopathy Screening:** 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. **Refraction related to Medicare-covered eye service (1 each calendar year):** $0 copay **Medicare-covered Glaucoma and Diabetic Retinopathy Screening:** $0 copay	**Exam to Diagnose and Treat Diseases and Conditions of the Eye:** $0 copay **Refraction related to Medicare-covered eye service (1 each calendar year):** $0 copay **Medicare-covered Glaucoma and Diabetic Retinopathy Screening:** $0 copay

	Standard ($0.00)	Thrift ($53.00)	Core ($103.00)	Premier ($227.00)
COVERED MEDICAL AND HOSPITAL BENEFITS				
	Routine eye exam (1 exam and 1 refraction each calendar year): $0 copay **Medicare-covered Eyeglasses or Contact Lenses After Cataract Surgery:** $45 copay	**Medicare-covered Eyeglasses or Contact Lenses After Cataract Surgery:** 20% of the total cost	**Routine eye exam (1 exam and 1 refraction each calendar year):** $0 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.	**Routine eye exam (1 exam and 1 refraction each calendar year):** $0 copay **Medicare-covered Eyeglasses or Contact Lenses After Cataract Surgery:** $0 copay **Contact Lenses, Eyeglasses (Frames and Lenses):** Our plan will reimburse up to $100 for non-Medicare-covered eyewear per calendar year.
Mental Health Services (including inpatient)	**Inpatient Visit:** $425 copay per day for days 1 through 5 $0 copay for days 6 through 90 $0 copay for up to an additional 60 lifetime reserve days.	**Inpatient Visit:** $350 copay per day for days 1 through 5 $0 copay for days 6 through 90 $0 copay for up to an additional 60 lifetime reserve days.	**Inpatient Visit:** $200 copay per day for days 1 through 5 $0 copay for days 6 through 90 $0 copay for up to an additional 60 lifetime reserve days.	**Inpatient Visit:** $150 copay per day for days 1 through 5 $0 copay for days 6 through 90 $0 copay for up to an additional 60 lifetime reserve days.

	Standard ($0.00)	Thrift ($53.00)	Core ($103.00)	Premier ($227.00)
COVERED MEDICAL AND HOSPITAL BENEFITS				
	For Services Provided by a Psychiatrist: $60 copay for group therapy visits. $60 copay for individual therapy visits. **For Services Provided by Other Mental Health Care Providers:** $35 copay for group therapy visits. $35 copay for individual therapy visits.	**For Services Provided by a Psychiatrist or Other Mental Health Care Providers:** 20% of the total cost for group therapy visits. 20% of the total cost for individual therapy visits.	**For Services Provided by a Psychiatrist:** $15 copay for group therapy visits. $15 copay for individual therapy visits. **For Services Provided by Other Mental Health Care Providers:** $0 copay for group therapy visits. $0 copay for individual therapy visits.	**For Services Provided by a Psychiatrist or Other Mental Health Care Providers:** $0 copay for group therapy visits. $0 copay for individual therapy visits.
Skilled Nursing Facility (SNF)	$0 copay for days 1 through 20 $221 copay per day for days 21 through 100 Our plan covers up to 100 days in a SNF	$0 copay for days 1 through 20 $221 copay per day for days 21 through 100 Our plan covers up to 100 days in a SNF	$0 copay for days 1 through 20 $100 copay per day for days 21 through 100 Our plan covers up to 100 days in a SNF	$0 copay for days 1 through 20 $50 copay per day for days 21 through 100 Our plan covers up to 100 days in a SNF
Outpatient Rehabilitation Services	**Physical or Speech Therapy Visit:** $60 copay	**Physical, Speech, or Occupational Therapy Visit:** 20% of the total cost	**Physical, Speech, or Occupational Therapy Visit:** $15 copay	**Physical, Speech, or Occupational Therapy Visit:** $0 copay

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COVERED MEDICAL AND HOSPITAL BENEFITS				
	Occupational Therapy Visit: $45 copay			
Ambulance Services	$350 copay per ground trip 20% of the total cost per air trip	20% of the total cost per trip	$200 copay per ground trip 20% of the total cost per air trip	$100 copay per ground trip 20% of the total cost per air trip
Transportation (non-emergency)	Not covered			
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 up to a $35 copay per a one-month supply. 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 up to a $35 copay per a one-month supply. 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 up to a $35 copay per a one-month supply.	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 up to a $35 copay per a one-month supply.

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ADDITIONAL BENEFITS AND SERVICES				
Chiropractic Services	$15 copay for Medicare-covered chiropractic services.	20% of the total cost for Medicare-covered chiropractic services.	$15 copay for Medicare-covered chiropractic services.	$0 copay for Medicare-covered chiropractic services.
Diabetic Testing Supplies	**Medicare-covered Abbott FreeStyle® (InsuLinx, Lite, Optium EZ, Optium Neo, Precision Neo, or Precision Xtra) and Ascensia Contour® (Next or Plus) test strips, diabetic testing supplies, and blood glucose monitors (BGMs) and Abbott FreeStyle Libre and Dexcom continuous glucose monitors (CGMs):** $0 copay for CGMs when obtained at a retail pharmacy or 20% of the total cost when obtained from a medical supplier and for Medica-approved non-preferred manufacturer exceptions. $0 copay for BGMs when obtained at a retail pharmacy or 20% of the total cost when obtained from a medical supplier and for Medica-approved non-preferred manufacturer exceptions. 20% of the total cost for test strips and diabetic testing supplies and for Medica-approved non-preferred manufacturer exceptions.		**Medicare-covered Abbott FreeStyle® (InsuLinx, Lite, Optium EZ, Optium Neo, Precision Neo, or Precision Xtra) and Ascensia Contour® (Next or Plus) test strips, diabetic testing supplies, and blood glucose monitors (BGMs) and Abbott FreeStyle Libre and Dexcom continuous glucose monitors (CGMs):** $0 copay for CGMs when obtained at a retail pharmacy or 20% of the total cost when obtained from a medical supplier and for Medica-approved non-preferred manufacturer exceptions. $0 copay for BGMs when obtained at a retail pharmacy or 20% of the total cost when obtained from a medical supplier and for Medica-approved non-preferred manufacturer exceptions. $0 copay for test strips and diabetic testing supplies and for Medica-approved non-preferred manufacturer exceptions.	
eVisits by Amwell®	$0 copay	Not covered	$0 copay	$0 copay
Visitor/Traveler Benefit	Visitor/Traveler 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 12 consecutive months. You may receive all plan covered services at in-network cost sharing when using the Visitor/Traveler benefit.			

	Standard ($0.00)	Thrift ($53.00)	Core ($103.00)	Premier ($227.00)
ADDITIONAL BENEFITS AND SERVICES				
Foot Care *(podiatry services)*	$60 copay for Medicare-covered podiatry services.	20% of the total cost for Medicare-covered podiatry services.	$15 copay for Medicare-covered podiatry services.	$0 copay for Medicare-covered podiatry services.
Health and Wellness Education Programs	**HealthAdvocate℠ 24-hour NurseLine:** $0 copay **One Pass™ Fitness Program:** $0 annual fee	**HealthAdvocate℠ 24-hour NurseLine:** $0 copay **One Pass™ Fitness Program:** Not covered	**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)	30% 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. 30% of the total cost for Medicare-covered diabetic footwear and inserts.	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 Medicare-covered diabetic footwear and inserts.	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 Medicare-covered diabetic footwear and inserts.	$0 copay for durable medical equipment, prosthetic devices and related medical supplies, unless noted below. $0 copay for surgical supplies, splints or casts. $0 copay for Medicare-covered diabetic footwear and inserts.

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ADDITIONAL BENEFITS AND SERVICES				
	Up to a $35 copay for a one-month supply of insulin furnished through an external insulin pump. The deductible does not apply.	Up to a $35 copay for a one-month supply of insulin furnished through an external insulin pump. The deductible does not apply.	Up to a $35 copay for a one-month supply of insulin furnished through an external insulin pump.	Up to a $35 copay for a one-month supply of insulin furnished through an external insulin pump.
Outpatient Substance Use Disorder Services	**Group Therapy Visit:** $30 copay **Individual Therapy Visit:** $30 copay	**Group Therapy Visit:** 20% of the total cost **Individual Therapy Visit:** 20% of the total cost	**Group Therapy Visit:** $15 copay **Individual Therapy Visit:** $15 copay	**Group Therapy Visit:** $0 copay **Individual Therapy Visit:** $0 copay
Over-The-Counter (OTC) Drugs and Supplies Health and wellness products from OTC item catalog	You are eligible for a $25 semi-annual allowance to be used toward the purchase of OTC health and wellness products from the item catalog.	Not covered	You are eligible for a $50 semi-annual allowance to be used toward the purchase of OTC health and wellness products from the item catalog.	You are eligible for a $50 semi-annual allowance to be used toward the purchase of OTC health and wellness products from the item catalog.
Renal Dialysis	20% of the total cost			

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English: ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-952-3455 (TTY: 711) for Medica, call 1-877-317-2410 (TTY: 711) for Dean Health Plan/Prevea360 Health Plan, or speak to your provider.

Spanish: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia de idiomas. También están disponibles de forma gratuita asistencia y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-952-3455 (TTY: 711) para Medica, llame al 1-877-317-2410 (TTY: 711) para Dean Health Plan/Prevea360 Health Plan o hable con su proveedor de atención médica.

Vietnamese/Việt: LƯU Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-952-3455 (TTY: 711) đối với Medica, gọi theo số 1-877-317-2410 (TTY: 711) đối với Dean Health Plan/Prevea360 Health Plan hoặc trao đổi với nhà cung cấp dịch vụ của quý vị.

Chinese Traditional: 注意：如果您說中文，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-800-952-3455 (TTY: 711) 聯絡 Medica，致電 1-877-317-2410 (TTY: 711) 聯絡 Dean Health Plan/Prevea360 Health Plan，或與您的提供者討論。

Hmong/Lus Hmoob: LUS CEEV: Yog hais tias koj hais Lus Hmoob ces muaj kev pab txhais lus pub dawb rau koj. Muaj khoom siv thiab muaj kev saib xyuas pab uas tsim nyog los npaj kom muaj cov ntaub ntawv uas siv tau dawb. Hu rau 1-800-952-3455 (TTY: 711) rau Medica, hu rau 1-877-317-2410 (TTY: 711) rau Dean Health Plan/Prevea360 Health Plan, los sis tham rau koj tus kws kuaj mob.

German/Deutsch: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-800-952-3455 (TTY: 711) für Medica bzw. 1-877-317-2410 (TTY: 711) für Dean Health Plan/Prevea360 Health Plan oder sprechen Sie mit Ihrem Gesundheitsdienstleister.

Cushitic-Oromo: XIYYEEFFANNOO: Ingiliffaa dubbattu taanaan, tajaajilli deggersa afaan bilisaa ni jira. Tajaajilli deggersa bu'ura dhiheessii odeeffannoo kaffaltii tokko malee ni jira. Lakkoofsa bilbilaa 1-800-952-3455 (TTY: 711) Tajaajila Fayyaaf, lakkoofsa Medica 1-877-317-2410 (TTY: 711), Dean Health Plan/Prevea360 Health Plan, ykn dhiheessaa keessan dubbisaa.

العربية/Arabic

كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. تنبيه: (الهاتف النصي: 711) للتواصل مع 1-800-952-3455اتصل على الرقم المعلومات بتنسيقات يمكن الوصول إليها مجانًا. Dean Health Plan، اتصل على الرقم 1-877-317-2410 (الهاتف النصي: 711) بشأن خطة الرعاية الصحية Medica Plan/Prevea360 Health Plan

Korean/한국어: 주의: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. Medica 의 경우 1-800-952-3455(TTY: 711)번으로, Dean Health Plan/Prevea360 Health Plan 의 경우 1-877-317-2410(TTY: 711)번으로 전화하시거나, 서비스 제공업체에 문의하십시오.

Russian/Русский: Если вы говорите по-русски, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-952-3455 (TTY: 711) относительно Medica, позвоните по телефону 1-877-317-2410 (TTY: 711) относительно Dean Health Plan/Prevea360 Health Plan или обратитесь к своему поставщику услуг.

Laos/ ລາວ: ຂໍ້ຄວນເອົາໃຈໃສ່: ຖ້າທ່ານເວົ້າພາສາລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ນອກຈາກນີ້ ຈະມີເຄື່ອງຊ່ວຍເສີມ ແລະ
ບໍລິການແບບທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້ໂດຍບໍ່ເສຍຄ່າ. ໂທຫາເບີ 1-800-952-3455 (TTY: 711) ສຳລັບ Medica, ໂທ 1-877-317-2410 (TTY: 711) ສຳລັບ Dean Health Plan/Prevea360 Health Plan ຫຼື ຕິດຕໍ່ຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

French/ Français: ATTENTION : si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-952-3455 (TTY : 711) pour Medica, appelez le 1-877-317-2410 (TTY : 711) pour le régime de santé Dean Health Plan/Prevea360, ou parlez à votre prestataire de santé.

Serbo-Croatian: PAŽNJA: Ako govorite srpski, dostupne su vam besplatne usluge tumača. Odgovarajuća dodatna pomagala i usluge za pružanje informacija u pristupačnim formatima su takođe dostupne besplatno. Za Medica zdravstveno osiguranje pozovite 1-800-952-3455 (TTY: 711), za Dean/Prevea360 zdravstveno osiguranje pozovite 1-877-317-2410 (TTY: 711) ili razgovarajte sa svojim pružaocem usluga.

Tagalog: PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-952-3455 (TTY: 711) para sa Medica, tumawag sa 1-877-317-2410 (TTY: 711) para sa Dean Health Plan/Prevea360 Health Plan, o makipag-usap sa iyong tagapagbigay ng serbisyo.

Karen/ထၢနှာ်လီၤဖဲအံၤ: ဟ်သူဉ်ဟ်သး– နမ့ၢ်ကတိၤကညီကျိာ်နၫ် တၢ်အိဉ်ဒီး ကျိာ်တၢ်ဆိဉ်ထွဲမၤစၢၤ လၢတလာ်ဘူဉ်လာ်စ့ၤလၢနဂီၢ်လီၤ. တၢ်အိဉ်ဒီး ပှၤနီၢ်ခိက့ၢ်ဂီၤတဆူဉ်တကျၢၤအဂီၢ်
ပီးလီဒီးတၢ်တိစၢၤမၤစၢၤလၢအကြၢးအဘဉ် လၢကဟ့ဉ်တၢ်ဂ့ၢ်တၢ်ကျိၤ လၢတၢ်မၤနှ်အီၤသ့တဖဉ် လၢတလာ်ဘူဉ်လာ်စ့ၤ လၢနဂီၢ်လီၤ. ကိး 1-800-952-3455 (TTY: 711) လၢ Medica အဂီၢ်, ကိး 1-877-317-2410 (TTY: 711) လၢ Dean Health Plan/Prevea360 Health Plan အဂီၢ်, မ့တမ့ၢ် ကတိၤတၢ်ဒီး နပှၤလၢဟ့ဉ်နၤတၢ်ကွၢ်ထွဲတက့ၢ်.

Amharic/ አማርኛ:- ማሳሰቢያ፡- አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎት በነፃ ይቀርብልዎታል። መረጃን በተደራሽ ቅርጸት ለማቅረብ ተገቢ የሆኑ ተጨማሪ እገዛዎች እና አገልግሎቶች እንዲሁ በነፃ ይገኛሉ። ለMedica በ1-800-952-3455 (TTY: 711) ይደውሉ፣ ለDean የጤና እቅድ/Prevea360 የጤና እቅድ በ1-877-317-2410 (TTY: 711) ይደውሉ ወይም ለእርስዎን አቅራቢ የሆነውን ያነጋግሩ።



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

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