

Benefit Highlights

Medica HealthCare Plans MedicareMax Plus (HMO SNP)

This is a short description of 2018 plan benefits. The values shown represent a range based upon the amount of the Medicare Parts A and B cost sharing covered by the state. For complete information and for costs for those without Medicare Parts A and B cost sharing covered by the state, please refer to your Summary of Benefits or Evidence of Coverage. Limitations, exclusions, and restrictions may apply.

Plan Costs

If you have full Medicaid benefits or are a Qualified Medicare Beneficiary, you will pay \$0 for your Medicare-covered services. You may have small copays for your Part D prescription drugs.

| | Your Cost |
|----------------------|-----------|
| Monthly plan premium | \$0 |

Medical Benefits

| | Your Cost |
|--|---|
| Doctor's office visit | Primary Care Provider: \$0 copay Specialist: \$0 copay (referral needed) |
| Preventive services | \$0 copay |
| Inpatient hospital care | \$0 copay per day for unlimited days |
| Skilled nursing facility (SNF) | \$0 copay per day: days 1-100 |
| Outpatient surgery | \$0 copay |
| Diabetes monitoring supplies | \$0 copay for covered brands |
| Home health care | \$0 copay |
| Diagnostic radiology services (such as MRIs, CT scans) | \$0 copay |
| Diagnostic tests and procedures (non-radiological) | \$0 copay |
| Lab services | \$0 copay |
| Outpatient x-rays | \$0 copay |
| Ambulance | \$0 copay |
| Emergency care | \$0 copay or \$80 copay (\$0 copay for worldwide coverage) |
| Urgently needed services | \$0 copay (worldwide) |
| Annual out-of-pocket maximum* | \$0 or \$500 |

*The most you may pay in a year for medical care covered by the plan.

Benefits and Services Beyond Original Medicare

| | Your Cost |
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| Vision - routine eye exams | \$0 copay; 1 every year |
| Vision - eyewear | \$0 copay every year; up to \$200 for lenses/frames and contacts |
| Dental - preventive | \$0 copay for covered services (exam, cleaning, fluoride, x-rays) |
| Dental - comprehensive | Covered; for a complete list of services and copays, please contact the plan |

| | Your Cost |
|--|---|
| Foot care - routine | \$0 copay; 6 visits per year |
| Hearing - routine exam | \$0 copay; 1 per year |
| Hearing aids | \$600 allowance per ear, maximum benefit of \$1,200 every 2 years, up to 2 hearing aids |
| Transportation | \$0 copay; unlimited one-way trips per year to or from approved locations |
| Fitness program through Optum® Fitness Advantage | Basic fitness center membership at participating network fitness center locations at no cost to you. For the complete details about the program, please visit fitnessadvantage.optum.com , and click the link in the footer entitled Terms and Conditions. |
| Over-the-Counter Benefit | \$82 credit per month to use from a plan approved listing of products. |
| Home Delivered Meals | \$0 copay; Coverage for at home meal benefit. Restrictions apply. |
| NurseLine SM | Speak with a registered nurse (RN) 24 hours a day, 7 days a week |

Prescription Drugs

If you don't qualify for Low-Income Subsidy (LIS), you pay the Medicare Part D cost share outlined in the Evidence of Coverage. If you do qualify for Low-Income Subsidy (LIS) you pay:

| | |
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| Annual prescription deductible | \$0, or \$0 for Tier 1 and Tier 2; \$83 for Tier 3, Tier 4 and Tier 5 drugs, depending on the level of "Extra Help" you receive |
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30-day supply from retail network pharmacy

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| Generic (including brand drugs treated as generic) | \$0, \$1.25, \$3.35 copay, or 15% coinsurance Drugs that are in Tier 1 and Tier 2* are always \$0 copay. |
| All other drugs | \$0, \$3.70, \$8.35 copay, or 15% coinsurance Drugs that are in Tier 1 and Tier 2* are always \$0 copay. |

* Tier includes enhanced drug coverage

Medica HealthCare is insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract and a contract with the State Medicaid Program. Enrollment in the plan depends on the plan's contract renewal with Medicare. This plan is available to anyone who has both Medical Assistance from the State and Medicare. Benefits, premium and/or copayments/coinsurance may change on January 1 of each year. Premiums, copays, coinsurance, and deductibles may vary based on the level of Extra Help you receive. Please contact the plan for further details. This information is not a complete description of benefits. Contact the plan for more information. You must continue to pay your Medicare Part B premium, if not otherwise paid for under Medicaid or by another third party. Limitations, co-payments, and restrictions may apply.

OptumRx is an affiliate of UnitedHealthcare Insurance Company. You are not required to use OptumRx home delivery for a 90 day supply of your maintenance medication.