2015

Summary of Benefits

H5211

Advocare Spirit Rx (HMO-POS)
Advocare Spirit (HMO-POS)
Advocare Essence Rx (HMO-POS)
Advocare Essence (HMO-POS)

SecurityHealth Plan℠
Advocare
Medicare Advantage Coverage

H5211_MC-778-2292-C-08-14 accepted

Summary of Benefits

January 1, 2015 – December 31, 2015

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 health plan (such as **Advocare Spirit Rx (HMO-POS), Advocare Spirit (HMO-POS), Advocare Essence Rx (HMO-POS) or Advocare Essence (HMO-POS)**).

TIPS FOR COMPARING YOUR MEDICARE CHOICES

This Summary of Benefits booklet gives you a summary of what Advocare plans cover and what you pay.

- If you want to compare our plan with other Medicare health plans, ask for their Summary of Benefits booklets. Or, use the Medicare Plan Finder at http://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 http://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 Advocare plans
- Monthly premium, deductible and limits on how much you pay for covered services
- Covered medical and hospital benefits
- Prescription drug benefits

This document is available in other formats such as large print.

This document may be available in a non-English language. For additional information, call us at 1-877-998-0998 or 715-221-9897. TTY users call 1-877-727-2232.

THINGS TO KNOW ABOUT ADVOCARE PLANS

HOURS OF OPERATION

You can call us 7 days a week from 8 a.m. to 8 p.m. Central time.

ADVOCARE PLAN PHONE NUMBERS AND WEBSITE

- If you are a member of this plan, call toll-free 1-877-998-0998.
- If you are not a member of this plan, call toll-free 1-888-456-2188.
- Our website: https://www.securityhealth.org/advocare

WHO CAN JOIN?

To join an Advocare plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Our service area includes the following counties in Wisconsin: Adams, Ashland, Barron, Bayfield, Burnett, Chippewa, Clark, Columbia, Dane, Douglas, Dunn, Eau Claire, Forest, Green, Iowa, Iron, Jackson, Jefferson, Juneau, Langlade, Lincoln, Marathon, Marquette, Monroe*, Oneida, Pepin, Portage, Price, Richland, Rusk, Sauk, Sawyer, Shawano*, Taylor, Trempealeau*, Vilas, Washburn, Waukesha, Waupaca, Waushara and Wood.

*denotes partial county. Only the following ZIP codes in these counties are included in the service area:
Monroe County – 54666
Shawano County – 54408, 54409, 54414, 54416, 54427, 54450, 54486 and 54499
Trempealeau County - 54758

WHICH DOCTORS, HOSPITALS AND PHARMACIES CAN I USE?

Security Health Plan has a network of doctors, hospitals, pharmacies and other providers. For some services you can use providers that are not in our network.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

You can see our plans' provider directory at our website (https://www.securityhealth.org/advocareproviders).

You can see our plans' pharmacy directory at our website (https://www.securityhealth.org/advocarepharmacies).

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

WHAT DO WE COVER?

Like all Medicare health plans, we cover everything that Original Medicare covers – and *more*.

- **Our 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.
- **Our plan members also get *more than what is* covered by Original Medicare.** Some of the extra benefits are outlined in this booklet.

Advocare Spirit (HMO-POS) and Advocare Essence (HMO-POS) cover Part B drugs including chemotherapy and some drugs administered by your provider. However, these plans do NOT cover Part D prescription drugs.

Advocare Spirit Rx (HMO-POS) and Advocare Essence Rx (HMO-POS) cover Part D drugs. In addition, these plans cover Part B drugs such as chemotherapy and some drugs administered by your provider.

- You can see the complete formulary (list of Part D prescription drugs) and any restrictions on our website, https://www.securityhealth.org/advocareformulary.
- Or, call us and we will send you a copy of the formulary.

HOW WILL I DETERMINE MY DRUG COSTS?

Our plan groups each medication into one of six "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Initial Coverage, Coverage Gap and Catastrophic Coverage.

Summary of Benefits

January 1, 2015 – December 31, 2015

MONTHLY PREMIUM, DEDUCTIBLE AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES

	ADVOCARE SPIRIT RX (HMO-POS)	ADVOCARE SPIRIT (HMO-POS)	ADVOCARE ESSENCE RX (HMO-POS)	ADVOCARE ESSENCE (HMO-POS)
How much is the monthly premium?	$225 per month. In addition, you must keep paying your Medicare Part B premium	$160 per month. In addition, you must keep paying your Medicare Part B premium	$77 per month. In addition, you must keep paying your Medicare Part B premium	$15 per month. In addition, you must keep paying your Medicare Part B premium
How much is the deductible?	This plan has deductibles for some hospital and medical services. $1,500 per year for out-of-network services. This plan does not have a deductible for Part D prescription drugs.	This plan has deductibles for some hospital and medical services. $1,500 per year for out-of-network services.	This plan has deductibles for some hospital and medical services. $1,500 per year for out-of-network services. This plan does not have a deductible for Part D prescription drugs.	This plan has deductibles for some hospital and medical services. $1,500 per year for out-of-network services.
Is there any limit on how much I will pay for my covered services?	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limits in this plan: • $1,200 for services you receive from in-network providers	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limits in this plan: • $1,200 for services you receive from in-network providers	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limits in this plan: • $3,400 for services you receive from in-network providers	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limits in this plan: • $3,400 for services you receive from in-network providers

	ADVOCARE SPIRIT RX (HMO-POS)	ADVOCARE SPIRIT (HMO-POS)	ADVOCARE ESSENCE RX (HMO-POS)	ADVOCARE ESSENCE (HMO-POS)
Is there any limit on how much I will pay for my covered services? *(continued)*	• $3,500 for services you receive from out-of-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.	• $3,500 for services you receive from out-of-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums.	• $3,500 for services you receive from out-of-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.	• $3,500 for services you receive from out-of-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums.
Is there a limit on how much the plan will pay?	No. There are no limits on how much our plan will pay.	No. There are no limits on how much our plan will pay.	No. There are no limits on how much our plan will pay.	No. There are no limits on how much our plan will pay.

Security Health Plan of Wisconsin, Inc., is an HMO plan with a Medicare contract. Enrollment in Security Health Plan depends on contract renewal.

COVERED MEDICAL AND HOSPITAL BENEFITS

NOTE: SERVICES WITH A [1] MAY REQUIRE PRIOR AUTHORIZATION.
SERVICES WITH A [2] MAY REQUIRE A REFERRAL FROM YOUR DOCTOR.

	ADVOCARE SPIRIT RX (HMO-POS)	ADVOCARE SPIRIT (HMO-POS)	ADVOCARE ESSENCE RX (HMO-POS)	ADVOCARE ESSENCE (HMO-POS)
OUTPATIENT CARE AND SERVICES				
Acupuncture and other alternative therapies	Not covered	Not covered	Not covered	Not covered
Ambulance	• In-network: $150 copay	• In-network: $150 copay	• In-network: $200 copay	• In-network: $200 copay
	We cover Medicare-covered ambulance benefits worldwide.			
Chiropractic care	Manipulation of the spine to correct a subluxation (when one or more of the bones of your spine move out of position): • In-network: $20 copay • Out-of-network: 20% of the cost after you pay your deductible Routine chiropractic visit: • In-network: $20 copay	Manipulation of the spine to correct a subluxation (when one or more of the bones of your spine move out of position): • In-network: $20 copay • Out-of-network: 20% of the cost after you pay your deductible Routine chiropractic visit: • In-network: $20 copay	Manipulation of the spine to correct a subluxation (when one or more of the bones of your spine move out of position): • In-network: $20 copay • Out-of-network: 20% of the cost after you pay your deductible Routine chiropractic visit: • In-network: $20 copay	Manipulation of the spine to correct a subluxation (when one or more of the bones of your spine move out of position): • In-network: $20 copay • Out-of-network: 20% of the cost after you pay your deductible Routine chiropractic visit: • In-network: $20 copay
	Covered routine chiropractic visits do not include maintenance care. Members will pay 100 percent of charges for maintenance care visits. Additional routine chiropractic benefits only include medical office visits, X-rays, subluxations other than to the spine, and therapies.			
Dental services	Limited dental services (this does not include services in connection with care, treatment, filling, removal or replacement of teeth): • In-network: You pay nothing	Limited dental services (this does not include services in connection with care, treatment, filling, removal or replacement of teeth): • In-network: You pay nothing	Limited dental services (this does not include services in connection with care, treatment, filling, removal or replacement of teeth): • In-network: You pay nothing	Limited dental services (this does not include services in connection with care, treatment, filling, removal or replacement of teeth): • In-network: You pay nothing
	In general, preventive dental benefits such as cleanings are not covered.			

	Advocare Spirit Rx (HMO-POS)	Advocare Spirit (HMO-POS)	Advocare Essence Rx (HMO-POS)	Advocare Essence (HMO-POS)
Diabetic supplies and services	Diabetes monitoring supplies: • In-network: You pay nothing • Out-of-network: 20% of the cost after you pay your deductible Diabetes self-management training: • In-network: You pay nothing • Out-of-network: 20% of the cost after you pay your deductible Therapeutic shoes or inserts: • In-network: You pay nothing • Out-of-network: 20% of the cost after you pay your deductible	Diabetes monitoring supplies: • In-network: You pay nothing • Out-of-network: 20% of the cost after you pay your deductible Diabetes self-management training: • In-network: You pay nothing • Out-of-network: 20% of the cost after you pay your deductible Therapeutic shoes or inserts: • In-network: You pay nothing • Out-of-network: 20% of the cost after you pay your deductible	Diabetes monitoring supplies: • In-network: You pay nothing • Out-of-network: 20% of the cost after you pay your deductible Diabetes self-management training: • In-network: You pay nothing • Out-of-network: 20% of the cost after you pay your deductible Therapeutic shoes or inserts: • In-network: You pay nothing • Out-of-network: 20% of the cost after you pay your deductible	Diabetes monitoring supplies: • In-network: You pay nothing • Out-of-network: 20% of the cost after you pay your deductible Diabetes self-management training: • In-network: You pay nothing • Out-of-network: 20% of the cost after you pay your deductible Therapeutic shoes or inserts: • In-network: You pay nothing • Out-of-network: 20% of the cost after you pay your deductible
	Advocare plans generally cover specific "preferred" products only. Accu-Chek® and OneTouch® brand meters and testing supplies are the preferred products for Advocare plan members. If the doctor provides you services in addition to diabetes self-management training, separate cost sharing may apply. Copayments apply if an office visit is billed.			
Diagnostic tests, lab and radiology services, and X-rays	Diagnostic radiology services (such as MRIs, CT scans): • In-network: $150 copay • Out-of-network: 20% of the cost after you pay your deductible Diagnostic tests and procedures: • In-network: You pay nothing	Diagnostic radiology services (such as MRIs, CT scans): • In-network: $150 copay • Out-of-network: 20% of the cost after you pay your deductible Diagnostic tests and procedures: • In-network: You pay nothing	Diagnostic radiology services (such as MRIs, CT scans): • In-network: $200 copay • Out-of-network: 20% of the cost after you pay your deductible Diagnostic tests and procedures: • In-network: You pay nothing	Diagnostic radiology services (such as MRIs, CT scans): • In-network: $200 copay • Out-of-network: 20% of the cost after you pay your deductible Diagnostic tests and procedures: In-network: You pay nothing

	ADVOCARE SPIRIT RX (HMO-POS)	**ADVOCARE SPIRIT (HMO-POS)**	**ADVOCARE ESSENCE RX (HMO-POS)**	**ADVOCARE ESSENCE (HMO-POS)**
Diagnostic tests, lab and radiology services, and X-rays *(Continued)*	• Out-of-network: 20% of the cost after you pay your deductible Lab services: • In-network: You pay nothing • Out-of-network: 20% of the cost after you pay your deductible Outpatient X-rays: • In-network: You pay nothing • Out-of-network: 20% of the cost after you pay your deductible Therapeutic radiology services (such as radiation treatment for cancer): • In-network: You pay nothing • Out-of-network: 20% of the cost after you pay your deductible	• Out-of-network: 20% of the cost after you pay your deductible Lab services: • In-network: You pay nothing • Out-of-network: 20% of the cost after you pay your deductible Outpatient X-rays: • In-network: You pay nothing • Out-of-network: 20% of the cost after you pay your deductible Therapeutic radiology services (such as radiation treatment for cancer): • In-network: You pay nothing • Out-of-network: 20% of the cost after you pay your deductible	• Out-of-network: 20% of the cost after you pay your deductible Lab services: • In-network: You pay nothing • Out-of-network: 20% of the cost after you pay your deductible Outpatient X-rays: • In-network: You pay nothing • Out-of-network: 20% of the cost after you pay your deductible Therapeutic radiology services (such as radiation treatment for cancer): • In-network: You pay nothing • Out-of-network: 20% of the cost after you pay your deductible	• Out-of-network: 20% of the cost after you pay your deductible Lab services: • In-network: You pay nothing • Out-of-network: 20% of the cost after you pay your deductible Outpatient X-rays: • In-network: You pay nothing • Out-of-network: 20% of the cost after you pay your deductible Therapeutic radiology services (such as radiation treatment for cancer): • In-network: You pay nothing • Out-of-network: 20% of the cost after you pay your deductible
	Copayments apply per day for each of six tests: MRI tests, CT scans, PET scans, ultrasounds, echocardiograms and nuclear medicine cardiac stress tests. If the doctor provides you services in addition to outpatient diagnostic procedures, tests and lab services, copayments will apply if a primary care or specialty care office visit is billed.			
Doctor's office visits[1,2]	Primary care physician visit: • In-network: You pay nothing • Out-of-network: 20% of the cost after you pay your deductible	Primary care physician visit: • In-network: You pay nothing • Out-of-network: 20% of the cost after you pay your deductible	Primary care physician visit: • In-network: $20 copay • Out-of-network: 20% of the cost after you pay your deductible	Primary care physician visit: • In-network: $20 copay • Out-of-network: 20% of the cost after you pay your deductible

	Advocare Spirit Rx (HMO-POS)	Advocare Spirit (HMO-POS)	Advocare Essence Rx (HMO-POS)	Advocare Essence (HMO-POS)
Doctor's office visits[1,2] *(Continued)*	Specialist visit: • In-network: $25 copay Out-of-network: 20% of the cost after you pay your deductible	Specialist visit: • In-network: $25 copay Out-of-network: 20% of the cost after you pay your deductible	Specialist visit: • In-network: $50 copay Out-of-network: 20% of the cost after you pay your deductible	Specialist visit: • In-network: $50 copay Out-of-network: 20% of the cost after you pay your deductible
	A member must receive a referral from his or her primary care provider and prior authorization from Security Health Plan for an initial visit to a surgeon in and out of network for these procedures: knee arthroscopy, total knee or hip replacement, elective back surgery and carpal tunnel surgery.			
Durable medical equipment *(wheelchairs, oxygen, etc.)*	• In-network: 20% of the cost • Out-of-network: 20% of the cost after you pay your deductible If you go to a preferred vendor, your cost may be less. Contact us for a list of preferred vendors.	• In-network: 20% of the cost • Out-of-network: 20% of the cost after you pay your deductible If you go to a preferred vendor, your cost may be less. Contact us for a list of preferred vendors.	• In-network: 20% of the cost • Out-of-network: 20% of the cost after you pay your deductible If you go to a preferred vendor, your cost may be less. Contact us for a list of preferred vendors.	• In-network: 20% of the cost • Out-of-network: 20% of the cost after you pay your deductible If you go to a preferred vendor, your cost may be less. Contact us for a list of preferred vendors.
	All Medicare Part B drugs used with durable medical equipment (such as nebulizers, insulin pumps, etc.) will have a 20 percent coinsurance applied for all Advocare plans.			
Emergency care	$65 copay If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient hospital care" section of this booklet for other costs.	$65 copay If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient hospital care" section of this booklet for other costs.	$65 copay If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient hospital care" section of this booklet for other costs.	$65 copay If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient hospital care" section of this booklet for other costs.
	Emergency room self-administered drugs will be covered at 100 percent. We cover emergency care anywhere in the world.			

	ADVOCARE SPIRIT RX (HMO-POS)	ADVOCARE SPIRIT (HMO-POS)	ADVOCARE ESSENCE RX (HMO-POS)	ADVOCARE ESSENCE (HMO-POS)
Foot care *(podiatry services)*	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: • In-network: $25 copay • Out-of-network: 20% of the cost after you pay your deductible	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: • In-network: $25 copay • Out-of-network: 20% of the cost after you pay your deductible	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: • In-network: $50 copay • Out-of-network: 20% of the cost after you pay your deductible	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: • In-network: $50 copay • Out-of-network: 20% of the cost after you pay your deductible
	Advocare plans will cover medically necessary treatment of injuries and diseases of the feet. You pay 100 percent for routine foot care unless Medicare coverage criteria are met.			
Hearing services	Exam to diagnose and treat hearing and balance issues: • In-network: $25 copay • Out-of-network: 20% of the cost after you pay your deductible Routine hearing exam: • In-network: $25 copay. You are covered for up to one every year. • Out-of-network: 20% of the cost after you pay your deductible. There may be a limit to how often these services are covered.	Exam to diagnose and treat hearing and balance issues: • In-network: $25 copay • Out-of-network: 20% of the cost after you pay your deductible Routine hearing exam: • In-network: $25 copay. You are covered for up to one every year. • Out-of-network: 20% of the cost after you pay your deductible. There may be a limit to how often these services are covered.	Exam to diagnose and treat hearing and balance issues: • In-network: $50 copay • Out-of-network: 20% of the cost after you pay your deductible Routine hearing exam: • In-network: $50 copay. You are covered for up to one every year. • Out-of-network: 20% of the cost after you pay your deductible. There may be a limit to how often these services are covered.	Exam to diagnose and treat hearing and balance issues: • In-network: $50 copay • Out-of-network: 20% of the cost after you pay your deductible Routine hearing exam: • In-network: $50 copay. You are covered for up to one every year. • Out-of-network: 20% of the cost after you pay your deductible. There may be a limit to how often these services are covered.
	Hearing aids, batteries and related supplies are not covered. Hearing exams and services related to selecting or evaluating a hearing aid are not covered.			

	ADVOCARE SPIRIT RX (HMO-POS)	ADVOCARE SPIRIT (HMO-POS)	ADVOCARE ESSENCE RX (HMO-POS)	ADVOCARE ESSENCE (HMO-POS)
Home health care	• In-network: You pay nothing • Out-of-network: 20% of the cost after you pay your deductible	• In-network: You pay nothing • Out-of-network: 20% of the cost after you pay your deductible	• In-network: You pay nothing • Out-of-network: 20% of the cost after you pay your deductible	• In-network: You pay nothing • Out-of-network: 20% of the cost after you pay your deductible
	To qualify for home health benefits you must be confined to your home, be under a plan of treatment reviewed and approved by a physician, and require a medically necessary qualifying skilled nursing service. Security Health Plan pays 365 Medicare-qualified days annually.			
Mental health care	Inpatient visit: Our plan covers an unlimited number of days for an inpatient hospital stay. • In-network: ○ $250 copay per stay ○ You pay nothing per day for days 91 and beyond • Out-of-network: ○ $1,500 deductible for inpatient hospital and mental health care ○ 20% of the cost per stay Outpatient group therapy visit: • In-network: $25 copay • Out-of-network: 20% of the cost after you pay your deductible Outpatient individual therapy visit:	Inpatient visit: Our plan covers an unlimited number of days for an inpatient hospital stay. • In-network: ○ $250 copay per stay ○ You pay nothing per day for days 91 and beyond • Out-of-network: ○ $1,500 deductible for inpatient hospital and mental health care ○ 20% of the cost per stay Outpatient group therapy visit: • In-network: $25 copay • Out-of-network: 20% of the cost after you pay your deductible Outpatient individual therapy visit:	Inpatient visit: Our plan covers an unlimited number of days for an inpatient hospital stay. • In-network: ○ $300 copay per day for days 1 through 5 ○ You pay nothing per day for days 6 through 90 ○ You pay nothing per day for days 91 and beyond • Out-of-network: ○ $1,500 deductible for inpatient hospital and mental health care ○ 20% of the cost per stay Outpatient group therapy visit: • In-network: $40 copay • Out-of-network: 20% of the cost after you pay your deductible Outpatient individual therapy visit:	Inpatient visit: Our plan covers an unlimited number of days for an inpatient hospital stay. • In-network: ○ $300 copay per day for days 1 through 5 ○ You pay nothing per day for days 6 through 90 ○ You pay nothing per day for days 91 and beyond • Out-of-network: ○ $1,500 deductible for inpatient hospital and mental health care ○ 20% of the cost per stay Outpatient group therapy visit: • In-network: $40 copay • Out-of-network: 20% of the cost after you pay your deductible Outpatient individual therapy visit:

	Advocare Spirit Rx (HMO-POS)	Advocare Spirit (HMO-POS)	Advocare Essence Rx (HMO-POS)	Advocare Essence (HMO-POS)
Mental health care *(Continued)*	• In-network: $25 copay • Out-of-network: 20% of the cost after you pay your deductible	• In-network: $25 copay • Out-of-network: 20% of the cost after you pay your deductible	• In-network: $40 copay • Out-of-network: 20% of the cost after you pay your deductible	• In-network: $40 copay • Out-of-network: 20% of the cost after you pay your deductible
	Copayments for inpatient stays <u>will not</u> start over if the member is transitioned to an inpatient acute or rehabilitation unit within the same facility or to another hospital. Copayments <u>will</u> start over if the member is readmitted following a discharge home or transitioned from a swing bed or skilled nursing facility.			
Outpatient rehabilitation	Cardiac (heart) rehab services (for a maximum of two 1-hour sessions per day for up to 36 sessions up to 36 weeks): • In-network: You pay nothing • Out-of-network: 20% of the cost after you pay your deductible Occupational therapy visit: • In-network: $20 copay • Out-of-network: 20% of the cost after you pay your deductible Physical therapy and speech and language therapy visit: • In-network: $20 copay • Out-of-network: 20% of the cost after you pay your deductible	Cardiac (heart) rehab services (for a maximum of two 1-hour sessions per day for up to 36 sessions up to 36 weeks): • In-network: You pay nothing • Out-of-network: 20% of the cost after you pay your deductible Occupational therapy visit: • In-network: $20 copay • Out-of-network: 20% of the cost after you pay your deductible Physical therapy and speech and language therapy visit: • In-network: $20 copay • Out-of-network: 20% of the cost after you pay your deductible	Cardiac (heart) rehab services (for a maximum of two 1-hour sessions per day for up to 36 sessions up to 36 weeks): • In-network: You pay nothing • Out-of-network: 20% of the cost after you pay your deductible Occupational therapy visit: • In-network: $20 copay • Out-of-network: 20% of the cost after you pay your deductible Physical therapy and speech and language therapy visit: • In-network: $20 copay • Out-of-network: 20% of the cost after you pay your deductible	Cardiac (heart) rehab services (for a maximum of two 1-hour sessions per day for up to 36 sessions up to 36 weeks): • In-network: You pay nothing • Out-of-network: 20% of the cost after you pay your deductible Occupational therapy visit: • In-network: $20 copay • Out-of-network: 20% of the cost after you pay your deductible Physical therapy and speech and language therapy visit: • In-network: $20 copay • Out-of-network: 20% of the cost after you pay your deductible
	There are no limits to the number of medically necessary rehabilitation services you may have in a year. Only one copayment will be applied per day.			

	ADVOCARE SPIRIT RX (HMO-POS)	ADVOCARE SPIRIT (HMO-POS)	ADVOCARE ESSENCE RX (HMO-POS)	ADVOCARE ESSENCE (HMO-POS)
Outpatient substance abuse	Group therapy visit: • In-network: $0-$25 copay, depending on the service • Out-of-network: 20% of the cost after you pay your deductible Individual therapy visit: • In-network: $0-$25 copay, depending on the service Out-of-network: 20% of the cost after you pay your deductible	Group therapy visit: • In-network: $0-$25 copay, depending on the service • Out-of-network: 20% of the cost after you pay your deductible Individual therapy visit: • In-network: $0-$25 copay, depending on the service Out-of-network: 20% of the cost after you pay your deductible	Group therapy visit: • In-network: $0-$50 copay, depending on the service • Out-of-network: 20% of the cost after you pay your deductible Individual therapy visit: • In-network: $0-$50 copay, depending on the service Out-of-network: 20% of the cost after you pay your deductible	Group therapy visit: • In-network: $0-$50 copay, depending on the service • Out-of-network: 20% of the cost after you pay your deductible Individual therapy visit: • In-network: $0-$50 copay, depending on the service Out-of-network: 20% of the cost after you pay your deductible
	You pay a $0 copayment for select services. **Spirit plans:** If a specialty care evaluation is billed, you pay $25 copayment. **Essence plans:** If a primary care evaluation is billed, you pay $20 copayment. If a mental health specialty care evaluation is billed, you pay $40 copayment. If a different specialty care evaluation is billed, you pay $50 copayment.			
Outpatient surgery	Ambulatory surgical center: • In-network: You pay nothing • Out-of-network: 20% of the cost after you pay your deductible Outpatient hospital: • In-network: $0-$200 copay, depending on the service • Out-of-network: 20% of the cost after you pay your deductible	Ambulatory surgical center: • In-network: You pay nothing • Out-of-network: 20% of the cost after you pay your deductible Outpatient hospital: • In-network: $0-$200 copay, depending on the service • Out-of-network: 20% of the cost after you pay your deductible	Ambulatory surgical center: • In-network: $0-150 copay, depending on the service • Out-of-network: 20% of the cost after you pay your deductible Outpatient hospital: • In-network: $0-$400 copay, depending on the service • Out-of-network: 20% of the cost after you pay your deductible	Ambulatory surgical center: • In-network: $0-150 copay, depending on the service • Out-of-network: 20% of the cost after you pay your deductible Outpatient hospital: • In-network: $0-$400 copay, depending on the service • Out-of-network: 20% of the cost after you pay your deductible

	Advocare Spirit Rx (HMO-POS)	Advocare Spirit (HMO-POS)	Advocare Essence Rx (HMO-POS)	Advocare Essence (HMO-POS)
	Self-administered drugs in the hospital outpatient setting will be covered at 100 percent. Copayments in association with a colonoscopy, sigmoidoscopy and proctosigmoidoscopy will be waived. If a polyp is found and removed, no copayment will apply. Lab work associated with testing the polyp will also be covered at 100 percent.			
Over-the-counter items	Not covered	Not covered	Not covered	Not covered
Prosthetic devices *(braces, artificial limbs, etc.)*	Prosthetic devices: • In-network: 20% of the cost • Out-of-network: 20% of the cost after you pay your deductible Related medical supplies: • In-network: 0-20% of the cost, depending on the supply • Out-of-network: 20% of the cost after you pay your deductible	Prosthetic devices: • In-network: 20% of the cost • Out-of-network: 20% of the cost after you pay your deductible Related medical supplies: • In-network: 0-20% of the cost, depending on the supply • Out-of-network: 20% of the cost after you pay your deductible	Prosthetic devices: • In-network: 20% of the cost • Out-of-network: 20% of the cost after you pay your deductible Related medical supplies: • In-network: 0-20% of the cost, depending on the supply • Out-of-network: 20% of the cost after you pay your deductible	Prosthetic devices: • In-network: 20% of the cost • Out-of-network: 20% of the cost after you pay your deductible Related medical supplies: • In-network: 0-20% of the cost, depending on the supply • Out-of-network: 20% of the cost after you pay your deductible
	Ostomy, wound care and urological supplies are covered at 100 percent with no member cost sharing.			
Renal dialysis	• In-network: You pay nothing	• In-network: You pay nothing	• In-network: You pay nothing	• In-network: You pay nothing
	You pay nothing for out-of-network renal dialysis services. Certain drugs for dialysis are covered under your Medicare Part B drug benefit.			
Transportation	Not covered	Not covered	Not covered	Not covered
Urgent care	$0-25 copay, depending on the service	$0-25 copay, depending on the service	$20-50 copay, depending on the service	$20-50 copay, depending on the service
	This coverage is available worldwide. Copayments are based on whether a primary care or specialty care office visit is billed.			

	ADVOCARE SPIRIT RX (HMO-POS)	ADVOCARE SPIRIT (HMO-POS)	ADVOCARE ESSENCE RX (HMO-POS)	ADVOCARE ESSENCE (HMO-POS)
Vision services	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): • In-network: $0-25 copay, depending on the service • Out-of-network: 20% of the cost after you pay your deductible Routine eye exam: • In-network: $0-25 copay, depending on the service • Out-of-network: 20% of the cost after you pay your deductible Eyeglasses or contact lenses after cataract surgery: • In-network: You pay nothing	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): • In-network: $0-25 copay, depending on the service • Out-of-network: 20% of the cost after you pay your deductible Routine eye exam: • In-network: $0-25 copay, depending on the service • Out-of-network: 20% of the cost after you pay your deductible Eyeglasses or contact lenses after cataract surgery: • In-network: You pay nothing	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): • In-network: $0-50 copay, depending on the service • Out-of-network: 20% of the cost after you pay your deductible Routine eye exam: • In-network: $0-50 copay, depending on the service • Out-of-network: 20% of the cost after you pay your deductible Eyeglasses or contact lenses after cataract surgery: • In-network: You pay nothing	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): • In-network: $0-50 copay, depending on the service • Out-of-network: 20% of the cost after you pay your deductible Routine eye exam: • In-network: $0-50 copay, depending on the service • Out-of-network: 20% of the cost after you pay your deductible Eyeglasses or contact lenses after cataract surgery: • In-network: You pay nothing
	Refraction will be covered at 100 percent. One eye exam every 12 months is covered at 100 percent in or out of network. For additional exams, copayments will be based on whether a primary care or specialty care office visit is billed.			

	ADVOCARE SPIRIT RX (HMO-POS)	ADVOCARE SPIRIT (HMO-POS)	ADVOCARE ESSENCE RX (HMO-POS)	ADVOCARE ESSENCE (HMO-POS)
Preventive care	• In-network: You pay nothing • Out-of-network: You pay nothing Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colonoscopy • Colorectal cancer screenings • Depression screening • Diabetes screenings • Fecal occult blood test • Flexible sigmoidoscopy • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections	• In-network: You pay nothing • Out-of-network: You pay nothing Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colonoscopy • Colorectal cancer screenings • Depression screening • Diabetes screenings • Fecal occult blood test • Flexible sigmoidoscopy • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections	• In-network: You pay nothing • Out-of-network: You pay nothing Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colonoscopy • Colorectal cancer screenings • Depression screening • Diabetes screenings • Fecal occult blood test • Flexible sigmoidoscopy • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections	• In-network: You pay nothing • Out-of-network: You pay nothing Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colonoscopy • Colorectal cancer screenings • Depression screening • Diabetes screenings • Fecal occult blood test • Flexible sigmoidoscopy • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections

	ADVOCARE SPIRIT RX (HMO-POS)	ADVOCARE SPIRIT (HMO-POS)	ADVOCARE ESSENCE RX (HMO-POS)	ADVOCARE ESSENCE (HMO-POS)
Preventive care *(Continued)*	screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered.	screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered.	screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered.	screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered.
	The Zostavax shingles vaccine and tetanus-diphtheria-pertussis (Tdap) vaccine given as routine vaccinations are covered only for members with Part D coverage. The Tdap vaccine when given as part of urgently needed wound care is covered for all members. Any office visit copayment associated with a Medicare-covered preventive service will be waived.			
Hospice	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.

	ADVOCARE SPIRIT RX (HMO-POS)	ADVOCARE SPIRIT (HMO-POS)	ADVOCARE ESSENCE RX (HMO-POS)	ADVOCARE ESSENCE (HMO-POS)
INPATIENT CARE				
Inpatient hospital care	Our plan covers an unlimited number of days for an inpatient hospital stay. • In-network: ○ $250 copay per stay ○ You pay nothing per day for days 91 and beyond • Out-of-network: ○ $1,500 deductible for inpatient hospital and mental health care ○ 20% of the cost per stay	Our plan covers an unlimited number of days for an inpatient hospital stay. • In-network: ○ $250 copay per stay ○ You pay nothing per day for days 91 and beyond • Out-of-network: ○ $1,500 deductible for inpatient hospital and mental health care ○ 20% of the cost per stay	Our plan covers an unlimited number of days for an inpatient hospital stay. • In-network: ○ $300 copay per day for days 1 through 5 ○ You pay nothing per day for days 6 through 90 ○ You pay nothing per day for days 91 and beyond • Out-of-network: ○ $1,500 deductible for inpatient hospital and mental health care ○ 20% of the cost per stay	Our plan covers an unlimited number of days for an inpatient hospital stay. • In-network: ○ $300 copay per day for days 1 through 5 ○ You pay nothing per day for days 6 through 90 ○ You pay nothing per day for days 91 and beyond • Out-of-network: ○ $1,500 deductible for inpatient hospital and mental health care ○ 20% of the cost per stay
	Copayments for inpatient stays <u>will not</u> start over if the member is transitioned to an inpatient rehabilitation or psychiatric unit within the same facility or to another hospital. Copayments <u>will</u> start over if the member is readmitted following a discharge home or transitioned from a swing bed or skilled nursing facility.			
Inpatient mental health care	For inpatient mental health care, see the "Mental health care" section of this booklet.	For inpatient mental health care, see the "Mental health care" section of this booklet.	For inpatient mental health care, see the "Mental health care" section of this booklet.	For inpatient mental health care, see the "Mental health care" section of this booklet.

	ADVOCARE SPIRIT RX (HMO-POS)	ADVOCARE SPIRIT (HMO-POS)	ADVOCARE ESSENCE RX (HMO-POS)	ADVOCARE ESSENCE (HMO-POS)
Skilled nursing facility (SNF)[18]	Our plan covers up to 100 days in a SNF. • In-network: ○ You pay $0 each day, for days 1-6. ○ You pay $40 each day, for days 7-20. ○ You pay $0 each day, for days 21-100. • Out-of-network: ○ $1,500 deductible ○ 20% of the cost per stay	Our plan covers up to 100 days in a SNF. • In-network: ○ You pay $0 each day, for days 1-6. ○ You pay $40 each day, for days 7-20. ○ You pay $0 each day, for days 21-100. • Out-of-network: ○ $1,500 deductible ○ 20% of the cost per stay	Our plan covers up to 100 days in a SNF. • In-network: ○ You pay $0 each day, for days 1-6. ○ You pay $40 each day, for days 7-45. ○ You pay $0 each day, for days 46-100. • Out-of-network: ○ $1,500 deductible ○ 20% of the cost per stay	Our plan covers up to 100 days in a SNF. • In-network: ○ You pay $0 each day, for days 1-6. ○ You pay $40 each day, for days 7-45. ○ You pay $0 each day, for days 46-100. • Out-of-network: ○ $1,500 deductible ○ 20% of the cost per stay
	No hospital stay required. Physician evaluation required. Services must be in a Medicare-certified SNF and meet Medicare criteria. Custodial care is not covered. A stay is an admission to get skilled care. You receive notice when your skilled care ends. A new stay begins if you receive skilled care again. You may have multiple stays per benefit period.			

	ADVOCARE SPIRIT RX (HMO-POS)	ADVOCARE SPIRIT (HMO-POS)	ADVOCARE ESSENCE RX (HMO-POS)	ADVOCARE ESSENCE (HMO-POS)
PRESCRIPTION DRUG BENEFITS				
How much do I pay?	For Part B drugs such as chemotherapy drugs: • In-network: 20% of the cost • Out-of-network: 20% of the cost after you pay your deductible Other Part B drugs: • In-network: 0-20% of the cost, depending on the drug • Out-of-network: 20% of the cost after you pay your deductible	For Part B drugs such as chemotherapy drugs: • In-network: 20% of the cost • Out-of-network: 20% of the cost after you pay your deductible Other Part B drugs: • In-network: 0-20% of the cost, depending on the drug • Out-of-network: 20% of the cost after you pay your deductible Our plan does not cover Part D prescription drugs.	For Part B drugs such as chemotherapy drugs: • In-network: 20% of the cost • Out-of-network: 20% of the cost after you pay your deductible Other Part B drugs: • In-network: 0-20% of the cost, depending on the drug • Out-of-network: 20% of the cost after you pay your deductible	For Part B drugs such as chemotherapy drugs: • In-network: 20% of the cost • Out-of-network: 20% of the cost after you pay your deductible Other Part B drugs: • In-network: 0-20% of the cost, depending on the drug • Out-of-network: 20% of the cost after you pay your deductible Our plan does not cover Part D prescription drugs.
	All Medicare Part B drugs used with durable medical equipment (such as nebulizers, insulin pumps, etc.) will have a 20% coinsurance applied for all Advocare plans. Members pay 100% for drugs not covered by Medicare. If you have chosen Part D coverage, please refer to the formulary for the list of home infusion drugs that qualify for $0 copay.			

<table>
<tr><th></th><th>ADVOCARE SPIRIT RX (HMO-POS)</th><th>ADVOCARE ESSENCE RX (HMO-POS)</th></tr>
<tr><td>Initial Coverage</td><td>
You pay the following until your total yearly drug costs reach $2,960. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

You may get your drugs at network retail pharmacies and mail-order pharmacies.

Standard retail cost-sharing
<table>
<tr><th>Tier</th><th>One-month supply</th><th>Two-month supply</th><th>Three-month supply</th></tr>
<tr><td>Tier 1 (Preferred generic)</td><td>$5 copay</td><td>$10 copay</td><td>$15 copay</td></tr>
<tr><td>Tier 2 (Non-preferred generic)</td><td>$15 copay</td><td>$30 copay</td><td>$45 copay</td></tr>
<tr><td>Tier 3 (Preferred brand)</td><td>$45 copay</td><td>$90 copay</td><td>$135 copay</td></tr>
<tr><td>Tier 4 (Non-preferred brand</td><td>$95 copay</td><td>$190 copay</td><td>$285 copay</td></tr>
<tr><td>Tier 5 (Specialty tier)</td><td>33% of the cost</td><td>Not offered</td><td>Not offered</td></tr>
<tr><td>Tier 6 (Vaccines)</td><td>$0</td><td>Not offered</td><td>Not offered</td></tr>
</table>
Standard mail order cost-sharing
<table>
<tr><th>Tier</th><th>One-month supply</th><th>Two-month supply</th><th>Three-month supply</th></tr>
<tr><td>Tier 1 (Preferred generic)</td><td>$5 copay</td><td>$10 copay</td><td>$15 copay</td></tr>
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You may get your drugs at network retail pharmacies and mail-order pharmacies.

Standard retail cost-sharing
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<tr><th>Tier</th><th>One-month supply</th><th>Two-month supply</th><th>Three-month supply</th></tr>
<tr><td>Tier 1 (Preferred generic)</td><td>$6 copay</td><td>$12 copay</td><td>$18 copay</td></tr>
<tr><td>Tier 2 (Non-preferred generic)</td><td>$19 copay</td><td>$38 copay</td><td>$57 copay</td></tr>
<tr><td>Tier 3 (Preferred brand)</td><td>$45 copay</td><td>$90 copay</td><td>$135 copay</td></tr>
<tr><td>Tier 4 (Non-preferred brand</td><td>$95 copay</td><td>$190 copay</td><td>$285 copay</td></tr>
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<tr><th></th><th>ADVOCARE SPIRIT RX (HMO-POS)</th><th>ADVOCARE ESSENCE RX (HMO-POS)</th></tr>
<tr><td>Initial Coverage
(Continued)</td><td>
<table>
<tr><td>Tier 4 (Non-preferred brand</td><td>$95 copay</td><td>$190 copay</td><td>$285 copay</td></tr>
<tr><td>Tier 5 (Specialty tier)</td><td>33% of the cost</td><td>Not offered</td><td>Not offered</td></tr>
</table>
If you reside in a long-term care facility, you pay the same as at a retail pharmacy.

You may get drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy.</td><td>
<table>
<tr><td>Tier 4 (Non-preferred brand</td><td>$95 copay</td><td>$190 copay</td><td>$285 copay</td></tr>
<tr><td>Tier 5 (Specialty tier)</td><td>33% of the cost</td><td>Not offered</td><td>Not offered</td></tr>
</table>
If you reside in a long-term care facility, you pay the same as at a retail pharmacy.

You may get drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy.</td></tr>
<tr><td></td><td colspan="2">We cover drugs filled at an out-of-network pharmacy only when you are not able to use a network pharmacy. Use of an out-of-network pharmacy will only be approved in certain non-routine situations. If the cost of your drug is less than the listed copay, you will only pay the lower amount. For more details see the Advocare plan formulary.</td></tr>
<tr><td>Coverage gap</td><td>Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $2,960.

After you enter the coverage gap, you pay 45% of the plan's cost for covered brand name drugs and 65% of the plan's cost for covered generic drugs until your costs total $4,700, which is the end of the coverage gap. Not everyone will enter the coverage gap.</td><td>Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $2,960.

After you enter the coverage gap, you pay 45% of the plan's cost for covered brand name drugs and 65% of the plan's cost for covered generic drugs until your costs total $4,700, which is the end of the coverage gap. Not everyone will enter the coverage gap.</td></tr>
<tr><td>Catastrophic coverage</td><td>After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,700, you pay the greater of:
5% of the cost, or
$2.65 copay for generic (including brand drugs treated as generic) and a $6.60 copayment for all other drugs.</td><td>After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,700, you pay the greater of:
5% of the cost, or
$2.65 copay for generic (including brand drugs treated as generic) and a $6.60 copayment for all other drugs.</td></tr>
</table>

Additional information about Advocare plans

A primary care office visit includes general/family practice, internal medicine, obstetrics/gynecology, pediatrics and a visit with a nurse practitioner or physician's assistant. A specialty care office visit covers all other physician specialties.

Utilization management (UM): We employ doctors, nurses and other staff to ensure that members receive the right care at the right place and time. Learn about our UM procedures at https://www.securityhealth.org/right-care.

Care management, health coaching and other services are also offered free to help our members stay healthy. Learn more at https://www.securityhealth.org/live-healthier.

We take the confidentiality of our member's health information seriously. View our Notice of Privacy Practices online at https://www.securityhealth.org/privacy. Call for a paper copy: 1-877-998-0998.

A comprehensive medication review is one of several Medication Therapy Management (MTM) services we offer free to all members with Part D coverage. MTM services ensure you get the best results from your medications and keep your out-of-pocket costs down. To learn more call Pharmacy Services: 1-877-873-5611.

Out-of-network cost sharing will apply towards the in-network out-of-pocket maximum, but in-network cost sharing will NOT apply towards the out-of-network out-of-pocket maximum. Out-of-network cost sharing does not apply to emergency care, urgently needed care or oral anticoagulation therapy testing and associated blood draws.

Multi-language insert

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 1-877-998-0998. Someone who speaks English 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 1-877-998-0998. 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 1-877-998-0998。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 1-877-998-0998。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 1-877-998-0998. 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 1-877-998-0998. 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 chýõng sức khỏe và chýõng trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-877-998-0998 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 1-877-998-0998. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean:
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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 1-877-998-0998. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic:
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Hindi:

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È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-877-998-0998. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

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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 1-877-998-0998. 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 1-877-998-0998. Ta usługa jest bezpłatna.

Japanese:

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