# Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services MEDICA ND Individual Choice Bronze Share Plus Limited

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to www.medica.com/2021IndChoicePolicies or call 888-592-8211. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 888-592-8211 to request a copy.

| Important Questions   | Answers  | Why This Matters:   |
|---|--|---|
| What is the overall <u>deductible</u> ?                                   | <b>\$0</b> at Indian Health Care <u>Provider</u> (IHCP) or with IHCP <u>referral</u> at non-IHCP; <b>\$2,300</b> Individual / <b>\$6,900</b> Family for non-IHCP <u>network</u> services. There is no coverage for non-network services. | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .   |
| Are there services covered<br>before you meet your<br><u>deductible</u> ? | Yes. <u>Preventive care</u> , preventive prescriptions and <u>copay</u> services from <u>network providers</u> are covered before you meet your <u>deductible</u> .  | This <u>plan</u> covers some items and services even if you haven't yet<br>met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may<br>apply. For example, this <u>plan</u> covers certain <u>preventive services</u><br>without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a<br>list of covered <u>preventive services</u> at<br><u>https://www.healthcare.gov/coverage/preventive-care-benefits</u> .   |
| Are there other <u>deductibles</u> for specific services?                 | No.  | You don't have to meet <u>deductibles</u> for specific services.  |
| What is the <u>out-of-pocket limit</u><br>for this <u>plan</u> ?          | <b>\$8,550</b> Individual/ <b>\$17,100</b> Family for non-IHCP <u>network</u> services.<br>There is no coverage for non-network services.  | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.   |
| What is not included in the<br>out-of-pocket limit?                       | Premiums, balance billing charges and health care this plan doesn't cover.   | Even though you pay these expenses, they don't count toward the out-of-pocket limit.  |
| Will you pay less if you use a<br>network provider?                       | <b>Yes.</b> Visit <u>www.medica.com/SearchIndividualChoice</u> or call 888-592-8211 (TTY:711) for a list of <u>network providers</u> .   | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| Do you need a <u>referral</u> to see a <u>specialist</u> ?                | No.  | You can see the specialist you choose without a referral.   |

All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.

|  |  | What You Will Pay   |   |  |   |
|--|--|---|---|--|---|
| Common Medical<br>Event  | Services You May<br>Need                         | Indian Health Care Provider<br>(IHCP)<br>(You will pay the least) | Non-IHCP Network<br>Provider<br>(You will pay more)   | Non-IHCP<br>Non-Network<br>Provider<br>(You will pay the most) | Limitations, Exceptions & Other Important<br>Information  |
| If you visit a health care provider's office   | Primary care visit to treat an injury or illness | No charge   | Primary care: 50%<br>coinsurance<br>Retail health clinics:<br>50% coinsurance<br>Chiropractic care:<br>50% coinsurance                                      | Not covered  | Limited to 20 visits/ year for chiropractic care. <u>Cost</u><br>sharing waived at non-IHCP with IHCP referral.   |
| or clinic  | <u>Specialist</u> visit                          | No charge   | 50% <u>coinsurance</u>  | Not covered  | Cost sharing waived at non-IHCP with IHCP referral.   |
|  | Preventive care/<br>screening/<br>immunization   | No charge   | No charge.<br><u>Deductible</u> does not<br>apply.  | Not covered  | You may have to pay for services that aren't preventive.<br>Ask your <u>provider</u> if the services you need are<br>preventive. Then check what your <u>plan</u> will pay for. <u>Cost</u><br><u>sharing</u> waived at non-IHCP with IHCP <u>referral</u> .  |
| If you have a test   | Diagnostic test<br>(x-ray, blood work)           | No charge   | 50% <u>coinsurance</u>  | Not covered  | Cost sharing waived at non-IHCP with IHCP referral.   |
| lf you have a test   | Imaging (CT/PET<br>scans, MRIs)                  | No charge   | 50% <u>coinsurance</u>  | Not covered  | *May require prior authorization. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> .  |
|  | Generic drugs                                    | No charge   | \$30 <u>copay</u> /<br>prescription.<br><u>Deductible</u> does not<br>apply.  | Not covered  |   |
| If you need drugs to<br>treat your illness or<br>condition   | Preferred brand<br>drugs                         | No charge   | \$200 <u>copay</u> /<br>prescription.<br><u>Deductible</u> does not<br>apply.   | Not covered  | Up to a 31-day supply per prescription. *May require<br>prior authorization. For non-preferred retail drugs, 50%<br><u>coinsurance</u> for orally-administered cancer treatment<br>medications. Proton pump inhibitors (except for<br>members 12 years of age and younger, and those<br>members who have a feeding tube) and non-sedating |
| More information about<br>prescription drug<br>coverage is available at<br>www.medica.com/<br>BrRx3. | brand drugs                                      | No charge   | 70% <u>coinsurance</u>  | Not covered  | members who have a feeding tube) and non-sedating<br>antihistamines are not covered. Insulin: Your cost-share<br>will not exceed \$25 per retail prescription unit. *Refer to   |
|  |  | No charge   | Preferred: \$700<br>copay/ prescription.<br>Deductible does not<br>apply<br>Non-Preferred: \$800<br>copay/ prescription.<br>Deductible<br>does not<br>apply | Not covered  | the Exceptions to the Drug List section of your Policy o<br>Coverage for more details. No charge for preventive<br>drugs. <u>Cost sharing</u> waived at non-IHCP with IHCP<br>referral.   |

\* For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.medica.com/2021IndChoicePolicies</u>.

# Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services MEDICA® ND Individual Choice Bronze Share Plus Limited

Coverage Period: Beginning on or after 01/01/2021 Coverage for: Individual or Family | Plan Type: HMO

|  | What You Will Pay                                    |   |   |  |   |
|--|--|---|---|--|---|
| Common Medical<br>Event                  | Services You May<br>Need                             | Indian Health Care Provider<br>(IHCP)<br>(You will pay the least) | Non-IHCP Network<br>Provider<br>(You will pay more)           | Non-IHCP<br>Non-Network<br>Provider<br>(You will pay the most) | Limitations, Exceptions & Other Important<br>Information  |
| If you have outpatient                   | Facility fee (e.g.,<br>ambulatory surgery<br>center) | No charge   | 50% coinsurance   | Not covered  | *May require prior authorization. <u>Cost sharing</u> waived at non-IHCP with IHCP referral.  |
| surgery                                  | Physician/surgeon<br>fees                            | No charge   | 50% coinsurance   | Not covered  | *May require prior authorization. <u>Cost sharing</u> waived at non-IHCP with IHCP referral.  |
|  | Emergency room<br>care                               | No charge   | 50% <u>coinsurance</u>  | 50% <u>coinsurance</u>   | Network deductible applies. Cost sharing waived at non-IHCP with IHCP referral.   |
| If you need immediate medical attention  | Emergency medical<br>transportation                  | No charge   | 50% <u>coinsurance</u>  | 50% <u>coinsurance</u>   | Network deductible applies. Cost sharing waived at non-IHCP with IHCP referral.   |
|  | <u>Urgent care</u>                                   | No charge   | 50% <u>coinsurance</u>  | 50% <u>coinsurance</u>   | Netword <u>deductible</u> applies. <u>Cost sharing</u> waived at non-IHCP with IHCP referral.   |
| If you have a hospital                   | Facility fee (e.g.,<br>hospital room)                | No charge   | 50% <u>coinsurance</u>  | Not covered  | *May require prior authorization. <u>Cost sharing</u> waived at non-IHCP with IHCP referral.  |
| stay                                     | Physician/surgeon<br>fees                            | No charge   | 50% <u>coinsurance</u>  | Not covered  | *May require prior authorization. <u>Cost sharing</u> waived at non-IHCP with IHCP referral.  |
| lf you need mental<br>health, behavioral | Outpatient services                                  | No charge   | 50% <u>coinsurance</u>  | Not covered  | *May require prior authorization. <u>Cost sharing</u> waived at non-IHCP with IHCP referral.  |
| health, or substance<br>abuse services   | Inpatient services                                   | No charge   | 50% <u>coinsurance</u>  | Not covered  | *May require prior authorization. <u>Cost sharing</u> waived at non-IHCP with IHCP referral.  |
|  | Office visits  | No charge   | Prenatal: 50%<br>coinsurance<br>Postnatal: 50%<br>coinsurance | Not covered  | Cost sharing does not apply to <u>network preventive</u><br>services. Depending on the type of services, <u>coinsurance</u>   |
|  | Childbirth/delivery<br>professional<br>services      | No charge   | 50% coinsurance   | Not covered  | may apply. Maternity care may include tests and<br>services described elsewhere in the SBC (i.e.<br>ultrasound). *May require prior authorization. <u>Cost</u><br><u>sharing</u> waived at non-IHCP with IHCP referral. |
|  | Childbirth/delivery<br>facility services             | No charge   | 50% <u>coinsurance</u>  | Not covered  |   |

\* For more information about limitations and exceptions, see the plan or policy document at www.medica.com/2021IndChoicePolicies.

# Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services MEDICA ND Individual Choice Bronze Share Plus Limited

Coverage Period: Beginning on or after 01/01/2021 Coverage for: Individual or Family | Plan Type: HMO

|  |                               | What You Will Pay   |   |  |  |  |
|--|-------------------------------|---|---|--|--|--|
| Common Medical<br>Event  | Services You May<br>Need      | Indian Health Care Provider<br>(IHCP)<br>(You will pay the least) | Non-IHCP Network<br>Provider<br>(You will pay more) | Non-IHCP<br>Non-Network<br>Provider<br>(You will pay the most) | Limitations, Exceptions & Other Important<br>Information   |  |
|  | Home health care              | No charge   | 50% coinsurance                                     | Not covered  | *May require prior authorization. Limited to 4 hours/day;<br>40 visits/year. <u>Cost sharing</u> waived at non-IHCP with<br>IHCP <u>referral</u> .   |  |
| lf you need bein   | Rehabilitation<br>services    | No charge   | 50% <u>coinsurance</u>                              | Not covered  | Limited to 30 visits per therapy/year. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> .  |  |
| If you need help<br>recovering or have<br>other special health | Habilitation services         | No charge   | 50% <u>coinsurance</u>                              | Not covered  | Limited to 30 visits per therapy/year. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> .  |  |
| needs  | Skilled nursing care          | No charge   | 50% <u>coinsurance</u>                              | Not covered  | *May require prior authorization. Limited to 30 days/year.<br>Cost sharing waived at non-IHCP with IHCP referral.  |  |
|  | Durable medical<br>equipment  | No charge   | 50% <u>coinsurance</u>                              | Not covered  | *May require prior authorization. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> .   |  |
|  | Hospice services              | No charge   | 50% <u>coinsurance</u>                              | Not covered  | Cost sharing waived at non-IHCP with IHCP referral.  |  |
|  | Children's eye<br>exam        | No charge   | 50% coinsurance                                     | Not covered  | Limited to one refractive eye exam/ year to end of month member turns 19. Cost sharing waived at non-IHCP with IHCP referral.  |  |
| If your child needs<br>dental or eye care                      | Children's glasses            | No charge   | 50% <u>coinsurance</u>                              | Not covered  | Coverage is limited to one pair of frames every 2 calendar years and one pair of lenses every calendar year. Contact lenses are limited to once every calendar year. Cost sharing waived at non-IHCP with IHCP referral. |  |
|  | Children's dental<br>check-up | Not covered   | Not covered   | Not covered  | Coverage is available through a stand-alone dental policy.   |  |

### **Excluded Services & Other Covered Services:**

| Services Your <u>Plan</u> Generally Does NOT Cover (Check          | your policy or <u>plan</u> document for more i | nformation and a list of any other <u>excluded services</u> .) |
|--|--|--|
| <ul> <li>*Abortion elective induced except as medically</li> </ul> | <ul> <li>Dental care (Adult)</li> </ul>        | Non-emergency care when traveling outside the                  |

- \*Abortion, elective, induced, except as medically necessary to protect the life of the mother
- Acupuncture
- Chiropractic care exceeding 20 visits per member per year.
- Cosmetic surgery

- Dental care (Adult)
  Dental care (Child) (coverage is available through a stànd-alone dental policy.)
- Dental check-up
- Hearing aids
- Infertility nreatment
- Long-term care

- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care except for some conditions
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

Bariatric surgery limited to one surgery per member with prior authorization

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Medica at 888-592-8211 or the North Dakota Commissioner of Insurance at 701-328-2440 or 800-247-0560. Other coverage options may be available to you too, including buying individual insurance coverage through the <u>Health Insurance Marketplace</u>. For more information about the <u>Marketplace</u>, visit <u>www.HealthCare.gov</u> or call 1-800-318-2596.

#### Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact: Medica at 888-592-8211 or the North Dakota Commissioner of Insurance at 701-328-2440 or 800-247-0560.

#### Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**Does this plan meet Minimum Value Standards? NA** If your <u>plan</u> doesn't meet the <u>Minimum Value Standards</u>, you may be eligible for a <u>premium tax credit</u> to help you pay for a <u>plan</u> through the <u>Marketplace</u>.

#### Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 888-592-8211 Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 888-592-8211 Chinese (中文): 如果需要中文的帮助,请拨打这个号码 888-592-8211 Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 888-592-8211

------ To see examples of how this plan might cover costs for a sample medical situation, see the next section. ------

## MEDICA ND Individual Choice Bronze Share Plus Limited

#### About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage.

| <b>Peg is Having a Baby</b><br>(9 months of in-network prenatal care and a hospital | (a |
|---|----|
| delivery)   |    |

- The <u>plan's</u> overall <u>deductible</u>: \$0
- **Specialist** coinsurance: 0%
- Hospital (facility) <u>coinsurance</u>: 0%
- Other <u>coinsurance</u>: 0%

#### This EXAMPLE event includes services like:

Specialist office visits (prenatal care) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (ultrasounds and blood work) Specialist visit (anesthesia)

**Total Example Cost** 

### \$12,700

#### In this example, Peg would pay:

| Cost Sharing               |      |
|----------------------------|------|
| Deductibles                | \$0  |
| <u>Copayments</u>          | \$0  |
| Coinsurance                | \$0  |
| What isn't covered         |      |
| Limits or exclusions       | \$60 |
| The total Peg would pay is |      |

#### Managing Joe's Type 2 Diabetes a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible: \$0
- Specialist coinsurance: 0%
- Hospital (facility) <u>coinsurance</u>: 0%
- Other <u>coinsurance</u>: 0%

#### This EXAMPLE event includes services like:

Primary care physician office visits (including disease education) Diagnostic tests (blood work) Prescription drugs Durable medical equipment (glucose meter)

#### Total Example Cost

#### In this example, Joe would pay:

| Cost Sharing               |     |  |
|----------------------------|-----|--|
| <u>Deductibles</u>         | \$0 |  |
| <u>Copayments</u>          | \$0 |  |
| <u>Coinsurance</u>         | \$0 |  |
| What isn't covered         |     |  |
| Limits or exclusions       | \$0 |  |
| The total Joe would pay is | \$0 |  |

#### Mia's Simple Fracture (in-network emergency room visit and follow up care)

- The plan's overall deductible: \$0
- Specialist coinsurance: 0%
- Hospital (facility) <u>coinsurance</u>: 0%
- Other <u>coinsurance</u>: 0%

#### This EXAMPLE event includes services like:

Emergency room care (including medical supplies) Diagnostic test (x-ray) Durable medical equipment (crutches) Rehabilitation services (physical therapy)

#### \$5,600 Total Example Cost \$2,800

#### In this example, Mia would pay:

| Cost Sharing               |     |
|----------------------------|-----|
| Deductibles                | \$0 |
| <u>Copayments</u>          | \$0 |
| Coinsurance                | \$0 |
| What isn't covered         |     |
| Limits or exclusions       | \$0 |
| The total Mia would pay is | \$0 |

Note: These numbers assume the patient received care from an IHCP provider or with IHCP referral at a non-IHCP. If you receive care from a non-IHCP provider without a referral from an IHCP, your costs may be higher. The plan would be responsible for the other costs of these EXAMPLE covered services.

#### Discrimination is Against the Law

Medica complies with applicable Federal civil rights laws and will not discriminate against any person on the basis of race, color, national origin, age, disability or sex. Medica:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: TTY communication and written information in other formats (large print, audio, other formats).
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters and information written in other languages.

If you need these services, call the number included in this document or on the back of your Medica ID card. If you believe that Medica has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Civil Rights Coordinator, Mail Route CP250, PO Box 9310, Minneapolis, MN 55443-9310, 952-992-3422 (phone/fax), TTY 711, civilrightscoordinator@medica.com.

You can file a grievance in person or by mail, fax, or email. You may also contact the Civil Rights Coordinator if you need assistance with filing a complaint.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

### If you want free help translating this information, call the number included in this document or on the back of your Medica ID card.

Si desea asistencia gratuita para traducir esta información, llame al número que figura en este documento o en la parte posterior de su tarjeta de identificación de Medica.

Yog koj xav tau kev pab dawb kom txhais daim ntawv no, hu rau tus xov tooj nyob hauv daim ntawv no los yog nyob nraum qab ntawm koj daim npav Medica ID.

如果您需要免費翻譯此資訊,請致電本文檔中或者在您的Medica ID卡背面包含的號碼。

Nếu quý vị muốn trợ giúp dịch thông tin này miễn phí, hãy gọi vào số có trong tài liệu này hoặc ở mặt sau thẻ ID Medica của quý vị.

Odeeffannoo kana gargaarsa tolaan akka isinii hiikamu yoo barbaaddan, lakkoobsa barruu kana keessatti argamu ykn ka dugda kaardii Waraqaa Eenyummaa Medica irra jiruun bilbila'a.

اذاكنت تريدمساعدة مجانية في ترجمة هذه المعلومات. فاتصل على ألرقم الوارد في هذه الوثيقة أو على ظهر بطاقة تعريف ميديكا الخاصة بك.

Если Вы хотите получить бесплатную помощь в переводе этой информации, позвоните по номеру телефона, указанному в данном документе и на обратной стороне Вашей индентификационной карты Medica.

່ ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປຂໍ້ມູນນີ້ຟຣີ, ໃຫ້ໂທຫາເລກໝາຍ ທີ່ມີຢູ່ໃນເອກະສານນີ້ ຫຼື ຢູ່ດ້ານຫຼັງຂອງບັດ Medica ຂອງທ່ານ. 이 정보를 번역하는 데 무료로 도움을 받고 싶으시면, 이 문서에 포함된 전화번호나 Medica ID 카드 뒷면의 전화번호로 전화하십시오.

Si vous voulez une assistance gratuite pour traduire ces informations, appelez le numéro indiqué dans ce document ou au dos de votre carte d'identification Medica.

နမ့်၊အဲဉ်ိဳးတၢ်ကိုးထံစၢၤကလီနှုန်းတဂ်က်တဂ်ကိုးအံၤလ၊အကလီနှဉ်,ကိုးလီတဲစိနီဉ်င်္ဂလ၊အပဉ် ယုဉ်လ၊လ်ာတီလံာမီအပူးအံးမှတမှု၊ဖနန္နနိုင်စေလော်အုဉ်သးဓးကဲ့အလို၊ခံတကပၤအဖိခ်ဉ်နှဉ်တက်.

Kung nais mo ng libreng tulong sa pagsasalin ng impormasyong ito, tawagan ang numero na kasama sa dokumentong ito o sa likod ng iyong Kard ng Medica ID.

ይህን መረጃ ለመተርጎም ነጻ እርዳታ የሚፈልጉ ከሆነ በዝ ሀ ሰነድ ዉስጥ ያለውን ቁጥር ወይም Medica መታወቅያ ካርድዎ በስተጀርባ ያለውን ይደውሉ።

Ako želite besplatnu pomoć za prijevod ovih informacija, nazovite broj naveden u ovom dokumentu ili na poleđini svoje ID kartice Medica.

Díí t'áá jíík'e shá ata' hodoonih nínízingo éí ninaaltsoos Medica bee néího'dílzinígí bine'déé' námboo biká'ígíiji' béésh bee hodíilnih.

Wenn Sie bei der Übersetzung dieser Informationen kostenlose Hilfe in Anspruch nehmen möchten, rufen Sie bitte die in diesem Dokument oder auf der Rückseite Ihrer Medica-ID-Karte angegebene Nummer an.