

*Your guide to*  
Medica Advantage Solution<sup>SM</sup>  
Standard with Rx Plan



Summary of Benefits for  
H2410-015

**January 1 – December 31, 2009**

**Minnesota  
North Dakota**



# Section I:

## Introduction to the Summary of Benefits for Medica Advantage Solution<sup>SM</sup> Standard with Rx Plan January 1 – December 31, 2009

*Thank you for your interest in Medica Advantage Solution<sup>SM</sup> Standard with Rx. Our plan is offered by Medica Health Plans, a Medicare Advantage Private Fee-for-Service organization. This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Medica Advantage Solution Standard with Rx and ask for the "Evidence of Coverage."*

### You Have Choices In Your Health Care

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan. Another option is a Medicare Advantage Private Fee-for-Service plan, like Medica Advantage Solution Standard with Rx. You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare program.

You may join or leave a plan only at certain times. Please call Medica Advantage Solution Standard with Rx at the telephone numbers listed at the end of this introduction or **1-800-MEDICARE (1-800-633-4227)** for more information. TTY users should call **1-877-486-2048**. You can call 24 hours a day, 7 days a week.

### How Can I Compare My Options?

You can compare Medica Advantage Solution Standard with Rx and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers and what the Original Medicare Plan covers.

Our members receive all of the benefits that the Original Medicare Plan offers. We also offer more benefits, which may change from year to year.

## Where Is Medica Advantage Solution Standard with Rx Available?

The service area for this plan includes:

### Minnesota

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Aitkin	Itasca	Pope
Anoka	Jackson	Ramsey
Becker	Kanabec	Red Lake
Beltrami	Kandiyohi	Redwood
Benton	Kittson	Renville
Big Stone	Koochiching	Rice
Blue Earth	Lac qui Parle	Rock
Brown	Lake	Roseau
Carlton	Le Sueur	St. Louis
Carver	Lincoln	Scott
Cass	Lyon	Sherburne
Chippewa	Mc Leod	Sibley
Chisago	Mahnomen	Stearns
Clay	Marshall	Steele
Clearwater	Martin	Stevens
Cottonwood	Meeker	Swift
Crow Wing	Mille Lacs	Todd
Dakota	Morrison	Traverse
Dodge	Mower	Wabasha
Douglas	Murray	Wadena
Faribault	Nicollet	Waseca
Fillmore	Nobles	Washington
Freeborn	Norman	Watonwan
Goodhue	Olmsted	Wilkin
Grant	Otter Tail	Wright
Hennepin	Pine	Yellow Medicine
Hubbard	Pipestone	
Isanti	Polk	

### North Dakota

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Barnes	LaMoure	Sargent
Cass	Ransom	Stutsman
Dickey	Richland	Traill

**You must live in one of these counties to join the plan.**

### Who is Eligible to Join Medica Advantage Solution Standard with Rx?

You can join Medica Advantage Solution Standard with Rx if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. However, individuals with End-Stage Renal Disease are generally not eligible to enroll in Medica Advantage Solution Standard with Rx unless they are members of our organization and have been since their dialysis began.

## Can I Choose My Doctors?

A Medicare Advantage Private Fee-for-Service plan works differently than a Medicare supplement plan. Your doctor or hospital is not required to agree to accept the plan's terms and conditions, and thus may choose not to treat you, with the exception of emergencies. If your doctor or hospital does not agree to accept our payment terms and conditions, they may choose not to provide healthcare services to you, except in emergencies.

## Does My Plan Cover Medicare Part B or Part D Drugs?

Medica Advantage Solution Standard with Rx does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

## Where Can I Get My Prescriptions if I Join This Plan?

Medica Advantage Solution Standard with Rx has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a Pharmacy Directory or visit us at <http://www.medica.com/C12/DrugFormularyPartD/default.aspx>. Our customer service number is listed at the end of this introduction.

Medica Advantage Solution Standard with Rx has a list of preferred pharmacies. At these pharmacies, you may get your drugs at a lower copay or coinsurance. You may go to an other network pharmacy, but you may have to pay more for your prescription drugs.

## What is a Prescription Drug Formulary?

Medica Advantage Solution Standard with Rx uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will

send a formulary to you and you can see our complete formulary on our Web site at <http://www.medica.com/C12/DrugFormularyPartD/default.aspx>.

If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

## How Can I Get Extra Help With Prescription Drug Plan Costs?

If you qualify for extra help with your Medicare prescription drug plan costs, your premium and costs at the pharmacy will be lower. When you join Medica Advantage Solution Standard with Rx, Medicare will tell us how much extra help you are getting. Then we will let you know the amount you will pay. If you are not getting this extra help, you can see if you qualify by calling **1-800-MEDICARE (1-800-633-4227)**, TTY users should call **1-877-486-2048**. You can call 24 hours a day, 7 days a week.

## What Are My Protections in This Plan?

All Medicare Advantage Plans agree to stay in the program for a full year at a time. Each year, the plans decide whether to continue for another year. Even if a Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of Medica Advantage Solution Standard with Rx, you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug

that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug.

### **What is a Medication Therapy Management (MTM) Program?**

A Medication Therapy Management (MTM) Program is a free service we may offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact Medica Advantage Solution Standard with Rx for more details.

### **What Types of Drugs May Be Covered Under Medicare Part B?**

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact Medica Advantage Solution Standard with Rx for more details.

- Some Antigens: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
- Osteoporosis Drugs: Injectable drugs for osteoporosis for certain women with Medicare.
- Erythropoietin (Epoetin alpha or Epogen®): By injection if you have End-Stage Renal Disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
- Hemophilia Clotting Factors: Self-administered clotting factors if you have hemophilia.

- Injectable Drugs: Most injectable drugs administered incident to a physician's service.
- Immunosuppressive Drugs: Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- Some Oral Cancer Drugs: If the same drug is available in injectable form.
- Oral Anti-Nausea Drugs: If you are part of an anti-cancer chemotherapeutic regimen. Inhalation and infusion drugs provided through DME.

**Please call Medica Health Plans for more information about this plan. Visit us at [www.medica.com](http://www.medica.com) or, call us:**

#### **Customer Service Hours:**

8 a.m. to 8 p.m., CST, seven days a week. Please note that access to a representative is limited on the weekends/holidays during certain times of the year.

Current members should call

**952-992-2300 or 1-800-234-8755**

(TTY: **952-992-3650 or 1-800-234-8819**).

Prospective members should call

**952-992-2345 or 1-800-906-5432**

(TTY: **952-992-3650 or 1-800-234-8819**).

#### **For questions related to the Medicare Part D**

**Prescription Drug program**, current members should call **1-800-234-8755** (TTY: **1-800-234-8819**) and prospective members should call **1-800-906-5432** (TTY: **1-800-234-8819**).

**For more information about Medicare**, please call Medicare at **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**. You can call 24 hours a day, 7 days a week. Or, visit [www.medicare.gov](http://www.medicare.gov) on the Web.

**If you have special needs, this document may be available in other formats.**

# Section II:

## Summary of Benefits for Medica Advantage Solution<sup>SM</sup> Standard with Rx for Contract Year 2009

If you have any questions about this plan's benefits or costs, please contact Medica Health Plans at 952-992-2300 or 1-800-234-8755 (for current members) or 952-992-2345 or 1-800-906-5432 (for prospective members).

Benefit	Original Medicare
<b>IMPORTANT INFORMATION</b>	
<p>1. <b>Premium and Other Important Information</b></p>	<ul style="list-style-type: none"> <li>• In 2009 the monthly Part B premium is \$96.40 and the yearly Part B deductible amount is \$135.</li> <li>• If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.</li> </ul>
<p>2. <b>Doctor and Hospital Choice</b> (for more information, see Emergency Care – #15 and Urgently Needed Care – #16)</p>	<ul style="list-style-type: none"> <li>• You may go to any doctor, specialist or hospital that accepts Medicare.</li> </ul>
<b>INPATIENT CARE</b>	
<p>3. <b>Inpatient Hospital Care</b> (includes Substance Abuse and Rehabilitation Services)</p>	<ul style="list-style-type: none"> <li>• In 2009 the amounts for each benefit period (3) are: Days 1–60: \$1,068 deductible Days 61–90: \$267 per day Days 91–150: \$534 per lifetime reserve day. (4)</li> </ul> <p>Please call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. (4)</p>
<p>4. <b>Inpatient Mental Health Care</b></p>	<ul style="list-style-type: none"> <li>• Same deductible and copay as inpatient hospital care (see “Inpatient Hospital Care” above).</li> <li>• 190 day lifetime limit in a Psychiatric Hospital.</li> </ul>
<p>5. <b>Skilled Nursing Facility</b> (in a Medicare-certified skilled nursing facility)</p>	<ul style="list-style-type: none"> <li>• In 2009 the amounts for each benefit period (3) after at least a 3-day covered hospital stay are: Days 1–20: \$0 per day Days 21–100: \$133.50 per day</li> <li>• 100 days for each benefit period. (3)</li> </ul>

(1) Each year, you pay a total of one \$135 deductible.

(2) If a doctor or supplier does not accept assignment, their costs are often higher, which means you may pay more.

(3) A “benefit period” starts the day you go into a hospital or skilled nursing facility. It ends when you go for

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- \$23.90 monthly plan premium in addition to your monthly Medicare Part B premium.
- \$3,350 out-of-pocket limit.
- All Medicare services covered under the out-of-pocket limit.

- You may go to any doctor, specialist or hospital that accepts the plan's payment.
- You may have to pay a separate copay for certain doctor office visits.

- You may go to any doctor, specialist or hospital that accepts the plan's Terms & Conditions of payment except in emergencies.
- \$550 copay for each Medicare-covered hospital stay.
- \$0 copay for additional hospital days.
- No limit to the number of days covered by the plan each benefit period. (3)

- \$550 copay for each Medicare-covered hospital stay.
- \$0 copay for additional hospital days.
- You get up to 190 days in a Psychiatric Hospital in a lifetime.

- For a stay at a Skilled Nursing Facility, you pay:  
Days 1–9: \$0 copay per day.  
Days 10–100: \$90.00 copay per day.
- Plan covers up to 100 days each benefit period. (3)
- No prior hospital stay is required.

60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

(4) Lifetime reserve days can only be used once.

If you have any questions about this plan's benefits or costs, please contact Medica Health Plans at 952-992-2300 or 1-800-234-8755 (for current members) or 952-992-2345 or 1-800-906-5432 (for prospective members).

Benefit	Original Medicare
<b>INPATIENT CARE (CONTINUED)</b>	
<p>6. <b>Home Health Care</b> (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)</p>	<ul style="list-style-type: none"> <li>• \$0 copay.</li> </ul>
<p>7. <b>Hospice</b></p>	<ul style="list-style-type: none"> <li>• You pay part of the cost for outpatient drugs and inpatient respite care.</li> <li>• You must receive care from a Medicare-certified hospice.</li> </ul>
<b>OUTPATIENT CARE</b>	
<p>8. <b>Doctor Office Visits</b></p>	<ul style="list-style-type: none"> <li>• 20% coinsurance. (1) (2)</li> </ul>
<p>9. <b>Chiropractic Services</b></p>	<ul style="list-style-type: none"> <li>• Routine care not covered.</li> <li>• 20% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers. (1) (2)</li> </ul>
<p>10. <b>Podiatry Services</b></p>	<ul style="list-style-type: none"> <li>• Routine care is not covered.</li> <li>• You pay 20% for medically necessary foot care, including care for medical conditions affecting the lower limbs. (1) (2)</li> </ul>
<p>11. <b>Outpatient Mental Health Care</b></p>	<ul style="list-style-type: none"> <li>• 50% coinsurance for most outpatient mental health services. (1) (2)</li> </ul>
<p>12. <b>Outpatient Substance Abuse Care</b></p>	<ul style="list-style-type: none"> <li>• 20% coinsurance. (1) (2)</li> </ul>

(1) Each year, you pay a total of one \$135 deductible.

(2) If a doctor or supplier does not accept assignment, their costs are often higher, which means you may pay more.

(3) A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for

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- \$0 copay for Medicare-covered home health visits.

- You must receive care from a Medicare-certified hospice.

- You may go to any doctor, specialist or hospital that accepts the plan's payment.
- \$15 copay for each primary care doctor office visit for Medicare-covered benefits.
- \$30 copay for each specialist visit for Medicare-covered benefits.
- See #33 – Physical Exams for more information.

- \$30 copay for Medicare-covered visits.
- Medicare-covered chiropractic visits are for manual manipulation of the spine to correct a displacement or misalignment of a joint or body part.

- \$30 copay for each Medicare-covered visit.
- Medicare-covered podiatry benefits are for medically-necessary foot care.

- \$30 copay for each Medicare-covered individual or group therapy visit.

- \$30 copay for Medicare-covered individual or group visits.

60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

(4) Lifetime reserve days can only be used once.

If you have any questions about this plan's benefits or costs, please contact Medica Health Plans at 952-992-2300 or 1-800-234-8755 (for current members) or 952-992-2345 or 1-800-906-5432 (for prospective members).

Benefit	Original Medicare
<b>OUTPATIENT CARE (CONTINUED)</b>	
<b>13. Outpatient Services/Surgery</b>	<ul style="list-style-type: none"> <li>• 20% coinsurance for the doctor. (1) (2)</li> <li>• 20% of outpatient facility charges. (1) (2)</li> </ul>
<b>14. Ambulance Services</b> (medically necessary ambulance services)	<ul style="list-style-type: none"> <li>• 20% coinsurance. (1) (2)</li> </ul>
<b>15. Emergency Care</b> (you may go to any emergency room if you reasonably believe you need emergency care)	<ul style="list-style-type: none"> <li>• 20% coinsurance for the doctor. (1) (2)</li> <li>• 20% of facility charge, or a set copay per emergency room visit. (1) (2)</li> <li>• You don't have to pay the emergency room copay if you are admitted to the hospital for the same condition within 3 days of the emergency room visit. (1)</li> <li>• NOT covered outside the U.S. except under limited circumstances.</li> </ul>
<b>16. Urgently Needed Care</b> (this is NOT emergency care, and in most cases, is out of the service area)	<ul style="list-style-type: none"> <li>• 20% coinsurance or a set copay. (1) (2)</li> <li>• NOT covered outside the U.S. except under limited circumstances.</li> </ul>
<b>17. Outpatient Rehabilitation Services</b> (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	<ul style="list-style-type: none"> <li>• 20% coinsurance. (1) (2)</li> </ul>
<b>OUTPATIENT MEDICAL SERVICES AND SUPPLIES</b>	
<b>18. Durable Medical Equipment</b> (includes wheelchairs, oxygen, etc.)	<ul style="list-style-type: none"> <li>• 20% coinsurance. (1) (2)</li> </ul>
<b>19. Prosthetic Devices</b> (includes braces, artificial limbs and eyes, etc.)	<ul style="list-style-type: none"> <li>• 20% coinsurance. (1) (2)</li> </ul>

(1) Each year, you pay a total of one \$135 deductible.

(2) If a doctor or supplier does not accept assignment, their costs are often higher, which means you may pay more.

(3) A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for

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- 20% of the cost for each Medicare-covered ambulatory surgical center visit.
  - 20% of the cost for each Medicare-covered outpatient hospital facility visit.
- 20% of the cost for Medicare-covered ambulance benefits.
- \$50 copay for Medicare-covered emergency room visits.
  - Worldwide coverage.
  - If you are admitted to the hospital within 24 hours for the same condition, you pay \$0 for the emergency room visit.
- Cost sharing is the same as Doctor Office Visit cost sharing (see “Doctor Office Visits” in #8).
- \$30 copay for Medicare-covered Occupational Therapy visits.
  - \$30 copay for Medicare-covered Physical Therapy and/or Speech/Language Therapy visits.
- 25% of the cost for Medicare-covered items.
- 25% of the cost for Medicare-covered items.

60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

(4) Lifetime reserve days can only be used once.

If you have any questions about this plan's benefits or costs, please contact Medica Health Plans at 952-992-2300 or 1-800-234-8755 (for current members) or 952-992-2345 or 1-800-906-5432 (for prospective members).

Benefit	Original Medicare
<b>OUTPATIENT MEDICAL SERVICES AND SUPPLIES (CONTINUED)</b>	
<p><b>20. Diabetes Self-Monitoring Training, Nutrition Therapy and Supplies</b> (includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)</p>	<ul style="list-style-type: none"> <li>• 20% coinsurance. (1) (2)</li> <li>• Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.</li> </ul>
<p><b>21. Diagnostic Tests, X-Rays, and Lab Services</b></p>	<ul style="list-style-type: none"> <li>• 20% coinsurance for diagnostic tests and X-rays. (1) (2)</li> <li>• \$0 copay for Medicare-covered lab services.</li> <li>• Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most routine screening tests, like checking your cholesterol.</li> </ul>
<b>PREVENTIVE SERVICES</b>	
<p><b>22. Bone Mass Measurement</b> (for people with Medicare who are at risk)</p>	<ul style="list-style-type: none"> <li>• 20% coinsurance. (1) (2)</li> <li>• Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.</li> </ul>
<p><b>23. Colorectal Screening Exams</b> (for people with Medicare age 50 and older)</p>	<ul style="list-style-type: none"> <li>• 20% coinsurance. (1) (2)</li> <li>• Covered when you are high risk or when you are age 50 and older.</li> </ul>
<p><b>24. Immunizations</b> (Flu vaccine, Hepatitis B vaccine—for people with Medicare who are at risk, Pneumonia vaccine)</p>	<ul style="list-style-type: none"> <li>• \$0 copay for the Flu and Pneumonia vaccines.</li> <li>• 20% coinsurance for Hepatitis B vaccine. (1) (2)</li> <li>• You may only need the Pneumonia vaccine once in your lifetime. Please contact your doctor for further details.</li> </ul>

(1) Each year, you pay a total of one \$135 deductible.

(2) If a doctor or supplier does not accept assignment, their costs are often higher, which means you may pay more.

(3) A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for

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- \$0 copay for Diabetes self-monitoring training.
- \$0 copay for Nutrition Therapy for Diabetes.
- 25% of the cost for Medicare-covered Diabetes supplies.

- \$15 to \$30 copay [or 20% of the cost] for:
  - Medicare-covered lab services
  - Medicare-covered diagnostic procedures and tests
  - Medicare-covered X-rays
  - Medicare-covered diagnostic radiology services
  - Medicare-covered therapeutic radiology services

- \$0 copay for each Medicare-covered Bone Mass Measurement.

- \$0 copay for Medicare-covered Colorectal Screening Exams.

- \$0 copay for the Flu and Pneumonia vaccines.
- \$0 copay for the Hepatitis B vaccine.

60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

(4) Lifetime reserve days can only be used once.

If you have any questions about this plan's benefits or costs, please contact Medica Health Plans at 952-992-2300 or 1-800-234-8755 (for current members) or 952-992-2345 or 1-800-906-5432 (for prospective members).

Benefit	Original Medicare
<b>PREVENTIVE SERVICES (CONTINUED)</b>	
<p><b>25. Mammograms (Annual Screening)</b> (for women with Medicare age 40 and older)</p>	<ul style="list-style-type: none"> <li>• 20% coinsurance. (2)</li> <li>• Covered once a year for all women with Medicare age 40 and older. One baseline mammogram covered for women with Medicare between age 35 and 39.</li> </ul>
<p><b>26. Pap Smears and Pelvic Exams</b> (for women with Medicare)</p>	<ul style="list-style-type: none"> <li>• \$0 copay for Pap smears. (2)</li> <li>• Covered once every 2 years. Covered once a year for women with Medicare at high risk.</li> <li>• 20% coinsurance for Pelvic Exams. (2)</li> </ul>
<p><b>27. Prostate Cancer Screening Exams</b> (for men with Medicare age 50 and older)</p>	<ul style="list-style-type: none"> <li>• 20% coinsurance for the digital rectal exam. (2)</li> <li>• \$0 for the PSA test; 20% coinsurance for other related services. (2)</li> <li>• Covered once a year for all men with Medicare over age 50.</li> </ul>
<p><b>28. End-Stage Renal Disease (ESRD)</b></p>	<ul style="list-style-type: none"> <li>• 20% coinsurance for renal dialysis. (1) (2)</li> <li>• 20% coinsurance for Nutrition Therapy for End-Stage Renal Disease. (1) (2)</li> <li>• Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.</li> </ul>

(1) Each year, you pay a total of one \$135 deductible.

(2) If a doctor or supplier does not accept assignment, their costs are often higher, which means you may pay more.

(3) A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for

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- \$0 copay for Medicare-covered Screening Mammograms.
- \$0 copay for Medicare-covered Pap Smears and Pelvic Exams.
- \$0 copay for Medicare-covered Prostate Cancer Screening Exams.
- \$0 copay for renal dialysis.
- \$0 copay for Nutrition Therapy for End-Stage Renal Disease.

60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

(4) Lifetime reserve days can only be used once.

If you have any questions about this plan's benefits or costs, please contact Medica Health Plans at 952-992-2300 or 1-800-234-8755 (for current members) or 952-992-2345 or 1-800-906-5432 (for prospective members).

Benefit

Original Medicare

PREVENTIVE SERVICES (CONTINUED)

29. Prescription Drugs

- Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.

(1) Each year, you pay a total of one \$135 deductible.

(2) If a doctor or supplier does not accept assignment, their costs are often higher, which means you may pay more.

(3) A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for

### Drugs Covered Under Medicare Part B

#### General

- 20% of the cost for Medicare Part B-covered drugs (including Part B-covered chemotherapy drugs).

### Drugs Covered Under Medicare Part D

#### General

- This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at <http://www.medica.com/C12/DrugFormularyPartD/default.aspx> on the Web.
- Different out-of-pocket costs may apply for people who have limited incomes, live in long term care facilities, or have access to Indian/Tribal/Urban (Indian Health Service).
- The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).
- Total yearly drug costs are the total drug costs paid by both you and the plan.
- The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.
- Some drugs have quantity limits.
- Your provider must get prior authorization from Medica Advantage Solution Standard with Rx for certain drugs.
- You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plan's Web site, formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.
- If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.

60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

(4) Lifetime reserve days can only be used once.

If you have any questions about this plan's benefits or costs, please contact Medica Health Plans at 952-992-2300 or 1-800-234-8755 (for current members) or 952-992-2345 or 1-800-906-5432 (for prospective members).

Benefit

Original Medicare

**PREVENTIVE SERVICES (CONTINUED)**

**29. Prescription Drugs (continued)**

- (1) Each year, you pay a total of one \$135 deductible.
- (2) If a doctor or supplier does not accept assignment, their costs are often higher, which means you may pay more.
- (3) A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for

## In-Network

- \$0 deductible.

### Initial Coverage

- You pay the following until total yearly drug costs reach \$2,700:

#### Retail Pharmacy

##### Generic

- \$10 copay for a one-month (31-day) supply of drugs in this tier from a preferred pharmacy
- \$30 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy
- \$10 copay for a one-month (31-day) supply of drugs in this tier from an other network pharmacy

##### Preferred Brand

- \$40 copay for a one-month (31-day) supply of drugs in this tier from a preferred pharmacy
- \$120 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy
- \$40 copay for a one-month (31-day) supply of drugs in this tier from an other network pharmacy

##### Non-Preferred Brand

- \$82 copay for a one-month (31-day) supply of drugs in this tier from a preferred pharmacy
- \$246 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy
- \$82 copay for a one-month (31-day) supply of drugs in this tier from an other network pharmacy

##### Specialty

- 25% coinsurance for a one-month (31-day) supply of drugs in this tier from a preferred pharmacy
- 25% coinsurance for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy
- 25% coinsurance for a one-month (31-day) supply of drugs in this tier from an other network pharmacy

60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

- (4) Lifetime reserve days can only be used once.

If you have any questions about this plan's benefits or costs, please contact Medica Health Plans at 952-992-2300 or 1-800-234-8755 (for current members) or 952-992-2345 or 1-800-906-5432 (for prospective members).

Benefit

Original Medicare

**PREVENTIVE SERVICES (CONTINUED)**

**29. Prescription Drugs (continued)**

- (1) Each year, you pay a total of one \$135 deductible.
- (2) If a doctor or supplier does not accept assignment, their costs are often higher, which means you may pay more.
- (3) A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for

### Long Term Care Pharmacy

Generic

- \$10 copay for a one-month (31-day) supply of drugs in this tier

Preferred Brand

- \$40 copay for a one-month (31-day) supply of drugs in this tier

Non-Preferred Brand

- \$82 copay for a one-month (31-day) supply of drugs in this tier

Specialty

- 25% coinsurance for a one-month (31-day) supply of drugs in this tier

### Mail Order

Generic

- \$20 copay for a three-month (90-day) supply of drugs in this tier

Preferred Brand

- \$80 copay for a three-month (90-day) supply of drugs in this tier

Non-Preferred Brand

- \$164 copay for a three-month (90-day) supply of drugs in this tier

Specialty

- 25% coinsurance for a three-month (90-day) supply of drugs in this tier

### Coverage Gap

- After your total yearly drug costs reach \$2,700, you pay 100% until your yearly out-of-pocket drug costs reach \$4,350.

### Catastrophic Coverage

- After your yearly out-of-pocket drug costs reach \$4,350, you pay the greater of:
  - \$2.40 copay for generic (including brand drugs treated as generic) and \$6.00 copay for all other drugs, or
  - 5% coinsurance

60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

- (4) Lifetime reserve days can only be used once.

If you have any questions about this plan's benefits or costs, please contact Medica Health Plans at 952-992-2300 or 1-800-234-8755 (for current members) or 952-992-2345 or 1-800-906-5432 (for prospective members).

Benefit

Original Medicare

PREVENTIVE SERVICES (CONTINUED)

29. Prescription Drugs (continued)

- (1) Each year, you pay a total of one \$135 deductible.
- (2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.
- (3) A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit ends when you

## Out-of-Network

- Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Medica Advantage Solution Standard with Rx.

### Out-of-Network Initial Coverage

- You will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$2,700:

#### Out-of-Network Pharmacy

Generic

- \$10 copay for a one-month (31-day) supply of drugs in this tier

Preferred Brand

- \$40 copay for a one-month (31-day) supply of drugs in this tier

Non-Preferred Brand

- \$82 copay for a one-month (31-day) supply of drugs in this tier

Specialty

- 25% coinsurance for a one-month (31-day) supply of drugs in this tier

### Out-of-Network Coverage Gap

- After your total yearly drug costs reach \$2,700, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,350. You will not be reimbursed by Medica Advantage Solution Standard with Rx for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Medica Advantage Solution Standard with Rx so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.

### Out-of-Network Catastrophic Coverage

- After your yearly out-of-pocket drug costs reach \$4,350, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus the following:
  - A \$2.40 copay for generic (including brand drugs treated as generic) and a \$6.00 copay for all other drugs, or
  - 5% coinsurance.

have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

(4) Lifetime reserve days can only be used once.

If you have any questions about this plan's benefits or costs, please contact Medica Health Plans at 952-992-2300 or 1-800-234-8755 (for current members) or 952-992-2345 or 1-800-906-5432 (for prospective members).

Benefit	Original Medicare
<b>PREVENTIVE SERVICES (CONTINUED)</b>	
30. <b>Dental Services</b>	<ul style="list-style-type: none"> <li>Preventive dental services (such as cleaning) are not covered.</li> </ul>
31. <b>Hearing Services</b>	<ul style="list-style-type: none"> <li>Routine hearing exams and hearing aids are not covered.</li> <li>20% coinsurance for diagnostic hearing exams. (1) (2)</li> </ul>
32. <b>Vision Services</b>	<ul style="list-style-type: none"> <li>20% coinsurance for diagnosis and treatment of diseases and conditions of the eye. (1) (2)</li> <li>Routine eye exams and glasses not covered.</li> <li>Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery. (1) (2)</li> <li>Annual glaucoma screenings covered for people at risk. (1) (2)</li> </ul>
33. <b>Physical Exams</b>	<ul style="list-style-type: none"> <li>20% coinsurance for one exam within the first 12 months of your new Medicare Part B coverage. (1) (2)</li> <li>When you get Medicare Part B, you can get a one-time physical exam within the first 12 months of your new Part B coverage. The coverage does not include lab tests.</li> </ul>
34. <b>Health/Wellness Education</b>	<ul style="list-style-type: none"> <li>Smoking Cessation: Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period if you are diagnosed with a smoking-related illness or are taking medicine that may be affected by tobacco. Each counseling attempt includes up to four face-to-face visits. You pay coinsurance, and Part B deductible applies.</li> </ul>
35. <b>Transportation (Routine)</b>	<ul style="list-style-type: none"> <li>Not covered.</li> </ul>
36. <b>Acupuncture</b>	<ul style="list-style-type: none"> <li>Not covered.</li> </ul>

(1) Each year, you pay a total of one \$135 deductible.

(2) If a doctor or supplier does not accept assignment, their costs are often higher, which means you may pay more.

(3) A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for

## Medica Advantage Solution Standard with Rx

- In general, preventive dental benefits (such as cleaning) are not covered.
- \$30 copay for Medicare-covered dental benefits.
- Hearing aids are not covered.
- \$30 copay for Medicare-covered diagnostic hearing exams.
- \$30 copay for up to 1 routine hearing test every year.
- Non-Medicare-covered eye exams and glasses are not covered.
- \$30 copay for one pair of eyeglasses or contact lenses after cataract surgery.
- \$30 copay for exams to diagnose and treat diseases and conditions of the eye.
- \$15 copay for routine exams.
- Limited to 1 exam every year.
- \$15 copay for Medicare-covered benefits.
- This plan covers health/wellness education benefits.
  - Written health education materials, including newsletters
  - Additional Smoking Cessation
  - Health club membership/fitness classes
  - Nursing hotline
- This plan does not cover routine transportation.
- This plan does not cover Acupuncture.

60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

(4) Lifetime reserve days can only be used once.





For more information on Medica Medicare Solutions® plans, call **952-992-2345** or **1-800-906-5432**. TTY users may call **952-992-3650** or **1-800-234-8819**.

**Hours of operation:**

8 a.m. to 8 p.m., CST, seven days a week. Please note that access to a representative is limited on the weekends/holidays during certain times of the year.

Visit us on the Web at **[www.medica.com](http://www.medica.com)**.

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