

MEDICA®

SOUTH DAKOTA

Medica Direct
Short-TermSM
for Individuals



Health plans as individual
as you and your family.

Medica Direct
Short-TermSM
for Individuals



For times of transition.

A job search. A layoff. Graduation from college. A new business venture. Whatever the reason, there are times when you find yourself without health care coverage. Yet without a comprehensive health plan, you can jeopardize your future financial well being.

That's why there's Medica Direct Short-TermSM for Individuals, a plan for individuals and families who need quality health care coverage during times of transition. By offering 30, 60 or 90 days of coverage, this innovative plan provides everything you need to avoid the financial risk associated with major medical expenses.

Three easy steps to peace of mind:

STEP 1. Choose the deductible level that fits your needs: \$300, \$500 or \$1,000.

STEP 2. Choose the length of time you or your family will be covered: 30, 60 or 90 days.

STEP 3. Decide when you need coverage to start: Either the day we receive your completed application and payment or any date you choose within 60 days of signing the application.

Note: You receive the highest level of benefits with the lowest out-of-pocket costs when you use a network provider. If you choose a non-network provider, you will be responsible for any deductible, coinsurance or copayment, and the difference between Medica's non-network reimbursement amount (generally based on a fee schedule) and the non-network provider's billed charges.

Who is eligible?

You are eligible for Medica Direct Short-Term if you reside in Medica's South Dakota service area and fall between the ages of 18 and 65, provided there is no overlap with Medicare. Dependent children are covered through age 24, or through age 29 if they're full-time students.

You are not eligible if:

- You are a foreign citizen.
- You are covered by Medicare.
- You or a dependent is pregnant or an expectant parent.
- You've been denied coverage by another health insurance carrier.
- You have other health care coverage.
- You are currently confined to or are in a health care facility.
- You do or will reside outside the South Dakota service area during the coverage period.
- You have been diagnosed with certain medical conditions in the last 10 years (as listed on the application form).
- Newborns under 90 days old are not eligible for coverage.

We've got you covered.

Medica Direct Short-Term pays for a wide variety of medically necessary care and services, subject to the terms of the policy. An Outline of Coverage is listed. If you would like a copy of a policy for this product, call Medica's Sales Department.

Pre-existing condition.

A pre-existing condition is a health condition in which medical advice, diagnosis, care or treatment was recommended or received within 12 months immediately before your enrollment date. Pre-existing conditions are not covered under the Medica Direct Short-Term plan.

When is my coverage effective?

When your application has been approved, your effective coverage date will be the later of: 1) the date we received your application and payment of premium in our office; or 2) the date you requested on your application, provided that such date is no more than 60 days from the date you signed the application.

Policy term and termination.

The policy is issued for the number of days you select: 30, 60 or 90 days. You may terminate the policy if we receive written notification within 10 days of Medica's receipt. This policy may not be renewed but you may re-apply.

The subsequent policy will not be a continuation of the first policy. **Any condition which may have been covered by the first policy will be considered a pre-existing condition and will not be covered by a subsequent policy.**





How to apply.

Get started now. To apply for a Medica Direct Short-Term health plan, simply follow these steps:

1. Fill out the application completely. If you answer 'yes' to any of the eligibility questions in section D, you are not eligible for coverage under the plan.
2. Include all dependents to be covered on the application.
3. Include your full policy check or money order payment with the application. Your application will not be accepted if payment is not received in full. Refer to the premium chart when calculating your premium or contact Medica to determine your rate.
4. Mail your application* and payment in the enclosed pre-paid envelope.

Want to know more?

Call your independent insurance agent or talk with one of Medica's Sales Department experts, available to help from 8 a.m. to 5 p.m. Monday through Thursday, as well as Friday, 9 a.m. – 5 p.m.

952-992-2080
(TTY) 952-992-3650

1-800-670-5935
(TTY) 1-800-234-8819

* A completed application does not mean you will be approved.

A glossary of terms for the times when you need clarity.

DEDUCTIBLE

Deductible is the fixed dollar amount of eligible charges you will pay each policy term before your Medica Direct Short-Term plan begins to pay. With our plan, you have deductible options as low as \$300 and up to \$1,000. If you are purchasing a family plan, the deductible amount is the same for all family members with a limit of three deductibles per family each policy term.

COINSURANCE

Coinsurance is the percentage amount of eligible charges you are responsible to pay the provider after you have met your deductible. The Medica Direct Short-Term plan pays 80 percent for all eligible charges for covered services obtained from network providers and non-network providers. The remaining percentage amount of 20 percent is your coinsurance.

PROVIDER NETWORK

Medica has an extensive provider network. There is a good chance your current physician is part of the network. You receive the highest level of benefits and lower out-of-pocket expenses when you use network providers. Call Medica CallLink at 1-866-715-0915 or visit us at www.medica.com to see if your doctor is in our network.

Medica does not want to get between you and your physician, so in most circumstances, we do not require our members to obtain prior approval to obtain coverage for services from non-network providers. **You can seek services from providers who are not contracted with Medica, but you will be required to pay the difference between Medica's non-network reimbursement amount (generally based on a fee schedule) and the charges your non-network provider bills (in addition to the deductible and coinsurance). This amount will not count towards your deductible or out-of-pocket maximum.**

ELIGIBLE CHARGES

Medica Direct Short-Term eligible charges are paid generally based on Medica's fee schedule. This is the amount that Medica's network providers have agreed to accept for eligible services rendered to Medica members.

If you receive services from a non-network provider, you will also pay the difference between Medica's non-network reimbursement amount (generally based on a fee schedule) and the charges your non-network provider bills. This amount could be significant and will not count towards your deductible or out-of-pocket maximum.

DRUG FORMULARY

The Medica Formulary is a list of generic and brand name outpatient prescription medications which are covered. A team of physicians and pharmacists meet regularly to review and update the list to be sure the Formulary remains responsive to the needs of our members and providers throughout the year. Your doctor can use this list to select covered medications for your health care needs, while helping you maximize your prescription drug benefit.

If you use a network pharmacy and your prescribed drug is on Medica's Formulary, the prescription will be filled and dispensed to you for your applicable copayment or coinsurance. As with all drugs, your doctor will need to determine if a generic drug is the best drug for you to take. If the prescribed drug is not on the Formulary, you are responsible for the cost of the drug. In some instances, you can request a Formulary exception through Medica's Formulary Exception process.

If you want to confirm if your physician is a Medica provider, please contact Medica CallLink at 1-866-715-0915 or visit us at www.medica.com.

OUTLINE OF COVERAGE

Medica Direct Short-TermSM for Individuals

An Outline of Coverage to help you understand your Short-Term health plan coverage.

This high level overview is not meant to be all-inclusive. If you have questions, call Medica's Sales Department at 952-992-2080 or 1-800-670-5935.

You should read your policy carefully. This Outline of Coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will determine your benefits. The policy itself sets forth in detail the rights and obligations of both you and Medica Insurance Company. It is therefore important that you read your policy carefully.

\$300 TO \$1,000 OPTIONS MOST BENEFITS PAID AT 80%*

Deductible	Out-of-pocket Maximum
\$300	\$1,300
\$500	\$1,500
\$1,000	\$2,000

Limit of three deductibles per family each year. Family out-of-pocket costs limited to three times the out-of-pocket maximum.

Lifetime maximum per person

\$1 million per person

Cancer screenings
Physician services
Inpatient and outpatient hospital services
Ambulatory surgical centers
Emergency care and ambulance service
Medical supplies, X-ray and lab services
Semi-private hospital room and supplies
Physical, speech and occupational therapy
Prescription drugs

80% coverage

Treatment of alcoholism (coverage is limited to a maximum of 30 days care in a 6-month consecutive month period)

80% coverage

Home health (coverage is limited to a maximum benefit of 40 visits)

80% coverage

Skilled nursing

80% coverage

* **Remember:** You receive the highest level of benefits with the lowest out-of-pocket costs when you use a network provider. You will be responsible for any deductible or coinsurance, and the difference between Medica's non-network reimbursement amount (generally based on a fee schedule) and the non-network provider's billed charges.

This is only a summary. Your policy will provide a detailed description of what is and is not covered.

AUTHORIZATION Requirements

Prior Authorization

Prior authorization from Medica Insurance Company (MIC) may be required before you receive certain services or supplies in order to determine whether a particular service or supply is medically necessary and a benefit. MIC uses written procedures and criteria when reviewing your request for prior authorization. To request prior authorization for a service or supply, either you, your representative, or your attending provider must call MIC.

Some of the services that may require prior authorization from MIC include:

- Reconstructive or restorative surgery
- Home health care
- Medical supplies and durable medical equipment
- Outpatient surgical procedures
- Skilled nursing facility services
- In-network benefits for services from non-network providers

Referrals

Certain health services are covered only upon referral. All referrals to non-network providers and certain types of network providers must be prior authorized by MIC to be eligible for coverage at your highest level of benefits. MIC uses a limited network of hospitals for the treatment of alcoholism.

Exclusions

The following services, supplies, and associated expenses are not covered under this plan. This is not a complete list. Please consult the Policy for more detail.

GENERAL EXCLUSIONS

1. Preventive health services (e.g. well child check, immunizations, etc.).
2. Services that are not medically necessary. This includes but is not limited to services inconsistent with the medical standards and accepted practice parameters of the community and services inappropriate – in terms of type, frequency, level, setting, and duration – to the diagnosis or condition.
3. Services or drugs used to treat conditions that are cosmetic in nature, unless otherwise determined to be reconstructive.
4. A drug, device, or medical treatment or procedure that is investigative.
5. Services for genetic screening and testing except when:
 - a. Recommended by a genetic counselor as predictive of a disease process, and treatment standards of care exist for the disease process; or
 - b. Reproductive choices would be made based on the test findings.
6. Nutritional and electrolyte substances.
7. Physical or occupational or speech therapy when there is no reasonable expectation that the condition will improve over a predictable period of time.
8. Neuropsychological evaluations/cognitive testing, except for the diagnosis or treatment of a medical illness or injury.
9. Custodial care, unskilled nursing, or unskilled rehabilitation services.
10. Respite or rest care except for Hospice Services.
11. Services for which benefits have been paid under worker's compensation, employer liability, or any similar law.
12. Services received before coverage under this Policy becomes effective.
13. Services received after coverage under this Policy ends.
14. Services prohibited by law or regulation, or illegal under South Dakota law.
15. Services to treat injuries that occur while on military duty, and any services received as a result of war, or any act of war (whether declared or undeclared).
16. Exams, other evaluations or other services for employment, insurance, or licensure, unless otherwise covered by MIC.
17. Exams, other evaluations or other services for judicial or administrative proceedings or research, except emergency examination of a child ordered by judicial authorities, or which MIC determines is medically necessary, or as otherwise covered by MIC.
18. Services not received from or under the direction of a physician.
19. Services for or related to intensive behavior therapy treatment programs for the treatment of autism spectrum disorders. Examples of such services include, but are not limited to, Intensive Early Intervention Behavior Therapy Services (IEIBTS), Intensive Behavioral Intervention (IBI), and Lovaas therapy.
20. Infertility services and services and drugs for or related to assisted reproductive technology (ART), artificial insemination, or in vitro fertilization.
21. Charges for services by a non-network provider in excess of the non-network provider reimbursement amount.
22. Maternity care services, including prenatal care.
23. Implants for the purpose of contraception.
24. Therapeutic acupuncture.
25. Services billed by acupuncturist.
26. Growth hormone.
27. Services to treat a pre-existing condition.
28. Services and supplies to the extent paid or payable under Medicare.
29. Services provided to your dependents if you have subscriber coverage only.
30. Charges that are eligible, paid, or payable under any medical payment, personal injury protection, automobile or other coverage that is payable without regard to fault, including charges that are applied toward any deductible, or coinsurance requirement of such coverage.
31. Services for private-duty nursing.
32. Functional capacity evaluations and related services for vocational purposes or for determination of disability or pension benefits.
33. Services for chemotherapy, supplies, and drugs.
34. Services for or in connection with fetal tissue transplantation.
35. Services which are not within the scope of licensure or certification of the provider.
36. Services received outside the United States.
37. Non-emergency services received outside the United States.
38. Charges for giving injections which can be self-administered.
39. Drugs and supplies when prescribed for the purposes of family planning.

Medica Direct for Individuals
Health plans created just for you.

MEDICA®

PO Box 9310, Minneapolis, MN 55440-9310

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