

MEDICA®

MINNESOTA



INDIVIDUAL PLANS FROM MEDICA

Health coverage for you and your family.

For coverage beginning 7/1/2008 or later.



Whatever the reason, when it comes to health care coverage, sometimes you're on your own.

A job search. A business venture. A college graduation. With health care costs continuing to rise, that's not an easy place to be. Especially when you consider that without a quality health plan you can jeopardize your future.

Introducing Medica's Individual products, the plans that let you decide how and where to spend your health care dollars. By giving you more control over things like deductibles and premiums, it's flexible, affordable and consumer friendly. With many different options to choose from, you'll find the plan you need when you're picking up the tab.

MEDICA SOLOSM

Let's face it. Everyone says, "It'll never happen to me." But then it does. The unexpected. Deep down, you've always known it's better to be safe than sorry. Lucky for you, Medica Solo offers affordable health insurance coverage on a self-only basis — that's why it's called Solo. If you're an adult, you can buy it for yourself or a dependent.

Medica Solo is designed to be very affordable, with young adults (ages 19-29) in mind, but it's available to Minnesota residents from age 3 months through age 64.

MEDICA DIRECT HSASM

for Individuals

A high-deductible plan that lets you set aside dollars in an optional health savings account (HSA). These funds can pay for deductibles and other qualified out-of-pocket medical costs. You pay lower monthly premiums and receive tax advantages, while still getting prescription benefits, preventive care and major medical coverage. You'll also have access to online decision support tools.

MEDICA DIRECT SHORT-TERMSM

for Individuals

Quality health care coverage for 30, 60 or 90 days. This plan provides temporary coverage for individuals and families to avoid the financial risk associated with major medical expenses.

MEDICA DIRECT VALUESM

for Individuals

Flexible coverage, with deductibles ranging from \$150 to \$5,000.

MEDICA DIRECT DENTALSM

for Individuals

For policyholders ages 18 through 64. Available to persons who apply for Medica Solo, Medica Direct HSA or Medica Direct Value. Offers affordable, comprehensive coverage that protects you and your family. Choose from three dental plans and coverage levels with the freedom to see any dentist.

Network choice

You may see medical providers of your choice. More than 96% of Minnesota providers are in Medica's network. You receive the highest level of benefits and the lowest out-of-pocket costs when you use providers that are part of this network. If you choose to receive services or supplies from a non-network provider, you are responsible for both any deductible, coinsurance or copayment owed and the difference between Medica's non-network reimbursement amount (generally based on a fee schedule) and the amount billed by the non-network provider.

Travel Program

You can receive Medica-style coverage when you travel in the United States but outside of Medica's service area so long as you use a Travel Program provider. Find more Travel Program information at medica.com:

- ▶ Click on **Medica Products**
- ▶ Click on **Medica Direct HSA for Individuals, Medica Solo or Medica Direct Value for Individuals**
- ▶ Scroll down to **Find a Doctor**
- ▶ Click on **Travel Program**

SOLO

Annual deductible

The deductible is subject to a “cost of living” increase on an annual basis, in an amount no greater than the Consumer Price Index, which is the federal measure of the rate of inflation.

Annual out-of-pocket maximum for covered medical services and supplies*

The out-of-pocket maximum is subject to a “cost of living” increase on an annual basis, in an amount no greater than the Consumer Price Index, which is the federal measure of the rate of inflation.

Office visits

For non-preventive office visits in any setting (e.g., physician, mental health, chiropractor). Your copay applies toward your deductible and out-of-pocket maximum. Your copay applies to the doctor’s charge, but other charges for services received that day, such as for lab work or X-rays, will apply toward your deductible.

Preventive care

Includes routine physicals, cancer screening, and one refractive eye exam per calendar year.

Urgent care visit

Your copay applies toward your deductible and out-of-pocket maximum.

Emergency room visit

Your copay applies toward your deductible and out-of-pocket maximum.

Prescription drugs

Deductible and out-of-pocket maximum does not apply.

Prescription drug annual maximum benefit

Eyewear

Eyeglasses and contact lenses.

Lab and X-ray services

Hospital services and surgical services

Ambulance

Medical supplies

Chiropractic, occupational, physical, and speech therapy

Home health care up to \$25,000 per calendar year

Mental health care

Substance abuse

Skilled nursing facility services (limited to 120 days per calendar year)

Prenatal care

Well-child services to age 6, immunizations to age 18

Maternity labor, delivery, and post partum care

Lifetime maximum

Lowest deductible	Middle deductible	Highest deductible
\$3,000*	\$6,000*	\$9,000*
Equal to deductible. Coverage is generally 100% after deductible.*		
\$30 copay for each of the first three visits per calendar year. After third visit, deductible applies.*	\$40 copay for each of the first three visits per calendar year. After third visit, deductible applies.*	\$50 copay for each of the first three visits per calendar year. After third visit, deductible applies.*
\$200 first dollar (cumulative), then applies to deductible.*		
For first visit each calendar year, \$100 copay paid by you, with any remainder paid by Medica; subsequent visits apply to the deductible.*		
For first visit each calendar year, \$200 copay paid by you, with any remainder paid by Medica; subsequent visits apply to the deductible.* Copay applies to facility charges only; professional fees apply toward the deductible.*		
\$5 generic copay/\$50 single-source brand-name formulary copay/\$90 brand-name non-formulary copay. You pay the difference when a generic is available and is not chosen. Specialty drug coinsurance paid by you: 20% formulary/40% non-formulary. Specialty drug maximum paid by you per script: \$200 formulary/\$400 non-formulary. No coverage at out-of-network pharmacies. Several categories of drugs are excluded, including infertility and erectile dysfunction.		
\$2,000 maximum paid by Medica per calendar year. This maximum includes all covered drugs: generic, brand-name formulary, brand-name non-formulary and specialty.		
Maximum of \$50 covered per calendar year.		
100% after deductible*		
100%*		
100%*		
No coverage		
\$5 Million		

*You receive the highest level of benefits and the lowest out-of-pocket costs when you use a network provider. If you choose to receive services from a non-network provider, you will be responsible for the deductible and the difference between Medica’s non-network reimbursement amount (generally based on a fee schedule) and the non-network provider’s billed charges. The difference between Medica’s non-network reimbursement amount and the non-network provider’s billed charges does not apply to your deductible or your out-of-pocket maximum.

Pre-existing conditions that you had within the first six months before your enrollment date may not be covered during the first 18 months following your enrollment date. However, if you have maintained continuous health care coverage, the pre-existing limitation applies during the first 12 months following your enrollment date. In addition, this 12-month period may be reduced by the amount of time you maintained qualifying coverage before your enrollment date.

	HSA						VALUE				SHORT-TERM		
	80% Plan			100% Plan									
Deductible level*	Single	\$1,400	\$1,800	Single	\$1,800	\$2,850	\$150	\$500	\$1,000	\$1,500	\$300	\$500	\$1,000
	Family	\$2,800	\$3,650	Family	\$2,400	\$3,500	Family maximum of 3 times		\$2,500	\$5,000	Family maximum of 3 times		
					\$3,650	\$5,500			Family maximum of 3 times				
					\$4,500	\$7,000							
Out-of-pocket maximum	Single	\$2,350	\$2,950	Single	\$1,800	\$2,850	\$1,150	\$1,500	\$2,000	\$2,500	\$1,300	\$1,500	\$2,000
	Family	\$3,650	\$4,650	Family	\$2,400	\$3,500	Family maximum of 3 times		\$3,500	\$6,000	Family maximum of 3 times		
					\$3,650	\$5,500			Family maximum of 3 times				
					\$4,500	\$7,000							
Lifetime maximum per person	\$5 million			\$5 million			\$5 million		\$5 million		\$1 million		
Office visits for sickness, injury, screenings and physicals	80% coverage			100% coverage			80% coverage		80% coverage		80% coverage		
Inpatient and outpatient X-ray and lab services	80% coverage			100% coverage			80% coverage		80% coverage		80% coverage		
Emergency room care and ambulance service	80% coverage			100% coverage			80% coverage		80% coverage		80% coverage		
Medical supplies	80% coverage			100% coverage			80% coverage		80% coverage		80% coverage		
Chiropractic, occupational, physical and speech therapy	80% coverage			100% coverage			80% coverage		80% coverage		80% coverage		
Well Child services to age 6, immunizations to age 18	100% coverage**			100% coverage**			100% coverage**		100% coverage**		100% coverage**		
Home health care (Limit of \$25,000 a year)	80% coverage			100% coverage			80% coverage		80% coverage		80% coverage		
Prescription drugs	\$15 copayment or 80% coverage			100% coverage			A separate \$250 Rx deductible applies to the \$500 plan; \$15 copayment or 80% coverage		\$15 copayment or 80% coverage		80% coverage		
Behavioral health care	80% coverage (optional)			100% coverage (optional)			80% coverage		80% coverage (optional)		No coverage		
Substance abuse	80% coverage			100% coverage			80% coverage (optional)		80% coverage (optional)		80% coverage		
Prenatal care	100% coverage**			100% coverage**			100% coverage**		100% coverage**		100% coverage**		
Delivery and post-delivery care	First 12 months, 0% coverage; thereafter 80%			First 12 months, 0% coverage; thereafter 100%			First 12 months, 0% coverage; thereafter 80%		First 12 months, 0% coverage; thereafter 80%		No coverage		
Pre-existing conditions	Pre-existing conditions that you had 6 months before your enrollment date may not be covered during the first 18 months following your enrollment date. However, if you have maintained continuous health care coverage, the pre-existing condition limitation applies during the first 12 months following your enrollment date. In addition, this 12-month period may be reduced by the amount of time you maintained coverage before your enrollment date.												
												Any pre-existing condition you had prior to your effective date will not be covered.	

*Unless otherwise noted, your deductible must be met before benefits will be covered. For the HSA plans, the entire family deductible must be met before benefits will be covered, unless otherwise noted.

**Deductible does not apply.

Provider network

You receive the highest level of benefits and the lowest out-of-pocket costs when you use providers who are part of our network. If you choose to receive services from a non-contracted provider, you will be responsible for any deductible, coinsurance or copayment, and the difference between Medica's fee schedule and the non-network provider's billed charges.

Medica's Individual Plans — health and dental plans created just for you.

This summary of benefits is not meant to be all-inclusive. If you have questions, call the Medica Sales Department at 952-992-2080 or 1-800-670-5935.

Learn more

For more information about Medica's Individual Plans, contact your Medica broker, visit us online or give us a call, Monday through Thursday, 8 a.m. – 5 p.m., or Friday, 9 a.m. – 5 p.m.

952-992-2080
(TTY) 952-992-3650
1-800-670-5935
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