YOUR GUIDE TO SHOPPING
INDIVIDUAL + FAMILY PLANS

Family matters

Medica®

You, your spouse, a toddler, and a baby on the way

You're raising a growing family. The youngsters are making regular trips to their doctor for sore throats, routine wellness visits, and the odd emergency. There might be another baby on the way before long. You have a lot to balance in your life, and you're exploring ways to manage your family's health without breaking the budget. It's important to find a health plan that will help you and your family keep on top of your health – and meet your budget.

We've put together this guide to help you figure out the basics, including plan types, coverage levels, how to sign up, and more. With that info in hand, you can feel confident about making the right choice — **the one that works for you.**

Questions? We're here to help.

Call **1 (888) 818-1138** (TTY: **711**) to talk to one of our consultants. They can help you evaluate your situation, and make the best coverage choice for you and your budget.

Visit **Medica.com** for valuable information and resources to help you make the best coverage decisions.

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What should you think about before you shop?

Making informed choices with respect to the plan features above will have a BIG impact on what you spend for care, and how you'll spend it.

It pays to consider your health care needs, your financial resources and your comfort with risk and volatility. Focus on these items, plus a few extra things, to find the best plan for you. Use this booklet to guide you through the process.

Coverage levels

Health insurance doesn't pay for every medical expense. You and your plan each pay part of the cost. That's called cost sharing. The coverage level you buy will determine your cost sharing.

How it works

Insurance plans come in four "metal" categories. What's the difference between them? It comes down to how much you pay for your care – your premium – and how much your plan pays.

Balancing costs and benefits

The higher the coverage level, the higher the premium. Premiums are higher for platinum and gold plans because the insurer covers more of the medical care costs for you and everyone on your plan. Silver and bronze plans have lower premiums, but you'll pay more of your medical expenses. You'll want to balance the level you want with the premium you can afford.

We expect kids to need a lot of health care. Their parents can get sick or have accidents, too. So how do you decide what's right for you and your family? Start by thinking about the number of doctor visits and prescription drugs you're likely to use in the next year. Your answer can point you toward the best coverage level based on your estimated use of services.

How many doctor visits and prescriptions will you use next year?

VERY FEW

Consider a **bronze plan.** These are best if you go to the doctor or pharmacy frequently. You pay a higher premium, but your out-of-pocket care costs will be lower.

IN BETWEEN

Consider a **silver plan.** The are best if you aren't sure how often you'll go to the doctor or pharmacy. Your premium and out-of-pocket care costs will be more evenly balanced.

MANY

Consider a **gold plan.** These are best if you don't go to the doctor or pharmacy very often. You pay a lower premium, but your out-of-pocket care costs will be higher.

What's covered?

All plans cover a comprehensive list of health care services called benefits. You and your health plan share the cost for these services. They include:

- Most same-day services (office visits, outpatient services)
- Emergency services
- Prescription drugs
- Hospitalization (including surgery and overnight stays)
- Pregnancy, maternity, and newborn care (both before and after birth)
- Pediatric services (medical care for children)
- Rehabilitative and habilitative services and devices (these help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)
- Mental health and substance abuse services
- Preventive care and chronic disease management

Specific services vary based on the state you live in. There's no annual limit on the value of services you can receive in these categories as long as you receive them from a provider in your network. **You can see what each plan covers by viewing its plan document.**

Preventive care available at no cost

Preventive care that you get from a network provider is available at no cost to you. Preventive care, commonly known as your annual checkup or physical, can help you spot or avoid health problems. It also includes services like:

- Annual exams
- Recommended vaccines such as tetanus, HPV, and influenza
- Cancer screenings such as skin, breast, and cervical (Pap test)
- Obesity screening and counseling
- Alcohol abuse and tobacco use screenings, and help to stop
- Screenings for blood pressure, high cholesterol, diabetes, and depression

Find out more about preventive care at **Medica.com/Prevention.**

You're not just covered, you're cared for.

Plan types

What's the difference between plan types? It has to do with when and how you pay for your health care, and how predictable your expenses will be.

With a copay plan you will pay:

- Primary care office visit copays
- Specialty care office visit copays
- Prescription copays

With a share plan you will pay:

- The full cost of a primary care office visit until your deductible is met
- The full cost of a specialty care office visit until your deductible is met
- Prescription copays

With a value plan you will pay:

- The full cost of a primary care office visit until your deductible is met
- The full cost of a specialty care office visit until your deductible is met
- The full cost of prescriptions until your deductible is met

With an HSA-compatible plan you will pay*:

- The full cost of a primary care office visit until your deductible is met
- The full cost of a specialty care office visit until your deductible is met
- The full cost of prescriptions until your deductible is met

**HSA-compatible plans are the only plans you can use an HSA (health savings account) for qualifying expenses. See page 18 for more details.*

Since you have kids, you'll need a plan that covers doctor visits and won't break your budget. Ask yourself if you're prepared to handle instability in terms of when health care costs occur and how much you'll have to pay at any given time.

How comfortable are you with unpredictable medical expenses?

COMFORTABLE

Consider a **high deductible plan.** Generally they have lower premiums, but you'll pay most of your expenses for medical care and prescription drugs up front, before the plan starts to pay.

IN BETWEEN

Consider a **catastrophic plan.** These plans have lower premiums, and you only pay a fixed copay amount for your first three primary care visits – even if you haven't fully paid your deductible. You'll pay most of your expenses for other medical care and prescription drugs up front, before the plan starts to pay.

UNCOMFORTABLE

Consider a **copay plan.** These generally have higher premiums, but for many routine services and prescriptions, you'll pay only the fixed copay amount, even if you haven't fully paid your deductible. Copays are the most predictable way to pay for your care and prescriptions.

Comparing health care costs

The examples below show how costs could be different across plans for a simple fracture. Use these examples to see, in general, how much financial protection you'll get if you'recovered under each plan.

In-network services such as:

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

Could cost you **$1,900.** Below, you can view examples of how you and your plan would share the costs.

BRONZE HSA PLAN

Plan's deductible: $6,200
Specialist copay: N/A
Coinsurance: 20%

YOU PAY:	
Deductibles	$1,900
Copays	$0
Coinsurance	$0
TOTAL	**$1,900**

Bronze HSA plan pays $0

SILVER COPAY PLAN

Plan's deductible: $3,700
Specialist copay: $60
Coinsurance: 40%

YOU PAY:	
Deductibles	$1,700
Copays	$100
Coinsurance	$0
TOTAL	**$1,800**

Silver Copay plan pays $100

GOLD COPAY PLAN

Plan's deductible: $750
Specialist copay: $60
Coinsurance: 30%

YOU PAY:	
Deductibles	$750
Copays	$100
Coinsurance	$300
TOTAL	**$1,150**

Gold Copay plan pays $750

Don't use the examples to estimate your actual costs under each plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

Networks

When you pick a plan, it's not just about the coverage you get, it's also about who and where you receive care. This is your network.

Every Health Plan Has a Network

The network tells you the providers, clinics, pharmacies and hospitals you can use when you receive care. Some plans limit your choices or require you to get services from the plan's network. Others pay a share of the costs for providers outside the plan's network.

Medica offers three types of networks:

1. **Care System Networks**
   Smaller networks based around provider care system(s)
2. **Tiered Networks**
   Offer incentives to seek care with Tier 1 — Preferred Providers for lower out-of-pocket care costs.
3. **Broad Networks**
   Large networks with access to many providers.

Balancing Costs and Access

The larger the network, typically the higher the premium. Plans with large networks and wide selection of providers generally have higher premiums. Plans with more localized, smaller networks generally have lower premiums. There's a trade-off you need to consider. Choosing a plan with a smaller network can save you on monthly premiums, but if you aren't satisfied with the choices your network provides, you'll likely end up paying significantly more for services provided out of your network.

Make a list of all the providers you use. If you want to continue to see them, you'll want to be sure they're in your plan's network. So eliminate the plans that don't provide access.

Premiums for similar plans may vary, based on the network offered. But avoid going for the lowest-priced plan if the doctor you want to see isn't in that plan's network.

Here's a point to keep in mind: It's important to pick a health plan with a network that meets your needs. It's also important to always use network providers when you need care. **Check out our flyer on out-of-network care to learn more** about the financial risks you face when you use a provider who's not in your network.

Prescription drugs

Prescriptions can be expensive. If you take prescription drugs on a regular basis, take time to check out how your drugs are covered and what your share of the costs will be.

Not all drugs are covered

Every plan has a drug list that defines drugs that are covered and how much of the cost you'll need to pay. Most health insurance companies keep their drug list online. You can also call to find this information. Drug lists are typically made up of drugs that provide the most value and have proven safety and effectiveness. That helps keep your share of the costs at their lowest.

What if your medications aren't covered?

Many insurance plans don't cover certain brand-name drugs, but do cover their generic equivalents. A brand-name drug is protected by a patent for a certain amount of time. That means only one manufacturer can make the drug during that period. Once the patent expires, other companies can make generic versions of the drug.

Generic drugs have the same active ingredients as their brand-name counterpart and must meet the same quality standards as brand-name drugs, but they're usually less expensive.

The Food and Drug Administration (FDA) regulates both brand-name and generic drugs.

Prescription drug prices can be a burden on your finances. For example, a prescription for a particular medication can be hundreds of dollars, and the cost varies depending where you buy it. So keep these questions in mind as you review your plan options.

Ask yourself how perscription drugs could affect your finances

- Are your current prescriptions covered by this plan?
- How will you pay for your prescriptions under the plan? Is there a copay or coinsurance?
- Will you need to pay the full price for drugs before you hit your deductible?
- Are the pharmacies in the network convenient for you?

When you can buy a plan

Open Enrollment Period

November 1 — December 15*

This is a fixed time period each year when anyone can buy an individual or family health plan.

Special Enrollment Period

A Special Enrollment Period lets you buy coverage outside the Open Enrollment Period. It's specific to you and can only be triggered by what's called a qualifying life event. Here are some examples:

- **Losing health coverage:** Involuntarily losing health coverage due to job loss, or a change in eligibility for employment-based coverage.
- **Household changes:** Getting married or divorced, having a baby or adopting a child, or a death in the family.
- **Change to where you live:** A permanent move to a different ZIP code or county could cause you to lose access to your health insurance.
- **Other complicated or less common situations:** Your state's Health Insurance Marketplace will have a complete list.

If any of these situations apply to you, here's what you need to know:

Your Special Enrollment Period will be open for 60 days from the date of your qualifying event. You must buy an individual or family plan, or make a change to your existing plan, during that 60-day time period.

You'll need to submit proof of the qualifying event. Your state's Health Insurance Marketplace — or the insurer you select — will let you know what documents are required with your application and your options for sending them in.

**Some states may extend this window. You can confirm your enrollment window with your state's Health Insurance Marketplace.*

Help paying for your insurance

Many people who buy their own insurance can get financial assistance to help pay for their premiums and out-of-pocket costs — and a lot of them don't even know it.

Two kinds of help

Your estimated household income and other household information determine what you qualify for. That help may cover most or even all of your health care costs.

1 **Premium tax credits**

You can use a tax credit to lower your monthly premium. This is what you pay each month for your insurance. If your estimated income falls between 100-400% of the federal poverty level for your household size, you qualify for a premium tax credit. You can use this credit to enroll in any metal level (platinum, gold, silver or bronze) plan

2 **Cost-share Reduction (CSR) plans**

CSR plans help reduce your out-of-pocket costs by giving you a discount that lowers your deductibles, copays, and coinsurance. For the discount to apply, you must enroll in a silver metal level plan.

To receive any assistance that you may be qualified for, you must buy your plan through your state's Health Insurance Marketplace. The Marketplace can also help you apply for public insurance coverage if your income makes you eligible.

How to sign up

Ready to enroll? Here's where you can buy a plan

Your state's Health Insurance Marketplace

A Health Insurance Marketplace is a government-sponsored online store where multiple companies offer individual and family policies. Where you live determines the Marketplace you use to sign up. Some states have their own, while others participate in the federal Marketplace.

We offer plans in multiple states across the country. Find details about where you can sign up based on where you live:

Health Insurance Marketplace

HEALTHCARE.GOV

The Health Insurance Marketplace in Iowa, Kansas, Missouri, Nebraska, North Dakota, Oklahoma, and Wisconsin

1 (800) 318-2596
Healthcare.gov

MNsure
Where you choose health coverage

MNSURE

The Health Insurance Marketplace in Minnesota

1 (855) 366-7873
MNsure.org

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Call us at **1 (888) 818-1138** (TTY: **711**).

Email us at **MedicaIndividualProducts@Medica.com**

Find an agent or broker in your community at **Medica.com/Agent**

Glossary

Learning the Lingo? Knowing these health insurance terms can help you understand what your health plan includes and how it works.

BENEFITS

Health care services covered with some level of payment by your insurance plan.

COINSURANCE

A percentage of the charges for a health care service that you pay.

COVERED SERVICES

Medical services that are included in your health plan (also called benefits). You and your insurer will share the cost of these services. Most covered services count toward your deductible and out-of-pocket maximum.

DEDUCTIBLE

The amount you pay each year before your insurance starts to pay. There are two types:

Non-embedded deductible
Everyone on the plan shares one family deductible.

Embedded deductible
Each family member has his or her own deductible, in addition to a shared family deductible.

HEALTH INSURANCE MARKETPLACE

A government-sponsored online store where multiple companies offer individual and family policies. If you qualify for financial assistance, you must buy your plan through the Marketplace to receive it.

NETWORK

A group of doctors, clinics, hospitals, pharmacies or other health care providers that contract with your health insurer to provide services to its members, generally at discounted rates.

HEALTH SAVINGS ACCOUNT (HSA)

A special bank account that lets you save tax-free dollars to cover the cost of medical expenses.

NON-COVERED SERVICES

Medical services that are not included in your health plan (also called exclusions). You pay the full cost of these services, and they don't count toward your deductible or out-of-pocket maximum. Examples may includes cosmetic procedures, experimental drugs and refractive eye surgery.

OUT-OF-POCKET MAXIMUM

The most you will pay in a year for health care services covered by your insurance. Deductibles, copays and coinsurance are counted toward the out-of-pocket maximum, but premiums are not.

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.

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