

Your guide to
Medica Prime Solution®
Basic and Enhanced



Summary of Benefits for
H2450-001/H2450-002
H2450-005/H2450-006

January 1 – December 31, 2009

Minnesota

Section I:

Introduction to the Summary of Benefits for Medica Prime Solution® Basic and Enhanced Plans January 1 – December 31, 2009

Thank you for your interest in Medica Prime Solution.® Our plan is offered by Medica Insurance Company, a Medicare Cost Managed Care 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 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 health plan, like Medica Prime Solution.

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 Prime Solution at the number listed at the end of this introduction or call **1-800-MEDICARE (1-800-633-4227)** for more information. TTY users should call **1-877-486-2048**. You can call this number 24 hours a day, 7 days a week.

How can I compare my options?

You can compare Medica Prime Solution 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 Prime Solution available?

The service area for this plan includes:

Minnesota

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

* **Partial county**
ZIP codes
Lake 55609, 55616

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

Who is eligible to join Medica Prime Solution?

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

Can I choose my doctors?

Medica Prime Solution has formed a network of

doctors, specialists, and hospitals. You can use any doctor who is part of our network. You may also go to doctors outside of our network. The health providers in our network can change at any time. You can ask for a current Provider Directory for an up-to-date list. Our customer service number is listed at the end of this introduction.

What happens if I go to a doctor who's not in your network?

You can always choose to go to a doctor outside our network. We may not pay for the services you receive outside of our network, but Medicare will pay for its share of charges it approves. You will be responsible for Original Medicare deductible and coinsurance.

Does my plan cover Medicare Part B or Part D drugs?

Medica Prime Solution does cover Medicare Part B prescription drugs and if you purchase the Medica Part D Rider, Medicare Part D prescription drugs.

Where can I get my prescriptions if I join this plan and purchase the Medica Part D Rider?

Medica Prime Solution 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 Prime Solution has a list of preferred pharmacies. At these pharmacies, you may get your drugs at a lower co-pay 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 Prime Solution uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or 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 Prime Solution, 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 this number 24 hours a day, 7 days a week.

What are my protections in this plan?

All Medicare Cost 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 Cost 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.

If you purchase a Medica Part D Rider, the following applies: 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 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 Prime Solution 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 Prime Solution 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 Insurance Company for more information about Medica Prime Solution. Visit us at 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 (TTY: **952-992-3650**)
or **1-800-234-8755** (TTY: **1-800-234-8819**)

Prospective members should call
952-992-2345 (TTY: **952-992-3650**)
or **1-800-906-5432** (TTY: **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**)

Prospective members should call
1-800-906-5432 (TTY: **1-800-234-8819**)

For more information about Medicare:

Call **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** on the Web.

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

Section II:

Summary of Benefits for Medica Prime Solution® for Contract Year 2009

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

Benefit	Original Medicare
IMPORTANT INFORMATION	
<p>1. Premium and Other Important Information</p>	<ul style="list-style-type: none"> In 2009 the monthly Part B Premium is \$96.40 and the yearly Part B deductible amount is \$135. (2)
<p>2. Doctor and Hospital Choice (for more information, see Emergency Care – #15 and Urgently Needed Care – #16)</p>	<ul style="list-style-type: none"> You may go to any doctor, specialist or hospital that accepts Medicare.
INPATIENT CARE	
<p>3. Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)</p>	<ul style="list-style-type: none"> 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) <p>Please call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. (4)</p>

(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

Medica Prime Solution Basic

Medica Prime Solution Enhanced

- \$69.00 monthly plan premium in addition to your monthly Medicare Part B premium.

In-Network

- There is a \$3,000 in-network out-of-pocket limit. All plan services covered under the out-of-pocket limit except the optional supplemental riders.

In-Network

- No referral required for network doctors, specialists, and hospitals.
- You may have to pay a separate copay for certain doctor office visits.

Out-of-Network

- Plan covers you when you travel in the U.S. under the Medica Extended Absence Program. You must call Medica Customer Service to initiate this benefit.

In and Out-of-Network

- You can use any network doctor. If you go to out-of-network doctors the plan may not cover the services, but Medicare will pay its share for Medicare-covered services. When Medicare pays its share, you pay the Medicare Part B deductible and coinsurance.

- \$110.00 monthly plan premium in addition to your monthly Medicare Part B premium.

In-Network

- There is a \$3,000 in-network out-of-pocket limit. All plan services covered under the out-of-pocket limit except the optional supplemental riders.

In-Network

- No referral required for network doctors, specialists, and hospitals.

Out-of-Network

- Plan covers you when you travel in the U.S. under the Medica Extended Absence Program. You must call Medica Customer Service to initiate this benefit.

In and Out-of-Network

- You can use any network doctor. If you go to out-of-network doctors the plan may not cover the services, but Medicare will pay its share for Medicare-covered services. When Medicare pays its share, you pay the Medicare Part B deductible and coinsurance.

In-Network

- \$100 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.

In-Network

- \$0 copay.
- No limit to the number of days covered by the plan each benefit period.

for 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 at 1-800-234-8755 (for current members) or 1-800-906-5432 (for prospective members).

Benefit	Original Medicare
INPATIENT CARE (CONTINUED)	
4. Inpatient Mental Health Care	<ul style="list-style-type: none"> • Same deductible and copay as inpatient hospital care (see "Inpatient Hospital Care" above). • 190 day lifetime limit in a Psychiatric Hospital.
5. Skilled Nursing Facility (in a Medicare-certified skilled nursing facility)	<ul style="list-style-type: none"> • 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. • There is a limit of 100 days for each benefit period. (3)
6. Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	<ul style="list-style-type: none"> • \$0 copay.
7. Hospice	<ul style="list-style-type: none"> • You pay part of the cost for outpatient drugs and inpatient respite care. • You must receive care from a Medicare-certified hospice.
OUTPATIENT CARE	
8. Doctor Office Visits	<ul style="list-style-type: none"> • 20% coinsurance. (1) (2)

(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

Medica Prime Solution Basic

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<p>In-Network</p> <ul style="list-style-type: none"> • \$100 copay for each Medicare-covered hospital stay. • \$0 copay for additional hospital days. • Contact the plan for details about coverage in a Psychiatric Hospital beyond 190 days. 	<p>In-Network</p> <ul style="list-style-type: none"> • \$0 copay. • Contact the plan for details about coverage in a Psychiatric Hospital beyond 190 days.
<p>In-Network</p> <ul style="list-style-type: none"> • \$0 copay for SNF services. • Plan covers up to 100 days each benefit period. • 3-day prior hospital stay is required. 	<p>In-Network</p> <ul style="list-style-type: none"> • \$0 copay for SNF services. • Plan covers up to 100 days each benefit period. • 3-day prior hospital stay is required.
<p>In-Network</p> <ul style="list-style-type: none"> • \$0 to \$10 copay for each Medicare-covered home health visit. 	<p>In-Network</p> <ul style="list-style-type: none"> • \$0 copay for Medicare-covered home health visits.
<p>General</p> <ul style="list-style-type: none"> • You must receive care from a Medicare-certified hospice. 	<p>General</p> <ul style="list-style-type: none"> • You must receive care from a Medicare-certified hospice.
<p>General</p> <ul style="list-style-type: none"> • See #33 "Physical Exams," for more information. <p>In-Network</p> <ul style="list-style-type: none"> • \$10 copay for each primary care doctor visit for Medicare-covered benefits. • \$10 copay for each in-area, network urgent care Medicare-covered visit. • \$10 copay for each specialist visit for Medicare-covered benefits. 	<p>General</p> <ul style="list-style-type: none"> • See #33 "Physical Exams," for more information. <p>In-Network</p> <ul style="list-style-type: none"> • \$0 copay for each primary care doctor visit for Medicare-covered benefits. • \$0 copay for each in-area, network urgent care Medicare-covered visit. • \$0 copay for each specialist doctor visit for Medicare-covered benefits.

for 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 at 1-800-234-8755 (for current members) or 1-800-906-5432 (for prospective members).

Benefit	Original Medicare
OUTPATIENT CARE (CONTINUED)	
9. Chiropractic Services	<ul style="list-style-type: none"> • Routine care not covered. • 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)
10. Podiatry Services	<ul style="list-style-type: none"> • Routine care not covered. • 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs. (1) (2)
11. Outpatient Mental Health Care	<ul style="list-style-type: none"> • 50% coinsurance for most outpatient mental health services. (1) (2)
12. Outpatient Substance Abuse Care	<ul style="list-style-type: none"> • 20% coinsurance. (1) (2)
13. Outpatient Services/Surgery	<ul style="list-style-type: none"> • 20% coinsurance for the doctor. (1) (2) • 20% of outpatient facility charges. (1) (2)
14. Ambulance Services (medically necessary ambulance services)	<ul style="list-style-type: none"> • 20% coinsurance. (1) (2)

(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

Medica Prime Solution Basic

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<p>In-Network</p> <ul style="list-style-type: none"> • \$10 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. 	<p>In-Network</p> <ul style="list-style-type: none"> • \$0 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.
<p>In-Network</p> <ul style="list-style-type: none"> • \$10 copay for each Medicare-covered visit. • Medicare-covered podiatry benefits are for medically-necessary foot care. 	<p>In-Network</p> <ul style="list-style-type: none"> • \$0 copay for Medicare-covered podiatry benefits. • Medicare-covered podiatry benefits are for medically-necessary foot care.
<p>In-Network</p> <ul style="list-style-type: none"> • \$10 copay for each Medicare-covered individual or group therapy visit. 	<p>In-Network</p> <ul style="list-style-type: none"> • \$0 copay for Medicare-covered Mental Health visits.
<p>In-Network</p> <ul style="list-style-type: none"> • \$10 copay for Medicare-covered individual or group visits. 	<p>In-Network</p> <ul style="list-style-type: none"> • \$0 copay for Medicare-covered visits.
<p>In-Network</p> <ul style="list-style-type: none"> • \$50 copay for each Medicare-covered ambulatory surgical center visit. • \$0 to \$50 copay for each Medicare-covered outpatient hospital facility visit. 	<p>In-Network</p> <ul style="list-style-type: none"> • \$0 copay for each Medicare-covered ambulatory surgical center visit. • \$0 copay for each Medicare-covered outpatient hospital facility visit.
<p>In-Network</p> <ul style="list-style-type: none"> • \$25 copay for Medicare-covered ambulance services. 	<p>In-Network</p> <ul style="list-style-type: none"> • \$0 copay for Medicare-covered ambulance services.

for 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 at 1-800-234-8755 (for current members) or 1-800-906-5432 (for prospective members).

Benefit	Original Medicare
OUTPATIENT CARE (CONTINUED)	
<p>15. Emergency Care (you may go to any emergency room if you reasonably believe you need emergency care)</p>	<ul style="list-style-type: none"> • 20% coinsurance for the doctor. (1) (2) • 20% of facility charge, or a set copay per emergency room visit. (1) (2) • 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. • NOT covered outside the U.S. except under limited circumstances.
<p>16. Urgently Needed Care (this is NOT emergency care, and in most cases, is out of the service area)</p>	<ul style="list-style-type: none"> • 20% coinsurance, or a set copay. (1) (2) • NOT covered outside the U.S. except under limited circumstances.
<p>17. Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)</p>	<ul style="list-style-type: none"> • 20% coinsurance. (1) (2)
OUTPATIENT MEDICAL SERVICES AND SUPPLIES	
<p>18. Durable Medical Equipment (includes wheelchairs, oxygen, etc.)</p>	<ul style="list-style-type: none"> • 20% coinsurance. (1) (2)
<p>19. Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)</p>	<ul style="list-style-type: none"> • 20% coinsurance. (1) (2)
<p>20. Diabetes Self-Monitoring Training, Nutrition Therapy and Supplies (includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)</p>	<ul style="list-style-type: none"> • 20% coinsurance. (1) (2) • 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.

(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

Medica Prime Solution Basic

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<p>In-Network</p> <ul style="list-style-type: none"> • \$50 copay for Medicare-covered emergency room visits. <p>Out-of-Network</p> <ul style="list-style-type: none"> • Worldwide coverage. <p>In and Out-of-Network</p> <ul style="list-style-type: none"> • If you are admitted to the hospital within 24-hour(s) for the same condition, you pay \$0 for the emergency room visit. 	<p>In-Network</p> <ul style="list-style-type: none"> • \$0 copay for Medicare-covered emergency room visits. <p>Out-of-Network</p> <ul style="list-style-type: none"> • Worldwide coverage.
<p>General</p> <ul style="list-style-type: none"> • \$50 copay for Medicare-covered urgently needed care visits. 	<p>General</p> <ul style="list-style-type: none"> • \$0 copay for Medicare-covered urgently needed care visits.
<p>In-Network</p> <ul style="list-style-type: none"> • \$10 copay for Medicare-covered Occupational Therapy visits. • \$10 copay for Medicare-covered Physical Therapy and/or Speech/Language Therapy visits. 	<p>In-Network</p> <ul style="list-style-type: none"> • \$0 copay for Medicare-covered Occupational Therapy visits. • \$0 copay for Medicare-covered Physical Therapy and/or Speech/Language Therapy visits.
<p>In-Network</p> <ul style="list-style-type: none"> • You pay 20% of the cost for Medicare-covered items. 	<p>In-Network</p> <ul style="list-style-type: none"> • \$0 copay for Medicare-covered items.
<p>In-Network</p> <ul style="list-style-type: none"> • You pay 20% of the cost for Medicare-covered items. 	<p>In-Network</p> <ul style="list-style-type: none"> • You pay 0%–20% of the cost for Medicare-covered items.
<p>In-Network</p> <ul style="list-style-type: none"> • You pay 20% of the cost for Diabetes self-monitoring training. • You pay 20% of the cost for Nutrition Therapy for Diabetes. • You pay 20% of the cost for Diabetes supplies. 	<p>In-Network</p> <ul style="list-style-type: none"> • You pay 20% of the cost for Diabetes self-monitoring training. • You pay 20% of the cost for Nutrition Therapy for Diabetes. • \$0 copay for Diabetes supplies.

for 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 at 1-800-234-8755 (for current members) or 1-800-906-5432 (for prospective members).

Benefit	Original Medicare
OUTPATIENT MEDICAL SERVICES AND SUPPLIES (CONTINUED)	
21. Diagnostic Tests, X-Rays, and Lab Services	<ul style="list-style-type: none"> • 20% coinsurance for diagnostic tests and X-rays. (1) (2) • \$0 copay for Medicare-covered lab services. • 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.
PREVENTIVE SERVICES	
22. Bone Mass Measurement (for people with Medicare who are at risk)	<ul style="list-style-type: none"> • 20% coinsurance. (1) (2) • Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.
23. Colorectal Screening Exams (for people with Medicare age 50 and older)	<ul style="list-style-type: none"> • 20% coinsurance. (1) (2) • Covered when you are high risk or when you are age 50 and older.
24. Immunizations (Flu vaccine, Hepatitis B vaccine – for people with Medicare who are at risk, Pneumonia vaccine)	<ul style="list-style-type: none"> • \$0 copay for Flu and Pneumonia vaccines. • 20% coinsurance for Hepatitis B vaccine. (1) (2) • You may only need the Pneumonia vaccine once in your lifetime. Please contact your doctor for more information.

(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

Medica Prime Solution Basic

Medica Prime Solution Enhanced

In-Network

- \$0 copay for the following Medicare-covered service(s):
 - Lab services
 - Diagnostic procedures and tests
 - X-rays
 - Diagnostic radiology services (not including X-rays)
 - Therapeutic radiology services

In-Network

- \$0 copay for the following Medicare-covered service(s):
 - Lab services
 - Diagnostic procedures and tests
 - X-rays
 - Diagnostic radiology services (not including X-rays)
 - Therapeutic radiology services

In-Network

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

In-Network

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

In-Network

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

In-Network

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

In-Network

- \$0 copay for Flu and Pneumonia vaccines.
- No referral needed for Flu and Pneumonia vaccines.
- \$0 copay for Hepatitis B vaccine.
- No referral needed for other immunizations.

In-Network

- \$0 copay for Flu and Pneumonia vaccines.
- No referral needed for Flu and Pneumonia vaccines.
- \$0 copay for Hepatitis B vaccine.
- No referral needed for other immunizations.

for 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 at 1-800-234-8755 (for current members) or 1-800-906-5432 (for prospective members).

Benefit	Original Medicare
PREVENTIVE SERVICES (CONTINUED)	
<p>25. Mammograms (Annual Screening) (for women with Medicare age 40 and older)</p>	<ul style="list-style-type: none"> • 20% coinsurance. (2) • No referral needed for Medicare-covered screenings. • 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.
<p>26. Pap Smears and Pelvic Exams (for women with Medicare)</p>	<ul style="list-style-type: none"> • \$0 copay for Pap Smears. (2) • Covered once every 2 years. Covered once a year for women with Medicare at high risk. (2) • 20% coinsurance for Pelvic Exams. (2)
<p>27. Prostate Cancer Screening Exams (for men with Medicare age 50 and older)</p>	<ul style="list-style-type: none"> • \$0 copay for the PSA test and 20% coinsurance for the digital rectal exam and other related services. (2) • Covered once a year for all men with Medicare over age 50.
<p>28. End-Stage Renal Disease (ESRD)</p>	<ul style="list-style-type: none"> • 20% coinsurance for renal dialysis. • 20% coinsurance for Nutrition Therapy for End-Stage Renal Disease. • 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.

(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

Medica Prime Solution Basic

Medica Prime Solution Enhanced

In-Network

- \$0 copay for Medicare-covered Screening Mammograms.

In-Network

- \$0 copay for:
 - Medicare-covered Pap Smears and Pelvic Exams
 - Up to one additional Pap Smear(s) and Pelvic Exam(s) every year

In-Network

- \$0 copay for Medicare-covered Prostate Cancer Screening Exams.

General

- Cost plan members pay Fee-for-Service cost sharing for out-of-area dialysis.

In-Network

- \$0 copay for renal dialysis.
- You pay 20% of the cost for Nutrition Therapy for End-Stage Renal Disease.

In-Network

- \$0 copay for Medicare-covered Screening Mammograms.

In-Network

- \$0 copay for:
 - Medicare-covered Pap Smears and Pelvic Exams
 - Up to one additional Pap Smear(s) and Pelvic Exam(s) every year

In-Network

- \$0 copay for Medicare-covered Prostate Cancer Screening Exams.

General

- Cost plan members pay Fee-for-Service cost sharing for out-of-area dialysis.

In-Network

- \$0 copay for renal dialysis.
- You pay 20% of the cost for Nutrition Therapy for End-Stage Renal Disease.

for 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 at 1-800-234-8755 (for current members) or 1-800-906-5432 (for prospective members).

Benefit	Original Medicare
ADDITIONAL BENEFITS	
<p>29. Prescription Drugs</p>	<ul style="list-style-type: none"> • 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.
<p>30. Dental Services</p>	<ul style="list-style-type: none"> • Preventive dental services (such as cleaning) are not covered.
<p>31. Hearing Services</p>	<ul style="list-style-type: none"> • Routine hearing exams and hearing aids are not covered. • 20% coinsurance for diagnostic hearing exams. (1) (2)

(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

Medica Prime Solution Basic

Medica Prime Solution Enhanced

Drugs Covered Under Medicare Part B General

- You pay 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 does offer prescription drug coverage as an optional benefit. See Optional Supplemental Packages 1 and 2 for more information.

In-Network

- In general, preventive dental benefits (such as cleaning) are not covered. However, this plan covers preventive dental services for an extra cost. See Optional Supplemental Package 3 below.
- 0% of the cost for Medicare-covered dental benefits.

In-Network

- \$10 copay for Medicare-covered diagnostic hearing exams.
- \$0 copay for:
 - Up to 1 routine hearing test every year.
 - Up to 1 fitting evaluation for a hearing aid every year.
- \$0 copay for hearing aids.
- \$450 limit for fitting evaluations and hearing aids every year.

Drugs Covered Under Medicare Part B General

- You pay 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 does offer prescription drug coverage as an optional benefit. See Optional Supplemental Packages 1 and 2 for more information.

In-Network

- In general, preventive dental benefits (such as cleaning) are not covered. However, this plan covers preventive dental services for an extra cost. See Optional Supplemental Package 3 below.
- 0% of the cost for Medicare-covered dental benefits.

In-Network

- \$0 copay for Medicare-covered diagnostic hearing exams.
- \$0 copay for:
 - Up to 1 routine hearing test every year.
 - Up to 1 fitting evaluation for a hearing aid every year.
- \$0 copay for hearing aids.
- \$450 limit for fitting evaluations and hearing aids every year.

for 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 at 1-800-234-8755 (for current members) or 1-800-906-5432 (for prospective members).

Benefit	Original Medicare
ADDITIONAL BENEFITS (CONTINUED)	
32. Vision Services	<ul style="list-style-type: none"> • Medicare pays for one pair of eyeglasses or contact lenses after each cataract surgery. (1) (2) • For people with Medicare who are at risk, you are covered for annual glaucoma screenings. (1) (2) • 20% coinsurance for diagnosis and treatment of diseases and conditions of the eye. (1) (2) • Routine eye exams and glasses are not covered.
33. Physical Exams	<ul style="list-style-type: none"> • 20% coinsurance for one exam within the first 12 months of your new Medicare Part B coverage. (1) (2) • When you get Medicare Part B, you can receive a one time physical exam within the first 12 months of your new Part B coverage. The coverage does not include lab tests.
34. Health/Wellness Education	<ul style="list-style-type: none"> • 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.
35. Transportation (Routine)	<ul style="list-style-type: none"> • Not covered.
36. Acupuncture	<ul style="list-style-type: none"> • Not covered.

(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

Medica Prime Solution Basic

Medica Prime Solution Enhanced

In-Network

- 20% of the cost for one pair of eyeglasses or contact lenses after cataract surgery.
- \$10 copay for exams to diagnose and treat diseases and conditions of the eye.
- \$0 copay for up to 1 routine eye exam every year.
- 0% of the cost for up to 1 pair of glasses every two years.
- 0% of the cost for up to 1 pair of contacts every two years.
- \$125 limit for non-Medicare covered eye wear every two years.

In-Network

- \$0 copay for routine physical exams.
- Limited to one exam every year.

In-Network

- This plan covers the following health/wellness education benefits:
 - Written health education materials, including newsletters
 - Additional Smoking Cessation
 - Health Club Membership/Fitness Classes
 - Nursing Hotline

In-Network

- This plan does not cover routine transportation.

In-Network

- This plan does not cover Acupuncture.

In-Network

- 20% of the cost for one pair of eyeglasses or contact lenses after cataract surgery.
- \$0 copay for diagnosis and treatment for diseases and conditions of the eye
 - and up to 1 routine eye exam every year.
- 0% of the cost for up to 1 pair of glasses every two years.
- 0% of the cost for up to 1 pair of contacts every two years.
- \$125 limit for non-Medicare covered eye wear every two years.

In-Network

- \$0 copay for routine physical exams.
- Limited to one exam every year.

In-Network

- This plan covers the following health/wellness education benefits:
 - Written health education materials, including newsletters
 - Additional Smoking Cessation
 - Health Club Membership/Fitness Classes
 - Nursing Hotline

In-Network

- This plan does not cover routine transportation.

In-Network

- This plan does not cover Acupuncture.

for 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 at 1-800-234-8755 (for current members) or 1-800-906-5432 (for prospective members).

Benefit	Original Medicare
OPTIONAL BENEFITS (Call Medica for details)	
OPTIONAL SUPPLEMENTAL PACKAGE #1: Medica Part D Rider – Modified Standard Rx	
Prescription Drugs	

This Rider's Prescription Drugs benefit information continues on page 22

- (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

Drugs Covered Under Medicare Part D General

- You pay \$28.30 each month, in addition to your monthly plan premium of \$69.00 per month and for the Medicare Part B premium, for these optional benefits.
- 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 Prime Solution 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.

Drugs Covered Under Medicare Part D General

- You pay \$28.30 each month, in addition to your monthly plan premium of \$110.00 per month and for the Medicare Part B premium, for these optional benefits.
- 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 Prime Solution 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.

for 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 at 1-800-234-8755 (for current members) or 1-800-906-5432 (for prospective members).

Benefit	Original Medicare
OPTIONAL BENEFITS (Call Medica for details) (CONTINUED)	
OPTIONAL SUPPLEMENTAL PACKAGE #1: (CONTINUED)	
Prescription Drugs (continued)	

This Rider's Prescription Drugs benefit information continues on page 24

- (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

- 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.

In-Network

- \$0 deductible.

Initial Coverage

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

Retail Pharmacy

Generic

- \$13 copay for a one-month (31-day) supply of drugs in this tier from a preferred pharmacy
- \$39 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy
- \$13 copay for a one-month (31-day) supply of drugs in this tier from an other network pharmacy

Preferred Brand

- \$35 copay for a one-month (31-day) supply of drugs in this tier from a preferred pharmacy
- \$105 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy
- \$35 copay for a one-month (31-day) supply of drugs in this tier from an other network pharmacy

- 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.

In-Network

- \$0 deductible.

Initial Coverage

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

Retail Pharmacy

Generic

- \$13 copay for a one-month (31-day) supply of drugs in this tier from a preferred pharmacy
- \$39 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy
- \$13 copay for a one-month (31-day) supply of drugs in this tier from an other network pharmacy

Preferred Brand

- \$35 copay for a one-month (31-day) supply of drugs in this tier from a preferred pharmacy
- \$105 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy
- \$35 copay for a one-month (31-day) supply of drugs in this tier from an other network pharmacy

for 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 at 1-800-234-8755 (for current members) or 1-800-906-5432 (for prospective members).

Benefit	Original Medicare
OPTIONAL BENEFITS (Call Medica for details) (CONTINUED)	
OPTIONAL SUPPLEMENTAL PACKAGE #1: (CONTINUED)	
Prescription Drugs (continued)	

This Rider's Prescription Drugs benefit information continues on page 26

- (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

Medica Prime Solution Basic

Medica Prime Solution Enhanced

Non-Preferred Brand

- \$71 copay for a one-month (31-day) supply of drugs in this tier from a preferred pharmacy
- \$213 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy
- \$71 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

Long Term Care Pharmacy

Generic

- \$13 copay for a one-month (31-day) supply of drugs in this tier

Preferred Brand

- \$35 copay for a one-month (31-day) supply of drugs in this tier

Non-Preferred Brand

- \$71 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

Non-Preferred Brand

- \$71 copay for a one-month (31-day) supply of drugs in this tier from a preferred pharmacy
- \$213 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy
- \$71 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

Long Term Care Pharmacy

Generic

- \$13 copay for a one-month (31-day) supply of drugs in this tier

Preferred Brand

- \$35 copay for a one-month (31-day) supply of drugs in this tier

Non-Preferred Brand

- \$71 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

for 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 at 1-800-234-8755 (for current members) or 1-800-906-5432 (for prospective members).

Benefit	Original Medicare
OPTIONAL BENEFITS (Call Medica for details) (CONTINUED)	
OPTIONAL SUPPLEMENTAL PACKAGE #1: (CONTINUED)	
Prescription Drugs (continued)	

This Rider's Prescription Drugs benefit information continues on page 28

- (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

Mail Order

Generic

- \$26 copay for a three-month (90-day) supply of drugs in this tier

Preferred Brand

- \$70 copay for a three-month (90-day) supply of drugs in this tier

Non-Preferred Brand

- \$142 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

Mail Order

Generic

- \$26 copay for a three-month (90-day) supply of drugs in this tier

Preferred Brand

- \$70 copay for a three-month (90-day) supply of drugs in this tier

Non-Preferred Brand

- \$142 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

for 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.

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Benefit	Original Medicare
OPTIONAL BENEFITS (Call Medica for details) (CONTINUED)	
OPTIONAL SUPPLEMENTAL PACKAGE #1: (CONTINUED)	
Prescription Drugs (continued)	

This Rider's Prescription Drugs benefit information continues on page 30

- (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

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 Prime Solution.

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

- \$13 copay for a one-month (31-day) supply of drugs in this tier

Preferred Brand

- \$35 copay for a one-month (31-day) supply of drugs in this tier

Non-Preferred Brand

- \$71 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

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 Prime Solution.

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

- \$13 copay for a one-month (31-day) supply of drugs in this tier

Preferred Brand

- \$35 copay for a one-month (31-day) supply of drugs in this tier

Non-Preferred Brand

- \$71 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

for 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 at 1-800-234-8755 (for current members) or 1-800-906-5432 (for prospective members).

Benefit	Original Medicare
OPTIONAL BENEFITS (Call Medica for details) (CONTINUED)	
OPTIONAL SUPPLEMENTAL PACKAGE #1: (CONTINUED)	
Prescription Drugs (continued)	
OPTIONAL SUPPLEMENTAL PACKAGE #2: Medica Part D Rider – Enhanced Rx	
Prescription Drugs	

This Rider’s Prescription Drugs benefit information continues on page 32

- (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

reach \$4,350. You will not be reimbursed by Medica Prime Solution for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Medica Prime Solution 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.

reach \$4,350. You will not be reimbursed by Medica Prime Solution for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Medica Prime Solution 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.

Drugs Covered Under Medicare Part D General

- You pay \$49.80 each month, in addition to your monthly plan premium of \$69.00 per month and the Medicare Part B premium, for these optional benefits.
- 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).

Drugs Covered Under Medicare Part D General

- You pay \$49.80 each month, in addition to your monthly plan premium of \$110.00 per month and the Medicare Part B premium, for these optional benefits.
- 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).

for 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 at 1-800-234-8755 (for current members) or 1-800-906-5432 (for prospective members).

Benefit	Original Medicare
OPTIONAL BENEFITS (Call Medica for details) (CONTINUED)	
OPTIONAL SUPPLEMENTAL PACKAGE #2: (CONTINUED)	
Prescription Drugs (continued)	

This Rider's Prescription Drugs benefit information continues on page 34

- (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

Medica Prime Solution Basic

Medica Prime Solution Enhanced

- 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 Prime Solution 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.

- 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 Prime Solution 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.

for 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 at 1-800-234-8755 (for current members) or 1-800-906-5432 (for prospective members).

Benefit	Original Medicare
OPTIONAL BENEFITS (Call Medica for details) (CONTINUED)	
OPTIONAL SUPPLEMENTAL PACKAGE #2: (CONTINUED)	
Prescription Drugs (continued)	

This Rider's Prescription Drugs benefit information continues on page 36

- (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

In-Network

- \$0 deductible

Initial Coverage

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

Retail Pharmacy

Generic

- \$13 copay for a one-month (31-day) supply of drugs in this tier from a preferred pharmacy
- \$39 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy
- \$13 copay for a one-month (31-day) supply of drugs in this tier from an other network pharmacy

Preferred Brand

- \$35 copay for a one-month (31-day) supply of drugs in this tier from a preferred pharmacy
- \$105 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy
- \$35 copay for a one-month (31-day) supply of drugs in this tier from an other network pharmacy

In-Network

- \$0 deductible

Initial Coverage

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

Retail Pharmacy

Generic

- \$13 copay for a one-month (31-day) supply of drugs in this tier from a preferred pharmacy
- \$39 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy
- \$13 copay for a one-month (31-day) supply of drugs in this tier from an other network pharmacy

Preferred Brand

- \$35 copay for a one-month (31-day) supply of drugs in this tier from a preferred pharmacy
- \$105 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy
- \$35 copay for a one-month (31-day) supply of drugs in this tier from an other network pharmacy

for 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 at 1-800-234-8755 (for current members) or 1-800-906-5432 (for prospective members).

Benefit	Original Medicare
OPTIONAL BENEFITS (Call Medica for details) (CONTINUED)	
OPTIONAL SUPPLEMENTAL PACKAGE #2: (CONTINUED)	
Prescription Drugs (continued)	

This Rider's Prescription Drugs benefit information continues on page 38

- (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

Medica Prime Solution Basic

Medica Prime Solution Enhanced

Non-Preferred Brand

- \$71 copay for a one-month (31-day) supply of drugs in this tier from a preferred pharmacy
- \$213 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy
- \$71 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

Long Term Care Pharmacy

Generic

- \$13 copay for a one-month (31-day) supply of drugs in this tier

Preferred Brand

- \$35 copay for a one-month (31-day) supply of drugs in this tier

Non-Preferred Brand

- \$71 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

Non-Preferred Brand

- \$71 copay for a one-month (31-day) supply of drugs in this tier from a preferred pharmacy
- \$213 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy
- \$71 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

Long Term Care Pharmacy

Generic

- \$13 copay for a one-month (31-day) supply of drugs in this tier

Preferred Brand

- \$35 copay for a one-month (31-day) supply of drugs in this tier

Non-Preferred Brand

- \$71 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

for 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 at 1-800-234-8755 (for current members) or 1-800-906-5432 (for prospective members).

Benefit	Original Medicare
OPTIONAL BENEFITS (Call Medica for details) (CONTINUED)	
OPTIONAL SUPPLEMENTAL PACKAGE #2: (CONTINUED)	
Prescription Drugs (continued)	

This Rider's Prescription Drugs benefit information continues on page 40

- (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

Mail Order

Generic

- \$26 copay for a three-month (90-day) supply of drugs in this tier

Preferred Brand

- \$70 copay for a three-month (90-day) supply of drugs in this tier

Non-Preferred Brand

- \$142 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

- The plan covers all Formulary Generics through the coverage gap.

You pay the following:

Retail Pharmacy

Generic

- \$13 copay for a one-month (31-day) supply of all drugs covered in this tier from a preferred pharmacy
- \$39 copay for a three-month (90-day) supply of all drugs covered in this tier from a preferred pharmacy
- \$13 copay for a one-month (31-day) supply of all drugs you get at an other network pharmacy

Mail Order

Generic

- \$26 copay for a three-month (90-day) supply of drugs in this tier

Preferred Brand

- \$70 copay for a three-month (90-day) supply of drugs in this tier

Non-Preferred Brand

- \$142 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

- The plan covers all Formulary Generics through the coverage gap.

You pay the following:

Retail Pharmacy

Generic

- \$13 copay for a one-month (31-day) supply of all drugs covered in this tier from a preferred pharmacy
- \$39 copay for a three-month (90-day) supply of all drugs covered in this tier from a preferred pharmacy
- \$13 copay for a one-month (31-day) supply of all drugs you get at an other network pharmacy

for 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 at 1-800-234-8755 (for current members) or 1-800-906-5432 (for prospective members).

Benefit	Original Medicare
OPTIONAL BENEFITS (Call Medica for details) (CONTINUED)	
OPTIONAL SUPPLEMENTAL PACKAGE #2: (CONTINUED)	
Prescription Drugs (continued)	

This Rider's Prescription Drugs benefit information continues on page 42

- (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

Long Term Care Pharmacy

Generic

- \$13 copay for a one-month (31-day) supply of all drugs

Mail Order

Generic

- \$26 copay for a three-month (90-day) supply of all drugs covered in this tier

- For all other covered drugs, 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:
 - A \$2.40 copay for generic (including brand drugs treated as generic) and a \$6.00 copay for all other drugs, or
 - 5% coinsurance.

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 Prime Solution.

Long Term Care Pharmacy

Generic

- \$13 copay for a one-month (31-day) supply of all drugs

Mail Order

Generic

- \$26 copay for a three-month (90-day) supply of all drugs covered in this tier

- For all other covered drugs, 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:
 - A \$2.40 copay for generic (including brand drugs treated as generic) and a \$6.00 copay for all other drugs, or
 - 5% coinsurance.

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 Prime Solution.

for 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 at 1-800-234-8755 (for current members) or 1-800-906-5432 (for prospective members).

Benefit

Original Medicare

IMPORTANT INFORMATION

OPTIONAL SUPPLEMENTAL PACKAGE #2: (CONTINUED)

Prescription Drugs
(continued)

This Rider's Prescription Drugs benefit information continues on page 44

- (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 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

- \$13 copay for a one-month (31-day) supply of drugs in this tier

Preferred Brand

- \$35 copay for a one-month (31-day) supply of drugs in this tier

Non-Preferred Brand

- \$71 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

- The plan covers All Formulary Generics through the gap.

You will be reimbursed for these drugs purchased out-of-network up to the full cost of the drug minus the following:

Generic

- \$13 copay for a one-month (31-day) supply of all drugs covered in this tier

Preferred Brand

- 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

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

- \$13 copay for a one-month (31-day) supply of drugs in this tier

Preferred Brand

- \$35 copay for a one-month (31-day) supply of drugs in this tier

Non-Preferred Brand

- \$71 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

- The plan covers All Formulary Generics through the gap.

You will be reimbursed for these drugs purchased out-of-network up to the full cost of the drug minus the following:

Generic

- \$13 copay for a one-month (31-day) supply of all drugs covered in this tier

Preferred Brand

- 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

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 at 1-800-234-8755 (for current members) or 1-800-906-5432 (for prospective members).

Benefit

Original Medicare

IMPORTANT INFORMATION

OPTIONAL SUPPLEMENTAL PACKAGE #2: (CONTINUED)

Prescription Drugs
(continued)

This Rider's Prescription Drugs benefit information continues on page 46

- (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

Medica Prime Solution Basic

Medica Prime Solution Enhanced

yearly out-of-pocket drug costs reach \$4,350. You will not be reimbursed by Medica Prime Solution for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Medica Prime Solution so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.

Non-Preferred Brand

- 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 Prime Solution for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Medica Prime Solution so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.

Specialty

- 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

yearly out-of-pocket drug costs reach \$4,350. You will not be reimbursed by Medica Prime Solution for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Medica Prime Solution so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.

Non-Preferred Brand

- 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 Prime Solution for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Medica Prime Solution so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.

Specialty

- 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

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 at 1-800-234-8755 (for current members) or 1-800-906-5432 (for prospective members).

Benefit

Original Medicare

IMPORTANT INFORMATION

OPTIONAL SUPPLEMENTAL PACKAGE #2: (CONTINUED)

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

Medica Prime Solution Basic

Medica Prime Solution Enhanced

reimbursed by Medica Prime Solution for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Medica Prime Solution 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.

reimbursed by Medica Prime Solution for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Medica Prime Solution 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 at 1-800-234-8755 (for current members) or 1-800-906-5432 (for prospective members).

Benefit	Original Medicare
OPTIONAL BENEFITS (Call Medica for details) (CONTINUED)	
OPTIONAL SUPPLEMENTAL PACKAGE #3: Medica SeniorDental®	
Premium and Other Important Information	
Dental Services	

- (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

Medica Prime Solution Basic

Medica Prime Solution Enhanced

SeniorDental is available to MINNESOTA residents only. SeniorDental is administered by Delta Dental® of Minnesota.

- You pay \$38.00 each month, in addition to your monthly plan premium of \$69.00 and the Medicare Part B premium, for these optional benefits:
 - Dental Services.

- \$0 copay for the following:
 - oral exams and cleanings up to 2 visits every year.
 - dental bitewing X-rays one set every year.
- \$1,000 limit every year for these benefits.
- Plan offers additional comprehensive dental benefits. Contact plan for details.

SeniorDental is available to MINNESOTA residents only. SeniorDental is administered by Delta Dental® of Minnesota.

- You pay \$38.00 each month, in addition to your monthly plan premium of \$110.00 and the Medicare Part B premium, for these optional benefits:
 - Dental Services.

- \$0 copay for the following:
 - oral exams and cleanings up to 2 visits every year.
 - dental bitewing X-rays one set every year.
- \$1,000 limit every year for these benefits.
- Plan offers additional comprehensive dental benefits. Contact plan for details.

for 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**.

MEDICA®

PO Box 9310, Minneapolis, MN 55440-9310

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