

**CONTACT US** 

When it comes to health insurance, there are no stupid questions. Contact your local Medica broker, give us a call, or drop us a line. We'll do our best to get you an answer within one working day.

**HOURS** 

Monday – Thursday: 8 a.m. to 5 p.m.  
Friday: 9 a.m. to 5 p.m.

**PHONE** 

952-992-2080  
1-800-670-5935

Hearing Impaired: Please call the National Relay Center at 1-800-855-2880 and ask for one of the numbers listed above.

**EMAIL** 

MedicaSolo@medica.com

**WEB** 

www.MedicaSolo.com



**MEDICA**<sup>®</sup>

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IFB5371-11210

# BEFORE DOUBLE DARE BECOMES URGENT CARE



**Medica Solo**<sup>SM</sup>  
Coverage for One Person

**Minnesota**

**BENEFIT SUMMARY**

This information is valid January 2011 through December 2011.

## PLAN HIGHLIGHTS ▼ WHAT'S INCLUDED

- Medica Solo is a one-person plan.
- Applicants must be between ages 19 and 64.
- Please see the Minnesota Medica Solo Rate Guide to calculate your monthly premium.
- This is a brief overview of the plan. Please see a policy document available on [medica.com](http://medica.com) for complete details.

BENEFITS	IN-NETWORK COVERAGE			
<b>In-network annual deductible options</b>	\$3,000	\$6,000	\$9,000	\$12,000
<b>In-network annual out-of-pocket maximum</b>	\$4,000	\$7,000	\$10,000	\$13,000
<b>Office visits</b> Non-preventive care (e.g., physician, chiropractor)	\$30 copay for the first 3 visits per calendar year; after 3rd, 80% coverage after deductible	\$40 copay for the first 3 visits per calendar year; after 3rd, 80% coverage after deductible	\$50 copay for the first 3 visits per calendar year; after 3rd, 80% coverage after deductible	\$60 copay for the first 3 visits per calendar year; after 3rd, 80% coverage after deductible
Preventive care	100% coverage (Copay, coinsurance and deductible do not apply)			
<b>Prescription drugs</b>	<i>Preferred generic drugs:</i> \$10 copay <i>Preferred brand-name drugs:</i> You pay 100% at Medica's discounted rate You have the option to increase your prescription drug coverage. See details on next page.			
<b>Convenience care center visits</b>	\$20 copay for first 3 visits per calendar year; after 3rd, 80% coverage after deductible			
<b>Urgent care center visits</b>	\$100 copay for first visit per calendar year; after 1st, 80% coverage after deductible			
<b>Emergency room</b>	\$200 copay for first visit per calendar year; after 1st, 80% coverage after deductible			
<b>Lab and X-ray services</b>	80% coverage after deductible			
<b>Hospital services</b>				
<b>Ambulance</b>				
<b>Surgery</b>				
<b>Eyewear</b>	Medica pays up to \$50 per calendar year			
<b>Maternity</b>	Maternity, labor, delivery, and postpartum care not covered 100% coverage for prenatal care (deductible does not apply)			
<b>Other eligible healthcare services</b>	80% coverage after deductible			

ADDITIONAL COVERAGE OPTIONS	
<b>Remove mental health/substance abuse coverage</b>	You have the option to remove your mental health and substance abuse coverage already included in the plan. <i>Choosing to remove this coverage <b>reduces</b> your monthly rate. Check the rate guide to see your monthly rate.</i>
<b>Upgrade prescription drug coverage</b>	You can increase your prescription drug coverage. Increased coverage would include: <i>Preferred brand-name drugs:</i> \$50 copay <i>Non-preferred drugs:</i> \$100 copay This coverage is in addition to the preferred generic drug coverage already included in the plan. <i>Choosing to upgrade this coverage <b>increases</b> your monthly rate. Check the rate guide to see your monthly rate.</i>

TRAVEL PROGRAM	
<b>Program details</b>	You receive in-network coverage when you travel in the United States and use a Travel Program provider. Find more information on the Minnesota Product Features page.

BENEFITS	OUT-OF-NETWORK COVERAGE*
<b>Out-of-network annual deductible</b>	Out-of-network annual deductible is double the in-network annual deductible
<b>Out-of-network annual out-of-pocket maximum</b>	There is no out-of-pocket maximum for out-of-network services
<b>Benefit coverage</b>	60% coverage after deductible
<b>Lifetime maximum benefits</b>	\$1 million
<b>Other details</b>	If you visit an out-of-network healthcare provider, certain services may be excluded or limited. Please see a Medica Solo policy on <a href="http://medica.com">medica.com</a> for details.

\*If you choose to receive services or supplies from a non-network provider, you are responsible for any difference between Medica's non-network reimbursement amounts (generally based on a fee schedule) and the charges billed by the non-network provider.

## THE NITTY-GRITTY ▼ WHAT ELSE DO I NEED TO KNOW

- Some services, such as lab work and X-rays, will apply toward your deductible and will not be covered by a copayment.
- A pre-existing condition exclusion may apply. If continuous qualifying health coverage has been maintained, this limitation is in effect for 12 months, but will be reduced based upon length of previously qualifying coverage. If continuous qualifying health coverage has not been maintained, this limitation is in effect for the first 18 months.
- Services not covered include custodial care or rest care; most dental services; cosmetic services; refractive eye surgery; infertility services; and services that are investigational, not medically necessary or received while on military duty.
- The deductible is subject to a "cost of living" increase on a yearly basis. This "cost of living" increase is tied to the Consumer Price Index (CPI).