

Contact us.

Contact your local Medica broker, give us a call, or drop us a line.

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.

Hours

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

You may also visit us at
medica.com or e-mail us at
medicaindividualproducts@medica.com.

MEDICA®

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Medica Encore™ is a service mark of Medica Health Plans.

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retire early. travel. volunteer.
new hobby. spend time with family.
ow to knit. grow a vegetable garden.
build our dream home. spoil my
go running. collect antiques. start
go rock climbing. try that new
join a book club. take care of
father. go fishing. get a part-t

**WE HAVE A PLAN
FOR YOUR PLAN.**

Health insurance
for what's ahead.

Medica Encore™
Coverage for one or two people.

Minnesota Benefit Summary

This information is valid January 2011
through December 2011.

Plan Highlights

- Medica Encore is a one-person or a two-person “1+Anyone” plan.
- Primary applicants must be between ages 19 and 64. Additional applicants must be at least 60 days old.
- Please see the Minnesota Medica Encore Rate Guide to calculate your monthly premium.
- This is a brief overview of the plan. Please see a policy document available on medica.com for complete details.

BENEFITS	IN-NETWORK COVERAGE	
In-network annual deductible options	One-Person Plan	Two-Person Plan
	\$4,000	\$6,000
	\$6,500	\$7,500
	\$9,000	\$9,000
In-network annual out-of-pocket maximum	Equal to chosen deductible	
Office and urgent care visits Non-preventive care (e.g., physician, chiropractor)	Option A: \$20 copayment (no visit limit) Option B: \$40 copayment (no visit limit) Option C: \$60 copayment (no visit limit)	
Preventive care	100% coverage (Copayment, coinsurance and deductible do not apply)	
Convenience care center visits	\$10 copayment (no visit limit)	
Prescription drugs	Preferred generic drugs: \$10 copayment Preferred brand-name drugs: You pay 100% at Medica's discounted rate You have the option to increase your prescription drug coverage. See details on next page.	
Emergency room	100% coverage after deductible	
Lab and X-ray services		
Hospital services		
Ambulance		
Surgery		
Eyewear	Medica pays up to \$125 per person within a rolling 24-month period	
Maternity	100% coverage for prenatal care (deductible does not apply) Maternity, labor, delivery, and postpartum care not covered	
Other eligible healthcare services	100% coverage after deductible	

ADDITIONAL COVERAGE OPTIONS

Remove mental health/substance abuse coverage

You have the option to remove your mental health and substance abuse coverage already included in the plan. *Choosing to remove this coverage **reduces** your monthly rate. Check the rate guide to see your monthly rate.*

Upgrade prescription drug coverage

You can increase your prescription drug coverage. Increased coverage would include:
Preferred brand-name drugs: \$50 copayment
Non-preferred drugs: \$100 copayment
This coverage is in addition to the preferred generic drug coverage already included in the plan. *Choosing to upgrade this coverage **increases** your monthly rate. Check the rate guide to see your monthly rate.*

TRAVEL PROGRAM

Program details

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*

Out-of-network annual deductible

Out-of-network annual deductible is double the in-network annual deductible

Out-of-network annual out-of-pocket maximum

There is no out-of-pocket maximum for out-of-network services

Benefit coverage

60% coverage after deductible

Lifetime maximum benefits

\$1 million

Other details

If you visit an out-of-network healthcare provider, certain services may be excluded or limited. Please see a Medica Encore policy on medica.com 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.

Other Important Information

- Copayments do not apply to your deductible and out-of-pocket maximum. Some services, such as lab work and X-rays, will apply toward your deductible and will not be covered by a copayment.
- For individuals ages 19 and over, 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.
- On a two-person plan, the deductible is shared.
- 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).