BEFORE DOUBLE DARE BECOMES URGENT CARE

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Medica Solo℠

Health Insurance for Individuals

MedicaSolo.com

This information is valid for the 2009 calendar year.

BECAUSE IT SEEMED LIKE A GOOD IDEA AT THE TIME

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FLYING SOLO YET?

Let's face it. Everyone says, "It'll never happen to me." But then it does. The unexpected. Deep down, you've always known it's better to be safe than sorry. Lucky for you, Medica Solo offers affordable health insurance coverage, so your wallet can be safe — and you can save your moolah for other stuff. **Refer to Plan Highlights for more details on the following:**

- Copays for Office Visits
- Vision Benefits
- Low Copay for Generic Drugs
- $200 Right Away for Preventive Care
- $200 Copay for First ER Visit
- Three Annual Deductible Options
- No Long-Term Contract
- $2,000 Annual Maximum Benefit for Prescription Drugs

THE CLUB. ARE YOU ELIGIBLE?

It's called Medica Solo because it's self-only coverage. If you're an adult, you can buy it for yourself or a dependent. You also have to pass a health test. It's not hard, but lifestyle counts. If you smoke, have put on extra pounds, or have other health factors, you may pay more or not be offered coverage.

To buy Medica Solo, you have to match the stuff on this list:

- Aged 3 Months to 64 Years
- Minnesota Resident
- General Good Health

THE GREENS. HOW CHEAP IS IT?

If you're 19–29 years old, Medica Solo costs about $69–$99 per month, depending on your health and the annual deductible you choose: $3,100, $6,200, or $9,300. Copays apply to your deductible. If your annual expenses exceed your deductible, the plan kicks in and pays 100%, up to $5 million over your lifetime. **See Plan Highlights for more details on the following:**

DOCTORS

The plan pays $200 right away for a year of physicals and routine care. If you get sick, your copay depends on your plan: $30, $40, or $50 for each visit (up to 3 times a calendar year).

PRESCRIPTIONS

Generics save you money. **The generic drug copay is $5, while brand-name drugs cost $50–$90, or more.** There is a $2,000 annual maximum benefit for prescription drugs.

EMERGENCIES

You pay $100 for your first urgent care visit and $200 for your first visit to the ER.

SPECS

The plan pays $50 a year for glasses and contacts.

RATES ▶

	DEDUCTIBLE		
AGE	$3,100	$6,200	$9,300
90 days-18	$83.63	$66.46	$57.51
19-29	$99.42	$79.01	$68.38
30-31	$104.60	$83.13	$71.94
32-33	$107.18	$85.19	$73.73
34-35	$108.74	$86.41	$74.79
36-37	$110.16	$87.55	$75.76
38-39	$114.18	$90.74	$78.52
40-41	$122.46	$97.33	$84.23
42-43	$129.45	$102.88	$89.04
44-45	$141.75	$112.66	$97.50
46-47	$155.22	$123.35	$106.75
48-49	$172.56	$137.14	$118.68
50-51	$193.92	$154.12	$133.37
52-53	$215.92	$171.60	$148.51
54-55	$237.93	$189.09	$163.64
56-57	$262.15	$208.33	$180.29
58-59	$276.25	$219.54	$190.00
60-64	$289.20	$229.82	$198.91

NOTE: Newborns under 90 days old are not eligible for coverage. If you have a birthday during the first month of coverage, you should use your new age to determine the correct rate. The actual rate offered may be up to 40% higher based on tobacco use and other health factors. Rates are valid through December 2009.

BEFORE YOU GO BELLY UP...

contact your local Medica broker or visit MedicaSolo.com and apply today.

THE SKINNY. WHAT'S INCLUDED?

Medica Solo has a copay for the first three times you are sick and have an office visit. The office visit copay applies to the doctor's charge, but other charges for services received that day, such as for lab work or X-rays, will apply toward your deductible.

The plan also covers the first $200 you spend each year on routine stuff, like physicals. And there's a stop-smoking program and a 24-hour nurse line. Prenatal care is included, but the plan doesn't cover maternity care, labor and delivery, or post partum care. Why? Because Medica Solo is self-only coverage. Also, remember, this is just a summary. Be sure to take a look at the policy on MedicaSolo.com for details.

PLAN HIGHLIGHTS	LOWEST DEDUCTIBLE OPTION	MIDDLE DEDUCTIBLE OPTION	HIGHEST DEDUCTIBLE OPTION
Annual deductible The deductible is subject to a "cost of living" increase on an annual basis, in an amount no greater than the Consumer Price Index, which is the federal measure of the rate of inflation.	$3,100*	$6,200*	$9,300*
Annual out-of-pocket maximum for covered medical services and supplies* The out-of-pocket maximum is subject to a "cost of living" increase on an annual basis, in an amount no greater than the Consumer Price Index, which is the federal measure of the rate of inflation.	Equal to deductible. Coverage is generally 100% after deductible.*		
Office visits For non-preventive office visits in any setting (e.g., physician, mental health, chiropractor). Your copay applies toward your deductible and out-of-pocket maximum. Your copay applies to the doctor's charge, but other charges for services received that day, such as for lab work or X-rays, will apply toward your deductible.	$30 copay for each of the first three visits per calendar year. After third visit, deductible applies.*	$40 copay for each of the first three visits per calendar year. After third visit, deductible applies.*	$50 copay for each of the first three visits per calendar year. After third visit, deductible applies.*
Preventive care Includes routine physicals, cancer screening, and one refractive eye exam per calendar year.	$200 first dollar (cumulative), then applies to deductible.*		
Urgent care visit Your copay applies toward your deductible and out-of-pocket maximum.	For first visit each calendar year, $100 copay paid by you, with any remainder paid by Medica; subsequent visits apply to the deductible.*		
Emergency room visit Your copay applies toward your deductible and out-of-pocket maximum.	For first visit each calendar year, $200 copay paid by you, with any remainder paid by Medica; subsequent visits apply to the deductible.* Copay applies to facility charges only; professional fees apply toward the deductible.*		
Prescription drugs Deductible and out-of-pocket maximum does not apply.	$5 generic copay/$50 single-source brand-name formulary copay/$90 brand-name non-formulary copay. You pay the difference when a generic is available and is not chosen. Specialty drug coinsurance paid by you: 20% formulary/40% non-formulary. Specialty drug maximum paid by you per script: $200 formulary/$400 non-formulary. No coverage at out-of-network pharmacies. Several categories of drugs are excluded, including infertility and erectile dysfunction.		
Prescription drug annual maximum benefit	$2,000 maximum paid by Medica per calendar year. This maximum includes all covered drugs: generic, brand-name formulary, brand-name non-formulary and specialty.		
Eyewear Eyeglasses and contact lenses	Maximum of $50 covered per calendar year.		
Lab and X-ray services	100% after deductible*		
Hospital services and surgical services			
Ambulance			
Medical supplies			
Chiropractic, occupational, physical, and speech therapy			
Home health care up to $25,000 per calendar year			
Mental health care			
Substance abuse			
Skilled nursing facility services (limited to 120 days per calendar year)			
Prenatal care	100%*		
Well-child services to age 6, immunizations to age 18	100%*		
Maternity labor, delivery, and post partum care	No coverage		
Lifetime maximum	$5 Million		

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

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

BEFORE STICKING THE LANDING BECOMES STUCK WITH THE BILL

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THE NITTY-GRITTY. WHAT ELSE DO I NEED TO KNOW?

Okay, here's some important technical stuff:

PRENATAL CARE

Medica Solo provides benefits for prenatal care services.

MATERNITY CARE

Medica Solo does not cover maternity care services, which include maternity labor and delivery services, and post partum care services.

PRESCRIPTION DRUGS

Medica Solo provides a maximum of $2,000 annually for outpatient prescription drug coverage. After Medica has paid $2,000 for outpatient prescription drugs during a calendar year, you are responsible for the full amount of any additional outpatient prescription drug costs incurred in that year. The $2,000 annual maximum is calculated on what Medica pays, not on any copayments that you pay. A new $2,000 annual maximum outpatient prescription drug benefit begins every January 1st.

DEDUCTIBLES

Effective January 1, 2010, all Medica Solo members are subject to an annual increase of their calendar year deductible and calendar year out-of-pocket maximum. This increase will never be higher than the Consumer Price Index (CPI), which is the federal measure of the rate of inflation.

For more details, see Plan Highlights, view the entire Policy of Coverage at MedicaSolo.com, or contact Medica at the phone numbers listed on the back of this brochure.

TRAVEL PROGRAM

You can receive Medica-style coverage when you travel in the United States but outside of Medica's service area so long as you use a Travel Program provider. Find more Travel Program information online at MedicaSolo.com. Once you are there, click on "The Greens" and then on "doctor network" and "Travel Program" to find the details.

NETWORK CHOICE

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

NOTICE CONCERNING POLICYHOLDER RIGHTS IN AN INSOLVENCY UNDER THE MINNESOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION LAW

If the insurer that issued your life, annuity, or health insurance policy becomes impaired or insolvent, you are entitled to compensation for your policy from the assets of that insurer. The amount you recover will depend on the financial condition of the insurer.

In addition, residents of Minnesota who purchase life insurance, annuities, or health insurance from insurance companies authorized to do business in Minnesota are protected, **subject to limits and exclusions**, in the event the insurer becomes financially impaired or insolvent. This protection is provided by the Minnesota Life and Health Insurance Guaranty Association.

Minnesota Life and Health Insurance Guaranty Association
4760 White Bear Parkway, Suite 101
White Bear Lake, MN 55110
Telephone: 651-407-3149
Fax: 651-407-3150

The **maximum amount** the guaranty association will pay for all policies issued on one life by the same insurer **is limited to $300,000. Subject to this $300,000 limit**, the guaranty association will pay up to $300,000 in life insurance death benefits, $100,000 in net cash surrender and net cash withdrawal values for life insurance, $300,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values, $100,000 in annuity net cash surrender and net cash withdrawal values, $300,000 in present value of annuity benefits for annuities which are part of a structured settlement or for annuities in regard to which periodic annuity benefits, for a period of not less than the annuitant's lifetime or for a period certain of not less than ten years, have begun to be paid on or before the date of impairment or insolvency, or if no coverage limit has been specified for a covered policy or benefit, the coverage limit shall be $300,000 in present value. Unallocated annuity contracts issued to retirement plans, other than defined benefit plans, established under section 401, 403(b), or 457 of the Internal Revenue Code of 1986, as amended through December 31, 1992, are covered up to $100,000 in net cash surrender and net cash withdrawal values, for Minnesota residents covered by the plan provided, however, that the association shall not be responsible for more than $7,500,000 in claims from all Minnesota residents covered by the plan. If total claims exceed $7,500,000, the $7,500,000 shall be prorated among all claimants. These are the maximum claim amounts. Coverage by the Guaranty Association is also subject to other substantial limitations and exclusions and requires continued residency in Minnesota. If your claim exceeds the Guaranty Association's limits, you may still recover a part or all of that amount from the proceeds of the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The Guaranty Association assesses insurers licensed to sell life and health insurance in Minnesota after the insolvency occurs. Claims are paid from this assessment.

The coverage provided by the Guaranty Association is not a substitute for using care in selecting insurance companies that are well managed and financially stable. In selecting an insurance company or policy, you should not rely on coverage by the Guaranty Association.

This notice is required by Minnesota state law to advise policyholders of life, annuity, or health insurance policies of their rights in the event their insurance carrier becomes financially insolvent. This notice no way implies that the company currently has any type of financial problems. All life, annuity, and health insurance policies are required to provide this notice.

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. – 5 p.m., Friday: 9 a.m. – 5 p.m.

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952-992-3650 (TTY) • 1-800-234-8819 (TTY)
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