

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.

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®

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IFB5371-11110



BEFORE DOUBLE DARE BECOMES URGENT CARE



Medica SoloSM

Health Insurance for Individuals

Minnesota

PRODUCT SUMMARY

This information is valid October 1, 2010
through December 31, 2010.

MONTHLY RATES ▼

FIRST Find your age range.
SECOND Choose a deductible level.



AGE	DEDUCTIBLE OPTIONS		
	▼ \$3,150 ▼	▼ \$6,300 ▼	▼ \$9,450 ▼
19-29	\$122.79	\$100.66	\$89.09
30-31	\$129.19	\$105.89	\$93.73
32-33	\$132.38	\$108.51	\$96.04
34-35	\$134.31	\$110.09	\$97.44
36-37	\$136.06	\$111.53	\$98.71
38-39	\$141.02	\$115.59	\$102.32
40-41	\$151.25	\$123.98	\$109.74
42-43	\$159.89	\$131.06	\$116.00
44-45	\$175.08	\$143.50	\$127.01
46-47	\$191.71	\$157.14	\$139.08
48-49	\$213.13	\$174.70	\$154.63
50-51	\$239.51	\$196.32	\$173.77
52-53	\$266.69	\$218.60	\$193.49
54-55	\$293.88	\$240.89	\$213.21
56-57	\$323.77	\$265.39	\$234.90
58-59	\$341.20	\$279.68	\$247.55
60+	\$357.19	\$292.78	\$259.15

NOTE: Applicants must be ages 19 and older. If you have a birthday during the first month of coverage, you should use your new age to determine the correct rate. Tobacco users to age 36 will receive a 10% higher rate, tobacco users over age 36 through 49 will receive a 20% higher rate and tobacco users ages 50 and older will receive a 35% high rate. The actual rate offered may be up to 40% higher than the standard rate based on tobacco use and other health factors. Rates are valid through December 31, 2010.

For applicants ages 19 and over, pre-existing conditions that you had within the six months before your enrollment date may not be covered during the first 18 months following your enrollment date. However, if you have maintained qualifying health coverage prior to your enrollment date, the 18 month period may be reduced.

PLAN HIGHLIGHTS ▼

BENEFITS*	IN-NETWORK COVERAGE**		
	LOWEST DEDUCTIBLE OPTION	MIDDLE DEDUCTIBLE OPTION	HIGHEST DEDUCTIBLE OPTION
Annual deductible	\$3,150	\$6,300	\$9,450
Office visits Non-preventive office visits (e.g., Physician, mental health, substance abuse, chiropractor)	You pay a \$30 copay for each of the first three visits per calendar year. After third visit, deductible applies.	You pay a \$40 copay for each of the first three visits per calendar year. After third visit, deductible applies.	You pay a \$50 copay for each of the first three visits per calendar year. After third visit, deductible applies.
Preventive care Routine physicals, cancer screening, and immunizations	Medica covers 100% (deductible doesn't apply).		
Urgent care visit	For first visit each calendar year, you pay a \$100 copay, with any remainder paid by Medica; subsequent visits apply to the deductible.		
Emergency room visit	For first visit each calendar year, you pay a \$200 copay, with any remainder paid by Medica; subsequent visits apply to the deductible. Copay applies to network or non-network facility charges only; professional fees apply toward the deductible.		
Prescription drugs List of Preferred Drugs (Formulary) applies	You pay a \$5 preferred generic copay / \$50 single-source preferred brand-name copay / \$90 non-preferred brand-name copay. You pay the difference when a generic is available and is not chosen. You pay a specialty drug coinsurance: 20% preferred / 40% non-preferred. You pay a specialty drug maximum per script: \$200 preferred / \$400 non-preferred. No coverage at out-of-network pharmacies.		
Eyewear Eyeglasses and contact lenses	Medica covers a maximum of \$50 per calendar year.		
Maternity labor, delivery, and postpartum care	No coverage.		
Other eligible health care services	Generally subject to deductible.*		

*This is a brief review of the general benefits of this plan. Services not covered include custodial care or rest care; eye wear; most dental services; cosmetic services; refractive eye surgery; infertility services; services that are investigational, not medically necessary or received while on military duty. Please see a Minnesota Medica Solo policy document for a complete list of exclusions and a detailed explanation of your coverage.

**If you choose to receive services or supplies from a non-network provider, you are responsible for the deductible, any coinsurance 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.

Visit www.MedicaSolo.com for more information.