

**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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# BEFORE DOUBLE DARE BECOMES URGENT CARE



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

**Wisconsin**

**BENEFIT SUMMARY**

This information is valid July 2011  
through June 2012.

## PLAN HIGHLIGHTS ▼ WHAT'S INCLUDED

- Medica Solo is a one-person plan.
- Applicants must be between ages 19 and 64.
- Please see the Wisconsin 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>	Tier 1: \$10 copay Tier 2: 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>	Prenatal, labor, delivery, and postpartum care not covered; complications of pregnancy are covered as required by WI law			
<b>Other eligible healthcare services</b>	80% coverage after deductible			

### ADDITIONAL COVERAGE OPTIONS

#### Upgrade prescription drug\* coverage

You can increase your prescription drug coverage. Increased coverage would include:  
 Tier 2: \$50 copay  
 Tier 3: \$100 copay

This coverage is in addition to the Tier 1 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.*

\*Tiers represent a cost level within prescription drug categories. The prescription drug coverage under your health plan will differ for each of these tiers.

**Tier 1:** Generally includes generic drugs and a few lower cost brand-name drugs.

**Tier 2:** Generally includes higher cost generic and brand-name drugs.

**Tier 3:** Generally includes highest cost generic or brand-name drugs.

### 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 Wisconsin 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 12 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).