

Your guide to
Medica Prime Solution®
Value



Summary of Benefits for
H2450-007

January 1 – December 31, 2008

Section I:

Introduction to the Summary of Benefits for Medica Prime Solution® Value Plan January 1 – December 31, 2008

Thank you for your interest in Medica Prime Solution.® Our plan is offered by Medica Insurance Company, a Medicare Cost Managed Care plan. This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Medica and ask for the "Evidence of Coverage."

You have choices in your health care

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan. Another option is a Medicare health plan, like Medica Prime Solution.

You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare program.

You may join or leave a plan only at certain times. Please call Medica Insurance Company at the number listed at the end of this introduction or call **1-800-MEDICARE (1-800-633-4227)** for more information. TTY users should call **1-877-486-2048**. You can call 24 hours a day, 7 days a week.

How can I compare my options?

You can compare Medica Prime Solution and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers and what the Original Medicare Plan covers.

Our members receive all of the benefits that the Original Medicare Plan offers. We also offer more benefits, which may change from year to year.

Where is Medica Prime Solution available?

The service area for this plan includes:

Minnesota

Aitkin	Itasca	Polk
Anoka	Jackson	Pope
Becker	Kanabec	Ramsey
Beltrami	Kandiyohi	Red Lake
Benton	Kittson	Redwood
Big Stone	Koochiching	Renville
Blue Earth	Lac Qui Parle	Rice
Brown	*Lake	Rock
Carlton	Lake of the Woods	Roseau
Carver	Le Sueur	Scott
Cass	Lincoln	Sherburne
Chippewa	Lyon	Sibley
Chisago	Mahnomen	St. Louis
Clay	Marshall	Stearns
Clearwater	McLeod	Steele
Cottonwood	Meeker	Stevens
Crow Wing	Mille Lacs	Swift
Dakota	Morrison	Todd
Dodge	Murray	Traverse
Douglas	Nicollet	Wadena
Faribault	Nobles	Washington
Fillmore	Norman	Watonwan
Goodhue	Olmsted	Wilkin
Grant	Otter Tail	Wright
Hennepin	Pennington	Yellow Medicine
Hubbard	Pine	
Isanti	Pipestone	

* **Partial county**
ZIP codes
Lake 55609, 55616

North Dakota

Barnes	Griggs	Sargent
Cass	LaMoure	Steele
Dickey	Ransom	Stutsman
Grand Forks	Richland	Traill

South Dakota

Brookings	Grant	Minnehaha
Brown	Hamlin	Moody
Day	Lincoln	Roberts
Deuel	Marshall	

Wisconsin

Ashland	Douglas	St. Croix
Barron	Pierce	Washburn
Bayfield	Polk	
Burnett	Sawyer	

You must live in one of these counties to join the plan.

Who is eligible to join Medica Prime Solution?

You can join Medica Prime Solution if you are entitled to Medicare Part A and enrolled in Medicare Part B or enrolled in Medicare Part B only and live in the service area. However, individuals with End-Stage Renal Disease generally are not eligible to enroll in Medica Prime Solution unless they are members of this organization and have been since their dialysis began.

Can I choose my doctors?

Medica Prime Solution has formed a network of doctors, specialists, and hospitals. You can use any doctor who is part of our network. You may also go to doctors outside of our network. The health providers in our network can change at any time. You can ask for a current Provider Directory for an up-to-date list or visit us at www.medica.com. Our customer service number is listed at the end of this introduction.

What happens if I go to a doctor who's not in your network?

You can always choose to go to a doctor outside our network. We may not pay for the services you receive outside of our network, but Medicare will pay for its share of charges it approves. You will be responsible for Original Medicare deductible and co-insurance.

Does my plan cover Medicare Part B or Part D drugs?

Medica Prime Solution does cover Medicare Part B prescription drugs and if you purchase the Medica Part D Rider, Medicare Part D prescription drugs. As a member of Medica Prime Solution you can receive prescription drug coverage by joining another Prescription Drug Plan. You can only join one Medicare Prescription Drug Plan.

Where can I get my prescriptions if I join this plan and purchase the Medica Part D Rider?

Medica Prime Solution has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a

current Pharmacy Network List or visit us at www.medica.com. Our customer service number is listed at the end of this introduction.

Medica Insurance Company has a list of preferred retail pharmacies. At these pharmacies, you may get your drugs at a lower copay or coinsurance. You may go to a non-preferred pharmacy, but you may have to pay more for your prescription drugs.

What is a prescription drug formulary?

Medica Prime Solution uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at www.medica.com.

If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

How can I get extra help with prescription drug plan costs?

If you qualify for extra help with your Medicare prescription drug plan costs, your premium and costs at the pharmacy will be lower. When you join Medica Prime Solution, Medicare will tell us how much extra help you are getting. Then we will let you know the amount you will pay. If you are not getting this extra help you can see if you qualify by calling **1-800-MEDICARE (1-800-633-4227)**, TTY users should call **1-877-486-2048**. You can call this number 24 hours a day, 7 days a week.

What are my protections in this plan?

All Medicare Cost Plans agree to stay in the program for a full year at a time. Each year, the plans decide whether to continue for another year. Even if a

Medicare Cost Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

If you purchase a Medica Part D Rider, the following applies: You have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug.

What is a Medication Therapy Management (MTM) Program?

A Medication Therapy Management (MTM) Program is a free service we offer. You may be identified to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact Medica Prime Solution for more details.

Please call Medica Insurance Company for more information about this plan. Visit us at www.medica.com or, call us:

Customer Service Hours:

8 a.m. to 8 p.m., CST, seven days a week. Please note access to a representative is limited on the weekends/holidays during certain times of the year.

Current members should call
952-992-2300 (TTY: **952-992-3650**)
or **1-800-234-8755** (TTY: **1-800-234-8819**)

Prospective members should call
952-992-2345 (TTY: **952-992-3650**)
or **1-800-906-5432** (TTY: **1-800-234-8819**)

For questions related to the Medicare Part D Prescription Drug program:

Current members should call
1-800-234-8755 (TTY: **1-800-234-8819**)

Prospective members should call
1-800-906-5432 (TTY: **1-800-234-8819**)

For more information about Medicare:

Call **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**. You can call 24 hours a day, 7 days a week. Or, visit **www.medicare.gov** on the Web.

If you have special needs, this document may be available in other formats.

Section II:

Summary of Benefits for Medica Prime Solution® for Contract Year 2008

If you have any questions about this plan's benefits or costs, please contact Medica at 1-800-234-8755 (for current members) or 1-800-906-5432 (for prospective members).

Benefit	Original Medicare
IMPORTANT INFORMATION	
<p>1. Premium and Other Important Information</p>	<ul style="list-style-type: none"> You pay the Medicare Part B premium of \$96.40 each month. <p>Most people will pay the standard monthly Part B premium. Some people will have to pay a higher premium because of their yearly income (over \$82,000 for singles, \$164,000 for married couples in 2008). For more information on Part B premiums based on income, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p>
<p>2. Doctor and Hospital Choice (for more information, see Emergency Care – #15 and Urgently Needed Care – #16)</p>	<ul style="list-style-type: none"> You may go to any doctor, specialist or hospital that accepts Medicare.
<p>3. Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)</p>	<ul style="list-style-type: none"> You pay for each benefit period (3): Days 1–60: an initial deductible of \$1,024 Days 61–90: \$256 each day. Days 91–150: \$512 each lifetime reserve day. (4) <p>Please call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. (4)</p>
<p>4. Inpatient Mental Health Care</p>	<ul style="list-style-type: none"> You pay the same deductible and copayments as inpatient hospital care (above) except Medicare beneficiaries may only receive 190 days in a Psychiatric Hospital in a lifetime.

(1) Each year, you pay a total of one \$135 deductible.

(2) If a doctor or supplier does not accept assignment, their costs are often higher, which means you may pay more.

(3) A “benefit period” starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended,

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- You pay \$35.00 each month.
- You also continue to pay the Medicare Part B premium of \$96.40 each month.
- There is a \$3,000 maximum out-of-pocket limit every year.
- Unless otherwise noted, out-of-network services are not covered.

- You do NOT need a referral to go to network doctors, specialists and hospitals.
- You can use any doctor who is part of our network.
- A separate doctor office visit copayment may apply for certain services.
- You are covered for U.S. visitor/travel benefits under the Medica Extended Absence Program. You must call Medica Customer Service to initiate this benefit.
- If you go to out-of-network doctors, the plan may not cover the services, but Medicare will pay its share for Medicare-covered services. When Medicare pays its share, you pay the Medicare deductibles and coinsurance.

- You pay \$400 for each Medicare-covered stay at a network hospital.
- You are covered for 90 days each benefit period.

- You pay \$400 for each Medicare-covered stay at a network hospital.
- Medicare beneficiaries may only receive 190 days in a Psychiatric Hospital in a lifetime.

a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

(4) Lifetime reserve days can only be used once.

If you have any questions about this plan's benefits or costs, please contact Medica at 1-800-234-8755 (for current members) or 1-800-906-5432 (for prospective members).

Benefit	Original Medicare
INPATIENT CARE (CONTINUED)	
5. Skilled Nursing Facility (in a Medicare-certified skilled nursing facility)	<ul style="list-style-type: none"> You pay for each benefit period (3), following at least a 3-day covered hospital stay: Days 1–20: \$0 for each day. Days 21–100: \$128 for each day. There is a limit of 100 days for each benefit period. (3)
6. Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	<ul style="list-style-type: none"> There is no copayment for all covered home health visits.
7. Hospice	<ul style="list-style-type: none"> You pay part of the cost for outpatient drugs and inpatient respite care. You must receive care from a Medicare-certified hospice.
OUTPATIENT CARE	
8. Doctor Office Visits	<ul style="list-style-type: none"> You pay 20% of Medicare-approved amounts. (1) (2)
9. Chiropractic Services	<ul style="list-style-type: none"> You pay 20% of Medicare-approved amounts. (1) (2) You are covered for manual manipulation of the spine to correct subluxation, provided by chiropractors or other qualified providers. You pay 100% for routine care.
10. Podiatry Services	<ul style="list-style-type: none"> You pay 20% of Medicare-approved amounts. (1) (2) You are covered for medically necessary foot care, including care for medical conditions affecting the lower limbs. You pay 100% for routine care.

(1) Each year, you pay a total of one \$135 deductible.

(2) If a doctor or supplier does not accept assignment, their costs are often higher, which means you may pay more.

(3) A “benefit period” starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended,

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- You pay:
 - \$0 each day for day(s) 1–20.
 - \$128 each day for day(s) 21–100 for a Medicare-covered stay at a Skilled Nursing Facility.
- Three-day prior hospital stay is required.
- You are covered for 100 days each benefit period.

- There is no copayment for Medicare-covered home health visits.

- You must receive care from a Medicare-certified hospice.

- You pay 20% of the cost for each primary care doctor office visit for Medicare-covered services.
- You pay 20% of the cost for each specialist visit for Medicare-covered services.
- See #33 – Physical Exams for more information.

- You pay 20% of the cost for each Medicare-covered visit.
- Medicare-covered chiropractic visits are for manual manipulation of the spine to correct a displacement or misalignment of a joint or body part.

- You pay 20% of the cost for each Medicare-covered visit.
- Medicare-covered podiatry benefits are for medically-necessary foot care.

a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

(4) Lifetime reserve days can only be used once.

If you have any questions about this plan's benefits or costs, please contact Medica at 1-800-234-8755 (for current members) or 1-800-906-5432 (for prospective members).

Benefit	Original Medicare
OUTPATIENT CARE (CONTINUED)	
11. Outpatient Mental Health Care	<ul style="list-style-type: none"> You pay 50% of Medicare-approved amounts for most outpatient mental health services. (1) (2)
12. Outpatient Substance Abuse Care	<ul style="list-style-type: none"> You pay 20% of Medicare-approved amounts. (1) (2)
13. Outpatient Services/Surgery	<ul style="list-style-type: none"> You pay 20% of Medicare-approved amounts for the doctor. (1) (2) You pay 20% of outpatient facility charges. (1) (2)
14. Ambulance Services (medically necessary ambulance services)	<ul style="list-style-type: none"> You pay 20% of Medicare-approved amounts or applicable fee schedule charge. (1) (2)
15. Emergency Care (you may go to any emergency room if you reasonably believe you need emergency care)	<ul style="list-style-type: none"> You pay 20% of the facility charge or applicable copayment for each emergency room visit; you do NOT pay this amount if you are admitted to the hospital for the same condition within three days of the emergency room visit. (1) (2) You pay 20% of doctor charges. (1) (2) NOT covered outside the U.S. except under limited circumstances.
16. Urgently Needed Care (this is NOT emergency care, and in most cases, is out of the service area)	<ul style="list-style-type: none"> You pay 20% of Medicare-approved amounts or applicable copayment. (1) (2) NOT covered outside the U.S. except under limited circumstances.
17. Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	<ul style="list-style-type: none"> You pay 20% of Medicare-approved amounts. (1) (2)

(1) Each year, you pay a total of one \$135 deductible.

(2) If a doctor or supplier does not accept assignment, their costs are often higher, which means you may pay more.

(3) A “benefit period” starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended,

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- For Medicare-covered Mental Health services, you pay 20% of the cost for each individual/group therapy visit.
- For Medicare-covered services, you pay 20% of the cost for each individual/group visit.
- You pay 20% of the cost for each Medicare-covered visit to an ambulatory surgical center.
- You pay 20% of the cost for each Medicare-covered visit to an outpatient hospital facility.
- You pay 20% of the cost for Medicare-covered ambulance services.
- You pay \$50 for each Medicare-covered emergency room visit.
- Not covered outside the U.S. except under limited circumstances. Contact the plan for more details.
- You pay \$50 for each Medicare-covered urgently needed care visit.
- NOT covered outside the U.S. except under limited circumstances.
- You pay 20% of the cost for each Medicare-covered Occupational Therapy visit.
- You pay 20% of the cost for each Medicare-covered Physical Therapy and/or Speech/Language Therapy visit.

a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

(4) Lifetime reserve days can only be used once.

If you have any questions about this plan's benefits or costs, please contact Medica at 1-800-234-8755 (for current members) or 1-800-906-5432 (for prospective members).

Benefit	Original Medicare
OUTPATIENT MEDICAL SERVICES AND SUPPLIES	
18. Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	<ul style="list-style-type: none"> You pay 20% of Medicare-approved amounts. (1) (2)
19. Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)	<ul style="list-style-type: none"> You pay 20% of Medicare-approved amounts. (1) (2)
20. Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies (includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)	<ul style="list-style-type: none"> You pay 20% of Medicare-approved amounts. (1) (2)
21. Diagnostic Tests, X-Rays, and Lab Services	<ul style="list-style-type: none"> You pay 20% of Medicare-approved amounts, except for approved lab services. (1) (2) There is no copayment for Medicare-approved lab services. Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most routine screening tests, like checking your cholesterol.
PREVENTIVE SERVICES	
22. Bone Mass Measurement (for people with Medicare who are at risk)	<ul style="list-style-type: none"> You pay 20% of Medicare-approved amounts. (1) (2) Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.

(1) Each year, you pay a total of one \$135 deductible.

(2) If a doctor or supplier does not accept assignment, their costs are often higher, which means you may pay more.

(3) A “benefit period” starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended,

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- You pay 20% of the cost for each Medicare-covered item.
- You pay 20% of the cost for each Medicare-covered item.
- You pay 20% of the cost for Medicare-covered Diabetes self-monitoring training.
- You pay 20% of the cost for Nutrition Therapy for Diabetes.
- You pay 20% of the cost for each Medicare-covered Diabetes Supply item.
- You pay:
 - 20% of the cost for each Medicare-covered lab services.
 - 20% of the cost for each Medicare-covered diagnostic radiology services.
 - 20% of the cost for each Medicare-covered therapeutic radiology services.
 - 20% of the cost for each Medicare-covered X-ray visit.
 - 20% of the cost for each Medicare-covered diagnostic procedures and tests.
- You pay 20% of the cost for each Medicare-covered Bone Mass Measurement.

a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

(4) Lifetime reserve days can only be used once.

If you have any questions about this plan's benefits or costs, please contact Medica at 1-800-234-8755 (for current members) or 1-800-906-5432 (for prospective members).

Benefit	Original Medicare
PREVENTIVE SERVICES (CONTINUED)	
23. Colorectal Screening Exams (for people with Medicare age 50 and older)	<ul style="list-style-type: none"> You pay 20% of Medicare-approved amounts. (1) (2) Covered when you are high risk or when you are age 50 and older.
24. Immunizations (Flu vaccine, Hepatitis B vaccine - for people with Medicare who are at risk, Pneumonia vaccine)	<ul style="list-style-type: none"> There is no copayment for the Pneumonia and Flu vaccines. You pay 20% of Medicare-approved amounts for the Hepatitis B vaccine. (1) (2) You may only need the Pneumonia vaccine once in your lifetime. Please contact your doctor for further details.
25. Mammograms (Annual Screening) (for women with Medicare age 40 and older)	<ul style="list-style-type: none"> You pay 20% of Medicare-approved amounts. (2) No referral necessary for Medicare-covered screenings. Covered once a year for all women with Medicare age 40 and older. One baseline mammogram covered for women with Medicare age 35 and 39.
26. Pap Smears and Pelvic Exams (for women with Medicare)	<ul style="list-style-type: none"> There is no copayment for a Pap Smear once every two years, annually for beneficiaries at high risk. (2) You pay 20% of Medicare-approved amounts for Pelvic Exams. (2)
27. Prostate Cancer Screening Exams (for men with Medicare age 50 and older)	<ul style="list-style-type: none"> There is no copayment for the PSA test and a copayment of 20% of Medicare-approved amounts for the digital rectal exam and other related services. (2) Covered once a year for all men with Medicare over age 50.
28. End-Stage Renal Disease (ESRD)	<ul style="list-style-type: none"> You pay 20% of the cost for Medicare-covered dialysis. (1) (2)

(1) Each year, you pay a total of one \$135 deductible.

(2) If a doctor or supplier does not accept assignment, their costs are often higher, which means you may pay more.

(3) A “benefit period” starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended,

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- You pay 20% of the cost for each Medicare-covered Colorectal Screening Exam.
- There is no copayment for the Pneumonia and Flu vaccines.
- No referral necessary for Pneumonia and Flu vaccines.
- You pay 20% of the cost for the Hepatitis B vaccine.
- No referral necessary for other immunizations.
- You pay 20% of the cost for each Medicare-covered Screening Mammogram.
- No referral necessary for Medicare-covered screenings.
- You pay 20% of the cost for each Medicare-covered Pap Smear and Pelvic Exam.
- You pay 20% of the cost for each Medicare-covered Prostate Cancer Screening Exam.
- You pay 20% of the cost for Medicare-covered in- and out-of-area dialysis.
- You pay 20% of the cost for Medicare-covered Nutrition Therapy for Renal Disease.

a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

(4) Lifetime reserve days can only be used once.

If you have any questions about this plan's benefits or costs, please contact Medica at 1-800-234-8755 (for current members) or 1-800-906-5432 (for prospective members).

Benefit	Original Medicare
ADDITIONAL BENEFITS	
29. Prescription Drugs	<ul style="list-style-type: none"> • Most drugs not covered. (You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan.)
30. Dental Services	<ul style="list-style-type: none"> • Preventive dental services (such as cleaning) are not covered.
31. Hearing Services	<ul style="list-style-type: none"> • Routine hearing exams and hearing aids are not covered. • You pay 20% of Medicare-approved amounts for diagnostic hearing exams. (1) (2)
32. Vision Services	<ul style="list-style-type: none"> • You are covered for one pair of eyeglasses or contact lenses after each cataract surgery. (1) (2) • For people with Medicare who are at risk, you are covered for annual glaucoma screenings. (1) (2) • You pay 20% of Medicare-approved amounts for diagnosis and treatment for diseases and conditions of the eye. (1) (2) • Routine eye exams and glasses are not covered.
33. Physical Exams	<ul style="list-style-type: none"> • You pay 20% for one exam within the first 6 months of your new Medicare Part B coverage. (1) (2) • When you get Medicare Part B, you can receive a one time physical exam within the first 6 months of your new Part B coverage. The coverage does not include lab tests.
34. Health/Wellness Education	<ul style="list-style-type: none"> • Not covered.

(1) Each year, you pay a total of one \$135 deductible.

(2) If a doctor or supplier does not accept assignment, their costs are often higher, which means you may pay more.

(3) A “benefit period” starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended,

Drugs Covered under Medicare Part B – General

- You pay 20% of the cost for Medicare Part B-covered drugs.

Drugs Covered under Medicare Part D – General

- This plan does offer prescription drug coverage as an optional benefit. See Optional Supplemental Package 1 for more information.

- In general, preventive dental services (such as cleaning) are not covered.
- You pay 20% of the cost for each Medicare-covered dental benefit.

- Routine hearing exams and hearing aids are not covered.
- You pay 20% of the cost for each Medicare-covered diagnostic hearing exams.

- Non-Medicare-covered eye exams and glasses are not covered.
- You pay:
 - 20% of the cost for Medicare-covered eye wear (one pair of eyeglasses or contact lenses after each cataract surgery).
 - 20% of the cost for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye).

- When you get Medicare Part B, you can receive a one time physical exam within the first 6 months of your new Part B coverage. The coverage does not include lab tests.
- You pay 20% for one exam within the first 6 months of your new Medicare Part B coverage.
- Routine physical exams are not covered.

- You are covered for the following health/wellness benefits:
 - Written health education materials, including newsletters
 - Nursing Hotline
 - SilverSneakers® Fitness Program at participating fitness centers

a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

- (4) Lifetime reserve days can only be used once.

If you have any questions about this plan's benefits or costs, please contact Medica at 1-800-234-8755 (for current members) or 1-800-906-5432 (for prospective members).

Benefit	Original Medicare
OPTIONAL BENEFITS (Call Medica for details)	
OPTIONAL SUPPLEMENTAL PACKAGE #1: Medica Part D Rider – Modified Standard Rx	
Prescription Drugs	

This Rider's Prescription Drugs benefit information continues on page 18

- (1) Each year, you pay a total of one \$135 deductible.
- (2) If a doctor or supplier does not accept assignment, their costs are often higher, which means you may pay more.
- (3) A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended,

Drugs Covered Under Medicare Part D

General

- You pay \$26.70 each month, in addition to your monthly plan premium of \$35 per month and the Medicare Part B premium, for these optional benefits.
- This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at www.medica.com on the Web.
- Different out-of-pocket costs may apply for people who have limited incomes, live in long term care facilities, or have access to Indian/Tribal/Urban (Indian Health Service).
- The plan offers national in-network prescription coverage. This means that you will pay the same amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).
- Total yearly drug costs are the total drug costs paid by both you and the plan.
- The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.
- Some drugs have quantity limits.
- Your provider must get prior authorization from Medica Health Plans for certain drugs.
- The plan will pay for certain over-the-counter drugs as part of its utilization management program. Some over-the-counter drugs are less expensive than prescription drugs and work just as well. Contact the plan for details.
- If the actual cost of a drug is less than the normal copay amount for that drug, you will pay the actual cost, not the higher copay amount.
- There is no deductible.

a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

(4) Lifetime reserve days can only be used once.

If you have any questions about this plan's benefits or costs, please contact Medica at 1-800-234-8755 (for current members) or 1-800-906-5432 (for prospective members).

Benefit	Original Medicare
OPTIONAL BENEFITS (Call Medica for details) (CONTINUED)	
OPTIONAL SUPPLEMENTAL PACKAGE #1: (CONTINUED)	
Prescription Drugs (continued)	

This Rider's Prescription Drugs benefit information continues on page 20

- (1) Each year, you pay a total of one \$135 deductible.
- (2) If a doctor or supplier does not accept assignment, their costs are often higher, which means you may pay more.
- (3) A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended,

In-Network

Initial Coverage

- You pay the following until total yearly drug costs reach \$2,510:

Retail Pharmacy

Generic

- \$12 copay for a one-month (31-day) supply of drugs from a preferred pharmacy
- \$36 copay for a three-month (90-day) supply of drugs from a preferred pharmacy
- \$12 copay for a one-month (31-day) supply of drugs from a non-preferred pharmacy

Preferred Brand-name

- \$32 copay for a one-month (31-day) supply of drugs from a preferred pharmacy
- \$96 copay for a three-month (90-day) supply of drugs from a preferred pharmacy
- \$32 copay for a one-month (31-day) supply of drugs from a non-preferred pharmacy

Non-Preferred Brand

- \$63 copay for a one-month (31-day) supply of drugs from a preferred pharmacy
- \$189 copay for a three-month (90-day) supply of drugs from a preferred pharmacy
- \$63 copay for a one-month (31-day) supply of drugs from a non-preferred pharmacy

Specialty

- 25% coinsurance for a one-month (31-day) supply of drugs from a preferred pharmacy
- 25% coinsurance for a three-month (90-day) supply of drugs from a preferred pharmacy
- 25% coinsurance for a one-month (31-day) supply of drugs from a non-preferred pharmacy

Long Term Care Pharmacy

Generic

- \$12 copay for a one-month (31-day) supply of drugs

Preferred Brand-name

- \$32 copay for a one-month (31-day) supply of drugs

Non-Preferred Brand

- \$63 copay for a one-month (31-day) supply of drugs

Specialty

- 25% coinsurance for a one-month (31-day) supply of drugs

a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

- (4) Lifetime reserve days can only be used once.

If you have any questions about this plan's benefits or costs, please contact Medica at 1-800-234-8755 (for current members) or 1-800-906-5432 (for prospective members).

Benefit	Original Medicare
OPTIONAL BENEFITS (Call Medica for details) (CONTINUED)	
OPTIONAL SUPPLEMENTAL PACKAGE #1: (CONTINUED)	
Prescription Drugs (continued)	

This Rider's Prescription Drugs benefit information continues on page 22

- (1) Each year, you pay a total of one \$135 deductible.
- (2) If a doctor or supplier does not accept assignment, their costs are often higher, which means you may pay more.
- (3) A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended,

Mail Order

Generic

- \$24 copay for a three-month (90-day) supply of drugs

Preferred Brand-name

- \$64 copay for a three-month (90-day) supply of drugs

Non-Preferred Brand

- \$126 copay for a three-month (90-day) supply of drugs

Specialty

- 25% coinsurance for a three-month (90-day) supply of drugs

Coverage Gap

- After your total yearly drug costs reach \$2,510, you pay 100% until your yearly out-of-pocket drug costs reach \$4,050.

Catastrophic Coverage

- After your yearly out-of-pocket drug costs reach \$4,050, you pay the greater of:
 - \$2.25 copay for generic (including brand drugs treated as generic) and \$5.60 copay for all other drugs, or
 - 5% coinsurance

a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

- (4) Lifetime reserve days can only be used once.

If you have any questions about this plan’s benefits or costs, please contact Medica at 1-800-234-8755 (for current members) or 1-800-906-5432 (for prospective members).

Benefit	Original Medicare
OPTIONAL BENEFITS (Call Medica for details) (CONTINUED)	
OPTIONAL SUPPLEMENTAL PACKAGE #1: (CONTINUED)	
<p>Prescription Drugs (continued)</p>	

- (1) Each year, you pay a total of one \$135 deductible.
- (2) If a doctor or supplier does not accept assignment, their costs are often higher, which means you may pay more.
- (3) A “benefit period” starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended,

Out-of-Network

- Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may pay more than the copay if you get your drugs at an out-of-network pharmacy.

Initial Coverage

- You pay the following until total yearly drug costs reach \$2,510:
 - Generic
 - \$12 copay for a one-month (31-day) supply of drugs
 - Preferred Brand-name
 - \$32 copay for a one-month (31-day) supply of drugs
 - Non-Preferred Brand
 - \$63 copay for a one-month (31-day) supply of drugs
 - Specialty
 - 25% coinsurance for a one-month (31-day) supply of drugs

Coverage Gap

- After your total yearly drug costs reach \$2,510, you pay 100% until your yearly out-of-pocket drug costs reach \$4,050.

Catastrophic Coverage

- After your yearly out-of-pocket drug costs reach \$4,050, you pay the greater of:
 - \$2.25 copay for generic (including brand drugs treated as generic) and \$5.60 copay for all other drugs, or
 - 5% coinsurance

a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

(4) Lifetime reserve days can only be used once.

For more information on Medica Medicare Solutions® plans, call **952-992-2345** or **1-800-906-5432**. TTY users may call **952-992-3650** or **1-800-234-8819**.

Hours of operation:

8 a.m. to 8 p.m., CST, seven days a week. Please note that access to a representative is limited on the weekends/holidays during certain times of the year.

Visit us on the web at **www.medica.com**.

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