

MEDICA®

SOUTH DAKOTA

Medica Direct
HSASM
for Individuals



Health plans as individual
as you and your family.

For coverage beginning
February 1, 2009 or later.

Medica Direct
HSASM
for Individuals

"High-deductible
health plans
designed to work
with an optional
health savings
account."



The affordable health plan with tax advantages.

Lower premiums. Attractive tax savings. Greater financial control. This is Medica Direct HSASM for Individuals, the affordable health plan designed for those who are paying their own way. It's the plan that gives you the choices and tools you need to spend your health care dollars the way you want—wisely.

A health savings account (HSA) plan combines aspects of your health coverage with sound financial planning. A high deductible plan makes your premium more affordable while protecting you from major medical bills. A personal health savings account (HSA) helps pay your deductible while offering federal tax benefits.

*Choose the affordable
Medica Direct HSA for Individuals plan,
and start taking charge of your health care
decisions today.*

We've made affordability a choice.

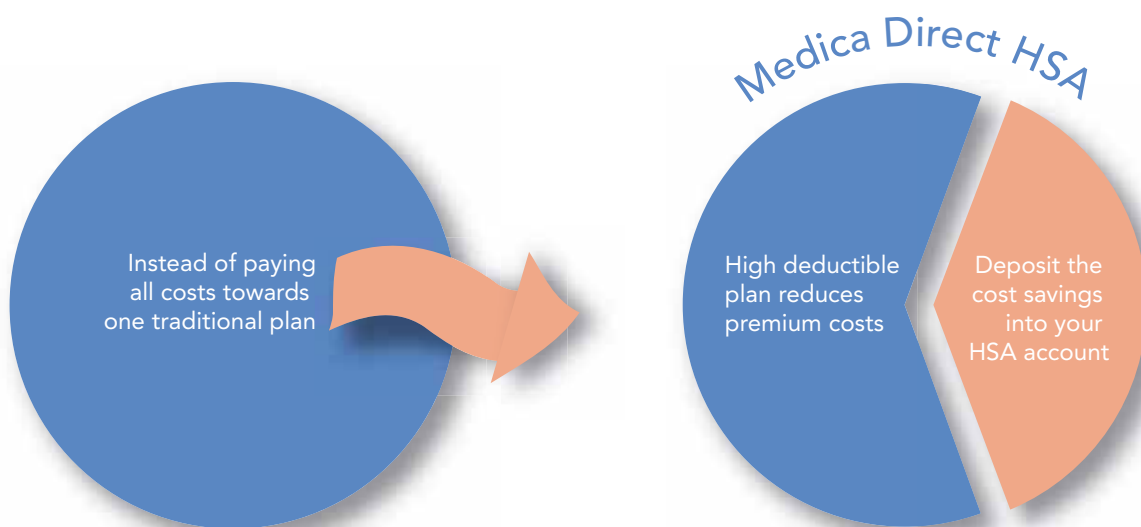
Medica Direct HSA is a high deductible health plan with various deductible and coinsurance options. The plan offers prescription benefits, coverage for preventive care, major medical expenses and access to our extensive provider network.

Please see the Outline of Coverage in this brochure for specific details about our product offerings.

A plan with tax advantages.

The Medica Direct HSASM high deductible plan gives you the option to open a federally qualified health savings account (HSA). Setting aside dollars in your HSA account will give you important federal tax savings—and a smart way to pay for deductibles, coinsurance, and qualified out-of-pocket medical costs.

While you can choose any qualified organization to administer your account and investment of funds, Medica has simplified the process by working with industry leaders to offer ease of enrollment and discounted pricing. Getting started is as easy as visiting www.medica.com. Once there, click on “Medica Products”, then click on “Medica Direct HSA for Individuals”.



Fund flexibility gives you control.

With an HSA, you control the money in your account. Because your funds are portable, they move with you if you retire, take a job or switch plans. You can make contributions until April 15 following the plan year, and use your funds to pay for things like:

- ▶ Health care deductibles and coinsurance.
- ▶ IRS Section 213(d) eligible medical expenses, such as:
 - Qualified long-term care services
 - Eyeglasses, contact lenses and contact lens solution needed for medical reasons
 - Laser eye surgery
 - Chiropractic care
 - Dental treatment
 - Prescription and over-the-counter medications

For a complete list of 213(d) eligible expenses contained in IRS Publication 502, go to www.irs.gov/pub/irs-pdf/p502.pdf.

- ▶ Qualified long-term care insurance or COBRA coverage.
- ▶ At retirement to pay uncovered Medicare expenses and certain Medicare premiums.

Non-eligible expenses are subject to IRS penalty and tax.



Visit **MainStreetMedica.com** for important online tools.

This resource can help you stay in control and make informed decisions, including:

- ▶ Personalized health information for each covered family member.
- ▶ Decision-support tools:
 - Treatment cost estimator — you choose how much to spend
 - Quality data on hospitals, physicians, clinics, radiology centers, surgery centers, pharmacies and other health care providers
 - Health-related news and articles
- ▶ Medica's List of Preferred Drugs (formulary).
- ▶ *Find A Doctor* locator.

Be covered when you're away with our 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. Chiropractic services, mental health/substance abuse treatment and transplant services are not included in this expanded national coverage. Find more Travel Program information at medica.com:

- ▶ Click on **Medica Products**
- ▶ Click on **Medica Direct HSA for Individuals**
- ▶ Scroll down to **Find A Doctor**
- ▶ Click on **Travel Program**

How to enroll in Medica Direct HSA for Individuals

Complete the Medica Direct HSA enrollment application. You will need to choose single or family coverage, your level of coverage (80% or 100%), and your deductible level. Fill out the application completely. Eligibility is determined by Medica. This includes the requirements that you must be a U.S. citizen and not eligible for Medicare. Also, you must reside in Medica's South Dakota service area. Include all dependents (if any) to be covered on the application. Include your initial monthly premium check or money order payment with the application. Your application will not be accepted if payment is not received in full. Refer to the premium chart when calculating your premium or contact Medica to determine your rate. Then simply return your completed application and payment to Medica in the enclosed pre-paid envelope.

If you want to establish an HSA account, you may choose any qualified trustee. Medica has established relationships with industry leaders. For more information, please visit medica.com. Once there, click on "Medica Products", then click on "Medica Direct HSA for Individuals". You are not required to use any particular HSA administrator in order to utilize the Medica health plan, and setting up an HSA is always optional.



What about pre-existing conditions?

Pre-existing conditions that you had within the 6 months before your enrollment date may not be covered during the first 12 months following your enrollment date. However, if you have maintained continuous health care coverage, the pre-existing condition 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.

Learn more.

For specific details regarding your deductible and benefit options, please see the Summary of Benefits contained in this brochure. The materials included in this packet are not meant to be all-inclusive. For more information simply give us a call at 952-992-2080 or 1-800-670-5935. A Medica sales person will be on hand Monday through Thursday, 8 a.m. to 5 p.m., and Friday from 9 a.m. to 5 p.m. You can also visit us online at www.medica.com.

Medica Direct HSASM for Individuals South Dakota

An Outline of Coverage to help you understand your high deductible health plan coverage.

The following is an Outline of Coverage for the Medica Direct HSA plan. It is a high level overview and not meant to be all-inclusive. If you have questions, contact your Medica broker or call Medica's Sales Department at 952-992-2080 or 1-800-670-5935.

OUTLINE OF COVERAGE

You should read your policy carefully. This Outline of Coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will determine your benefits. The policy itself sets forth in detail the rights and obligations of both you and Medica Insurance Company. It is therefore important that you read your policy carefully.

Lifetime maximum per person

Office visits for sickness, injury, screenings and physicals

Inpatient and outpatient X-ray and lab services

Inpatient and outpatient hospital services

Emergency room care and ambulance service

Medical supplies

Chiropractic, occupational, physical and speech therapy

Well-child services to age 6, immunizations to age 18

Home health care up to \$25,000 a year

Formulary prescription drugs

Mental health services (treatment of biologically based illness)

Treatment of alcoholism (coverage is limited to a maximum of 30 days care in any 6 consecutive month period and a lifetime maximum of 90 days of care)

Maternity (delivery and post-delivery care)

Skilled nursing services (120 days per year limit)

Note: Pre-existing conditions that you had within the six months before your enrollment date may not be covered during the first 12 months following your enrollment date. However, if you have maintained continuous health care coverage, the pre-existing condition 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.

	Deductible*	Out-of-pocket maximum**
Single	\$1,450	\$2,600
	\$1,850	\$3,000
Family	\$2,900	\$3,950
	\$3,750	\$4,750
A family must meet the entire deductible before any benefits will be paid, except where noted.		

\$5 million

80% after deductible

80% after deductible

80% after deductible

80% after deductible

80% after deductible

80% after deductible

80% after deductible

80% after deductible

80% after deductible

80% after deductible

80% after deductible

First 18 months, 0% coverage; thereafter,
80% after deductible

80% after deductible

	Deductible*	Out-of-pocket maximum**
Single	\$2,250	\$2,250
	\$2,900	\$2,900
Family	\$4,350	\$4,350
	\$5,600	\$5,600
A family must meet the entire deductible before any benefits will be paid, except where noted.		

\$5 million

100% after deductible

100% after deductible

100% after deductible

100% after deductible

100% after deductible

100% after deductible

100% after deductible

100% after deductible

100% after deductible

100% after deductible

100% after deductible

First 18 months, 0% coverage;
thereafter, 100% after deductible

100% after deductible

* Any portion of the yearly deductible satisfied during the last three months of a calendar year (October, November or December) can be applied toward the next calendar year's deductible.

* 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 any deductible and coinsurance, and the difference between Medica's non-network reimbursement amount (generally based on a fee schedule) and the non-network provider's billed charges.

This is only a summary. Your policy will provide a detailed description of what is and is not covered.

Authorization Requirements

Prior Authorization

Prior authorization from Medica Insurance Company (MIC) may be required before you receive certain services or supplies in order to determine whether a particular service or supply is medically necessary and a benefit. MIC uses written procedures and criteria when reviewing your request for prior authorization. To request prior authorization for a service or supply, either you, your representative, or your attending provider must call MIC.

Some of the services that may require prior authorization from MIC include:

- ▶ Reconstructive or restorative surgery
- ▶ Organ and bone marrow transplant
- ▶ Home health care
- ▶ Medical supplies and durable medical equipment
- ▶ Outpatient surgical procedures
- ▶ Skilled nursing facility services
- ▶ In-network benefits for services from non-network providers



Referrals

Certain health services are covered only upon referral. All referrals to non-network providers and certain types of network providers must be prior authorized by MIC to be eligible for coverage at your highest level of benefits. In particular, MIC will arrange for mental health services and treatment of alcoholism benefits. MIC uses a limited network of hospitals for the provision of mental health and treatment of alcoholism benefits.

Premiums, Renewability and Continuation of Coverage

Premium

Payment of premium is due on the first day of each calendar month. The grace period for the subscriber's payment of monthly premiums will be 31 days from the date a premium is due. If you pay the premium at any time during this grace period, your policy shall remain in force. If premium is not paid by the end of the grace period, coverage will end as of the last day of month through which you have paid.

Medica Insurance Company may change this premium during the year with 30 days written notice to you. Premiums are subject to change one time within a 12 month period, for the entire block of business. The following factors will be reflected in your individual rates:

- ▶ Individual demographics including age, gender, family composition and tobacco use
- ▶ Health status of the block of business as determined by the claims experience for the block of business
- ▶ The expected increase in the overall cost of health care

Continuation

South Dakota law requires that a covered dependent spouse be offered the opportunity to pay for an extension of health coverage (called continuation coverage) in certain instances where health coverage would otherwise end. The subscriber's covered dependent spouse has the right to continuation coverage if he or she loses coverage under the Policy for either of the following reasons: a) divorce from the subscriber; or b) the subscriber's eligibility for Medicare or security disability benefits.

Exclusions

The following services, supplies and associated expenses are not covered under this plan. This is not a complete list. Please consult the policy for more detail.

GENERAL EXCLUSIONS

1. Services that are not medically necessary. This includes but is not limited to services inconsistent with the medical standards and accepted practice parameters of the community and services inappropriate — in terms of type, frequency, level, setting, and duration — to the diagnosis or condition.
2. Services or drugs used to treat conditions that are cosmetic in nature, unless otherwise determined to be reconstructive.
3. A drug, device or medical treatment or procedure that is investigative.
4. Services for genetic screening and testing except when:
 - a. Recommended by a genetic counselor as predictive of a disease process, and treatment standards of care exist for the disease process; or
 - b. Reproductive choices would be made based on the test findings.
5. Nutritional and electrolyte substances.
6. Physical or occupational or speech therapy when there is no reasonable expectation that the condition will improve over a predictable period of time.
7. Neuropsychological evaluations/cognitive testing, except for the diagnosis or treatment of a medical illness or injury.
8. Custodial care, unskilled nursing or unskilled rehabilitation services.
9. Respite or rest care except for Hospice Services.
10. Services for which benefits have been paid under worker's compensation, employer liability, or any similar law.
11. Services received before coverage under this Policy becomes effective.
12. Services received after coverage under this Policy ends.
13. Services prohibited by law or regulation, or illegal under South Dakota law.
14. Services to treat injuries that occur while on military duty, and any services received as a result of war, or any act of war (whether declared or undeclared).
15. Exams, other evaluations or other services for employment, insurance, or licensure, unless otherwise covered by MIC.
16. Exams, other evaluations or other services for judicial or administrative proceedings or research, except emergency examination of a child ordered by judicial authorities, or which MIC determines is medically necessary, or as otherwise covered by MIC under this Policy.
17. Services not received from or under the direction of a physician.
18. Services for or related to intensive behavior therapy treatment programs for the treatment of autism spectrum disorders. Examples of such services include, but are not limited to, Intensive Early Intervention Behavior Therapy Services (IEIBTS), Intensive Behavioral Intervention (IBI), and Lovaas therapy.
19. Infertility services and services and drugs for or related to assisted reproductive technology (ART), artificial insemination or in vitro fertilization.
20. Charges for services by a non-network provider in excess of the non-network provider reimbursement amount.
21. Maternity care services during the first 18 months following your enrollment date.
22. Implants for the purpose of contraception.
23. Therapeutic acupuncture.
24. Services billed by acupuncturist.
25. Growth hormone.
26. Services to treat a pre-existing condition.
27. Services and supplies to the extent paid or payable under Medicare.
28. Services provided to your dependents if you have subscriber coverage only.
29. Charges that are eligible, paid, or payable under any medical payment, personal injury protection, automobile or other coverage that is payable without regard to fault, including charges that are applied toward any deductible, or coinsurance requirement of such coverage.
30. Services for private-duty nursing.
31. Functional capacity evaluations and related services for vocational purposes or for determination of disability or pension benefits.
32. Services for chemotherapy, supplies, drugs, and aftercare in connection with a human organ transplant that is not covered.
33. Services for or in connection with fetal tissue transplantation.
34. Services which are not within the scope of licensure or certification of the provider.
35. Services received outside the United States.
36. Charges for giving injections which can be self-administered.
37. Services for a mental illness that is not a biologically-based mental illness.
38. Relationship counseling beyond initial evaluation and brief intervention services.



A glossary of terms for the times when you need clarity.

HIGH DEDUCTIBLE HEALTH PLAN

A High Deductible Health Plan (HDHP) is a health insurance plan with a minimum deductible (in 2009) of \$1,150 (self-only coverage) or \$2,300 (family coverage). The annual out-of-pocket (including deductibles and copays) cannot exceed \$5,800 (self-only coverage) or \$11,600 (family coverage). These guidelines are set by federal law. The dollar limits will be adjusted for inflation each year. An HDHP with a fourth quarter deductible carryover benefit (such as Medica Direct HSA) must have a deductible at least 25 percent higher than the standard minimum.

COINSURANCE

Coinsurance is the percentage amount of eligible charges you are responsible to pay the provider after you have met your deductible. If you select the 80 percent coinsurance plan, Medica Direct HSA plan pays 80 percent for all eligible charges for covered services obtained from network providers and non-network providers. The remaining percentage amount of normally 20 percent is your coinsurance.

PROVIDER NETWORK

Medica has an extensive provider network. There is a good chance your current physician is part of the network. You receive the highest level of benefits and lower out-of-pocket expenses when you use network providers. Call Medica CallLink at 1-866-715-0915 or visit us at www.medica.com to see if your doctor is in our network.

Medica does not want to get between you and your physician, so in most circumstances, we do not require our members to obtain prior approval to obtain coverage for services from non-network providers. **You can seek services from providers who are not contracted with Medica, but you will be required to pay the difference between Medica's non-network reimbursement amount (generally based on a fee schedule) and the charges your non-network provider bills (in addition to the deductible and coinsurance). This amount will not count towards your deductible or out-of-pocket maximum.**

ELIGIBLE CHARGES

Medica Direct HSA eligible charges are generally paid based on Medica's fee schedule. This is the amount that Medica's network providers have agreed to accept for eligible services rendered to Medica members.

If you receive services from a non-network provider, you will also pay the difference between Medica's non-network reimbursement amount (generally based on a fee schedule) and the charges your non-network provider bills. If you have the 80% coinsurance plan, you will also be required to pay your 20% coinsurance. This amount could be significant and will not count towards your deductible or out-of-pocket maximum.

DRUG FORMULARY

The Medica Formulary is a list of generic and brand name outpatient prescription medications which are covered. A team of physicians and pharmacists meet regularly to review and update the list to be sure the Formulary remains responsive to the needs of our members and providers throughout the year. Your doctor can use this list to select covered medications for your health care needs, while helping you maximize your prescription drug benefit.

If you use a network pharmacy and your prescribed drug is on Medica's Formulary, the prescription will be filled and dispensed to you for your applicable copayment or coinsurance. As with all drugs, your doctor will need to determine if a generic drug is the best drug for you to take. If the prescribed drug is not on the Formulary, you are responsible for the cost of the drug. In some instances, you can request a Formulary exception through Medica's Formulary Exception process.

Contact us.

For more information or to locate a Medica broker to assist you, contact Medica at:

952-992-2080 or 1-800-670-5935
TTY: 952-992-3650 or 1-800-234-8819

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

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

Medica Direct for Individuals

Health plans created just for you.

MEDICA®

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