Medica Group Prime Solution options
January 1, 2018 through December 31, 2018

Type of Service	Group Prime Solution with Part D	Group Prime Solution Standard Part D	Group Prime Solution without Part D
Premium Monthly, per person	$300.00	$138.00	$95.00
Network	Medica Choice Passport®, a large nation-wide network of providers. You can visit any doctor, clinic or facility in the network without a referral.		
Residency Requirements/ Service Area	Must live in Medica's Prime Solution service area which includes all Minnesota counties, 46 counties in North Dakota, 65 counties in South Dakota and 13 counties in Wisconsin.		
Medicare	Must have Parts A and B of Medicare.		
Annual Medical Deductible	None	None	$150
Annual Out-of-Pocket Maximum Copay and coinsurance amounts for medical services received from in-network providers	$1,000	$3,000	$1,000
Preventive Care (e.g., flu and pneumonia vaccines, diabetic screenings, colorectal cancer screenings)	100% coverage. Other preventive services are available. There are some covered services that have a cost.		
Inpatient Hospital Unlimited number of days per hospital stay	$100 copay per admission		
Outpatient Hospital	$50 copay per admission		
Doctor Visits Primary Care Provider Specialist	 $15 copay per visit $15 copay per visit	 $0 copay per visit $10 copay per visit	 $15 copay per visit $15 copay per visit
Physical Therapy & Chiropractic	$15 copay per visit	$10 copay per visit	$15 copay per visit
Diagnostic Services/Labs/Imaging Lab services Radiology (e.g., MRIs, CT scans) Diagnostic tests, outpatient x-rays Therapeutic radiology (e.g., cancer treatment)	 100% coverage $15 copay per visit $15 copay per visit $15 copay per visit	 100% coverage $10 copay per visit $10 copay per visit $10 copay per visit	 100% coverage $15 copay per visit $15 copay per visit $15 copay per visit
Urgent Care	$15 copay per visit	$0-$10 copay per visit, depending on service	$15 copay per visit
Emergency (In or Out-of-Network) Copay waived if admitted to hospital within 24 hours (U.S. only).	$65 copay per visit	$50 copay per visit	$65 copay per visit
Ambulance	$75 copay	$25 copay	$75 copay
Skilled Nursing Facility (SNF)	100% coverage for up to 100 days in a SNF.		
Mental Health Services Inpatient: up to 90 days per stay per benefit period, plus up to 60 Medicare covered lifetime reserve days Outpatient: group or individual therapy	$100 copay per stay $15 copay per visit	$100 copay per stay $10 copay per visit	$100 copay per stay $15 copay per visit

Type of Service	Group Prime Solution with Part D		Group Prime Solution Standard Part D		Group Prime Solution without Part D
Prescription Drug Benefits (no deductible)	**Standard Retail Cost-Sharing**		**Standard Retail Cost-Sharing**		Coverage for Medicare Part B drugs only (see below)
	30-day supply	90-day supply	30-day supply	90-day supply	
Tier 1 (Preferred Generic)	$10 copay	$30 copay	$2 copay	$6 copay	
Tier 2 (Generic)	$20 copay	$60 copay	$8 copay	$24 copay	
Tier 3 (Preferred Brand)	$35 copay	$105 copay	$35 copay	$105 copay	
Tier 4 (Non-Preferred Brand)	$65 copay	$195 copay	50% of the cost	50% of the cost	
Tier 5 (Specialty Tier)	$100 copay	$300 copay	33% of the cost	50% of the cost	
Mail Order Prescription Program	2 copayments for 90-day supply		2 copayments for 90-day supply		Not applicable
Benefits through the Medicare Part D prescription drug gap (donut hole)	See above for benefits through the Part D gap (donut hole). After your yearly out-of-pocket costs (including drugs purchased through both retail and mail order pharmacies) reach $5,000, you pay the greater of: 5% of the cost or $3.35 copay for generic (including brand name treated as generic) and an $8.35 co-pay for all other drugs.		See above for benefits until total yearly drug costs (including what the plan has paid and what you paid) reaches $3,750. After that, you pay 35% of the plan's cost for covered brand name drugs, and 44% of the plan's costs for covered generic drugs until your costs (including drugs purchased through both retail and mail order pharmacies) total $5,000. After your yearly out-of-pocket costs reach $5,000, you pay the greater of: 5% of the cost, or $3.35 copay for generic (including brand name treated as generic) and an $8.35 co-pay for all other drugs.		Not applicable
Medicare Part B Drugs	20% coinsurance				
Medical Equipment and Supplies (Durable medical equipment, diabetes supplies, prosthetic devices & related medical supplies)	100% coverage		20% coinsurance		100% coverage
Vision Services					
Routine eye exam	100% coverage (for up to 1 per year)		100% coverage (for up to 1 per year)		100% coverage (for up to 1 per year)
Exam to diagnose & treat diseases	$15 copay per visit		$0-10 copay, depending on the service		$15 copay per visit
Eyeglass or contact lens allowance	$150/year allowance for non-Medicare covered eye ware; $30 copay for eye ware after cataract surgery		$75/year allowance for non-Medicare covered eye ware; $30 copay for eye ware after cataract surgery		$150/year allowance for non-Medicare covered eye ware; $30 copay for eye ware after cataract surgery
Hearing Services					
Routine hearing exam	100% coverage (for up to 1 per year)		100% coverage (for up to 1 per year)		100% coverage (for up to 1 per year)
Exam to diagnose/treat hearing issues	$15 copay per visit		$0-10 copay, depending on the service		$15 copay
Hearing fitting/evaluation & hearing aids	$500/year allowance		$400/year allowance		$500/year allowance
Limited Dental Services	100% coverage; does not include services in connection with care, treatment, filling, removal or replacement of teeth.				
Wellness Programs	Silver Sneakers® Fitness Program: $0 annual fee. Health Advocate™ 24 hour NurseLine: $0 copayment.				
Out of Area Travel Benefit & Non-Emergency Services	Extended Absence benefits include routine, non-emergency coverage outside the service area but within the United States. Coverage for up to nine consecutive months. Must call Medica to activate this option if away more than three months.				
Out-of-Network Services	Medicare benefits only unless Extended Absence Option is activated out of the Medica service area				

This comparison does not contain complete descriptions of benefits. Contact Medica at (1-800-906-5432) for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums, and/or copayments/coinsurance may change on January 1 or each year. You must continue to pay your Medicare Part B premium. The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.