Primary Applicant's Name:

MEDICA®

Medica Individual and Family Plans

Thank you for applying for a Medica health plan!

MINNESOTA APPLICATION FORM

General Medica policy information

- This application, if approved, will issue an individual/family policy only. The policy is not offered as a group health plan and Medica strictly prohibits it to be used as such.
- Your Social Security Number will be used for the purpose of identification only.
- Any person named on this application who is pregnant or an expectant parent (including adoption) is not eligible for a Medica Individual and Family plan.
- Online applications are available at **medica.com.** Applying online may reduce your application's processing time.

Completing your application

- Complete all sections within the application thoroughly and accurately. Applications with missing or inaccurate information will be delayed in processing and may result in rescission of your policy.
- Questions in Section F pertain to all persons listed in this application. All questions answered "Yes" in Sections F2 through F4 require a complete explanation in Section F5.

Submitting your application

- Submit your premium payment along with your application. If the full first month's premium payment is not received, your application cannot be processed.
- Please complete, sign and date your application and mail to Medica. All adults, including dependent children age 18 and over, must sign. Primary applicants must be 19 years of age or older.
- Your application form is valid for a period of 60 days from the date you sign it. After 60 days, a new application must be completed in full if you wish to be considered for coverage.
- See Section G for information on your effective date. Medica will notify you if you (or anyone listed in this application) have been approved and the effective date of coverage. The processing time for your application is approximately two to four weeks. **Do not cancel any existing coverage until the Medica policy has been approved, issued and accepted by you.**
- Make a copy of your completed application for your personal records. If you are approved for coverage, this copy will become a part of your contract.

Contact us if you have questions

Please contact a Medica Sales Service Specialist at 952-992-2080 or 1-800-670-5935 between 8:00 a.m. and 5:00 p.m., Monday through Thursday, and 9:00 a.m. and 5:00 p.m. on Friday.

SECTION A CURRENT MEDICA MEMBERSHIP STATUS

❑ I am a new applicant not currently covered under a Medica policy.

❑ I currently have Medica coverage and I want to switch to a different Medica plan.

I am covered under Medica I.D. number: | | | | | | | | | | | | | | |

If your current Medica policy is through your employer, please indicate your employer's name:

❑ I currently have a Medica Individual and Family plan and want to add the dependent(s) I've listed in Section B.

I am covered under Medica I.D. number: | | | | | | | | | | | | | | |

Would you like to keep your current plan?. . . . . ❑ Yes ❑ No

If Yes, do not complete Section C.

SECTION B

APPLICANT INFORMATION

Primary Applicant

Last name:	First name:	Middle initial:

Marital status:	Preferred telephone number:	Alternate telephone number:	Best time to call:
❑ Single ❑ Married			❑ Morning ❑ Afternoon

Email address *(by providing you agree that Medica may send you e-mails):*

Applicant's home address

Street:	City:	State:	Zip Code:

Applicant's billing address *(if different than home address)*

Street:	City:	State:	Zip Code:

Mailing preference

Please send all mail (other than billing statements) such as my enrollment packet, ID cards and claims information to:

❑ Home address ❑ Billing address

List each person applying for coverage. Add additional pages if necessary.

Note: Medica Encore is a two-person maximum policy. Medica Solo, Medica Symphony, and Medica Symphony for HSA, and Harmony with Medica and Fairview are family policies. Your application will not be processed if you exceed the maximum number of persons allowed on your selected plan.

First name Middle initial Last name	Social Security No.	Sex	Relationship to applicant	Birth date *mo/day/yr*	Height	Present weight	Weight one year ago
		M F	(primary applicant)		ft. in.	lbs.	lbs.
		M F			ft. in.	lbs.	lbs.
		M F			ft. in.	lbs.	lbs.
		M F			ft. in.	lbs.	lbs.
		M F			ft. in.	lbs.	lbs.
		M F			ft. in.	lbs.	lbs.

SECTION C

C PLAN AND BENEFITS SELECTION

Note: Medica cannot process your application if your Plan and Benefits Selection page is not completed. This page can be found as the last page of your application. You may also find it online at **medica.com.** *If you are adding a dependent to your current plan, you do not need to complete Section C.*

SECTION D

D PAYMENT INFORMATION

Note: You can find your rate online at **medica.com.** Your initial payment should reflect the rate quoted online.

D1 First month payment *(first payment **must** be submitted with this application)*

Choose payment method:

❑ Check *(make payable to Medica)* ❑ Credit Card *(submit with the Credit Card Form)*

Amount paid with this application:

$

D2 Ongoing payments

Choose payment method:

❑ Check ❑ ACH Automatic Payment from your checking account *(you **must** complete the ACH Authorization Form)*

SECTION E

E OTHER INSURANCE INFORMATION

Note: Incomplete information in this section may result in a pre-existing condition limitation applied to claims for individuals age 19 and older, and a resulting delay in claims payment could occur.

1. Would this coverage replace or change any existing health insurance? . . . . . ❑ Yes ❑ No
2. Is any person named on the application covered by Medicare? . . . . . ❑ Yes ❑ No
3. Do you currently have any health insurance or have you had any health insurance within the past 63 days? . . . . . ❑ Yes ❑ No

If Yes, you **must** provide your health coverage history for the past 18 months by completing the insurance information below:

Initial plan effective date *(mm/dd/yyyy)*	Coverage end date *(mm/dd/yyyy)*	List all persons covered under policy	Name of insurance company	Type of insurance
				❑ Individual ❑ Group ❑ COBRA
				❑ Individual ❑ Group ❑ COBRA

SECTION F

F HEALTH INFORMATION

Note: Any change in applicant's or dependent's health history that occurs between your signature date on this application and the effective date of coverage must be reported to Medica immediately. This includes doctor visits, diagnosed conditions or diseases, or any other medical related issues. This information may be used in determination and/or reversal of policy acceptance. If you do not inform Medica of health changes, your policy may be rescinded.

F1 SECTION F1: Is any person or has any person named on this application:

A. Had a positive pregnancy test in the last 90 days, or are currently an expectant parent (male or female), regardless of whether or not the mother is listed on the application? . . . . . ❑ Yes ❑ No

If Yes, list all individuals: _____

B. Used tobacco/nicotine products within the last 12 months? . . . . . ❑ Yes ❑ No

If Yes, list all individuals: _____

C. Currently disabled, hospitalized, on medical leave or receiving disability or workers' compensations benefits? . . . ❑ Yes ❑ No

If Yes, please provide details: _____

SECTION F HEALTH INFORMATION (continued)

Note: Answer every question in Sections F2 through F4 by checking a "Yes" or "No" box or by checking the health conditions that apply. Complete Section F5 for all conditions checked or all questions answered "Yes" for you and each person applying for coverage.

F2 SECTION F2: Has any person named on this application ever been diagnosed with, treated for, or consulted with a physician or practitioner for:

A. Heart attack, coronary artery disease, heart bypass surgery, angioplasty, heart valve replacement, congestive heart failure or cardiomyopathy? ❑ Yes ❑ No
B. Aneurysm, Muscular Dystrophy, ALS or Multiple Sclerosis? ❑ Yes ❑ No
C. Emphysema, chronic obstructive pulmonary disease (COPD) or pulmonary or cystic fibrosis? ❑ Yes ❑ No
D. Hepatitis C, cirrhosis of the liver or Crohn's disease? ❑ Yes ❑ No
E. Diabetes Type II? ❑ Yes ❑ No
F. Leukemia, Hodgkin's Disease, lymphoma or other type of cancer; including but not limited to breast, colon, kidney, lung or prostate? ❑ Yes ❑ No
G. HIV Positive or AIDS? ❑ Yes ❑ No
H. Scleroderma, systemic lupus or Diabetes Type I? ❑ Yes ❑ No
I. Organ transplant (other than cornea)? ❑ Yes ❑ No

F3 SECTION F3: Within the past 5 years, has any person named on this application been diagnosed with, treated for, or consulted with a physician or practitioner about any of the following (check all boxes that apply):

1. Heart, Cardiovascular or Circulatory Disorder

❑ a. High Blood Pressure or Hypertension
❑ b. Chest Pain or Angina
❑ c. Heart Murmur, Mitral Valve Prolapse, Heart Valve Condition or Irregular Heartbeat
❑ d. Blood Clot, Embolism, Carotid Artery Blockage, Phlebitis or Edema
❑ e. Congenital Heart Condition
❑ f. Peripheral Artery or Vascular Disease (PAD)
❑ g. Other Cardiovascular, Circulatory or Heart Condition
❑ **No to all Heart, Cardiovascular or Circulatory disorders**

2. Blood, Endocrine, Pituitary or Lymph Node Disorder

❑ a. Elevated Cholesterol or Triglycerides
❑ b. High or Low Blood Sugar or Sugar Intolerance
❑ c. Anemia or Hepatitis A, B, D, E or G
❑ d. Hemophilia or Hemochromatosis
❑ e. Obesity
❑ f. Thyroid disorder or goiter
❑ g. Recurrence of Enlarged or Swollen Lymph Node
❑ h. Other Blood, Endocrine, Pituitary or Lymph Node Condition
❑ **No to all Blood, Endocrine, Pituitary or Lymph Node disorders**

3. Digestive Disorder

❑ a. Gastroesophageal Reflux Disease (GERD), Gastritis or Heartburn
❑ b. Stomach Ulcer
❑ c. Irritable Bowel Syndrome (IBS), Chronic Diarrhea, Colitis or Ulcerative Colitis
❑ d. Diverticulitis, Diverticulosis, Hemorrhoids or Colon Polyps
❑ e. Jaundice or Pancreatitis
❑ f. Other Stomach, Liver, Pancreas, Spleen, Colon or Gallbladder Condition
❑ **No to all Digestive disorders**

4. Genitourinary Disorder – Kidney, Bladder, Prostate, Urethra, Ureter

❑ a. Kidney or Bladder Infection, Protein or Blood in Urine
❑ b. Kidney stone
❑ c. Prostatitis, Enlarged Prostate or Elevated PSA
❑ d. Renal Insufficiency
❑ e. Other Genitourinary Condition
❑ **No to all Genitourinary disorders**

5. Congenital or Developmental Disorder

❑ a. Cleft Palate or Cleft Lip
❑ b. Autism, Asperger's or Pervasive Development Disorder
❑ c. Developmental Disorder or Delay, Down's Syndrome or Mental Disability
❑ d. Club Foot/Feet
❑ e. Other Congenital or Developmental Condition
❑ **No to all Congenital or Developmental disorders**

6. Cyst, Growth, Lump, Mass or Tumor

❑ a. Melanoma
❑ b. Cyst, Growth, Lump, Mass or Tumor
❑ **No to all Cyst, Growth, Lump, Mass or Tumor conditions**

SECTION F HEALTH INFORMATION (continued)

SECTION F3 (continued): Within the past 5 years, has any person named on this application been diagnosed with, treated for, or consulted with a physician or practitioner about any of the following (check all boxes that apply):

7. Muscle, Bone, Joint, Immune System Disorder
- ❑ a. Back Pain, Neck Pain, Spine or Disc Condition
- ❑ b. Knee Injury or Condition
- ❑ c. Osteoarthritis, Gout, Bursitis, Tendonitis, Rheumatoid Arthritis
- ❑ d. Fibromyalgia or Chronic Fatigue Syndrome
- ❑ e. TMJ or Carpal Tunnel Syndrome
- ❑ f. Connective Tissue Disorder
- ❑ g. Rotator Cuff Syndrome or Tear or Shoulder Condition
- ❑ h. Internal Fixation Device (screws, plates, pins), Prosthesis, Amputation or Joint Replacement
- ❑ i. Other Muscle, Bone, Joint or Immune System Condition
- ❑ **No to all Muscle, Bone, Joint, Immune System disorders**

8. Brain or Nervous System Disorder
- ❑ a. Migraines or Recurrent Headaches
- ❑ b. Epilepsy, Seizures, Tics or Tremors
- ❑ c. Dizziness or Fainting
- ❑ d. Transient Ischemic Attack (TIA) or Stroke
- ❑ e. Alzheimer's, Dementia or Parkinson's
- ❑ f. Paralysis
- ❑ g. Cerebral Palsy
- ❑ h. Concussion, Head Trauma, Brain Injury or Memory Loss
- ❑ i. Other Brain or Nervous System Condition
- ❑ **No to all Brain or Nervous System disorders**

9. Respiratory Disorder
- ❑ a. Asthma
- ❑ b. Allergies or Hay Fever
- ❑ c. Chronic Bronchitis
- ❑ d. Sleep Apnea
- ❑ e. Shortness of Breath
- ❑ f. Tuberculosis
- ❑ g. Other Respiratory Condition
- ❑ **No to all Respiratory disorders**

10. Female Reproductive System Disorder
- ❑ a. Abnormal Pap Smear
- ❑ b. Abnormal Mammogram
- ❑ c. Infertility
- ❑ d. Endometriosis, Polycystic Ovarian Syndrome (PCOS), Pelvic Inflammatory Disease
- ❑ e. Uterine Fibroids
- ❑ f. Menstrual Condition
- ❑ g. Multiple Miscarriages
- ❑ h. Cervical, Ovarian, Uterine or Vaginal Condition
- ❑ i. Other Female Reproductive Condition
- ❑ **No to all Female Reproductive System disorders**

11. Male Reproductive System Disorder
- ❑ a. Infertility
- ❑ b. Penile or Testicular Condition
- ❑ c. Other Male Reproductive Condition
- ❑ **No to all Male Reproductive System disorders**

12. Sexually Transmitted Disease
- ❑ a. Genital Warts or Genital Herpes
- ❑ b. Human Papilloma Virus (HPV)
- ❑ c. Chlamydia, Gonorrhea or Syphilis
- ❑ d. Other Sexually Transmitted Disease
- ❑ **No to all Sexually Transmitted Diseases**

13. Mental, Emotional or Psychological Disorder
- ❑ a. Anxiety, Depression, Panic Disorder
- ❑ b. Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD)
- ❑ c. Anorexia or Bulimia
- ❑ d. Bipolar or Schizophrenia
- ❑ e. Psychiatric or Psychological Counseling or Therapy
- ❑ f. Obsessive Compulsive Disorder or Personality Disorder
- ❑ g. Other Mental, Emotional or Psychological Condition
- ❑ **No to all Mental, Emotional or Psychological disorders**

14. Skin Disorder
- ❑ a. Acne
- ❑ b. Rosacea, Eczema or Psoriasis
- ❑ c. Skin Cancer
- ❑ d. Other Skin Condition
- ❑ **No to all Skin disorders**

15. Eye, Ear, Nose or Throat Condition
- ❑ a. Cataracts, Glaucoma, Retinitis, Retinal Tear or Blindness
- ❑ b. Recurrent Ear Infections
- ❑ c. Hearing Loss
- ❑ d. Cochlear Implant
- ❑ e. Deviated Nasal Septum, Recurrent Sinusitis
- ❑ f. Recurrent Tonsillitis
- ❑ g. Other Eye, Ear, Nose or Throat Condition
- ❑ **No to all Eye, Ear, Nose or Throat conditions**

SECTION F

F HEALTH INFORMATION (continued)

F4

SECTION F4: Within the past 5 years, has any person named on this application:

A. Been hospitalized? ❑ Yes ❑ No

B. Been evaluated for or treated for alcoholism, chemical dependency, drug abuse? ❑ Yes ❑ No

C. Been advised to have, or are considering, a consultation, surgery, treatment or testing which has not yet been performed? ❑ Yes ❑ No

D. Had an MRI, CT scan, stress test, echocardiogram, electrocardiogram, X-ray or other diagnostic testing? ❑ Yes ❑ No

E. Been seen by a medical provider for any health condition not already listed on this application (excluding common cold or flu)? ❑ Yes ❑ No

F. Been advised by a medical provider to modify or restrict eating or drinking habits? ❑ Yes ❑ No

G. Been declined coverage, charged an increased rate, or had benefits excluded from a health insurance policy because of a health condition? ❑ Yes ❑ No

F5

SECTION F5: If you checked any health conditions and/or checked "Yes" to any questions in sections F2-F4, please complete this section and provide us with complete details. Add additional pages if necessary.

Question number & letter:	Person's name:	Treatment received:			Physician's name:
	Medical condition:	Hospitalized? ❑ Yes ❑ No	Onset date:	Complete recovery date:	Physician's address:

Question number & letter:	Person's name:	Treatment received:			Physician's name:
	Medical condition:	Hospitalized? ❑ Yes ❑ No	Onset date:	Complete recovery date:	Physician's address:

Question number & letter:	Person's name:	Treatment received:			Physician's name:
	Medical condition:	Hospitalized? ❑ Yes ❑ No	Onset date:	Complete recovery date:	Physician's address:

Question number & letter:	Person's name:	Treatment received:			Physician's name:
	Medical condition:	Hospitalized? ❑ Yes ❑ No	Onset date:	Complete recovery date:	Physician's address:

Question number & letter:	Person's name:	Treatment received:			Physician's name:
	Medical condition:	Hospitalized? ❑ Yes ❑ No	Onset date:	Complete recovery date:	Physician's address:

Question number & letter:	Person's name:	Treatment received:			Physician's name:
	Medical condition:	Hospitalized? ❑ Yes ❑ No	Onset date:	Complete recovery date:	Physician's address:

SECTION

F HEALTH INFORMATION (continued)

F6

SECTION F6: Please list the date and results of the last physical exam for all persons named on this application. For female applicants, please include date and result of last pap smear:

Person's name:	Results of exam:	Blood pressure reading:	Physician's name:
Date of physical exam:		Cholesterol reading:	Physician's address:

Person's name:	Results of exam:	Blood pressure reading:	Physician's name:
Date of physical exam:		Cholesterol reading:	Physician's address:

Person's name:	Results of exam:	Blood pressure reading:	Physician's name:
Date of physical exam:		Cholesterol reading:	Physician's address:

Person's name:	Results of exam:	Blood pressure reading:	Physician's name:
Date of physical exam:		Cholesterol reading:	Physician's address:

Person's name:	Results of exam:	Blood pressure reading:	Physician's name:
Date of physical exam:		Cholesterol reading:	Physician's address:

F7

SECTION F7: Please list all prescription medications filled in the last 12 months for any persons named on this application. Add additional pages if necessary.

Person's name:	Drug name:			Generic? ❑ Yes ❑ No	Currently taking? ❑ Yes ❑ No
Medical condition:	Dosage: ❑ mg ❑ ml	Number taken each day:	Number of refills per year:		If "No", date stopped:

Person's name:	Drug name:			Generic? ❑ Yes ❑ No	Currently taking? ❑ Yes ❑ No
Medical condition:	Dosage: ❑ mg ❑ ml	Number taken each day:	Number of refills per year:		If "No", date stopped:

Person's name:	Drug name:			Generic? ❑ Yes ❑ No	Currently taking? ❑ Yes ❑ No
Medical condition:	Dosage: ❑ mg ❑ ml	Number taken each day:	Number of refills per year:		If "No", date stopped:

Person's name:	Drug name:			Generic? ❑ Yes ❑ No	Currently taking? ❑ Yes ❑ No
Medical condition:	Dosage: ❑ mg ❑ ml	Number taken each day:	Number of refills per year:		If "No", date stopped:

SECTION G

EFFECTIVE DATE OF COVERAGE

Notes:

- Coverage must start on the 1st day of any month. Coverage can begin the day after the application is received by Medica.
- The effective date must be within 60 days of the application's signature date.
- If no effective date is indicated, your effective date would automatically be the next available effective date.

I'm requesting an effective date of:	Month:	❑ 1st

SECTION H

AUTHORIZATION AND REPRESENTATION

TO BE SIGNED BY APPLICANTS

I represent that the information provided herein is true and complete to the best of my knowledge and belief. I understand that Medica may rescind coverage back to the effective date of coverage for fraud and intentional material misrepresentation.

I authorize any hospital, clinic, institution, physician, insurance company, Intelliscript or other organization, institution or person to give Medica or any of its designees any and all records of information pertaining to medical history or services rendered to Us including, but not limited to, information relating to any Medica records or medical insurance claims, consultations or treatments; outpatient or inpatient hospital services; prescription information and lab work.

I understand that:

1. This information will be used for underwriting, risk rating, enrollment or eligibility for benefits;
2. Medica may re-disclose the information without authorization as permitted by law, which means it may no longer be protected by privacy rules;
3. I may revoke this authorization in writing. Revocation will not affect any actions taken by Medica prior to Medica's receipt of the revocation. Unless revoked, this authorization will remain in effect for the term of my coverage;
4. Benefits under the policy, if approved, will be based upon the selection made in Section C, unless Medica has offered, and I have accepted in writing, an alternative plan. I understand that if I, or any person named on this application do(es) not qualify for the coverage selected, Medica may offer alternative plans to some or all of us.
5. I have the right to see and correct my personal information in accordance with the law;
6. I have the right to review Medica's Privacy Notice before signing this application and to request a copy at any time.
7. I authorize Medica to release information related to my Medica enrollment (including information from my medical records) to my insurance broker should I choose to name one. This includes information related to any applicant listed within this application.
8. For individuals age 19 and older, if approved for coverage, a pre-existing condition limitation may apply. If continuous qualifying health coverage has been maintained, this pre-existing condition limitation is in effect for 12 months, but will be reduced based upon length of previous qualifying coverage. If continuous qualifying health coverage has not been maintained, this pre-existing condition limitation is in effect for the first 18 months.
9. I authorize Medica to disclose any information in its possession to any of my providers who will manage or coordinate my care.

Please keep a copy of your completed application for your records. If you are approved for coverage, this copy will become a part of your contract.

Signature of Primary Applicant: Date:
X

As an additional applicant named on this application, I authorize Medica to disclose my protected health information to the Primary Applicant regarding this application.

Signature of Additional Applicant Age 18 or Older: Date:	Signature of Additional Applicant Age 18 or Older: Date:
X	X
Signature of Additional Applicant Age 18 or Older: Date:	Signature of Additional Applicant Age 18 or Older: Date:
X	X

Note: Finished filling out your application? Be sure you have all of the following pieces:

1. Original application, including signatures of everyone over the age of 18 who in listed on the application
2. Section C, Plan and Benefits Selection
3. Estimated initial payment for first month's premium *(include credit card form or check)*

Additional items you *may* have to your application:

4. Additional pages for Section F, Health Information *(if necessary)*
5. ACH form *(if you are enrolling in automatic payment from your checking account)*

Return completed applications to:
Medica Insurance Company
Mail Route CP312
PO Box 9310
Minneapolis, MN 55440-9310

or Fax to:
952-992-2511

SECTION

I AGENT USE ONLY

I certify that I have reviewed this application. If application was completed by agent, agent certifies that he/she personally completed this application, that each question was asked separately, that the answers recorded in this application are complete and accurate as given.

Signature of Agent: X	Date:	Agent number:
Print agent's name:	Telephone number:	

SECTION

J FOR OFFICE USE ONLY

Date received:	Policy effective date:	Plan code:	PE mo.:	Reviewed by: Date: A D	Payment ID:	Amount:

MEDICA PRIVACY NOTICE

Medica takes its responsibility of protecting your personal information seriously. Where possible, Medica de-identifies or encrypts personal information. We use and disclose personal information only to the extent necessary to conduct treatment, payment and health care operations, or to comply with legal, regulatory or accreditation requirements.

Medica and its business associates obtain, maintain, use and share personal information to carry out certain routine activities. Routine activities include: (i) treatment-related activities, such as referring you to a doctor or other provider; (ii) payment-related activities, such as paying a claim for medical services rendered; and (iii) health care operations, such as professional peer review.

The law also gives you rights to access, copy, and amend your personal information. You have the right to request restrictions on certain uses and disclosures of your personal information. You also have the right to obtain information about how and when your personal information has been used and disclosed.

Medica's full Privacy Notice is available upon request by calling 1-800-670-5935 or by going to www.medica.com.

MEDICA®

Mail Route CP312, PO Box 9310, Minneapolis, MN 55440-9310

SECTION

C PLAN AND BENEFITS SELECTION

Plan selection: Select either Medica Solo℠, Medica Encore℠, Medica Symphony® or Medica Symphony® for HSA and complete the additional information below it. Additional plan options are available on the following page. Visit medica.com to learn more about plan benefits.

Note: You must complete each box within your selected plan's column. Only complete information underneath your chosen plan.

	Medica Solo ❑	Medica Encore ❑	Medica Symphony ❑	Medica Symphony for HSA ❑
	Answer 3 questions below	**Answer 4 questions below**	**Answer 4 questions below**	**Answer 2 questions below**
1.	**Choose your plan coverage and select your deductible level:**			
	80% one-person coverage. Select deductible level: ❑ $3,150 ❑ $6,300 ❑ $9,450 ❑ $12,600 80% family coverage. Select deductible level: ❑ $6,300 ❑ $12,600 ❑ $18,900 ❑ $25,200 100% one-person coverage. Select deductible level: ❑ $3,150 ❑ $6,300 ❑ $9,450 ❑ $12,600 100% family coverage. Select deductible level: ❑ $6,300 ❑ $12,600 ❑ $18,900 ❑ $25,200	100% one-person coverage. Select deductible level: ❑ $4,150 ❑ $6,800 ❑ $9,450 100% two-person coverage. Select deductible level: ❑ $6,300 ❑ $7,850 ❑ $9,450	100% one-person coverage. Select deductible level: ❑ $2,050 ❑ $3,650 ❑ $5,200 ❑ $7,300 ❑ $10,450 100% family coverage. Select deductible level: ❑ $4,150 ❑ $7,300 ❑ $10,450 ❑ $14,650 ❑ $20,950	80% one-person coverage. Select deductible level: ❑ $1,550 ❑ $3,150 ❑ $5,200 80% family coverage. Select deductible level: ❑ $3,150 ❑ $5,700 ❑ $8,350 100% one-person coverage. Select deductible level: ❑ $2,050 ❑ $3,450 ❑ $4,800 ❑ $6,200 100% family coverage. Select deductible level: ❑ $4,150 ❑ $7,300 ❑ $9,950 ❑ $12,500
2.	**Select your office visit copayment option:**			
	Your copayment is tied to your deductible level	❑ Option A: $20 copayment ❑ Option B: $40 copayment	❑ Option A: $30 copayment ❑ Option B: $60 copayment	***Not applicable***
3.	**Mental health and substance abuse coverage option:** Choose if you would like to keep or remove the mental health and substance abuse coverage currently offered in your selected plan. This option is **only** available at the time of your initial application. This option will be in force for the duration of your policy. *Removing coverage reduces your monthly rate.*			
	❑ Keep coverage ❑ Remove coverage	❑ Keep coverage ❑ Remove coverage	❑ Keep coverage ❑ Remove coverage	❑ Keep coverage ❑ Remove coverage
4.	**Prescription drug coverage option:** Choose if you would like to increase your prescription drug coverage. This option is **only** available at the time of your initial application. This option will be in force for the duration of your policy. *Choosing this option increases your monthly rate.*			
	❑ Keep Tier 1-only coverage ❑ Increase coverage to include Tier 2 and 3	❑ Keep Tier 1-only coverage ❑ Increase coverage to include Tier 2 and 3	❑ Keep Tier 1-only coverage ❑ Increase coverage to include Tier 2 and 3	***Not applicable***

SECTION C

PLAN AND BENEFITS SELECTION (continued)

Harmony with Medica and Fairview

This unique health plan features integrated coverage and care between Medica and Fairview.

Note: You must complete each box within your selected plan type's column. Only complete information underneath your chosen plan type.

	Copay Plan ❑	Health Savings Account (HSA) Compatible Plan ❑
	Answer 5 questions below	**Answer 3 questions below**
1.	**Choose your plan coverage and select your deductible level:**	
	One-Person Coverage ❑ $2,050 ❑ $3,450 ❑ $5,200 ❑ $7,300 ❑ $10,450 **Family Coverage** ❑ $4,150 ❑ $7,300 ❑ $10,450 ❑ $14,650 ❑ $20,950	**One-Person Coverage** ❑ $2,050 ❑ $3,450 ❑ $5,200 **Family Coverage** ❑ $4,150 ❑ $7,300 ❑ $10,450
2.	**Select your office visit copayment option:**	
	❑ Option A: $30 copayment ❑ Option B: $60 copayment	***Not applicable***
3.	**Mental health and substance abuse coverage option:** Choose if you would like to keep or remove the mental health and substance abuse coverage currently offered in your selected plan. This option is only available at the time of your initial application. This option will be in force for the duration of your policy. *Removing coverage reduces your monthly rate.*	
	❑ Keep coverage ❑ Remove coverage	❑ Keep coverage ❑ Remove coverage
4.	**Prescription drug coverage option:** Choose if you would like to increase your prescription drug coverage. This option is only available at the time of your initial application. This option will be in force for the duration of your policy. Choosing this option increases your monthly rate.	
	❑ Keep Tier 1-only coverage ❑ Upgrade coverage to include Tier 2 and 3	***Not applicable***
5.	**Email address:** An email address is required to apply as part of Harmony with Medica and Fairview's near-paperless experience.	