### Important Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>$7,900 Individual / $15,800 Family for in-network services. There is no coverage for out-of-network services.</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes. Preventive care, preventive prescriptions and copay services from in-network providers are covered before you meet your deductible.</td>
<td>This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits">https://www.healthcare.gov/coverage/preventive-care-benefits</a>.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>No.</td>
<td>You don't have to meet deductibles for specific services.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>$7,900 Individual / $15,800 Family for in-network services. There is no coverage for out-of-network services.</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Premiums, balance-billing charges and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td><strong>Will you pay less if you use a network provider?</strong></td>
<td>Yes. Visit <a href="https://www.medica.com/choiceproviders">www.medica.com/choiceproviders</a> or call 888-592-8211 (TTY:711) for a list of network providers.</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td><strong>Do you need a referral to see a specialist?</strong></td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>

*For more information about limitations and exceptions, see the plan or policy document at www.Medica.com/members.*
## Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

**WI Individual Choice Catastrophic**

**Coverage Period:** Beginning on or after 01/01/2019  
**Coverage for:** Individual or Family  
**Plan Type:** EPO

---

**Common Medical Event** | **Services You May Need** | **What You Will Pay** | **Limitations, Exceptions & Other Important Information**
--- | --- | --- | ---
**If you visit a health care provider’s office or clinic** |  |  |  
Primary care visit to treat an injury or illness | In-Network Provider (You will pay the least) | Deductible does not apply. After first 3 visits, 0% coinsurance.  
Deductible does not apply. | Out-of-Network Provider (You will pay the most) | Not covered  
First 3 visit limit applies to primary care visits, including retail health clinics.  
Chiropractic care is covered at 0% coinsurance after deductible.  
You may have to pay for services that aren’t preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.

Specialist visit | 0% coinsurance | Not covered |  
Preventive care/ screening/ immunization | No charge. Deductible does not apply. | Not covered |  

**If you have a test** |  |  |  
Diagnostic test (x-ray, blood work) | 0% coinsurance | Not covered | ---none---  
Imaging (CT/PET scans, MRIs) | 0% coinsurance | Not covered | ---none---

**If you need drugs to treat your illness or condition** |  |  |  
Generic drugs | 0% coinsurance | Not covered | Up to a 31-day supply per prescription. Proton pump inhibitors (except for members 12 years of age and younger, and those members who have a feeding tube) and non-sedating antihistamines are not covered. Refer to the Exceptions to the Drug List section of your Policy of Coverage for more details. No charge for preventive drugs.

Preferred brand drugs | 0% coinsurance | Not covered |  
Non-Preferred brand drugs | 0% coinsurance | Not covered |  
Specialty drugs | Preferred: 0% coinsurance  
Non-Preferred: 0% coinsurance | Not covered |  
---

All **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.
## Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

**WI Individual Choice Catastrophic**

### Coverage Period:
Beginning on or after 01/01/2019

### Coverage for:
Individual or Family  
Plan Type: EPO

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>0% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>0% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>0% coinsurance</td>
<td>Covered as an in-network benefit</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>0% coinsurance</td>
<td>Covered as an in-network benefit</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>0% coinsurance</td>
<td>Covered as an in-network benefit</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>0% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>0% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>0% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>0% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>Prenatal: No charge. Deductible does not apply. Postnatal: 0% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>0% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>0% coinsurance</td>
<td>Not covered</td>
</tr>
</tbody>
</table>
## Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

### WI Individual Choice Catastrophic

**Coverage Period:** Beginning on or after 01/01/2019

**Coverage for:** Individual or Family  | **Plan Type:** EPO

### What You Will Pay

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>In-Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td><strong>Home health care</strong></td>
<td>0% coinsurance</td>
<td>Not covered</td>
<td>Limited to 60 visits/ year.</td>
</tr>
<tr>
<td></td>
<td><strong>Rehabilitation services</strong></td>
<td>0% coinsurance</td>
<td>Not covered</td>
<td>Limited to 20 visits per therapy/ year.</td>
</tr>
<tr>
<td></td>
<td><strong>Habilitation services</strong></td>
<td>0% coinsurance</td>
<td>Not covered</td>
<td>Limited to 20 visits per therapy/ year.</td>
</tr>
<tr>
<td></td>
<td><strong>Skilled nursing care</strong></td>
<td>0% coinsurance</td>
<td>Not covered</td>
<td>Limited to 30 days/ year. Coverage is limited to 60 days/ year for inpatient rehabilitation.</td>
</tr>
<tr>
<td></td>
<td><strong>Durable medical equipment</strong></td>
<td>0% coinsurance</td>
<td>Not covered</td>
<td>Limited to one purchase per item every three years for most items.</td>
</tr>
<tr>
<td></td>
<td><strong>Hospice services</strong></td>
<td>0% coinsurance</td>
<td>Not covered</td>
<td>---none---</td>
</tr>
<tr>
<td><strong>If your child needs dental or eye care</strong></td>
<td><strong>Children’s eye exam</strong></td>
<td>0% coinsurance</td>
<td>Not covered</td>
<td>Limited to one refractive eye exam/ year to end of month member turns 19.</td>
</tr>
<tr>
<td></td>
<td><strong>Children’s glasses</strong></td>
<td>0% coinsurance</td>
<td>Not covered</td>
<td>Limited to one pair of glasses or contacts/ year to end of glasses member turns 19.</td>
</tr>
<tr>
<td></td>
<td><strong>Children’s dental check-up</strong></td>
<td>Not covered</td>
<td>Not covered</td>
<td>No coverage for dental check-ups.</td>
</tr>
</tbody>
</table>
### Excluded Services & Other Covered Services:

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</th>
</tr>
</thead>
</table>
| ● Acupuncture  
● Bariatric surgery  
● Cosmetic surgery  
● Dental care (Adult)  
● Elective, induced abortions, except as medically necessary to protect the life of the mother or in the case of rape or incest  
● Infertility treatment  
● Long-term Care  
● Non-emergency care when traveling outside the U.S.  
● Private duty nursing  
● Routine eye care (Adult)  
● Routine foot care except for some conditions  
● Weight loss programs |

<table>
<thead>
<tr>
<th>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)</th>
</tr>
</thead>
</table>
| ● Chiropractic care  
● Hearing aids limited to one per ear every 3 years |
Your Rights to Continue Coverage:
There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Wisconsin Office of the Commissioner of Insurance at 800-236-8517 outside of Madison or 608-266-0103 in Madison. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:
There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Wisconsin Office of the Commissioner of Insurance at 800-236-8517 outside of Madison or 608-266-0103 in Madison.

Does this plan provide Minimum Essential Coverage? Yes.
If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes.
If your plan doesn’t meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
For assistance, call the number included in this document or on the back of your ID card.
Dine k’ehji shich’i’ hadoodzhin ninizingo, beesh bee hane’e binumber naaltsoos bikaahigii bich’i’ hodiilnih e i doodaii bee neehozin biniiyee nanitiniigii bine’dee bikaa doo aldo’.

Para sa tulong sa Tagalog, tawagan ang numerong kabilang sa dokumentong ito o sa likod ng iyong ID card.
Para obtener asistencia en español, llame al número de teléfono que se incluye en este documento o al dorso de su tarjeta de identificación.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.
**About these Coverage Examples:**

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments, and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg Is Having a Baby
(9 months of in-network prenatal care and a hospital delivery)

- The plan’s overall deductible: $7,900
- Specialist coinsurance: 0%
- Hospital (facility) coinsurance: 0%
- Other coinsurance: 0%

This EXAMPLE event includes services like:
- Specialist office visits (prenatal care)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (ultrasounds and blood work)
- Specialist visit (anesthesia)

**Total Example Cost** $12,800

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$7,900</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered** $60

The total Peg would pay is $7,960

### Managing Joe’s type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan’s overall deductible: $7,900
- Specialist copayment: 0%
- Hospital (facility) coinsurance: 0%
- Other coinsurance: 0%

This EXAMPLE event includes services like:
- Primary care physician office visits (including disease education)
- Diagnostic tests (blood work)
- Prescription drugs
- Durable medical equipment (glucose meter)

**Total Example Cost** $7,400

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$6,900</td>
</tr>
<tr>
<td>Copayments</td>
<td>$90</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered** $0

The total Joe would pay is $6,990

### Mia’s Simple Fracture
(in-network emergency room visit and follow up care)

- The plan’s overall deductible: $7,900
- Specialist copayment: 0%
- Hospital (facility) coinsurance: 0%
- Other coinsurance: 0%

This EXAMPLE event includes services like:
- Emergency room care (including medical supplies)
- Diagnostic test (x-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)

**Total Example Cost** $1,900

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,900</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered** $0

The total Mia would pay is $1,900

The plan would be responsible for the other costs of these EXAMPLE covered services.
Discrimination is Against the Law

Medica complies with applicable Federal civil rights laws and will not discriminate against any person on the basis of race, color, national origin, age, disability or sex. Medica:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  TTY communication and written information in other formats (large print, audio, other formats).
- Provides free language services to people whose primary language is not English, such as:
  Qualified interpreters and information written in other languages.

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You can file a grievance in person or by mail, fax, or email. You may also contact the Civil Rights Coordinator if you need assistance with filing a complaint.


If you want free help translating this information, call the number included in this document or on the back of your Medica ID card.

Si desea asistencia gratuita para traducir esta información, llame al número que figura en este documento o en la parte posterior de su tarjeta de identificación de Medica.

Yog koj xav tau kev pab dawb kom bxais daim ntawv no, hu rau tus xov boj nyob hauv daim ntawv no los yog nyob nraum qab ntawm koj daim npav Medica ID.

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