Medica Prime Solution® (Cost) Plan

For Wisconsin Residents Only

2024 Rider Enrollment Form

A PLEASE READ BEFORE COMPLETING YOUR APPLICATION

You may enroll in the Medica Prime Solution Wisconsin Rider (1) when you initially enroll in the Medica Prime Solution Total plan, or (2) up to 30 days after your initial enrollment effective date, or (3) during the Annual Election Period. **You must be a Medica Prime Solution Total plan member and live in our Wisconsin service area in order to add this Rider. You must pay a monthly premium of $39.00 for this Rider that is additional to the $215.00 Prime Solution Total plan premium.** You must continue to pay your Part B premium and the premium for any other optional riders you elect.

B WISCONSIN RIDER DESCRIPTION

Under this Rider, members have the following additional coverage.
Please Note: Some benefit restrictions do apply.

Medica Prime Solution Total Benefits
This Rider provides coverage for certain cost-sharing amounts not covered by the Medica Prime Solution Total plan.

Skilled Nursing Facility Care
This Rider provides additional coverage for 30 days of skilled nursing care that is not covered by Medicare (per Medicare benefit period). No prior hospital stay is required, but the services must be medically necessary, as certified by your attending Medica-contracted physician every seven days. The facility must be a licensed skilled care nursing facility and a Medica-contracted provider.

Additional Home Health Care Services
This Rider provides coverage for up to 365 home care visits per calendar year. The 365 visits include those paid by Medicare. You must obtain prior approval for these services. Coverage is limited to cases when hospitalization or skilled nursing facility confinement is necessary if home care were not provided, and the necessary care cannot be provided by immediate family members without undue hardship to the patient's family.

Return completed applications one of three ways:

Mail	Fax	Securely Upload
Medica PO Box 740110 Atlanta, GA 30374-0110	1 (855) 250-2166	Medica.com/EnrollmentUpload

Medica®

1	**PERSONAL INFORMATION**				
	Legal First Name	Middle Initial	Last Name		
	Gender ❍ Male ❍ Female	Primary Telephone (*With area code)* (_____) _____ - _____		Birthdate _ _ _ _ / _ _ _ _ / _ _ _ _ _ _ _ _ (M M / D D / Y Y Y Y)	
	Medica Member Number *(required)*		Medicare Number		
	Permanent Residence Address				
	Street	City	State	Zip Code	County
	Mailing Address *(If different than Permanent Resident Address)*				
	Street	City	State	Zip Code	County
	Email Address *Optional – By providing your email, you agree Medica may send you communications about your plan.*				

2	SIGN & DATE

Authorization:

I authorize Medica, its claims administrator, the Centers for Medicare and Medicaid Services (and its designee(s)), plans, brokers of record, providers and any other person or entity to share my health information with each other as is necessary for treatment, payment and health care operations. I also authorize this information to be released to Medicare who may release it for research and other purposes which follow all applicable federal law. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by applicable privacy rules. I further understand that I have the right to revoke this authorization, at any time, by contacting Medica in writing. Medica conditions enrollment on this authorization and my revocation or failure to provide authorization may affect my enrollment. However, if I revoke this authorization, it will not affect any actions already taken by Medica prior to Medica's receipt of the revocation. Unless revoked, this authorization remains in effect until termination of coverage. The information provided on this application is accurate and complete. I understand and agree that any omissions or incorrect statements knowingly made by me on this application may invalidate my coverage. I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that: 1) this person is authorized under state law to complete this enrollment and 2) documentation of this authority is available upon request by Medica or Medicare.

X _____ ___ / ___ / ___

Applicant or Authorized Representative Signature — Today's Date

If you are the authorized representative, you must provide the following information:

Name:	Phone Number:
Address:	Relationship to Enrollee:

Note: I understand that I am responsible for the $39.00 per month Wisconsin Rider premium in addition to my Medica Prime Solution Total plan premium.

AGENT USE ONLY

_____ _____

Agent Printed Name — ID Number

X _____ (____) ____ - _____ __ __ / __ __ / __ __ __ __

Agent Signature — Agent Telephone — (M M / D D / Y Y Y Y) Agent's Receipt Date

PO Box 9310, Minneapolis, MN 55440-9310

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