MEMBER TIPS

SUMMARY OF BENEFITS & COVERAGE (SBC) DOCUMENT

ENROLLED IN INDIVIDUAL & FAMILY PLANS

IMPORTANT INFORMATION FOUND IN YOUR SBC

The SBC is a summary of your health plan's benefits and coverage in a question-and-answer format. Think of the SBC like a nutrition label for health plan benefits. All plans present answers to the same questions in the same format. This way you can easily compare plans to find one that works best for you.

Deductible and out-of-pocket limit. See page 1 of your plan's SBC to view your deductible(s) and out-of-pocket limit(s).

What you will pay. These columns show how the service is covered when you use a network or out-of-network provider.

Common medical event and services you may need. Look here for a list of common health care services.

Limits, exceptions and other important information. This column shows any limits or exceptions that apply to a service.

Deductible does not apply. Your plan may cover some items and services even if you haven't met your deductible.

Coinsurance. After you have met your deductible, coinsurance applies (unless otherwise noted).

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

MEDICA. **WI Individual Choice Catastrophic**

Coverage Period:
Coverage for: Individual or Family | **Plan Type:** PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.medica.com/members or call 888-592-8211. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 888-592-8211 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$7,350** Individual / **$14,700** Family for in-network services, **$20,000** Individual / **$40,000** Family out-of-network.	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.
Are there services covered before you meet your deductible?	Yes. Preventive care, preventive prescriptions, and copay services from in-network providers are covered before you meet your deductible.	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 https://www.healthcare.gov/coverage/preventive-care-benefits.
Are there other deductibles for specific services?	**No.**	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$7,350** Individual/ **$14,700** Family for in-network services. No out-of-pocket limit for out-of-network services.	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.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover, out-of-network deductible and coinsurance.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	**Yes.** Visit www.medica.com/choiceproviders or call 888-592-8211 (TTY:711) for a list of network providers.	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.
Do you need a referral to see a specialist?	**No.**	You can see the specialist you choose without a referral.

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* For more information about limitations and exceptions, see the plan or policy document at www.medica.com/members.

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Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

MEDICA. **WI Individual Choice Catastrophic**

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All coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay: In-Network Provider (You will pay the least)	What You Will Pay: Out-of-network Provider (You will pay the most)	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	Primary care: $30 copay for first 3 clinic visits/ year. Deductible does not apply. After first 3 visits, 0% coinsurance. Retail health clinics: $20 copay for first 3 clinic visits/ year. Deductible does not apply. After first 3 visits, 0% coinsurance.	50% coinsurance	First 3 visit limit applies to primary care visits, including retail health clinics. Chiropractic care covered at 0% coinsurance after deductible.
	Specialist visit	0% coinsurance	50% coinsurance	---none---
	Preventive care/ screening/ immunization	No charge. Deductible does not apply.	50% coinsurance	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.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	50% coinsurance	---none---
	Imaging (CT/PET scans, MRIs)	0% coinsurance	50% coinsurance	---none---
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.medica.com/ifbpharmacy.	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	

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Note: Your cost-sharing may be different than the examples shown in this tip sheet.

KEY TERMS TO KNOW

» **Deductible**: The amount you pay each year before your insurance starts to pay.

» **Out-of-pocket limit**: The most you will pay in a year for health care services covered by your insurance. Deductibles, copays and coinsurance are counted toward the out-of-pocket limit, but premiums are not.

» **Coinsurance**: A percentage of the charges for health care services that you pay.

» **Copay**: A set amount you pay up front for some services or prescriptions.

» **Network**: A group of doctors, clinics, hospitals, pharmacies or other health care providers that contract with your health insurer to provide services to its members, generally at discounted rates.

Definitions of other key terms can be found at **healthcare.gov/glossary**.

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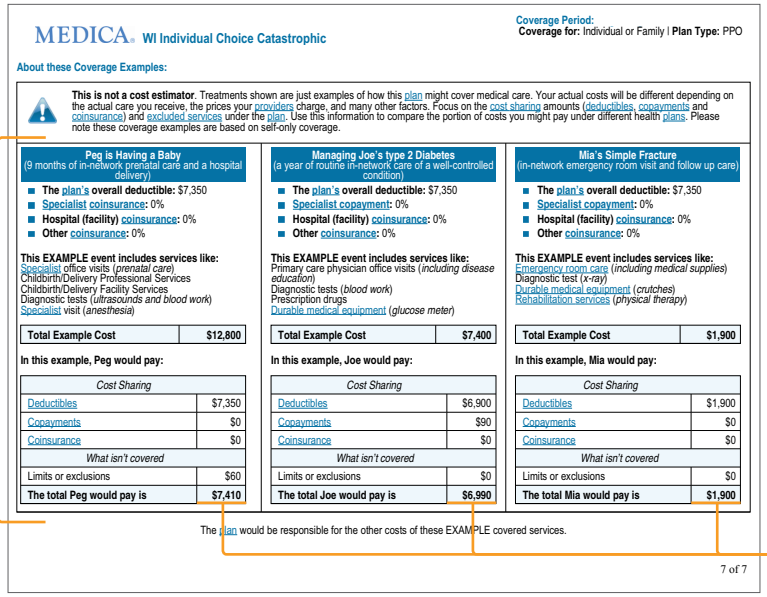
Coverage examples. Use these examples to understand how you and your plan might share costs for certain services. Remember that the amounts shown are not your actual costs.



MEDICA. WI Individual Choice Catastrophic

Coverage Period:
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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)	Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	Mia's Simple Fracture (in-network emergency room visit and follow up care)
■ The plan's overall deductible: $7,350 ■ Specialist coinsurance: 0% ■ Hospital (facility) coinsurance: 0% ■ Other coinsurance: 0%	■ The plan's overall deductible: $7,350 ■ Specialist copayment: 0% ■ Hospital (facility) coinsurance: 0% ■ Other coinsurance: 0%	■ The plan's overall deductible: $7,350 ■ Specialist copayment: 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*)	**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*)	**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 $12,800	**Total Example Cost** $7,400	**Total Example Cost** $1,900
In this example, Peg would pay:	**In this example, Joe would pay:**	**In this example, Mia would pay:**
Cost Sharing	*Cost Sharing*	*Cost Sharing*
Deductibles $7,350	Deductibles $6,900	Deductibles $1,900
Copayments $0	Copayments $90	Copayments $0
Coinsurance $0	Coinsurance $0	Coinsurance $0
What isn't covered	*What isn't covered*	*What isn't covered*
Limits or exclusions $60	Limits or exclusions $0	Limits or exclusions $0
The total Peg would pay is $7,410	**The total Joe would pay is** $6,990	**The total Mia would pay is** $1,900

The plan would be responsible for the other costs of these EXAMPLE covered services.

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Total you pay. The amounts listed here are an example. Your costs will vary based on your plan and where you receive care.

HOW TO VIEW YOUR SBC

You can view your SBC and Uniform Glossary on your secure member site on **medica.com/IndividualLogin**. Or, you may request a paper copy by calling the number on the back of your Medica ID card. We'll mail your documents to you within 7 business days.

For an overview of how cost-sharing works, read our "Deductibles, Copays and Coinsurance" tip sheet found on **medica.com/ifbmembertips**.

Have a question?

Call Customer Service at the number on the back of your Medica ID card.

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