

2018 KANSAS INDIVIDUAL & FAMILY HEALTH PLAN OPTIONS

Side-by-Side Plan Comparison: Medica ConnectSM

Plans are available as a one-person or family plan through the Health Insurance Marketplace (HealthCare.gov).

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MEDICA[®]

Individual & Family Health Plans

For Individuals & Families
 Who Meet Certain Income
 Requirements

NETWORK BENEFITS	GOLD COPAY PLUS		GOLD COPAY		SILVER COPAY		SILVER COPAY 94% CSR
	Tier 1 - Preferred	Tier 2 - Standard	Tier 1 - Preferred	Tier 2 - Standard	Tier 1 - Preferred	Tier 2 - Standard	
Individual deductible	\$1,000	\$1,500	\$750	\$1,500	\$3,500	\$4,500	\$100
Individual out-of-pocket maximum	\$5,000	\$7,000	\$6,000	\$7,000	\$7,000	\$7,350	\$1,000
Family deductible	\$3,000	\$4,500	\$2,250	\$4,500	\$10,500	\$13,500	\$300
Family out-of-pocket maximum	\$10,000	\$14,000	\$12,000	\$14,000	\$14,000	\$14,700	\$2,000
Coinsurance	30% after deductible	30% after deductible	30% after deductible	30% after deductible	40% after deductible	40% after deductible	5% after deductible
OFFICE VISITS							
Preventive care	No cost – 100% coverage	No cost – 100% coverage	No cost – 100% coverage	No cost – 100% coverage	No cost – 100% coverage	No cost – 100% coverage	No cost - 100% coverage
Primary care	\$30 copay	\$60 copay	\$30 copay	\$60 copay	\$30 copay	\$60 copay	\$30 copay
Convenience care	\$10 copay	\$20 copay	\$10 copay	\$20 copay	\$10 copay	\$20 copay	\$10 (preferred) or \$20 (standard) copay
virtuwell[®] e-visits	\$20 copay	\$20 copay	\$20 copay	\$20 copay	\$20 copay	\$20 copay	\$20 copay
Specialty care	\$30 copay	\$120 copay	\$60 copay	\$120 copay	\$60 copay	\$120 copay	\$60 copay
Urgent care	\$30 copay	\$60 copay	\$30 copay	\$60 copay	\$30 copay	\$60 copay	\$30 copay
PRESCRIPTION DRUGS (MEDICA DRUG LIST)							
Preferred generic	\$5 copay	\$5 copay	\$5 copay	\$5 copay	\$5 copay	\$5 copay	\$5 copay
Generic	\$5 copay	\$5 copay	\$10 copay	\$10 copay	\$10 copay	\$10 copay	\$10 copay
Preferred brand	\$35 copay	\$35 copay	30% coinsurance after deductible	30% coinsurance after deductible	40% coinsurance after deductible	40% coinsurance after deductible	5% coinsurance after deductible
Non-preferred brand	\$150 copay	\$150 copay	50% coinsurance after deductible	50% coinsurance after deductible	60% coinsurance after deductible	60% coinsurance after deductible	25% coinsurance after deductible
FACILITY VISITS							
Lab and X-ray services	\$30 copay per visit. Copay waived if services performed during an office visit.	30% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible	40% coinsurance after deductible	40% coinsurance after deductible	5% coinsurance after deductible
Emergency room	\$150 copay per visit	30% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible	40% coinsurance after deductible	40% coinsurance after deductible	5% coinsurance after deductible
Hospital services (Inpatient facility charge)	\$250 copay per day for the first five days; then 100% coverage (deductible does not apply). Professional fees apply toward deductible.	30% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible	40% coinsurance after deductible	40% coinsurance after deductible	5% coinsurance after deductible
Hospital services (Outpatient facility charge)	\$150 copay. Professional fees apply toward deductible.	30% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible	40% coinsurance after deductible	40% coinsurance after deductible	5% coinsurance after deductible
Enhanced imaging tests (e.g. MRI, PET scan)	\$250 copay per test	30% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible	40% coinsurance after deductible	40% coinsurance after deductible	5% coinsurance after deductible
Ambulance, surgery, home healthcare, maternity and other eligible healthcare services	30% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible	40% coinsurance after deductible	40% coinsurance after deductible	5% coinsurance after deductible

Things to Keep in Mind

- You can choose individual or family coverage. Plans are available for individuals to age 65. Dependent coverage to age 26. You decide how to cover your family—whether that's individual coverage for each family member or a shared family plan. The choice is yours!
- All family plans have an embedded individual out-of-pocket maximum. This means each covered family member only needs to satisfy their individual out-of-pocket maximum, not the entire family amount, before receiving 100 percent coverage.
- This brochure is a brief overview of the plans. For complete benefit details, limitations, and exclusions please see a Medica insurance policy. This can be found by visiting medica.com or requesting a paper copy by calling **1-844-577-5267**.

NETWORK BENEFITS	For Individuals & Families Who Meet Certain Income Requirements				For Individuals & Families Under Age 30 or Those With an Eligible Exemption		
	SILVER COPAY 87% CSR	SILVER COPAY 73% CSR	BRONZE COPAY		BRONZE HSA PLUS	BRONZE HSA	CATASTROPHIC
			Tier 1 - Preferred	Tier 2 - Standard			
Individual deductible	\$500	\$2,500	\$6,850	\$6,850	\$2,600	\$6,000	\$7,350
Individual out-of-pocket maximum	\$2,000	\$5,850	\$7,350	\$7,350	\$6,650	\$6,650	\$7,350
Family deductible	\$1,500	\$7,500	\$13,700	\$13,700	\$5,200	\$12,000	\$14,700
Family out-of-pocket maximum	\$4,000	\$11,700	\$14,700	\$14,700	\$13,300	\$13,300	\$14,700
Coinsurance	20% after deductible	30% after deductible	50% after deductible	50% after deductible	40% after deductible	20% after deductible	0% after deductible
OFFICE VISITS							
Preventive care	No cost – 100% coverage	No cost – 100% coverage	No cost - 100% coverage	No cost - 100% coverage	No cost – 100% coverage	No cost – 100% coverage	No cost – 100% coverage
Primary care	\$30 copay	\$30 copay	\$80 copay	\$120 copay	40% coinsurance after deductible	20% coinsurance after deductible	\$30 copay for first 3 visits*
Convenience care	\$10 (preferred) or \$20 (standard) copay	\$10 (preferred) or \$20 (standard) copay	\$10 copay	\$20 copay	40% coinsurance after deductible	20% coinsurance after deductible	\$10 (preferred) or \$20 (standard) copay for first 3 visits*
virtuwell® e-visits	\$20 copay	\$20 copay	\$20 copay	\$20 copay	40% coinsurance after deductible	20% coinsurance after deductible	\$20 copay for first 3 visits*
Specialty care	\$60 copay	\$60 copay	\$150 copay	\$225 copay	40% coinsurance after deductible	20% coinsurance after deductible	0% coinsurance after deductible
Urgent care	\$30 copay	\$30 copay	\$80 copay	\$120 copay	40% coinsurance after deductible	20% coinsurance after deductible	0% coinsurance after deductible
PRESCRIPTION DRUGS (MEDICA DRUG LIST)							
Preferred generic	\$5 copay	\$5 copay	\$10 copay	\$10 copay	40% coinsurance after deductible	20% coinsurance after deductible	0% coinsurance after deductible
Generic	\$10 copay	\$10 copay	\$20 copay	\$20 copay	40% coinsurance after deductible	20% coinsurance after deductible	0% coinsurance after deductible
Preferred brand	20% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible	40% coinsurance after deductible	20% coinsurance after deductible	0% coinsurance after deductible
Non-preferred brand	40% coinsurance after deductible	50% coinsurance after deductible	70% coinsurance after deductible	70% coinsurance after deductible	40% coinsurance after deductible	20% coinsurance after deductible	0% coinsurance after deductible
FACILITY VISITS							
Lab and X-ray services	20% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible	40% coinsurance after deductible	20% coinsurance after deductible	0% coinsurance after deductible
Emergency room	20% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible	40% coinsurance after deductible	20% coinsurance after deductible	0% coinsurance after deductible
Hospital services (Inpatient facility charge)	20% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible	40% coinsurance after deductible	20% coinsurance after deductible	0% coinsurance after deductible
Hospital services (Outpatient facility charge)	20% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible	40% coinsurance after deductible	20% coinsurance after deductible	0% coinsurance after deductible
Enhanced imaging tests (e.g. MRI, PET scan)	20% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible	40% coinsurance after deductible	20% coinsurance after deductible	0% coinsurance after deductible
Ambulance, surgery, home healthcare, maternity and other eligible healthcare services	20% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible	40% coinsurance after deductible	20% coinsurance after deductible	0% coinsurance after deductible

* Primary, convenience care, and virtuwell e-visits copay subject to combined 3-visit maximum per person per calendar year. After 3rd visit, you pay 0% coinsurance after deductible.

Medica is a Qualified Health Plan issuer in the Health Insurance Marketplace. You may be able to receive help paying your health insurance premium or qualify for plans with reduced deductibles, copays and coinsurance. These plans are called Cost-Share Reduction plans. If you're a member of a federally recognized tribe, you may qualify for additional cost-sharing benefits. To see if you're eligible, please visit healthcare.gov © 2017 Medica. Medica® is a registered service mark of Medica Health Plans. "Medica" refers to the family of health plan businesses that includes Medica Health Plans, Medica Health Plans of Wisconsin, Medica Insurance Company, Medica Self-Insured, and Medica Health Management, LLC.

2018 KANSAS INDIVIDUAL & FAMILY HEALTH PLAN OPTIONS

Side-by-Side Plan Comparison: Select by MedicaSM Featuring Care at Saint Luke's Health System

Plans are available as a one-person or family plan through the Health Insurance Marketplace (HealthCare.gov).



NETWORK BENEFITS	GOLD COPAY PLUS	GOLD COPAY	SILVER COPAY	For Individuals & Families Who Meet Certain Income Requirements		
				SILVER COPAY 94% CSR	SILVER COPAY 87% CSR	SILVER COPAY 73% CSR
Individual deductible	\$1,000	\$750	\$3,500	\$100	\$500	\$2,500
Individual out-of-pocket maximum	\$5,000	\$6,000	\$7,000	\$1,000	\$2,000	\$5,850
Family deductible	\$3,000	\$2,250	\$10,500	\$300	\$1,500	\$7,500
Family out-of-pocket maximum	\$10,000	\$12,000	\$14,000	\$2,000	\$4,000	\$11,700
Coinsurance	30% after deductible	30% after deductible	40% after deductible	5% after deductible	20% after deductible	30% after deductible
OFFICE VISITS						
Preventive care	No cost – 100% coverage	No cost – 100% coverage	No cost – 100% coverage	No cost – 100% coverage	No cost – 100% coverage	No cost – 100% coverage
Primary care	\$30 copay	\$30 copay	\$30 copay	\$30 copay	\$30 copay	\$30 copay
Convenience care - preferred providers	\$10 copay	\$10 copay	\$10 copay	\$10 copay	\$10 copay	\$10 copay
Convenience care - standard providers	\$20 copay	\$20 copay	\$20 copay	\$20 copay	\$20 copay	\$20 copay
virtuwell [®] e-visits	\$20 copay	\$20 copay	\$20 copay	\$20 copay	\$20 copay	\$20 copay
Specialty care	\$30 copay	\$60 copay	\$60 copay	\$60 copay	\$60 copay	\$60 copay
Urgent care	\$30 copay	\$30 copay	\$30 copay	\$30 copay	\$30 copay	\$30 copay
PRESCRIPTION DRUGS (MEDICA DRUG LIST)						
Preferred generic	\$5 copay	\$5 copay	\$5 copay	\$5 copay	\$5 copay	\$5 copay
Generic	\$5 copay	\$10 copay	\$10 copay	\$10 copay	\$10 copay	\$10 copay
Preferred brand	\$35 copay	30% coinsurance after deductible	40% coinsurance after deductible	5% coinsurance after deductible	20% coinsurance after deductible	30% coinsurance after deductible
Non-preferred brand	\$150 copay	50% coinsurance after deductible	60% coinsurance after deductible	25% coinsurance after deductible	40% coinsurance after deductible	50% coinsurance after deductible
FACILITY VISITS						
Lab and X-ray services	\$30 copay per visit. Copay waived if services performed during an office visit.	30% coinsurance after deductible	40% coinsurance after deductible	5% coinsurance after deductible	20% coinsurance after deductible	30% coinsurance after deductible
Emergency room	\$150 copay per visit	30% coinsurance after deductible	40% coinsurance after deductible	5% coinsurance after deductible	20% coinsurance after deductible	30% coinsurance after deductible
Hospital services (Inpatient facility charge)	\$250 copay per day for the first five days; then 100% coverage (deductible does not apply). Professional fees apply toward deductible.	30% coinsurance after deductible	40% coinsurance after deductible	5% coinsurance after deductible	20% coinsurance after deductible	30% coinsurance after deductible
Hospital services (Outpatient facility charge)	\$150 copay. Professional fees apply toward deductible.	30% coinsurance after deductible	40% coinsurance after deductible	5% coinsurance after deductible	20% coinsurance after deductible	30% coinsurance after deductible
Enhanced imaging tests (e.g. MRI, PET scan)	\$250 copay per test	30% coinsurance after deductible	40% coinsurance after deductible	5% coinsurance after deductible	20% coinsurance after deductible	30% coinsurance after deductible
Ambulance, surgery, home healthcare, maternity and other eligible healthcare services	30% coinsurance after deductible	30% coinsurance after deductible	40% coinsurance after deductible	5% coinsurance after deductible	20% coinsurance after deductible	30% coinsurance after deductible

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For Individuals & Families
 Under Age 30 or Those With
 an Eligible Exemption



NETWORK BENEFITS	BRONZE COPAY	BRONZE HSA PLUS	BRONZE HSA	CATASTROPHIC
Individual deductible	\$6,850	\$2,600	\$6,000	\$7,350
Individual out-of-pocket maximum	\$7,350	\$6,650	\$6,650	\$7,350
Family deductible	\$13,700	\$5,200	\$12,000	\$14,700
Family out-of-pocket maximum	\$14,700	\$13,300	\$13,300	\$14,700
Coinsurance	50% after deductible	40% after deductible	20% after deductible	0% after deductible
OFFICE VISITS				
Preventive care	No cost - 100% coverage	No cost – 100% coverage	No cost – 100% coverage	No cost – 100% coverage
Primary care	\$80 copay	40% coinsurance after deductible	20% coinsurance after deductible	\$30 copay for first 3 visits*
Convenience care - preferred providers	\$10 copay	40% coinsurance after deductible	20% coinsurance after deductible	\$10 copay for first 3 visits*
Convenience care - standard providers	\$20 copay	40% coinsurance after deductible	20% coinsurance after deductible	\$20 copay for first 3 visits*
virtuwell® e-visits	\$20 copay	40% coinsurance after deductible	20% coinsurance after deductible	\$20 copay for first 3 visits*
Specialty care	\$150 copay	40% coinsurance after deductible	20% coinsurance after deductible	0% coinsurance after deductible
Urgent care	\$80 copay	40% coinsurance after deductible	20% coinsurance after deductible	0% coinsurance after deductible
PRESCRIPTION DRUGS (MEDICA DRUG LIST)				
Preferred generic	\$10 copay	40% coinsurance after deductible	20% coinsurance after deductible	0% coinsurance after deductible
Generic	\$20 copay	40% coinsurance after deductible	20% coinsurance after deductible	0% coinsurance after deductible
Preferred brand	50% coinsurance after deductible	40% coinsurance after deductible	20% coinsurance after deductible	0% coinsurance after deductible
Non-preferred brand	70% coinsurance after deductible	40% coinsurance after deductible	20% coinsurance after deductible	0% coinsurance after deductible
FACILITY VISITS				
Lab and X-ray services	50% coinsurance after deductible	40% coinsurance after deductible	20% coinsurance after deductible	0% coinsurance after deductible
Emergency room	50% coinsurance after deductible	40% coinsurance after deductible	20% coinsurance after deductible	0% coinsurance after deductible
Hospital services (Inpatient facility charge)	50% coinsurance after deductible	40% coinsurance after deductible	20% coinsurance after deductible	0% coinsurance after deductible
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Enhanced imaging tests (e.g. MRI, PET scan)	50% coinsurance after deductible	40% coinsurance after deductible	20% coinsurance after deductible	0% coinsurance after deductible
Ambulance, surgery, home healthcare, maternity and other eligible healthcare services	50% coinsurance after deductible	40% coinsurance after deductible	20% coinsurance after deductible	0% coinsurance after deductible

* Primary, convenience care, and virtuwell e-visits copay subject to combined 3-visit maximum per person per calendar year. After 3rd visit, you pay 0% coinsurance after deductible.

Things to Keep in Mind

- You can choose individual or family coverage. Plans are available for individuals to age 65. Dependent coverage to age 26. You decide how to cover your family—whether that's individual coverage for each family member or a shared family plan. The choice is yours!
- All family plans have an embedded individual out-of-pocket maximum. This means each covered family member only needs to satisfy their individual out-of-pocket maximum, not the entire family amount, before receiving 100 percent coverage.
- This brochure is a brief overview of the plans. For complete benefit details, limitations, and exclusions please see a Medica insurance policy. This can be found by visiting medica.com or requesting a paper copy by calling **1-844-577-5267**.

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Medica is a Qualified Health Plan issuer in the Health Insurance Marketplace.

You may be able to receive help paying your health insurance premium or qualify for plans with reduced deductibles, copays and coinsurance. These plans are called Cost-Share Reduction plans. If you're a member of a federally recognized tribe, you may qualify for additional cost-sharing benefits. To see if you're eligible, please visit healthcare.gov.

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