



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, go to [www.Medica.com/2020InspirePolicies](http://www.Medica.com/2020InspirePolicies) or call 866-269-6805. 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 866-269-6805 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<b>\$7,200</b> Individual / <b>\$14,400</b> Family for <a href="#">network</a> services. There is no coverage for non-network services.	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> , preventive prescriptions and <a href="#">copay</a> services from <a href="#">network providers</a> are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits">https://www.healthcare.gov/coverage/preventive-care-benefits</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<b>\$8,150</b> Individual/ <b>\$16,300</b> Family for <a href="#">network</a> services. There is no coverage for non-network services.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance billing</a> charges and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. Visit <a href="http://www.Medica.com/InspireNetwork">www.Medica.com/InspireNetwork</a> or call 866-269-6805 (TTY:711) for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



All [copayment](#) and [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		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	Primary care: \$80 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply. Retail health clinics: \$20 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply. Chiropractic care: \$80 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	Not covered	50% <a href="#">coinsurance</a> for other outpatient services. Primary care visits provided at an outpatient facility may be subject to <a href="#">coinsurance</a> and <a href="#">deductible</a> .
	<a href="#">Specialist</a> visit	\$150 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	Not covered	---none---
	<a href="#">Preventive care/ screening/ immunization</a>	No charge. <a href="#">Deductible</a> does not apply.	Not covered	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	50% <a href="#">coinsurance</a>	Not covered	---none---
	Imaging (CT/PET scans, MRIs)	50% <a href="#">coinsurance</a>	Not covered	*May require prior authorization.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b>  More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.Medica.com/RxListB">www.Medica.com/RxListB</a> .	Generic drugs	\$30 <a href="#">copay</a> / prescription. <a href="#">Deductible</a> does not apply.	Not covered	Up to a 31-day supply per prescription. *May require prior authorization. For preferred/non-preferred retail and <a href="#">specialty drugs</a> , \$150 <a href="#">copay</a> for orally-administered cancer treatment medications. <a href="#">Deductible</a> does not apply. 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	\$160 <a href="#">copay</a> / prescription. <a href="#">Deductible</a> does not apply.	Not covered	
	Non-Preferred brand drugs	70% <a href="#">coinsurance</a>	Not covered	
	<a href="#">Specialty drugs</a>	Preferred: \$600 <a href="#">copay</a> / prescription. <a href="#">Deductible</a> does not apply Non-Preferred: \$700 <a href="#">copay</a> / prescription. <a href="#">Deductible</a> does not apply	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	50% <a href="#">coinsurance</a>	Not covered	*May require prior authorization.
	Physician/surgeon fees	50% <a href="#">coinsurance</a>	Not covered	*May require prior authorization.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Network deductible</a> applies.
	<a href="#">Emergency medical transportation</a>	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Network deductible</a> applies.
	<a href="#">Urgent care</a>	\$80 <a href="#">copay</a> / visit. <a href="#">Deductible</a> does not apply.	\$80 <a href="#">copay</a> / visit. <a href="#">Deductible</a> does not apply.	---none---
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	50% <a href="#">coinsurance</a>	Not covered	*May require prior authorization.
	Physician/surgeon fees	50% <a href="#">coinsurance</a>	Not covered	*May require prior authorization.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$80 <a href="#">copay</a> / visit. <a href="#">Deductible</a> does not apply.	Not covered	50% <a href="#">coinsurance</a> for other outpatient services. Other outpatient services include intensive outpatient programs, diagnostic evaluations and psychological testing. *May require prior authorization.
	Inpatient services	50% <a href="#">coinsurance</a>	Not covered	*May require prior authorization.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you are pregnant	Office visits	Prenatal: 50% <a href="#">coinsurance</a> Postnatal: 50% <a href="#">coinsurance</a>	Not covered	<a href="#">Cost sharing</a> does not apply to <a href="#">network preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	50% <a href="#">coinsurance</a>	Not covered	
	Childbirth/delivery facility services	50% <a href="#">coinsurance</a>	Not covered	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	50% <a href="#">coinsurance</a>	Not covered	*May require prior authorization.
	<a href="#">Rehabilitation services</a>	50% <a href="#">coinsurance</a>	Not covered	---none---
	<a href="#">Habilitation services</a>	50% <a href="#">coinsurance</a>	Not covered	---none---
	<a href="#">Skilled nursing care</a>	50% <a href="#">coinsurance</a>	Not covered	*May require prior authorization.
	<a href="#">Durable medical equipment</a>	50% <a href="#">coinsurance</a>	Not covered	*May require prior authorization.
	<a href="#">Hospice services</a>	50% <a href="#">coinsurance</a>	Not covered	Respite care is limited to 5 consecutive days, up to a lifetime maximum of 15 inpatient days and 15 outpatient days.
If your child needs dental or eye care	Children's eye exam	\$80 <a href="#">copay</a> / visit. <a href="#">Deductible</a> does not apply.	Not covered	Limited to one refractive eye exam/ year to end of month member turns 19.
	Children's glasses	50% <a href="#">coinsurance</a>	Not covered	Limited to one pair of glasses or contacts/ year to end of month member turns 19.
	Children's dental check-up	Not covered	Not covered	No coverage for dental check-ups.

## Excluded Services & Other Covered Services:

### Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- |  |  |  |
|--|--|--|
| ● *Abortion, elective, induced, except as medically necessary to protect the life of the mother or in the case of rape or incest | ● Dental Care (Adult)                                | ● Private Duty Nursing                         |
| ● Acupuncture  | ● Dental check-up                                    | ● Routine eye care (Adult)                     |
| ● Cosmetic Surgery   | ● Hearing aids                                       | ● Routine foot care except for some conditions |
|  | ● Long Term Care                                     | ● Weight Loss programs                         |
|  | ● Non-emergency care when traveling outside the U.S. |  |

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- |  |                     |  |
|--|---------------------|--|
| ● Bariatric Surgery with prior authorization | ● Chiropractic Care | ● Infertility Treatment (excludes some services) |
|--|---------------------|--|

### 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: Medica at 866-269-6805 or the Iowa Insurance Division at 1-515-281-5705 or 1-877-955-1212. 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](http://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: Medica at 866-269-6805 or the Iowa Insurance Division at 1-515-281-5705 or 1-877-955-1212.

### 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:

Spanish (Español): Para obtener asistencia en Español, llame al 800-952-3455.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-952-3455.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 800-952-3455.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijijigo holne' 800-952-3455.

----- 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](#): \$7,200
- [Specialist copayment](#): \$150
- Hospital (facility) [coinsurance](#): 50%
- Other [coinsurance](#): 50%

**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
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$7,200
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$950
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$8,210</b>

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

- The [plan's](#) overall [deductible](#): \$7,200
- [Specialist copayment](#): \$150
- Hospital (facility) [coinsurance](#): 50%
- Other [coinsurance](#): 50%

**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
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$2,300
<a href="#">Copayments</a>	\$1,400
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$3,700</b>

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

- The [plan's](#) overall [deductible](#): \$7,200
- [Specialist copayment](#): \$150
- Hospital (facility) [coinsurance](#): 50%
- Other [coinsurance](#): 50%

**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
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$1,700
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,900</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Wenn Sie bei der Übersetzung dieser Informationen kostenlose Hilfe in Anspruch nehmen möchten, rufen Sie bitte die in diesem Dokument oder auf der Rückseite Ihrer Medica-ID-Karte angegebene Nummer an.