MEDICA® MO Select by Medica Gold Copay

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The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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 <u>www.Medica.com/2020SelectPolicies</u> or call 866-269-6806. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 866-269-6806 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$850 Individual / \$2,550 Family for network services.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> , preventive prescriptions and <u>copay</u> services from <u>network providers</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$7,400 Individual/ \$14,800 Family for network services.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges and health care this plan doesn't cover.	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/SelectProviders or call 866-269-6806 (TTY:711) for a list of	

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services $\overline{MEDICA}_{@}$ MO Select by Medica Gold Copay



All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.

		What You Will Pay		
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Non-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/visit. Deductible does not apply. Retail health clinics: \$20 copay/visit. Deductible does not apply. Chiropractic care: \$30 copay/visit. Deductible does not apply.	Not covered	30% <u>coinsurance</u> for other outpatient services. Primary care visits provided at an outpatient facility may be subject to <u>coinsurance</u> and <u>deductible</u> .
provider s office of chilic	Specialist visit	\$60 copay/ visit. Deductible does not apply.	Not covered	none
	Preventive care/ screening/ immunization	No charge. Deductible does not apply.	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	Not covered	none
If you have a test	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not covered	*May require prior authorization.

^{*} For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.Medica.com/2020SelectPolicies</u>.

What You Will Pay			u Will Pay	
Common Medical Event	Services You May Need	Network Provider	Non-Network Provider	Limitations, Exceptions & Other Important Information
		(You will pay the least)	(You will pay the most)	important information
	Generic drugs	\$15 <u>copay/</u> prescription. <u>Deductible</u> does not apply.	Not covered	Up to a 31-day supply per prescription. *May require prior authorization. For
If you need drugs to treat your illness or condition	Preferred brand drugs	\$70 copay/ prescription. Deductible does not apply.	Not covered	preferred/non-preferred retail and specialty drugs, \$60 copay for orally-administered cancer treatment medications. Deductible does not
More information about prescription drug coverage	Non-Preferred brand drugs	50% coinsurance	Not covered	apply. Proton pump inhibitors (except for members 12 years of age
is available at www.Medica.com/RxListG.	Specialty drugs	Preferred: \$500 copay/ prescription. Deductible does not apply Non-Preferred: \$600 copay/ prescription. Deductible does not apply	Not covered	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.
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Not covered	*May require prior authorization.
surgery	Physician/surgeon fees	30% coinsurance	Not covered	*May require prior authorization.
	Emergency room care	30% coinsurance	30% coinsurance	Network deductible applies.
If you need immediate medical attention	Emergency medical transportation	30% coinsurance	30% coinsurance	Network deductible applies.
medical attention	Urgent care	\$30 copay/ visit. Deductible does not apply.	\$30 <u>copay/</u> visit. <u>Deductible</u> does not apply.	none
If you have a beenital atoy	Facility fee (e.g., hospital room)	30% coinsurance	Not covered	*May require prior authorization.
If you have a hospital stay	Physician/surgeon fees	30% coinsurance	Not covered	*May require prior authorization.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 copay/ visit. Deductible does not apply. 30% coinsurance for other outpatient services.	Not covered	*May require prior authorization. Other outpatient services include- Intensive outpatient programs, diagnostic evaluations & psychological testing.
	Inpatient services	30% coinsurance	Not covered	*May require prior authorization.

^{*} For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.Medica.com/2020SelectPolicies</u>.

		What You Will Pay		
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
	Office visits	Prenatal: 30% coinsurance Postnatal: 30% coinsurance	Not covered	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may
If you are pregnant	Childbirth/delivery professional services	30% coinsurance	Not covered	apply. Maternity care may include tests and services described
	Childbirth/delivery facility services	30% coinsurance	Not covered	elsewhere in the SBC (i.e. ultrasound).
	Home health care	30% coinsurance	Not covered	*May require prior authorization. Limited to 100 intermittent skilled nursing visits and 82 extended hours home care visits/year.
If you need help	Rehabilitation services	30% coinsurance	Not covered	Limited to 20 physical therapy and 20 occupational therapy visits/year.
If you need help recovering or have other special health needs	Habilitation services	30% coinsurance	Not covered	Limited to 20 physical therapy and 20 occupational therapy visits/year.
	Skilled nursing care	30% coinsurance	Not covered	*May require prior authorization. Limited to 150 days/year.
	Durable medical equipment	30% coinsurance	Not covered	*May require prior authorization.
	Hospice services	30% coinsurance	Not covered	none
	Children's eye exam	\$30 <u>copay</u> / visit. <u>Deductible</u> does not apply.	Not covered	Coverage limited to end of month member turns 19.
If your child needs dental or eye care	Children's glasses	30% coinsurance	Not covered	Limited to one pair of glasses/year and one pair of contacts/year to end of month member turns 19.
	Children's dental check-up	Not covered	Not covered	No coverage for dental check-ups.

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Coverage for: Individual or Family | Plan Type: EPO

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.)

- *Abortions, elective, induced, except as medically necessary to protect the life of the mother.
- Acupuncture
- Bariatric Surgery

- Cosmetic Surgery
- Dental Care (Adult)
- Dental check-up
- Infertility Treatment
- Long Term Care

- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care except for some conditions
- Weight Loss programs

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

Chiropractic Care

- Hearing aids limited to 1 hearing aid per ear every 48 months. Newborn hearing aids provided for initial amplification following a newborn hearing screening.
- Private Duty Nursing limited to 82 visits

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Coverage Period: Beginning on or after 01/01/2020 Coverage for: Individual or Family | Plan Type: EPO

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 866-269-6806 or the Missouri Department of Insurance, Consumer Affairs Division, 1-800-726-7390 or www.insurance.mo.gov/consumers/complaints/index.php. 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: Missouri Department of Insurance, Consumer Affairs Division, 1-800-726-7390 or www.insurance.mo.gov/consumers/complaints/index.php.

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 888-592-8211 Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 888-592-8211 Chinese (中文): 如果需要中文的帮助,请拨打这个号码 888-592-8211

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 888-592-8211

----- To see examples of how this plan might cover costs for a sample medical situation, see the next section. -------

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About these Coverage Examples:



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

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>: \$850

Specialist copayment: \$60

■ Hospital (facility) <u>coinsurance</u>: 30%

■ Other coinsurance: 30%

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		
<u>Deductibles</u>	\$850	
<u>Copayments</u>	\$20	
Coinsurance	\$3,100	
What isn't covered		
Limits or exclusions	\$60	
The total Peg would pay is	\$4,030	

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

■ The plan's overall deductible: \$850

Specialist copayment: \$60

■ Hospital (facility) coinsurance: 30%

Other coinsurance: 30%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)

Diagnostić tests (blood work)

Prescription drug's

Durable medical equipment (glucose meter)

Total Example Cost	\$7,400
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In this example, Joe would pay:

Cost Sharing		
<u>Deductibles</u>	\$850	
<u>Copayments</u>	\$800	
Coinsurance	\$400	
What isn't covered		
Limits or exclusions	\$0	
The total Joe would pay is	\$2,050	

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible: \$850

Specialist copayment: \$60

■ Hospital (facility) <u>coinsurance</u>: 30%

■ Other coinsurance: 30%

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	
<u>Deductibles</u>	\$850
<u>Copayments</u>	\$100
Coinsurance	\$300
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,250

The <u>plan</u> 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.

If you need these services, call the number included in this document or on the back of your Medica ID card. If you believe that Medica has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Civil Rights Coordinator, Mail Route CP250, PO Box 9310, Minneapolis, MN 55443-9310, 952-992-3422 (phone/fax), TTY 711, civilrightscoordinator@medica.com.

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.

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.

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 txhais daim ntawv no, hu rau tus xov tooj nyob hauv daim ntawv no los yog nyob nraum qab ntawm koj daim npav Medica ID.

如果您需要免費翻譯此資訊,請致電本文檔中或者在您的Medica ID卡背面包含的號碼。

Nếu quý vị muốn trợ giúp dịch thông tin này miễn phí, hãy gọi vào số có trong tài liều này hoặc ở mặt sau thẻ ID Medica của quý vị.

Odeeffannoo kana gargaarsa tolaan akka isinii hiikamu yoo barbaaddan, lakkoobsa barruu kana keessatti argamu ykn ka dugda kaardii Waraqaa Eenyummaa Medica irra jiruun bilbila'a.

اذا كنت تريد مساعدة مجانية في ترجمة هذه المعلومات, فاتصل على ألرقم الوارد في هذه الوثيقة أوعلى ظهر بطاقة تعريف ميديكا الخاصة بك.

Если Вы хотите получить бесплатную помощь в переводе этой информации, позвоните по номеру телефона, указанному в данном документе и на обратной стороне Вашей индентификационной карты Medica.

ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປຂໍ້ມູນນີ້ຟຣີ, ໃຫ້ໂທຫາເລກໝາຍ ທີ່ມີຢູ່ໃນເອກະສານນີ້ ຫຼື ຢູ່ດ້ານຫຼັງຂອງບັດ Medica ຂອງທ່ານ. 이 정보를 번역하는 데 무료로 도움을 받고 싶으시면, 이 문서에 포함된 전화번호나 Medica ID 카드 뒷면의 전화번호로 전화하십시오.

Si vous voulez une assistance gratuite pour traduire ces informations, appelez le numéro indiqué dans ce document ou au dos de votre carte d'identification Medica.

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Kung nais mo ng libreng tulong sa pagsasalin ng impormasyong ito, tawagan ang numero na kasama sa dokumentong ito o sa likod ng iyong Kard ng Medica ID.

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Ako želite besplatnu pomoć za prijevod ovih informacija, nazovite broj naveden u ovom dokumentu ili na poleđini svoje ID kartice Medica.

Díí t'áá jíík'e shá ata' hodoonih nínízingo éí ninaaltsoos Medica bee néího'dílzinígí bine'déé' námboo biká'ígíjjj' béésh bee hodíilnih.

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