# Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services MEDICA® IA Medica with CHI Health Silver Copay Zero

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/2020CHIPolicies or call 866-269-6803. 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 866-269-6803 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	<b>\$0</b> for <u>network</u> services. There is no coverage for non-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 <u>deductible</u> ?	Yes.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount.
Are there other deductibles 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> ?	<b>\$0</b> for <u>network</u> services. There is no coverage for non-network services.	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance billing charges and health care this plan doesn't cover.	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a <u>network</u> <u>provider</u> ?	<b>Yes.</b> Visit <u>www.Medica.com/Uninet</u> or call 866-269-6803 (TTY:711) for a list of <u>network providers</u> .	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 <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

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 Yo	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)	
	Primary care visit to treat an injury or illness	No charge	Not covered	none
If you visit a health care provider's office or clinic	<u>Specialist</u> visit	No charge	Not covered	none
	Preventive care/ screening/ immunization	No charge	Not covered	none
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	none
n you have a test	Imaging (CT/PET scans, MRIs)	No charge	Not covered	*May require prior authorization.
If you need drugs to treat	Generic drugs	No charge	Not covered	Up to a 31-day supply per prescription. *May require prior authorization. Proton pump inhibitors
your illness or condition	Preferred brand drugs	No charge	Not covered	authorization. Proton pump inhibitors ( (except for members 12 years of age ) and younger, and those members
More information about prescription drug coverage is available at www.Medica.com/ RxListS.	Non-Preferred brand drugs	No charge	Not covered	who have a feeding tube) and non-sedating antihistamines are not
	Specialty drugs	Preferred: No charge Non-preferred: No charge	Not covered	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)	No charge	Not covered	*May require prior authorization.
surgery	Physician/surgeon fees	No charge	Not covered	*May require prior authorization.
	Emergency room care	No charge	No charge	none
If you need immediate medical attention	Emergency medical transportation	No charge	No charge	none
	Urgent care	No charge	No charge	none
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	*May require prior authorization.
n you nave a nospital stay	Physician/surgeon fees	No charge	Not covered	*May require prior authorization.

\* For more information about limitations and exceptions, see the plan or policy document at www.Medica.com/2020CHIPolicies.

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

		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 need mental health, behavioral health, or	Outpatient services	No charge	Not covered	*May require prior authorization.
substance abuse services	Inpatient services	No charge	Not covered	*May require prior authorization.
If you are pregnant	Office visits	No charge	Not covered	
	Childbirth/delivery professional services	No charge	Not covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	No charge	Not covered	
	Home health care	No charge	Not covered	*May require prior authorization.
	Rehabilitation services	No charge	Not covered	none
	Habilitation services	No charge	Not covered	none
If you need help recovering or have other	Skilled nursing care	No charge	Not covered	*May require prior authorization.
recovering or have other special health needs	Durable medical equipment	No charge	Not covered	*May require prior authorization.
	Hospice services	No charge	Not covered	Respite care is limited to 5 consecutive days, up to a lifetime maximum of 15 inpatient days and 15 outpatient days.
	Children's eye exam	No charge	Not covered	Limited to one refractive eye exam/ year to end of month member turns 19.
If your child needs dental or eye care	Children's glasses	No charge	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 <u>Plan</u> Generally Does NOT Cover (Check	your policy or plan document for more information ar	nd a list of any other <u>excluded services</u> .)
<ul> <li>*Abortion, elective, induced, except as medically necessary to protect the life of the mother or in the case of rape or incest</li> <li>Acupuncture</li> <li>Cosmetic Surgery</li> </ul>	<ul> <li>Dental Care (Adult)</li> <li>Dental check-up</li> <li>Hearing aids</li> <li>Long Term Care</li> <li>Non-emergency care when traveling outside the U.S.</li> </ul>	<ul> <li>Private Duty Nursing</li> <li>Routine eye care (Adult)</li> <li>Routine foot care except for some conditions</li> <li>Weight Loss programs</li> </ul>
<ul> <li>Other Covered Services (Limitations may apply to thes</li> <li>Bariatric Surgery with prior authorization</li> </ul>	<ul> <li>se services. This isn't a complete list. Please see your</li> <li>Chiropractic Care</li> </ul>	<ul> <li>plan document.)</li> <li>Infertility Treatment (excludes some services)</li> </ul>

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 866-269-6803 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 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 <u>explanation of benefits</u> you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact: Medica at 866-269-6803 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 <u>plan</u> doesn't meet the <u>Minimum Value Standards</u>, you may be eligible for a <u>premium tax credit</u> to help you pay for a <u>plan</u> through the <u>Marketplace</u>.

#### 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, kwijijgo holne' 800-952-3455.

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

## MEDICA. IA Medica with CHI Health Silver Copay Zero

#### 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 prenatal care and a hospital

delivery)

- The plan's overall deductible: \$0
- Specialist copayment: \$0
- Hospital (facility) <u>coinsurance</u>: 0%
- Other <u>coinsurance</u>: 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*)

**Total Example Cost** 

\$12,800

#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
<u>Copayments</u>	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$60

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

- The plan's overall deductible: \$0
- Specialist copayment: \$0
- Hospital (facility) <u>coinsurance</u>: 0%
- Other <u>coinsurance</u>: 0%

#### 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

#### In this example, Joe would pay:

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

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

- The plan's overall deductible: \$0
- Specialist copayment: \$0
- Hospital (facility) <u>coinsurance</u>: 0%
- Other <u>coinsurance</u>: 0%

#### 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	
Deductibles	\$0
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
What isn't covered	·
Limits or exclusions	\$0
The total Mia would pay is	\$0

The plan 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.

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Nếu quý vị muốn trợ giúp dịch thông tin này miễn phí, hãy gọi vào số có trong tài liệu 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.

إذا كنت تريد مساعدة مجانية في ترجمة هذه المعلومات. فاتصل على ألرقم الوارد في هذه الوثيقة أو على 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.

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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.

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