MEDICA NE Elevate by Medica Gold Share

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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/2020ElevatePolicies</u> or call 866-810-5296. 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 866-810-5296 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$550 Individual / \$1,650 Family 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 deductible?	Yes. <u>Preventive care</u> , preventive prescriptions and <u>copay</u> services from <u>network</u> <u>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 <u>https://www.healthcare.gov/coverage/preventive-care-benefits</u> .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	\$7,200 Individual/ \$14,400 Family for network services. There is no coverage for non-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 <u>out-of-pocket</u> <u>limit?</u>	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 <u>network</u> <u>provider</u> ?	Yes. Visit www.Medica.com/ElevateProviders or call 866-810-5296 (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 <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services MEDICA. NE Elevate by Medica Gold Share



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 No (You will pay the least) (You	on-Network Provider 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: 35% coinsurance. Retail health clinics: 35% coinsurance Chiropractic care: 35% coinsurance for chiropractic and osteopathic manipulations.	Not covered	Manipulations limited to 20 visits/ year. See Rehabilitation and Habilitation for other limits that may apply.	
	Specialist visit	35% coinsurance	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 <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.	
If you have a test	Diagnostic test (x-ray, blood work)	35% coinsurance	Not covered	none	
If you have a test	Imaging (CT/PET scans, MRIs)	35% coinsurance	Not covered	*Prior authorization required for PET scans.	
	Generic drugs	\$15 <u>copay/</u> prescription. <u>Deductible</u> does not apply.	Not covered		
If you need drugs to treat your illness or condition	Preferred brand drugs	\$70 copay/ prescription. Deductible does not apply.	Not covered	Up to a 31-day supply per prescription. *May require prior authorization. For non-preferred reta drugs, 35% coinsurance for orally-administered cancer treatment medications. Proton pump inhibitors (except for members 12 years of age ar younger, and those members who have a feeding tube) and non-sedating antihistamines are not	
More information about prescription drug coverage is available at	Non-Preferred brand drugs	50% coinsurance	Not covered		
www.Medica.com/ RxListG.	Specialty drugs	Preferred: \$500 copay/ prescription. Non-Preferred: \$600 copay/ prescription. Deductible does not apply	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.	

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

		What You Will Pay			
Common Medical Event	Services You May Need	Network Provider N (You will pay the least) (You	on-Network Provider u will pay the most)	Limitations, Exceptions & Other Important Information	
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	35% coinsurance	Not covered	*May require prior authorization.	
surgery	Physician/surgeon fees	35% coinsurance	Not covered	*May require prior authorization.	
	Emergency room care	35% coinsurance	35% coinsurance	Network deductible applies.	
If you need immediate medical attention	Emergency medical transportation	35% coinsurance	35% coinsurance	Network deductible applies.	
	Urgent care	35% coinsurance	35% coinsurance	Network deductible applies.	
If you have a hospital stay	Facility fee (e.g., hospital room)	35% coinsurance	Not covered	Notification required. *May require prior authorization.	
, ,	Physician/surgeon fees	35% coinsurance	Not covered	*May require prior authorization.	
If you need mental health,	Outpatient services	35% coinsurance	Not covered	*May require prior authorization.	
If you need mental health, behavioral health, or substance abuse services	Inpatient services	35% coinsurance	Not covered	Notification required. *May require prior authorization.	
If you are pregnant	Office visits	Prenatal: 35% coinsurance Postnatal: 35% coinsurance	Not covered	Cost sharing does not apply to network preventive	
	Childbirth/delivery professional services	35% coinsurance	Not covered	Cost sharing does not apply to network preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).	
	Childbirth/delivery facility services	35% coinsurance	Not covered		

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

		What You Will Pay			
Common Medical Event	Services You May Need	Network Provider N (You will pay the least) (You	on-Network Provider u will pay the most)	Limitations, Exceptions & Other Important Information	
	Home health care	35% coinsurance	Not covered	Limited to 4 hours/ day; 60 visits/ year. *Prior authorization required.	
	Rehabilitation services	35% coinsurance	Not covered	Outpatient physical, occupational, speech and physiotherapy: 45 visits/ year. Outpatient cardiac rehabilitation: 18 visits per event/ year. Outpatient pulmonary rehabilitation: 18 visits/ year.	
If you need help recovering or have other special health needs	Habilitation services	35% coinsurance	Not covered	Outpatient physical, occupational, speech and physiotherapy: 45 visits/ year. Outpatient cardiac rehabilitation: 18 visits per event/ year. Outpatient pulmonary rehabilitation: 18 visits/ year.	
	Skilled nursing care	35% coinsurance	Not covered	Limited to 60 inpatient days/ year. *Prior authorization required.	
	Durable medical equipment	35% coinsurance	Not covered	*May require prior authorization.	
	Hospice services	35% coinsurance	Not covered	none	
	Children's eye exam	35% coinsurance	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	35% coinsurance	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.	

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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
- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Dental check-up

- Hearing aids except for members 18 years of age and younger; coverage is limited to \$3,000 every 48 months per covered child affected by a hearing impairment.
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.

- Private Duty Nursing
- Routine eyé 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 <u>plan</u> document.)

 Chiropractic and osteopathic manipulations limited to 20 visits per year

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 866-810-5296 or the Nebraska Department of Insurance, PO Box 82089, Lincoln, NE 68501-2089, 402-471-2201 or 1-877-564-7323. 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 <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. 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 866-810-5296 or the Nebraska Department of Insurance, PO Box 82089, Lincoln, NE 68501-2089, 402-471-2201 or 1-877-564-7323.

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, kwiijigo 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 <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: \$550

■ Specialist coinsurance: 35%

■ Hospital (facility) <u>coinsurance</u>: 35%

Other coinsurance: 35%

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>	\$550	
Copayments	\$20	
Coinsurance	\$3,700	
What isn't covered		
Limits or exclusions	\$60	
The total Peg would pay is	\$4,330	

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

■ The plan's overall deductible: \$550

■ Specialist coinsurance: 35%

■ Hospital (facility) coinsurance: 35%

■ Other coinsurance: 35%

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>	\$550	
<u>Copayments</u>	\$600	
Coinsurance	\$900	
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: \$550

Specialist coinsurance: 35%

■ Hospital (facility) <u>coinsurance</u>: 35%

■ Other coinsurance: 35%

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>	\$550	
<u>Copayments</u>	\$0	
Coinsurance	\$500	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$1,050	

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.

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.

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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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