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/2020InsurePolicies or call 800-918-6165. 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 800-918-6165 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$0 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 plan covers some items and services even if you haven't yet met the deductible amount.
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> ?	\$0 for <u>network</u> services. There is no coverage for non-network services.	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges and health care this plan doesn't cover.	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
Will you pay less if you use a <u>network provider</u> ?	call 800-918-6165 (11Y:/11) for a list	This <u>plan</u> uses a <u>provider network</u> . You will pay the least if you use a <u>provider</u> in the Tier 1 - preferred <u>network</u> . You will pay more if you use a <u>provider</u> in the Tier 2 - standard <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider</u> 's charge and what your <u>plan</u> pays (<u>balance</u> <u>billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the specialist you choose without a referral.

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 Y	′ou Will Pay	
Common Medical Event	Services You May Need	Tier 1- Preferred and Tier 2- Standard Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
	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	Specialist visit	No charge	Not covered	none
<u>p</u>	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 nave 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
If you need drugs to treat your illness or condition	Preferred brand drugs	No charge	Not covered	except for members 12 years of age and vounger, and those members
More information about prescription drug coverage is available at	Non-Preferred brand drugs	No charge	Not covered	who have a feeding tube) and non-sedating antihistamines are not covered. *Refer to the Exceptions to
www.Medica.com/ RxList.	Specialty drugs	Preferred: No charge Non-preferred: No charge	Not covered	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

		What Ye	ou Will Pay	
Common Medical Event	Services You May Need	Tier 1- Preferred and Tier 2- Standard Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	*May require prior authorization.
n you have a hospital stay	Physician/surgeon fees	No charge	Not covered	*May require prior authorization.
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.
	Office visits	No charge	Not covered	
If you are pregnant	Childbirth/delivery professional services		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 special health needs	Skilled nursing care	No charge	Not covered	*May require prior authorization.
	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:

 *Abortion, elective, induced, except as medically necessary to protect the life of the mother or in the case of rape or incest Acupuncture Cosmetic Surgery 	 Dental Care (Adult) Dental check-up Hearing aids Long Term Care Non-emergency care when traveling outside the U.S. 	 Private Duty Nursing Routine eye care (Adult) Routine foot care except for some conditions Weight Loss programs
er Covered Services (Limitations may apply to thes	e services. This isn't a complete list. Please see your	<u>plan</u> 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 800-918-6165 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 800-918-6165 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 Insure Bronze H 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 <u>plan's</u> overall <u>deductible</u>: \$0
- **Specialist** coinsurance: 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	

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 coinsurance: 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 coinsurance: 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.

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 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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