# MEDICA. IA Insure Bronze H Plus Limited

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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 <a href="www.Medica.com/2020InsurePolicies">www.Medica.com/2020InsurePolicies</a> or call 800-918-6165. For general definitions of common terms, such as <a href="mailto:allowed amount">allowed amount</a>, <a href="mailto:balance billing">balance billing</a>, <a href="mailto:coinsurance">coinsurance</a>, <a href="copayment">copayment</a>, <a href="mailto:deductible">deductible</a>, <a href="mailto:provider">provider</a>, or other <a href="mailto:underlined">underlined</a> terms see the Glossary. You can view the Glossary at <a href="https://www.healthcare.gov/sbc-glossary">https://www.healthcare.gov/sbc-glossary</a> or call 800-918-6165 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$0 at Indian Health Care Provider (IHCP) or with IHCP referral at non-IHCP; \$3,700 Individual / \$7,400 Family for non-IHCP Tier1 - preferred network and Tier 2 - standard network 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?	<b>Yes</b> . Preventive care and preventive prescriptions from non-IHCP network providers are covered before you meet your deductible.	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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits">https://www.healthcare.gov/coverage/preventive-care-benefits</a> .
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> ?	\$6,900 Individual/ \$13,800 Family for non-IHCP Tier 1 - preferred and Tier 2 - standard 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 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/InsureNetwork or call 800-918-6165 (TTY:711) for a list of network providers.	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's</u> charge and what your <u>plan</u> pays ( <u>balance 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.

# Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services $\overline{MEDICA}_{\text{\tiny{\$}}}$ IA Insure Bronze H Plus Limited



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

		What You Will Pay				
Common Medical Event	Services You May Need	Indian Health Care Provider (IHCP) (You will pay th	Non-IHCP Tier 1-Preferr and Tier 2-Standard Network Provider e least) (You will pay more)	Non-Network Provider	Limitations, Exceptions & Other Important Information	
If you visit a health care provider's office	Primary care visit to treat an injury or illness	No charge	Primary care: 40% coinsurance Retail health clinics: 40% coinsurance Chiropractic care: 40% coinsurance	Not covered	Cost sharing waived at non-IHCP with IHCP referral.	
or clinic	Specialist visit	No charge	40% coinsurance	Not covered	Cost sharing waived at non-IHCP with IHCP referral.	
	Preventive care/ screening/ immunization	No charge	No charge. <u>Deductible</u> does not apply.	Not covered	You may have to pay for services that aren't preventive. A your <u>provider</u> if the services you need are preventive. The check what your <u>plan</u> will pay for. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> .	
If you have a test	Diagnostic test (x-ray, blood work)	No charge	40% coinsurance	Not covered	Cost sharing waived at non-IHCP with IHCP referral.	
If you have a test	Imaging (CT/PET scans, MRIs)	No charge	40% coinsurance	Not covered	*May require prior authorization. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> .	
	Generic drugs	No charge	40% coinsurance	Not covered	Up to a 31 day supply per prescription *May require prior	
If you need drugs to treat your illness or condition	Preferred brand drugs	No charge	40% coinsurance	Not covered	Up to a 31-day supply per prescription. *May require prior authorization. For preferred and non-preferred specialty drugs, 20% coinsurance for orally-administered cancer treatment medications. Proton pump inhibitors (except for	
More information about prescription drug	Non-Preferred brand drugs	No charge	40% coinsurance	Not covered	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	
coverage is available at www.Medica.com/ RxList.	Specialty drugs	No charge	Preferred: 30% coinsurance Non-Preferred: 50% coinsurance	Not covered	section of your Policy of Coverage for more details. No charge for preventive drugs. Cost sharing waived at non-IHCP with IHCP referral.	

<sup>\*</sup> For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.Medica.com/2020InsurePolicies</u>.

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	What You Will Pay					
Common Medical Event	Services You May Need	Indian Health Care Provider (IHCP) (You will pay th	Non-IHCP Tier 1-Prefer and Tier 2-Standard Network Provider e least) (You will pay more)	Non-Network Provider	Limitations, Exceptions & Other Important Information	
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	No charge	40% coinsurance	Not covered	*May require prior authorization. Cost sharing waived at non-IHCP with IHCP referral.	
surgery	Physician/surgeon fees	No charge	40% coinsurance	Not covered	*May require authorization. Cost sharing waived at non-IHCP with IHCP referral.	
	Emergency room care	No charge	40% coinsurance	40% coinsurance	Network deductible applies. Cost sharing waived at non-IHCP with IHCP referral.	
If you need immediate medical attention	Emergency medical transportation	No charge	40% coinsurance	40% coinsurance	Network deductible applies. Cost sharing waived at non-IHCP with IHCP referral.	
	Urgent care	No charge	40% coinsurance	40% coinsurance	Network deductible applies. Cost sharing waived at non-IHCP with IHCP referral.	
If you have a hospital	Facility fee (e.g., hospital room)	No charge	40% coinsurance	Not covered	*May require prior authorization. Cost sharing waived at non-IHCP with IHCP referral.	
stáy	Physician/surgeon fees	No charge	40% coinsurance	Not covered	*May require authorization. Cost sharing waived at non-IHCP with IHCP referral.	
If you need mental health, behavioral	Outpatient services	No charge	40% coinsurance	Not covered	*May require prior authorization. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> .	
health, or substance abuse services	Inpatient services	No charge	40% coinsurance	Not covered	*May require prior authorization. Cost sharing waived at non-IHCP with IHCP referral.	
	Office visits	No charge	Prenatal: 40% coinsurance Postnatal: 40% coinsurance	Not covered	Cost sharing does not apply to network preventive services.	
If you are pregnant	Childbirth/delivery professional services	No charge	40% coinsurance	Not covered	Depending on the type of services, <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> .	
	Childbirth/delivery facility services	No charge	40% coinsurance	Not covered		

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Common Medical Services You May Need		What You Will Pay			
		Indian Health Care Provider (IHCP) (You will pay th	Non-IHCP Tier 1-Preferi and Tier 2-Standard Network Provider e least) (You will pay more)	red Non-IHCP Non-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
	Home health care	No charge	40% coinsurance	Not covered	*May require prior authorization. Cost sharing waived at non-IHCP with IHCP referral.
	Rehabilitation services	No charge	40% coinsurance	Not covered	Cost sharing waived at non-IHCP with IHCP referral.
If you need help	Habilitation services	No charge	40% coinsurance	Not covered	Cost sharing waived at non-IHCP with IHCP referral.
rećovering or have other special health needs	Skilled nursing care	No charge	40% coinsurance	Not covered	*May require prior authorization. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> .
	Durable medical equipment		40% coinsurance	Not covered	*May require authorization. Cost sharing waived at non-IHCP with IHCP referral.
	Hospice services	No charge	40% coinsurance	Not covered	Respite care is limited to 5 consecutive days, up to a lifetime maximum of 15 inpatient days and 15 outpatient days. Cost sharing waived at non-IHCP with IHCP referral.
	Children's eye exam	No charge	40% coinsurance	Not covered	Limited to one refractive eye exam/ year to end of month member turns 19. Cost sharing waived at non-IHCP with IHCP referral.
If your child needs dental or eye care	Children's glasses	No charge	40% coinsurance	Not covered	Limited to one pair of glasses or contacts/ year to end of month member turns 19. Cost sharing waived at non-IHCP with IHCP referral.
	Children's dental check-up	Not covered	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 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
- Private Duty Nursing
- 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.)

- Bariatric Surgery with prior authorization
- Chiropractic Care

Infertility Treatment (excludes some services)

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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 800-918-6165 or the lowa 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 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 800-918-6165 or the lowa 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, kwiijigo holne' 800-952-3455.

----- 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 prenatal care and a hospital delivery)

■ The plan's overall deductible: \$0

■ Specialist coinsurance: 0%

■ Hospital (facility) coinsurance: 0%

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

Cost Sharing		
<u>Deductibles</u>	\$0	
<u>Copayments</u>	\$0	
Coinsurance		
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 coinsurance: 0%

#### 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>	\$0
Copayments	\$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) coinsurance: 0%

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

Note: These numbers assume the patient received care from an IHCP <u>provider</u> or with IHCP <u>referral</u> at a non-IHCP. If you receive care from a non-IHCP <u>provider</u> without a <u>referral</u> from an IHCP, your costs may be higher. 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.

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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.

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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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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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