



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/2021SelectPolicies](http://www.medica.com/2021SelectPolicies) or call 866-269-6806. 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 866-269-6806 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$0	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes.	This <a href="#">plan</a> covers items and services even if you haven't yet met the <a href="#">deductible</a> amount.
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	Not Applicable	This <a href="#">plan</a> does not have an <a href="#">out-of-pocket limit</a> on your expenses.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Not Applicable	This <a href="#">plan</a> does not have an <a href="#">out-of-pocket limit</a> on your expenses.
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. Visit <a href="http://www.medica.com/SearchSelect">www.medica.com/SearchSelect</a> or call 866-269-6806 (TTY:711) for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	No charge	Not covered	---none---
	<a href="#">Specialist</a> visit	No charge	Not covered	---none---
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	Not covered	---none---
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	*May require prior authorization.
<b>If you need drugs to treat your illness or condition</b>  More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.medica.com/BrRx3">www.medica.com/BrRx3</a> .	Generic drugs	No charge	Not covered	Up to a 31-day supply per prescription. *May require prior authorization. Proton pump inhibitors (except for members 12 years of age and younger, and those members who have a feeding tube) and non-sedating antihistamines are not covered. Insulin: Your cost-share will not exceed \$25 per retail prescription unit. *Refer to the Exceptions to the Drug List section of your Policy of Coverage for more details. No charge for preventive drugs.
	Preferred brand drugs	No charge	Not covered	
	Non-Preferred brand drugs	No charge	Not covered	
	<a href="#">Specialty drugs</a>	Preferred: No charge Non-Preferred: No charge	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	*May require prior authorization.
	Physician/surgeon fees	No charge	Not covered	*May require prior authorization.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need immediate medical attention	<a href="#">Emergency room care</a>	No charge	No charge	<a href="#">Network deductible</a> applies. If a non-network <a href="#">provider</a> charges more than the <a href="#">allowed amount</a> , you may have to pay the difference ( <a href="#">balance billing</a> ).
	<a href="#">Emergency medical transportation</a>	No charge	No charge	---none---
	<a href="#">Urgent care</a>	No charge	No charge	If a non-network <a href="#">provider</a> charges more than the <a href="#">allowed amount</a> , you may have to pay the difference ( <a href="#">balance billing</a> ).
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	*May require prior authorization.
	Physician/surgeon fees	No charge	Not covered	*May require prior authorization.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	Not covered	*May require prior authorization.
	Inpatient services	No charge	Not covered	*May require prior authorization.
If you are pregnant	Office visits	Prenatal: No charge Postnatal: No charge	Not covered	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	No charge	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No charge	Not covered	*May require prior authorization. Limited to 100 intermittent skilled nursing visits and 82 extended hours home care visits/year.
	<a href="#">Rehabilitation services</a>	No charge	Not covered	Limited to 20 physical therapy and 20 occupational therapy visits/year.
	<a href="#">Habilitation services</a>	No charge	Not covered	Limited to 20 physical therapy and 20 occupational therapy visits/year.
	<a href="#">Skilled nursing care</a>	No charge	Not covered	*May require prior authorization. Limited to 150 days/year.
	<a href="#">Durable medical equipment</a>	No charge	Not covered	*May require prior authorization.
	<a href="#">Hospice services</a>	No charge	Not covered	---none---
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Coverage limited to end of month member turns 19.
	Children's glasses	No charge	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	Coverage is available through a stand-alone dental policy.

## 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. | ● Cosmetic surgery   | ● Non-emergency care when traveling outside the U.S. |
| ● Acupuncture   | ● Dental care (Adult)  | ● Routine eye care (Adult)                           |
| ● Bariatric surgery   | ● Dental care (Child) (coverage is available through a stand-alone dental policy.) | ● Routine foot care except for some conditions       |
|   | ● Dental check-up  | ● Weight loss programs                               |
|   | ● Infertility treatment  |  |
|   | ● Long-term care   |  |

### 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 |
|---------------------|---|---|

### 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](http://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](http://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 on how 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](http://www.insurance.mo.gov/consumers/complaints/index.php).

### Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

### Does this plan meet Minimum Value Standards? NA

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, kwijigo holne' 888-592-8211

----- 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 [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). 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 [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	\$12,700
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$60</b>

### 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) [coinsurance](#): 0%
- Other [coinsurance](#): 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	\$5,600
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$0</b>

### 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	\$2,800
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$0</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.



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>.

Wenn Sie bei der Übersetzung dieser Informationen kostenlose Hilfe in Anspruch nehmen möchten, rufen Sie bitte die in diesem Dokument oder auf der Rückseite Ihrer Medica-ID-Karte angegebene Nummer an.