



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/2022MUHealthPolicies or call 877-329-8270. 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 877-329-8270 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$6,500 Individual / \$13,000 Family for network services.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible ?	Yes. Preventive care , preventive prescriptions and copay services from network providers are covered before you meet your deductible .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	\$8,700 Individual / \$17,400 Family for network services.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit 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/FindMUHealthProviders or call 877-329-8270 (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 referral to see a specialist ?	No.	You can see the specialist you choose without a referral .



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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Primary care: \$25 copay /visit. Deductible does not apply. Retail health clinics: \$20 copay /visit. Deductible does not apply. Chiropractic care: \$25 copay /visit. Deductible does not apply.	Not covered	40% coinsurance for other outpatient services. Primary care visits provided at an outpatient facility may be subject to coinsurance and deductible .
	Specialist visit	\$110 copay /visit. Deductible does not apply.	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 provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	40% coinsurance	Not covered	---none---
	Imaging (CT/PET scans, MRIs)	40% coinsurance	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 drugs to treat your illness or condition More information about prescription drug coverage is available at www.medica.com/RxList2022 .	Generic drugs	\$10 copay /prescription. Deductible does not apply.	Not covered	Up to a 31-day supply per prescription. *May require prior authorization. For preferred/non-preferred retail and specialty drugs , \$110 copay for orally-administered cancer treatment medications. Deductible does not apply. 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	\$120 copay /prescription. Deductible does not apply.	Not covered	
	Non-Preferred brand drugs	60% coinsurance	Not covered	
	Specialty drugs	\$700 copay /prescription. Deductible does not apply.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance	Not covered	*May require prior authorization.
	Physician/surgeon fees	40% coinsurance	Not covered	*May require prior authorization.
If you need immediate medical attention	Emergency room care	40% coinsurance	40% coinsurance	Network deductible applies.
	Emergency medical transportation	40% coinsurance	40% coinsurance	Network deductible applies.
	Urgent care	\$25 copay /visit. Deductible does not apply.	\$25 copay /visit. Deductible does not apply.	If a non-network provider charges more than the allowed amount , you may have to pay the difference (balance billing).
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance	Not covered	*May require prior authorization.
	Physician/surgeon fees	40% coinsurance	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 mental health, behavioral health, or substance abuse services	Outpatient services	\$25 copay /visit. Deductible does not apply. 40% coinsurance for other outpatient services.	Not covered	*May require prior authorization. Other outpatient services include- Intensive outpatient programs, diagnostic evaluations & psychological testing.
	Inpatient services	40% coinsurance	Not covered	*May require prior authorization.
If you are pregnant	Office visits	Prenatal: 40% coinsurance Postnatal: 40% coinsurance	Not covered	Cost sharing does not apply for preventive services . Depending on the type of services, a copayment , coinsurance , or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	40% coinsurance	Not covered	
	Childbirth/delivery facility services	40% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	40% coinsurance	Not covered	*May require prior authorization. Limited to 100 intermittent skilled nursing visits and 82 extended hours home care visits/year.
	Rehabilitation services	40% coinsurance	Not covered	Outpatient: Limited to 20 physical therapy and 20 occupational therapy visits/year, unless medically necessary; Cardiac rehabilitation 36 visits/year.
	Habilitation services	40% coinsurance	Not covered	Outpatient: Limited to 20 physical therapy and 20 occupational therapy visits/year, unless medically necessary; Cardiac rehabilitation 36 visits/year.
	Skilled nursing care	40% coinsurance	Not covered	*May require prior authorization. Limited to 150 days/year.
	Durable medical equipment	40% coinsurance	Not covered	*May require prior authorization.
	Hospice services	40% coinsurance	Not covered	---none---

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 your child needs dental or eye care	Children's eye exam	\$25 copay /visit. Deductible does not apply.	Not covered	Coverage limited to end of month member turns 19.
	Children's glasses	40% coinsurance	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](#).)

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|---|--|--|
| ● *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.)

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| ● 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 |
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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 877-329-8270 or the Missouri Department of Insurance, Consumer Affairs Division, 1-800-726-7390 or 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 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: Medica at 877-329-8270 or the Missouri Department of Insurance, Consumer Affairs Division, 1-800-726-7390 or 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 :	\$6,500
■ Specialist copayment :	\$110
■ Hospital (facility) coinsurance :	40%
■ Other coinsurance :	40%

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:

<i>Cost Sharing</i>	
Deductibles	\$6,500
Copayments	\$10
Coinsurance	\$1,900
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$8,470

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

■ The plan's overall deductible :	\$6,500
■ Specialist copayment :	\$110
■ Hospital (facility) coinsurance :	40%
■ Other coinsurance :	40%

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:

<i>Cost Sharing</i>	
Deductibles	\$1,100
Copayments	\$900
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$2,000

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

■ The plan's overall deductible :	\$6,500
■ Specialist copayment :	\$110
■ Hospital (facility) coinsurance :	40%
■ Other coinsurance :	40%

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:

<i>Cost Sharing</i>	
Deductibles	\$2,600
Copayments	\$200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800

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.