

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="https://www.Medica.com/MUHealthPolicies-2023">www.Medica.com/MUHealthPolicies-2023</a> or call 1-877-329-8270. 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 <a href="https://www.healthcare.gov/sbc-glossary">www.healthcare.gov/sbc-glossary</a> or call 1-877-329-8270 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$5,400 individual / \$10,800 family for 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. Preventive care and preventive prescriptions from 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</u> <u>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 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?	\$7,500 individual / \$15,000 family for 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. See <a href="https://www.Medica.com/SearchMUHealthNetwork-2023">www.Medica.com/SearchMUHealthNetwork-2023</a> or call 1-877-329-8270 (TTY: 711) for a list of <a href="https://network.providers">network</a> providers.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's 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 referral to see a specialist?	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 You Will Pay			
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information	
If you visit a health care	Primary care visit to treat an injury or illness	Primary care: 20% coinsurance Retail health clinics: 20% coinsurance Chiropractic care: 20% coinsurance	Not covered	none	
provider's office or clinic	Specialist visit	20% coinsurance	Not covered	none	
	Preventive care/ screening/immunization	No charge. <u>Deductible</u> does not apply.	Not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.	
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Not covered	none	
,	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	*May require prior authorization.	
If you need drugs to treat your illness or condition	Generic drugs	Preferred Generic: 20% coinsurance Generic: 20% coinsurance	Not covered	Up to a 31-day supply per prescription.  *May require prior authorization. For specialty drugs, 20% coinsurance for orally-administered cancer treatment medications. 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	
More information about prescription drug coverage is available at www.Medica.com/MODrugList-2023	Preferred brand drugs	20% coinsurance	Not covered		
	Non-Preferred brand drugs	20% coinsurance	Not covered		
	Specialty drugs	30% coinsurance	Not covered	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)	20% coinsurance	Not covered	*May require prior authorization.	
surgery	Physician/surgeon fees	20% coinsurance	Not covered	*May require prior authorization.	

<sup>\*</sup> For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.Medica.com/MUHealthPolicies-2023</u>.

		What You Will Pay			
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information	
	Emergency room care	20% coinsurance	20% coinsurance	Network deductible applies.	
If you need immediate	Emergency medical transportation	20% coinsurance	20% coinsurance	Network deductible applies.	
médical attention	Urgent care	20% coinsurance	20% coinsurance	Network deductible applies. If a non-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).	
If you have a basnital atoy	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	*May require prior authorization.	
If you have a hospital stay	Physician/surgeon fees	20% coinsurance	Not covered	*May require prior authorization.	
If you need mental health,	Outpatient services	20% coinsurance	Not covered	*May require prior authorization.	
behavioral health, or substance abuse services	Inpatient services	20% coinsurance	Not covered	*May require prior authorization.	
If you are pregnant	Office visits	Prenatal: 20% coinsurance Postnatal: 20% 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	20% coinsurance	Not covered		
	Childbirth/delivery facility services	20% coinsurance	Not covered		

<sup>\*</sup> For more information about limitations and exceptions, see the plan or policy document at www.Medica.com/MUHealthPolicies-2023.

		What You Will Pay		
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
	Home health care	20% coinsurance	Not covered	*May require prior authorization. Limited to 100 intermittent skilled nursing visits and 82 extended hours home care visits/year.
If you need help recovering or have other special health needs	Rehabilitation services	20% coinsurance	Not covered	Outpatient: Limited to 20 physical therapy and 20 occupational therapy visits/year, unless medically necessary; Cardiac rehabilitation 36 visits/year. This visit limit does not apply to services for treatment of autism spectrum disorder.
	Habilitation services	20% coinsurance	Not covered	Outpatient: Limited to 20 physical therapy and 20 occupational therapy visits/year, unless medically necessary; Cardiac rehabilitation 36 visits/year. This visit limit does not apply with respect to services for mental health and substance use disorder conditions.
	Skilled nursing care	20% coinsurance	Not covered	*May require prior authorization. Limited to 150 days/year.
	Durable medical equipment	20% coinsurance	Not covered	*May require prior authorization.
	Hospice services	20% coinsurance	Not covered	none
	Children's eye exam	20% coinsurance	Not covered	Coverage limited to end of month member turns 19.
If your child needs dental or eye care	Children's glasses	20% 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.

<sup>\*</sup> For more information about limitations and exceptions, see the plan or policy document at www.Medica.com/MUHealthPolicies-2023.

Coverage Period: Beginning on or after 01/01/2023 Coverage for: Individual or Family | Plan Type: EPO

#### **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
- Acupuncture
- Bariatric surgery

- Cosmetic surgery
- Dental care (Adult)
- Dental care (Child) (coverage is available through a stand-alone dental policy)
- Dental check-up
- Infertility treatment
- Long-term care

- Non-emergency care when traveling outside the U.S.
- 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.)

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

Coverage Period: Beginning on or after 01/01/2023

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 1-877-329-8270, the Missouri Department of Insurance, Consumer Affairs Division, 1-800-726-7390 or <a href="https://www.insurance.mo.gov/consumers/complaints/index.php">www.insurance.mo.gov/consumers/complaints/index.php</a>, or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <a href="https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa/">https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa/</a>. Other coverage options may be available to you, too, including buying individual insurance coverage through the <a href="https://www.delthologov/marketplace">Health Insurance</a> <a href="https://www.delthologov/marketplace">Marketplace</a>. For more information about the <a href="https://www.delthologov/marketplace">Marketplace</a>. When the supplementary the supplementary the supplementary the supplementary that the supplementary the supplementary that the su

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 1-877-329-8270, 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? Not Applicable.

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 1-888-592-8211.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-592-8211.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-592-8211.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-592-8211.

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 <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	g is Having a Baby	
(9 months of in-net	twork pre-natal care a	nd a hospital
	delivery)	
The other lands	11	<b>AF 40</b>

The plan's overall deductible \$5,400 Specialist coinsurance 20% 20% Hospital (facility) coinsurance Other coinsurance 20%

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

■ The plan's overall deductible \$5,400 **Specialist coinsurance** 20% 20% **Hospital (facility) coinsurance** Other coinsurance 20%

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

■ The plan's overall deductible \$5,400 **Specialist coinsurance** 20% Hospital (facility) coinsurance 20% Other coinsurance 20%

#### 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)

#### This EXAMPLE event includes services like:

Primary care physician office visits (including disease education)

Diagnostić tests (blood work)

Prescription drugs

**Total Example Cost** 

Durable medical equipment (alucose meter)

#### 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** \$12,700

In this exam	ple, Joe	would	pay:

Total Example Cost
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# In this example, Peg would pay:

Cost Sharing		
<u>Deductibles</u>	\$5,400	
<u>Copayments</u>	\$0	
Coinsurance	\$1,200	
What isn't covered		
Limits or exclusions	\$60	
The total Peg would pay is	\$6,660	

#### Cost Sharing \$2,300 Deductibles

\$300 Copayments \$0 Coinsurance What isn't covered \$0 Limits or exclusions The total Joe would pay is \$2,600

# In this example, Mia would pay:

\$5,600

Cost Sharing	
<u>Deductibles</u>	\$2,800
Copayments	\$0
Coinsurance	\$0
What isn't covered	
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.

Coverage for: Individual or Family | Plan Type: EPO

# 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 tarieta 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.

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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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