



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/SelectPolicies-2023](http://www.Medica.com/SelectPolicies-2023) or call 1-866-269-6806. 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 [www.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 1-866-269-6806 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$1,500 individual / \$3,000 family for <a href="#">network</a> services.	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> and preventive prescriptions from <a href="#">network providers</a> are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits">https://www.healthcare.gov/coverage/preventive-care-benefits</a> .
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> ?	\$9,100 individual / \$18,200 family for <a href="#">network</a> services.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.Medica.com/SearchSelectNetwork-2023">www.Medica.com/SearchSelectNetwork-2023</a> or call 1-866-269-6806 (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	Primary care: \$0 <a href="#">copay</a> /visit. Retail health clinics: \$0 <a href="#">copay</a> /visit. Chiropractic care: \$0 <a href="#">copay</a> /visit.	Not covered	50% <a href="#">coinsurance</a> for other outpatient services. Primary care visits provided at an outpatient facility may be subject to <a href="#">coinsurance</a> and <a href="#">deductible</a> .
	<a href="#">Specialist</a> visit	\$160 <a href="#">copay</a> /visit.	Not covered	---none---
	<a href="#">Preventive care/screening</a> /immunization	No charge. <a href="#">Deductible</a> does not apply.	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)	50% <a href="#">coinsurance</a>	Not covered	---none---
	Imaging (CT/PET scans, MRIs)	50% <a href="#">coinsurance</a>	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/MODrugList-2023">www.Medica.com/MODrugList-2023</a>	Generic drugs	Preferred Generic: \$30 <a href="#">copay</a> /prescription. <a href="#">Deductible</a> does not apply. Generic: \$30 <a href="#">copay</a> /prescription. <a href="#">Deductible</a> does not apply.	Not covered	Up to a 31-day supply per prescription. *May require prior authorization. For preferred/non-preferred retail drugs, \$160 <a href="#">copay</a> for orally-administered cancer treatment medications. <a href="#">Deductible</a> 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	\$200 <a href="#">copay</a> /prescription. <a href="#">Deductible</a> does not apply.	Not covered	
	Non-Preferred brand drugs	70% <a href="#">coinsurance</a>	Not covered	
	<a href="#">Specialty drugs</a>	\$750 <a href="#">copay</a> /prescription. <a href="#">Deductible</a> does not apply.	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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% <a href="#">coinsurance</a>	Not covered	*May require prior authorization.
	Physician/surgeon fees	50% <a href="#">coinsurance</a>	Not covered	*May require prior authorization.
If you need immediate medical attention	<a href="#">Emergency room care</a>	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Network deductible</a> applies.
	<a href="#">Emergency medical transportation</a>	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Network deductible</a> applies.
	<a href="#">Urgent care</a>	\$0 <a href="#">copay</a> /visit.	\$0 <a href="#">copay</a> /visit.	<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> ).
If you have a hospital stay	Facility fee (e.g., hospital room)	50% <a href="#">coinsurance</a>	Not covered	*May require prior authorization.
	Physician/surgeon fees	50% <a href="#">coinsurance</a>	Not covered	*May require prior authorization.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$0 <a href="#">copay</a> /visit. 50% <a href="#">coinsurance</a> for other outpatient services.	Not covered	*May require prior authorization. Other outpatient services include- Intensive outpatient programs, diagnostic evaluations & psychological testing.
	Inpatient services	50% <a href="#">coinsurance</a>	Not covered	*May require prior authorization.
If you are pregnant	Office visits	Prenatal: 50% <a href="#">coinsurance</a> Postnatal: 50% <a href="#">coinsurance</a>	Not covered	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	50% <a href="#">coinsurance</a>	Not covered	
	Childbirth/delivery facility services	50% <a href="#">coinsurance</a>	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>	50% <a href="#">coinsurance</a>	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>	50% <a href="#">coinsurance</a>	Not covered	Outpatient: Limited to 20 physical therapy and 20 occupational therapy visits/year, unless medically necessary; Cardiac <a href="#">rehabilitation</a> 36 visits/year. This visit limit does not apply to services for treatment of autism spectrum disorder.
	<a href="#">Habilitation services</a>	50% <a href="#">coinsurance</a>	Not covered	Outpatient: Limited to 20 physical therapy and 20 occupational therapy visits/year, unless medically necessary; Cardiac <a href="#">rehabilitation</a> 36 visits/year. This visit limit does not apply with respect to services for mental health and substance use disorder conditions.
	<a href="#">Skilled nursing care</a>	50% <a href="#">coinsurance</a>	Not covered	*May require prior authorization. Limited to 150 days/year.
	<a href="#">Durable medical equipment</a>	50% <a href="#">coinsurance</a>	Not covered	*May require prior authorization.
	<a href="#">Hospice services</a>	50% <a href="#">coinsurance</a>	Not covered	---none---
If your child needs dental or eye care	Children's eye exam	\$0 <a href="#">copay</a> /visit.	Not covered	Coverage limited to end of month member turns 19.
	Children's glasses	50% <a href="#">coinsurance</a>	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](#).)**

- |   |  |  |
|---|--|--|
| <ul style="list-style-type: none"> <li>• Abortions, elective, induced, except as medically necessary to protect the life of the mother</li> <li>• Acupuncture</li> <li>• Bariatric surgery</li> </ul> | <ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> <li>• Dental care (Child) (coverage is available through a stand-alone dental policy)</li> <li>• Dental check-up</li> <li>• Infertility treatment</li> <li>• Long-term care</li> </ul> | <ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Routine eye care (Adult)</li> <li>• Routine foot care except for some conditions</li> <li>• Weight loss programs</li> </ul> |
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**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)**

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|---|--|---|
| <ul style="list-style-type: none"> <li>• Chiropractic care</li> </ul> | <ul style="list-style-type: none"> <li>• Hearing aids limited to 1 hearing aid per ear every 48 months. Newborn hearing aids provided for initial amplification following a newborn hearing screening</li> </ul> | <ul style="list-style-type: none"> <li>• Private-duty nursing limited to 82 visits</li> </ul> |
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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 1-866-269-6806, 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), or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa>. Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](http://www.HealthCare.gov). For more information about the [Marketplace](http://www.HealthCare.gov), 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: Medica at 1-866-269-6806, 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).

**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, kwijigo 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 [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 <a href="#">plan's</a> overall deductible	\$1,500
■ <a href="#">Specialist copayment</a>	\$160
■ Hospital (facility) <a href="#">coinsurance</a>	50%
■ Other <a href="#">coinsurance</a>	50%

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>	\$1,500
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$4,800
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$6,370</b>

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

■ The <a href="#">plan's</a> overall deductible	\$1,500
■ <a href="#">Specialist copayment</a>	\$160
■ Hospital (facility) <a href="#">coinsurance</a>	50%
■ Other <a href="#">coinsurance</a>	50%

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>	\$1,100
<a href="#">Copayments</a>	\$900
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$2,000</b>

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

■ The <a href="#">plan's</a> overall deductible	\$1,500
■ <a href="#">Specialist copayment</a>	\$160
■ Hospital (facility) <a href="#">coinsurance</a>	50%
■ Other <a href="#">coinsurance</a>	50%

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>	\$1,500
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$500
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,200</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.