Medica

: WellFirst by Medica Silver 3550X03 (AI/AN Limited Cost Sharing) **Coverage for: Individual/Family | Plan Type: EPO**

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, sbc.MO-central.medica.com/individual or call 877-379-7599 (TTY: 711). 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 877-379-7599 (TTY: 711) 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; or $3,550 / individual $7,100 / family	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 and preventive prescriptions 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?	$7,500 individual / $15,000 family.	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. See MO-central.medica.com/find-a-doctor or call 877-379-7599 (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
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP Network Provider (You will pay more)	Out-of-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	No charge	20% coinsurance after deductible	Not Covered	No coverage for chiropractic maintenance or long-term therapy.
	Specialist visit	No charge	20% coinsurance after deductible	Not Covered	No coverage for infertility services. No coverage for acupuncture.
	Preventive care/screening/ immunization	No charge	No charge	Not Covered	Services under the Affordable Care Act (ACA) guidelines will be covered as preventive. Services may have a limit on number of visits and/or specific age requirements. For additional information please see the Preventive Services section in your Member Certificate. You may have to pay for services that are not 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)	No charge	20% coinsurance after deductible	Not Covered	Select diagnostic testing (e.g., genetic testing) and radiology services require prior authorization from our Medical Affairs Division. Failure to obtain prior
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance after deductible	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
					authorization for any medically necessary covered services which requires an authorization, you, the Member, will be responsible for paying 100% of the total cost.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at MO-central.medica.com/Individuals-and-Families/Pharmacy-benefits/Drug-formulary	Preferred generic drugs (Tier 1)	No charge / prescription (retail and mail order)	20% coinsurance after deductible / prescription (retail); Mail order maintenance prescriptions, a 90-day supply at coinsurance listed above.	Not Covered (retail and mail order)	None
	Non-Preferred generic, Preferred brand drugs (Tier 2)	No charge / prescription (retail and mail order)	20% coinsurance after deductible / prescription (retail); Mail order maintenance prescriptions, a 90-day supply at coinsurance listed above.	Not Covered (retail and mail order)	
	Non-preferred generic, Non-preferred brand drugs (Tier 3)	No charge / prescription (retail and mail order)	20% coinsurance after deductible / prescription (retail); Mail order maintenance prescriptions, a 90-day supply at coinsurance listed above.	Not Covered (retail and mail order)	
	Specialty drugs (Tier 4)	No charge / prescription (retail); Mail order maintenance prescriptions not covered.	20% coinsurance after deductible / prescription (retail); Mail order maintenance	Not Covered (retail and mail order)	Infertility drugs not covered (retail and mail order).

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
			prescriptions not covered.		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance after deductible	Not Covered	Select outpatient surgeries require prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for any medically necessary covered services which requires an authorization, you, the Member, will be responsible for paying 100% of the total cost.
	Physician/surgeon fees	No charge	20% coinsurance after deductible	Not Covered	
If you need immediate medical attention	Emergency room care	No charge	20% coinsurance after deductible	20% coinsurance after deductible	Initial emergency services are covered with out-of-network providers
	Emergency medical transportation	No charge	20% coinsurance after deductible	20% coinsurance after deductible	None
	Urgent care	No charge	20% coinsurance after deductible	20% coinsurance after deductible	Initial urgent care services are covered with out-of-network providers.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance after deductible	Not Covered	Elective inpatient admissions and services require prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for any medically necessary covered services which requires an authorization, you, the Member, will be responsible for paying 100% of the total cost.
	Physician/surgeon fees	No charge	20% coinsurance after deductible	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	20% coinsurance after deductible	Not Covered	None
	Inpatient services	No charge	20% coinsurance after deductible	Not Covered	None
If you are pregnant	Office visits	No charge	20% coinsurance after deductible	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	No charge	20% coinsurance after deductible	Not Covered	
	Childbirth/delivery facility services	No charge	20% coinsurance after deductible	Not Covered	
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance after deductible	Not Covered	100 visits/contract period. Requires prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for any medically necessary covered services which requires an authorization, you, the Member, will be responsible for paying 100% of the total cost.
	Rehabilitation services	No charge	20% coinsurance after deductible	Not Covered	Inpatient Rehabilitation Care - 150 days/contract period combined with skilled nursing care. Physical and Occupational

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
					Therapy - 20 visits per therapy type/contract period. Speech therapy is unlimited. Services for custodial care are a policy exclusion. Physical, Occupational and Speech Therapy services require prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for any medically necessary covered services which requires an authorization, you, the Member, will be responsible for paying 100% of the total cost.
	Habilitation services	No charge	20% coinsurance after deductible	Not Covered	Habilitative therapies - 20 visits per therapy type/contract period. Speech therapy is unlimited. Services for custodial care are a policy exclusion. Physical, Occupational and Speech Therapy services require prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for any medically necessary covered services which requires an authorization,

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
					you, the Member, will be responsible for paying 100% of the total cost.
	Skilled nursing care	No charge	20% coinsurance after deductible	Not Covered	150 days/contract period combined with inpatient rehabilitative confinement. Requires prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for any medically necessary covered services which requires an authorization, you, the Member, will be responsible for paying 100% of the total cost.
	Durable medical equipment	No charge	20% coinsurance after deductible	Not Covered	Durable medical equipment as stated in our medical policies requires prior authorization from our Medical Affairs Division. Failure to obtain prior authorization for any medically necessary covered services which requires an authorization, you, the Member, will be responsible for paying 100% of the total cost.
	Hospice services	No charge	20% coinsurance after deductible	Not Covered	Requires prior authorization from our Medical Affairs Division. Failure to obtain prior

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
					authorization for any medically necessary covered services which requires an authorization, you, the Member, will be responsible for paying 100% of the total cost.
If your child needs dental or eye care	Children's eye exam	No charge	20% coinsurance after deductible	Not Covered	None
	Children's glasses	No charge	20% coinsurance after deductible	Not Covered	One pair per contract year.
	Children's dental check-up	Not Covered	Not Covered	Not Covered	This policy does not include pediatric dental services as required under the federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact your insurance carrier, agent, or the Federally Facilitated Exchange if you wish to purchase pediatric dental coverage or a stand-alone dental services product.

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 (except in cases when the life of the mother is endangered)
- Acupuncture
- Bariatric Surgery
- Cosmetic services including surgery
- Dental care (Adult)
- Infertility Treatment
- Long-term care
- Non-emergency care when travelling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- 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 one aid per ear every 36 months)
- Private-duty nursing (Limited to 82 visits per Contract Period)

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 877-379-7599 (TTY: 711) or MO-central.medica.com; U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa; Missouri Department of Commerce and Insurance at (573) 751-4126 or https://insurance.mo.gov/consumers; or Healthcare.gov at www.Healthcare.gov or call 1-800-318-2596. 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: Missouri Department of Commerce and Insurance, Division of Consumer Affairs at https://insurance.mo.gov/consumers/complaints/index.php or call 1-800-726-7390.

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 the 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 877-379-7599 (TTY: 711).
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 877-379-7599 (TTY: 711).
Chinese (中文): 如果需要中文的帮助, 请拨打这个号码877-379-7599 (TTY: 711).
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 877-379-7599 (TTY: 711).

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	$3,550
Specialist coinsurance	0%
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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$0**

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

The plan's overall deductible	$3,550
Specialist coinsurance	0%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$0**

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

The plan's overall deductible	$3,550
Specialist coinsurance	0%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$0**

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

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

Discrimination is Against the Law

The Health Plan complies with applicable Federal civil rights laws and will not discriminate against any person based on his or her race, color, creed, religion, national origin, sex, gender, gender identity, health status including mental and physical medical conditions, marital status, familial status, status with regard to public assistance, disability, sexual orientation, age, political beliefs, membership or activity in a local commission, or any other classification protected by law. The Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: TTY communication and written information in other formats such as large print, audio, and braille.
- 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, contact the number on the back of your identification card. If you believe that we have failed to provide these services or discriminated in another way on the basis of your race, color, creed, religion, national origin, sex, gender, gender identity, health status including mental and physical medical conditions, marital status, familial status, status with regard to public assistance, disability, sexual orientation, age, political beliefs, membership or activity in a local commission, or any other classification protected by law, you can file a grievance with: Civil Rights Coordinator, Mail Route CP250, PO Box 9310, Minneapolis, MN 55443-9310, 952-992-3422, 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, TTY: 800-537-7697. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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