

**MEDICA** MO Balance by Medica Gold Share



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/2021BalancePolicies](http://www.medica.com/2021BalancePolicies) or call 877-329-8310. 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 877-329-8310 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$550 Individual / \$1,650 Family for <u>network</u> 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. <u>Preventive care</u> , preventive prescriptions and <u>copay</u> services from <u>network providers</u> are covered before you meet your <u>deductible</u> .	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 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?	\$7,900 Individual/ \$15,800 Family for <u>network</u> 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?	<u>Premiums</u> , <u>balance billing</u> charges and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. Visit <a href="http://www.medica.com/SearchBalance">www.medica.com/SearchBalance</a> or call 877-329-8310 (TTY:711) for a list of <u>network providers</u> .	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 <u>specialist</u> you choose without a <u>referral</u> .



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: 35% <a href="#">coinsurance</a> Retail health clinics 35% <a href="#">coinsurance</a> Chiropractic care: 35% <a href="#">coinsurance</a>	Not covered	35% <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	35% <a href="#">coinsurance</a>	Not covered	---none---
	<a href="#">Preventive care/screening/immunization</a>	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)	35% <a href="#">coinsurance</a>	Not covered	---none---
	Imaging (CT/PET scans, MRIs)	35% <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/GoldSRx3">www.medica.com/GoldSRx3</a> .	Generic drugs	\$5 <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 non-preferred retail drugs, 35% <a href="#">coinsurance</a> 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 section of your Policy of Coverage for more details. No charge for preventive drugs.
	Preferred brand drugs	\$80 <a href="#">copay</a> / prescription. <a href="#">Deductible</a> does not apply.	Not covered	
	Non-Preferred brand drugs	50% <a href="#">coinsurance</a>	Not covered	
	<a href="#">Specialty drugs</a>	Preferred: \$500 <a href="#">copay</a> / prescription. <a href="#">Deductible</a> does not apply Non-Preferred: \$600 <a href="#">copay</a> / prescription. <a href="#">Deductible</a> does not apply	Not covered	

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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)	35% <a href="#">coinsurance</a>	Not covered	*May require prior authorization.
	Physician/surgeon fees	35% <a href="#">coinsurance</a>	Not covered	*May require prior authorization.
If you need immediate medical attention	<a href="#">Emergency room care</a>	35% <a href="#">coinsurance</a>	35% <a href="#">coinsurance</a>	<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>	35% <a href="#">coinsurance</a>	35% <a href="#">coinsurance</a>	<a href="#">Network deductible</a> applies.
	<a href="#">Urgent care</a>	35% <a href="#">coinsurance</a>	35% <a href="#">coinsurance</a>	<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)	35% <a href="#">coinsurance</a>	Not covered	*May require prior authorization.
	Physician/surgeon fees	35% <a href="#">coinsurance</a>	Not covered	*May require prior authorization.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	35% <a href="#">coinsurance</a>	Not covered	*May require prior authorization.
	Inpatient services	35% <a href="#">coinsurance</a>	Not covered	*May require prior authorization.
If you are pregnant	Office visits	Prenatal: 35% <a href="#">coinsurance</a> Postnatal: 35% <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	35% <a href="#">coinsurance</a>	Not covered	
	Childbirth/delivery facility services	35% <a href="#">coinsurance</a>	Not covered	

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.medica.com/2021BalancePolicies](http://www.medica.com/2021BalancePolicies).

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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 need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	35% <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>	35% <a href="#">coinsurance</a>	Not covered	Limited to 20 physical therapy and 20 occupational therapy visits/year.
	<a href="#">Habilitation services</a>	35% <a href="#">coinsurance</a>	Not covered	Limited to 20 physical therapy and 20 occupational therapy visits/year.
	<a href="#">Skilled nursing care</a>	35% <a href="#">coinsurance</a>	Not covered	*May require prior authorization. Limited to 150 days/year.
	<a href="#">Durable medical equipment</a>	35% <a href="#">coinsurance</a>	Not covered	*May require prior authorization.
	<a href="#">Hospice services</a>	35% <a href="#">coinsurance</a>	Not covered	---none---
<b>If your child needs dental or eye care</b>	Children's eye exam	35% <a href="#">coinsurance</a>	Not covered	Coverage limited to end of month member turns 19.
	Children's glasses	35% <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.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.medica.com/2021BalancePolicies](http://www.medica.com/2021BalancePolicies).

**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

### 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 877-329-8310 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](#): \$550
- [Specialist coinsurance](#): 35%
- Hospital (facility) [coinsurance](#): 35%
- Other [coinsurance](#): 35%

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>	\$550
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$3,700
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,320</b>

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

- The [plan's](#) overall [deductible](#): \$550
- [Specialist coinsurance](#): 35%
- Hospital (facility) [coinsurance](#): 35%
- Other [coinsurance](#): 35%

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>	\$550
<a href="#">Copayments</a>	\$500
<a href="#">Coinsurance</a>	\$500
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,550</b>

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

- The [plan's](#) overall [deductible](#): \$550
- [Specialist coinsurance](#): 35%
- Hospital (facility) [coinsurance](#): 35%
- Other [coinsurance](#): 35%

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>	\$550
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$800
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,360</b>

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

