Medica®: EPO00009/PHA04069

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, visit Wellfirstbenefits.com/medicaemployees or call 833-942-2159 (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 www.healthcare.gov/sbc-glossary or call 833-942-2159 (TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$500 / Individual $1,500 / 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 services 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?	$3,500 individual / $7,000 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 wellfirstbenefits.com/find-a-doc/ or call 833-942-2159 (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)	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	**Primary care:** $40 copay/visit. Deductible does not apply. **Chiropractic:** $40 copay/visit. Deductible does not apply. **Virtual:** $25 copay/visit. Deductible does not apply.	Not Covered	In-network primary care visits provided at an outpatient facility may be subject to deductible and coinsurance. No coverage for Chiropractic maintenance or long-term therapy.
	Specialist visit	$40 copay/visit. Deductible does not apply.	Not Covered	In-network specialist visits provided at an outpatient facility may be subject to deductible and coinsurance.
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	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)	**Lab:** No charge. Deductible does not apply. **Xray:** 20% coinsurance after deductible	Not Covered	Lab tests performed in a setting other than office, outpatient hospital/ASC or inpatient hospital will incur deductible and coinsurance cost share.

	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	Not Covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at navitus.com.	Preferred generic drugs (Tier 1)	**Retail:** $15 copay /prescription (retail). Deductible does not apply. **Mail order:** 93-day supply for 2 copays. Deductible does not apply.	Not Covered (retail and mail order)	Up to a 31-day supply/ retail or 93-day supply/ mail order prescription.Insulin: Your cost-share will not exceed $25 per retail prescription unit.
	Non-Preferred generic, Preferred brand drugs (Tier 2)	**Retail:** $55 copay /prescription (retail). Deductible does not apply. **Mail order:** 93-day supply for 2 copays. Deductible does not apply.	Not Covered (retail and mail order)	
	Non-preferred generic, Non-preferred brand drugs (Tier 3)	**Retail:** $100 copay /prescription (retail). Deductible does not apply. **Mail order:** 93-day supply for 2 copays. Deductible does not apply.	Not Covered (retail and mail order)	
	Specialty drugs (Tier 4)	**Preferred:** 20% coinsurance. No more than $200 copay/prescription. Deductible does not apply. **Non-preferred:** 40% coinsurance. Deductible does not apply. **Mail order:** Not covered.	Not Covered (retail and mail order)	Up to a 31-day supply per prescription received from a designated specialty pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	Not Covered	None
	Physician/surgeon fees	20% coinsurance after deductible	Not Covered	
If you need immediate medical attention	Emergency room care	20% coinsurance after deductible	20% coinsurance after in-network deductible	Initial emergency services are covered with out-of-network providers.

	Emergency medical transportation	20% coinsurance after deductible	20% coinsurance after in-network deductible	None
	Urgent care	$40 copay/visit. Deductible does not apply.	$40 copay/visit. Deductible does not apply.	Initial urgent care services are covered with out-of-network providers. Some services received during an urgent care visit may be covered under another benefit in this document. The most specific and appropriate benefit will apply for each service received during an urgent care visit.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	Not Covered	None
	Physician/surgeon fees	20% coinsurance after deductible	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40 copay/visit. Deductible does not apply.	Not Covered	Includes intensive outpatient programs.
	Inpatient services	20% coinsurance after deductible	Not Covered	Residential treatment is covered as part of inpatient services.
If you are pregnant	Office visits	No charge. Deductible does not apply.	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 after deductible	Not Covered	
	Childbirth/delivery facility services	20% coinsurance after deductible	Not Covered	
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	Not Covered	120 visits/calendar year.
	Rehabilitation services	$40 copay/therapy/day. Deductible does not apply.	Not Covered	Services for custodial care are a policy exclusion.
	Habilitation services	$40 copay/therapy/day. Deductible does not apply.	Not Covered	Services for custodial care are a policy exclusion.
	Skilled nursing care	20% coinsurance after deductible	Not Covered	Limited to 120 days/calendar year.
	Durable medical equipment	20% coinsurance after deductible	Not Covered	None

		Insulin pumps/supplies: 20% coinsurance		
	Hospice services	No charge. Deductible does not apply.	Not Covered	None
If your child needs dental or eye care	Children's eye exam	No charge. Deductible does not apply.	Not Covered	None
	Children's glasses	Not Covered	Not Covered	Glasses are not covered by the plan.
	Children's dental check-up	Not Covered	Not Covered	Dental check-ups are not covered by the plan.

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.)

- Cosmetic services including surgery
- Dental care (Adult)
- Dental check-up
- Glasses
- Long-term care
- Non-emergency care when travelling outside the U.S.
- Private-duty nursing
- 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.)

- Acupuncture (Limited to 15 visits per calendar year)
- Bariatric Surgery
- Chiropractic care
- Hearing aids (Limited to one aid per ear every 36 months)
- Infertility Treatment ($5,000 medical/$3,000 pharmacy per calendar year)
- Routine eye care (Adult)

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 Employee Health Plan at 833-942-2159 (TTY: 711); U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/ebsa/healthreform. 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 your **plan** administrator or you may contact Medica Employee Health Plan at Wellfirstbenefits.com/medicaemployees or 833-942-2159 (TTY: 711); You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/ebsa/healthreform.

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? Yes.
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 833-942-2159 (TTY: 711).
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 833-942-2159 (TTY: 711).
Chinese (中文): 如果需要中文的帮助, 请拨打这个号码833-942-2159 (TTY: 711).
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 833-942-2159 (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	$500
Specialist copayment	$40
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	$500
Copayments	$10
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,470**

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

The plan's overall deductible	$500
Specialist copayment	$40
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	$500
Copayments	$900
Coinsurance	$60
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,460**

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

The plan's overall deductible	$500
Specialist copayment	$40
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	$500
Copayments	$200
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,000**

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