MEDICA® **NE Medica with CHI Health Silver Copay 94 CSR**

**Coverage Period: Beginning on or after 01/01/2018**
**Coverage for:** Individual or Family | **Plan Type:** PPO

**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 www.medica.com/members or call 866-269-6803. 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 866-269-6803 to request a copy.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | **$100** Individual / **$300** Family for in-network services, **$20,000** Individual / **$40,000** Family out-of-network. | 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 policy, the overall family deductible must be met before the plan begins to pay. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care, preventive prescriptions, and copay services from in-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?** | **$1,000** Individual/ **$2,000** Family for in-network services. No out-of-pocket limit for out-of-network services. | 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, health care this plan doesn't cover, out-of-network deductible and coinsurance. | 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.** Visit www.medica.com/uninet or call 866-269-6803 (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. |



* For more information about limitations and exceptions, see the plan or policy document at www.medica.com/members.

All 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 |
|---|---|---|---|---|
| | | In-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: $30 copay/ visit. Deductible does not apply.<br>Retail health clinics: $10 copay/ visit for preferred clinics or $20 copay/ visit for non-preferred clinics. Deductible does not apply.<br>Chiropractic care: $30 copay/ visit for chiropractic and osteopathic manipulations. Deductible does not apply. | 50% coinsurance | Manipulations limited to 20 visits/ year. See Rehabilitation & Habilitation for other limits that may apply. |
| | Specialist visit | $60 copay/ visit. Deductible does not apply. | 50% coinsurance | ---none--- |
| | Preventive care/ screening/ immunization | No charge. Deductible does not apply. | 50% coinsurance | You may have to pay for services that aren't 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) | 5% coinsurance | 50% coinsurance | ---none--- |
| | Imaging (CT/PET scans, MRIs) | 5% coinsurance | 50% coinsurance | Prior authorization required for PET scans. |

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| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network Provider (You will pay the least) | Out-of-network Provider (You will pay the most) | |
| **If you need drugs to treat your illness or condition**<br>More information about prescription drug coverage is available at **www.medica.com/ifbpharmacy**. | Generic drugs | Preferred Generic: $5 copay/ prescription. Deductible does not apply.<br>Generic: $10 copay/ prescription. Deductible does not apply. | Not covered | Up to a 31-day supply per prescription. Prior authorization may be required. For non-preferred brand and preferred/non-preferred specialty drugs, 5% 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. 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 | 5% coinsurance | Not covered | |
| | Non-Preferred brand drugs | 25% coinsurance | Not covered | |
| | Specialty drugs | Preferred: 30% coinsurance<br>Non-Preferred: 50% coinsurance | Not covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 5% coinsurance | 50% coinsurance | Prior authorization may be required. |
| | Physician/surgeon fees | 5% coinsurance | 50% coinsurance | Prior authorization may be required. |
| **If you need immediate medical attention** | Emergency room care | 5% coinsurance | Covered as an in-network benefit | ---none--- |
| | Emergency medical transportation | 5% coinsurance | Covered as an in-network benefit | ---none--- |
| | Urgent care | $30 copay/ visit. Deductible does not apply. | Covered as an in-network benefit | ---none--- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 5% coinsurance | 50% coinsurance | Notification required. Prior authorization may be required. |
| | Physician/surgeon fees | 5% coinsurance | 50% coinsurance | ---none--- |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $30 copay/ visit. Deductible does not apply. | 50% coinsurance | ---none--- |
| | Inpatient services | 5% coinsurance | 50% coinsurance | Notification required. Prior authorization may be required. (110048) |

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| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network Provider (You will pay the least) | Out-of-network Provider (You will pay the most) | |
| **If you are pregnant** | Office visits | Prenatal: No charge. Deductible does not apply. Postnatal: 5% coinsurance | 50% coinsurance | Cost sharing does not apply to in-network preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | 5% coinsurance | 50% coinsurance | |
| | Childbirth/delivery facility services | 5% coinsurance | 50% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 5% coinsurance | Not covered | Limited to 60 days/ year. Prior authorization required. |
| | Rehabilitation services | 5% coinsurance | 50% coinsurance | Outpatient physical, occupational, speech and physiotherapy: 45 visits/ year. Outpatient cardiac rehabilitation: 18 visits per event/ year. Outpatient pulmonary rehabilitation: 18 visits/ year. |
| | Habilitation services | 5% coinsurance | 50% coinsurance | Outpatient physical, occupational, speech and physiotherapy: 45 visits/ year. Outpatient cardiac rehabilitation: 18 visits per event/ year. Outpatient pulmonary rehabilitation: 18 visits/ year. |
| | Skilled nursing care | 5% coinsurance | 50% coinsurance | Limited to 60 inpatient days/ year. Prior authorization required. |
| | Durable medical equipment | 5% coinsurance | 50% coinsurance | ---none--- |
| | Hospice services | 5% coinsurance | Not covered | ---none--- |

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| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network Provider (You will pay the least) | Out-of-network Provider (You will pay the most) | |
| **If your child needs dental or eye care** | Children's eye exam | $30 copay/ visit. Deductible does not apply. | 50% coinsurance | Limited to one refractive eye exam/ year to end of month member turns 19. |
| | Children's glasses | 5% coinsurance | 50% coinsurance | Limited to one pair of glasses or contacts/ year to end of month member turns 19. |
| | Children's dental check-up | Not covered | Not covered | No coverage for dental check-ups. |



* For more information about limitations and exceptions, see the plan or policy document at www.medica.com/members.

## 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.)**

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Elective, induced abortions, except as medically necessary to protect the life of the mother
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- 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

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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: Nebraska Department of Insurance, PO Box 82089, Lincoln, NE 68501-2089, 402-471-2201 or 1-877-564-7323. 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 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: Nebraska Department of Insurance, PO Box 82089, Lincoln, NE 68501-2089, 402-471-2201 or 1-877-564-7323.

## Does this plan provide Minimum Essential Coverage? Yes.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

## Does this plan meet 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.

For assistance, call the number included in this document or on the back of your ID card.

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若需要中文协助，请拨打本文件内或您会员卡背面的电话号码。

Para sa tulong sa Tagalog, tawagan ang numerong kabilang sa dokumentong ito o sa likod ng iyong ID card.

Para obtener asistencia en español, llame al número de teléfono que se incluye en este documento o al dorso de su tarjeta de identificación.

---------- *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 prenatal care and a hospital delivery)

- **The plan's overall deductible:** $100
- **Specialist copayment:** $60
- **Hospital (facility) coinsurance:** 5%
- **Other coinsurance:** 5%

**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** | **$12,800** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $100 |
| Copayments | $10 |
| Coinsurance | $600 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$770** |

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

- **The plan's overall deductible:** $100
- **Specialist copayment:** $60
- **Hospital (facility) coinsurance:** 5%
- **Other coinsurance:** 5%

**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** | **$7,400** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $100 |
| Copayments | $500 |
| Coinsurance | $100 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$700** |

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

- **The plan's overall deductible:** $100
- **Specialist copayment:** $60
- **Hospital (facility) coinsurance:** 5%
- **Other coinsurance:** 5%

**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** | **$1,900** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $100 |
| Copayments | $100 |
| Coinsurance | $80 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$280** |

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

## 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 tarjeta 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.

如果您需要免費翻譯此資訊，請致電本文檔中或者在您的Medica ID卡背面包含的號碼。

Nếu quý vị muốn trợ giúp dịch thông tin này miễn phí, hãy gọi vào số có trong tài liệu 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.

إذا كنت تريد مساعدة مجانية في ترجمة هذه المعلومات. فاتصل على الرقم الوارد في هذه الوثيقة أو على ظهر بطاقة تعريف ميديكا الخاصة بك.

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.

ถ้าท่านต้องการความช่วยเหลือในการแปลข้อมูลนี้ฟรี, ให้โทหาเลขหมายที่มีอยู่ในเอกะสารนี้ หรื อยู่ด้านหลังของบัต Medica ของท่าน.

이 정보를 번역하는 데 무료로 도움을 받고 싶으시면, 이 문서에 포함된 전화번호나 Medica ID 카드 뒷면의 전화번호로 전화하십시오.

Si vous voulez une assistance gratuite pour traduire ces informations, appelez le numéro indiqué dans ce document ou au dos de votre carte d'identification Medica.

နမ္ပါအဲ့ဒီ:တ၀်ကျိုးထံစ၊းကလီန္ဂါန၊တ၀်ဂ့၀်တ၀်ကျိုးအံ၊လ၊းအကလီန္ဂဉ်.ကိုးလီတဲစီနိဉ်ဂံ၀်လ၊းအပဉ်ယာ်လ၊းလံာ်တီလံာ်မီအပူ၊းအံ၊မ့တမ့ာ်ဖဲနန္ဂနိုင်ခလေံာ်အုဉ်သးခးကၠအလီာ်ခံတကပ၊းအဖီခိဉ်နှဉ်တကၠာ်.

Kung nais mo ng libreng tulong sa pagsasalin ng impormasyong ito, tawagan ang numero na kasama sa dokumentong ito o sa likod ng iyong Kard ng Medica ID.

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Ako želite besplatnu pomoć za prijevod ovih informacija, nazovite broj naveden u ovom dokumentu ili na poleđini svoje ID kartice Medica.

Díí t'áá jíík'e shá ata' hodoonih nínízingo éí ninaaltsoos Medica bee néího'dílzinígí bine'déé' námboo biká'ígííjį' béésh bee hodíilnih.

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