MEDICA®

OK Harmony by Medica Bronze Copay (Limited)

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/HarmonyPolicies or call 866-839-3961. 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 866-839-3961 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; **$6,850** Individual / **$13,700** Family for non-IHCP in-network services. **$20,550** Individual / **$41,100** Family for out-of-network services.	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 care prescriptions and copay services from non-IHCP 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?	**$7,900** Individual/ **$15,800** Family for non-IHCP in-network services. Not applicable out-of-network.	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/HarmonyProviders or call 866-839-3961 (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 In-Network Provider (You will pay more)	Non-IHCP 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	Primary care: $80 copay/ visit. Deductible does not apply. Retail health clinics: $10 copay/ visit. Deductible does not apply. Chiropractic care: $80 copay/ visit. Deductible does not apply.	50% coinsurance	Cost sharing waived at non-IHCP with IHCP referral.
	Specialist visit	No charge	$160 copay/ visit. Deductible does not apply.	50% coinsurance	Cost sharing waived at non-IHCP with IHCP referral.
	Preventive care/ screening/ immunization	No charge	No charge. Deductible does not apply.	Immunizations covered 0% coinsurance for members to age 18. Deductible does not apply. Other services: 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. Cost sharing waived at non-IHCP with IHCP referral.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	50% coinsurance	50% coinsurance	Cost sharing waived at non-IHCP with IHCP referral.
	Imaging (CT/PET scans, MRIs)	No charge	50% coinsurance	50% coinsurance	*May require prior authorization. Cost sharing waived at non-IHCP with IHCP referral.

Common Medical Event	Services You May Need	What You Will Pay: Indian Health Care Provider (IHCP) (You will pay the least)	What You Will Pay: Non-IHCP In-Network Provider (You will pay more)	What You Will Pay: Non-IHCP Out-of-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at **www.medica.com/ DrugListB**.	Generic drugs	No charge	Preferred Generic: $10 copay/ prescription. Deductible does not apply. Generic: $30 copay/ prescription. Deductible does not apply.	50% coinsurance for diabetic equipment, supplies and drugs. Other drugs or services are not covered.	Up to a 31-day supply per prescription. For non-preferred brand, 50% 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. Cost sharing waived at non-IHCP with IHCP referral.
	Preferred brand drugs	No charge	$160 copay/ prescription. Deductible does not apply.	50% coinsurance for diabetic equipment, supplies and drugs. Other drugs or services are not covered.	
	Non-Preferred brand drugs	No charge	70% coinsurance	50% coinsurance for diabetic equipment, supplies and drugs. Other drugs or services are not covered.	
	Specialty drugs	No charge	Preferred: $600 copay/ prescription. Deductible does not apply Non-Preferred: 50% coinsurance	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	50% coinsurance	50% coinsurance	*May require prior authorization. Cost sharing waived at non-IHCP with IHCP referral.
	Physician/surgeon fees	No charge	50% coinsurance	50% coinsurance	*May require prior authorization. Cost sharing waived at non-IHCP with IHCP referral.

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 In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	No charge	50% coinsurance	50% coinsurance	Non-IHCP in-network deductible applies out-of-network. Cost sharing waived at non-IHCP with IHCP referral.
	Emergency medical transportation	No charge	50% coinsurance	50% coinsurance	Non-IHCP in-network deductible applies out-of-network. Cost sharing waived at non-IHCP with IHCP referral.
	Urgent care	No charge	$80 copay/ visit. Deductible does not apply.	$80 copay/ visit. Deductible does not apply.	Cost sharing waived at non-IHCP with IHCP referral.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	50% coinsurance	50% coinsurance	Rehabilitative and habilitative services each limited to 30 days/ year. *May require prior authorization. Cost sharing waived at non-IHCP with IHCP referral.
	Physician/surgeon fees	No charge	50% coinsurance	50% coinsurance	*May require prior authorization. Cost sharing waived at non-IHCP with IHCP referral.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	$80 copay/ visit. Deductible does not apply. 50% coinsurance for other outpatient services.	50% coinsurance	*May require prior authorization. Other outpatient services include intensive outpatient programs, diagnostic evaluations & psychological testing. Cost sharing waived at non-IHCP with IHCP referral.
	Inpatient services	No charge	50% coinsurance	50% coinsurance	*May require prior authorization. Cost sharing waived at non-IHCP with IHCP referral.
If you are pregnant	Office visits	No charge	Prenatal: 50% coinsurance Postnatal: 50% coinsurance	50% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing waived at non-IHCP with IHCP referral.
	Childbirth/delivery professional services	No charge	50% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	No charge	50% coinsurance	50% coinsurance	

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 In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	50% coinsurance	Not covered	Limited to 30 visits. Extended hours home care limited to 85 visit/year. *May require prior authorization. Cost sharing waived at non-IHCP with IHCP referral.
	Rehabilitation services	No charge	50% coinsurance	50% coinsurance	Physical, occupational and speech therapies limited to 25 visits/year combined in & out-of-network. Cost sharing waived at non-IHCP with IHCP referral.
	Habilitation services	No charge	50% coinsurance	50% coinsurance	Physical, occupational and speech therapies limited to 25 visits/year combined in & out-of-network. Cost sharing waived at non-IHCP with IHCP referral.
	Skilled nursing care	No charge	50% coinsurance	50% coinsurance	Limited to 30 days/year combined in and out-of-network. *May require prior authorization. Cost sharing waived at non-IHCP with IHCP referral.
	Durable medical equipment	No charge	50% coinsurance	50% coinsurance	*May require prior authorization. Cost sharing waived at non-IHCP with IHCP referral.
	Hospice services	No charge	50% coinsurance	Not covered	Cost sharing waived at non-IHCP with IHCP referral.
If your child needs dental or eye care	Children's eye exam	No charge	$80 copay/ visit. Deductible does not apply.	50% coinsurance	Limited to one refractive eye exam/ year to end of month member turns 19. Cost sharing waived at non-IHCP with IHCP referral.
	Children's glasses	No charge	50% coinsurance	50% coinsurance	Limited to one pair of glasses/ year and one pair of contacts/ year to end of month member turns 19. Cost sharing waived at non-IHCP with IHCP referral.
	Children's dental check-up	Not covered	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/HarmonyPolicies.

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 when the life of mother is endangered)
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental check-up
- Infertility treatment
- Long-term care
- Non-emergency care when traveling 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 1 hearing aid per ear every 48 months. 4 additional ear molds for members up to 2 years of age.
- Private duty nursing limited to 85 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 866-269-6806 or the Oklahoma Insurance Department, Consumer Assistance at 1-800-522-0071. 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: Oklahoma Insurance Department, Consumer Assistance at 1-800-522-0071.

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.

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, kwiijigo 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:** $0
- **Specialist copayment:** $0
- **Hospital (facility) coinsurance:** 0%
- **Other coinsurance:** 0%

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	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$60**

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

- **The plan's overall deductible:** $0
- **Specialist copayment:** $0
- **Hospital (facility) coinsurance:** 0%
- **Other coinsurance:** 0%

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	$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:** $0
- **Specialist copayment:** $0
- **Hospital (facility) coinsurance:** 0%
- **Other coinsurance:** 0%

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	$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

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.

اذا 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.

ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປຂໍ້ມູນນີ້ຟຣີ, ໃຫ້ໂທຫາເລກໝາຍທີ່ມີຢູ່ໃນເອກະສານນີ້ ຫຼື ຢູ່ດ້ານຫຼັງຂອງບັດ Medica ຂອງທ່ານ.

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.

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

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