



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 800-918-6164. 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 800-918-6164 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$3,700 Individual / \$11,100 Family for Tier 1 - preferred and \$4,700 Individual / \$14,100 Family for Tier 2 - standard in-network services. No coverage out-of-network . Tier 1 preferred deductible applies to Tier 2-standard deductible . In-network deductible will not exceed Tier 2 limit.	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 ?	\$7,600 Individual/ \$15,200 Family for Tier 1 - preferred and \$7,900 Individual/ \$15,800 Family for Tier 2 - standard in-network services. There is no coverage out-of-network . Tier 1 preferred out-of-pocket applies to Tier 2-standard out-of-pocket . In-network out-of-pocket will not exceed Tier 2 limit.	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.	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/insurenetwork or call 800-918-6164 (TTY:711) for a list of network providers .	This plan uses a provider network . You will pay the least if you use a provider in the Tier 1 - preferred network . You will pay more if you use a provider in the Tier 2 - standard 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 [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
		Tier 1 - Preferred In-Network Provider (You will pay the least)	Tier 2 - Standard In-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	Primary care: \$30 copay / visit. Deductible does not apply. Retail health clinics: \$10 copay / visit. Deductible does not apply. Chiropractic care: \$30 copay / visit for chiropractic and osteopathic manipulations. Deductible does not apply.	Primary care: \$60 copay / visit. Deductible does not apply. Retail health clinics: \$20 copay / visit. Deductible does not apply. Chiropractic care: \$60 copay / visit for chiropractic and osteopathic manipulations. Deductible does not apply.	Not covered	Manipulations limited to 20 visits/ year. See Rehabilitation and Habilitation for other limits that may apply.
	Specialist visit	\$60 copay / visit. Deductible does not apply.	\$120 copay / visit. Deductible does not apply.	Not covered	---none---
	Preventive care/ screening/ immunization	No charge. Deductible does not apply.	No charge. Deductible does not apply.	Not covered	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)	40% coinsurance	40% coinsurance	Not covered	---none---
	Imaging (CT/PET scans, MRIs)	40% coinsurance	40% coinsurance	Not covered	Prior authorization required for PET scans.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions & Other Important Information
		Tier 1 - Preferred In-Network Provider (You will pay the least)	Tier 2 - Standard In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.medica.com/DrugListS .	Generic drugs	Preferred Generic: \$10 copay /prescription. Deductible does not apply. Generic: \$20 copay /prescription. Deductible does not apply.	Covered as a Tier 1- Preferred in-network benefit.	Not covered	Up to a 31-day supply per prescription. Prior authorization may be required. For non- preferred brand and non- preferred specialty drugs, 40% 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	\$120 copay /prescription. Deductible does not apply.	Covered as a Tier 1- Preferred in-network benefit.	Not covered	
	Non- Preferred brand drugs	60% coinsurance	Covered as a Tier 1- Preferred in-network benefit.	Not covered	
	Specialty drugs	Preferred : \$550 copay /prescription. Deductible does not apply. Non- Preferred : 50% coinsurance	Covered as a Tier 1- Preferred in-network benefit.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance	40% coinsurance	Not covered	Prior authorization may be required.
	Physician/surgeon fees	40% coinsurance	40% coinsurance	Not covered	Prior authorization may be required.
If you need immediate medical attention	Emergency room care	40% coinsurance	Covered as a Tier 1- Preferred benefit.	Covered as a Tier 1- Preferred benefit.	---none---
	Emergency medical transportation	40% coinsurance	Covered as a Tier 1- Preferred benefit.	Covered as a Tier 1- Preferred benefit.	---none---
	Urgent care	\$30 copay /visit. Deductible does not apply.	Covered as a Tier 1- Preferred benefit.	Covered as a Tier 1- Preferred benefit.	---none---

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions & Other Important Information
		Tier 1 - Preferred In-Network Provider (You will pay the least)	Tier 2 - Standard In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance	40% coinsurance	Not covered	Notification required. Prior authorization may be required.
	Physician/surgeon fees	40% coinsurance	40% coinsurance	Not covered	---none---
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 copay / visit. Deductible does not apply.	\$60 copay / visit. Deductible does not apply.	Not covered	---none---
	Inpatient services	40% coinsurance	40% coinsurance	Not covered	Notification required. Prior authorization may be required.
If you are pregnant	Office visits	Prenatal: No charge. Deductible does not apply. Postnatal: 40% coinsurance	Prenatal: No charge. Deductible does not apply. Postnatal: 40% coinsurance	Not covered	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	40% coinsurance	40% coinsurance	Not covered	
	Childbirth/delivery facility services	40% coinsurance	40% coinsurance	Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions & Other Important Information
		Tier 1 - Preferred In-Network Provider (You will pay the least)	Tier 2 - Standard In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	40% coinsurance	40% coinsurance	Not covered	Limited to 60 days/ year. Prior authorization required.
	Rehabilitation services	40% coinsurance	40% coinsurance	Not covered	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	40% coinsurance	40% coinsurance	Not covered	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	40% coinsurance	40% coinsurance	Not covered	Limited to 60 inpatient days/ year. Prior authorization required.
	Durable medical equipment	40% coinsurance	40% coinsurance	Not covered	---none---
	Hospice services	40% coinsurance	40% coinsurance	Not covered	---none---
If your child needs dental or eye care	Children's eye exam	\$30 copay / visit. Deductible does not apply.	\$60 copay / visit. Deductible does not apply.	Not covered	Limited to one refractive eye exam/ year to end of month member turns 19.
	Children's glasses	40% coinsurance	40% coinsurance	Not covered	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	Not covered	No coverage for dental check-ups.

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 | ● Hearing aids | ● Private duty nursing |
| ● Bariatric surgery | ● Infertility treatment | ● Routine eye care (Adult) |
| ● Cosmetic surgery | ● Long-term care | ● Routine foot care except for some conditions |
| ● Dental care (Adult) | ● Non-emergency care when traveling outside the U.S. | ● Weight loss programs |
| ● Elective, induced abortions, except as medically necessary to protect the life of the mother | | |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Chiropractic and osteopathic manipulations limited to 20 visits per year

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](#).

Language Access Services:

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

Dine k'ehji shich'i' hadoodzih ninizingo, beesh bee hane'e binumber naaltsoos bikaahigii bich'i' hodiilnih ei doodaii bee neehozin biniye nanitinigii bine'dee bikaa doo aldo'.

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](#): \$3,700
- [Specialist copayment](#): \$60
- Hospital (facility) [coinsurance](#): 40%
- Other [coinsurance](#): 40%

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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$3,700
Copayments	\$20
Coinsurance	\$3,000
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$6,780

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

- The [plan's](#) overall [deductible](#): \$3,700
- [Specialist copayment](#): \$60
- Hospital (facility) [coinsurance](#): 40%
- Other [coinsurance](#): 40%

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$2,300
Copayments	\$700
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$3,000

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

- The [plan's](#) overall [deductible](#): \$3,700
- [Specialist copayment](#): \$60
- Hospital (facility) [coinsurance](#): 40%
- Other [coinsurance](#): 40%

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,700
Copayments	\$100
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,800

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, civilrightscordinator@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.

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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 идентификационной карты Medica.

ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປຂໍ້ມູນນີ້ພໍລິ, 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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Dii t'áá jík'e shá ata' hodoonih nínízingo éi ninaaltsoos Medica bee néího'dílnínígí bine'déé' námbuu biká'ígíjii' béésh bee hodiílnih.

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