MEDICA® **OK Medica Quest Silver Copay Zero**

Coverage Period: Beginning on or after 01/01/2021
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, go to www.medica.com/2021QuestPolicies or call 866-582-7035. 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 866-582-7035 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes.	This plan covers items and services even if you haven't yet met the deductible amount.
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?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Yes. Visit www.medica.com/SearchQuest or call 866-582-7035 (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
		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	No charge	0% coinsurance	If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Specialist visit	No charge	0% coinsurance	If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Preventive care/ screening/ immunization	No charge	0% 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 an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
If you have a test	Diagnostic test (x-ray, blood work)	No charge	0% coinsurance	If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Imaging (CT/PET scans, MRIs)	No charge	0% coinsurance	*May require prior authorization. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at **www.medica.com/ SilverRx3**.	Generic drugs	No charge	0% coinsurance for diabetic equipment, supplies and drugs. Other drugs or services are not covered.	Up to a 31-day supply per prescription. *May require prior authorization. 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. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Preferred brand drugs	No charge	0% coinsurance for diabetic equipment, supplies and drugs. Other drugs or services are not covered.	
	Non-Preferred brand drugs	No charge	0% coinsurance for diabetic equipment, supplies and drugs. Other drugs or services are not covered.	
	Specialty drugs	Preferred: No charge Non-Preferred: No charge	Not covered	

* For more information about limitations and exceptions, see the plan or policy document at www.medica.com/2021QuestPolicies.
^Out-of-Network services received in the state of Oklahoma, except Emergency Services.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	0% coinsurance	*May require prior authorization. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Physician/surgeon fees	No charge	0% coinsurance	*May require prior authorization. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
If you need immediate medical attention	Emergency room care	No charge	No charge	Network deductible applies. If a non-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Emergency medical transportation	No charge	No charge	If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Urgent care	No charge	No charge	Network deductible applies. If a non-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	0% coinsurance	*May require prior authorization. Rehabilitative and habilitative services each limited to 30 days/ year. Notification required. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Physician/surgeon fees	No charge	0% coinsurance	*May require prior authorization. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	0% coinsurance	*May require prior authorization. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Inpatient services	No charge	0% coinsurance	*May require prior authorization. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).

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	No charge	0% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Childbirth/delivery professional services	No charge	0% coinsurance	
	Childbirth/delivery facility services	No charge	0% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	*May require prior authorization. Limited to 30 visits. Extended hours home care limited to 85 visit/year. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Rehabilitation services	No charge	0% coinsurance	Physical, occupational and speech therapies limited to 25 visits/year combined in & out-of-network. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Habilitation services	No charge	0% coinsurance	Physical, occupational and speech therapies limited to 25 visits/year combined in & out-of-network. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Skilled nursing care	No charge	0% coinsurance	*May require prior authorization. Limited to 30 days/year combined in and out-of-network. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Durable medical equipment	No charge	0% coinsurance	*May require prior authorization. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Hospice services	No charge	Not covered	If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).

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	No charge	0% coinsurance	Limited to one refractive eye exam/ year to end of month member turns 19. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Children's glasses	No charge	0% coinsurance	Limited to one pair of glasses/ year and one pair of contacts/ year to end of month member turns 19. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Children's dental check-up	Not covered	Not covered	Coverage is available through a stand-alone dental policy.

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 the mother is endangered)
- 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
- 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 up to 85 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: Medica at 866-582-7035 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 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: Oklahoma Insurance Department, Consumer Assistance at 1-800-522-0071.

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, 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	**$12,700**

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	**$5,600**

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	**$2,800**

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**

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.

ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປຂໍ້ມູນນີ້ຟຣີ, ໃຫ້ໂທຫາເລກໝາຍ ທີ່ມີຢູ່ໃນເອກະສານນີ້ 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.

နမ်းအုပ်ီးတ၊်ကျိုးထံစ၊းကလီန်,နးတ၊်ဂ့၊်တ၊်ကျိုးအံၤလ၊းအကလီန်ဉ်,ကိးလီတဲစိနိဉ်ဂ်၊်လ၊းအပဉ် ယာ့်လ၊းလံာ်တီလံာ်မီအပူၤအံၤမ့တမ့၊်ဖဲနနှိုင်ခလော်အုဉ်သးခးကဲ့အလီၢ်ခံတကပၤအဖီခိဉ်နှဉ်တက့၊်.

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'ígíijį' béésh bee hodíilnih.

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