



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/2022BalancePolicies](http://www.medica.com/2022BalancePolicies) or call 877-329-8310. 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 877-329-8310 to request a copy.

| Important Questions   | Answers  | Why This Matters:   |
|---|--|---|
| <b>What is the overall <a href="#">deductible</a>?</b>                                | \$0 Individual / \$0 Family for in-network services.<br>\$9,900 Individual / \$29,700 Family for out-of-network services.  | Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .  |
| <b>Are there services covered before you meet your <a href="#">deductible</a>?</b>    | Yes. <a href="#">Preventive care</a> , preventive prescriptions and <a href="#">copay</a> services from in-network <a href="#">providers</a> are covered before you meet your <a href="#">deductible</a> . | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits">https://www.healthcare.gov/coverage/preventive-care-benefits</a> .   |
| <b>Are there other <a href="#">deductibles</a> for specific services?</b>             | No.  | You don't have to meet <a href="#">deductibles</a> for specific services.   |
| <b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b> | \$1,850 Individual / \$3,700 Family for in-network services. Not applicable out-of-network.  | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.   |
| <b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>               | <a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, health care this <a href="#">plan</a> doesn't cover, out-of-network <a href="#">deductible</a> and <a href="#">coinsurance</a> .       | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .   |
| <b>Will you pay less if you use a <a href="#">network provider</a>?</b>               | Yes. Visit <a href="http://www.medica.com/FindBalanceProviders">www.medica.com/FindBalanceProviders</a> or call 877-329-8310 (TTY:711) for a list of <a href="#">network providers</a> .                   | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| <b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>    | No.  | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .  |



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<br>(You will pay the least)   | Out-of-Network^ Provider<br>(You will pay the most)  |   |
| If you visit a health care <a href="#">provider's</a> office or clinic | Primary care visit to treat an injury or illness        | Primary care: 15% <a href="#">coinsurance</a><br>Retail health clinics: 15% <a href="#">coinsurance</a><br>Chiropractic care: 15% <a href="#">coinsurance</a> | 50% <a href="#">coinsurance</a>  | ---none---  |
|  | <a href="#">Specialist</a> visit                        | 15% <a href="#">coinsurance</a>   | 50% <a href="#">coinsurance</a>  | ---none---  |
|  | <a href="#">Preventive care/screening</a> /immunization | No charge. <a href="#">Deductible</a> does not apply.   | Immunizations covered 0% <a href="#">coinsurance</a> for members to age 18. <a href="#">Deductible</a> does not apply. Other services: 50% <a href="#">coinsurance</a> | You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for. |
| If you have a test   | <a href="#">Diagnostic test</a> (x-ray, blood work)     | 15% <a href="#">coinsurance</a>   | 50% <a href="#">coinsurance</a>  | ---none---  |
|  | Imaging (CT/PET scans, MRIs)                            | 15% <a href="#">coinsurance</a>   | 50% <a href="#">coinsurance</a>  | *May require prior authorization.   |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.medica.com/2022BalancePolicies](http://www.medica.com/2022BalancePolicies).

^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<br>(You will pay the least)                                       | Out-of-Network^ Provider<br>(You will pay the most)  |  |
| <b>If you need drugs to treat your illness or condition</b><br><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.medica.com/RxList2022">www.medica.com/RxList2022</a> . | Generic drugs                                    | \$0 <a href="#">copay</a> /prescription. <a href="#">Deductible</a> does not apply.   | 50% <a href="#">coinsurance</a> for diabetic equipment, supplies and drugs. Other drugs or services are not covered. | Up to a 31-day supply per prescription.<br>*May require prior authorization. For non-preferred retail drugs, 15% <a href="#">coinsurance</a> 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. Insulin: Your cost-share will not exceed \$25 per retail prescription unit.<br>*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                            | \$65 <a href="#">copay</a> /prescription. <a href="#">Deductible</a> does not apply.  | 50% <a href="#">coinsurance</a> for diabetic equipment, supplies and drugs. Other drugs or services are not covered. |  |
|   | Non-Preferred brand drugs                        | 25% <a href="#">coinsurance</a>   | 50% <a href="#">coinsurance</a> for diabetic equipment, supplies and drugs. Other drugs or services are not covered. |  |
|   | <a href="#">Specialty drugs</a>                  | \$150 <a href="#">copay</a> /prescription. <a href="#">Deductible</a> does not apply. | Not covered  |  |
| <b>If you have outpatient surgery</b>   | Facility fee (e.g., ambulatory surgery center)   | 15% <a href="#">coinsurance</a>   | 50% <a href="#">coinsurance</a>  | *May require prior authorization.  |
|   | Physician/surgeon fees                           | 15% <a href="#">coinsurance</a>   | 50% <a href="#">coinsurance</a>  | *May require prior authorization.  |
| <b>If you need immediate medical attention</b>  | <a href="#">Emergency room care</a>              | 15% <a href="#">coinsurance</a>   | 15% <a href="#">coinsurance</a>  | In-network <a href="#">deductible</a> applies.   |
|   | <a href="#">Emergency medical transportation</a> | 15% <a href="#">coinsurance</a>   | 15% <a href="#">coinsurance</a>  | In-network <a href="#">deductible</a> applies.   |
|   | <a href="#">Urgent care</a>                      | 15% <a href="#">coinsurance</a>   | 15% <a href="#">coinsurance</a>  | In-network <a href="#">deductible</a> applies. If a non-network <a href="#">provider</a> charges more than the <a href="#">allowed amount</a> , you may have to pay the difference ( <a href="#">balance billing</a> ).  |
| <b>If you have a hospital stay</b>  | Facility fee (e.g., hospital room)               | 15% <a href="#">coinsurance</a>   | 50% <a href="#">coinsurance</a>  | *May require prior authorization. Rehabilitative and habilitative services each limited to 30 days/year. Notification required.  |
|   | Physician/surgeon fees                           | 15% <a href="#">coinsurance</a>   | 50% <a href="#">coinsurance</a>  | *May require prior authorization.  |

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| Common Medical Event   | Services You May Need                     | What You Will Pay   |   | Limitations, Exceptions & Other Important Information   |
|--|---|---|---|---|
|  |   | In-Network Provider<br>(You will pay the least)   | Out-of-Network^ Provider<br>(You will pay the most) |   |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                       | 15% <a href="#">coinsurance</a>   | 50% <a href="#">coinsurance</a>                     | *May require prior authorization.   |
|  | Inpatient services                        | 15% <a href="#">coinsurance</a>   | 50% <a href="#">coinsurance</a>                     | *May require prior authorization.   |
| <b>If you are pregnant</b>   | Office visits                             | Prenatal: 15% <a href="#">coinsurance</a><br>Postnatal: 15% <a href="#">coinsurance</a> | 50% <a href="#">coinsurance</a>                     | <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
|  | Childbirth/delivery professional services | 15% <a href="#">coinsurance</a>   | 50% <a href="#">coinsurance</a>                     |   |
|  | Childbirth/delivery facility services     | 15% <a href="#">coinsurance</a>   | 50% <a href="#">coinsurance</a>                     |   |
| <b>If you need help recovering or have other special health needs</b>            | <a href="#">Home health care</a>          | 15% <a href="#">coinsurance</a>   | Not covered   | *May require prior authorization. Limited to 30 visits. Extended hours home care limited to 85 visit/year.  |
|  | <a href="#">Rehabilitation services</a>   | 15% <a href="#">coinsurance</a>   | 50% <a href="#">coinsurance</a>                     | Physical, occupational and speech therapies limited to 25 visits/year combined in & out-of-network.   |
|  | <a href="#">Habilitation services</a>     | 15% <a href="#">coinsurance</a>   | 50% <a href="#">coinsurance</a>                     | Physical, occupational and speech therapies limited to 25 visits/year combined in & out-of-network.   |
|  | <a href="#">Skilled nursing care</a>      | 15% <a href="#">coinsurance</a>   | 50% <a href="#">coinsurance</a>                     | *May require prior authorization. Limited to 30 days/year combined in and out-of-network.   |
|  | <a href="#">Durable medical equipment</a> | 15% <a href="#">coinsurance</a>   | 50% <a href="#">coinsurance</a>                     | *May require prior authorization.   |
|  | <a href="#">Hospice services</a>          | 15% <a href="#">coinsurance</a>   | Not covered   | Respite care is limited to 5 consecutive days, up to a lifetime maximum of 15 inpatient days and 15 outpatient days.  |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.medica.com/2022BalancePolicies](http://www.medica.com/2022BalancePolicies).^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<br>(You will pay the least) | Out-of-Network^ Provider<br>(You will pay the most) |  |
| <b>If your child needs dental or eye care</b> | Children's eye exam        | 15% <a href="#">coinsurance</a>                 | 50% <a href="#">coinsurance</a>                     | Limited to one refractive eye exam/year to end of month member turns 19.                           |
|   | Children's glasses         | 15% <a href="#">coinsurance</a>                 | 50% <a href="#">coinsurance</a>                     | Limited to one pair of glasses/year and one pair of contacts/year to end of month member turns 19. |
|   | Children's dental check-up | Not covered                                     | Not covered   | Coverage is available through a stand-alone dental policy.   |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.medica.com/2022BalancePolicies](http://www.medica.com/2022BalancePolicies).^Out-of-Network services received in the state of Oklahoma, except [Emergency Services](#).

## 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 877-329-8310 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](http://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, kwijigo 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 <a href="#">plan's</a> overall <a href="#">deductible</a> : | \$0 |
| ■ <a href="#">Specialist coinsurance</a> :                        | 15% |
| ■ Hospital (facility) <a href="#">coinsurance</a> :               | 15% |
| ■ Other <a href="#">coinsurance</a> :                             | 15% |

**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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

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

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$0            |
| <a href="#">Copayments</a>        | \$0            |
| <a href="#">Coinsurance</a>       | \$1,700        |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$1,760</b> |

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

|   |     |
|---|-----|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> : | \$0 |
| ■ <a href="#">Specialist coinsurance</a> :                        | 15% |
| ■ Hospital (facility) <a href="#">coinsurance</a> :               | 15% |
| ■ Other <a href="#">coinsurance</a> :                             | 15% |

**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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

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

| Cost Sharing                      |              |
|-----------------------------------|--------------|
| <a href="#">Deductibles</a>       | \$0          |
| <a href="#">Copayments</a>        | \$400        |
| <a href="#">Coinsurance</a>       | \$300        |
| What isn't covered                |              |
| Limits or exclusions              | \$0          |
| <b>The total Joe would pay is</b> | <b>\$700</b> |

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

|   |     |
|---|-----|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> : | \$0 |
| ■ <a href="#">Specialist coinsurance</a> :                        | 15% |
| ■ Hospital (facility) <a href="#">coinsurance</a> :               | 15% |
| ■ Other <a href="#">coinsurance</a> :                             | 15% |

**This EXAMPLE event includes services like:**

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

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

| Cost Sharing                      |              |
|-----------------------------------|--------------|
| <a href="#">Deductibles</a>       | \$0          |
| <a href="#">Copayments</a>        | \$0          |
| <a href="#">Coinsurance</a>       | \$400        |
| What isn't covered                |              |
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$400</b> |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.



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.**

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Wenn Sie bei der Übersetzung dieser Informationen kostenlose Hilfe in Anspruch nehmen möchten, rufen Sie bitte die in diesem Dokument oder auf der Rückseite Ihrer Medica-ID-Karte angegebene Nummer an.