



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/2022ValuePolicies](http://www.medica.com/2022ValuePolicies) 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 <a href="#">deductible</a> ?	\$8,000 Individual / \$16,000 Family for in-network services. \$24,000 Individual / \$48,000 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> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> and preventive prescriptions 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> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$8,700 Individual / \$17,400 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.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<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> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. Visit <a href="http://www.medica.com/FindQuestProviders">www.medica.com/FindQuestProviders</a> or call 866-582-7035 (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.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	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 (You will pay the least)	Out-of-Network^ Provider (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: 10% <a href="#">coinsurance</a> Retail health clinics: 10% <a href="#">coinsurance</a> Chiropractic care: 10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	---none---
	<a href="#">Specialist</a> visit	10% <a href="#">coinsurance</a>	40% <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: 40% <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)	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	---none---
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a>	40% <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/2022ValuePolicies](http://www.medica.com/2022ValuePolicies).

^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)	
<b>If you need drugs to treat your illness or condition</b>  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	10% <a href="#">coinsurance</a>	40% <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. *May require prior authorization. For preferred/non-preferred retail and <a href="#">specialty drugs</a> , 10% <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. *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	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> for diabetic equipment, supplies and drugs. Other drugs or services are not covered.	
	Non-Preferred brand drugs	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> for diabetic equipment, supplies and drugs. Other drugs or services are not covered.	
	<a href="#">Specialty drugs</a>	10% <a href="#">coinsurance</a>	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	*May require prior authorization.
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	*May require prior authorization.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	In-network <a href="#">deductible</a> applies.
	<a href="#">Emergency medical transportation</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	In-network <a href="#">deductible</a> applies.
	<a href="#">Urgent care</a>	10% <a href="#">coinsurance</a>	10% <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)	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	*May require prior authorization.
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	*May require prior authorization.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	*May require prior authorization.
	Inpatient services	10% <a href="#">coinsurance</a>	40% <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/2022ValuePolicies](http://www.medica.com/2022ValuePolicies).^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)	
<b>If you are pregnant</b>	Office visits	Prenatal: 10% <a href="#">coinsurance</a> Postnatal: 10% <a href="#">coinsurance</a>	40% <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	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	10% <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>	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Physical, occupational and speech therapies limited to 25 visits/year combined in & out-of-network.
	<a href="#">Habilitation services</a>	10% <a href="#">coinsurance</a>	40% <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>	10% <a href="#">coinsurance</a>	40% <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>	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	*May require prior authorization.
	<a href="#">Hospice services</a>	10% <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.
<b>If your child needs dental or eye care</b>	Children's eye exam	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Limited to one refractive eye exam/year to end of month member turns 19.
	Children's glasses	10% <a href="#">coinsurance</a>	40% <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/2022ValuePolicies](http://www.medica.com/2022ValuePolicies).^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 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](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 [plan's](#) overall [deductible](#): \$8,000
- [Specialist coinsurance](#): 10%
- Hospital (facility) [coinsurance](#): 10%
- Other [coinsurance](#): 10%

**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>	\$8,000
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$300
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$8,360</b>

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

- The [plan's](#) overall [deductible](#): \$8,000
- [Specialist coinsurance](#): 10%
- Hospital (facility) [coinsurance](#): 10%
- Other [coinsurance](#): 10%

**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>	\$2,300
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$2,600</b>

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

- The [plan's](#) overall [deductible](#): \$8,000
- [Specialist coinsurance](#): 10%
- Hospital (facility) [coinsurance](#): 10%
- Other [coinsurance](#): 10%

**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>	\$2,800
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,800</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.**

ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປຂໍ້ມູນນີ້ຟຣີ, ໃຫ້ໂທຫາເລກໝາຍທີ່ມີຢູ່ໃນເອກະສານນີ້ ຫຼື ຢູ່ດ້ານຫຼ້າຂອງບັດ Medica ຂອງທ່ານ.

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.