



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/InsurePolicies-2023](http://www.Medica.com/InsurePolicies-2023) or call 1-800-918-6164. 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 [www.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 1-800-918-6164 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$0 at Indian Health Care <a href="#">Provider</a> (IHCP) or with IHCP <a href="#">referral</a> at non-IHCP; <b>\$3,000</b> individual / <b>\$6,000</b> family for non-IHCP Tier 1 - preferred <a href="#">network</a> and Tier 2 - standard <a href="#">network</a> services. There is no coverage for non-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 non-IHCP <a href="#">network 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> ?	<b>\$6,000</b> individual / <b>\$12,000</b> family for non-IHCP Tier 1 - preferred and Tier 2 - standard <a href="#">network</a> services. There is no coverage for non-network services.	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 and health care this <a href="#">plan</a> doesn't cover.	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. See <a href="http://www.Medica.com/SearchInsureNetwork-2023">www.Medica.com/SearchInsureNetwork-2023</a> or call 1-800-918-6164 (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 the least if you use a <a href="#">provider</a> in the Tier 1 - preferred <a href="#">network</a> . You will pay more if you use a <a href="#">provider</a> in the Tier 2 - standard <a href="#">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
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP Tier 1 - Preferred and Tier 2 - Standard Network Provider (You will pay more)	Non-IHCP Non-Network Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	No charge	Primary care: 0% <a href="#">coinsurance</a> Retail health clinics: 0% <a href="#">coinsurance</a> Chiropractic care: 0% <a href="#">coinsurance</a> for chiropractic and osteopathic manipulations.	Not covered	Manipulations limited to 20 visits/year. See <a href="#">Rehabilitation</a> and <a href="#">Habilitation</a> for other limits that may apply. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .
	<a href="#">Specialist</a> visit	No charge	Tier 1 - Preferred: 0% <a href="#">coinsurance</a> Tier 2 - Standard: 0% <a href="#">coinsurance</a>	Not covered	<a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .
	<a href="#">Preventive care/screening</a> /immunization	No charge	No charge. <a href="#">Deductible</a> does not apply.	Not covered	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	0% <a href="#">coinsurance</a>	Not covered	<a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .
	Imaging (CT/PET scans, MRIs)	No charge	0% <a href="#">coinsurance</a>	Not covered	*Prior authorization required for PET scans. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .
<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/NEDrugList-2023">www.Medica.com/NEDrugList-2023</a>	Generic drugs	No charge	Preferred Generic: 0% <a href="#">coinsurance</a> Generic: 0% <a href="#">coinsurance</a>	Not covered	Up to a 31-day supply per prescription. *May require prior authorization. For <a href="#">specialty drugs</a> , 0% <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. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .
	Preferred brand drugs	No charge	0% <a href="#">coinsurance</a>	Not covered	
	Non-Preferred brand drugs	No charge	0% <a href="#">coinsurance</a>	Not covered	
	<a href="#">Specialty drugs</a>	No charge	10% <a href="#">coinsurance</a>	Not covered	

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 Tier 1 - Preferred and Tier 2 - Standard Network Provider (You will pay more)	Non-IHCP Non-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	0% <a href="#">coinsurance</a>	Not covered	*May require prior authorization. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .
	Physician/surgeon fees	No charge	0% <a href="#">coinsurance</a>	Not covered	*May require prior authorization. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .
If you need immediate medical attention	<a href="#">Emergency room care</a>	No charge	0% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	<a href="#">Network deductible</a> applies. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .
	<a href="#">Emergency medical transportation</a>	No charge	0% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	<a href="#">Network deductible</a> applies. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .
	<a href="#">Urgent care</a>	No charge	0% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	<a href="#">Network deductible</a> applies. If a non-network provider charges more than the <a href="#">allowed amount</a> , you may have to pay the difference ( <a href="#">balance billing</a> ). <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	0% <a href="#">coinsurance</a>	Not covered	Notification required. *May require prior authorization. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .
	Physician/surgeon fees	No charge	0% <a href="#">coinsurance</a>	Not covered	*May require prior authorization. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	0% <a href="#">coinsurance</a>	Not covered	*May require prior authorization. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .
	Inpatient services	No charge	0% <a href="#">coinsurance</a>	Not covered	Notification required. *May require prior authorization. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .
If you are pregnant	Office visits	No charge	Prenatal: 0% <a href="#">coinsurance</a> Postnatal: 0% <a href="#">coinsurance</a>	Not covered	<a href="#">Cost sharing</a> does not apply to <a href="#">network preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> may apply.
	Childbirth/delivery professional services	No charge	0% <a href="#">coinsurance</a>	Not covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .
	Childbirth/delivery facility services	No charge	0% <a href="#">coinsurance</a>	Not covered	

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 Tier 1 - Preferred and Tier 2 - Standard Network Provider (You will pay more)	Non-IHCP Non-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No charge	0% <a href="#">coinsurance</a>	Not covered	Limited to 4 hours/day; 60 visits/year. *Prior authorization required. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .
	<a href="#">Rehabilitation services</a>	No charge	0% <a href="#">coinsurance</a>	Not covered	Outpatient: Physical, occupational, speech and physiotherapy 45 visits/year; Cardiac <a href="#">rehabilitation</a> 18 visits/year; Pulmonary <a href="#">rehabilitation</a> 18 visits/year. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> . This visit limit does not apply to services for treatment of autism spectrum disorder.
	<a href="#">Habilitation services</a>	No charge	0% <a href="#">coinsurance</a>	Not covered	Outpatient: Physical, occupational, speech and physiotherapy 45 visits/year; Cardiac <a href="#">rehabilitation</a> 18 visits/year; Pulmonary <a href="#">rehabilitation</a> 18 visits/year. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> . This visit limit does not apply to services for treatment of autism spectrum disorder.
	<a href="#">Skilled nursing care</a>	No charge	0% <a href="#">coinsurance</a>	Not covered	Limited to 60 inpatient days/year. *Prior authorization required. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .
	<a href="#">Durable medical equipment</a>	No charge	0% <a href="#">coinsurance</a>	Not covered	*May require prior authorization. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .
	<a href="#">Hospice services</a>	No charge	0% <a href="#">coinsurance</a>	Not covered	<a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .
If your child needs dental or eye care	Children's eye exam	No charge	0% <a href="#">coinsurance</a>	Not covered	Limited to one refractive eye exam/year to end of month member turns 19. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .
	Children's glasses	No charge	0% <a href="#">coinsurance</a>	Not covered	Limited to one pair of glasses or contacts/year to end of month member turns 19. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> .
	Children's dental check-up	Not covered	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, elective, induced, except as medically necessary to protect the life of the mother
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Child) (coverage is available through a stand-alone dental policy)
- Dental check-up
- Hearing aids except for members 18 years of age and younger; coverage is limited to \$3,000 every 48 months per covered child affected by a hearing impairment
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care except for some conditions
- Weight loss programs

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: Medica at 1-800-918-6164 or the Nebraska Department of Insurance, PO Box 95087, Lincoln, NE 68509-5087, 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](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: Medica at 1-800-918-6164 or the Nebraska Department of Insurance, PO Box 95087, Lincoln, NE 68509-5087, 402-471-2201 or 1-877-564-7323.

**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? Not Applicable.**

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 1-888-592-8211.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-592-8211.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-592-8211.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijijigo holne' 1-888-592-8211.

*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)		Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The <a href="#">plan's</a> overall deductible	\$0	■ The <a href="#">plan's</a> overall deductible	\$0	■ The <a href="#">plan's</a> overall deductible	\$0
■ <a href="#">Specialist coinsurance</a>	0%	■ <a href="#">Specialist coinsurance</a>	0%	■ <a href="#">Specialist coinsurance</a>	0%
■ Hospital (facility) <a href="#">coinsurance</a>	0%	■ Hospital (facility) <a href="#">coinsurance</a>	0%	■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	0%	■ Other <a href="#">coinsurance</a>	0%	■ Other <a href="#">coinsurance</a>	0%
<b>This EXAMPLE event includes services like:</b> <a href="#">Specialist</a> office visits ( <i>prenatal care</i> ) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <a href="#">Diagnostic tests</a> ( <i>ultrasounds and blood work</i> ) <a href="#">Specialist</a> visit ( <i>anesthesia</i> )		<b>This EXAMPLE event includes services like:</b> <a href="#">Primary care physician</a> office visits ( <i>including disease education</i> ) <a href="#">Diagnostic tests</a> ( <i>blood work</i> ) <a href="#">Prescription drugs</a> <a href="#">Durable medical equipment</a> ( <i>glucose meter</i> )		<b>This EXAMPLE event includes services like:</b> <a href="#">Emergency room care</a> ( <i>including medical supplies</i> ) <a href="#">Diagnostic test</a> ( <i>x-ray</i> ) <a href="#">Durable medical equipment</a> ( <i>crutches</i> ) <a href="#">Rehabilitation services</a> ( <i>physical therapy</i> )	
<b>Total Example Cost</b>	<b>\$12,700</b>	<b>Total Example Cost</b>	<b>\$5,600</b>	<b>Total Example Cost</b>	<b>\$2,800</b>
<b>In this example, Peg would pay:</b>		<b>In this example, Joe would pay:</b>		<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0	<a href="#">Deductibles</a>	\$0	<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$0	<a href="#">Copayments</a>	\$0	<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0	<a href="#">Coinsurance</a>	\$0	<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$0	Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$60</b>	<b>The total Joe would pay is</b>	<b>\$0</b>	<b>The total Mia would pay is</b>	<b>\$0</b>

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.

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>.

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.