



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/BalancePolicies-24 or call 1-877-329-8310. 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 www.healthcare.gov/sbc-glossary or call 1-877-329-8310 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall deductible ? | \$9,100 individual / \$18,200 family for in-network services. \$27,300 individual / \$54,600 family for out-of-network services. | 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 plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible . |
| Are there services covered before you meet your deductible ? | Yes. Preventive care and preventive prescriptions from 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 ? | \$9,450 individual / \$18,900 family for in-network services. Not applicable out-of-network. | 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, out-of-network deductible and coinsurance . | 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. See www.Medica.com/SearchBalanceNetwork-24 or call 1-877-329-8310 (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 | Primary care: 5% coinsurance Retail health clinics: 5% coinsurance Chiropractic care: 5% coinsurance | 35% coinsurance | None |
| | Specialist visit | 5% coinsurance | 35% coinsurance | None |
| | Preventive care/screening /immunization | No charge. Deductible does not apply. | Immunizations covered 0% coinsurance for members to age 18. Deductible does not apply. Other services: 35% 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 you have a test | Diagnostic test (x-ray, blood work) | 5% coinsurance | 35% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 5% coinsurance | 35% coinsurance | *May require prior authorization. |

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.Medica.com/BalancePolicies-24.

[^]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 need drugs to treat your illness or condition More information about prescription drug coverage is available at www.Medica.com/OKDrugList-24 | Generic drugs | Preferred Generic: 5% coinsurance Generic: 5% coinsurance | 35% 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. For specialty drugs , 5% 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. 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 | 5% coinsurance | 35% coinsurance for diabetic equipment, supplies and drugs. Other drugs or services are not covered. | |
| | Non-Preferred brand drugs | 5% coinsurance | 35% coinsurance for diabetic equipment, supplies and drugs. Other drugs or services are not covered. | |
| | Specialty drugs | 5% coinsurance | Not covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 5% coinsurance | 35% coinsurance | *May require prior authorization. |
| | Physician/surgeon fees | 5% coinsurance | 35% coinsurance | *May require prior authorization. |
| If you need immediate medical attention | Emergency room care | 5% coinsurance | 5% coinsurance | In-network deductible applies. |
| | Emergency medical transportation | 5% coinsurance | 5% coinsurance | In-network deductible applies. |
| | Urgent care | 5% coinsurance | 5% coinsurance | In-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) | 5% coinsurance | 35% coinsurance | *May require prior authorization. |
| | Physician/surgeon fees | 5% coinsurance | 35% coinsurance | *May require prior authorization. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | 5% coinsurance | 35% coinsurance | *May require prior authorization. |
| | Inpatient services | 5% coinsurance | 35% coinsurance | *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 (You will pay the least) | Out-of-Network^ Provider (You will pay the most) | |
| If you are pregnant | Office visits | Prenatal: 5% coinsurance Postnatal: 5% coinsurance | 35% coinsurance | Cost sharing does not apply for preventive services . Depending on the type of services, a copayment , coinsurance , or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |
| | Childbirth/delivery professional services | 5% coinsurance | 35% coinsurance | |
| | Childbirth/delivery facility services | 5% coinsurance | 35% coinsurance | |
| If you need help recovering or have other special health needs | Home health care | 5% coinsurance | Not covered | *May require prior authorization. Limited to 30 visits. Extended hours home care limited to 85 visit/year. |
| | Rehabilitation services | Outpatient physical, occupational, speech therapy: 5% coinsurance Other outpatient Rehabilitation : 5% coinsurance | 35% coinsurance | Physical, occupational and speech therapies limited to 25 visits/year combined in & out-of-network. This visit limit does not apply to services for treatment of autism and autism spectrum disorder. Other outpatient: 30 day limit. |
| | Habilitation services | Outpatient physical, occupational, speech therapy: 5% coinsurance Other outpatient Habilitation : 5% coinsurance | 35% coinsurance | Physical, occupational and speech therapies limited to 25 visits/year combined in & out-of-network. This visit limit does not apply to services for treatment of autism and autism spectrum disorder. Other outpatient: 30 visit limit. |
| | Skilled nursing care | 5% coinsurance | 35% coinsurance | *May require prior authorization. Limited to 30 days/year combined in and out-of-network. |
| | Durable medical equipment | 5% coinsurance | 35% coinsurance | *May require prior authorization. |
| | Hospice services | 5% coinsurance | 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/BalancePolicies-24.^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 your child needs dental or eye care | Children's eye exam | 5% coinsurance | 35% coinsurance | Limited to one refractive eye exam/year to end of month member turns 19. |
| | Children's glasses | 5% coinsurance | 35% coinsurance | 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/BalancePolicies-24.^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) | ● Dental care (Child) (coverage is available through a stand-alone dental policy) | ● Non-emergency care when traveling outside the U.S. |
| ● Acupuncture | ● Dental check-up | ● Routine eye care (Adult) |
| ● Bariatric surgery | ● Infertility treatment | ● Routine foot care |
| ● Cosmetic surgery | ● Long-term care | ● Weight loss programs |
| ● Dental care (Adult) | | |

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 1-877-329-8310, the Oklahoma Insurance Department, Consumer Assistance, 1-800-522-0071 or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa>. 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? 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): Dinekehgo shika at'ohwol ninisingo, kwijjigo 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)

| | |
|-----------------------------------------------------------------|---------|
| ■ The plan's overall deductible | \$9,100 |
| ■ Specialist coinsurance | 5% |
| ■ Hospital (facility) coinsurance | 5% |
| ■ Other coinsurance | 5% |

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 | \$9,100 |
| Copayments | \$0 |
| Coinsurance | \$100 |
| What isn't covered | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$9,260 |

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

| | |
|-----------------------------------------------------------------|---------|
| ■ The plan's overall deductible | \$9,100 |
| ■ Specialist coinsurance | 5% |
| ■ Hospital (facility) coinsurance | 5% |
| ■ Other coinsurance | 5% |

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 | \$2,300 |
| Copayments | \$300 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Joe would pay is | \$2,600 |

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

| | |
|-----------------------------------------------------------------|---------|
| ■ The plan's overall deductible | \$9,100 |
| ■ Specialist coinsurance | 5% |
| ■ Hospital (facility) coinsurance | 5% |
| ■ Other coinsurance | 5% |

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 | \$2,800 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$2,800 |

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.