



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 ?	\$5,900 individual / \$11,800 family for in-network services. \$17,700 individual / \$35,400 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 ?	\$9,100 individual / \$18,200 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: \$40 copay /visit. Deductible does not apply. Retail health clinics: \$20 copay /visit. Deductible does not apply. Chiropractic care: \$40 copay /visit. Deductible does not apply.	50% coinsurance	40% coinsurance for other outpatient services. Primary care visits provided at an outpatient facility may be subject to coinsurance and deductible .
	Specialist visit	\$80 copay /visit. Deductible does not apply.	50% 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: 50% 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)	40% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	40% coinsurance	50% 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: \$20 copay /prescription. Deductible does not apply. Generic: \$20 copay /prescription. Deductible does not apply.	50% 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 non-preferred retail and specialty drugs , \$80 copay for orally-administered cancer treatment medications. Deductible does not apply. 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	\$40 copay /prescription. Deductible does not apply.	50% coinsurance for diabetic equipment, supplies and drugs. Other drugs or services are not covered.	
	Non-Preferred brand drugs	\$80 copay /prescription	50% coinsurance for diabetic equipment, supplies and drugs. Other drugs or services are not covered.	
	Specialty drugs	\$350 copay /prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance	50% coinsurance	*May require prior authorization.
	Physician/surgeon fees	40% coinsurance	50% coinsurance	*May require prior authorization.
If you need immediate medical attention	Emergency room care	40% coinsurance	40% coinsurance	In-network deductible applies.
	Emergency medical transportation	40% coinsurance	40% coinsurance	In-network deductible applies.
	Urgent care	\$60 copay /visit. Deductible does not apply.	\$60 copay /visit. Deductible does not apply.	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)	40% coinsurance	50% coinsurance	*May require prior authorization. Rehabilitative and habilitative services each limited to 30 days/year. Notification required.
	Physician/surgeon fees	40% coinsurance	50% 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 mental health, behavioral health, or substance abuse services	Outpatient services	\$40 copay /visit. Deductible does not apply. 40% coinsurance for other outpatient services	50% coinsurance	*May require prior authorization. Other outpatient services include intensive outpatient programs, diagnostic evaluations & psychological testing.
	Inpatient services	40% coinsurance	50% coinsurance	*May require prior authorization.
If you are pregnant	Office visits	Prenatal: 40% coinsurance Postnatal: 40% coinsurance	50% 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	40% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	40% coinsurance	50% coinsurance	

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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 need help recovering or have other special health needs	Home health care	40% 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: \$40 copay /visit. Deductible does not apply. Other outpatient Rehabilitation : 40% coinsurance	50% 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: \$40 copay /visit. Deductible does not apply. Other outpatient Habilitation : 40% coinsurance	50% 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	40% coinsurance	50% coinsurance	*May require prior authorization. Limited to 30 days/year combined in and out-of-network.
	Durable medical equipment	40% coinsurance	50% coinsurance	*May require prior authorization.
	Hospice services	40% coinsurance	Not covered	Respite care is limited to 5 consecutive days.
If your child needs dental or eye care	Children's eye exam	\$40 copay /visit. Deductible does not apply.	50% coinsurance	Limited to one refractive eye exam/year to end of month member turns 19.
	Children's glasses	40% coinsurance	50% 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 .)		
<ul style="list-style-type: none">● Abortion (except when the life of the mother is endangered)● Acupuncture● Bariatric surgery● Cosmetic surgery● Dental care (Adult)	<ul style="list-style-type: none">● Dental care (Child) (coverage is available through a stand-alone dental policy)● Dental check-up● Infertility treatment● Long-term care	<ul style="list-style-type: none">● 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.)		
<ul style="list-style-type: none">● Chiropractic care	<ul style="list-style-type: none">● Hearing aids limited to 1 hearing aid per ear every 48 months. 4 additional ear molds for members up to 2 years of age	<ul style="list-style-type: none">● 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	\$5,900
■ Specialist copayment	\$80
■ Hospital (facility) coinsurance	40%
■ Other coinsurance	40%

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$5,900
Copayments	\$10
Coinsurance	\$2,100
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$8,070

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

■ The plan's overall deductible	\$5,900
■ Specialist copayment	\$80
■ Hospital (facility) coinsurance	40%
■ Other coinsurance	40%

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,100
Copayments	\$800
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$1,900

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

■ The plan's overall deductible	\$5,900
■ Specialist copayment	\$80
■ Hospital (facility) coinsurance	40%
■ Other coinsurance	40%

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,600
Copayments	\$200
Coinsurance	\$0
<i>What isn't covered</i>	
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>.

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.