



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/PinnaclePolicies-2024](http://www.Medica.com/PinnaclePolicies-2024) or call 1-877-347-0267. 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 1-877-347-0267 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<b>\$1,700</b> individual / <b>\$3,400</b> family for <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> , preventive prescriptions and <a href="#">copay</a> services from <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>\$8,700</b> individual / <b>\$17,400</b> family for <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/SearchPinnacleNetwork-2024">www.Medica.com/SearchPinnacleNetwork-2024</a> or call 1-877-347-0267 (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
		Network Provider (You will pay the least)	Non-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="#">copay</a> /visit. <a href="#">Deductible</a> does not apply. Retail health clinics: \$10 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply. Chiropractic care: \$10 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	Not covered	30% <a href="#">coinsurance</a> for other outpatient services. Primary care visits provided at an outpatient facility may be subject to <a href="#">coinsurance</a> and <a href="#">deductible</a> . Limited to 20 visits/year for chiropractic care. Visits with Medica's designated Virtual Care <a href="#">providers</a> are covered at No Charge, <a href="#">deductible</a> does not apply.
	<a href="#">Specialist</a> visit	\$85 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	Not covered	None
	<a href="#">Preventive care/screening</a> /immunization	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. Limited to one physical exam/year, unless additional visits are necessary.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	30% <a href="#">coinsurance</a>	Not covered	None
	Imaging (CT/PET scans, MRIs)	30% <a href="#">coinsurance</a>	Not covered	*May require prior authorization.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="http://www.Medica.com/AZDrugList-2024">prescription drug coverage</a> is available at <a href="http://www.Medica.com/AZDrugList-2024">www.Medica.com/AZDrugList-2024</a>	Generic drugs	Preferred Generic: \$0 <a href="#">copay</a> /prescription. <a href="#">Deductible</a> does not apply. Generic: \$15 <a href="#">copay</a> /prescription. <a href="#">Deductible</a> does not apply.	Not covered	Up to a 31-day supply per prescription. *May require prior authorization. For non-preferred retail and <a href="#">specialty drugs</a> , \$85 <a href="#">copay</a> for orally-administered cancer treatment medications. <a href="#">Deductible</a> 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	\$80 <a href="#">copay</a> /prescription. <a href="#">Deductible</a> does not apply.	Not covered	
	Non-Preferred brand drugs	50% <a href="#">coinsurance</a>	Not covered	
	<a href="#">Specialty drugs</a>	\$550 <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)	30% <a href="#">coinsurance</a>	Not covered	*May require prior authorization.
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	Not covered	*May require prior authorization.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Network deductible</a> applies.
	<a href="#">Emergency medical transportation</a>	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Network deductible</a> applies.
	<a href="#">Urgent care</a>	\$10 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	\$10 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	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)	30% <a href="#">coinsurance</a>	Not covered	*May require prior authorization.
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	Not covered	*May require prior authorization.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$10 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	Not covered	30% <a href="#">coinsurance</a> for other outpatient services. Other outpatient services include intensive outpatient programs, diagnostic evaluations and psychological testing. *May require prior authorization.
	Inpatient services	30% <a href="#">coinsurance</a>	Not covered	*May require prior authorization.
If you are pregnant	Office visits	Prenatal: 30% <a href="#">coinsurance</a> Postnatal: 30% <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. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). *May require prior authorization.
	Childbirth/delivery professional services	30% <a href="#">coinsurance</a>	Not covered	
	Childbirth/delivery facility services	30% <a href="#">coinsurance</a>	Not covered	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	30% <a href="#">coinsurance</a>	Not covered	*May require prior authorization. Limited to 42 visits per member per year.
	<a href="#">Rehabilitation services</a>	30% <a href="#">coinsurance</a>	Not covered	Outpatient: Physical, occupational, speech, cardiac, and pulmonary limited to 60 visits combined/year. This visit limit does not apply to services for treatment of autism spectrum disorder.
	<a href="#">Habilitation services</a>	30% <a href="#">coinsurance</a>	Not covered	Outpatient: Physical, occupational, speech, cardiac, and pulmonary limited to 60 visits combined/year. This visit limit does not apply to services for treatment of autism spectrum disorder.
	<a href="#">Skilled nursing care</a>	30% <a href="#">coinsurance</a>	Not covered	*May require prior authorization. Limited to 90 days/year.
	<a href="#">Durable medical equipment</a>	30% <a href="#">coinsurance</a>	Not covered	*May require prior authorization.
	<a href="#">Hospice services</a>	30% <a href="#">coinsurance</a>	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	\$10 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	Not covered	Limited to one refractive eye exam/year to end of month member turns 19.
	Children's glasses	30% <a href="#">coinsurance</a>	Not covered	Coverage is limited to one pair of frames every calendar year and one pair of lenses every calendar year. Contact lenses are limited to once every calendar year.
	Children's dental check-up	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 | ● 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   | ● Private-duty nursing                               |
| ● Chiropractic care exceeding 20 visits per member per year                                    | ● Hearing aids (exceeding 1 hearing aid per ear, per year)                        | ● Routine eye care (Adult)                           |
| ● Cosmetic surgery   | ● Infertility treatment   | ● Routine foot care except for some conditions       |
| ● Dental care (Adult)  | ● Long-term care  | ● Weight loss programs                               |

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)**

- Bariatric surgery with prior authorization



**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 1-877-347-0267 or the Arizona Department of Insurance, 100 N. 15th Avenue, Suite 102, Phoenix, AZ 85007-2624, Phone No. 1-602-364-2499 or 1-800-325-2548. 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 1-877-347-0267 or the Arizona Department of Insurance, 100 N. 15th Avenue, Suite 102, Phoenix, AZ 85007-2624, Phone No. 1-602-364-2499 or 1-800-325-2548.

**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)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,700
■ <a href="#">Specialist copayment</a>	\$85
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	30%

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

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,700
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$2,800
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,560</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>	\$1,700
■ <a href="#">Specialist copayment</a>	\$85
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	30%

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

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,100
<a href="#">Copayments</a>	\$600
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,700</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>	\$1,700
■ <a href="#">Specialist copayment</a>	\$85
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	30%

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

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,700
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,200</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>.

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.