



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](http://www.Medica.com) or call 1 (877) 335-9108 (TTY: 711). 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) 335-9108 (TTY: 711) to request a copy.

| Important Questions                                                             | Answers                                                                                                                                                                                                     | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | <b>\$1,500</b> per person / <b>\$3,000</b> per family in-network and <b>\$3,000</b> per person / <b>\$6,000</b> per 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> , lab services, preventive prescriptions, <a href="#">copayments</a> , virtual care and <a href="#">prescription drugs</a> from in-network <a href="#">providers</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>\$4,000</b> per person / <b>\$8,000</b> per family in-network. <b>\$8,000</b> per person / <b>\$16,000</b> per family for out-of-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/FindCare">www.Medica.com/FindCare</a> or call 1 (877) 335-9108 (TTY: 711) for a list of Medica with CHI Health <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 don't need a <a href="#">referral</a> to see a <a href="#">specialist</a> .                                                                                                                         | 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<br>(You will pay the least)                                                                                                                                                                                                                                                                                                                                                             | Out-of-Network Provider<br>(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       | <b>Primary care:</b> \$30 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.<br><b>Chiropractic:</b> \$30 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.<br><b>Retail Health:</b> \$15 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.<br><b>Virtual:</b> <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply. | <b>Primary:</b> 40% <a href="#">coinsurance</a><br><b>Chiropractic:</b> 40% <a href="#">coinsurance</a><br><b>Retail Health:</b> 40% <a href="#">coinsurance</a><br><b>Virtual:</b> 40% <a href="#">coinsurance</a> | In-network primary care visits provided at an outpatient facility may be subject to <a href="#">coinsurance</a> and <a href="#">deductible</a> . Limited to 30 visits per member, per year for chiropractic care. |
|                                                                        | <a href="#">Specialist</a> visit                       | \$60 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.                                                                                                                                                                                                                                                                                                                               | 40% <a href="#">coinsurance</a>                                                                                                                                                                                     | In-network <a href="#">specialist</a> visits provided at an outpatient facility may be subject to <a href="#">coinsurance</a> and <a href="#">deductible</a> .                                                    |
|                                                                        | <a href="#">Preventive care/screening/immunization</a> | No charge. <a href="#">Deductible</a> does not apply.                                                                                                                                                                                                                                                                                                                                                       | 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)    | <b>Lab:</b> No charge. <a href="#">Deductible</a> does not apply.<br><b>X-ray:</b> 20% <a href="#">coinsurance</a>                                                                                                                                                                                                                                                                                          | <b>Lab:</b> 40% <a href="#">coinsurance</a><br><b>X-ray:</b> 40% <a href="#">coinsurance</a>                                                                                                                        | None                                                                                                                                                                                                              |
|                                                                        | Imaging (CT/PET scans, MRIs)                           | 20% <a href="#">coinsurance</a>                                                                                                                                                                                                                                                                                                                                                                             | 40% <a href="#">coinsurance</a>                                                                                                                                                                                     | None                                                                                                                                                                                                              |

| Common Medical Event                                                                                                                                                                                                                                  | Services You May Need                            | What You Will Pay                                                                                                                                                                                                                                                         |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                         |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                       |                                                  | In-Network Provider<br>(You will pay the least)                                                                                                                                                                                                                           | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="http://www.Medica.com/DrugCost8">prescription drug coverage</a> is available at <a href="http://www.Medica.com/DrugCost8">www.Medica.com/DrugCost8</a> | Generic drugs                                    | <b>Preventive:</b> Designated preventive drugs: No charge. <a href="#">Deductible</a> does not apply.<br><b>Retail:</b> \$10/prescription. <a href="#">Deductible</a> does not apply.<br><b>Mail order:</b> \$30/prescription. <a href="#">Deductible</a> does not apply. | 40% <a href="#">coinsurance</a>                    | Up to a 31-day supply/retail or 93-day supply/mail order prescription.<br>Mail order drugs not covered out-of-network.<br>Insulin: Your cost-share will not exceed \$25 per retail prescription unit.<br>ACA preventive drugs covered at no charge. <a href="#">Deductible</a> does not apply. |
|                                                                                                                                                                                                                                                       | Preferred brand drugs                            | <b>Preventive:</b> Designated preventive drugs: No charge. <a href="#">Deductible</a> does not apply.<br><b>Retail:</b> \$30/prescription. <a href="#">Deductible</a> does not apply.<br><b>Mail order:</b> \$90/prescription. <a href="#">Deductible</a> does not apply. | 40% <a href="#">coinsurance</a>                    |                                                                                                                                                                                                                                                                                                |
|                                                                                                                                                                                                                                                       | Non-preferred brand drugs                        | <b>Preventive:</b> Benefit does not apply.<br><b>Retail:</b> \$50/prescription. <a href="#">Deductible</a> does not apply.<br><b>Mail order:</b> \$150/prescription. <a href="#">Deductible</a> does not apply.                                                           | 40% <a href="#">coinsurance</a>                    |                                                                                                                                                                                                                                                                                                |
|                                                                                                                                                                                                                                                       | <a href="#">Specialty drugs</a>                  | <b>Preferred:</b> 20% <a href="#">coinsurance</a> . No more than \$200 <a href="#">copay</a> /prescription. <a href="#">Deductible</a> does not apply.<br><b>Non-Preferred:</b> 40% <a href="#">coinsurance</a> . <a href="#">Deductible</a> does not apply.              | Not covered                                        | Up to a 31-day supply per prescription received from a designated specialty pharmacy.                                                                                                                                                                                                          |
| <b>If you have outpatient surgery</b>                                                                                                                                                                                                                 | Facility fee (e.g., ambulatory surgery center)   | 20% <a href="#">coinsurance</a>                                                                                                                                                                                                                                           | 40% <a href="#">coinsurance</a>                    | None                                                                                                                                                                                                                                                                                           |
|                                                                                                                                                                                                                                                       | Physician/surgeon fees                           | 20% <a href="#">coinsurance</a>                                                                                                                                                                                                                                           | 40% <a href="#">coinsurance</a>                    | None                                                                                                                                                                                                                                                                                           |
| <b>If you need immediate medical attention</b>                                                                                                                                                                                                        | <a href="#">Emergency room care</a>              | 20% <a href="#">coinsurance</a>                                                                                                                                                                                                                                           | 20% <a href="#">coinsurance</a>                    | In-network <a href="#">deductible</a> and out-of-pocket applies.                                                                                                                                                                                                                               |
|                                                                                                                                                                                                                                                       | <a href="#">Emergency medical transportation</a> | 20% <a href="#">coinsurance</a>                                                                                                                                                                                                                                           | 20% <a href="#">coinsurance</a>                    | In-network <a href="#">deductible</a> and out-of-pocket applies.                                                                                                                                                                                                                               |
|                                                                                                                                                                                                                                                       | <a href="#">Urgent care</a>                      | \$30 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.                                                                                                                                                                                             | 40% <a href="#">coinsurance</a>                    | None                                                                                                                                                                                                                                                                                           |

| Common Medical Event                                                      | Services You May Need                     | What You Will Pay                                                                                                                                   |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                          |
|---------------------------------------------------------------------------|-------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                           | In-Network Provider<br>(You will pay the least)                                                                                                     | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                 |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)        | 20% <a href="#">coinsurance</a>                                                                                                                     | 40% <a href="#">coinsurance</a>                    | None                                                                                                                                                                                                                                                                                                                                            |
|                                                                           | Physician/surgeon fees                    | 20% <a href="#">coinsurance</a>                                                                                                                     | 40% <a href="#">coinsurance</a>                    | None                                                                                                                                                                                                                                                                                                                                            |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | \$30 <a href="#">copay</a> /office visit. <a href="#">Deductible</a> does not apply. 20% <a href="#">coinsurance</a> for other outpatient services. | 40% <a href="#">coinsurance</a>                    | Other outpatient services include intensive outpatient programs, diagnostic evaluations and psychological testing. *May require prior authorization.                                                                                                                                                                                            |
|                                                                           | Inpatient services                        | 20% <a href="#">coinsurance</a>                                                                                                                     | 40% <a href="#">coinsurance</a>                    | Residential treatment is covered as part of inpatient services.                                                                                                                                                                                                                                                                                 |
| If you are pregnant                                                       | Office visits                             | No charge. <a href="#">Deductible</a> does not apply.                                                                                               | 40% <a href="#">coinsurance</a>                    | <a href="#">Cost sharing</a> does not apply to in-network <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., certain ultrasounds.) |
|                                                                           | Childbirth/delivery professional services | 20% <a href="#">coinsurance</a>                                                                                                                     | 40% <a href="#">coinsurance</a>                    |                                                                                                                                                                                                                                                                                                                                                 |
|                                                                           | Childbirth/delivery facility services     | 20% <a href="#">coinsurance</a>                                                                                                                     | 40% <a href="#">coinsurance</a>                    |                                                                                                                                                                                                                                                                                                                                                 |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>          | 20% <a href="#">coinsurance</a>                                                                                                                     | 40% <a href="#">coinsurance</a>                    | Limited to 60 visits per member per year in and out-of-network combined.                                                                                                                                                                                                                                                                        |
|                                                                           | <a href="#">Rehabilitation services</a>   | \$30 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.                                                                       | 40% <a href="#">coinsurance</a>                    | Outpatient physical, occupational, and speech therapy combined for Rehabilitative and Habilitative, in-network and out-of-network: 60 visits/year. Visit limits are not applicable to behavioral health conditions.                                                                                                                             |
|                                                                           | <a href="#">Habilitation services</a>     | \$30 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.                                                                       | 40% <a href="#">coinsurance</a>                    | Outpatient physical, occupational, and speech therapy combined for Rehabilitative and Habilitative, in-network and out-of-network: 60 visits/year. Visit limits are not applicable to behavioral health conditions.                                                                                                                             |
|                                                                           | <a href="#">Skilled nursing care</a>      | 20% <a href="#">coinsurance</a>                                                                                                                     | 40% <a href="#">coinsurance</a>                    | 60-day limit combined in and out-of-network per member per year.                                                                                                                                                                                                                                                                                |
|                                                                           | <a href="#">Durable medical equipment</a> | 20% <a href="#">coinsurance</a>                                                                                                                     | 40% <a href="#">coinsurance</a>                    | None                                                                                                                                                                                                                                                                                                                                            |
|                                                                           | <a href="#">Hospice services</a>          | 20% <a href="#">coinsurance</a>                                                                                                                     | 40% <a href="#">coinsurance</a>                    | None                                                                                                                                                                                                                                                                                                                                            |
| If your child needs dental or eye care                                    | Children's eye exam                       | Not covered                                                                                                                                         | Not covered                                        | None                                                                                                                                                                                                                                                                                                                                            |
|                                                                           | Children's glasses                        | Not covered                                                                                                                                         | Not covered                                        | Glasses are not covered by the <a href="#">plan</a> .                                                                                                                                                                                                                                                                                           |
|                                                                           | Children's dental check-up                | Not covered                                                                                                                                         | Not covered                                        | Dental check-ups are not covered by the <a href="#">plan</a> .                                                                                                                                                                                                                                                                                  |



**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 other [excluded services](#).)**

- |                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                 |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Bariatric surgery</li> <li>• Chiropractic care exceeding 30 visits per member per year</li> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> </ul> | <ul style="list-style-type: none"> <li>• Dental check-up</li> <li>• Glasses</li> <li>• Hearing aids except for members under age 19; coverage is limited to \$3,000 every 48 months per covered child affected by a hearing impairment</li> </ul> | <ul style="list-style-type: none"> <li>• Infertility treatment</li> <li>• Long-term care</li> <li>• Private-duty nursing</li> <li>• Routine eye care (Adult)</li> <li>• Routine foot care except for some conditions</li> <li>• Weight loss programs</li> </ul> |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

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

- Non-emergency care when traveling outside the U.S.

**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 **1 877-335-9108** (TTY: **711**) for group health coverage subject to ERISA, Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform); for all other group health coverage, Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). 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: for group health coverage subject to ERISA, Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform); for all other group health coverage you may also contact Medica at **1 877-335-9108** (TTY: **711**) or the Nebraska Department of Insurance, PO Box 95087, Lincoln, NE 68509-5087, 402-471-0888 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 the Minimum Value Standard? Yes.**

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 (800) 952-3455** (TTY: **711**).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1 (800) 952-3455** (TTY: **711**).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 **1 (800) 952-3455** (TTY: **711**).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' **1 (800) 952-3455** (TTY: **711**).

*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> | \$1,500 |
| ■ <a href="#">Specialist copayment</a>                          | \$60    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%     |
| ■ Other <a href="#">coinsurance</a>                             | 20%     |

**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>       | \$1,500        |
| <a href="#">Copayments</a>        | \$10           |
| <a href="#">Coinsurance</a>       | \$1,700        |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$3,270</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> | \$1,500 |
| ■ <a href="#">Specialist copayment</a>                          | \$60    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%     |
| ■ Other <a href="#">coinsurance</a>                             | 20%     |

**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>       | \$800          |
| <a href="#">Copayments</a>        | \$400          |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Joe would pay is</b> | <b>\$1,200</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> | \$1,500 |
| ■ <a href="#">Specialist copayment</a>                          | \$60    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%     |
| ■ Other <a href="#">coinsurance</a>                             | 20%     |

**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>       | \$1,500        |
| <a href="#">Copayments</a>        | \$200          |
| <a href="#">Coinsurance</a>       | \$100          |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,800</b> |

Note: The amount the patient pays assumes the patient is not participating in a Flexible Spending Account (FSA), a Health Savings Account (HSA), or a Health Reimbursement Arrangement (HRA), including an HRA funded through a Voluntary Employee Beneficiary Association (VEBA-HRA). If you have a FSA, HSA, HRA, or VEBA-HRA, then you may have additional funds that could help cover certain out-of-pocket expenses such as [deductibles](#), [copayments](#), [coinsurance](#), and benefits otherwise not covered.

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

**Notice of Availability of Language Assistance Services and Auxiliary Aids and Services**

**English:** ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-952-3455 (TTY: 711) for Medica, call 1-877-317-2410 (TTY: 711) for Dean Health Plan/Prevea360 Health Plan, or speak to your provider.

**Spanish:** ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia de idiomas. También están disponibles de forma gratuita asistencia y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-952-3455 (TTY: 711) para Medica, llame al 1-877-317-2410 (TTY: 711) para Dean Health Plan/Prevea360 Health Plan o hable con su proveedor de atención médica.

**Vietnamese/Việt:** LƯU Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-952-3455 (TTY: 711) đối với Medica, gọi theo số 1-877-317-2410 (TTY: 711) đối với Dean Health Plan/Prevea360 Health Plan hoặc trao đổi với nhà cung cấp dịch vụ của quý vị.

**Chinese Traditional:** 注意：如果您說中文，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-800-952-3455 (TTY: 711) 聯絡 Medica，致電 1-877-317-2410 (TTY: 711) 聯絡 Dean Health Plan/Prevea360 Health Plan，或與您的提供者討論。

**Hmong/Lus Hmoob:** LUS CEEV: Yog hais tias koj hais Lus Hmoob ces muaj kev pab txhais lus pub dawb rau koj. Muaj khoom siv thiab muaj kev saib xyuas pab uas tsim nyog los npaj kom muaj cov ntaub ntawv uas siv tau dawb. Hu rau 1-800-952-3455 (TTY: 711) rau Medica, hu rau 1-877-317-2410 (TTY: 711) rau Dean Health Plan/Prevea360 Health Plan, los sis tham rau koj tus kws kuaj mob.

**German/Deutsch:** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzen zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-800-952-3455 (TTY: 711) für Medica bzw. 1-877-317-2410 (TTY: 711) für Dean Health Plan/Prevea360 Health Plan oder sprechen Sie mit Ihrem Gesundheitsdienstleister.

**Cushitic-Oromo:** XIYYEEFFANNOO: Ingiliffaa dubbattu taanaan, tajaajilli deggersa afaan bilisaa ni jira. Tajaajilli deggersa bu'ura dhiheessii odeeffannoo kaffaltii tokko malee ni jira. Lakkoofsa bilbilaa 1-800-952-3455 (TTY: 711) Tajaajila Fayyaaf, lakkoofsa Medica 1-877-317-2410 (TTY: 711), Dean Health Plan/Prevea360 Health Plan, ykn dhiheessaa keessan dubbisaa.

**Arabic/العربية**

كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. تنبيه: (الهاتف النصي: 711) للتواصل مع 1-800-952-3455 اتصل على الرقم المعلومات بتنسيقات يمكن الوصول إليها مجانًا. Dean Health، اتصل على الرقم 1-877-317-2410 (الهاتف النصي: 711) بشأن خطة الرعاية الصحية Medica Plan/Prevea360 Health Plan

**Korean/한국어:** 주의: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. Medica 의 경우 1-800-952-3455(TTY: 711)번으로, Dean Health Plan/Prevea360 Health Plan 의 경우 1-877-317-2410(TTY: 711)번으로 전화하시거나, 서비스 제공업체에 문의하십시오.

**Russian/Русский:** Если вы говорите по-русски, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-952-3455 (TTY: 711) относительно Medica, позвоните по телефону 1-877-317-2410 (TTY: 711) относительно Dean Health Plan/Prevea360 Health Plan или обратитесь к своему поставщику услуг.

**Laos/ ລາວ:** ຂໍຄວນເອົາໃຈໃສ່: ຖ້າທ່ານເວົ້າພາສາລາວ, ຈະມີບໍລິການຊ່ວຍເຫຼືອພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ນອກຈາກນີ້ ຈະມີເຄື່ອງຊ່ວຍເຫຼືອ ແລະ ບໍລິການແບບທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້ໂດຍບໍ່ເສຍຄ່າ. ໂທຫາໂປ 1-800-952-3455 (TTY: 711) ສໍາລັບ Medica, ໂທ 1-877-317-2410 (TTY: 711) ສໍາລັບ Dean Health Plan/Prevea360 Health Plan ຫຼື ວິມັກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

**French/ Français:** ATTENTION : si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-952-3455 (TTY : 711) pour Medica, appelez le 1-877-317-2410 (TTY : 711) pour le régime de santé Dean Health Plan/Prevea360, ou parlez à votre prestataire de santé.

**Serbo-Croatian:** PAŽNJA: Ako govorite srpski, dostupne su vam besplatne usluge tumača. Odgovarajuća dodatna pomagala i usluge za pružanje informacija u pristupačnim formatima su također dostupne besplatno. Za Medica zdravstveno osiguranje pozovite 1-800-952-3455 (TTY: 711), za Dean/Prevea360 zdravstveno osiguranje pozovite 1-877-317-2410 (TTY: 711) ili razgovarajte sa svojim pružaocem usluga.

**Tagalog:** PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyonang tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-952-3455 (TTY: 711) para sa Medica, tumawag sa 1-877-317-2410 (TTY: 711) para sa Dean Health Plan/Prevea360 Health Plan, o makipag-usap sa iyong tagapagbigay ng serbisyo.

**Karen/ ထာနုာ်လီၤဖဲအံၤ:** ဟံသုာ်ဟံသး- နမ့ၢ်ကတိၤကညီၣ်န့ၢ် တၢ်အိၣ်ဒီး ကျိၣ်တၢ်ဆိၣ်ထွဲမၤစၢၤ လၢတလၢာ်ဘျုးလၢာ်လၢနဂီၢ်လီၤ. တၢ်အိၣ်ဒီး ပုၤနီၣ်ခိၣ်ကိၤတဆူၣ်တကျါအဂီၢ် ပီးလီၤဒီးတၢ်တိၤမၤစၢၤလၢအကြးအဘျုး လၢကဟ့ၣ်တၢ်ဂ့ၢ်တၢ်ကျိၣ် လၢတၢ်မၤန့ၢ်အိၣ်သ့တဖၣ် လၢတလၢာ်ဘျုးလၢာ်လၢနဂီၢ်လီၤ. ကိး 1-800-952-3455 (TTY: 711) လၢ Medica အဂီၢ်, ကိး 1-877-317-2410 (TTY: 711) လၢ Dean Health Plan/Prevea360 Health Plan အဂီၢ်, မ့တမ့ၢ်ကတိၤတၢ်ဒီး နပုၤလၢဟ့ၣ်နၤတၢ်ကွၢ်ထွဲတက့ၢ်.

**Amharic/ አማርኛ:-** ማሳሰቢያ:- አማርኛ የሚናገሩ ከሆኑ፣ የቋንቋ ድጋፍ አገልግሎት በነፃ ይቀርብልዎታል። ማረጃን በተደራሽ ቅርጸት ለማቅረብ ተገቢ የሆኑ ተጨማሪ እገዛዎች እና አገልግሎቶች እንዲሁ በነፃ ይገኛሉ። ለMedica በ1-800-952-3455 (TTY: 711) ይደውሉ፣ ለDean የጤና እቅድ/Prevea360 የጤና እቅድ በ1-877-317-2410 (TTY: 711) ይደውሉ ወይም ለእርስዎን አቅራቢ የሆነውን ያነጋግሩ።