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/2022ConnectPolicies or call 866-416-7438. 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 https://www.healthcare.gov/sbc-glossary or call 866-416-7438 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	<b>\$2,300</b> Individual / <b>\$6,900</b> Family for Tier 1 - preferred and Tier 2 - standard <u>network</u> services. There is no coverage for non-network services.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	<b>Yes.</b> <u>Preventive care</u> , preventive prescriptions and <u>copay</u> services from <u>network providers</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <u>https://www.healthcare.gov/coverage/preventive-care-benefits</u> .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	<b>\$8,700</b> Individual / <b>\$17,400</b> Family for Tier 1 - preferred and non-IHCP Tier 2 - standard network services. There is no coverage for non-network services.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket</u> <u>limit</u> ?	Premiums, balance-billing charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a <u>network</u> <u>provider</u> ?	<b>Yes.</b> Visit <u>www.medica.com/findconnectproviders</u> or call 866-416-7438 (TTY:711) for a list of <u>network</u> <u>providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay the least if you use a <u>provider</u> in the Tier 1 - preferred <u>network</u> . You will pay more if you use a <u>provider</u> in the Tier 2 - standard <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network</u> <u>provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.

	Services You May Need	What You Will Pay			
Common Medical Event		Tier 1-Preferred and Tier 2-Standard Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information	
If you visit a health care provider's office or	Primary care visit to treat an injury or illness	Primary care: 50% coinsurance Retail health clinics: 50% coinsurance Spinal manipulation: 50% coinsurance	Not covered	none	
clinic	Specialist visit	50% coinsurance	Not covered	none	
	Preventive care/ screening/immunization	No charge. <u>Deductible</u> does not apply.	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	50% coinsurance	Not covered	none	
n you have a lest	Imaging (CT/PET scans, MRIs)	50% coinsurance	Not covered	*May require prior authorization.	
If you need drugs to	Generic drugs	\$25 <u>copay</u> /prescription. <u>Deductible</u> does not apply.	Not covered	Up to a 31-day supply per prescription. *May require prior authorization. For non-preferred brand retail drugs, 50% coinsurance	
treat your illness or condition More information about prescription drug	Preferred brand drugs	\$200 <u>copay</u> /prescription. <u>Deductible</u> does not apply.	Not covered	for orally-administered cancer treatment medications. Proton pump inhibitors (except for members 12 years of age and younger, and those members who have a feeding tube) and non-sedating antihistamines are not covered. Insulin: Your cost-share will not exceed \$25 per retail	
coverage is available at www.medica.com/ KSBronSPRx.	Non-Preferred brand drugs	70% coinsurance	Not covered	prescription unit. *Refer to the Exceptions to the Drug List section of your Policy of Coverage for more details. No charge for preventive drugs.	
	Specialty drugs	\$750 <u>copay</u> /prescription. <u>Deductible</u> does not apply.	Not covered		

		What You Will Pay			
Common Medical Event	Services You May Need	Tier 1-Preferred and Tier 2-Standard Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% coinsurance	Not covered	*May require prior authorization.	
	Physician/surgeon fees	50% coinsurance	Not covered	*May require prior authorization.	
	Emergency room care	50% coinsurance	50% coinsurance	Network deductible applies.	
If you need immediate medical attention	Emergency medical transportation	50% coinsurance	50% coinsurance	Network deductible applies.	
medical attention	Urgent care	50% coinsurance	50% coinsurance	Network deductible applies. If a non-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).	
If you have a hospital	Facility fee (e.g., hospital room)	50% coinsurance	Not covered	*May require prior authorization.	
stay	Physician/surgeon fees	50% coinsurance	Not covered	*May require prior authorization.	
If you need mental health, behavioral	Outpatient services	50% coinsurance	Not covered	*May require prior authorization.	
health, or substance abuse services	Inpatient services	50% coinsurance	Not covered	*May require prior authorization.	
	Office visits	Prenatal: 50% <u>coinsurance</u> Postnatal: 50% <u>coinsurance</u>	Not covered	Cost sharing does not apply to network preventive services. Depending	
If you are pregnant	Childbirth/delivery professional services	50% coinsurance	Not covered	on the type of services, <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).	
	Childbirth/delivery facility services	50% coinsurance	Not covered		

	Services You May Need	What You Will Pay			
Common Medical Event		Tier 1-Preferred and Tier 2-Standard Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information	
	Home health care	50% coinsurance	Not covered	*May require prior authorization.	
	Rehabilitation services	50% coinsurance	Not covered	Speech therapy limited to 90 visits/year.	
If you need help	Habilitation services	50% coinsurance	Not covered	none	
recovering or have other special health	Skilled nursing care	50% coinsurance	Not covered	*May require prior authorization.	
needs	Durable medical equipment	50% coinsurance	Not covered	*May require prior authorization.	
	Hospice services	50% coinsurance	Not covered	none	
	Children's eye exam	50% coinsurance	Not covered	Coverage limited to end of month member turns 19.	
If your child needs dental or eye care	Children's glasses	50% coinsurance	Not covered	Limited to three pairs of glasses/year and one pair of contacts/year to end of month member turns 19. *Refer to the Vision section of your Schedule of Payments for more details.	
	Children's dental check-up	Not covered	Not covered	Coverage is available through a stand-alone dental policy.	

# **Excluded Services & Other Covered Services:**

<ul> <li>*Abortion, elective, induced, except as medically necessary to protect the life of the mother</li> <li>Acupuncture</li> <li>Bariatric surgery</li> <li>Cosmetic surgery</li> <li>Dental care (Adult)</li> </ul>	<ul> <li>Dental care (Child) (coverage is available through a stand-alone dental policy.)</li> <li>Dental check-up</li> <li>Hearing aids</li> <li>Long-term care</li> <li>Non-emergency care when traveling outside the U.S.</li> </ul>	<ul> <li>Routine eye care (Adult)</li> <li>Routine foot care except for some conditions</li> <li>Weight loss programs</li> </ul>
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• Infertility treatment

• Private-duty nursing

• Spinal manipulation services

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 866-416-7438 or the Kansas Insurance Department, 1300 SW Arrowhead Road, Topeka, KS 66604, 785-296-3071 or 1-800-432-2484. Other coverage options may be available to you too, including buying individual insurance coverage through the <u>Health Insurance Marketplace</u>. For more information about the <u>Marketplace</u>, visit <u>www.HealthCare.gov</u> 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 866-416-7438 or the Kansas Insurance Department, 1300 SW Arrowhead Road, Topeka, KS 66604, 785-296-3071 or 1-800-432-2484.

#### 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? NA

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 888-592-8211 Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 888-592-8211 Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 888-592-8211 Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 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.

<b>Peg is Having a Baby</b> (9 months of in-network prenatal care and delivery)	d a hospital	Managing Joe's Type 2 Diabet (a year of routine in-network care of a well condition)	<b>es</b> ll-controlled	Mia's Simple Fracture (in-network emergency room visit and foll	ow up care)
The <u>plan's</u> overall <u>deductible</u> :	\$2,300	The <u>plan's</u> overall <u>deductible</u> :	\$2,300	The <u>plan's</u> overall <u>deductible</u> :	\$2,300
Specialist coinsurance:	50%	Specialist coinsurance:	50%	Specialist coinsurance:	50%
■ Hospital (facility) coinsurance: 50%		Hospital (facility) <u>coinsurance</u> :	50%	Hospital (facility) <u>coinsurance</u> :	50%
• Other <u>coinsurance</u> :	50%	• Other <u>coinsurance</u> : 50%		Other <u>coinsurance</u> :	50%
This EXAMPLE event includes services Specialist office visits (prenatal care) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (ultrasounds and blood wo Specialist visit (anesthesia) Total Example Cost	-	This EXAMPLE event includes services Primary care physician office visits (includin education) Diagnostic tests (blood work) Prescription drugs Durable medical equipment (glucose meter Total Example Cost	ng disease	This EXAMPLE event includes services Emergency room care (including medical s Diagnostic test (x-ray) Durable medical equipment (crutches) Rehabilitation services (physical therapy) Total Example Cost	
n this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
Cost Sharing		Cost Sharing		Cost Sharing	
Deductibles	\$2,300	Deductibles	\$1,900	Deductibles	\$2,300
<u>Copayments</u>	\$10	<u>Copayments</u>	\$600	<u>Copayments</u>	\$10
Coinsurance	\$4,400	Coinsurance	\$0	<u>Coinsurance</u>	\$200
What isn't covered		What isn't covered		What isn't covered	
	imits or exclusions \$60		\$0	Limits or exclusions	\$0
Limits or exclusions	<b>φ</b> 00	Limits or exclusions	τ <del>τ</del>		÷ +

The plan would be responsible for the other costs of these EXAMPLE covered services.

#### Discrimination is Against the Law

Medica complies with applicable Federal civil rights laws and will not discriminate against any person on the basis of race, color, national origin, age, disability or sex. Medica:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: TTY communication and written information in other formats (large print, audio, other formats).
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters and information written in other languages.

If you need these services, call the number included in this document or on the back of your Medica ID card. If you believe that Medica has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Civil Rights Coordinator, Mail Route CP250, PO Box 9310, Minneapolis, MN 55443-9310, 952-992-3422 (phone/fax), TTY 711, civilrightscoordinator@medica.com.

You can file a grievance in person or by mail, fax, or email. You may also contact the Civil Rights Coordinator if you need assistance with filing a complaint.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

# If you want free help translating this information, call the number included in this document or on the back of your Medica ID card.

Si desea asistencia gratuita para traducir esta información, llame al número que figura en este documento o en la parte posterior de su tarjeta de identificación de Medica.

Yog koj xav tau kev pab dawb kom txhais daim ntawv no, hu rau tus xov tooj nyob hauv daim ntawv no los yog nyob nraum qab ntawm koj daim npav Medica ID.

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Nếu quý vị muốn trợ giúp dịch thông tin này miễn phí, hãy gọi vào số có trong tài liệu này hoặc ở mặt sau thẻ ID Medica của quý vị.

Odeeffannoo kana gargaarsa tolaan akka isinii hiikamu yoo barbaaddan, lakkoobsa barruu kana keessatti argamu ykn ka dugda kaardii Waraqaa Eenyummaa Medica irra jiruun bilbila'a.

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Если Вы хотите получить бесплатную помощь в переводе этой информации, позвоните по номеру телефона, указанному в данном документе и на обратной стороне Вашей индентификационной карты Medica.

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