Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services Medica. OK Harmony by Medica Bronze Copay Zero

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/2022HarmonyPolicies or call 866-839-3961. 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 866-839-3961 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|--|--|
| What is the overall <u>deductible</u> ? | \$0 | See the Common Medical Events chart below for your costs for services this <u>plan</u> covers. |
| Are there services covered before you meet your <u>deductible</u> ? | Yes. | This <u>plan</u> covers items and services even if you haven't yet met the <u>deductible</u> amount. |
| Are there other <u>deductibles</u> for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services. |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u> ? | Not Applicable | This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses. |
| What is not included in the out-of-pocket limit? | Not Applicable | This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses. |
| Will you pay less if you use a <u>network provider</u> ? | Yes. Visit <u>www.medica.com/FindHarmonyProviders</u> or call 866-839-3961 (TTY:711) for a list of <u>network providers</u> . | This <u>plan</u> uses a <u>provider</u> <u>network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's 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 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.

| Common Medical | Services You May Need | What You Will Pay | | | |
|---|--|--|---|--|--|
| Common Medical Event | | In-Network Provider (You will pay the least) | Out-of-Network^ Provider (You will pay the most) | Limitations, Exceptions & Other Important Information | |
| If you visit a health care <u>provider's</u> office or clinic | Primary care visit to treat an injury or illness | No charge | 0% coinsurance | If an <u>out-of-network provider</u> charges more than the <u>allowed</u> <u>amount</u> , you may have to pay the difference (<u>balance billing</u>). | |
| | <u>Specialist</u> visit | No charge | 0% coinsurance | If an <u>out-of-network provider</u> charges more than the <u>allowed</u> <u>amount</u> , you may have to pay the difference (<u>balance billing</u>). | |
| | Preventive care/ screening/immunization | No charge | 0% coinsurance | You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. If an <u>out-of-network</u> <u>provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference (<u>balance billing</u>). | |
| | Diagnostic test (x-ray, blood work) | No charge | 0% coinsurance | If an <u>out-of-network provider</u> charges more than the <u>allowed</u> <u>amount</u> , you may have to pay the difference (<u>balance billing</u>). | |
| If you have a test | Imaging (CT/PET scans, MRIs) | No charge | 0% coinsurance | *May require prior authorization. If an <u>out-of-network provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference (<u>balance billing</u>). | |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.medica.com/ RxList2022. | Generic drugs | No charge | 0% <u>coinsurance</u> for diabetic equipment, supplies and drugs. Other drugs or services are not covered. | Up to a 31-day supply per prescription. *May require prior authorization. Proton pump inhibitors (except for members ' 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 | |
| | Preferred brand drugs | No charge | 0% <u>coinsurance</u> for diabetic equipment, supplies and drugs. Other drugs or services are not covered. | | |
| | Non-Preferred brand drugs | No charge | 0% <u>coinsurance</u> for diabetic equipment, supplies and drugs. Other drugs or services are not covered. | List section of your Policy of Coverage for more details. No charge for preventive drugs. If an <u>out-of-network provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference (<u>balance billing</u>). | |
| | Specialty drugs | No charge | Not covered | | |

* For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.medica.com/2022HarmonyPolicies</u>. ^Out-of-Network services received in the state of Oklahoma, except <u>Emergency Services</u>.

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services Medica. OK Harmony by Medica Bronze Copay Zero

Coverage Period: Beginning on or after 01/01/2022 Coverage for: Individual or Family | Plan Type: PPO

| | | What You Will Pay | | | |
|--|--|--------------------------|-----------------------------|---|--|
| Common Medical Event | Services You May Need | In-Network Provider | Out-of-Network^ Provider | Limitations, Exceptions & Other Important Information | |
| | | (You will pay the least) | (You will pay the most) | | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No charge | 0% <u>coinsurance</u> | *May require prior authorization. If an <u>out-of-network provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference (<u>balance billing</u>). | |
| | Physician/surgeon fees | No charge | 0% coinsurance | *May require prior authorization. If an <u>out-of-network provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference (<u>balance billing</u>). | |
| | Emergency room care | No charge | No charge | none | |
| If you need immediate | Emergency medical transportation | No charge | No charge | none | |
| médical attention | Urgent care | No charge | No charge | If an <u>out-of-network provider</u> charges more than the <u>allowed</u> <u>amount</u> , you may have to pay the difference (<u>balance billing</u>). | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No charge | 0% <u>coinsurance</u> | *May require prior authorization. Rehabilitative and habilitative services each limited to 30 days/year. Notification required. If an <u>out-of-network provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference (<u>balance billing</u>). | |
| | Physician/surgeon fees | No charge | 0% <u>coinsurance</u> | *May require prior authorization. If an <u>out-of-network provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference (<u>balance billing</u>). | |
| If you need mental health, behavioral | Outpatient services | No charge | 0% <u>coinsurance</u> | *May require prior authorization. If an <u>out-of-network provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference (<u>balance billing</u>). | |
| health, or substance abuse services | Inpatient services | No charge | 0% <u>coinsurance</u> | *May require prior authorization. If an <u>out-of-network provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference (<u>balance billing</u>). | |
| | Office visits | No charge | 0% coinsurance | | |
| lf you are pregnant | Childbirth/delivery professional services | No charge | 0% coinsurance | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). If an <u>out-of-network</u> <u>provider</u> charges more than the <u>allowed amount</u> , you may | |
| | Childbirth/delivery facility services | No charge | 0% coinsurance | have to pay the difference (<u>balance billing</u>). | |

* For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.medica.com/2022HarmonyPolicies</u>. *Out-of-Network services received in the state of Oklahoma, except <u>Emergency Services</u>.

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services Medica. OK Harmony by Medica Bronze Copay Zero

Coverage Period: Beginning on or after 01/01/2022 Coverage for: Individual or Family | Plan Type: PPO

| Common Modical | | What You Will Pay | | | |
|--|------------------------------|--|--|--|--|
| Common Medical Event | Services You May Need | In-Network Provider (You will pay the least) | Out-of-Network^ Provider (You will pay the most) | Limitations, Exceptions & Other Important Information | |
| | Home health care | No charge | Not covered | *May require prior authorization. Limited to 30 visits. Extended hours home care limited to 85 visit/year. If an <u>out-of-network provider</u> charges more than the <u>allowed</u> <u>amount</u> , you may have to pay the difference (<u>balance billing</u>). | |
| | Rehabilitation services | No charge | 0% <u>coinsurance</u> | Physical, occupational and speech therapies limited to 25 visits/year combined in & out-of-network. If an <u>out-of-network</u> <u>provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference (<u>balance billing</u>). | |
| If you need help recovering or have other special health | Habilitation services | No charge | 0% coinsurance | Physical, occupational and speech therapies limited to 25 visits/year combined in & out-of-network. If an <u>out-of-network</u> <u>provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference (<u>balance billing</u>). | |
| needs | Skilled nursing care | No charge | 0% <u>coinsurance</u> | *May require prior authorization. Limited to 30 days/year combined in and out-of-network. If an <u>out-of-network provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference (<u>balance billing</u>). | |
| | Durable medical equipment | No charge | 0% coinsurance | *May require prior authorization. If an <u>out-of-network provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference (<u>balance billing</u>). | |
| | Hospice services | No charge | Not covered | If an <u>out-of-network provider</u> charges more than the <u>allowed</u> <u>amount</u> , you may have to pay the difference (<u>balance billing</u>). | |
| | Children's eye exam | No charge | 0% coinsurance | Limited to one refractive eye exam/year to end of month member turns 19. If an <u>out-of-network provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference (balance billing). | |
| If your child needs dental or eye care | Children's glasses | No charge | 0% coinsurance | Limited to one pair of glasses/year and one pair of contacts/year to end of month member turns 19. If an <u>out-of-network provider</u> charges more than the <u>allowed</u> <u>amount</u> , you may have to pay the difference (<u>balance billing</u>). | |
| | Children's dental check-up | Not covered | Not covered | Coverage is available through a stand-alone dental policy. | |

* For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.medica.com/2022HarmonyPolicies</u>. ^Out-of-Network services received in the state of Oklahoma, except <u>Emergency Services</u>.

Excluded Services & Other Covered Services:

| endangered) Acupuncture Bariatric surgery Cosmetic surgery | Dental care (Child) (coverage is available through a stand-alone dental policy.) Dental check-up Infertility treatment Long-term care Non-emergency care when traveling outside the U.S. | Routine eye care (Adult) Routine foot care Weight loss programs |
|---|--|---|
|---|--|---|

| Other Covered Services (Limitations may a | apply to these services. This isn't a complete list. Please see you | ır <u>plan</u> document.) |
|---|---|--|
| Chiropractic care | Hearing aids limited to 1 hearing aid per ear every 48 months. 4 additional ear molds for members up to 2 years of age. | Private-duty nursing limited up to 85 visits per year. |

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Medica at 866-839-3961 or the Oklahoma Insurance Department, Consumer Assistance at 1-800-522-0071. 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: Oklahoma Insurance Department, Consumer Assistance at 1-800-522-0071.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? NA If your <u>plan</u> doesn't meet the <u>Minimum Value Standards</u>, you may be eligible for a <u>premium tax credit</u> to help you pay for a <u>plan</u> through the <u>Marketplace</u>.

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 <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage.

| Peg is Having a Baby (9 months of in-network pre-natal care an delivery) | d a hospital | Managing Joe's Type 2 Diabete (a year of routine in-network care of a well condition) | es I-controlled | Mia's Simple Fracture (in-network emergency room visit and follo | w up care) |
|--|------------------------|---|---------------------------|---|----------------|
| The <u>plan's</u> overall <u>deductible</u> : | \$0 | The <u>plan's</u> overall <u>deductible</u> : | \$0 | The <u>plan's</u> overall <u>deductible</u> : | \$0 |
| Specialist copayment: | \$0 | Specialist copayment: | \$0 | Specialist copayment: | \$0 |
| Hospital (facility) <u>coinsurance</u>: | 0% | Hospital (facility) <u>coinsurance</u> : | 0% | Hospital (facility) <u>coinsurance</u> : | 0% |
| • Other <u>coinsurance</u> : | 0% | • Other <u>coinsurance</u> : | 0% | • Other <u>coinsurance</u> : | 0% |
| This EXAMPLE event includes services <u>Specialist</u> office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests</u> (<i>ultrasounds and blood wc</i> <u>Specialist</u> visit (<i>anesthesia</i>) | | This EXAMPLE event includes services I Primary care physician office visits (includin education) Diagnostic tests (blood work) Prescription drugs | ng disease | This EXAMPLE event includes services li Emergency room care (including medical su Diagnostic test (x-ray) Durable medical equipment (crutches) Rehabilitation services (physical therapy) | |
| <u>Specialist</u> visit (<i>anesthesia</i>) | | Durable medical equipment (glucose meter) |) | | |
| Specialist visit (anesthesia) Total Example Cost | \$12,700 | Durable medical equipment (glucose meter) Total Example Cost |) \$5,600 | Total Example Cost | \$2,800 |
| | | | , | Total Example Cost In this example, Mia would pay: | \$2,800 |
| Total Example Cost | | Total Example Cost | , | • | \$2,800 |
| Total Example Cost In this example, Peg would pay: | | Total Example Cost In this example, Joe would pay: | , | In this example, Mia would pay: | \$2,800 \$0 |
| Total Example Cost In this example, Peg would pay: Cost Sharing | \$12,700 | Total Example Cost In this example, Joe would pay: Cost Sharing | \$5,600 | In this example, Mia would pay: Cost Sharing | |
| Total Example Cost In this example, Peg would pay: Cost Sharing Deductibles | \$12,700 \$0 | Total Example Cost In this example, Joe would pay: Cost Sharing Deductibles | \$5,600 \$0 | In this example, Mia would pay: Cost Sharing Deductibles | \$0 |
| Total Example Cost In this example, Peg would pay: Cost Sharing Deductibles Copayments | \$12,700 \$0 \$0 | Total Example Cost In this example, Joe would pay: Cost Sharing Deductibles Copayments | \$5,600 \$0 \$0 | In this example, Mia would pay: Cost Sharing Deductibles Copayments | \$0 |
| Total Example Cost In this example, Peg would pay: Cost Sharing Deductibles Copayments Coinsurance | \$12,700 \$0 \$0 | Total Example Cost In this example, Joe would pay: Cost Sharing Deductibles Copayments Coinsurance | \$5,600 \$0 \$0 | In this example, Mia would pay: Cost Sharing Deductibles Copayments Coinsurance | \$0 |

The <u>plan</u> 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.

如果您需要免費翻譯此資訊,請致電本文檔中或者在您的Medica ID卡背面包含的號碼。

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.

اذاكنت تريدمساعدة مجانية في ترجمة هذه المعلومات. فاتصل على ألرقم الوارد في هذه الوثيقة أو على ظهر بطاقة تعريف ميديكا الخاصة بك.

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.

່ ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປຂໍ້ມູນນີ້ຟຣີ, ໃຫ້ໂທຫາເລກໝາຍ ທີ່ມີຢູ່ໃນເອກະສານນີ້ ຫຼື ຢູ່ດ້ານຫຼັງຂອງບັດ Medica ຂອງທ່ານ. 이 정보를 번역하는 데 무료로 도움을 받고 싶으시면, 이 문서에 포함된 전화번호나 Medica ID 카드 뒷면의 전화번호로 전화하십시오.

Si vous voulez une assistance gratuite pour traduire ces informations, appelez le numéro indiqué dans ce document ou au dos de votre carte d'identification Medica.

နမ့်၊အဲဉ်ိဳးတဂ်ကိုးထံစၢၤကလီနှုန်းတင်္ဂုတ်ကို၊အံၤလ၊အကလီနှဉ်,ကိုးလီတဲစိနီဉ်င်္ဂလ၊အပဉ် ယှာ်လ၊လ်ာတီလံာမီအပူ၊အံၤမ့တမ့၊ဖဲနန္နနိုင်ခလော်အုဉ်သးဓးက့အလို၊ခံတကပၤအဖိခ်ဉ်နှဉ်တက္ဂါ.

Kung nais mo ng libreng tulong sa pagsasalin ng impormasyong ito, tawagan ang numero na kasama sa dokumentong ito o sa likod ng iyong Kard ng Medica ID.

ይህን መረጃ ለመተርጎም ነጻ እርዳታ የሚፈልጉ ከሆነ በዝ ሀ ሰነድ ዉስጥ ያለውን ቁጥር ወይም Medica መታወቅያ ካርድዎ በስተጀርባ ያለውን ይደውሉ።

Ako želite besplatnu pomoć za prijevod ovih informacija, nazovite broj naveden u ovom dokumentu ili na poleđini svoje ID kartice Medica.

Díí t'áá jíík'e shá ata' hodoonih nínízingo éí ninaaltsoos Medica bee néího'dílzinígí bine'déé' námboo biká'ígíiji' béésh bee hodíilnih.

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.