Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services Medica. OK Harmony by Medica Silver Copay 87

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> ?	\$800 Individual / \$1,600 Family for in-network services. \$9,900 Individual / \$29,700 Family for out-of-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> ?	Yes. <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 <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> ?	\$2,700 Individual / \$5,400 Family for in-network services. Not applicable out-of-network.	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 out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover, out-of-network deductible and coinsurance.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 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 specialist you choose without a referral.

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.

		What Y			
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	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Primary care: \$10 <u>copay</u> /visit. <u>Deductible</u> does not apply. Retail health clinics: \$10 <u>copay</u> /visit. <u>Deductible</u> does not apply. Chiropractic care: \$10 <u>copay</u> /visit. <u>Deductible</u> does not apply.	50% coinsurance	20% <u>coinsurance</u> for other outpatient services. Primary care visits provided at an outpatient facility may be subject to <u>coinsurance</u> and <u>deductible</u> .	
	<u>Specialist</u> visit	\$65 <u>copay</u> /visit. <u>Deductible</u> does not apply.	50% coinsurance	none	
	Preventive care/ screening/immunization	No charge. <u>Deductible</u> does not apply.	Immunizations covered 0% coinsurance for members to age 18. <u>Deductible</u> does not apply. Other services: 50% 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 you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	none	
If you have a test	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	*May require prior authorization.	

		What Y			
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	
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	\$10 <u>copay</u> /prescription. <u>Deductible</u> does not apply.	50% <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. For preferred/non-preferred retail and specialty drugs, \$60 copay for	
	Preferred brand drugs	\$95 <u>copay</u> /prescription. Deductible does not apply.	50% <u>coinsurance</u> for diabetic equipment, supplies and drugs. Other drugs or services are not covered.	orally-administered cancer treatment medications. <u>Deductible</u> does not apply. Proton pump inhibitors (except for members 12 years of age and younger, and those members	
	Non-Preferred brand drugs	40% <u>coinsurance</u>	50% <u>coinsurance</u> for diabetic equipment, supplies and drugs. Other drugs or services are not covered.	who have a feeding tube) and non-sedating antihistamines are not covered. Insulin: Your cost-share will not exceed \$25 per retail prescription unit. *Refer to the Exceptions to the Drug List section of your Policy of Coverage for more details. No charge for preventive drugs.	
	Specialty drugs	\$450 <u>copay</u> /prescription. <u>Deductible</u> does not apply.	Not covered		
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	*May require prior authorization.	
surgery	Physician/surgeon fees	20% coinsurance	50% coinsurance	*May require prior authorization.	
	Emergency room care	20% coinsurance	20% coinsurance	In-network deductible applies.	
If you need immediate	Emergency medical transportation	20% coinsurance	20% coinsurance	In-network deductible applies.	
If you need immediate medical attention	<u>Urgent care</u>	\$10 <u>copay</u> /visit. <u>Deductible</u> does not apply.	\$10 <u>copay</u> /visit. <u>Deductible</u> does not apply.	If a non-network <u>provider</u> charges more than the <u>allowed 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)	20% coinsurance	50% coinsurance	*May require prior authorization. Rehabilitative and habilitative services each limited to 30 days/year. Notification required.	
	Physician/surgeon fees	20% coinsurance	50% coinsurance	*May require prior authorization.	

		What Y			
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	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$10 <u>copay</u> /visit. <u>Deductible</u> does not apply. 20% <u>coinsurance</u> for other outpatient services.	50% coinsurance	*May require prior authorization. Other outpatient services include intensive outpatient programs, diagnostic evaluations & psychological testing.	
	Inpatient services	20% coinsurance	50% coinsurance	*May require prior authorization.	
	Office visits	Prenatal: 20% <u>coinsurance</u> Postnatal: 20% <u>coinsurance</u>	50% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment,	
If you are pregnant	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	coinsurance, or <u>deductible</u> may apply. Maternity care may include tests and services described	
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	elsewhere in the SBC (i.e. ultrasound).	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	*May require prior authorization. Limited to 30 visits. Extended hours home care limited to 85 visit/year.	
	Rehabilitation services	20% coinsurance	50% <u>coinsurance</u>	Physical, occupational and speech therapies limited to 25 visits/year combined in & out-of-network.	
	Habilitation services	20% coinsurance	50% <u>coinsurance</u>	Physical, occupational and speech therapies limited to 25 visits/year combined in & out-of-network.	
	Skilled nursing care	20% coinsurance	50% coinsurance	*May require prior authorization. Limited to 30 days/year combined in and out-of-network.	
	Durable medical equipment	20% coinsurance	50% coinsurance	*May require prior authorization.	
	Hospice services	20% coinsurance	Not covered	Respite care is limited to 5 consecutive days, up to a lifetime maximum of 15 inpatient days and 15 outpatient days.	

* 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>.

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Common Medical Event		What You Will Pay			
	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	
If your child needs dental or eye care	Children's eye exam	\$10 <u>copay</u> /visit. <u>Deductible</u> does not apply.	50% coinsurance	Limited to one refractive eye exam/year to end of month member turns 19.	
	Children's glasses	20% coinsurance	50% coinsurance	Limited to one pair of glasses/year and one pair of contacts/year to end of month member turns 19.	
	Children's dental check-up	Not covered	Not covered	Coverage is available through a stand-alone dental policy.	

Excluded Services & Other Covered Services:

 *Abortion (except when the life of the mother is endangered) Acupuncture Bariatric surgery Cosmetic surgery 	 Dental care (Adult) 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
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan 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 and a hospital delivery)		Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
The <u>plan's</u> overall <u>deductible</u> :	\$800	The <u>plan's</u> overall <u>deductible</u> :	\$800	The <u>plan's</u> overall <u>deductible</u> :	\$800
Specialist copayment:	\$65	Specialist copayment:	\$65	Specialist copayment:	\$65
Hospital (facility) <u>coinsurance</u> :	20%	Hospital (facility) <u>coinsurance</u> :	20%	Hospital (facility) <u>coinsurance</u> :	20%
• Other <u>coinsurance</u> :	20%	• Other <u>coinsurance</u> :	20%	• Other <u>coinsurance</u> :	20%
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)		This EXAMPLE event includes services Primary care physician office visits (includin education) Diagnostic tests (blood work) Prescription drugs Durable medical equipment (glucose meter	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	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
Cost Sharing		Cost Sharing		Cost Sharing	
<u>Deductibles</u>	\$800	<u>Deductibles</u>	\$800	<u>Deductibles</u>	\$800
<u>Copayments</u>	\$0	<u>Copayments</u>	\$700	<u>Copayments</u>	\$100
Coinsurance	\$1,900	Coinsurance	\$70	Coinsurance	\$400
What isn't covered		What isn't covered		What isn't covered	
Limits or exclusions	\$60	Limits or exclusions	\$0	Limits or exclusions	\$0
The total Peg would pay is	\$2,760	The total Joe would pay is	\$1,570	The total Mia would pay is	\$1,300

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.

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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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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.

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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'ígíjji béésh bee hodíilnih.

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