

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/2022SelectPolicies or call 866-269-6806. 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 <a href="https://www.healthcare.gov/sbc-glossary">https://www.healthcare.gov/sbc-glossary</a> or call 866-269-6806 to request a copy.

Important	Answers	Why This Matters:
Questions  What is the overall deductible?	\$0 at Indian Health Care Provider (IHCP) or with IHCP referral at non-IHCP; \$8,000 Individual / \$16,000 Family for non-IHCP network 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 deductible?	Yes. Preventive care and preventive prescriptions from non-IHCP network providers are covered before you meet your deductible.	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</u> <u>services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits">https://www.healthcare.gov/coverage/preventive-care-benefits</a> .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	<b>\$8,700</b> Individual / <b>\$17,400</b> Family for non-IHCP <u>network</u> 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 out-of-pocket limit?	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> provider?	Yes. Visit <a href="https://www.medica.com/FindSelectProviders">www.medica.com/FindSelectProviders</a> or call 866-269-6806 (TTY:711) for a list of <a href="https://medica.com/FindSelectProviders">network providers</a> .	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 charge</u> and what your <u>plan pays (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 referral to see a specialist?	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 You Will Pay							
Common Medical Event	Services You May Need	(IHCP) Network No (You will pay the least) Provider		Non-IHCP Non-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	No charge	Primary care: 10% coinsurance Retail health clinics: 10% coinsurance Spinal manipulation: 10% coinsurance	Not covered	Cost sharing waived at non-IHCP with IHCP referral.		
or chine	Specialist visit	No charge	10% coinsurance	Not covered	Cost sharing waived at non-IHCP with IHCP referral.		
	Preventive care/ screening/immunization	No charge	No charge. Deductible does not apply.	Not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> .		
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	10% coinsurance	Not covered	Cost sharing waived at non-IHCP with IHCP referral.		
ii you nave a test	Imaging (CT/PET scans, MRIs)	No charge	10% coinsurance	Not covered	*May require prior authorization. Cost sharing waived at non-IHCP with IHCP referral.		
If you need drugs to	Generic drugs	No charge	10% coinsurance	Not covered	Up to a 31-day supply per prescription. *May require prior authorization. For specialty drugs, 10% coinsurance for orally-administered cancer treatment		
treat your illness or condition	Preferred brand drugs	No charge	10% coinsurance	Not covered	medications. Proton pump inhibitors (except for members 12 years of age and younger, and those members who have a feeding tube) and non-sedating		
More information about prescription drug coverage is available at www.medica.com/KSBronVRx.	Non-Preferred brand	No charge	10% coinsurance		members who have a feeding tube) and non-sedating antihistamines are not covered. Insulin: Your cost-share will not exceed \$25 per retail prescription unit. *Refer to the Exceptions to the Drug List section of your Policy of Coverage for more details. No charge		
	Specialty drugs	No charge	10% coinsurance	Not covered	for preventive drugs. Cost sharing waived at non-IHCP with IHCP referral.		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	10% coinsurance	Not covered	*May require prior authorization. Cost sharing waived at non-IHCP with IHCP referral.		
	Physician/surgeon fees	No charge	10% coinsurance	Not covered	*May require prior authorization. Cost sharing waived at non-IHCP with IHCP referral.		

<sup>\*</sup> For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.medica.com/2022SelectPolicies</u>.

		Wha	t You Will Pay		
Common Medical Event	Services You May Need	Indian Health Care Provider (IHCP) (You will pay the least)	Provider	Non-IHCP Non-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
	Emergency room care	No charge	10% coinsurance	10% coinsurance	Network deductible applies. Cost sharing waived at non-IHCP with IHCP referral.
If you need immediate	Emergency medical transportation	No charge	10% coinsurance	10% coinsurance	Network deductible applies. Cost sharing waived at non-IHCP with IHCP referral.
médical attention	Urgent care	No charge	10% coinsurance	10% coinsurance	Network deductible applies. If a non-network provider charges more than the allowed amount, you may have to pay the difference (balance billing). Cost sharing waived at non-IHCP with IHCP referral.
If you have a hospital	Facility fee (e.g., hospital room)	No charge	10% coinsurance	Not covered	*May require prior authorization. Cost sharing waived at non-IHCP with IHCP referral.
stay	Physician/surgeon fees	No charge	10% coinsurance	Not covered	*May require prior authorization. Cost sharing waived at non-IHCP with IHCP referral.
If you need mental health, behavioral	Outpatient services	No charge	10% coinsurance	Not covered	*May require prior authorization. Cost sharing waived at non-IHCP with IHCP referral.
health, or substance abuse services	Inpatient services	No charge	10% coinsurance	Not covered	*May require prior authorization. Cost sharing waived at non-IHCP with IHCP referral.
If you are pregnant	Office visits	No charge	Prenatal: 10% coinsurance Postnatal: 10% coinsurance	Not covered	Cost sharing does not apply to network preventive services. Depending on the type of services,
	professional services	No charge	10% coinsurance	Not covered	coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing waived at non-IHCP
	Childbirth/delivery facility services	No charge	10% coinsurance	Not covered	with IHCP referral.

<sup>\*</sup> For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.medica.com/2022SelectPolicies</u>.

		What You Will Pay				
Common Medical Event	Services You May Need	Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP Network Provider (You will pay more)	Non-IHCP Non-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information	
	Home health care	No charge	10% coinsurance	Not covered	*May require prior authorization. Cost sharing waived at non-IHCP with IHCP referral.	
	Rehabilitation services	No charge	10% coinsurance	Not covered	Speech therapy limited to 90 visits/year. Cost sharing waived at non-IHCP with IHCP referral.	
If you need help recovering or have	Habilitation services	No charge	10% coinsurance	Not covered	Cost sharing waived at non-IHCP with IHCP referral.	
other special health needs	Skilled nursing care	No charge	10% coinsurance	Not covered	*May require prior authorization. Cost sharing waived at non-IHCP with IHCP referral.	
	Durable medical equipment	No charge	10% coinsurance	Not covered	*May require prior authorization. Cost sharing waived at non-IHCP with IHCP referral.	
	Hospice services	No charge	10% coinsurance	Not covered	Cost sharing waived at non-IHCP with IHCP referral.	
If your child needs dental or eye care	Children's eye exam	No charge	10% coinsurance	Not covered	Coverage limited to end of month member turns 19. Cost sharing waived at non-IHCP with IHCP referral.	
	Children's glasses	No charge	10% 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. Cost sharing waived at non-IHCP with IHCP referral.	
	Children's dental check-up	Not covered	Not covered	Not covered	Coverage is available through a stand-alone dental policy.	

<sup>\*</sup> For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.medica.com/2022SelectPolicies</u>.

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

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

## Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- \*Abortion, elective, induced, except as medically necessary to protect the life of the mother
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Ădult)

- Dental care (Child) (coverage is available through a stand-alone dental policy.)
- Dental check-up
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the
- Routine eye care (Adult)
- Routine foot care except for some conditions
- Weight loss programs

# Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)

Infertility treatment

Private-duty nursing

Spinal manipulation services

**⊘ Medica**. KS Select by Medica Bronze Value + Dental Limited

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

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 866-269-6806 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 <a href="Health Insurance Marketplace">Health Insurance Marketplace</a>. For more information about the <a href="Marketplace">Marketplace</a>, visit <a href="https://www.HealthCare.gov">www.HealthCare.gov</a> 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 866-269-6806 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. ------

Coverage for: Individual or Family | Plan Type: EPO

# **⊘ Medica**. KS Select by Medica Bronze Value + Dental Limited

## **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.

(9 months of in-network prenatal care and a hospital delivery)	(
■ The <u>plan's</u> overall <u>deductible</u> : \$0	
■ Specialist coinsurance: 0%	
■ Hospital (facility) <u>coinsurance</u> : 0%	
Other coinsurance:	

#### Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)

oorialiiori)	
The plan's overall deductible:	\$0
Specialist coinsurance:	0%
Hospital (facility) coinsurance:	0%
Other coinsurance:	0%

Mia's Simple Fracture (in-network emergency room visit and follow up care)	
The plan's overall deductible: \$0	١

■ The <u>plan's</u> overall <u>deductible</u> :	\$0
Specialist coinsurance:	0%
Hospital (facility) coinsurance:	0%
Other coinsurance:	0%

#### 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)

#### 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)

This EXAMPLE	event	inc	ludes	servi	ices	like:

Emergency room care (including medical supplies)
Diagnostic test (x-ray)

Durable medical equipment (crutches)
Rehabilitation services (physical therapy)

Total Example Cost	\$12,700
--------------------	----------

Total Example Cost	\$2,800

# In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$60

# In this example, Joe would pay:

Cost Sharing		
<u>Deductibles</u>	\$0	
Copayments	\$0	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$0	
The total Joe would pay is	\$0	

In this examp	le, Mia	would	pay:
---------------	---------	-------	------

Cost Sharing	
<u>Deductibles</u>	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$0

Note: These numbers assume the patient received care from an IHCP <u>provider</u> or with IHCP <u>referral</u> at a non-IHCP. If you receive care from a non-IHCP <u>provider</u> without a <u>referral</u> from an IHCP, your costs may be higher.

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

# Coverage for: Individual or Family | Plan Type: EPO

#### 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 liều 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.

اذا كنت تريد مساعدة مجانية في ترجمة هذه المعلومات. فاتصل على ألرقم الوارد في هذه الوثيقة أوعلى 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.

နမှါအဲ့ဒိုးတါကိုးထံစၤကလီနှုံနာတာ်က်တာ်ကျိုးဆုံးလာအကလီနှုံဉ်,ကိုးလီတဲ့စိနီဉ်က်လာအပဉ် ယှာ်လာလာတီလာမီအပူးဆုံးမှတမှုါစုံနန္နနိုင်စေလာ်အဉ်သႊစုးကုအလိုခံတကပၤအဖီခိုဉ်နှဉ်တက္ကာ.

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 ለመተርንም ነጻ እርዳታ የሚፈልጉ ከሆነ በዝ ህ 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'ígíjjj' 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.