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 https://www.healthcare.gov/sbc-glossary or call 866-269-6806 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$8,700 Individual / \$17,400 Family for <u>network</u> 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</u> <u>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> ?	\$8,700 Individual / \$17,400 Family for <u>network</u> 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 network provider?	Yes. Visit <u>www.medica.com/FindSelectProviders</u> or call 866-269-6806 (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</u> <u>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.

	Services You May Need	What You Wi		
Common Medical Event		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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	Primary care: \$30 copay for first 3 clinic visits/year. <u>Deductible</u> does not apply. After first 3 visits, 0% <u>coinsurance</u> . Retail health clinics: \$20 <u>copay</u> for first 3 clinic visits/year. <u>Deductible</u> does not apply. After first 3 visits, 0% <u>coinsurance</u> .	Not covered	First 3 visit limit applies to primary care visits, including retail health clinics.
	<u>Specialist</u> visit	0% coinsurance	Not covered	Chiropractic care covered at 0% coinsurance after deductible.
	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 <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)	0% coinsurance	Not covered	none
,	Imaging (CT/PET scans, MRIs)	0% coinsurance	Not covered	*May require prior authorization.
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	0% coinsurance	Not covered	Up to a 31-day supply per prescription. *May require prior authorization. Proton
	Preferred brand drugs	0% coinsurance	Not covered	pump inhibitors (except for members 12 years of age and younger, and those members who have a feeding tube) and
	Non-Preferred brand drugs	0% coinsurance	Not covered	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
	Specialty drugs	0% coinsurance	Not covered	section of your Policy of Coverage for more details. No charge for preventive drugs.
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	Not covered	*May require prior authorization.
surgery	Physician/surgeon fees	0% coinsurance	Not covered	*May require prior authorization.

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

		What You W		
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
	Emergency room care	0% coinsurance	0% coinsurance	Network deductible applies.
If you need immediate	Emergency medical transportation	0% coinsurance	0% coinsurance	Network deductible applies.
medical attention	Urgent care	0% coinsurance	0% coinsurance	Network deductible applies. If a non-network provider charges more than the <u>allowed amount</u> , you may have to pay the difference (<u>balance billing</u>).
If you have a heapital atoy	Facility fee (e.g., hospital room)	0% coinsurance	Not covered	*May require prior authorization.
If you have a hospital stay	Physician/surgeon fees	0% coinsurance	Not covered	*May require prior authorization.
If you need mental health,	Outpatient services	0% coinsurance	Not covered	*May require prior authorization.
behavioral health, or substance abuse services	Inpatient services	0% coinsurance	Not covered	*May require prior authorization.
If you are pregnant	Office visits	Prenatal: 0% <u>coinsurance</u> Postnatal: 0% <u>coinsurance</u>	Not covered	Cost sharing does not apply for preventive services. Depending on the type of
	Childbirth/delivery professional services	0% coinsurance	Not covered	services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may
	Childbirth/delivery facility services	0% coinsurance	Not covered	include tests and services described elsewhere in the SBC (i.e. ultrasound).

	Services You May Need	What You Wi		
Common Medical Event		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need help recovering or have other special health needs	Home health care	0% <u>coinsurance</u>	Not covered	*May require prior authorization. Limited to 100 intermittent skilled nursing visits and 82 extended hours home care visits/year.
	Rehabilitation services	0% coinsurance	Not covered	Outpatient: Limited to 20 physical therapy and 20 occupational therapy visits/year, unless medically necessary; Cardiac <u>rehabilitation</u> 36 visits/year.
	Habilitation services	0% coinsurance	Not covered	Outpatient: Limited to 20 physical therapy and 20 occupational therapy visits/year, unless medically necessary; Cardiac <u>rehabilitation</u> 36 visits/year.
	Skilled nursing care	0% coinsurance	Not covered	*May require prior authorization. Limited to 150 days/year.
	Durable medical equipment	0% coinsurance	Not covered	*May require prior authorization.
	Hospice services	0% coinsurance	Not covered	none
If your child needs dental or eye care	Children's eye exam	0% coinsurance	Not covered	Coverage limited to end of month member turns 19.
	Children's glasses	0% coinsurance	Not covered	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:

Services Your Plan Generally Does NOT Cover (Chec	ck your policy or plan document for more information	and a list of any other <u>excluded services</u> .)
 *Abortions, elective, induced, except as medically necessary to protect the life of the mother. 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 except for some conditions Weight loss programs
Other Covered Services (Limitations may apply to the	ese services. This isn't a complete list. Please see you	ur <u>plan</u> document.)
Chiropractic care	 Hearing aids limited to 1 hearing aid per ear every 48 months. Newborn hearing aids provided for initial amplification following a newborn hearing screening. 	 Private-duty nursing limited to 82 visits

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 Missouri Department of Insurance, Consumer Affairs Division, 1-800-726-7390 or <u>www.insurance.mo.gov/consumers/complaints/index.php</u>. 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 866-269-6806 or the Missouri Department of Insurance, Consumer Affairs Division, 1-800-726-7390 or www.insurance.mo.gov/consumers/complaints/index.php.

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, kwijijgo 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 ar delivery)	nd a hospital	Managing Joe's Type 2 Diabet (a year of routine in-network care of a we condition)	tes ell-controlled	Mia's Simple Fracture (in-network emergency room visit and foll	ow up care)
The <u>plan's</u> overall <u>deductible</u> :	\$8,700	The <u>plan's</u> overall <u>deductible</u> :	\$8,700	The <u>plan's</u> overall <u>deductible</u> :	\$8,700
Specialist coinsurance:	0%	Specialist coinsurance:	0%	Specialist coinsurance:	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 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 (includi education) Diagnostic tests (blood work) Prescription drugs Durable medical equipment (glucose mete 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	
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>	\$8,700	<u>Deductibles</u>	\$2,300	<u>Deductibles</u>	\$2,800
<u>Copayments</u>	\$0	<u>Copayments</u>	\$90	<u>Copayments</u>	\$0
Coinsurance	\$0	<u>Coinsurance</u>	\$0	Coinsurance	\$0
What isn't covered		What isn't covered		What isn't covered	
Limits or exclusions	\$60	Limits or exclusions	\$0	Limits or exclusions	\$0
	i	The total Joe would pay is	\$2,390	The total Mia would pay is	\$2,800

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.

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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