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> ? | \$0 for <u>network</u> services. There is no coverage for non-network services. | 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 some items and services even if you haven't ye 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> ? | \$0 for <u>network</u> services. There is no coverage for non-network services. | 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? | Premiums, balance-billing charges and health care this plan doesn't cover. | 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/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 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.

| | | What You Will Pay | | | |
|---|--|---|--|---|--|
| 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 | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | No charge | Not covered | none | |
| | Specialist visit | No charge | Not covered | none | |
| | Preventive care/ screening/immunization | No charge | 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. | |
| If you have a test | Diagnostic test (x-ray, blood work) | No charge | Not covered | none | |
| | Imaging (CT/PET scans, MRIs) | No charge | 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/ KSGoldCRx. | Generic drugs | No charge | Not covered | Up to a 31-day supply per prescription. *May require prior authorization. Proton pump inhibitors (except for members 12 | |
| | Preferred brand drugs | No charge | Not covered | years of age and younger, and those members who have a feeding tube) and | |
| | Non-Preferred brand drugs | No charge | 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 | No charge | Not covered | section of your Policy of Coverage for more details. No charge for preventive drugs. | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No charge | Not covered | *May require prior authorization. | |
| | Physician/surgeon fees | No charge | Not covered | *May require prior authorization. | |
| If you need immediate medical attention | Emergency room care | No charge | No charge | none | |
| | Emergency medical transportation | No charge | No charge | none | |
| | Urgent care | No charge | No charge | 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>). | |

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

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services Medica. KS Select by Medica Gold Copay Zero

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

| | | What You Will Pay | | | |
|---|---|---|--|---|--|
| 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 | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No charge | Not covered | *May require prior authorization. | |
| Physician/surgeon fees No charge | | No charge | Not covered | *May require prior authorization. | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | No charge | Not covered | *May require prior authorization. | |
| | Inpatient services | No charge | Not covered | *May require prior authorization. | |
| lf you are pregnant | Office visits | No charge | Not covered | *May require prior outparization Maternity | |
| | Childbirth/delivery professional services | No charge | Not covered | *May require prior authorization. Maternity care may include tests and services described elsewhere in the SBC (i.e. | |
| | Childbirth/delivery facility services | No charge | Not covered | ultrasound). | |
| If you need help recovering or have other special health needs | Home health care | No charge | Not covered | *May require prior authorization. | |
| | Rehabilitation services | No charge | Not covered | Speech therapy limited to 90 visits/year. | |
| | Habilitation services | No charge | Not covered | none | |
| | Skilled nursing care | No charge | Not covered | *May require prior authorization. | |
| | Durable medical equipment | No charge | Not covered | *May require prior authorization. | |
| | Hospice services | No charge | Not covered | none | |
| If your child needs dental or eye care | Children's eye exam | No charge | Not covered | Coverage limited to end of month member turns 19. | |
| | Children's glasses | No charge | 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. | |

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

Excluded Services & Other Covered Services:

| Cosmetic surgery Dental care (Adult) Long-term care Non-emergency care when traveling outside the U.S. | e except for some conditions rams |
|---|--------------------------------------|
|---|--------------------------------------|

• 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 866-269-6806 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 Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov 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. ------

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 prenatal care and delivery) | d a hospital | Managing Joe's Type 2 Diabete (a year of routine in-network care of a well condition) | e s l-controlled | Mia's Simple Fracture (in-network emergency room visit and foll | ow 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 <u>Primary care physician</u> office visits (includin education) <u>Diagnostic tests</u> (blood work) <u>Prescription drugs</u> <u>Durable medical equipment</u> (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 | |
| Deductibles | \$0 | <u>Deductibles</u> | \$0 | <u>Deductibles</u> | \$0 |
| <u>Copayments</u> | \$0 | <u>Copayments</u> | \$0 | <u>Copayments</u> | \$0 |
| Coinsurance | \$0 | Coinsurance | \$0 | Coinsurance | \$0 |
| What isn't covered | | What isn't covered | | What isn't covered | <u> </u> |
| | | 12.20 | ¢Ο | L'instite en eveluetere | \$0 |
| Limits or exclusions | \$60 | Limits or exclusions | \$0 | Limits or exclusions | φυ |

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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