

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/QuestPolicies-2023 or call 1-866-582-7035. 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 www.healthcare.gov/sbc-glossary or call 1-866-582-7035 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$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 deductible?	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 https://www.healthcare.gov/coverage/preventive-care-benefits .
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> ?	\$3,000 individual / \$6,000 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 out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.Medica.com/SearchQuestNetwork-2023 or call 1-866-582-7035 (TTY: 711) for a list of network providers .	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider 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 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
If you visit a health care	Primary care visit to treat an injury or illness	Primary care: \$20 copay/visit. Deductible does not apply. Retail health clinics: \$20 copay/visit. Deductible does not apply. Chiropractic care: \$20 copay/visit. Deductible does not apply.	50% coinsurance	30% coinsurance for other outpatient services. Primary care visits provided at an outpatient facility may be subject to coinsurance and deductible.
provider's office or clinic	Specialist visit	\$40 <u>copay</u> /visit. <u>Deductible</u> does not apply.	50% coinsurance	none
	Preventive care/ screening/immunization	No charge. Deductible does not apply.	Immunizations covered 0% coinsurance for members to age 18. Deductible does not apply. Other services: 50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	50% coinsurance	none
ii you iiave a test	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	*May require prior authorization.

^{*} For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.Medica.com/QuestPolicies-2023</u>. ^Out-of-Network services received in the state of Oklahoma, except <u>Emergency Services</u>.

		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
If you need drugs to treat your illness or condition	Generic drugs	Preferred Generic: \$10 copay/prescription. Deductible does not apply. Generic: \$10 copay/prescription. Deductible does not apply.	50% coinsurance 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 non-preferred retail and specialty drugs, \$40 copay for orally-administered cancer treatment medications. Deductible
More information about prescription drug coverage is available at	Preferred brand drugs	\$20 copay/prescription. Deductible does not apply.	50% coinsurance for diabetic equipment, supplies and drugs. Other drugs or services are not covered.	does not apply. Proton pump inhibitors (except for members 12 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 List section of your Policy of Coverage for more
www.Medica.com/ OKDrugList-2023	Non-Preferred brand drugs	\$60 copay/prescription.	50% coinsurance for diabetic equipment, supplies and drugs. Other drugs or services are not covered.	
	Specialty drugs	\$250 copay/prescription.	Not covered	details. No charge for preventive drugs.
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	*May require prior authorization.
surgery	Physician/surgeon fees	30% coinsurance	50% coinsurance	*May require prior authorization.
	Emergency room care	30% coinsurance	30% coinsurance	In-network deductible applies.
If you need immediate medical attention	Emergency medical transportation	30% coinsurance	30% coinsurance	In-network deductible applies.
	Urgent care	\$30 copay/visit. Deductible does not apply.	\$30 <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)	30% coinsurance	50% coinsurance	*May require prior authorization. Rehabilitative and habilitative services each limited to 30 days/year. Notification required.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	*May require prior authorization.

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What You Will Pay Limitations, Exceptions & Other Out-of-Network[^] **Common Medical Event Services You May Need** In-Network **Important Information** Provider Provider (You will pay the most) (You will pay the least) *May require prior authorization. \$20 copay/visit. Deductible Other outpatient services include does not apply. If you need mental health, **Outpatient services** 50% coinsurance intensive outpatient programs. 30% coinsurance for other behavioral health, or diagnostic evaluations & outpatient services. substance abuse services psychological testing. Inpatient services 30% coinsurance 50% coinsurance *May require prior authorization. Cost sharing does not apply for Prenatal: 30% coinsurance Office visits 50% coinsurance preventive services. Depending on the type of services, a copayment, Postnatal: 30% coinsurance coinsurance, or deductible may apply. Maternity care may include tests and services described If you are pregnant Childbirth/delivery professional 30% coinsurance 50% coinsurance services elsewhere in the SBC (i.e. Childbirth/delivery facility services 30% coinsurance 50% coinsurance ultrasound).

^{*} For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.Medica.com/QuestPolicies-2023</u>.

^{*}Out-of-Network services received in the state of Oklahoma, except Emergency Services.

		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	30% coinsurance	Not covered	*May require prior authorization. Limited to 30 visits. Extended hours home care limited to 85 visit/year.
If you need help recovering or have other special health needs	Rehabilitation services	Outpatient physical, occupational, speech therapy: \$20 copay/visit. Deductible does not apply. Other outpatient Rehabilitation: 30% coinsurance	50% coinsurance	Physical, occupational and speech therapies limited to 25 visits/year combined in & out-of-network. This visit limit does not apply to services for treatment of autism and autism spectrum disorder. Other outpatient: 30 day limit.
	Habilitation services	Outpatient physical, occupational, speech therapy: \$20 copay/visit. Deductible does not apply. Other outpatient Habilitation: 30% coinsurance	50% coinsurance	Physical, occupational and speech therapies limited to 25 visits/year combined in & out-of-network. This visit limit does not apply to services for treatment of autism and autism spectrum disorder. Other outpatient: 30 visit limit.
	Skilled nursing care	30% coinsurance	50% coinsurance	*May require prior authorization. Limited to 30 days/year combined in and out-of-network.
	<u>Durable medical equipment</u>	30% coinsurance	50% coinsurance	*May require prior authorization.
	Hospice services	30% coinsurance	Not covered	Respite care is limited to 5 consecutive days, up to a lifetime maximum of 15 inpatient days and 15 outpatient days.
If your child needs dental or eye care	Children's eye exam	\$20 copay/visit. Deductible does not apply.	50% coinsurance	Limited to one refractive eye exam/year to end of month member turns 19.
	Children's glasses	30% 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.

^{*} For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.Medica.com/QuestPolicies-2023</u>. ^Out-of-Network services received in the state of Oklahoma, except <u>Emergency Services</u>.

Coverage Period: Beginning on or after 01/01/2023 Coverage for: Individual or Family | Plan Type: PPO

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 (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

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

Coverage Period: Beginning on or after 01/01/2023 Coverage for: Individual or Family | Plan Type: PPO

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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 1-866-582-7035, the Oklahoma Insurance Department, Consumer Assistance, 1-800-522-0071 or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa. 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: 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? Not Applicable.

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 1-888-592-8211.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-592-8211.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-592-8211. Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-592-8211.

To see examples of how this <u>plan</u> 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 delivery)	a hospital

The plan's overall deductible \$800

Specialist copayment \$40

Hospital (facility) coinsurance 30%

Other coinsurance 30%

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

The <u>plan's</u> overall deductible	\$800
Specialist copayment	\$40
Hospital (facility) coinsurance	30%
Other coinsurance	30%

Mia's Simple Fracture (in-network emergency room visit and follow up care)

The plan's overall deductible	\$800
Specialist copayment	\$40
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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)

<u>Diagnostić tests</u> (blood work)

Prescription drugs

Total Example Cost

<u>Durable medical equipment</u> (glucose meter)

This EXAMPLE event includes services 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>	\$800
Copayments	\$0
Coinsurance	\$2,200
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$3,060

In this example, Joe would pay:

\$800
\$600
\$100
\$0
\$1,500

In this example, Mia would pay:

\$5,600

Cost Sharing	
<u>Deductibles</u>	\$800
Copayments	\$90
Coinsurance	\$500
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,390

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

Coverage for: Individual or Family | Plan Type: PPO

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.

နမှါအဲ့ ောက်ကိုးထံစၤကလီန္စါနားတာ်က်တာ်ကျိုးအုံးလာအကလီန္ ဉ်,ကိုးလီတဲ့စီနီဉ်က်လာအပဉ် ယာလာလာတီလာမီအပူးအုံးမှတမှုစ်နန္နနိင်ဓေလာအာ့ဉ်သးခႏက္ခအလိုခံတကပၤအဖီခိုဉ်နှဉ်တက္ကာ.

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'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.