

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/SelectPolicies-2023 or call 1-866-269-6806. 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 www.healthcare.gov/sbc-glossary or call 1-866-269-6806 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$9,100 individual / \$18,200 family for 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 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 services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	\$9,100 individual / \$18,200 family for network 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 network provider?	Yes. See www.Medica.com/SearchSelectNetwork-2023 or call 1-866-269-6806 (TTY: 711) for a list of network providers.	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 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 Wi	Limitations, Exceptions & Other Important Information	
Common Medical Event	Services You May Need	Network Provider (You will pay the least) Non-Network Provider (You will pay the most)		
If you visit a health care	Primary care visit to treat an injury or illness	Primary care: 0% coinsurance Retail health clinics: 0% coinsurance Spinal manipulation: 0% coinsurance	Not covered	none
provider's office or clinic	Specialist visit	0% coinsurance	Not covered	none
	Preventive care/ screening/immunization	No charge. Deductible does not apply. Not covered		You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan 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	Generic drugs	Preferred Generic: 0% coinsurance Generic: 0% coinsurance	Not covered	Up to a 34-day supply per prescription. *May require prior authorization. For specialty drugs, 0% coinsurance for
your illness or condition More information about prescription drug	Preferred brand drugs	0% coinsurance	Not covered	orally-administered cancer treatment medications. Proton pump inhibitors (except for members 12 years of age and younger, and those members who have a feeding
coverage is available at www.Medica.com/ KSDrugList-2023	Non-Preferred brand drugs	0% coinsurance	Not covered	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/SelectPolicies-2023</u>.

		What You V	Limitations, Exceptions & Other Important Information		
Common Medical Event	Services You May Need	Network Non-Network Provider Provider (You will pay the least) (You will pay the most)			
	Emergency room care	0% coinsurance	0% coinsurance	Network deductible applies.	
If you need immediate medical attention	Emergency medical transportation	0% coinsurance	0% coinsurance	Network deductible applies.	
médical attention	Urgent care	0% coinsurance	0% coinsurance	Network deductible applies. If a non-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).	
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	Not covered	*May require prior authorization.	
ii you nave a nospitai stay	Physician/surgeon fees	0% coinsurance	Not covered	*May require prior authorization.	
If you need mental health, behavioral health, or	Outpatient services	0% coinsurance	Not covered	*May require prior authorization.	
substance abuse services	Inpatient services	0% coinsurance	Not covered	*May require prior authorization.	
	Office visits	Prenatal: 0% coinsurance Postnatal: 0% coinsurance	Not covered	Cost sharing does not apply to network	
If you are pregnant	Childbirth/delivery professional services	0% coinsurance	Not covered	preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC	
	Childbirth/delivery facility services	0% coinsurance	Not covered	(i.e. ultrasound).	
	Home health care	0% coinsurance	Not covered	*May require prior authorization.	
If you need help	Rehabilitation services	0% coinsurance	Not covered	Speech therapy limited to 90 visits/year. This visit limit does not apply to services for treatment of autism spectrum disorder.	
If you need help recovering or have other special health needs	Habilitation services	0% coinsurance	Not covered	none	
special fleath fleeus	Skilled nursing care	0% coinsurance	Not covered	*May require prior authorization.	
	Durable medical equipment	0% coinsurance	Not covered	*May require prior authorization.	
	Hospice services	0% coinsurance	Not covered	none	

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

Children's dental check-up

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

Coverage is available through a

stand-alone dental policy.

What You Will Pay Limitations, Exceptions & Other Important Information **Common Medical Event Services You May Need** Non-Network **Network** Provider (You will pay the least) Provider (You will pay the most) Coverage limited to end of month member turns 19. Children's eye exam 0% 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 If your child needs dental Children's glasses 0% coinsurance Not covered or eye care more details.

Not covered

Not covered

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

Coverage Period: Beginning on or after 01/01/2023 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 (Adult)

- 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 U.S.

- 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

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

Medica. KS Select by Medica Bronze Standard

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact: Medica at 1-866-269-6806 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? 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:

Other coinsurance



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 Diabet (a year of routine in-network care of a we condition)	Mia's Simple Fracture (in-network emergency room visit and follow up			
	The plan's overall deductible	\$9,100	The <u>plan's</u> overall deductible	\$9,100	■ The <u>plan's</u> overall deductible	,
	Specialist coinsurance	0%	Specialist coinsurance	0%	Specialist coinsurance	
	Hospital (facility) coinsurance	0%	Hospital (facility) coinsurance	0%	Hospital (facility) coinsurance	

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 (glucose meter)

Other coinsurance

This EXAMPLE event includes services like:

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

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

Other coinsurance

0%

Total Example Cost \$12,700		Total Example Cost \$5,600		Total Example Cost \$2,80	
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>	\$9,100	<u>Deductibles</u>	\$2,300	<u>Deductibles</u>	\$2,800

Cost Shaning		Cost Shaning	
<u>Deductibles</u>	\$9,100	<u>Deductibles</u>	\$2,300
Copayments	\$0	<u>Copayments</u>	\$300
Coinsurance	\$0	<u>Coinsurance</u>	\$0
What isn't covered		What isn't covered	
Limits or exclusions	\$60	Limits or exclusions	\$0
The total Peg would pay is	\$9,160	The total Joe would pay is	\$2,600

0%

Cost Sharing			
<u>Deductibles</u>	\$2,800		
<u>Copayments</u>	\$0		
Coinsurance	\$0		
What isn't covered			
Limits or exclusions	\$0		
The total Mia would pay is	\$2,800		

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

care)

\$9,100 0% 0%

0%

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 tarieta 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.

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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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Díí t'áá jíík'e shá ata' hodoonih nínízingo éí ninaaltsoos Medica bee néího'dílzinígí bine'déé' námboo biká'ígíjjj' béésh bee hodíilnih.

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