A

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-24 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?	\$7,850 individual / \$15,700 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. <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> ?	\$9,450 individual / \$18,900 family for <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 network provider?	Yes. See www.Medica.com/SearchSelectNetwork-24 or call 1-866-269-6806 (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 Y			
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	Primary care: \$0 copay/visit. Deductible does not apply. Retail health clinics: \$0 copay/visit. Deductible does not apply. Spinal manipulation: \$0 copay/visit. Deductible does not apply.	Not covered	50% coinsurance for other outpatient services. Primary care visits provided at an outpatient facility may be subject to coinsurance and deductible.	
	Specialist visit	\$150 copay/visit. Deductible does not apply.	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)	50% coinsurance	Not covered	None	
	Imaging (CT/PET scans, MRIs)	50% 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-24</u>.

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		What Y	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 mos			
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.Medica.com/KSDrugList-24	Generic drugs	Preferred Generic: \$25 copay/prescription. Deductible does not apply. Generic: \$30 copay/prescription. Deductible does not apply.		Up to a 34-day supply per prescription. *May require prior authorization. For preferred/non-preferred retail and specialty drugs, \$150 copay for orally-administered cancer treatmer medications. Deductible does not apply. Proton pump inhibitors	
	Preferred brand drugs	\$200 copay/prescription. Deductible does not apply.	Not covered	(except for members 12 years of age and younger, and those members who have a feeding tube) and	
	Non-Preferred brand drugs	70% 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 section of your Policy of	
	\$800 copay/prescription. Deductible does not apply. Not covered		Not covered	Drug List 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)	50% coinsurance	Not covered	*May require prior authorization.	
surgery	Physician/surgeon fees	50% coinsurance	Not covered	*May require prior authorization.	
	Emergency room care	50% coinsurance	50% coinsurance	Network deductible applies.	
If you need immediate medical attention	Emergency medical transportation	50% coinsurance	50% coinsurance	Network deductible applies.	
	<u>Urgent care</u>	\$0 copay/visit. Deductible does not apply.	\$0 copay/visit. Deductible 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 beenitel store	Facility fee (e.g., hospital room)	50% coinsurance	Not covered	*May require prior authorization.	
If you have a hospital stay	Physician/surgeon fees	50% 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-24</u>.

Durable medical equipment

Hospice services

What You Will Pay Limitations, Exceptions, & Other **Services You May Need Common Medical Event** Non-Network **Network Important Information** Provider (You will pay the most) **Provider** (You will pay the least) 50% coinsurance for other outpatient services. Other outpatient services \$0 copay/visit. Deductible include intensive outpatient **Outpatient services** Not covered If you need mental health, programs, diagnostic evaluations and psychological testing. *May does not apply. behavioral health, or substance abuse services require prior authorization. Inpatient services 50% coinsurance Not covered *May require prior authorization. Prenatal: 50% coinsurance Postnatal: 50% coinsurance Cost sharing does not apply to Not covered Office visits network preventive services Depending on the type of services. coinsurance may apply. Maternity care may include tests and services Childbirth/delivery professional If you are pregnant 50% coinsurance Not covered services described elsewhere in the SBC (i.e. Childbirth/delivery facility services 50% coinsurance Not covered ultrasound). Home health care 50% coinsurance Not covered *May require prior authorization. Speech therapy limited to 90 visits/year. This visit limit does not Rehabilitation services 50% coinsurance Not covered apply to services for treatment of autism spectrum disorder. If you need help recovering or have other Habilitation services 50% coinsurance Not covered None special health needs *May require prior authorization. Skilled nursing care 50% coinsurance Not covered

50% coinsurance

50% coinsurance

Not covered

Not covered

*May require prior authorization.

None

^{*} For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.Medica.com/SelectPolicies-24</u>.

Coverage Period: Beginning on or after 01/01/2024 Coverage for: Individual or Family | Plan Type: EPO

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		What Y		
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 your child needs dental or eye care	Children's eye exam	\$0 copay/visit. Deductible does not apply.	Not covered	Coverage limited to end of month member turns 19.
	Children's glasses	50% 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.
	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/SelectPolicies-24</u>.

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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 01/01/2024 Coverage for: Individual or Family | Plan Type: EPO

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:



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 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	\$7,850	■ The <u>plan's</u> overall <u>deductible</u>	\$7,850	■ The <u>plan's</u> overall <u>deductible</u>	\$7,850
Specialist copayment	\$150	Specialist copayment	\$150	Specialist copayment	\$150
Hospital (facility) <u>coinsurance</u>	50 %	Hospital (facility) coinsurance	50 %	Hospital (facility) coinsurance	50 %
Other <u>coinsurance</u>	50 %	Other <u>coinsurance</u>	50 %	Other <u>coinsurance</u>	50 %

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 (glucose meter)

This EXAMPLE event includes services like:

Rehabilitation services (physical therapy)

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

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	
<u>Deductibles</u>	\$7,850	<u>Deductibles</u>	\$1,100	<u>Deductibles</u>	\$2,600
Copayments	\$0	Copayments	\$900	Copayments	\$200
Coinsurance	\$1,600	Coinsurance	\$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
The total Peg would pay is	\$9,510	The total Joe would pay is	\$2,000	The total Mia would pay is	\$2,800

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

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- 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.

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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.

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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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