Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services MEDICA® MN Bold by M Health Fairview and Medica Silver Share

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/2021MHealthFairviewPolicies or call 877-335-8984. 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 877-335-8984 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall <u>deductible</u> ? | \$1,400 Individual / \$4,200 Family for <u>network</u> 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 <u>deductible</u> ? | Yes. <u>Preventive care</u> , preventive prescriptions, prenatal care 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 <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> ? | \$8,550 Individual/ \$17,100 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 <u>out-of-pocket limit</u> . |
| Will you pay less if you use a <u>network provider</u> ? | Yes. Visit <u>www.medica.com/SearchM-HealthFairview</u> or call 877-335-8984 (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 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 | Network Provider (You will pay the least) | Non-Network Provider (You will pay the most) | Limitations, Exceptions & Other Important Information |
| | Primary care visit to treat an injury or illness | Primary care: 50% coinsurance Retail health clinics: 50% coinsurance Chiropractic care: 50% coinsurance | Not covered | 50% <u>coinsurance</u> for other outpatient services. Primary care visits provided at an outpatient facility may be subject to <u>coinsurance</u> and <u>deductible</u> . |
| If you visit a health care provider's office or clinic | Specialist visit | 50% coinsurance | Not covered | none |
| | 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 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) | 50% coinsurance | Not covered | none |
| If you have a test | Imaging (CT/PET scans, MRIs) | 50% 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/ SSRx3MnNe. | Generic drugs | \$15 <u>copay</u> / prescription. <u>Deductible</u> does not apply. | Not covered | Up to a 31-day supply per prescription. *May require prior authorization. For non-preferred retail drugs, 50% <u>coinsurance</u> for orally-administered cancer treatment medications. Insulin: Your cost-share will not exceed \$25 per retail |
| | Preferred brand drugs | \$120 <u>copay</u> / prescription. Deductible does not apply. | Not covered | |
| | Non-Preferred brand drugs | 60% coinsurance | Not covered | prescription unit. *Refer to the Exceptions to the Drug List section of your Policy of Coverage for more details. No charge for preventive |
| | <u>Specialty drugs</u> | Preferred: \$650 <u>copay</u> / prescription. <u>Deductible</u> does not apply Non-Preferred: \$750 <u>copay</u> / prescription. <u>Deductible</u> does not apply | Not covered | of your Policy of Coverage for more details. No charge for preventive drugs, including some Over the Counter drugs obtained with a prescription. The list of covered drugs changes periodically. Notification of changes will be available 30 days prior to the change taking effect. |

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Coverage Period: Beginning on or after 01/01/2021 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 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. |
| | Emergency medical transportation | 50% coinsurance | 50% coinsurance | Network deductible applies. |
| If you need immediate medical attention | <u>Urgent care</u> | 50% coinsurance | 50% <u>coinsurance</u> | <u>Network deductible</u> applies. If a non-network <u>provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference (<u>balance</u> <u>billing</u>). |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 50% coinsurance | Not covered | Limited to a 365 day maximum/period of confinement, subject to the combined day limit. *May require prior authorization. |
| | Physician/surgeon fees | 50% coinsurance | Not covered | *May require prior authorization. |
| | Outpatient services | 50% coinsurance | Not covered | *May require prior authorization. |
| If you need mental health, behavioral health, or substance abuse services | Inpatient services | 50% coinsurance | Not covered | Limited to a 365 day maximum/period of confinement, subject to the combined day limit. *May require prior authorization. Residential treatment is covered as part of inpatient services. |
| If you are pregnant | Office visits | Prenatal: No charge. <u>Deductible</u> does not apply. Postnatal: 50% <u>coinsurance</u> | Not covered | Limited to a 365 day maximum/period of confinement, subject to the combined day limit. <u>Cost sharing</u> does not apply to |
| | Childbirth/delivery professional services | 50% coinsurance | Not covered | network preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services |
| | Childbirth/delivery facility services | 50% coinsurance | Not covered | described elsewhere in the SBC (i.e. ultrasound). |

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Coverage Period: Beginning on or after 01/01/2021 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 |
| | Home health care | 50% coinsurance | Not covered | Limited to 120 visits/ year. *May require prior authorization. |
| | Rehabilitation services | 50% coinsurance | Not covered | none |
| | Habilitation services | 50% coinsurance | Not covered | none |
| If you need help recovering or have other special health needs | Skilled nursing care | 50% coinsurance | Not covered | Limited to a 120 day maximum/ period of confinement, subject to the combined day limit. *May require prior authorization. |
| | Durable medical equipment | 50% coinsurance | Not covered | *May require prior authorization. |
| | Hospice services | 50% coinsurance | Not covered | Limited to a 30 day maximum for respite care and continuous care. |
| If your child needs dental or eye care | Children's eye exam | No charge. <u>Deductible</u> does not apply. | Not covered | Coverage limited to end of month member turns 19. |
| | Children's glasses | 50% coinsurance | Not covered | Limited to one pair of glasses or 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 (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.) | Hearing aids except for members 18 years of age and younger for hearing loss that is not correctable by other covered procedures; coverage is limited to one hearing aid per ear every three years. Infertility treatment Long-term care | Non-emergency care when traveling outside the U.S. Private-duty nursing Routine eye care (Adult) Routine foot care except for some conditions Weight loss programs | |

Dental check-up

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

• Chiropractic care

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 877-335-8984 or the Minnesota Department of Commerce at 651-539-1600 or 800-657-3602. 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.mnsure.org or call 651-539-2099 or 855-366-7873.

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 <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 877-335-8984 or the Minnesota Department of Commerce at 651-539-1600 or 800-657-3602.

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 <u>plan</u> doesn't meet the <u>Minimum Value Standards</u>, you may be eligible for a <u>premium tax credit</u> to help you pay for a <u>plan</u> through the <u>Marketplace</u>.

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. ------

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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 a hospital |
| delivery) |

- The plan's overall deductible: \$1,400
- Specialist coinsurance: 50%
- Hospital (facility) <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)

Total Example Cost

\$12,700

In this example, Peg would pay:

| Cost Sharing | | |
|----------------------------|---------|--|
| Deductibles | \$1,400 | |
| <u>Copayments</u> | \$10 | |
| Coinsurance | \$4,300 | |
| What isn't covered | | |
| Limits or exclusions | \$60 | |
| The total Peg would pay is | \$5,770 | |

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

- The plan's overall deductible: \$1,400
- Specialist coinsurance: 50%
- Hospital (facility) <u>coinsurance</u>: 50%
- Other <u>coinsurance</u>: 50%

This EXAMPLE event includes services like:

Primary care physician office visits (including disease education) Diagnostic tests (blood work) Prescription drugs Durable medical equipment (glucose meter)

Total Example Cost

In this example, Joe would pay:

| Cost Sharing | | |
|----------------------------|---------|--|
| Deductibles | \$1,400 | |
| <u>Copayments</u> | \$200 | |
| <u>Coinsurance</u> | \$600 | |
| What isn't covered | | |
| Limits or exclusions | \$0 | |
| The total Joe would pay is | \$2,200 | |

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

The plan's overall deductible: \$1,400

- Specialist ecineurance: 50%
- Specialist coinsurance: 50%
- Hospital (facility) <u>coinsurance</u>: 50%
- Other <u>coinsurance</u>: 50%

This EXAMPLE event includes services like:

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

\$5,600 Total Example Cost \$2,800

In this example, Mia would pay:

| Cost Sharing | | |
|----------------------------|---------|--|
| Deductibles | \$1,400 | |
| <u>Copayments</u> | \$10 | |
| Coinsurance | \$700 | |
| What isn't covered | | |
| Limits or exclusions | \$0 | |
| The total Mia would pay is | \$2,110 | |

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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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.

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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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Ako želite besplatnu pomoć za prijevod ovih informacija, nazovite broj naveden u ovom dokumentu ili na poleđini svoje ID kartice Medica.

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