A

The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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 <u>www.medica.com/2021EmpowerPolicies</u> or call 877-328-1363. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms, see the Glossary. You can view the Glossary at <a href="https://www.healthcare.gov/sbc-glossary">https://www.healthcare.gov/sbc-glossary</a> or call 877-328-1363 to request a copy.

Important					
Questions	Allsweis	vvily Tills matters.			
What is the overall deductible?	<b>\$0</b> 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 deductible?	Yes.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount.			
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.			
What is the out-of-pocket limit for this plan?	<b>\$0</b> 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, non-network deductible and coinsurance.	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</u> provider?	<b>Yes.</b> Visit <u>www.medica.com/SearchEmpower</u> or call 877-328-1363 (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 charge</u> and what your <u>plan pays (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.

	Services You May Need	What You Will Pay			
Common Medical Event		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	No charge	Not covered	none	
If you visit a health care provider's office or clinic	Specialist visit	No charge	Not covered	none	
	Preventive care/ screening/ immunization	No charge	Not covered	none	
lf von hove a toot	Diagnostic test (x-ray, blood work)	No charge	Not covered	none	
If you have a test	Imaging (CT/PET scans, MRIs)	No charge	Not covered	*May require prior authorization.	
If you need drugs to treat	Generic drugs				
your illness or condition	Preferred brand drugs	No charge	Not covered	Up to a 31-day supply per prescription. *May require prior authorization. Proton pump inhibitors (except for members 12 years of age and younger, and those members who have a feeding tube) and non-sedating	
More information about prescription drug coverage is	Non-Preferred brand drugs	No charge	Not covered	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	
available at www.medica.com/ BrRx2IA.	Specialty drugs	Preferred: No charge Non-preferred: No charge	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)	No charge	Not covered	*May require prior authorization.	
surgery	Physician/surgeon fees	No charge	Not covered	*May require prior authorization.	

<sup>\*</sup> For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.medica.com/2021EmpowerPolicies</u>.

	Services You May Need	What You Will Pay			
Common Medical Event		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information	
	Emergency room care			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 need immediate medical attention	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> ).	
If you have a beautiful story	Facility fee (e.g., hospital room)	No charge	Not covered	*May require prior authorization.	
If you have a hospital stay	Physician/surgeon fees	No charge	Not covered	*May require prior authorization.	
If you need mental health, behavioral health, or	Outpatient services	No charge	Not covered	*May require prior authorization.	
substance abuse services	Inpatient services	No charge	Not covered	*May require prior authorization.	
	Office visits No charge Not covered				
If you are pregnant	Childbirth/delivery professional services	No charge	Not covered	*May require prior authorization.	
	Childbirth/delivery facility services	No charge	Not covered		
	Home health care	No charge	Not covered	*May require prior authorization.	
	Rehabilitation services	No charge	Not covered	none	
If you need help	Habilitation services	No charge	Not covered	none	
recovering or have other special health needs	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	Respite care is limited to 5 consecutive days, up to a lifetime maximum of 15 inpatient days and 15 outpatient days.	

<sup>\*</sup> For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.medica.com/2021EmpowerPolicies</u>.

			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	
		Children's eye exam	No charge	Not covered	Limited to one refractive eye exam/ year to end of month member turns 19.	
	If your child needs dental or eye care	Children's glasses	No charge	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.	

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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 or in the case of rape or incest
- Acupuncture
- 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.

- Private-duty nursing
- Routine eyé care (Ădult)
- 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 plan document.)

- Bariatric surgery with prior authorization
- Chiropractic care

Infertility treatment (excludes some services)

Coverage Period: Beginning on or after 01/01/2021 Coverage for: Individual or Family | Plan Type: EPO

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 877-328-1363 or the lowa Insurance Division at 1-515-281-5705 or 1-877-955-1212. Other coverage options may be available to you too, including buying individual insurance coverage through the <a href="Health Insurance">Health Insurance</a> Marketplace. For more information about the <a href="Marketplace">Marketplace</a>, visit <a href="https://www.HealthCare.gov">www.HealthCare.gov</a> 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 <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 877-328-1363 or the lowa Insurance Division at 1-515-281-5705 or 1-877-955-1212.

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 a hospital delivery)

The plan's overall deductible: \$0

**Specialist coinsurance: 0%** 

Hospital (facility) coinsurance: 0%

Other coinsurance: 0%

#### 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				
<u>Deductibles</u>	\$0			
Copayments	\$0			
Coinsurance	\$0			
What isn't covered				
Limits or exclusions	\$60			
The total Peg would pay is				

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

The plan's overall deductible: \$0

**Specialist coinsurance: 0%** 

Hospital (facility) coinsurance: 0%

Other coinsurance: 0%

#### This EXAMPLE event includes services like:

Primary care physician office visits (including disease education)

Diagnostić tests (blood work)

Prescription drugs

Durable medical equipment (glucose meter)

#### **Total Example Cost** \$5,600

### In this example, Joe would pay:

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

## **Mia's Simple Fracture**

(in-network emergency room visit and follow up care)

The plan's overall deductible: \$0

**Specialist coinsurance: 0%** 

Hospital (facility) coinsurance: 0%

Other coinsurance: 0%

#### 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	\$2,800
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### In this example, Mia would pay:

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

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

### 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.

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