

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/2022AltruPolicies</u> or call 800-918-6474. 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 https://www.healthcare.gov/sbc-glossary or call 800-918-6474 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$0 for <u>network</u> services. There is no coverage for non-network services.	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
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 <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> ?	\$0 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.	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 network provider?	Yes. Visit <u>www.medica.com/findaltruproviders</u> or call 800-918-6474 (TTY:711) for a list of <u>network providers</u> .	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.

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	No charge	Not covered	Limited to 20 visits/year for chiropractic care.
Marian dala a basilibasia	Specialist visit	No charge	Not covered	none
If you visit a health care provider's office or clinic	Preventive care/ screening/immunization	No charge	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.
Maran barra a tant	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.
K d.d to to a t	Generic drugs	No charge	Not covered	Up to a 31-day supply per prescription. *May require prior authorization. Proton pump inhibitors
If you need drugs to treat your illness or condition More information about	Preferred brand drugs	No charge	Not covered	authorization. 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
prescription drug coverage is available at www.medica.com/ RxList2022.	Non-Preferred brand drugs	No charge	Not covered	not exceed \$25 per retail prescription
NXLISI2U22.	Specialty drugs	No charge	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)	No charge	Not covered	*May require prior authorization.
surgery	Physician/surgeon fees	No charge	Not covered	*May require prior authorization.
	Emergency room care	No charge	No charge	Network deductible applies.
If you need immediate medical attention	Emergency medical transportation	No charge	No charge	none
11 11 11 11 11	Urgent care	No charge	No charge	none

^{*} For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.medica.com/2022AltruPolicies</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** Provider (You will pay the most) (You will pay the least) *May require prior authorization. Facility fee (e.g., hospital room) No charge Not covered If you have a hospital stay Physician/surgeon fees No charge Not covered *May require prior authorization. If you need mental health, **Outpatient services** No charge *May require prior authorization. Not covered béhavioral health, or substance abuse services No charge Inpatient services *May require prior authorization. Not covered Office visits No charge Not covered Maternity care may include tests and services described elsewhere in the Childbirth/delivery professional If you are pregnant No charge Not covered SBC (i.e. ultrasound). *May require services prior authorization. Childbirth/delivery facility services No charge Not covered *May require prior authorization. Limited to 4 hours/day; 40 Home health care No charge Not covered visits/year. Outpatient: Limited to 30 visits per Rehabilitation services No charge therapy/year; Cardiac rehabilitation Not covered 30 visits/event. If you need help Outpatient: Limited to 30 visits per recovering or have other Habilitation services therapy/year; Cardiac <u>rehabilitation</u> 30 visits/event. No charge Not covered special health needs *May require prior authorization. Limited to 30 days/year. Skilled nursing care No charge Not covered

Not covered

Not covered

No charge

No charge

*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/2022AltruPolicies</u>.

Coverage Period: Beginning on or after 01/01/2022 Coverage for: Individual or Family | Plan Type: HMO

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) Limited to one refractive eye exam/year to end of month member Children's eye exam No charge Not covered turns 19. Coverage is limited to one pair of frames every 2 calendar years and one pair of lenses every calendar year. Contact lenses are limited to If your child needs dental Children's glasses No charge Not covered or eye care once every calendar year. Coverage is available through a stand-alone dental policy. Children's dental check-up Not covered Not covered

^{*} For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.medica.com/2022AltruPolicies</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
- Chiropractic care exceeding 20 visits per member per year.
- Cosmetic surgery

- Dental care (Adult)
- Dental care (Child) (coverage is available through a stand-alone dental policy.)
- Dental check-up
- Hearing aids
- Infertility treatment
- Long-term care

- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eyé 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.)

 Bariatric surgery limited to one surgery per member with prior authorization Medica ND Altru Prime by Medica Bronze Value Zero

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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 800-918-6474 or the North Dakota Commissioner of Insurance at 701-328-2440 or 800-247-0560. 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 <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact: Medica at 800-918-6474 or the North Dakota Commissioner of Insurance at 701-328-2440 or 800-247-0560.

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. -----------------

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

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 hosp delivery)	ital	(a)	M year of r
■ The <u>plan's</u> overall <u>deductible</u> :	\$0		The pl
Specialist coinsurance:	0%		Specia
Hospital (facility) coinsurance:	0%		Hospit
Other <u>coinsurance</u> :	0%		Other

Managing Joe's Type 2 Diabete	s
Managing Joe's Type 2 Diabete (a year of routine in-network care of a well	-controlled
condition)	
■ The <u>plan's</u> overall <u>deductible</u> :	\$

The plan's overall deductible:	\$(
Specialist coinsurance:	0%
Hospital (facility) coinsurance:	0%

r <u>coinsurance</u> :	0%	Other <u>coinsurance</u> :

Hospital (facility) coinsurance: 0% 0% This EXAMPLE event includes services like: This EXAMPLE event includes services like: Primary care physician office visits (including disease Emorgonov room care (including modical cumplice)

In this example, Mia would pay:

Specialist coinsurance:

The plan's overall deductible:

This EXAMPLE event includes services like: Specialist office visits (prenatal care) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests</u> (ultrasounds and blood work) Specialist visit (anesthesia)

<u>Diagnostic tests</u> (blood work)	
Prescription drugs	
Durable medical equipment (glucose meter)	

<u>Emergency room care</u> (moluumy medicai su	upiles)
Diagnostic test (x-ray)	
Durable medical equipment (crutches)	
Rehabilitation services (physical therapy)	
(physical therapy)	

Total Example Cost	\$12,700

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

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	\$60

education)

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

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

The <u>plan</u> would be responsible for the other costs of these EXAMPLE covered services.

\$0 0%

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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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