Coverage for: Individual or Family | Plan Type: HMO

⊘ Medica. ND Altru Prime by Medica Gold Copay Zero

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 www.medica.com/findaltruproviders or call 800-918-6474 (TTY:711) for a list of | |



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 | No charge | Not covered | Limited to 20 visits/year for chiropractic care. |
| If you viola a bookly some | 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. |
| | 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 would down to troot | Generic 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 |
| If you need drugs to treat your illness or condition More information about | Preferred brand drugs | No charge | Not covered | and younger, and those members |
| prescription drug coverage is available at www.medica.com/ RxList2022. | Non-Preferred brand drugs | No charge | 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 |
| MXLIS(2022. | 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 |
| | <u>Urgent care</u> | 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>.

| | What Yo | | ou 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 a hospital stay | Facility fee (e.g., hospital room) | No charge | Not covered | *May require prior authorization. |
| ii you nave a nospitai 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 | Maternity care may include tests and |
| If you are pregnant | Childbirth/delivery professional services | No charge | Not covered | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). *May require prior authorization. |
| | Childbirth/delivery facility services | No charge | Not covered | |
| | Home health care | No charge | Not covered | *May require prior authorization. Limited to 4 hours/day; 40 visits/year. |
| | Rehabilitation services | No charge | Not covered | Outpatient: Limited to 30 visits per therapy/year; Cardiac rehabilitation 30 visits/event. |
| If you need help recovering or have other special health needs | Habilitation services | No charge | Not covered | Outpatient: Limited to 30 visits per therapy/year; Cardiac rehabilitation 30 visits/event. |
| | Skilled nursing care | No charge | Not covered | *May require prior authorization. Limited to 30 days/year. |
| | <u>Durable medical equipment</u> | No charge | Not covered | *May require prior authorization. |
| | Hospice services | No charge | Not covered | none |

^{*} 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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| | Services You May Need | What Y | | |
|---|----------------------------|---|--|--|
| Common Medical Event | | 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 | No charge | Not covered | Limited to one refractive eye exam/year to end of month member turns 19. |
| | Children's glasses | No charge | Not covered | 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 once every calendar year. |
| | Children's dental check-up | Not covered | Not covered | Coverage is available through a stand-alone dental policy. |

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

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 (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 limited to one surgery per member with prior authorization Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Medica ND Altru Prime by Medica Gold Copay Zero

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

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

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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 hodelivery) | spital | Managing Joe's (a year of routine in-netwo |
|--|--------|---|
| ■ The plan's overall deductible: | \$0 | ■ The <u>plan's</u> overall <u>de</u> |
| Specialist copayment: | \$0 | Specialist copaymer |
| Hospital (facility) coinsurance: | 0% | Hospital (facility) co |
| Other coinsurance: | 0% | Other <u>coinsurance</u> : |
| This EXAMPLE event includes services like: | | This EXAMPLE event incl |

| (a y | Managing Joe's Type 2 Dial rear of routine in-network care of a condition) | betes well-controlled |
|------|--|---------------------------------|
| | The <u>plan's</u> overall <u>deductible</u> : | \$ |
| | • I II I | • |

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

| (in-network emergency room visit and follow | up care) |
|---|----------|
| ■ The <u>plan's</u> overall <u>deductible</u> : | \$0 |
| Specialist copayment: | \$0 |
| Hospital (facility) coinsurance: | 0% |
| Other coinsurance: | 0% |

Mia's Simple Fracture

Specialist office visits (prenatal care) Childbirth/Delivery Professional Services

Childbirth/Delivery Facility Services

<u>Diagnostic tests</u> (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

Durable medical equipment (glucose meter)

| | includes services like: |
|-------------------------|------------------------------|
| Emergency room care | (including medical supplies) |
| Diagnostic test (x-ray) | , |

<u>Durable medical equipment</u> (*crutches*) Rehabilitation services (physical therapy)

In this example, Mia would pay:

| Total Example Cost | \$12,700 |
|--------------------|----------|
|--------------------|----------|

| Total Example Cost | \$5,600 |
|--------------------|---------|
| | |

| Total Example Cost | \$2,800 |
|--------------------|----------|
| - | <u>-</u> |

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 | |

In this example, Joe would pay:

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

| | Cost Sharing | |
|--------------------|--------------|-----|
| <u>Deductibles</u> | | \$0 |
| Copayments | | \$0 |
| Coinsurance | | \$0 |
| | 14/1 | |

| 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.

Coverage Period: Beginning on or after 01/01/2022

Coverage for: Individual or Family | Plan Type: HMO

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 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.

ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປຂໍ້ມູນນີ້ຟຣີ, ໃຫ້ໂທຫາເລກໝາຍ ທີ່ມີຢູ່ໃນເອກະສານນີ້ ຫຼື ຢູ່ດ້ານຫຼັງຂອງບັດ Medica ຂອງທ່ານ. 이 정보를 번역하는 데 무료로 도움을 받고 싶으시면, 이 문서에 포함된 전화번호나 Medica ID 카드 뒷면의 전화번호로 전화하십시오.

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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.

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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