**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/2022ApplausePolicies or call 888-592-8211. 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 888-592-8211 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **$650** Individual / **$1,950** Family for network services. There is no coverage for non-network services. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | **Yes.** Preventive care, preventive prescriptions, prenatal care and copay services from network providers are covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits. |
| **Are there other deductibles for specific services?** | **No.** | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | **$2,900** Individual / **$5,800** Family for network services. There is no coverage for non-network services. | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billing charges (unless balanced billing is prohibited), 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.** Visit www.medica.com/findapplauseproviders or call 888-592-8211 (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 referral to see a specialist?** | **No.** | You can see the specialist you choose without a referral. |

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Non-Network Provider (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | Primary care: $10 copay/visit. Deductible does not apply. Retail health clinics: $10 copay/visit. Deductible does not apply. Chiropractic care: $10 copay/visit. Deductible does not apply. | Not covered | 30% coinsurance for other outpatient services. Primary care visits provided at an outpatient facility may be subject to coinsurance and deductible. |
| | Specialist visit | $50 copay/visit. Deductible does not apply. | Not covered | 30% coinsurance for other outpatient services. Specialist visits provided at an outpatient facility may be subject to coinsurance and deductible. |
| | 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) | 30% coinsurance | Not covered | ---none--- |
| | Imaging (CT/PET scans, MRIs) | 30% coinsurance | Not covered | *May require prior authorization. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Non-Network Provider (You will pay the most) | |
| **If you need drugs to treat your illness or condition**<br>More information about prescription drug coverage is available at **www.medica.com/RxList2022**. | Generic drugs | $5 copay/prescription. Deductible does not apply. | Not covered | Up to a 31-day supply per prescription. *May require prior authorization. For preferred/non-preferred retail and specialty drugs, $50 copay for orally-administered cancer treatment medications. Deductible does not apply. 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 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. |
| | Preferred brand drugs | $90 copay/prescription. Deductible does not apply. | Not covered | |
| | Non-Preferred brand drugs | 40% coinsurance | Not covered | |
| | Specialty drugs | $350 copay/prescription. Deductible does not apply. | Not covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 30% coinsurance | Not covered | *May require prior authorization. |
| | Physician/surgeon fees | 30% coinsurance | Not covered | *May require prior authorization. |
| **If you need immediate medical attention** | Emergency room care | 30% coinsurance | 30% coinsurance | Network deductible applies. |
| | Emergency medical transportation | 30% coinsurance | 30% coinsurance | Network deductible applies. |
| | Urgent care | $10 copay/visit. Deductible does not apply. | $10 copay/visit. Deductible does not apply. | If a non-network provider charges more than the allowed amount, you may have to pay the difference (balance billing). |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 30% 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 | 30% coinsurance | Not covered | *May require prior authorization. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Non-Network Provider (You will pay the most) | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $10 copay/visit. Deductible does not apply. | Not covered | 30% coinsurance for other outpatient services. Other outpatient services include intensive outpatient programs, diagnostic evaluations and psychological testing. *May require prior authorization. |
| | Inpatient services | 30% 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. Deductible does not apply. Postnatal: 30% coinsurance | Not covered | Limited to a 365 day maximum/period of confinement, subject to the combined day limit. Cost sharing does not apply to network preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | 30% coinsurance | Not covered | |
| | Childbirth/delivery facility services | 30% coinsurance | Not covered | |
| **If you need help recovering or have other special health needs** | Home health care | 30% coinsurance | Not covered | Limited to 120 visits/year. *May require prior authorization. |
| | Rehabilitation services | 30% coinsurance | Not covered | ---none--- |
| | Habilitation services | 30% coinsurance | Not covered | ---none--- |
| | Skilled nursing care | 30% 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 | 30% coinsurance | Not covered | *May require prior authorization. |
| | Hospice services | 30% coinsurance | Not covered | Limited to a 30 day maximum for respite care and continuous care. |



* For more information about limitations and exceptions, see the plan or policy document at www.medica.com/2022ApplausePolicies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Non-Network Provider (You will pay the most) | |
| **If your child needs dental or eye care** | Children's eye exam | No charge. Deductible does not apply. | Not covered | Coverage limited to end of month member turns 19. |
| | Children's glasses | 30% 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.)
- Dental check-up
- 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

**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 888-592-8211 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 claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Medica at 888-592-8211 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 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 plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. 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:** $650
- **Specialist copayment:** $50
- **Hospital (facility) coinsurance:** 30%
- **Other coinsurance:** 30%

**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 | $650 |
| Copayments | $0 |
| Coinsurance | $2,250 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$2,960** |

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

- **The plan's overall deductible:** $650
- **Specialist copayment:** $50
- **Hospital (facility) coinsurance:** 30%
- **Other coinsurance:** 30%

**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** **$5,600**

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $650 |
| Copayments | $700 |
| Coinsurance | $100 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$1,450** |

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

- **The plan's overall deductible:** $650
- **Specialist copayment:** $50
- **Hospital (facility) coinsurance:** 30%
- **Other coinsurance:** 30%

**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**

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $650 |
| Copayments | $100 |
| Coinsurance | $600 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,350** |

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.

إذا كنت تريد مساعدة مجانية في ترجمة هذه المعلومات، فاتصل على الرقم الوارد في هذه الوثيقة أو على 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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