

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/2022DirectPolicies</u> or call 888-592-8211. 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 888-592-8211 to request a copy.

| Important Questions   | Answers  | Why This Matters:   |
|---|--|---|
| What is the overall deductible?                               | \$3,400 Individual / \$6,800 Family. In-network and out-of-network deductibles combined.   | 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 policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.   |
| Are there services covered before you meet your deductible?   | Yes. Preventive care, preventive prescriptions and prenatal care from in-network providers are covered before you meet your deductible.                    | 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits">https://www.healthcare.gov/coverage/preventive-care-benefits</a> .  |
| 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> ? | \$3,400 Individual / \$6,800 Family. In-network and out-of-network out-of-pocket limits combined.  | 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 (unless balanced billing is prohibited), health care this plan doesn't cover, out-of-network deductible and coinsurance. | 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 <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                            | In-Network Provider (You will pay the least)   | Out-of-Network<br>Provider<br>(You will pay the most) | Limitations, Exceptions & Other Important Information   |
|   | Primary care visit to treat an injury or illness | Primary care: 0% coinsurance Retail health clinics: 0% coinsurance Chiropractic care: 0% coinsurance | 0% coinsurance  | none  |
| If you vioit a booth care   | Specialist visit                                 | 0% coinsurance   | 0% coinsurance  | none  |
| If you visit a health care provider's office or clinic                          | Preventive care/<br>screening/immunization       | No charge. <u>Deductible</u> does not apply.   | 0% coinsurance  | Immunizations for children under age 18 or well child care for children under age 6 covered as a network benefit. 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)              | 0% coinsurance   | 0% coinsurance  | none  |
|   | Imaging (CT/PET scans, MRIs)                     | 0% coinsurance   | 0% coinsurance  | *May require prior authorization.   |
|   | Generic drugs                                    | 0% coinsurance   | 0% coinsurance  | Up to a 31-day supply per prescription. *May require prior authorization. Insulin: Your   |
| If you need drugs to treat your illness or condition  More information about    | Preferred brand drugs                            | 0% coinsurance   | 0% coinsurance  | cost-share will not exceed \$25 per retail prescription unit. 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                             |
| prescription drug coverage<br>is available at<br>www.medica.com/<br>MNDrugList. | Non-Preferred brand drugs                        | 0% coinsurance   | 0% coinsurance  |   |
|   | Specialty drugs                                  | 0% coinsurance   | 0% coinsurance  | available 30 days prior to the change taking effect.  |
| If you have outpatient surgery  | Facility fee (e.g., ambulatory surgery center)   | 0% coinsurance   | 0% coinsurance  | *May require prior authorization.   |
|   | Physician/surgeon fees                           | 0% coinsurance   | 0% coinsurance  | *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/2022DirectPolicies</u>.

**What You Will Pay Limitations, Exceptions & Other Services You May Need Common Medical Event Out-of-Network** In-Network **Important Information** Provider (You will pay the least) Provider (You will pay the most) Emergency room care 0% coinsurance 0% coinsurance In-network deductible applies. Emergency medical transportation 0% coinsurance 0% coinsurance In-network deductible applies. If you need immediate In-network deductible applies. If a médical attention non-network provider charges more than the allowed amount, you may Urgent care 0% coinsurance 0% coinsurance have to pay the difference (balance billing). Facility fee (e.g., hospital room) 0% coinsurance 0% coinsurance \*May require prior authorization. If you have a hospital stay Physician/surgeon fees 0% coinsurance 0% coinsurance \*May require prior authorization. 0% coinsurance **Outpatient services** 0% coinsurance \*May require prior authorization. If you need mental health, \*May require prior authorization. Residential treatment is covered as béhavioral health, or Inpatient services 0% coinsurance 0% coinsurance substance abuse services part of inpatient services. Prenatal: 0% coinsurance. Prenatal: No charge. Cost sharing does not apply to Deductible does not apply. Postnatal: 0% coinsurance Deductible does not apply. Postnatal: 0% coinsurance Office visits In-Network preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services If you are pregnant Childbirth/delivery professional 0% coinsurance 0% coinsurance services described elsewhere in the SBC (i.e. ultrasound). Childbirth/delivery facility services 0% coinsurance 0% coinsurance Home health care 0% coinsurance 0% coinsurance \*May require prior authorization. Rehabilitation services 0% coinsurance 0% coinsurance ---none---If you need help Habilitation services 0% coinsurance 0% coinsurance ---none--recovering or have other special health needs Limited to 120 days/year. Skilled nursing care 0% coinsurance 0% coinsurance Durable medical equipment \*May require prior authorization. 0% coinsurance 0% coinsurance 0% coinsurance Hospice services Not covered ---none---

<sup>\*</sup> For more information about limitations and exceptions, see the plan or policy document at www.medica.com/2022DirectPolicies.

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

|  | Services You May Need      | What You Will Pay                                  |   |  |
|--|----------------------------|--|---|--|
| Common Medical Event                   |                            | In-Network<br>Provider<br>(You will pay the least) | Out-of-Network<br>Provider<br>(You will pay the most) | Limitations, Exceptions & Other Important Information                            |
| If your child needs dental or eye care | Children's eye exam        | No charge. <u>Deductible</u> does not apply.       | 0% coinsurance  | Coverage limited to end of month member turns 19.                                |
|  | Children's glasses         | 0% coinsurance                                     | 0% coinsurance  | 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.                       |

<sup>\*</sup> For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.medica.com/2022DirectPolicies</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
- 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 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

Chiropractic care

Routine eye care (Adult)

Medica MN Direct HSA Gold H

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

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 <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: \$3,400
 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)
Childbirth visit (anaethesis)

Specialist visit (anesthesia)

Total Example Cost \$12,700

# In this example, Peg would pay:

| Cost Sharing               |         |
|----------------------------|---------|
| <u>Deductibles</u>         | \$3,400 |
| Copayments                 | \$0     |
| Coinsurance                | \$0     |
| What isn't covered         |         |
| Limits or exclusions       | \$60    |
| The total Peg would pay is | \$3,460 |

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

The plan's overall deductible: \$3,400
 Specialist coinsurance: 0%
 Hospital (facility) coinsurance: 0%

Other <u>coinsurance</u>:

#### This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits (*including disease education*)

<u>Diagnostić tests</u> (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>         | \$2,300 |
| Copayments                 | \$300   |
| Coinsurance                | \$0     |
| What isn't covered         |         |
| Limits or exclusions       | \$0     |
| The total Joe would pay is | \$2,600 |

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

The plan's overall deductible: \$3,400
 Specialist coinsurance: 0%
 Hospital (facility) coinsurance: 0%

Other <u>coinsurance</u>:

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

# In this example, Mia would pay:

| Cost Sharing               |         |
|----------------------------|---------|
| <u>Deductibles</u>         | \$2,800 |
| Copayments                 | \$0     |
| Coinsurance                | \$0     |
| What isn't covered         |         |
| Limits or exclusions       | \$0     |
| The total Mia would pay is | \$2,800 |

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

0%

Coverage for: Individual or Family | Plan Type: PPO

### 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.

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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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Díí t'áá jíík'e shá ata' hodoonih nínízingo éí ninaaltsoos Medica bee néího'dílzinígí bine'déé' námboo biká'ígíiji' béésh bee hodíilnih.

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