



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/2022EmpowerPolicies</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 https://www.healthcare.gov/sbc-glossary or call 877-328-1363 to request a copy.

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Important Questions	Answers	Why This Matters:		
What is the overall deductible?	\$3,700 Individual / \$7,400 Family for network 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. Preventive care, preventive prescriptions and copay services from 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 https://www.healthcare.gov/coverage/preventive-care-benefits .		
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?	\$6,950 Individual / \$13,900 Family for network services. There is no coverage for non-network services.	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 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 <u>network</u> provider?	Yes. Visit <u>www.medica.com/FindEmpowerProviders</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 and what your 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 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 you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Primary care: \$20 copay/visit. Deductible does not apply. Retail health clinics: \$20 copay/visit. Deductible does not apply. Chiropractic care: \$20 copay/visit. Deductible does not apply. Characteristic care: \$20 copay/visit. Deductible does not apply.	Not covered	35% coinsurance for other outpatient services. Primary care visits provided at an outpatient facility may be subject to coinsurance and deductible.
	Specialist visit	\$75 copay/visit. Deductible does not apply.	Not covered	none
	Preventive care/ screening/immunization	No charge. <u>Deductible</u> 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)	35% coinsurance	Not covered	none
ii you iiave a test	Imaging (CT/PET scans, MRIs)	35% coinsurance	Not covered	*May require prior authorization.

^{*} For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.medica.com/2022EmpowerPolicies</u>.

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	Services You May Need	What \			
Common Medical Event		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information	
	Generic drugs	\$10 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, \$75 copay for	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.medica.com/ RxList22.	Preferred brand drugs	\$120 copay/prescription. Deductible does not apply.	Not covered	orally-administered cancer treatment medications. Deductible does not apply. Proton pump inhibitors (except for members 12 years of age and younger, and those members	
	Non-Preferred brand drugs	50% coinsurance	Not covered	and younger, and those members who have a feeding tube) and non-sedating antihistamines are not covered. Insulin: Your cost-share wi not exceed \$25 per retail prescriptio unit. *Refer to the Exceptions to the Drug List section of your Policy of Coverage for more details. No charge for preventive drugs.	
	Specialty drugs	\$650 copay/prescription. Deductible does not apply.	Not covered		
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	35% coinsurance	Not covered	*May require prior authorization.	
surgery	Physician/surgeon fees	35% coinsurance	Not covered	*May require prior authorization.	
	Emergency room care	35% coinsurance	35% coinsurance	Network deductible applies.	
If you need immediate	Emergency medical transportation	35% coinsurance	35% coinsurance	Network deductible applies.	
If you need immediate medical attention	Urgent care	\$20 <u>copay</u> /visit. <u>Deductible</u> does not apply.	\$20 copay/visit. Deductible does not apply.	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 boonital stay	Facility fee (e.g., hospital room)	35% coinsurance	Not covered	*May require prior authorization.	
If you have a hospital stay	Physician/surgeon fees	35% coinsurance	Not covered	*May require prior authorization.	

^{*} For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.medica.com/2022EmpowerPolicies</u>.

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 least) (You will pay the most) 35% <u>coinsurance</u> for other outpatient services. Other outpatient services \$20 copay/visit. Deductible include intensive outpatient **Outpatient services** Not covered If you need mental health, programs, diagnostic evaluations and psychological testing. *May does not apply. behavioral health, or substance abuse services require prior authorization. 35% coinsurance Inpatient services Not covered *May require prior authorization. Prenatal: 35% coinsurance Cost sharing does not apply to Office visits Not covered Postnatal: 35% coinsurance 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. If you are pregnant Childbirth/delivery professional 35% coinsurance Not covered services Childbirth/delivery facility services 35% coinsurance Not covered ultrasound). 35% coinsurance Home health care Not covered *May require prior authorization. Rehabilitation services 35% coinsurance Not covered ---none---Habilitation services 35% coinsurance Not covered ---none---If you need help Skilled nursing care 35% coinsurance *May require prior authorization. Not covered recovering or have other special health needs Durable medical equipment 35% coinsurance Not covered *May require prior authorization. Respite care is limited to 5 consecutive days, up to a lifetime maximum of 15 inpatient days and Hospice services 35% coinsurance Not covered 15 outpatient days. Limited to one refractive eve \$20 copay/visit. Deductible exam/year to end of month member Children's eve exam Not covered does not apply. turns 19. If your child needs dental Limited to one pair of glasses or contacts/year to end of month member turns 19. or eve care Children's glasses 35% coinsurance Not covered Coverage is available through a Children's dental check-up Not covered Not covered stand-alone dental policy.

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

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.)
- Dentăl check-up
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the

- 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 <u>plan</u> document.)

• Bariatric surgery with prior authorization

Chiropractic care

Infertility treatment (excludes some services)

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

Mia's Simple Fracture

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

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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.

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled

condition)

Peg is Having a Baby
(9 months of in-network prenatal care and a hospital
delivery)

\$3,700 The plan's overall deductible: \$75 **Specialist copayment:** 35% **Hospital (facility) coinsurance:**

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)

Cost Sharing

What isn't covered

Specialist visit (anesthesia)

Deductibles

Copayments

Coinsurance

Limits or exclusions

The total Peg would pay is

In this example, Peg would pay:

Other coinsurance:

This EXAMPLE event includes services like:

■ The plan's overall deductible:

Hospital (facility) coinsurance:

Specialist copayment:

Other coinsurance:

Primary care physician office visits (including disease education)

Diagnostić tests (blood work)

Prescription drugs

35%

\$3,700

\$2,600

\$6,370

\$10

\$60

Total Example Cost

Durable medical equipment (alucose meter)

This EXAMPLE event includes services like:

\$3,700

\$75

35%

35%

\$5,600

Emergency room care (including medical supplies)

Diagnostic test (x-ray)

Durable medical equipment (crutches) Rehabilitation services (physical therapy)

■ The plan's overall deductible:

Hospital (facility) coinsurance:

Specialist copayment:

Other coinsurance:

Total Example Cost \$12,700

In	this	example,	Joe	would	pay:
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Cost Sharing	
<u>Deductibles</u>	\$1,100
Copayments	\$800
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$1,900

Total Example Cost \$2.800

In this example, Mia would pay:

Cost Sharing		
<u>Deductibles</u>	\$2,600	
Copayments	\$200	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$2,800	

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

\$3,700

\$75

35%

35%

Coverage for: Individual or Family | Plan Type: EPO

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.

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.

Si vous voulez une assistance gratuite pour traduire ces informations, appelez le numéro indiqué dans ce document ou au dos de votre carte d'identification Medica.

နမှါအဲ့ဒိုးတါကိုးထံစၤကလီနှုံနာတာ်က်တာ်ကျိုးဆုံးလာအကလီနှုံဉ်,ကိုးလီတဲ့စိနီဉ်က်လာအပဉ် ယှာ်လာလာတီလာမီအပူးဆုံးမှတမှုါစုံနန္နနိုင်စေလာ်အဉ်သႊစုးကုအလိုခံတကပၤအဖီခိုဉ်နှဉ်တက္ကာ.

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'ígíjjj' béésh bee hodíilnih.

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