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/AltruPolicies-2023 or call 1-800-918-6474. 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 www.healthcare.gov/sbc-glossary or call 1-800-918-6474 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$1,900 individual / \$3,800 family for <u>network</u> 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 <u>deductible</u> ?	Yes. <u>Preventive care</u> , preventive prescriptions, prenatal care and <u>copay</u> services from <u>network providers</u> are covered before you meet your <u>deductible</u> .	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 <u>https://www.healthcare.gov/coverage/preventive-care-benefits</u> .
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> ?	\$7,200 individual / \$14,400 family for <u>network</u> 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 (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 <u>network provider</u> ?	Yes. See <u>www.Medica.com/SearchAltruNetwork-2023</u> or call 1-800-918-6474 (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</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 <u>specialist</u> you choose without a <u>referral</u> .

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 Y		
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 visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Primary care: 30% coinsurance Retail health clinics: 30% coinsurance Chiropractic care: 30% coinsurance	Not covered	none
	Specialist visit	30% coinsurance	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)	30% coinsurance	Not covered	none
If you have a test	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not covered	*May require prior authorization.

	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 need drugs to treat your illness or condition More information about prescription drug coverage is available at www.Medica.com/ MNDrugList-2023	Generic drugs	Preferred Generic: \$5 copay/prescription. Deductible does not apply. Generic: \$10 copay/prescription. Deductible does not apply.	Not covered	Up to a 31-day supply per prescription. *May require prior authorization. For non-preferred retail drugs, 30% <u>coinsurance</u> for orally-administered cancer treatment medications. Insulin: Your cost-share will not exceed \$25 per retail prescription unit. *Refer to the Exceptions to the Drug List section
	Preferred brand drugs	\$120 <u>copay</u> /prescription. <u>Deductible</u> does not apply.	Not covered	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
	Non-Preferred brand drugs	60% coinsurance	Not covered	drugs changes periodically. Notification of changes will be available 30 days prior to the change taking effect. Amounts reimbursed or
	Specialty drugs	\$650 <u>copay</u> /prescription. <u>Deductible</u> does not apply.	Not covered	paid by a <u>provider</u> or manufacturer, on your behalf for a product or service, will not apply toward your cost share.
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Not covered	*May require prior authorization.
surgery	Physician/surgeon fees	30% coinsurance	Not covered	*May require prior authorization.
	Emergency room care	30% coinsurance	30% coinsurance	Network deductible applies.
	Emergency medical transportation	30% coinsurance	30% coinsurance	Network deductible applies.
If you need immediate medical attention	<u>Urgent care</u>	30% coinsurance	30% coinsurance	Network deductible applies. If a non-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).

		What Y	Limitations, Exceptions & Other Important Information	
Common Medical Event	Services You May Need	y Need Network Non-Network Provider Provider (You will pay the least) (You will pay the mo		
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.
	Outpatient services	30% coinsurance	Not covered	*May require prior authorization.
If you need mental health, behavioral health, or substance abuse services	Inpatient services	30% <u>coinsurance</u>	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.
lf you are pregnant	Office visits	Prenatal: No charge. <u>Deductible</u> does not apply. Postnatal: 30% <u>coinsurance</u>	Not covered	Limited to a 365 day maximum/period of confinement, subject to the combined day limit. Cost sharing does not apply to
	Childbirth/delivery professional services	30% coinsurance	Not covered	network preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services
	Childbirth/delivery facility services	30% coinsurance	Not covered	described elsewhere in the SBC (i.e. ultrasound).

		What Y			
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	
	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	
If you need help recovering or have other special health needs	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.	
If your child needs dental or eye care	Children's eye exam	No charge. <u>Deductible</u> 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 *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 	 Your policy or plan document for more information an Hearing aids 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 	 nd a list of any other excluded services.) 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 <u>plan</u> 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 1-800-918-6474 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 <u>Health Insurance Marketplace</u>. For more information about the <u>Marketplace</u>, visit <u>www.mnsure.org</u> 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 <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. 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 1-800-918-6474 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? Not Applicable. 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 1-888-592-8211. Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-592-8211. Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-592-8211. Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-592-8211.

To see examples of how this <u>plan</u> 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 pre-natal care a delivery)	nd a hospital	Managing Joe's Type 2 Diabet (a year of routine in-network care of a we condition)	es Il-controlled	Mia's Simple Fracture (in-network emergency room visit and foll	ow up care)
The plan's overall deductible	\$1,900	The <u>plan's</u> overall deductible	\$1,900	The plan's overall deductible	\$1,900
Specialist coinsurance	30%	Specialist coinsurance	30 %	Specialist coinsurance	30%
 Hospital (facility) <u>coinsurance</u> 	30%	 Hospital (facility) <u>coinsurance</u> 	30 %	 Hospital (facility) <u>coinsurance</u> 	30%
Other <u>coinsurance</u>	30%	Other <u>coinsurance</u>	30%	0% ■ Other <u>coinsurance</u>	
This EXAMPLE event includes services <u>Specialist</u> office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests</u> (<i>ultrasounds and blood w</i> <u>Specialist</u> visit (<i>anesthesia</i>)		This EXAMPLE event includes services Primary care physician office visits (includin education) Diagnostic tests (blood work) Prescription drugs Durable medical equipment (glucose meter	ng disease	This EXAMPLE event includes services Emergency room care (including medical s Diagnostic test (x-ray) Durable medical equipment (crutches) Rehabilitation services (physical therapy)	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
n this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
Cost Sharing		Cost Sharing		Cost Sharing	
	\$1,900	Deductibles	\$1,900	<u>Deductibles</u>	\$1,900
Deductibles	ψ1,000				• • • •
Deductibles Copayments	\$10	Copayments	\$200	<u>Copayments</u>	\$10
			\$200 \$300	Copayments Coinsurance	\$10 \$300
Copayments	\$10	Copayments	-		
Copayments Coinsurance	\$10	Copayments Coinsurance	-	Coinsurance	

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.

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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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