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/EssentiaCarePolicies-2023 or call 1-877-407-8464. 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 1-877-407-8464 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$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 <u>deductible</u> ?	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 plan does not have an out-of-pocket limit on your expenses.
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.	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a <u>network provider</u> ?	Yes. See <u>www.Medica.com/SearchEssentiaCareNetwork-2023</u> or call 1-877-407-8464 (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 copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

		What			
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	none	
lf you visit a baalth aara	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 <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.	
If you have a test	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.	
	Generic drugs	No charge	Not covered	Up to a 31-day supply per prescription. *May require prior authorization. Insulin: Your cost-share will not exceed \$25 per	
If you need drugs to treat your illness or condition More information about	Preferred brand drugs	No charge	Not covered	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	
prescription drug coverage is available at www.Medica.com/ MNDrugList-2023	Non-Preferred brand drugs	No charge	Not covered	 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. Amounts reimbursed or taking effect. 	
	Specialty drugs	No charge	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.	

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services MN Essentia Choice Care with Medica Silver Share Zero Coverage Period: Beginning on or after 01/01/2023 Coverage for: Individual or Family | Plan Type: EPO

		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 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	none	
If	Emergency medical transportation	No charge	No charge	none	
If you need immediate medical attention	<u>Urgent care</u>	No charge	No charge	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 hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	Limited to a 365 day maximum/period of confinement, subject to the combined day limit. *May require prior authorization.	
	Physician/surgeon fees	No charge	Not covered	*May require prior authorization.	
	Outpatient services	No charge	Not covered	*May require prior authorization.	
If you need mental health, behavioral health, or substance abuse services	Inpatient services	No charge	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.	
	Office visits	No charge	Not covered	Limited to a 365 day maximum/	
If you are pregnant	Childbirth/delivery professional services	No charge	Not covered	 period of confinement, subject to th combined day limit. Maternity care may include tests and services 	
	Childbirth/delivery facility services	No charge	Not covered	described elsewhere in the SBC (i.e. ultrasound).	

* For more information about limitations and exceptions, see the plan or policy document at www.Medica.com/EssentiaCarePolicies-2023.

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services MN Essentia Choice Care with Medica Silver Share Zero Coverage Period: Beginning on or after 01/01/2023 Coverage for: Individual or Family | Plan Type: EPO

	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
	Home health care	No charge	Not covered	Limited to 120 visits/year. *May require prior authorization.
	Rehabilitation services	No charge	Not covered	none
	Habilitation services	No charge	Not covered	none
If you need help recovering or have other special health needs	Skilled nursing care	No charge	Not covered	Limited to a 120 day maximum/period of confinement, subject to the combined day limit. *May require prior authorization.
	Durable medical equipment	No charge	Not covered	*May require prior authorization.
	Hospice services	No charge	Not covered	Limited to a 30 day maximum for respite care and continuous care.
	Children's eye exam	No charge	Not covered	Coverage limited to end of month member turns 19.
If your child needs dental or eye care	Children's glasses	No charge	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:

 *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 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
• Chiropractic care	se services. This isn't a complete list. Please see your	<u>plan</u> document.)

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 1-877-407-8464 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 1-877-407-8464 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)	and a hospital	Managing Joe's Type 2 Diabete (a year of routine in-network care of a wel condition)	es l-controlled	Mia's Simple Fracture (in-network emergency room visit and follo	ow up care)
The <u>plan's</u> overall deductible	\$0	The <u>plan's</u> overall deductible	\$0	The <u>plan's</u> overall deductible	\$0
Specialist coinsurance	0%	Specialist coinsurance	0%	Specialist coinsurance	0%
 Hospital (facility) <u>coinsurance</u> 	0%	Hospital (facility) <u>coinsurance</u>	0%	 Hospital (facility) <u>coinsurance</u> 	0%
Other <u>coinsurance</u>	0%	• Other <u>coinsurance</u>	0%	• Other <u>coinsurance</u>	0%
This EXAMPLE event includes service <u>Specialist</u> office visits (prenatal care) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests</u> (ultrasounds and blood to <u>Specialist</u> visit (anesthesia)	;	This EXAMPLE event includes services I Primary care physician office visits (including 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
				Total Example Cost In this example, Mia would pay:	\$2,800
Total Example Cost		Total Example Cost		· · ·	\$2,800
Total Example Cost In this example, Peg would pay:		Total Example Cost In this example, Joe would pay:		In this example, Mia would pay:	\$ 2,800
Total Example Cost In this example, Peg would pay: Cost Sharing	\$12,700	Total Example Cost In this example, Joe would pay: Cost Sharing	\$5,600	In this example, Mia would pay: Cost Sharing	
Total Example Cost In this example, Peg would pay: Cost Sharing Deductibles	\$12,700 \$0	Total Example Cost In this example, Joe would pay: Cost Sharing Deductibles	\$5,600 \$0	In this example, Mia would pay: Cost Sharing Deductibles	\$0
Total Example Cost n this example, Peg would pay: Cost Sharing Deductibles Copayments	\$12,700 \$0 \$0	Total Example Cost In this example, Joe would pay: Cost Sharing Deductibles Copayments	\$5,600 \$0 \$0	In this example, Mia would pay: Cost Sharing Deductibles Copayments	\$0
Total Example Cost n this example, Peg would pay: Cost Sharing Deductibles Copayments Coinsurance	\$12,700 \$0 \$0	Total Example Cost In this example, Joe would pay: Cost Sharing Deductibles Copayments Coinsurance	\$5,600 \$0 \$0	In this example, Mia would pay: Cost Sharing Deductibles Copayments Coinsurance	\$0

The <u>plan</u> 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.

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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.

اذاكنت تريدمساعدة مجانبة في ترجمة هذه المعلومات, فاتصل على ألرقم 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.

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