

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 <a href="https://www.Medica.com/ElevatePolicies-2023">www.Medica.com/ElevatePolicies-2023</a> or call 1-866-810-5296. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other <a href="https://www.healthcare.gov/sbc-glossary">underlined</a> terms, see the Glossary. You can view the Glossary at <a href="https://www.healthcare.gov/sbc-glossary">www.healthcare.gov/sbc-glossary</a> or call 1-866-810-5296 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$1,500 individual / \$3,000 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. <u>Preventive care</u> and preventive prescriptions 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 <u>https://www.healthcare.gov/coverage/preventive-care-benefits</u> .
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?	\$9,100 individual / \$18,200 family for <a href="network">network</a> 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 <u>out-of-pocket</u> <u>limit?</u>	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> <u>provider</u> ?	Yes. See <a href="https://www.Medica.com/SearchElevateNetwork-2023">www.Medica.com/SearchElevateNetwork-2023</a> or call 1-866-810-5296 (TTY: 711) for a list of <a href="https://network.providers">network providers</a> .	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 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.</u>
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  I visit a health care		Not covered	50% coinsurance for other outpatient services. Primary care visits provided at an outpatient facility may be subject to coinsurance and deductible. Manipulations limited to 20 visits/year. See Rehabilitation and Habilitation for other limits that may apply.
	provider 5 office of chilic	Specialist visit	\$160 copay/visit.	Not covered	none
		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.
		Diagnostic test (x-ray, blood work)	50% coinsurance	Not covered	none
	If you have a test	Imaging (CT/PET scans, MRIs)	50% coinsurance	Not covered	*Prior authorization required for PET scans.

<sup>\*</sup> For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.Medica.com/ElevatePolicies-2023</u>.

		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 need drugs to treat your illness or condition	Generic drugs	Preferred Generic: \$30 copay/prescription.  Deductible does not apply. Generic: \$30 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, \$160 copay for orally-administered cancer treatment medications. Deductible does not
More information about prescription drug coverage is available at www.Medica.com/	Preferred brand drugs	\$200 copay/prescription.  Deductible does not apply.	Not covered	apply. Proton pump inhibitors (except for members 12 years of age and younger, and those members who have a feeding tube) and non-sedating antihistamines are not
NEDrugList-2023	Non-Preferred brand drugs	70% coinsurance	Not covered	non-sedating antihistamines are not covered. Insulin: Your cost-share will not exceed \$25 per retail prescription unit. *Refer to the Exceptions to the
	Specialty drugs	\$750 copay/prescription.  Deductible does not apply.	Not covered	Drug List section of your Policy of Coverage for more details. No charge for preventive drugs.
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	50% coinsurance	Not covered	*May require prior authorization.
surgery	Physician/surgeon fees	50% coinsurance	Not covered	*May require prior authorization.
	Emergency room care	50% coinsurance	50% coinsurance	Network deductible applies.
	Emergency medical transportation	50% coinsurance	50% coinsurance	Network deductible applies.
If you need immediate medical attention	Urgent care	\$0 copay/visit.	\$0 copay/visit.	Network deductible applies. 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)	50% coinsurance	Not covered	Notification required. *May require prior authorization.
, ,	Physician/surgeon fees	50% coinsurance	Not covered	*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/ElevatePolicies-2023</u>.

		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 need mental health, behavioral health, or substance abuse services	Outpatient services	\$0 copay/visit.	Not covered	50% coinsurance for other outpatient services. Other outpatient services include intensive outpatient programs, diagnostic evaluations and psychological testing. *May require prior authorization.	
	Inpatient services	50% coinsurance	Not covered	Notification required. *May require prior authorization.	
	Office visits	Prenatal: 50% coinsurance Postnatal: 50% coinsurance	Not covered	Cost sharing does not apply to network preventive services.	
If you are pregnant	Childbirth/delivery professional services	50% coinsurance	Not covered	Depending on the type of services, coinsurance may apply. Maternity care may include tests and services	
	Childbirth/delivery facility services	50% coinsurance	Not covered	described elsewhere in the SBC (i.e. ultrasound).	

<sup>\*</sup> For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.Medica.com/ElevatePolicies-2023</u>.

	What You Will Pay				
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	50% coinsurance	Not covered	Limited to 4 hours/day; 60 visits/year. *Prior authorization required.	
	Rehabilitation services	50% coinsurance	Not covered	Outpatient: Physical, occupational, speech and physiotherapy 45 visits/year; Cardiac rehabilitation 18 visits/year; Pulmonary rehabilitation 18 visits/year. This visit limit does not apply to services for treatment of autism spectrum disorder.	
If you need help recovering or have other special health needs	Habilitation services	50% coinsurance	Not covered	Outpatient: Physical, occupational, speech and physiotherapy 45 visits/year; Cardiac rehabilitation 18 visits/year; Pulmonary rehabilitation 18 visits/year. This visit limit does not apply to services for treatment of autism spectrum disorder.	
	Skilled nursing care	50% coinsurance	Not covered	Limited to 60 inpatient days/year. *Prior authorization required.	
	Durable medical equipment	50% coinsurance	Not covered	*May require prior authorization.	
	Hospice services	50% coinsurance	Not covered	none	
	Children's eye exam	\$0 copay/visit.	Not covered	Limited to one refractive eye exam/year to end of month member turns 19.	
If your child needs dental or eye care	Children's glasses	50% 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.	

<sup>\*</sup> For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.Medica.com/ElevatePolicies-2023</u>.

Coverage Period: Beginning on or after 01/01/2023 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
- 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; coverage is limited to \$3,000 every 48 months per covered child affected by a hearing impairment
- 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 and osteopathic manipulations limited to 20 visits per year

Coverage Period: Beginning on or after 01/01/2023 Coverage for: Individual or Family | Plan Type: EPO

**⊘ Medica**. NE Elevate by Medica Bronze Premier

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 1-866-810-5296 or the Nebraska Department of Insurance, PO Box 95087, Lincoln, NE 68509-5087, 402-471-2201 or 1-877-564-7323. Other coverage options may be available to you, too, including buying individual insurance coverage through the <a href="https://example.com/Health Insurance">Health Insurance</a> Marketplace. For more information about the <a href="https://example.com/Marketplace">Marketplace</a>. For more information

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 1-866-810-5296 or the Nebraska Department of Insurance, PO Box 95087, Lincoln, NE 68509-5087, 402-471-2201 or 1-877-564-7323.

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 <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.

Ped	is Having a Baby	
(9 months of in-net	work pre-natal care delivery)	and a hospital
		<b>4.5</b>

The <u>plan's</u> overall deductible \$1,500
 Specialist copayment \$160
 Hospital (facility) coinsurance 50%
 Other coinsurance 50%

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

The plan's overall deductible	\$1,500
Specialist copayment	\$160
Hospital (facility) coinsurance	50%
Other coinsurance	50%

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

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	The plan's overall deductible	\$1,500
	Specialist copayment	\$160
	Hospital (facility) coinsurance	<b>50</b> %
	Other coinsurance	50%

### 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)

This EXAMPLE	event	includes	services	like:
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<u>Primary care physician</u> office visits (*including disease education*)

Diagnostic tests (blood work)

Prescription drugs

<u>Durable medical equipment</u> (*glucose meter*)

### 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 \$12,700

Total Example Cost \$5,600
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Total Example Cost	\$2,800
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# In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,500
Copayments	\$10
Coinsurance	\$4,800
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$6,370

# In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,100
<u>Copayments</u>	\$900
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$2,000

## In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,500
Copayments	\$200
Coinsurance	\$500
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,200

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 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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Ako želite besplatnu pomoć za prijevod ovih informacija, nazovite broj naveden u ovom dokumentu ili na poleđini svoje ID kartice Medica.

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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