A

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/EngagePolicies-2023">www.Medica.com/EngagePolicies-2023</a> or call 1-866-510-7425. 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 <a href="https://www.healthcare.gov/sbc-glossary">www.healthcare.gov/sbc-glossary</a> or call 1-866-510-7425 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$75 individual / \$150 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> , 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 <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> ?	<b>\$1,400</b> individual / <b>\$2,800</b> 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 (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 network provider?	Yes. See <a href="https://www.Medica.com/SearchEngageNetwork-2023">www.Medica.com/SearchEngageNetwork-2023</a> or call 1-866-510-7425 (TTY: 711) for a list of <a href="https://network.providers">network providers</a> .	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No. Coordinate care through your primary care clinic or care system for benefits.	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	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
If you vioit a health care	Primary care visit to treat an injury or illness	Primary care: 10% coinsurance Retail health clinics: 10% coinsurance Chiropractic care: 10% coinsurance	Not covered	none
If you visit a health care provider's office or clinic	Specialist visit	10% coinsurance	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.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	Not covered	none
If you have a test	Imaging (CT/PET scans, MRIs)	10% 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/EngagePolicies-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: \$5 copay/prescription. Deductible does not apply. Generic: \$5 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, 10% coinsurance 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
More information about prescription drug coverage is available at www.Medica.com/	Preferred brand drugs	\$60 copay/prescription.  Deductible 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
MNDrugList-2023	Non-Preferred brand drugs	25% 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	\$150 <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)	10% coinsurance	Not covered	*May require prior authorization.
surgery	Physician/surgeon fees	10% coinsurance	Not covered	*May require prior authorization.
	Emergency room care	10% coinsurance	10% coinsurance	Network deductible applies.
	Emergency medical transportation	10% coinsurance	10% coinsurance	Network deductible applies.
If you need immediate medical attention	Urgent care	10% coinsurance	10% coinsurance	Network deductible applies. If a non-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).

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

		What Y	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	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% 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	10% coinsurance	Not covered	*May require prior authorization.	
	Outpatient services	10% coinsurance	Not covered	*May require prior authorization.	
If you need mental health, behavioral health, or substance abuse services	Inpatient services	10% coinsurance	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	Prenatal: No charge. <u>Deductible</u> does not apply.  Postnatal: 10% <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	
If you are pregnant	Childbirth/delivery professional services	10% coinsurance	Not covered	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.	
	Childbirth/delivery facility services	10% 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/EngagePolicies-2023</u>.

		What Y	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	10% coinsurance	Not covered	Limited to 120 visits/year. *May require prior authorization.	
	Rehabilitation services	10% coinsurance	Not covered	none	
	Habilitation services	10% coinsurance	Not covered	none	
If you need help recovering or have other special health needs	Skilled nursing care	10% 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	10% coinsurance	Not covered	*May require prior authorization.	
	Hospice services	10% coinsurance	Not covered	Limited to a 30 day maximum for respite care and continuous care.	
	Children's eye exam	No charge. <u>Deductible</u> does not apply.	Not covered	Coverage limited to end of month member turns 19.	
If your child needs dental or eye care	Children's glasses	10% 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/EngagePolicies-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 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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

• Chiropractic care

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

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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 1-866-510-7425 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 <a href="Health Insurance Marketplace">Health Insurance Marketplace</a>. For more information about the <a href="Marketplace">Marketplace</a>, visit <a href="https://www.mnsure.org">www.mnsure.org</a> 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 1-866-510-7425 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 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 pre-natal care and a delivery)	hospital	Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-cor condition)	ntrolled	(in-networ	Mia's Simple Fracture k emergency room visit and follo	w up care)
■ The <u>plan's</u> overall deductible	\$75	■ The <u>plan's</u> overall deductible	\$75	■ The p	lan's overall deductible	\$75
Specialist coinsurance	10%	<ul><li>Specialist coinsurance</li></ul>	10%	■ Speci	alist coinsurance	10%
<ul><li>Hospital (facility) coinsurance</li></ul>	10%	<ul><li>Hospital (facility) <u>coinsurance</u></li></ul>	10%	Hosp	ital (facility) <u>coinsurance</u>	10%
<ul><li>Other <u>coinsurance</u></li></ul>	10%	<ul><li>Other <u>coinsurance</u></li></ul>	10%	Other	coinsurance	10%

#### 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)

# Total Example Cost \$12,700

n this examp	le, Peg	would	pay:
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Cost Sharing	
<u>Deductibles</u>	\$75
Copayments	\$10
Coinsurance	\$1,000
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$1,145

#### This EXAMPLE event includes services like:

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

Diagnostic tests (blood work)

Prescription drugs

Durable medical equipment (glucose meter)

Total Example Cost \$3,000	Total Example Cost	\$5,600
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# In this example, Joe would pay:

Cost Sharing	
Deductibles	\$75
Copayments	\$200
Coinsurance	\$500
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$775

#### 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>	\$75
Copayments	\$10
Coinsurance	\$300
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$385

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

Coverage for: Individual or Family | Plan Type: EPO

## Discrimination is Against the Law

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- 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.

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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.

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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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