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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/DistinctPolicies-2023 or call 1-866-388-4419. 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 1-866-388-4419 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$2,100 individual / \$4,200 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 https://www.healthcare.gov/coverage/preventive-care-benefits .
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> ?	\$8,800 individual / \$17,600 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 www.Medica.com/SearchRidgeviewDistinctNetwork-2023 or call 1-866-388-4419 (TTY: 711) for a list of network providers .	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.	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.

		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 visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Primary care: 40% coinsurance Retail health clinics: 40% coinsurance Chiropractic care: 40% coinsurance	Not covered	none
	Specialist visit	40% 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.
W k	Diagnostic test (x-ray, blood work)	40% coinsurance	Not covered	none
If you have a test	Imaging (CT/PET scans, MRIs)	40% coinsurance	Not covered	*May require prior authorization.

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

What You Will Pay Limitations, Exceptions & Other Important Information **Common Medical Event Services You May Need** Non-Network Network Provider (You will pay the least) Provider (You will pay the most) Up to a 31-day supply per prescription. *May require prior authorization. For non-preferred retail drugs, 40% coinsurance for orally-administered cancer treatment medications. Insulin: Your cost-share will not exceed \$25 per retail Preferred Generic: \$5 copay/prescription.

Deductible does not apply.

Generic: \$20 Generic drugs Not covered copay/prescription.

Deductible does not apply. 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 drugs changes periodically. If you need drugs to treat your illness or condition More information about \$120 copay/prescription. prescription drug Deductible does not apply. Preferred brand drugs Not covered coverage is available at www.Medica.com/ drugs changes periodically.
Notification of changes will be available 30 days prior to the change taking effect. Amounts reimbursed or paid by a provider or manufacturer, MNDrugList-2023 60% coinsurance Non-Preferred brand drugs Not covered on your behalf for a product or service, will not apply toward your \$700 copay/prescription. Specialty drugs Not covered Deductible does not apply. cost share. Facility fee (e.g., ambulatory surgery 40% coinsurance Not covered *May require prior authorization. If you have outpatient center) surgery Physician/surgeon fees 40% coinsurance Not covered *May require prior authorization. Emergency room care Network deductible applies. 40% coinsurance 40% coinsurance Emergency medical transportation 40% coinsurance 40% coinsurance Network deductible applies. If you need immediate Network deductible applies. If a medical attention non-network provider charges more than the <u>allowed amount</u>, you may have to pay the difference (<u>balance</u> 40% coinsurance 40% coinsurance Urgent care billing).

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

		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)	40% 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	40% coinsurance	Not covered	*May require prior authorization.	
	Outpatient services	40% coinsurance	Not covered	*May require prior authorization.	
If you need mental health, behavioral health, or substance abuse services	Inpatient services	40% 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: 40% <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	40% 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	40% coinsurance	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/DistinctPolicies-2023.

		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	40% coinsurance	Not covered	Limited to 120 visits/year. *May require prior authorization.
	Rehabilitation services	40% coinsurance	Not covered	none
	Habilitation services	40% coinsurance	Not covered	none
If you need help recovering or have other special health needs	Skilled nursing care	40% 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	40% coinsurance	Not covered	*May require prior authorization.
	Hospice services	40% 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	40% 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.

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

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

Medica. MN Ridgeview Distinct by Medica Silver Share

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 1-866-388-4419 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 Health Insurance Marketplace. For more information about the Marketplace, visit www.mnsure.org 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 1-866-388-4419 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 <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 hospital
delivery)	
- The plan's everall deductible	ቀ ሳ ተሰ

The <u>plan's</u> overall deductible	\$2,100
Specialist coinsurance	40%
Hospital (facility) coinsurance	40%
Other coinsurance	40%

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

■ The <u>plan's</u> overall deductible	\$2,100
Specialist coinsurance	40%
Hospital (facility) coinsurance	40%
Other coinsurance	40%

	Mia's Sim	ple Frac	ture	
n-network	emergency ro	om visit	and follow	up care)

■ The <u>plan's</u> overall deductible	\$2,100
Specialist coinsurance	40%
■ Hospital (facility) coinsurance	40%
Other coinsurance	40%

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:

Primary care physician 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

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

Cost Sharing	
<u>Deductibles</u>	\$2,100
Copayments	\$10
Coinsurance	\$3,100
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$5,270

In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,900
Copayments	\$200
Coinsurance	\$300
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$2,400

In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$2,100
Copayments	\$10
Coinsurance	\$300
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,410

The plan 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

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 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.

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