

 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-24 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?	\$100 individual / \$200 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 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 deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	\$900 individual / \$1,800 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?	<u>Premiums</u> , <u>balance-billing</u> charges (unless balanced billing is prohibited), and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See www.Medica.com/SearchRidgeviewDistinctNetwork-24 or call 1-866-388-4419 (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 referral to see a specialist?	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.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Primary care: \$5 copay for the first 3 clinic visits/year. Deductible does not apply. After the first 3 visits, 20% coinsurance Retail health clinics: \$5 copay /visit. Deductible does not apply. Chiropractic care: \$5 copay for the first 3 clinic visits/year. Deductible does not apply. After the first 3 visits, 20% coinsurance	Not covered	20% coinsurance for other outpatient services. Primary care visits provided at an outpatient facility may be subject to coinsurance and deductible . Copayment for First 3 applies to primary care, specialist , urgent care , outpatient mental/behavioral health and substance abuse visits combined.
	Specialist visit	\$5 copay for the first 3 clinic visits/year. Deductible does not apply. After the first 3 visits, 20% coinsurance	Not covered	20% coinsurance for other outpatient services. Specialist visits provided at an outpatient facility may be subject to coinsurance and deductible . Copayment for First 3 applies to primary care, specialist , urgent care , outpatient mental/behavioral health and substance abuse visits combined.
	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)	20% coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	*May require prior authorization.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.Medica.com/MNDrugList-24	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 preferred/non-preferred retail and specialty drugs , \$5 copay for orally-administered cancer treatment medications. Deductible does not apply. Insulin: Your cost-share will not exceed \$25 per 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 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, on your behalf for a product or service, will not apply toward your cost share.
	Preferred brand drugs	\$60 copay /prescription. Deductible does not apply.	Not covered	
	Non-Preferred brand drugs	40% coinsurance	Not covered	
	Specialty drugs	\$150 copay /prescription. Deductible does not apply.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	*May require prior authorization.
	Physician/surgeon fees	20% coinsurance	Not covered	*May require prior authorization.
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Network deductible applies.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Network deductible applies.
	Urgent care	\$5 copay for the first 3 clinic visits/year. Deductible does not apply. After the first 3 visits, 20% coinsurance	\$5 copay for the first 3 clinic visits/year. Deductible does not apply. After the first 3 visits, 20% coinsurance	If a non-network provider charges more than the allowed amount , you may have to pay the difference (balance billing). Copayment for First 3 applies to primary care, specialist , urgent care , outpatient mental/behavioral health and substance abuse visits combined.

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.Medica.com/DistinctPolicies-24.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% 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	20% coinsurance	Not covered	*May require prior authorization.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$5 copay for the first 3 clinic visits/year. Deductible does not apply. After the first 3 visits, 20% coinsurance	Not covered	20% coinsurance for other outpatient services. Other outpatient services include intensive outpatient programs, diagnostic evaluations and psychological testing. *May require prior authorization. Copayment for First 3 applies to primary care, specialist , urgent care , outpatient mental/behavioral health and substance abuse visits combined.
	Inpatient services	20% 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.
If you are pregnant	Office visits	Prenatal: No charge. Deductible does not apply. Postnatal: 20% coinsurance	Not covered	Limited to a 365 day maximum/period of confinement, subject to the combined day limit. Cost sharing does not apply to network preventive services .
	Childbirth/delivery professional services	20% coinsurance	Not covered	Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	20% coinsurance	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	Limited to 120 visits/year. *May require prior authorization.
	Rehabilitation services	20% coinsurance	Not covered	None
	Habilitation services	20% coinsurance	Not covered	None
	Skilled nursing care	20% 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	20% coinsurance	Not covered	*May require prior authorization.
	Hospice services	20% 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. Deductible does not apply.	Not covered	Coverage limited to end of month member turns 19.
	Children's glasses	20% 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-24.

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](#).)

- | | | |
|---|---|---|
| <ul style="list-style-type: none">• Abortion, elective, induced, except as medically necessary to protect the life of the mother• Acupuncture• Bariatric surgery• Cosmetic surgery• Dental care (Adult) | <ul style="list-style-type: none">• Dental care (Child) (coverage is available through a stand-alone dental policy)• Dental check-up• Infertility treatment• Long-term care• Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none">• Non-formulary drugs• 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.)

- | | |
|---|--|
| <ul style="list-style-type: none">• Chiropractic care | <ul style="list-style-type: none">• Hearing aids |
|---|--|

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, kwijigo 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 [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 and a hospital delivery)

- The [plan's overall deductible](#) \$100
- [Specialist copayment](#) \$5
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$0
Coinsurance	\$800
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$960

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

- The [plan's overall deductible](#) \$100
- [Specialist copayment](#) \$5
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

This EXAMPLE event includes services like:

- [Primary care physician](#) office visits (*including disease education*)
- [Diagnostic tests](#) (*blood work*)
- [Prescription drugs](#)
- [Durable medical equipment](#) (*glucose meter*)

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

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$500
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$800

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

- The [plan's overall deductible](#) \$100
- [Specialist copayment](#) \$5
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$20
Coinsurance	\$500
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$620

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, civilrightscordinator@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 raus 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.

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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 идентификационной карты Medica.

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이 정보를 번역하는 데 무료로 도움을 받고 싶으시면, 이 문서에 포함된 전화번호나 Medica ID 카드 뒷면의 전화번호로 전화하십시오.

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