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/AltruPolicies-2025 or call 1 (800) 918-6474 (TTY: 711). 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 (800) 918-6474 (TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters:	
What is the overall deductible?	\$7,200 individual / \$14,400 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 y met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> mapply. 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 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> ?	\$9,200 individual / \$18,400 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/SearchAltruNetwork-2025 or call 1 (800) 918-6474 (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 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	Primary care: \$15 copay for first 3 clinic visits/year. Deductible does not apply. After first 3 visits, 50% coinsurance Retail health clinics: \$15 copay/visit. Deductible does not apply. Chiropractic care: \$15 copay for first 3 clinic visits/year. Deductible does not apply. After first 3 visits, 50% coinsurance	Not covered	50% 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	\$15 <u>copay</u> for first 3 clinic visits/year. <u>Deductible</u> does not apply. After tfirst 3 visits, 50% <u>coinsurance</u>	Not covered	50% 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. <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. Limited to one physical exam/year, unless additional visits are necessary.	
If you have a test	Diagnostic test (x-ray, blood work)	50% coinsurance	Not covered	None	
ii you liave a test	Imaging (CT/PET scans, MRIs)	50% coinsurance	Not covered	*May require prior authorization.	

^{*} For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.Medica.com/AltruPolicies-2025</u>.

		What Y	Limitations, Exceptions, & Other Important Information		
Common Medical Event	Services You May Need	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-2025	Preferred generic drugs	\$25 <u>copay/prescription</u> . <u>Deductible</u> does not apply.	Not covered	Up to a 31-day supply per prescription. *May require prior authorization. For generic, preferred/non-preferred retail and specialty drugs, \$15 copay for orally-administered cancer treatment medications. Deductible does not	
	Preferred brand, Non-preferred generic drugs	\$200 copay/prescription. Deductible does not apply.	Not covered	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. Drug manufacturer coupon amounts will apply toward your cost share. Prescription drug/manufacturer coupons count toward the deductible and out-of-pocket limits.	
	Non-Preferred brand, Non-preferred generic drugs	70% coinsurance	Not covered		
	Specialty drugs	\$750 copay/prescription. Deductible does not apply.	Not covered		
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.	
If you need immediate medical attention	Emergency medical transportation	50% coinsurance	50% coinsurance	Network deductible applies.	
	<u>Urgent care</u>	\$15 copay for first 3 clinic visits/year. Deductible does not apply. After first 3 visits, 50% coinsurance	\$15 copay for first 3 clinic visits/year. Deductible does not apply. After first 3 visits, 50% 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/AltruPolicies-2025.

		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 a hospital stay	Facility fee (e.g., hospital room)	50% 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	50% coinsurance	Not covered	*May require prior authorization.	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15 copay for first 3 clinic visits/year. Deductible does not apply. After first 3 visits, 50% coinsurance	Not covered	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	50% 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: 50% 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	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).	

^{*} For more information about limitations and exceptions, see the plan or policy document at www.Medica.com/AltruPolicies-2025.

Coverage Period: 01/01/2025 - 12/31/2025 Coverage for: Individual or Family | Plan Type: EPO

stand-alone dental policy.

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) Limited to 120 visits/year. *May Home health care 50% coinsurance Not covered require prior authorization. Rehabilitation services 50% coinsurance Not covered None Habilitation services 50% coinsurance Not covered None If you need help Limited to a 120 day maximum/period of confinement, recovering or have other special health needs Skilled nursing care 50% coinsurance Not covered subject to the combined day limit. *May require prior authorization. Durable medical equipment 50% coinsurance Not covered *May require prior authorization. Limited to a 30 day maximum for Hospice services 50% coinsurance Not covered respite care and continuous care. No charge. Deductible does Coverage limited to end of month Children's eye exam Not covered member turns 19. not apply. Limited to one pair of glasses or If your child needs dental contacts/year to end of month member turns 19. Children's glasses 50% coinsurance Not covered or eye care Coverage is available through a Children's dental check-up Not covered Not covered

^{*} For more information about limitations and exceptions, see the plan or policy document at www.Medica.com/AltruPolicies-2025.

⊘ Medica. MN Altru Prime by Medica Bronze Copay First 3

Coverage Period: 01/01/2025 - 12/31/2025 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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- 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.
- 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.)

Chiropractic care

 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

Coverage Period: 01/01/2025 - 12/31/2025

⊘ Medica. MN Altru Prime by Medica Bronze Copay First 3

Coverage for: Individual or Family | Plan Type: EPO

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 (800) 918-6474 (TTY: 711) 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 <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 (800) 918-6474 (TTY: 711) 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 (TTY: 711).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1 (888) 592-8211 (TTY: 711).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1 (888) 592-8211 (TTY: 711).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1 (888) 592-8211 (TTY: 711).

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)		Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The <u>plan's</u> overall <u>deductible</u>	\$7,200	■ The <u>plan's</u> overall <u>deductible</u>	\$7,200	■ The <u>plan's</u> overall <u>deductible</u>	\$7,200
Specialist copayment	\$15	Specialist copayment	\$15	Specialist copayment	\$15
Hospital (facility) coinsurance	50%	Hospital (facility) coinsurance	50%	Hospital (facility) coinsurance	50%
Other <u>coinsurance</u>	50%	Other <u>coinsurance</u>	50%	Other <u>coinsurance</u>	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:

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

<u>Diagnostić tests</u> (blood work)

Prescription drugs

Durable medical equipment (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
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
Cost Sharing		Cost Sharing		Cost Sharing	
<u>Deductibles</u>	\$7,200	<u>Deductibles</u>	\$1,100	<u>Deductibles</u>	\$2,600
Copayments	\$10	Copayments	\$700	Copayments	\$40
Coinsurance	\$1,400	Coinsurance	\$0	Coinsurance	\$0
What isn't covered		What isn't covered		What isn't covered	
Limits or exclusions	\$60	Limits or exclusions	\$0	Limits or exclusions	\$0
The total Peg would pay is	\$8,670	The total Joe would pay is	\$1,800	The total Mia would pay is	\$2,640

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 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.

如果您需要免費翻譯此資訊,請致電本文檔中或者在您的Medica ID卡背面包含的號碼。

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.

Si vous voulez une assistance gratuite pour traduire ces informations, appelez le numéro indiqué dans ce document ou au dos de votre carte d'identification Medica.

နမှါအဲ့ ောက်ကိုးထံစၤကလီန္စါနားတာ်က်တာ်ကျိုးအုံးလာအကလီန္ ဉ်,ကိုးလီတဲ့စီနီဉ်က်လာအပဉ် ယာလာလာတီလာမီအပူးအုံးမှတမှုစ်နန္နနိင်ဓေလာအာ့ဉ်သးခႏက္ခအလိုခံတကပၤအဖီခိုဉ်နှဉ်တက္ကာ.

Kung nais mo ng libreng tulong sa pagsasalin ng impormasyong ito, tawagan ang numero na kasama sa dokumentong ito o sa likod ng iyong Kard ng Medica ID.

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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'ígíjji' béésh bee hodíilnih.

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