Coverage for: Individual/Family | Plan Type: PPO

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">www.Medica.com</a> or call 1-952-945-8000 (Minneapolis/St. Paul Metro area) or 1-800-952-3455. 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 1-800-952-3455 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$4,000 per person / \$8,000 per family in-network and \$8,000 per person / \$16,000 per family for out-of-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 and prenatal care from in-network <u>providers</u> or well child and prenatal care from <u>out-of-network</u> <u>providers</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 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?	\$7,500 per person / \$15,000 per family in-network. \$19,500 per person / \$39,000 per family for out-of-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), health care this plan doesn't cover, out-of-network deductible and coinsurance.	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 provider</u> ?	Yes. See <a href="https://www.Medica.com/FindCare">www.Medica.com/FindCare</a> or call 1-952-945-8000 or 1-800-952-3455 (TTY: 711) for a list of Medica Choice with UnitedHealthcare <a href="https://www.network.com/network/network/">network</a> providers.	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 don't need a <u>referral</u> to see a <u>specialist</u> .	You can see the specialist you choose without a referral.



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

		What You	Will Pay			
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information		
If you visit a health care provider's	Primary care visit to treat an injury or illness	Primary care: 20% coinsurance Chiropractic: 20% coinsurance Retail Health: 20% coinsurance Virtual: 20% coinsurance	Primary: 50% coinsurance Chiropractic: 50% coinsurance Retail Health: 50% coinsurance Virtual: 50% coinsurance	Limited to 15 visits per member, per year for out-of-network chiropractic care.		
office or clinic	Specialist visit	20% coinsurance	50% coinsurance	None		
	Preventive care/ screening/ immunization	No charge. <u>Deductible</u> does not apply.	Well child care: 0% coinsurance. Deductible does not apply. Other services: 50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.		
If you have a test	Diagnostic test (x-ray, blood work)	Lab: 20% coinsurance X-ray: 20% coinsurance	50% coinsurance	None		
If you have a test	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	None		

**⊗** Medica.

		What You	Will Pay			
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least) Out-of-Network Provider (You will pay the most		Limitations, Exceptions & Other Important Information		
	Generic drugs	Preventive: Designated preventive drugs: No charge. Deductible does not apply.  Retail: 20% coinsurance Mail order: 20% coinsurance	50% coinsurance	Up to a 31-day supply/retail or 93-day supply/mail order prescription.  Mail order drugs not covered out-of-network.  Insulin: Your cost-share will not exceed \$25 per retail		
If you need drugs to treat your illness or condition More information about	Preferred brand drugs	Preventive: Designated preventive drugs: No charge.  Deductible does not apply.  Retail: 20% coinsurance  Mail order: 20% coinsurance	50% coinsurance	prescription unit. Some Over the Counter drugs can be obtained with a prescription at the preventive level of coverage. The list of covered drugs changes periodically. Notification of changes will be available 30 days prior to the		
prescription drug coverage is available at www.Medica.com/DrugCost2	Non-preferred brand drugs	Preventive: Benefit does not apply. Retail: 40% coinsurance Mail order: 40% coinsurance	50% coinsurance	change taking effect. ACA preventive drugs covered at no charge.  Deductible does not apply.		
	Specialty drugs	Preferred: 20% coinsurance No more than \$200 copay/prescription. Non-Preferred: 40% coinsurance	Not covered	Up to a 31-day supply per prescription received from a designated specialty pharmacy. Amounts reimbursed or paid by a provider or manufacturer, on your behalf for a product or service, will not apply toward your cost share.		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	None		
, ,	Physician/surgeon fees	20% coinsurance	50% coinsurance	None		
	Emergency room care	20% coinsurance	20% coinsurance	In-network deductible and out-of-pocket applies.		
If you need immediate medical attention	Emergency medical transportation	20% coinsurance	20% coinsurance	In-network deductible and out-of-pocket applies.		
	Urgent care	20% coinsurance	20% coinsurance	In-network deductible and out-of-pocket applies.		
If any bases have the last	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	None		
If you have a hospital stay	Physician/surgeon fees	20% coinsurance	50% coinsurance	None		
If you need mental health,	Outpatient services	20% coinsurance	50% coinsurance	None		
behavioral health, or substance abuse services	Inpatient services	20% coinsurance	50% coinsurance	Residential treatment is covered as part of inpatient services.		

		What You	Will Pay	Limitations, Exceptions & Other Important Information	
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)		
If you are pregnant	Office visits	Prenatal care: No charge.  Deductible does not apply.  Postnatal care: 20%  coinsurance	Prenatal care: 0% coinsurance. Deductible does not apply. Postnatal care: 50% coinsurance	Cost sharing does not apply to in-network preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply.  Maternity care may include tests and services described elsewhere in the SBC (i.e. certain	
ii you are pregnant	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. certain ultrasounds.)	
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	antaccurac.)	
	Home health care	20% coinsurance	50% coinsurance	120 visits in-network and 60 visits out-of-network per member per year.	
If you need help recovering or have other special health needs	Rehabilitation services	20% coinsurance	50% coinsurance	Physical and occupational therapy combined limited to 20 visits out-of-network per member per year. Out-of-network speech therapy is limited to 20 visits per member per year. Visit limits are not applicable to behavioral health conditions.	
	Habilitation services	20% coinsurance	50% coinsurance	Physical and occupational therapy combined limited to 20 visits out-of-network per member per year. Out-of-network speech therapy is limited to 20 visits per member per year. Visit limits are not applicable to behavioral health conditions.	
	Skilled nursing care	20% coinsurance	50% coinsurance	120 day limit combined in and out-of-network per member per year.	
	Durable medical equipment	20% coinsurance	50% coinsurance	None	
	Hospice services	20% coinsurance	50% coinsurance	None	
	Children's eye exam	No charge. <u>Deductible</u> does not apply.	50% coinsurance	None	
If your child needs dental or eye care	Children's glasses	Not covered	Not covered	Glasses are not covered by the plan.	
o. eye eare	Children's dental check-up	Not covered	Not covered	Dental check-ups are not covered by the plan.	

Coverage for: Individual/Family | Plan Type: PPO

### **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 other excluded services.)

- Acupuncture exceeding 15 visits per member per year for in-network and out-of-network acupuncture services combined
- Bariatric surgery
- Chiropractic care exceeding 15 visits per member per year out-of-network
- Cosmetic surgery

- Dental care (Adult)
- Dental check-up
- Glasses
- Infertility treatment

- · Long-term care
- Private-duty nursing
- Routine foot care except for specified conditions
- Weight loss programs

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

Hearing aids

• Non-emergency care when traveling outside the

Routine eye care (Adult)

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 1-800-952-3455 or for group health coverage subject to ERISA, Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or

www.dol.gov/ebsa/healthreform; for all other group health coverage, Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at
1-877-267-2323 x61565 or www.ccijo.cms.gov. 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.HealthCare.gov or call 1-800-318-2596.

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: for group health coverage subject to ERISA, Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <a href="https://www.dol.gov/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a>; for all other group health coverage you may also contact Medica at 1-800-952-3455 or the Minnesota Department of Commerce at (651) 539-1600 or 1-800-657-3602.

### 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 the Minimum Value Standard? Yes.

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 1-800-952-3455.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-952-3455.

Chinese (中文): 如果需要中文的帮助,请拨打这个号码 1-800-952-3455. Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-952-3455.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

Coverage for: Individual/Family | Plan Type: PPO

**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.

> 20% 20%

\$5.600

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)					
■ The <u>plan's</u> overall <u>deductible</u>	\$4,000				
■ Specialist coinsurance 20					
<ul><li>Hospital (facility) coinsurance</li></ul>	20%				
Other coinsurance	20%				

Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)				
■ The <u>plan's</u> overall <u>deductible</u>	\$4,000			
Specialist coinsurance	20%			

(111-1	letwork emergency room visit and	iollow up care)
	The plan's overall deductible	\$4,000
	Specialist coinsurance	20%
	Hospital (facility) coinsurance	20%
	Other coinsurance	20%

Mia's Simple fracture

### 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)	Jin,
Total Example Cost	\$12,700

Total Example Cost	\$12,700		

In this example, Peg would pay:		
Cost Sharing		
<u>Deductibles</u>	\$4,000	
Copayments	\$0	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$60	
The total Peg would pay is \$4,06		

This EXAM	PLE	event	includ	des s	ervi	ices	like:
<b>—</b> 1							

**Hospital (facility) coinsurance** 

Other coinsurance

**Total Example Cost** 

<u>Primary care physician</u> office visits (*including disease* education) Diagnostić tests (blood work) Prescription drugs

Durable medical equipment (glucose meter)

T - /
\$2,200
\$0
\$0
\$0
\$2,200

## 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** 

Ψ2,000
\$2,800
\$0
\$0
\$0
\$2,800

Note: The patient pays amounts assume the patient is not participating in a Flexible Spending Account (FSA), a Health Savings Account (HSA), or a Health Reimbursement Arrangement (HRA), including an HRA funded through a Voluntary Employee Beneficiary Association (VEBA-HRA). If you have a FSA, HSA, HRA, or VEBA-HRA, then you may have additional funds that could help cover certain out-of-pocket expenses such as deductibles, copayments, coinsurance, and benefits otherwise not covered.

The plan would be responsible for the other costs of these EXAMPLE covered services.

\$2,800

# 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.

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.

နမှါအဲ့ဒိုးတါကိုးထံစၤကလီနှုံနာတာ်က်တာ်ကျိုးဆုံးလာအကလီနှုံဉ်,ကိုးလီတဲ့စိနီဉ်က်လာအပဉ် ယှာ်လာလာတီလာမီအပူးဆုံးမှတမှုါစုံနန္နနိုင်စေလာ်အဉ်သႊစုးကုအလိုခံတကပၤအဖီခိုဉ်နှဉ်တက္ကာ.

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.

ይህን መረጃ ለመተርንም ነጻ እርዳታ የሚፈልጉ ከሆነ በዝ ህ ስነድ ዉስጥ ያለውን ቁጥር ወይም Medica መታወቅያ ካርድዎ በስተጀርባ ያለውን ይደውሉ።

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.

Wenn Sie bei der Übersetzung dieser Informationen kostenlose Hilfe in Anspruch nehmen möchten, rufen Sie bitte die in diesem Dokument oder auf der Rückseite Ihrer Medica-ID-Karte angegebene Nummer an.