



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 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 www.healthcare.gov/sbc-glossary 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 providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| Are there services covered before you meet your deductible? | Yes. Preventive care, preventive prescriptions and prenatal care from in-network providers or well child and prenatal care from out-of-network providers. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| 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 out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit 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 network provider? | Yes. See www.Medica.com/FindCare or call 1-952-945-8000 or 1-800-952-3455 (TTY: 711) for a list of Medica Choice with UnitedHealthcare 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 referral to see a specialist? | No. You don't need a referral to see a specialist. | 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.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions & Other Important Information |
|--|--|--|---|---|
| | | In-Network Provider (You will pay the least) | Out-of-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: 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. |
| | Specialist visit | 20% coinsurance | 50% coinsurance | None |
| | Preventive care/screening/immunization | No charge. Deductible 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 |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 50% coinsurance | None |



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|---|--|---|--|--|
| | | In-Network Provider (You will pay the least) | Out-of-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/DrugCost2 | 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 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 change taking effect. ACA preventive drugs covered at no charge. Deductible does not apply. |
| | Preferred brand drugs | Preventive: Designated preventive drugs: No charge. Deductible does not apply. Retail: 20% coinsurance Mail order: 20% coinsurance | 50% coinsurance | |
| | Non-preferred brand drugs | Preventive: Benefit does not apply. Retail: 40% coinsurance Mail order: 40% coinsurance | 50% coinsurance | |
| | Specialty drugs | Preferred: 20% coinsurance No more than \$200 copay /prescription. Non-Preferred: 40% coinsurance | Not covered | |
| 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 |
| If you need immediate medical attention | Emergency room care | 20% coinsurance | 20% coinsurance | In-network deductible and out-of-pocket applies. |
| | 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 you have a hospital stay | Facility fee (e.g., hospital room) | 20% coinsurance | 50% coinsurance | None |
| | Physician/surgeon fees | 20% coinsurance | 50% coinsurance | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | 20% coinsurance | 50% coinsurance | None |
| | Inpatient services | 20% coinsurance | 50% coinsurance | Residential treatment is covered as part of inpatient services. |



| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions & Other Important Information |
|--|---|---|---|--|
| | | 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 ultrasounds.) |
| | Childbirth/delivery professional services | 20% coinsurance | 50% coinsurance | |
| | Childbirth/delivery facility services | 20% coinsurance | 50% coinsurance | |
| If you need help recovering or have other special health needs | Home health care | 20% coinsurance | 50% coinsurance | 120 visits in-network and 60 visits out-of-network per member per year. |
| | 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 |
| If your child needs dental or eye care | Children's eye exam | No charge. Deductible does not apply. | 50% coinsurance | None |
| | Children's glasses | Not covered | Not covered | Glasses are not covered by the plan . |
| | Children's dental check-up | Not covered | Not covered | Dental check-ups are not covered by the plan . |



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](#).)

- | | | |
|---|---|--|
| <ul style="list-style-type: none">• 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 | <ul style="list-style-type: none">• Dental care (Adult)• Dental check-up• Glasses• Infertility treatment | <ul style="list-style-type: none">• 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.)

- | | | |
|--|--|--|
| <ul style="list-style-type: none">• Hearing aids | <ul style="list-style-type: none">• Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none">• 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.cciio.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 www.dol.gov/ebsa/healthreform; 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, kwijigo holne' 1-800-952-3455.

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 | \$4,000 |
| ■ Specialist coinsurance | 20% |
| ■ Hospital (facility) coinsurance | 20% |
| ■ Other coinsurance | 20% |

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

| Mia's Simple fracture (in-network emergency room visit and follow up care) | |
|---|---------|
| ■ The plan's overall deductible | \$4,000 |
| ■ Specialist coinsurance | 20% |
| ■ 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*)

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*)

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$4,000 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$4,060 |

In this example, Joe would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$2,200 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Joe would pay is | \$2,200 |

In this example, Mia would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$2,800 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$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.

