 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?	\$200 per person / \$600 per family in-network and \$400 per person / \$1,200 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, copayments, and prescription drugs from in-network providers and copayments, prescription drugs, well child and prenatal care out-of-network.	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?	\$1,200 per person / \$2,400 per family in-network. \$2,500 per person / \$7,500 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.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.



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: \$30 copay /visit. Deductible does not apply. Chiropractic: \$30 copay /visit. Deductible does not apply. Retail Health: \$15 copay /visit. Deductible does not apply. Virtual: \$15 copay /visit. Deductible does not apply.	Primary: 40% coinsurance Chiropractic: 40% coinsurance Retail Health: 40% coinsurance Virtual: 40% coinsurance	In-network primary care visits provided at an outpatient facility may be subject to coinsurance and deductible .
	Specialist visit	\$30 copay /visit. Deductible does not apply.	40% coinsurance	In-network specialist visits provided at an outpatient facility may be subject to coinsurance and deductible .
	Preventive care/screening/immunization	No charge. Deductible does not apply.	Well child care: 0% coinsurance Deductible does not apply. Other services: 40% 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	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	None



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 need drugs to treat your illness or condition More information about prescription drug coverage is available at www.Medica.com/DrugCost1	Generic drugs	Retail: \$11/prescription Deductible does not apply. Mail order: \$22/prescription Deductible does not apply.	\$11/prescription Deductible does not apply.	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 be \$0 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	Retail: \$11/prescription Deductible does not apply. Mail order: \$22/prescription Deductible does not apply.	\$11/prescription Deductible does not apply.	
	Non-preferred brand drugs	Retail: \$35/prescription Deductible does not apply. Mail order: \$70/prescription Deductible does not apply.	\$35/prescription Deductible does not apply.	
	Specialty drugs	Preferred: 20% coinsurance . No more than \$200 copay /prescription. Deductible does not apply. Non-Preferred: 40% coinsurance . Deductible does not apply.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	\$75 copay /visit. Deductible does not apply.	\$75/ copay /visit. Deductible does not apply.	In-network out-of-pocket applies.
	Emergency medical transportation	20% coinsurance	20% coinsurance	In-network deductible and out-of-pocket applies.
	Urgent care	\$30 copay /visit. Deductible does not apply.	40% coinsurance	None



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 have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 copay /visit. Deductible does not apply.	40% coinsurance	Coinsurance may apply for some in-network outpatient services such as intensive outpatient programs.
	Inpatient services	20% coinsurance	40% coinsurance	Residential treatment is covered as part of inpatient services.
If you are pregnant	Office visits	No charge. Deductible does not apply.	Prenatal care: 0% coinsurance . Deductible does not apply. Postnatal care: 40% 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	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	No coverage for home IV therapy out-of-network.
	Rehabilitation services	\$30 copay /visit. Deductible does not apply.	40% coinsurance	None
	Habilitation services	\$30 copay /visit. Deductible does not apply.	40% coinsurance	None
	Skilled nursing care	20% coinsurance	40% coinsurance	None
	Durable medical equipment	20% coinsurance	40% coinsurance	None
	Hospice services	20% coinsurance	Not covered	None
If your child needs dental or eye care	Children's eye exam	No charge. Deductible does not apply.	0% coinsurance . Deductible does not apply.	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 20 visits per member per year for in-network and out-of-network acupuncture services combined• Cosmetic surgery	<ul style="list-style-type: none">• Dental care (Adult)• Dental check - up• Glasses• Infertility treatment exceeding \$5,000 medical/\$3,000 pharmacy per member per calendar year combined for in-network and out-of-network	<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">• Bariatric surgery• Chiropractic Care	<ul style="list-style-type: none">• Hearing aids• 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 the Minnesota Department of Commerce at (651) 539-1600 or 1-800-657-3602 or the U.S. Department 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: your [plan](#) administrator or you may contact Medica at 1-800-952-3455.

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	\$200
■ Specialist copayment	\$30
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	25%

Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	
■ The plan's overall deductible	\$200
■ Specialist copayment	\$30
■ 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	\$200
■ Specialist copayment	\$30
■ 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
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Total Example Cost	\$5,600
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Total Example Cost	\$2,800
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$200
Copayments	\$0
Coinsurance	\$1,000
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$1,260

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$200
Copayments	\$400
Coinsurance	\$100
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$700

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$200
Copayments	\$200
Coinsurance	\$500
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$900

Note: The amount the patient pays assumes 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.

This self-funded group health [plan](#) is sponsored by your employer and administered by Medica Self Insured (MSI). 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 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 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.

إذا كنت تريد مساعدة مجانية في ترجمة هذه المعلومات، فاتصل على الرقم الوارد في هذه الوثيقة أو على ظهر بطاقة تعريف مديكا 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 идентификационной карты Medica.

ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປຂໍ້ມູນນີ້ຟຣີ, ໃຫ້ໂທຫາເລກໝາຍທີ່ມີຢູ່ໃນເອກະສານນີ້ 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.

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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.

Dii t'áá jiiik'e shá ata' hodoonih nínizingo éi ninaaltsoos Medica bee né'ího'dilzinígí bine'déé' námbuu biká'ígííji' 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.