



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 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 Medica at 1-800-952-3455 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|--|--|
| What is the overall deductible? | \$3,000 per person/ \$6,000 per family in-network and \$3,500 per person/ \$7,000 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 and prenatal care from in-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? | \$3,000 per person/ \$6,000 per family in-network. \$3,500 per person/ \$7,000 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, 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 or call 1-800-952-3455 or 711 (TTY users) 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: 0% coinsurance Chiropractic: 0% coinsurance Convenience: 0% coinsurance | Primary care: 0% coinsurance Chiropractic: 0% coinsurance Convenience: 0% coinsurance | Limited to 15 visits per member, per year combined for in-network and out-of-network chiropractic care. |
| | Specialist visit | 0% coinsurance | 0% coinsurance | ---none--- |
| | Preventive care/ screening/ immunization | No charge. Deductible does not apply. | 0% 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. Routine physicals are not covered out-of-network. |
| If you have a test | Diagnostic test (x-ray, blood work) | Lab: 0% coinsurance X-ray: 0% coinsurance | 0% coinsurance | ---none--- |
| | Imaging (CT/PET scans, MRIs) | 0% coinsurance | 0% coinsurance | ---none--- |
| 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 | Retail: 0% coinsurance Mail order: 0% coinsurance | 0% coinsurance | Up to a 31-day supply/ retail or 93-day supply/ mail order prescription. Mail order drugs not covered out-of-network. |
| | Preferred brand drugs | Retail: 0% coinsurance Mail order: 0% coinsurance | 0% coinsurance | |
| | Non-preferred brand drugs | Retail: 0% coinsurance Mail order: 0% coinsurance | 0% coinsurance | Up to a 31-day supply per prescription received from a designated specialty pharmacy. |
| | Specialty drugs | Preferred: 0% coinsurance Non-Preferred: 0% coinsurance | Not covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 0% coinsurance | 0% coinsurance | ---none--- |
| | Physician/surgeon fees | 0% coinsurance | 0% coinsurance | ---none--- |
| If you need immediate medical attention | Emergency room care | 0% coinsurance | 0% coinsurance | In-network deductible and out-of-pocket applies. |
| | Emergency medical transportation | 0% coinsurance | 0% coinsurance | In-network deductible and out-of-pocket applies. |
| | Urgent care | 0% coinsurance | 0% coinsurance | In-network deductible and out-of-pocket 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 have a hospital stay | Facility fee (e.g., hospital room) | 0% coinsurance | 0% coinsurance | ---none--- |
| | Physician/surgeon fees | 0% coinsurance | 0% coinsurance | ---none--- |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | 0% coinsurance | 0% coinsurance | ---none--- |
| | Inpatient services | 0% coinsurance | 0% coinsurance | ---none--- |
| If you are pregnant | Office visits | Prenatal care: No charge. Deductible does not apply. Postnatal care: 0% coinsurance | 0% coinsurance | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) |
| | Childbirth/delivery professional services | 0% coinsurance | 0% coinsurance | ---none--- |
| | Childbirth/delivery facility services | 0% coinsurance | 0% coinsurance | ---none--- |
| If you need help recovering or have other special health needs | Home health care | 0% coinsurance | 0% coinsurance | ---none--- |
| | Rehabilitation services | 0% coinsurance | 0% coinsurance | ---none--- |
| | Habilitation services | 0% coinsurance | 0% coinsurance | ---none--- |
| | Skilled nursing care | 0% coinsurance | 0% coinsurance | ---none--- |
| | Durable medical equipment | 0% coinsurance | 0% coinsurance | ---none--- |
| | Hospice services | 0% coinsurance | 0% coinsurance | ---none--- |
| If your child needs dental or eye care | Children's eye exam | No charge. Deductible does not apply. | 0% coinsurance | ---none--- |
| | Children's glasses | Eyeglass & contact lenses: 0% coinsurance . Plan payment maximum of \$200 every consecutive 2 years. Frames: Not covered | Eyeglass & contact lenses: 0% coinsurance . Plan payment maximum of \$200 every consecutive 2 years. Frames: Not covered | Member responsible over \$200. Limit combined per member in- and out-of-network regardless of age. |
| | 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 for out-of-network chiropractic care. ● Cosmetic Surgery | <ul style="list-style-type: none"> ● Dental Care (Adult) ● Dental check-up ● Glasses ● Hearing aids except for members 18 years of age and younger for hearing loss that is not correctable by other covered procedures; coverage is limited to one hearing aid per ear every three years. | <ul style="list-style-type: none"> ● 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.) | |
|--|--|
| <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 Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 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. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Plan Provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 800-952-3455.

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

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 800-952-3455.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 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](#): \$3,000
- [Specialist coinsurance](#): 0%
- [Hospital \(facility\) coinsurance](#): 0%
- [Other coinsurance](#): 0%

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 | \$12,800 |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$3,000 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$3,060 |

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

- The [plan's](#) overall [deductible](#): \$3,000
- [Specialist coinsurance](#): 0%
- [Hospital \(facility\) coinsurance](#): 0%
- [Other coinsurance](#): 0%

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 | \$7,400 |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$3,000 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Joe would pay is | \$3,000 |

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

- The [plan's](#) overall [deductible](#): \$3,000
- [Specialist coinsurance](#): 0%
- [Hospital \(facility\) coinsurance](#): 0%
- [Other coinsurance](#): 0%

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 | \$1,900 |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$1,900 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,900 |

This [plan](#) is a self-funded group health [plan](#) administered by Medica Self Insured. The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

