Effective January 01, 2020

MEDICA®

your ENROLLMENT GUIDE

Dunn County

CMP5635-1-00916

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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 document, call 1-800-952-3455.

Si desea recibir asistencia gratuita para la traducción de este documento, llame al 1-800-952-3455.

Yog koj xav tau kev pab dawb txhais daim ntawv no, hu rau 1-800-952-3455.

如果您需要我們免費幫您翻譯此文件，請致電 1-800-952-3455。

Nếu quý vị muốn giúp dịch tài liệu này miễn phí, gọi 1-800-952-3455.

Sanadnikun kaffaltiimaleeakkaisiniifhiikamuyoobarbaadd-an 1-800-952-3455 tiinbilbilaa.

إذا كنت ترغب في مساعدة مجانية لترجمة هذا المستند، فاتصل على الرقم 1-800-952-3455.

Если вы хотите получить бесплатную помощь в переводе этого документа, позвоните по телефону 1-800-952-3455.

ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອຟຣີໃນການແປເອກະສານນີ້, ໃຫ້ໂທຫາ 1-800-952-3455.

이 문서를 번역하는 데 무료로 도움을 받고 싶으시면 1-800-952-3455로 전화하십시오.

Si vous désirez obtenir gratuitement de l'aide pour traduire ce document, appelez le 1 800 952 3455.

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Kung nais mo ng libreng tulong sa pagsasalin ng dokumentong ito, tumawag sa 1-800-952-3455.

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Ako želite besplatnu pomoć za prijevod ovog dokumenta, nazovite 1-800-952-3455.

T'áá jiik'é díí naaltsoos t'áá nizaadk'ehjí bee shí ká'adoowoł ninízingo kojí' hodíílnih, 1-800-952-3455.

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CMP5635-1-00917

DECISIONS, DECISIONS...

Making choices can be fun – like deciding what color to paint your living room or where to go on your next vacation. But choosing your health insurance? Yeah, we get it – not so fun. Still, it doesn't have to be hard. This guide will explain what's covered, how much it will cost and how to find out which providers are in the network. Have questions? Help is just a call or click away.

Your group numbers:

25343 plan is $3000-0% HSA Passport
25355 plan is $3000-0% HSA CompleteHealth
25340 plan is $5000-0% HSA Passport
25344 plan is $5000-0% HSA CompleteHealth

Looking for more information about how insurance works?

Check out the tip sheets and videos at medica.com/membertips.

Watch your mailbox around the time your Medica plan starts.

If you have a new plan, we'll mail you an ID card and a kit with more detailed information about your benefits.

Once your plan starts, you can manage your benefits online.

Just log on to mymedica.com to order extra ID cards, track your claims, see what your plan covers and more.

Have questions or need more information?

Call us at 952-945-8000 or 800-952-3455. We're here to help!

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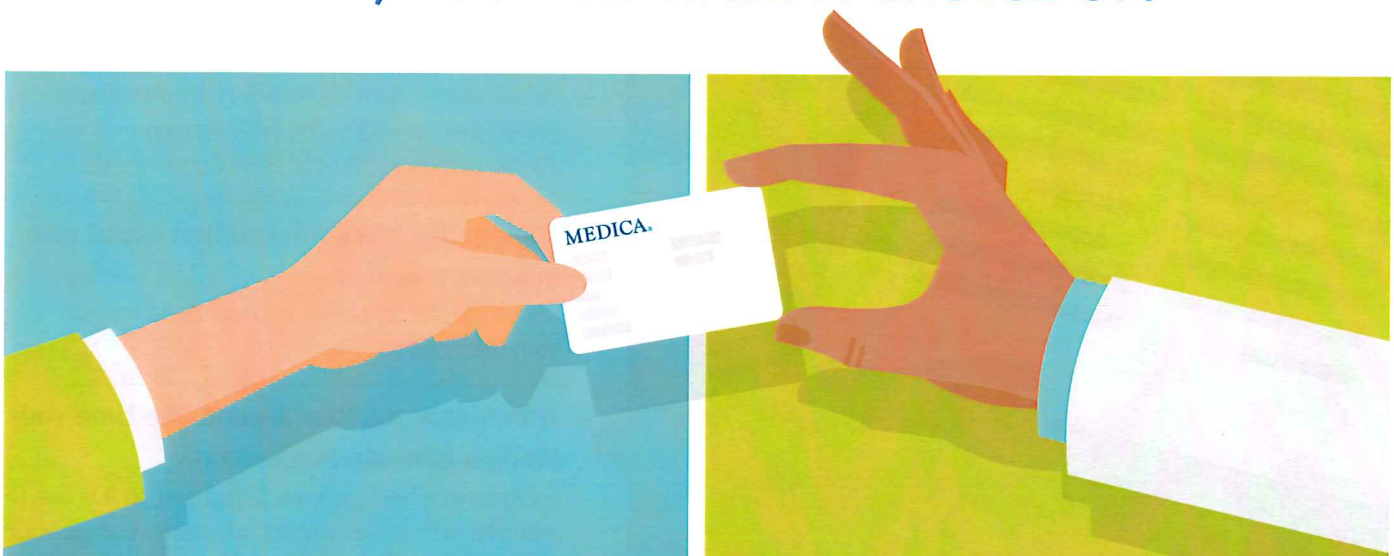
WHICH ONE SHOULD I CHOOSE?

When you have more than one plan to choose from, it can be hard to know which one to pick.

PLUS, YOU MAY HAVE A CHOICE OF:



PLAN BENEFITS

How your care is covered.

Your plan benefits determine how things are covered (for example, whether the plan has a deductible and/or coinsurance) and what your share of the costs will be. You'll find this information in the plan's **benefit summary**, available in this guide.

PROVIDER NETWORKS

Where you go for care.

What's a network? It's a group of doctors, hospitals and other health care providers who have a contract with Medica to provide services to our members, usually at a discount. You receive your highest level of benefits when you see providers in your plan's network.

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WHICH ONE SHOULD I CHOOSE?

If you have more than one network or plan to pick from, answering the following questions can help you pick what's right for you.

CHOOSING NETWORKS

- [ ] Know who's in the network
- [ ] Check the referral requirements
- [ ] Consider what size network you'll need

Is it important to keep your current doctor?

yes!

Check each plan's network to see whether your doctor, hospital and other health care providers are included. Be sure to choose a network that meets the needs of your entire family, since you'll all share the same network.

Do you need to see specialists?

With some networks, you'll need a referral to see a specialist in certain cases (for example, in a care system network, when you want to see a provider outside of your care system). With other networks, you won't need a referral as long as you stay in the network.

What size network do you need?

Plans with a smaller network usually have lower premiums. Accountable care organizations (ACOs) have a smaller network, but offer added features and support, usually at a lower cost. If an ACO is one of your options, and you and your family already see providers in that ACO, then this type of network might be right for you. If it's important to have access to a wider range of doctors and other providers, a larger network might be a better fit.

CHOOSING BENEFITS

- [ ] Understand your coverage
- [ ] Estimate your health care costs
- [ ] Know your maximum

Would you rather pay your costs up front, or as you go?

Plans with more coverage usually have higher premiums (the set amount you pay for your coverage), but offer lower costs when you receive care. Plans with lower premiums usually have higher deductibles and other out-of-pocket expenses, meaning you'll pay more as you receive care. To learn more about these terms, see the next section ("What's covered? How much will it cost?").

Are you expecting a lot of health care expenses this year?

Compare each plan's out-of-pocket expenses (the deductible, coinsurance, out-of-pocket maximum, etc.) to see which plan best fits your situation. To get an idea of your overall cost, be sure to also factor in your premiums.

What if you get seriously ill?

Could you afford to pay the plan's out-of-pocket maximum (also called an out-of-pocket limit)? This amount is the most you would pay for covered services in a year. After that, your plan pays 100%. Keep in mind that a plan may have an individual and a family limit, and separate limits for in- versus out-of-network care.

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WHAT'S COVERED?
HOW MUCH WILL IT COST?

When you get down to it, there are two types of health care costs:

PREMIUMS

Think of premiums like your health club dues, where you pay a monthly fee to access the gym. Your health insurance premiums give you a certain level of coverage, including 100% coverage of preventive care. Your plan also includes some nice extras, at no additional charge. These are like the hot tub or steam room in our health club example – you have access to them just because you're a member.

OUT-OF-POCKET COSTS

Out-of-pocket costs are what you pay as you receive care. These costs will vary depending on the plan you pick. Below are some examples of common out-of-pocket costs. To see which costs apply and how much you'll be responsible for, check the plan's **benefit summary**, available in this guide.

Premium

The amount you pay each month or every pay period for the insurance plan.

Have questions about your premium amounts? Check with your employer.

Copay

A set amount you pay up front when you receive care.

For example, $40 for a doctor visit.

Deductible

The amount you pay each year before your insurance starts to pay.

For example, if your deductible is **$2,000**, that's what you'll pay before your insurance starts to pay. Some charges don't count toward your deductible (for example, copays and services that aren't covered). And you might receive coverage for some things, like preventive care, even if you haven't met your deductible.

Coinsurance

Your share of the costs after you've paid your deductible. Coinsurance is a percentage of the charges for the service.

For example, you pay **20%** of the charges and Medica pays 80%.

Out-of-Pocket Maximum

The most you pay in a year for health care services covered by your insurance.

Once you meet this limit, your insurance pays 100% of any additional covered charges for the rest of the year.

To learn more about out-of-pocket costs, see the tip sheet at **medica.com/membertips**.

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Save money — see network providers

Many (though not all) plans have out-of-network benefits.

If they do, they'll be listed on the plan's **benefit summary**. But even with these benefits, your costs will be much higher if you see a provider outside your plan's network. That's because of three things:

1. **Out-of-network benefits cover less than in-network benefits.** For example, a plan may have 40% coinsurance for out-of-network care vs. 20% coinsurance for in-network care (this is just an example – for actual amounts, see a plan's **benefit summary** available in this guide).

2. **We negotiate discounts with network providers.** When you leave the network, you lose those discounts. So the percentage you're paying above? It's a percentage of the full bill, not the discounted amount when you see a network provider.

3. **We usually pay out-of-network providers less than the amount they bill.** When this happens, you're responsible for paying the balance to the provider.

So it really does pay to stay in your plan's network.
To see an example of how much more out-of-network care can cost, go to **medica.com/membertips**.

What about prescriptions?

You can see how a plan covers prescription drugs by looking at the **benefit summary**, available in this guide.

With some plans, you'll pay a set copay when you fill a prescription. With other plans, you'll pay the full cost of prescriptions until you meet your deductible. Rarely, a few plans have a combination of both copays and a deductible for prescriptions.

Whichever the case, it's helpful to know what to expect before you fill your prescriptions. And if you have a choice of plans that cover prescriptions differently, you'll want to compare potential costs under each plan. To get an idea of how much a particular drug will cost, you can use the online search tool. Just go to **mymedica.com** and choose Pharmacy Information (in the "Links and Tools" box on the right).

Once your plan starts, log in to mymedica.com to see prices specific to the plan you've chosen.
You'll also be able to look up pharmacies where you can fill your prescriptions. For ongoing prescriptions, many plans also offer mail order or 90-day refills.

GET THE DETAILS YOU NEED ONLINE

Once your plan starts, you can find the information you need on **mymedica.com**.

- ✓ See what your plan covers and find out your share of the costs
- ✓ Check prices for prescription drugs
- ✓ Track your claims
- ✓ See who's in your plan's network
- ✓ Print a temporary ID card or order extras
- ✓ Pick up some healthy habits and learn more about wellness

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MEDICA CHOICE® PASSPORT

A NATIONAL NETWORK

What's a national network? A national network includes providers in every state of the country. If you have family members living in different states (for example, kids away at college), a national network may be a good option for you. Or if you live outside of Medica's service area (Minnesota, North Dakota, South Dakota and western Wisconsin), you'll be offered a national network.

What are the features?

One of the largest networks in the nation

Nationwide coverage when you travel

No referrals needed

What's unique?

In addition to your plan coverage, this network includes:

The largest number of providers to choose from. With hundreds of thousands of providers throughout the nation, there's a good chance your current doctors are included in the Medica Choice Passport network.

Providers from many different care systems and hospital affiliations. If it's important to have access to a wide range of doctors and facilities, Medica Choice Passport is an excellent choice.

Nationwide coverage. No matter where you live in the U.S., you have access to network providers. And you're covered when you travel, too.

Direct access to specialists. See any provider in the network without a referral.

How do I find a provider in the network?

Go to **medica.com/findadoctor** and choose Medica Choice® with UnitedHealthcare Options PPO

Or call us at **952-945-8000** or **800-952-3455** (TTY users, call **711**)

CMP6914-1-00916

MEDICA COMPLETEHEALTH℠

(featuring care at Mayo Clinic)

AN ACCOUNTABLE CARE ORGANIZATION NETWORK

What's an accountable care organization (ACO) network? In an ACO, groups of doctors, nurses and other health care providers work together with your health plan to provide coordinated care. That means you receive enhanced care, usually at a lower cost.

What are the features?

A unique network of providers in southern Minnesota and western Wisconsin

Nationwide coverage when you travel

No referrals needed when you visit a Medica CompleteHealth provider

What's unique?

In addition to your plan coverage, this ACO includes:

Access to health care services covering basic care to complex, comprehensive care

Personalized care from a team of providers based on your unique needs

Coordinated care and support after a hospital stay or emergency room visit

24/7 nurse and advisor line

Online access to your Mayo Clinic health records

Help losing weight with the Mayo Clinic Diet program – free!

Who's in the network?

The network includes nearly 20 hospitals and 60 clinics in southern Minnesota and western Wisconsin. Providers include Mayo Clinic Health System locations in Minnesota and Wisconsin, Employee and Community Health at Mayo Clinic in Rochester and Kasson, Northfield Hospital & Clinics and Winona Health. All providers have direct access to Mayo Clinic's resources and expertise locally. If your provider determines you need specialty care at Mayo Clinic in Rochester, they will make the arrangements for your care.

How do I find a provider in the network?

Go to **medica.com/findadoctor** and choose Medica CompleteHealth

Or call us at **877-252-5564** (TTY users, call **711**)

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BUT WAIT, THERE'S MORE!

Your plan includes some nice "extras" that can help you get and stay healthy, at no extra cost to you. Once your coverage starts, we'll send you more information on ways to get the most out of your plan.

Value for Your Health Care Dollar Compare cost and quality to find the right provider.

Cost and quality can vary significantly among providers. Knowing the difference can help you save money and have better results. Look up cost ranges for common procedures at dozens of facilities using **Main Street Medica**. Or use the online provider search tool to find doctor-specific cost and quality information with Premium Designation. Both tools are available on **mymedica.com**.

Health Rewards Program Get inspired to make positive changes.

Taking steps to improve your health might be easier than you think. Whether you want to stress less, quit smoking or eat more fruits and veggies, **My Health Rewards by Medica®** makes it fun – and rewarding. You'll earn gift cards as you complete activities personalized just for you. To find your own path to better health, log on to **mymedica.com** and choose the Health & Wellness tab.

24-Hour Health Support Trusted answers any time of day or night.

Worried that your stomach bug could be serious? Wondering what to do about that cough that won't go away? The advisors and nurses at **Medica CallLink®** can help. They're available 24 hours a day, 365 days a year to answer your questions and help you make smart decisions about your health. Just call **800-962-9497** (TTY users, call **711**).

Member e-Newsletter Learn how to get the most from your Medica plan.

Get information about health topics and your benefits delivered right to your inbox. You'll find health tips, advice on making smart health decisions and details on the Medica programs available to you. To sign up, just register for **mymedica.com** and you'll automatically receive the ***4members* e-newsletter**.

Medicare Part D Creditable Coverage Notice

Important Notice from Medica* on behalf of Your Plan Sponsor** about Your Prescription Drug Coverage and Medicare ("Medicare Part D")

You may disregard this notice if you are not eligible for Medicare Part D, or will not become eligible within 12 months.

This notice pertains only to those members, and their covered dependents, who are eligible for Medicare Part D, or who will be eligible within the next 12 months. In general, an individual who is entitled to Part A and/or enrolled in Part B is eligible for Medicare Part D. In most instances, a person has Part A coverage if he or she has attained age 65 and receives monthly Social Security benefits or is a qualified railroad retirement beneficiary. Individuals under age 65 may also become entitled to Medicare Part A benefits if they receive at least 24 months of social security or railroad retirement benefits based on disability.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with your Plan Sponsor and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **Medica, in conjunction with your Plan Sponsor, has determined that the prescription drug coverage offered by your benefit plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered Creditable Coverage.**

When Can You Join a Medicare Drug Plan?

You can join a Medicare prescription drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose creditable prescription drug coverage, through no fault of your own, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you do decide to join a Medicare drug plan and drop your coverage with Medica, *WHICH INCLUDES BOTH YOUR MEDICAL AND PRESCRIPTION DRUG COVERAGE*, be aware that you may not be able to get this coverage back.

Please contact your Plan Sponsor for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with your Plan Sponsor and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or your current prescription drug coverage...
Contact our office for further information by calling the number listed on the back of your member ID card. If, however, you have a question about your eligibility for Medicare Part D, you should call 1-800-MEDICARE. **NOTE**: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage changes. You also may request a copy from Medica at any time.

For more information about your options under Medicare prescription drug coverage...
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048,
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the Medicare & You handbook for their telephone number) for personalized help,
- Visit www.medicare.gov .

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: September 1, 2018 forward
Name of Entity/Sender: Medica*
Contact--Position/Office: Customer Service
Address: Route CP 555, P.O. Box 9310, Minneapolis, MN 55440-310
Phone Number: 1-800-952-3455 or 952-945-8000 *(Or refer to number on back of ID card)*

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** Your Plan Sponsor is the entity that established your benefit plan, and is typically your employer (or former employer).

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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: In-Network Provider (You will pay the least)	What You Will Pay: Out-of-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:** 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	
	Specialty drugs	**Preferred:** 0% coinsurance **Non-Preferred:** 0% coinsurance	Not covered	Up to a 31-day supply per prescription received from a designated specialty pharmacy.
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: In-Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
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.)

- 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
- 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.
- 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.)

- Non-emergency care when traveling outside the U.S.
- 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, kwiijigo 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.

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 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 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.

နာမ်းဆဲ:တtill ကျိုးထံစကားလိုချင်တာကျေးဇူးလေးဆကလိုနှင့်,ကီးလိတဲစိုဂ်ဂ်ကိ်လေးဆပ်ဂ် ယုာ်လေးလော်တီလော်မီအပူးဆော်မ့တမ်ဗဲနနှနိုင်ခေလော်ဆုဂ်သးစးကုအလော်ခ်တကပေးအဖိစိုဂ်နှင်တကှ်.

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 ለመተርጎም ነጻ እርዳታ የሚፈልጉ ከሆነ በዝ ህ ሰነድ ዉስጥ ያለውን ቁጥር ወይም Medica መታወቅያ ካርድዎ በስተጀርባ ያለውን ይደዉሉ።

Ako želite besplatnu pomoć za prijevod ovih informacija, nazovite broj naveden u ovom dokumentu ili na poleđini svoje ID kartice Medica.

Díí t'áá jiík'e shá ata' hodoonih nínízingo éí ninaaltsoos Medica bee néího'dílzinígí bine'déé' námboo biká'ígíjíj' 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.

COMIFB-0119-I

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?	**$5,000** per person/ **$10,000** per family in-network and **$5,500** per person/ **$11,000** 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?	**$5,000** per person/ **$10,000** per family in-network. **$5,500** per person/ **$11,000** 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: In-Network Provider (You will pay the least)	What You Will Pay: Out-of-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:** 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	
	Specialty drugs	**Preferred:** 0% coinsurance **Non-Preferred:** 0% coinsurance	Not covered	Up to a 31-day supply per prescription received from a designated specialty pharmacy.
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: In-Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
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.)

- Acupuncture exceeding 15 visits per member per year for in-network and out-of-network acupuncture services combined.
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- Chiropractic care exceeding 15 visits per member per year for out-of-network chiropractic care.
- Cosmetic Surgery
- 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.
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- 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.)

- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)

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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:

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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, kwiijigo 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**: $5,000
- **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	$5,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,060**

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

- **The plan's overall deductible**: $5,000
- **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	$3,600
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$3,600**

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

- **The plan's overall deductible**: $5,000
- **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.

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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 1-877-252-5564. 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 1-877-252-5564 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 1-877-252-5564 or 711 (TTY users) for a list of Medica CompleteHealth 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: In-Network Provider (You will pay the least)	What You Will Pay: Out-of-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:** 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	
	Specialty drugs	**Preferred:** 0% coinsurance **Non-Preferred:** 0% coinsurance	Not covered	Up to a 31-day supply per prescription received from a designated specialty pharmacy.
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: In-Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
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.)

- 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
- 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.
- 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.)

- Non-emergency care when traveling outside the U.S.
- 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 1-877-252-5564 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 1-877-252-5564. 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, kwiijigo 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.

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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.

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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 1-877-252-5564. 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 1-877-252-5564 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$5,000** per person/ **$10,000** per family in-network and **$5,500** per person/ **$11,000** 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?	**$5,000** per person/ **$10,000** per family in-network. **$5,500** per person/ **$11,000** 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 1-877-252-5564 or 711 (TTY users) for a list of Medica CompleteHealth 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 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 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	
	Specialty drugs	**Preferred:** 0% coinsurance **Non-Preferred:** 0% coinsurance	Not covered	Up to a 31-day supply per prescription received from a designated specialty pharmacy.
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: In-Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
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.)

- 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
- 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.
- 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.)

- Non-emergency care when traveling outside the U.S.
- 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 1-877-252-5564 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 1-877-252-5564. 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, kwiijigo 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**: $5,000
- **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	$5,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,060**

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

- **The plan's overall deductible**: $5,000
- **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	$3,600
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$3,600**

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

- **The plan's overall deductible**: $5,000
- **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.