



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 by calling 1-855-400-9652. 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.dol.gov/ebsa/healthreform or www.cciio.cms.gov or call Medica at the numbers above to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$1,000 per single/ \$1,500 per single plus child(ren) / \$2,000 per family in-network and \$2,000 per single/ \$3,000 per single plus child(ren)/ \$4,000 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, copayments, hospice or prescription drugs from in-network providers and the first 5 hours of mental health or first 5 hours of substance abuse office visits from out-of-network providers.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits .
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	\$3,000 per single/ \$4,500 per single plus child(ren)/ \$6,000 per family in-network. \$6,000 per single/ \$9,000 per single plus child(ren)/ \$12,000 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 towards the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.medica.com or call 1-855-400-9652 or 711 (TTY users) for a list of Altru 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 [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
		Network Provider (You will pay the least)	Out-of-network (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: \$25 copay /visit then 20% coinsurance . Deductible does not apply. Chiropractic: \$25 copay /visit then 20% coinsurance . Deductible does not apply. Convenience: \$5 copay /visit, then 20% coinsurance . Deductible does not apply.	Primary care: 40% coinsurance Chiropractic: 40% coinsurance Convenience: 40% coinsurance	---none---
	Specialist visit	\$25 copay / visit, then 20% coinsurance . Deductible does not apply.	40% coinsurance	---none---
	Preventive care/ screening/ immunization	No charge. Deductible does not apply.	Not covered	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 and eye exams are not covered out-of-network .
If you have a test	Diagnostic test (x-ray, blood work)	Lab: 20% coinsurance X-ray: 20% coinsurance	40% coinsurance	---none---
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	---none---

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-network (You will pay the most)	
<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.medica.com/drugcost1</p>	Generic drugs	<p>Retail: \$15/ prescription, then 20% coinsurance. Deductible does not apply.</p> <p>Mail order: \$15/ prescription then 20% coinsurance. Deductible does not apply.</p>	Not covered	<p>Up to a 31-day supply/ retail or 93-day supply/ mail order prescription. Mail order drugs not covered out-of-network.</p>
	Preferred brand drugs	<p>Retail: \$20/ prescription, then 20% coinsurance. Deductible does not apply.</p> <p>Mail order: \$20/ prescription then 20% coinsurance. Deductible does not apply.</p>	Not covered	
	Non-preferred brand drugs	<p>Retail: \$20/ prescription, then 50% coinsurance. Deductible does not apply.</p> <p>Mail order: \$20/ prescription then 50% coinsurance. Deductible does not apply.</p>	Not covered	
	Specialty drugs	<p>Preferred: \$20/ prescription, then 20% coinsurance. Deductible does not apply.</p> <p>Non-Preferred: \$20/ prescription, then 50% coinsurance. Deductible does not apply.</p>	Not covered	
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	---none---
	Physician/surgeon fees	20% coinsurance	40% coinsurance	---none---
<p>If you need immediate medical attention</p>	Emergency room care	\$75 copay / visit then 20% coinsurance . Deductible does not apply.	Covered as an in-network benefit.	---none---
	Emergency medical transportation	20% coinsurance	Covered as an in-network benefit.	---none---
	Urgent care	\$25 copay / visit then 20% coinsurance . Deductible does not apply.	Covered as an in-network benefit.	---none---

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-network (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	---none---
	Physician/surgeon fees	20% coinsurance	40% coinsurance	---none---
If you need mental health, behavioral health, or substance abuse needs	Outpatient services	\$25 copay / visit then 20% coinsurance . Deductible does not apply.	40% coinsurance	No charge for the first 5 hours of mental health or first 5 hours of substance abuse outpatient services per year in or out-of-network . Outpatient cost-sharing will apply to additional services.
	Inpatient services	20% coinsurance	40% coinsurance	---none---
If you are pregnant	Office visits	No charge. Deductible does not apply.	40% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	---none---
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	---none---
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	---none---
	Rehabilitation services	\$25 copay / visit then 20% coinsurance . Deductible does not apply.	40% coinsurance	Physical, speech and occupational therapy limited to 90 visits combined for in-network and out-of-network per member per year.
	Habilitation services	\$25 copay / visit then 20% coinsurance . Deductible does not apply.	40% coinsurance	Physical, speech and occupational therapy limited to 90 visits combined for in-network and out-of-network per member per year.
	Skilled nursing care	20% coinsurance	40% coinsurance	---none---
	Durable medical equipment	20% coinsurance	40% coinsurance	---none---
	Hospice services	20% coinsurance	40% coinsurance	---none---
If your child needs dental or eye care	Children's eye exam	No charge. Deductible does not apply.	Not covered	---none---
	Children's glasses	Not covered	Not covered	Glasses are not covered by the plan .
	Children's dental check-up	Not covered	Not covered	Dental check-ups are not covered by the plan .

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of other excluded services .)		
<ul style="list-style-type: none"> ● Acupuncture ● Cosmetic Surgery ● Dental Care (Adult) ● Dental check-up ● Glasses 	<ul style="list-style-type: none"> ● Hearing aids except for members 18 years of age and younger for hearing loss due to functional congenital malformation of the ears 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"> ● Long Term Care ● Routine foot care except for specified conditions ● Weight Loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> ● Bariatric Surgery in-network only ● Chiropractic care 	<ul style="list-style-type: none"> ● Infertility treatment limited to \$5,000 medical/ \$3,000 pharmacy per member per year combined for in-network and out-of-network ● Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> ● Private-duty nursing ● 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: 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 1-855-400-9652. 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 Coverage 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 Coverage 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](#).

For assistance, call the number included in this document or on the back of your ID card.

Dine k'ehji shich'i' hadoodzih ninizingo, beesh bee hane'e binumber naaltsoos bikaahigii bich'i' hodiilnih ei doodaii bee neehozin biniiye nanitinigii bine'dee bikaa doo aldo'.

若需要中文协助，请拨打本文件内或您会员卡背面的电话号码。

Para sa tulong sa Tagalog, tawagan ang numerong kabilang sa dokumentong ito o sa likod ng iyong ID card.

Para obtener asistencia en español, llame al número de teléfono que se incluye en este documento o al dorso de su tarjeta de identificación.

----- *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](#): \$1,000
- [Specialist copayment](#): \$25
- Hospital (facility) [coinsurance](#): 20%
- Other [coinsurance](#): 20%

This EXAMPLE event includes services like:
[Specialist](#) office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
[Specialist](#) visit (*anesthesia*)

Total Example Cost	\$12,800
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$20
Coinsurance	\$1,900
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,980

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

- The [plan's](#) overall [deductible](#): \$1,000
- [Specialist copayment](#): \$25
- Hospital (facility) [coinsurance](#): 20%
- Other [coinsurance](#): 20%

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:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$900
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$2,100

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

- The [plan's](#) overall [deductible](#): \$1,000
- [Specialist copayment](#): \$25
- Hospital (facility) [coinsurance](#): 20%
- Other [coinsurance](#): 20%

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:

<i>Cost Sharing</i>	
Deductibles	\$800
Copayments	\$300
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,100

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.

