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 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.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 952-945-8000 or 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 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 Network Provider (You will pay the least)	Out-of-network (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:** $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:** 30% coinsurance **Chiropractic:** 30% coinsurance **Convenience:** 30% coinsurance	---none---
	Specialist visit	$25 copay/ visit, then 20% coinsurance. Deductible does not apply.	30% 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	30% coinsurance	---none---
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	---none---

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	 Out-of-network (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at www.medica.com/drugcost1**	Generic drugs	**Retail:** $15/ prescription, then 20% coinsurance. Deductible does not apply. **Mail order:** $15/ prescription then 20% coinsurance. Deductible does not apply.	Not covered.	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:** $20/ prescription, then 20% coinsurance. Deductible does not apply. **Mail order:** $20/ prescription then 20% coinsurance. Deductible does not apply.	Not covered.	
	Non-preferred brand drugs	**Retail:** $20/ prescription, then 50% coinsurance. Deductible does not apply. **Mail order:** $20/ prescription then 50% coinsurance. Deductible does not apply.	Not covered.	
	Specialty drugs	**Preferred:** $20/ prescription, then 20% coinsurance. Deductible does not apply. **Non-Preferred:** $20/ prescription, then 50% coinsurance. Deductible does not apply.	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)	20% coinsurance	30% coinsurance	---none---
	Physician/surgeon fees	20% coinsurance	30% coinsurance	---none---
If you need immediate medical attention	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 Network Provider (You will pay the least)	Out-of-network (You will pay the most)	Limitations, Exceptions & Other Important Information
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	---none---
	Physician/surgeon fees	20% coinsurance	30% 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.	30% 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	30% coinsurance	---none---
If you are pregnant	Office visits	No charge. Deductible does not apply.	30% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	---none---
	Childbirth/delivery facility services	20% coinsurance	30% coinsurance	---none---
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	---none---
	Rehabilitation services	$25 copay/ visit then 20% coinsurance. Deductible does not apply.	30% 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.	30% 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	30% coinsurance	---none---
	Durable medical equipment	20% coinsurance	30% coinsurance	---none---
	Hospice services	20% coinsurance	30% 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.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Dental check-up
- Glasses
- 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.
- 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.)

- Bariatric Surgery in-network only
- Chiropractic care
- 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.
- 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 1-800-952-3455. 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 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.

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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:

Cost Sharing	
Deductibles	$1,000
Copayments	$20
Coinsurance	$1,900
What isn't covered	
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:

Cost Sharing	
Deductibles	$1,000
Copayments	$900
Coinsurance	$200
What isn't covered	
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:

Cost Sharing	
Deductibles	$800
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,000**

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, ໃຫ້ໂທຫາເລກໝາຍທີ່ມີຢູ່ໃນເອກະສານນີ້ ຫຼື ຢູ່ດ້ານຫຼັງຂອງບັດ Medica ຂອງທ່ານ.

이 정보를 번역하는 데 무료로 도움을 받고 싶으시면, 이 문서에 포함된 전화번호나 Medica ID 카드 뒷면의 전화번호로 전화하십시오.

Si vous voulez une assistance gratuite pour traduire ces informations, appelez le numéro indiqué dans ce document ou au dos de votre carte d'identification Medica.

နမ့်အဲၣ်ဒိးတၢ်ကျိးထံစၢၤကလီနၢ်နၢ်ပၢၢ်တၢ်ကျိၤအံၤလၢအကလီနှၣ်,ကိးလီတဲစိနီၣ်ဂံၢ်လၢအပၣ်ယှာ်လၢလံာ်တီလံာ်မီအပူၤအံၤမ့တမ့ၢ်ဖဲနနဲၣ်ခဲလၢာ်အှၣ်သးခးက့အလီၢ်ခံတကပၤအဖီခိၣ်နှၣ်တက့ၢ်.

Kung nais mo ng libreng tulong sa pagsasalin ng impormasyong ito, tawagan ang numero na kasama sa dokumentong ito o sa likod ng iyong Kard ng Medica ID.

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

Díí t'áá jíík'e shá ata' hodoonih nínízingo éí ninaaltsoos Medica bee néího'dílzinígí bine'déé' námboo biká'ígíijį' béésh bee hodíílnih.

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.