**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, go to www.Medica.com or call 1-952-945-8000 (Minneapolis/St. Paul Metro area) or 1-800-952-3455. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-952-3455 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **$3,200** per person / **$6,400** per family in-network and **$6,500** per person / **$13,000** 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, preventive prescriptions 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?** | **$6,000** per person / **$12,000** per family in-network. **$18,000** per person / **$36,000** 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/FindCare or call 1-800-952-3455 (TTY: 711) for a list of Medica Choice with UnitedHealthcare network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | No. You don't need a referral to see a specialist. | You can see the specialist you choose without a referral. |

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions & Other Important Information |
|---|---|---|---|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | **Primary care:** 20% coinsurance<br>**Chiropractic:** 20% coinsurance<br>**Retail Health:** 20% coinsurance<br>**Virtual:** 20% coinsurance | **Primary:** 50% coinsurance<br>**Chiropractic:** 50% coinsurance<br>**Retail Health:** 50% coinsurance<br>**Virtual:** 50% coinsurance | Limited to 15 visits per member, per year for out-of-network chiropractic care. |
| | Specialist visit | 20% coinsurance | 50% coinsurance | None |
| | Preventive care/ screening/ immunization | No charge. Deductible does not apply. | 50% 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 and eye exams are not covered out-of-network. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | **Lab:** 20% coinsurance<br>**X-ray:** 20% coinsurance | 50% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 50% coinsurance | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions & Other Important Information |
|---|---|---|---|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.Medica.com/DrugCost2 | Generic drugs | **Preventive:** Designated preventive drugs: No charge. Deductible does not apply. **Retail:** 20% coinsurance **Mail order:** 20% coinsurance | 50% coinsurance | Up to a 31-day supply/retail or 93-day supply/mail order prescription. Mail order drugs not covered out-of-network. Insulin: Your cost-share will not exceed $25 per retail prescription unit. ACA preventive drugs covered at no charge. Deductible does not apply. |
| | Preferred brand drugs | **Preventive:** Designated preventive drugs: No charge. Deductible does not apply. **Retail:** 20% coinsurance **Mail order:** 20% coinsurance | 50% coinsurance | |
| | Non-preferred brand drugs | **Preventive:** Benefit does not apply. **Retail:** 40% coinsurance **Mail order:** 40% coinsurance | 50% coinsurance | |
| | Specialty drugs | **Preferred:** 20% coinsurance No more than $200 copay/prescription. **Non-Preferred:** 40% coinsurance | Not covered | Up to a 31-day supply per prescription received from a designated specialty pharmacy. Amounts reimbursed or paid by a provider or manufacturer, on your behalf for a product or service, will not apply toward your cost share. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 50% coinsurance | None |
| | Physician/surgeon fees | 20% coinsurance | 50% coinsurance | None |
| **If you need immediate medical attention** | Emergency room care | 20% coinsurance | 20% coinsurance | In-network deductible and out-of-pocket applies. |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | In-network deductible and out-of-pocket applies. |
| | Urgent care | 20% coinsurance | 20% coinsurance | In-network deductible and out-of-pocket applies. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 50% coinsurance | None |
| | Physician/surgeon fees | 20% coinsurance | 50% coinsurance | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 20% coinsurance | 50% coinsurance | None |
| | Inpatient services | 20% coinsurance | 50% coinsurance | Residential treatment is covered as part of inpatient services. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions & Other Important Information |
|---|---|---|---|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you are pregnant** | Office visits | **Prenatal care:** No charge. Deductible does not apply. **Postnatal care:** 20% coinsurance | 50% coinsurance | Cost sharing does not apply to in-network preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. certain ultrasounds.) |
| | Childbirth/delivery professional services | 20% coinsurance | 50% coinsurance | |
| | Childbirth/delivery facility services | 20% coinsurance | 50% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 50% coinsurance | Limited to 40 visits per member per year in and out-of-network combined. |
| | Rehabilitation services | 20% coinsurance | 50% coinsurance | Physical and occupational therapy combined limited to 20 visits out-of-network per member per year. Out-of-network speech therapy is limited to 20 visits per member per year. Visit limits are not applicable to behavioral health conditions. |
| | Habilitation services | 20% coinsurance | 50% coinsurance | Physical and occupational therapy combined limited to 20 visits out-of-network per member per year. Out-of-network speech therapy is limited to 20 visits per member per year. Visit limits are not applicable to behavioral health conditions. |
| | Skilled nursing care | 20% coinsurance | 50% coinsurance | 30 day limit combined in and out-of-network per member per year. |
| | Durable medical equipment | 20% coinsurance | 50% coinsurance | None |
| | Hospice services | 20% coinsurance | 50% 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 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 out-of-network
- Cosmetic surgery
- Dental check-up
- Glasses
- Hearing aids except for members 17 years of age and younger who are certified as deaf or hearing impaired if prescribed by a physician or licensed audiologist; coverage is limited to one hearing aid 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 for group health coverage subject to ERISA, Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; for all other group health coverage, Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: for group health coverage subject to ERISA, Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; for all other group health coverage you may also contact Medica at 1-800-952-3455 or the Wisconsin Office of Commissioner of Insurance at (608) 266-3585 or 1-800-236-8517.

**Does this Plan Provide Minimum Essential Coverage?** **Yes.**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**Does this Plan Meet the Minimum Value Standard?** **Yes.**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-952-3455.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-952-3455.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-952-3455.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-952-3455.

*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

## About these Coverage Examples:

**This is not a cost estimator**. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|---|
| The plan's overall deductible | $3,200 |
| Specialist coinsurance | 20% |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 25% |

**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** | **$12,700** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $3,200 |
| Copayments | $0 |
| Coinsurance | $1,300 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$4,560** |

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

| | |
|---|---|
| The plan's overall deductible | $3,200 |
| Specialist coinsurance | 20% |
| 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** | **$5,600** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $2,200 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$2,200** |

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

| | |
|---|---|
| The plan's overall deductible | $3,200 |
| Specialist coinsurance | 20% |
| 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** | **$2,800** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $2,800 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,800** |

Note: The amount the patient pays assumes the patient is not participating in a Flexible Spending Account (FSA), a Health Savings Account (HSA), or a Health Reimbursement Arrangement (HRA), including an HRA funded through a Voluntary Employee Beneficiary Association (VEBA-HRA). If you have a FSA, HSA, HRA, or VEBA-HRA, then you may have additional funds that could help cover certain out-of-pocket expenses such as deductibles, copayments, coinsurance, and benefits otherwise not covered.

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.

اذا كنت تريد مساعدة مجانية في ترجمة هذه المعلومات، فاتصل على ألرقم 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.

နမ့်အဲဂိီးတ်ကျိုးထံစားကလီန့်နုတ်ဂ့်တ်ကျိုးအံးလားအကလီန့ဉ်,ကိးလီတဲစိနိဉ်ဂံ်လားအပဉ် ယုဉ်လားလံ်တီလံ်မီအပူးအံးမ့တမ့်ဖဲနန့နိုဝလော်အုဉ်သးခးက့အလီ်ခံတကပးအဖီခိဉ်နှဉ်တက့်.

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'ígíįjį' 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.

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