Effective January 01, 2022

MEDICA®

your

ENROLLMENT GUIDE

Municipal Building Commission

CMP5635-1-00916

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 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 الرقم1-800-952-3455.

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.

နမ့်လိဉ်ဘဉ်တ်မၤစၢၤကလီလၢတ်ကွဲးကျိာ်ထံလံာ်အံၤအဃိ, ကိး 1-800-952-3455.

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

ይህን ሰነድ ለመተርጎም ነጻ እርዳታ ከፈለጉ በ 1-800-952-3455 ይደውሉ።

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 kojį' hodíílnih, 1-800-952-3455.

Wenn Sie kostenlose Hilfe zur Übersetzung dieses Dokuments wünschen, rufen Sie 1-800-952-3455 an.

COMIFB-0119-K

CMP5635-1-00919

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:

Medica Choice Passport 2000-20% plan is 23670
Medica Elect 2000-20% plan is 26371
Park Nicollet First 2000-20 plan is 26372
VantagePlus 2000-20% plan is 26374

WelcomeToMedica.com/PlanResources

Visit **WelcomeToMedica.com/PlanResources** to learn more about programs and resources to help you stay healthy, get support and make the most of your plan.

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.

What a choice!

You have a choice of benefit plans (how your care is covered) and provider networks (where you get care). Network choices are on the "About the Network" pages. Benefit summaries show your benefit plan choices. Note that each benefit plan option can be paired with any network option.

Have questions or need more information?

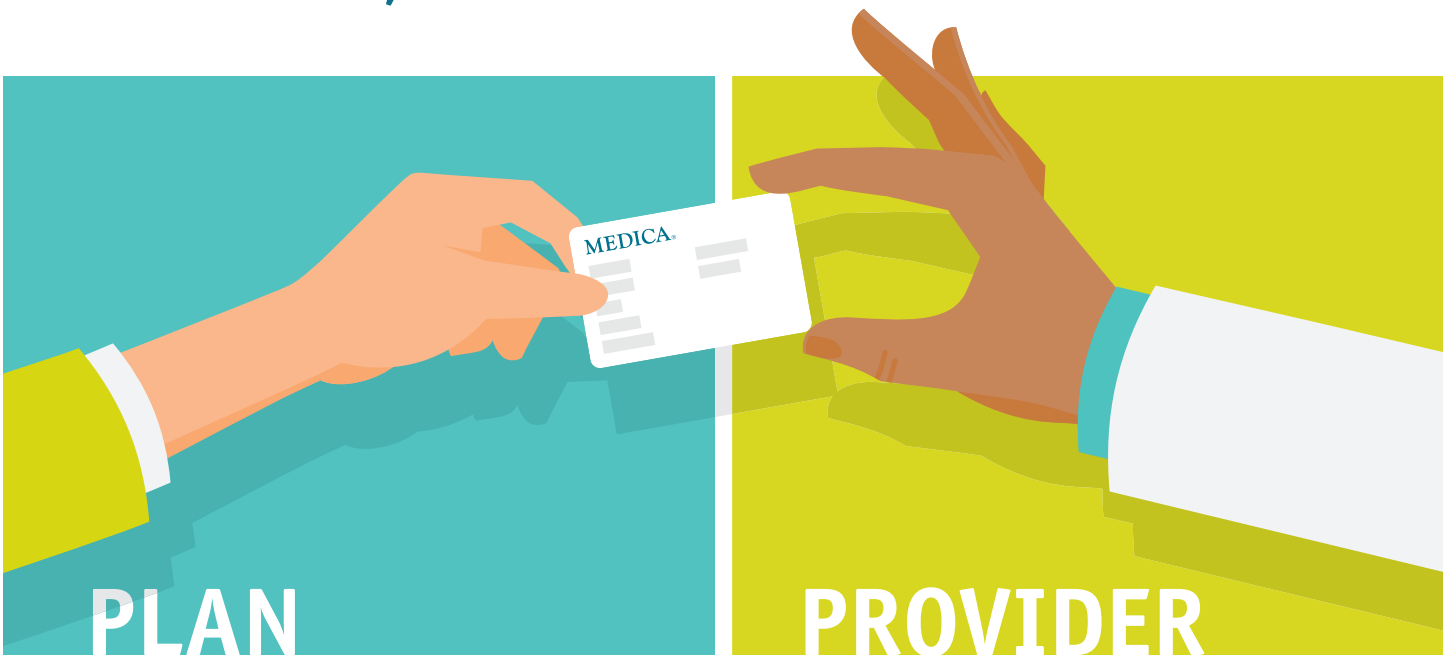
Call us at **1 (952) 945-8000** or **1 (800) 952-3455**. We're here to help!

CMP5721-1-00916

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

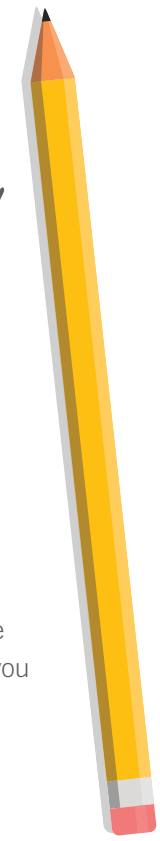
Where you go for care.

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.

CMP5637-1-00916

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?

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.

CMP5637-1-00916

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**.

CMP5644-1-00916

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

CMP5644-1-00916

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 Choice Plus

Or call us at **1 (952) 945-8000** or **1 (800) 952-3455** (TTY users, call **711**)

CMP5639-1-00920

MEDICA ELECT®

A CARE SYSTEM NETWORK

What's a care system network? It's a network made up of several groups of doctors, nurses and other health care providers that work together to take care of you. These groups of providers are called care systems.

What are the features?

A medium-sized regional network

Nationwide coverage when you travel

A medical home – you choose a primary care clinic and receive care from providers in your care system

What's unique?

You enroll in a primary care clinic. This is the main place you'll go when you need care. Each family member can choose a different primary care clinic.

Your primary care clinic is affiliated with a care system. If you need to see a specialist or go to the hospital, make sure they're in your care system.

Each family member can choose a different care system, as long as it's in the Medica Elect network. The care systems you can choose from are listed below.

If you can't get the care you need within your care system, you can ask for a referral to see a provider in another Medica Elect care system.

Who's in the network?

The following care systems are included in the Medica Elect network:

Allina Medical Clinics

Children's Health Network

Hennepin Healthcare

Integrity Health Network

Lakeview Medical Care System

Minnesota Healthcare Network

Park Nicollet Health Services

RiverWay/North Suburban Clinics

St. Luke's Care System

How do I find a provider in the network?

Go to **Medica.com/FindADoctor** and choose Medica Elect

Or call us at **1 (952) 945-8000** or **1 (800) 952-3455**
(TTY users, call **711**)

CMP5640-1-00920

PARK NICOLLET FIRST WITH MEDICA℠

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?

Access to an integrated health care system that includes more than 20 neighborhood clinics and features primary care, urgent care and more than 55 medical specialties

Nationwide coverage when you travel

No referrals needed when visiting a Park Nicollet First provider

What's unique?

In addition to your plan coverage, this ACO includes:

Same-day primary care appointments, plus weekend and evening hours

Urgent care locations, open late, seven days a week

24/7 nurse and advisor line

24/7 online diagnosis and treatment for 60 common medical conditions at **Virtuwell.com**

PerfectServe text messaging for clinic appointments

SmartCare℠, experience care on your terms — at the clinic, on your phone or online

Who's in the network?

In addition to primary care, specialty care and urgent care, the network includes direct access to Park Nicollet Methodist Hospital and Park Nicollet's specialty centers, including Bariatric Surgery & Weight Center, Burnsville Same Day Surgery Center, Frauenshuh Cancer Center, Heart and Vascular Center, Jane Brattain Breast Center, Melrose Center (for eating disorders), Struthers Parkinson's Center, Child & Family Behavioral Health (formerly Alexander Center), Joint Replacement Institute, Family Birth Center, Women's Center and TRIA Orthopaedic Center.

How do I find a provider in the network?

Go to **Medica.com/FindADoctor** and choose Park Nicollet First with Medica

Or call us at **1 (855) 727-5178** (TTY users, call **711**)

CMP10467-1-00920

ABOUT THE NETWORK

VANTAGEPLUS WITH MEDICA℠

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?

More than 4,400 primary and specialty care providers, 655 clinics and 12 hospitals

Nationwide coverage when you travel

See any primary or specialty care provider in the VantagePlus network

What's unique?

In addition to your plan coverage, this ACO includes:

A personal welcome call for new members.

One phone number to call for questions about your coverage or your care.

More convenient ways to receive care. Make same-day and virtual appointments, evening or weekend, or get an online diagnosis and treatment for certain conditions in less than an hour.

A 24/7 nurse line for quick answers to questions about your health.

Unique wellness programs, including:

- Online tools and resources to help you take steps to improve your health while earning gifts cards with My Health Rewards by Medica®
- Fit Choices℠ by Medica allows you to earn up to $20 each month when you meet your monthly visit requirement at a participating health club.*
- When you need help with life's challenges—whether it's personal, financial or legal concerns, you can call the Medica® Optum® Employee Assistance Program (EAP) 24/7 for timely, professional and confidential help.

*Contact Customer Service at the number on the back of your Medica ID card to see if your plan includes this program.

A three-month supply of medication for just two copays when you fill your prescription at a Fairview or North Memorial Health pharmacy (for pharmacy plans with a copay).

Dedicated help from a specialized pharmacist to make sure your medications are best for you and your conditions, lifestyle and budget.

Who's in the network?

As one of the largest accountable care organizations in Minnesota, VantagePlus has the providers you know and trust from M Health Fairview (the health care organization representing Fairview, University of Minnesota and M Physicians), North Memorial Health and many popular independent clinics.

How do I find a provider in the network?

Go to **Medica.com/FindADoctor** and choose VantagePlus with Medica

Or call us at **1 (866) 882-8493** (TTY users, call **711**)

CMP16302-1-00920

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.

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 rewards as you complete activities personalized just for you. To get started with My Health Rewards, download the Virgin Pulse app, free in the App Store and on Google Play.

Fit Choices℠ by Medica Program Motivation to hit the gym.

Workout 12 times per month at a participating fitness club and you can earn up to $20 per month. That's up to $240 a year. To learn more about **Fit Choices**℠ or to find a health club near you, go to **Medica.com/FitChoices**.

Chronic Condition Support Build healthy habits that last.

Help reduce your risk for chronic disease through **Omada for Prevention**, a digital lifestyle change program. Combining the latest technology with ongoing personal support, you can make the changes that matter most — whether that's around eating, activity, sleep or stress. It's an approach that can help you lose weight and reduce your risks for type 2 diabetes and heart disease. Watch for more information about this prevention program from your employer, or contact Medica customer service.

Employee Assistance Program When you need help with life's challenges.

Sometimes life throws you a curveball. Whether it's financial troubles, personal issues or family problems, we can help. Just call **1 (800) 626-7944** any time of day or night, any day of the year to talk with a counselor. They'll help you find the resources you need to get back on track.

Healthy Savings Program Eating healthier just got easier.

Save money on a variety of foods with the **Healthy Savings program**. It's almost like getting a free trip to the grocery store every month. If you live near a participating store, you'll be enrolled automatically in the program. Just watch your mailbox for more information and your Healthy Savings card.

Healthy Pregnancy & Parenting Program Get support during your parenthood journey.

Tap into personalized guidance, support, and coaching for your entire parenthood journey with the **Ovia Health** apps. They give you on-demand support and clinically backed guidance to help you achieve your health goals, whether that's tracking your period, getting pregnant, or navigating pregnancy, postpartum and parental wellness. Download Ovia Parenting, Ovia Pregnancy or Ovia Fertility for free from the App Store or Google Play. Enter your employer and health plan information to access all the unique tools and features.

Behavioral Health Support Manage stress, anxiety and depression symptoms

Connect with on-demand help for stress, depression and anxiety through the **Sanvello app**. Access coping tools, daily mood tracking, guided journeys and weekly progress check-ins to stay engaged and manage symptoms. You receive premium access as part of your plan's behavioral health benefits. Download the Sanvello app from the App Store or Google Play and select *Upgrade Through Your Insurance* to get started.

CMP5647-1-00920

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)*

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

COM3302-10918

Effective: June 11, 2003
Revised: September 23, 2013

HOW MEDICA PROTECTS YOUR PRIVACY

Summary

There are several state and federal laws requiring Medica Health Plans, Medica Health Plans of Wisconsin and Medica Insurance Company (collectively, "Medica") to protect its members' personal *health* information. The most comprehensive regulations were issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). These regulations have been updated from time to time. Essentially, HIPAA regulations require entities like Medica to provide you with information about how your protected health information may be used and disclosed, and to whom. This notice explains what your protected health information is. Regulations also describe how Medica must protect this information and how you can access your protected health information. Medica must follow the terms of its privacy notice. Medica may also change or amend its privacy notice as the laws and regulations change. However, if the notice is materially changed, Medica will make the revised privacy notice available to you.

There are also state and federal laws requiring Medica to protect your non-public personal *financial* information. The most comprehensive regulations were issued under the Gramm-Leach-Bliley Act ("GLBA"). The GLBA requires Medica to provide you with a notice about how your non-public personal financial information may be used and disclosed, and to whom.

When the law permits use and disclosure

The law permits Medica to use and disclose your personal health information for purposes of treatment, payment and health care operations without first obtaining your authorization. There are other limited circumstances when Medica may use and disclose your personal health information without your authorization, such as public health, regulatory and law enforcement activities. Whether personal health information is used or disclosed with or without your authorization, Medica uses and discloses personal health information only to those persons who need to know and only the minimum amount necessary to perform the required activity.

Your privacy rights

The law also gives you rights to access, copy and amend your personal health information. You have the right to request restrictions on certain uses and disclosures of your personal health information. You also have the right to obtain information about how and when your personal health information has been used and disclosed.

These duties, responsibilities and rights are described in more detail below.

MEDICA'S PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED UNDER STATE AND FEDERAL LAW, INCLUDING HIPAA, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THIS NOTICE IS INTENDED FOR MEDICA MEMBERS.

What is PHI?

Medica is committed to protecting and maintaining the privacy and confidentiality of information that relates to your past, present or future physical or mental health, healthcare services and payment for those services. HIPAA refers to this information as "protected health information" or "PHI." PHI includes information related to diagnosis and treatment plans, as well as demographic information such as name, address, telephone number, age, date of birth, and health history.

How does Medica protect your PHI?

Medica takes its responsibility of protecting your PHI seriously. Where possible, Medica de-identifies PHI. Medica uses and discloses only the minimum amount of PHI necessary for treatment, payment and operations, or to comply with legal or similar requirements. In addition to physical and technical safeguards, Medica has administrative safeguards such as policies and procedures that require Medica's employees to protect your PHI. Medica also provides training on privacy and security to its employees.

Medica protects the PHI of former members just as it protects the PHI of current members.

Under what circumstances does Medica use or disclose PHI?

Medica receives, maintains, uses and shares PHI only as needed to conduct or support: (i) treatment-related activities, such as referring you to a doctor; (ii) payment-related activities, such as paying a claim for medical services; and (iii) healthcare operations, such as developing wellness programs. Additional examples of these activities include:

- Enrollment and eligibility, benefits management, and utilization management
- Customer service
- Coordination of care
- Health improvement and disease management (for example, sending information on treatment alternatives or other health-related benefits)
- Premium billing and claims administration
- Complaints and appeals, underwriting, actuarial studies, and premium rating (however, Medica is prohibited from using or disclosing your PHI that is genetic information for underwriting purposes)
- Credentialing and quality assurance
- Business planning or management and general administrative activities (for example, employee training and supervision, legal consultation, accounting, auditing)
- Medica may, from time to time, contact you with important information about your health plan benefits. Such contacts may include telephone, mail or electronic mail messages.

With whom does Medica share PHI?

Medica shares PHI for treatment, payment and health care operations with your health care providers and other businesses that assist it in its operations. These businesses are called "business associates" in the HIPAA regulations. Medica requires these business associates to follow the same laws and regulations that Medica follows.

Public Health, Law Enforcement and Health Care Oversight. There are also other activities where the law allows or requires Medica to use or disclose your PHI without your authorization. Examples of these activities include:

- Public health activities (such as disease intervention);
- Healthcare oversight activities required by law or regulation (such as professional licensing, member satisfaction surveys, quality surveys, or insurance regulation);
- Law enforcement purposes (such as fraud prevention or in response to a subpoena or court order);
- Assisting in the avoidance of a serious and imminent threat to health or safety; and
- Reporting instances of abuse, neglect, domestic violence or other crimes.

Employee Benefit Plans. Medica has policies that limit the disclosure of PHI to employers. However, Medica must share some PHI (for example, enrollment information) with a group policyholder to administer its business. The group policyholder is responsible for protecting the PHI from being used for purposes other than health plan benefits.

Research. Medica may use or release PHI for research. Medica will ensure that only the minimum amount of information that identifies you will be disclosed or used for research. HIPAA allows Medica to disclose a very limited amount of your PHI, called a "limited data set" for research without your authorization. You have the right to opt-out of disclosing your PHI for research by contacting Medica as described below. If Medica uses any identifiers, Medica will request your permission first.

Family Members. Under some circumstances Medica may disclose information about you to a family member. However, Medica cannot disclose information about one spouse to another spouse, without permission. Medica may disclose some information about minor children to their parents. You should know, however, that state laws do not allow Medica to disclose certain information about minors—even to their parents.

When does Medica need your permission to use or disclose your PHI?

From time to time, Medica may need to use or disclose PHI where the laws require Medica to get your permission. Medica will not be able to release the PHI until you have provided a valid authorization. In this situation, you do not have to allow Medica to use or disclose your PHI. Medica will not take any action against you if you decide not to give your permission. You, or someone you authorize

(such as under a power of attorney or court-appointed guardian), may cancel an authorization you have given, except to the extent that Medica has already relied on and acted on your permission.

Your authorization is generally required for uses and disclosures of PHI not described in this notice, as well as uses and disclosures in connection with:

- **Psychotherapy Notes.** Medica must obtain your permission before making most uses and disclosures of psychotherapy notes.
- **Marketing.** Subject to limited exceptions, Medica must also obtain your permission before using or disclosing your PHI for marketing purposes.
- **Sales.** Additionally, Medica is not permitted to sell your PHI without your permission. However, there are some limited exceptions to this rule—such as where the purpose of the disclosure of PHI is for research or public health activities.

What are your rights to your PHI?
You have the following rights with regard to the PHI that Medica has about you. You, or your personal representative on your behalf, may:

Request restrictions of disclosure. You may ask Medica to limit how it uses and discloses PHI about you. Your request must be in writing and be specific as to the restriction requested and to whom it applies. Medica is not required to always agree to your restriction. However, if Medica does agree, Medica will abide by your request.

Request confidential communications. You may ask Medica to send your PHI to a different address or by fax instead of mail. Your request must be in writing. Medica will agree to your request if it is able.

Inspect or obtain a copy of your PHI. Medica keeps a designated record set of its members' medical records, billing records, enrollment information and other PHI used to make decisions about members and their benefits. You have the right to inspect and get a copy of your PHI maintained in this designated record set. Your request must be in writing on Medica's form. If the PHI is maintained electronically in a designated record set, you have a right to obtain a copy of it in electronic form. Medica will respond to your request within thirty (30) days of receipt. Medica may charge you a reasonable amount for providing copies. You should know that not all the information Medica maintains is available to you and there are certain times when other individuals, such as your doctor, may ask Medica not to disclose information to you.

Request a change to your PHI. If you think there is a mistake in your PHI or information is missing, you may send Medica a written request to make a correction or addition. Medica may not be able to agree to make the change. For example, if Medica received the information from a clinic, Medica cannot change the clinic information—only the clinic can. If Medica cannot make the change, it will let you know within thirty (30) days. You may send a statement explaining why you disagree, and Medica will respond to you. Your request, Medica's disagreement and your statement of disagreement will be maintained in Medica's designated record set.

Request an accounting of disclosures. You have the right to receive a list of disclosures Medica has made of your PHI. There are certain disclosures Medica does not have to track. For example, Medica is not required to list the times it disclosed your PHI when you gave Medica permission to disclose it. Medica is also not required to identify disclosures it made that go back more than six (6) years from the date you asked for the listing.

Receive a notice in the event of a breach. Medica will notify you, as required under federal regulations, of an unauthorized release, access, use or disclosure of your PHI. "Unauthorized" means that the release, access, use or disclosure was not authorized by you or permitted by law without your authorization. The federal regulations further define what is and what is not a "breach." Not every violation of HIPAA, therefore, will constitute a breach requiring a notice.

Request a copy of this notice. You may ask for a separate paper copy of this notice.

TO EXERCISE ANY OF THESE RIGHTS, PLEASE CONTACT CUSTOMER SERVICE AT THE TELEPHONE NUMBER ON THE BACK OF YOUR MEDICA ID CARD, OR CONTACT MEDICA AT P.O. BOX 9310, MINNEAPOLIS, MN 55440-9310.

File a complaint or grievance about Medica's privacy practices. If you feel your privacy rights have been violated by Medica, you may file a complaint. You will not be retaliated against for filing a complaint. To file a complaint with Medica, please contact Customer Service at the contact information listed above. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. To do so, write to the Office for Civil Rights, U.S. Department of Health & Human Services, 233 N. Michigan Ave. Suite 240, Chicago, IL 60601.

About this notice
Medica is required by law to maintain the privacy of PHI and to provide this notice. Medica is required to follow the terms and conditions of this notice. However, Medica may change this notice and its privacy practices, as long as the change is consistent with state and federal law. If Medica makes a material change to this notice, it will make the revised notice available to you within sixty (60) days of such change.

FINANCIAL INFORMATION PRIVACY NOTICE
THIS NOTICE EXPLAINS HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THIS NOTICE IS INTENDED FOR MEDICA MEMBERS.

How does Medica protect your information?
Medica takes its responsibility of protecting your information seriously. Medica maintains measures to protect your information from unauthorized use or disclosure. These measures include the use of policies and procedures, physical, electronic and procedural safeguards, secured files and buildings and restrictions on who and how your information may be accessed.

What information does Medica collect?
Medica may collect information about you including your name, street address, telephone number, date of birth, medical information, social security number, premium payment and claims history information.

How does Medica collect your information?
Medica collects information about you in a variety of ways. Medica obtains such information about you from:

- You, on your application for insurance coverage
- You, concerning your transactions with Medica, its affiliates or others
- Your physician, healthcare provider or other participants in the healthcare system
- Your employer
- Other third parties

Under what circumstances does Medica use or disclose non-public personal financial information?
Medica uses your non-public financial information for its everyday business operations. This includes using your information to perform certain activities in order to implement and administer the product or service in which you are enrolled. Examples of these activities include enrollment, customer service, processing premium payment, claims payment transactions, and benefit management.

Medica may disclose your information to the following entities for the following purposes:

- To Medica's affiliates to provide certain products and services.
- To Medica's contracted vendors who provide certain products and services on Medica's behalf.
- To a regulatory authority, government agency or a law enforcement official as permitted or required by law, subpoena or court order.

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT CUSTOMER SERVICE AT THE TELEPHONE NUMBER ON THE BACK OF YOUR MEDICA ID CARD, OR CONTACT MEDICA AT P.O. BOX 9310, MINNEAPOLIS, MN 55440-9310.

Medica

Medica Choice Passport MN 2000-20%

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

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$2,000** per person/ **$4,000** per family in-network and **$3,000** per person/ **$6,000** 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, prescription drugs and hospice from in-network providers or well child and prenatal care 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 person/ **$6,000** per family in-network. **$6,000** per person/ **$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 toward the out-of-pocket limit.
Will you pay less if you use a network provider?	**Yes.** See www.medica.com/findcare 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 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 **Chiropractic:** 20% coinsurance **Retail Health:** 20% coinsurance **Virtual:** 20% coinsurance	**Primary care:** 40% coinsurance **Chiropractic:** 40% coinsurance **Retail Health:** 40% coinsurance **Virtual:** 40% coinsurance	Limited to 15 visits per member, per year for out-of-network chiropractic care.
	Specialist visit	20% coinsurance	40% coinsurance	---none---
	Preventive care/ screening/ immunization	No charge. Deductible does not apply.	**Well child care:** 0% coinsurance. Deductible does not apply. **Other services:** 40% 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.
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
		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/drugcost1**	Generic drugs	**Retail:** $10/ prescription Deductible does not apply. **Mail order:** $20/ prescription Deductible does not apply.	40% 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. Some Over the Counter drugs can be obtained with a prescription at the preventive level of coverage. The list of covered drugs changes periodically. Notification of changes will be available 30 days prior to the change taking effect.
	Preferred brand drugs	**Retail:** $25/ prescription Deductible does not apply. **Mail order:** $50/ prescription Deductible does not apply.	40% coinsurance	
	Non-preferred brand drugs	**Retail:** $50/ prescription Deductible does not apply. **Mail order:** $100/ prescription Deductible does not apply.	40% coinsurance	
	Specialty drugs	**Preferred:** $25 copay/ prescription. Deductible does not apply. **Non-Preferred:** $50 copay/ prescription. 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	40% coinsurance	---none---
	Physician/surgeon fees	20% coinsurance	40% 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.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	---none---
	Physician/surgeon fees	20% coinsurance	40% coinsurance	---none---
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	---none---
	Inpatient services	20% coinsurance	40% coinsurance	Residential treatment is covered as part of inpatient services.
If you are pregnant	Office visits	No charge. Deductible does not apply.	**Prenatal care:** 0% coinsurance. Deductible does not apply. **Postnatal care:** 40% 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	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	120 visits in-network and 60 visits out-of-network, per member per year.
	Rehabilitation services	20% coinsurance	40% 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.
	Habilitation services	20% coinsurance	40% 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.
	Skilled nursing care	20% coinsurance	40% coinsurance	120 day limit combined in and out-of-network per member per year.
	Durable medical equipment	20% coinsurance	40% coinsurance	---none---
	Hospice services	No charge. Deductible does not apply.	40% 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 your child needs dental or eye care	Children's eye exam	No charge. Deductible does not apply.	40% coinsurance	---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 out-of-network.
- Chiropractic care exceeding 15 visits per member per year for out-of-network.
- 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 exceeding $5,000 medical/ $3,000 pharmacy per member per year combined for in-network and out-of-network.
- 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 Minnesota Department of Commerce at (651) 539-1600 or 1-800-657-3602.

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 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:** $2,000
- **Specialist coinsurance:** 20%
- **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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$1,000
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:** $2,000
- **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	$1,900
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,000**

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

- **The plan's overall deductible:** $2,000
- **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	$2,000
Copayments	$10
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,210**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Medica

Medica Elect MN 2000-20%

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

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$2,000** per person/ **$4,000** per family in-network and **$3,000** per person/ **$6,000** 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, prescription drugs and hospice from in-network providers or well child and prenatal care 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 person/ **$6,000** per family in-network. **$6,000** per person/ **$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 toward the out-of-pocket limit.
Will you pay less if you use a network provider?	**Yes.** See www.medica.com/findcare or call 952-945-8000 or 1-800-952-3455 or 711 (TTY users) for a list of Medica Elect 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?	**Yes.** This plan requires referrals for specialists outside your care system. Coordinate care through your primary care clinic or care system for best in-network benefits.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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 **Chiropractic:** 20% coinsurance **Retail Health:** 20% coinsurance **Virtual:** 20% coinsurance	**Primary:** 40% coinsurance **Chiropractic:** 40% coinsurance **Retail Health:** 40% coinsurance **Virtual:** 40% coinsurance	Limited to 15 visits per member, per year for out-of-network chiropractic care.
	Specialist visit	20% coinsurance	40% coinsurance	---none---
	Preventive care/ screening/ immunization	No charge. Deductible does not apply.	**Well child care:** 0% coinsurance. Deductible does not apply. **Other services:** 40% 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.
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
		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/drugcost1**	Generic drugs	**Retail:** $10/ prescription Deductible does not apply. **Mail order:** $20/ prescription Deductible does not apply.	40% 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 $25 exceed per retail prescription unit. Some Over the Counter drugs can be obtained with a prescription at the preventive level of coverage. The list of covered drugs changes periodically. Notification of changes will be available 30 days prior to the change taking effect.
	Preferred brand drugs	**Retail:** $25/ prescription Deductible does not apply. **Mail order:** $50/ prescription Deductible does not apply.	40% coinsurance	
	Non-preferred brand drugs	**Retail:** $50/ prescription Deductible does not apply. **Mail order:** $100/ prescription Deductible does not apply.	40% coinsurance	
	Specialty drugs	**Preferred:** $25 copay/ prescription. Deductible does not apply. **Non-Preferred:** $50 copay/ prescription. 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	40% coinsurance	---none---
	Physician/surgeon fees	20% coinsurance	40% 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.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	---none---
	Physician/surgeon fees	20% coinsurance	40% coinsurance	---none---
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	---none---
	Inpatient services	20% coinsurance	40% coinsurance	Residential treatment is covered as part of inpatient services.
If you are pregnant	Office visits	No charge. Deductible does not apply.	**Prenatal care:** 0% coinsurance. Deductible does not apply. **Postnatal care:** 40% 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	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	120 visits in-network and 60 visits out-of-network, per member per year.
	Rehabilitation services	20% coinsurance	40% 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.
	Habilitation services	20% coinsurance	40% 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.
	Skilled nursing care	20% coinsurance	40% coinsurance	120 day limit combined in and out-of-network per member per year.
	Durable medical equipment	20% coinsurance	40% coinsurance	---none---
	Hospice services	No charge. Deductible does not apply.	40% 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 your child needs dental or eye care	Children's eye exam	No charge. Deductible does not apply.	40% coinsurance	---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 out-of-network.
- Chiropractic care exceeding 15 visits per member per year for out-of-network.
- 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 exceeding $5,000 medical/ $3,000 pharmacy per member per year combined for in-network and out-of-network.
- 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 Minnesota Department of Commerce at (651) 539-1600 or 1-800-657-3602.

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 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:** $2,000
- **Specialist coinsurance:** 20%
- **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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$1,000
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:** $2,000
- **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	$1,900
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,000**

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

- **The plan's overall deductible:** $2,000
- **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	$2,000
Copayments	$10
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,210**

The plan would be responsible for the other costs of these EXAMPLE covered services.

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 1-855-727-5178. 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 1-855-727-5178 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$2,000** per person/ **$4,000** per family in-network and **$3,000** per person/ **$6,000** 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, prescription drugs and hospice from in-network providers or well child and prenatal care 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 person/ **$6,000** per family in-network. **$6,000** per person/ **$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 toward the out-of-pocket limit.
Will you pay less if you use a network provider?	**Yes.** See www.medica.com/findcare or call 1-855-727-5178 or 711 (TTY users) for a list of Park Nicollet 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 **Chiropractic:** 20% coinsurance **Retail Health:** 20% coinsurance **Virtual:** 20% coinsurance	**Primary care:** 40% coinsurance **Chiropractic:** 40% coinsurance **Retail Health:** 40% coinsurance **Virtual:** 40% coinsurance	Limited to 15 visits per member, per year for out-of-network chiropractic care.
	Specialist visit	20% coinsurance	40% coinsurance	---none---
	Preventive care/ screening/ immunization	No charge. Deductible does not apply.	**Well child care:** 0% coinsurance. Deductible does not apply. **Other services:** 40% 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.
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
		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/drugcost1**	Generic drugs	**Retail:** $10/ prescription Deductible does not apply. **Mail order:** $20/ prescription Deductible does not apply.	40% 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. Some Over the Counter drugs can be obtained with a prescription at the preventive level of coverage. The list of covered drugs changes periodically. Notification of changes will be available 30 days prior to the change taking effect.
	Preferred brand drugs	**Retail:** $25/ prescription Deductible does not apply. **Mail order:** $50/ prescription Deductible does not apply.	40% coinsurance	
	Non-preferred brand drugs	**Retail:** $50/ prescription Deductible does not apply. **Mail order:** $100/ prescription Deductible does not apply.	40% coinsurance	
	Specialty drugs	**Preferred:** $25 copay/ prescription. Deductible does not apply. **Non-Preferred:** $50 copay/ prescription. 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	40% coinsurance	---none---
	Physician/surgeon fees	20% coinsurance	40% 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.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	---none---
	Physician/surgeon fees	20% coinsurance	40% coinsurance	---none---
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	---none---
	Inpatient services	20% coinsurance	40% coinsurance	Residential treatment is covered as part of inpatient services.
If you are pregnant	Office visits	No charge. Deductible does not apply.	**Prenatal care:** 0% coinsurance. Deductible does not apply. **Postnatal care:** 40% 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	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	120 visits in-network and 60 visits out-of-network, per member per year.
	Rehabilitation services	20% coinsurance	40% 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.
	Habilitation services	20% coinsurance	40% 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.
	Skilled nursing care	20% coinsurance	40% coinsurance	120 day limit combined in and out-of-network per member per year.
	Durable medical equipment	20% coinsurance	40% coinsurance	---none---
	Hospice services	No charge. Deductible does not apply.	40% 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 your child needs dental or eye care	Children's eye exam	No charge. Deductible does not apply.	40% coinsurance	---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 out-of-network.
- Chiropractic care exceeding 15 visits per member per year for out-of-network.
- 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 exceeding $5,000 medical/ $3,000 pharmacy per member per year combined for in-network and out-of-network.
- 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 1-855-727-5178 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 1-855-727-5178 or the Minnesota Department of Commerce at (651) 539-1600 or 1-800-657-3602.

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 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:** $2,000
- **Specialist coinsurance:** 20%
- **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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$1,000
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:** $2,000
- **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	$1,900
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,000**

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

- **The plan's overall deductible:** $2,000
- **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	$2,000
Copayments	$10
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,210**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Medica

VantagePlus with Medica MN 2000-20%

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 1-866-882-8493. 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 1-866-882-8493 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$2,000** per person/ **$4,000** per family in-network and **$3,000** per person/ **$6,000** 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, prescription drugs and hospice from in-network providers or well child and prenatal care 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 person/ **$6,000** per family in-network. **$6,000** per person/ **$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 toward the out-of-pocket limit.
Will you pay less if you use a network provider?	**Yes.** See www.medica.com/findcare or call 1-866-882-8493 or 711 (TTY users) for a list of VantagePlus with Medica 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 **Chiropractic:** 20% coinsurance **Retail Health:** 20% coinsurance **Virtual:** 20% coinsurance	**Primary care:** 40% coinsurance **Chiropractic:** 40% coinsurance **Retail Health:** 40% coinsurance **Virtual:** 40% coinsurance	Limited to 15 visits per member, per year for out-of-network chiropractic care. Limited to 15 visits per member, per year combined for in-network and out-of-network acupuncture.
	Specialist visit	20% coinsurance	40% coinsurance	---none---
	Preventive care/ screening/ immunization	No charge. Deductible does not apply.	**Well child care:** 0% coinsurance. Deductible does not apply. **Other services:** 40% 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.
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
		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/drugcost1**	Generic drugs	**Retail:** $10/ prescription Deductible does not apply. **Mail order:** $20/ prescription Deductible does not apply.	40% 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. Some Over the Counter drugs can be obtained with a prescription at the preventive level of coverage. The list of covered drugs changes periodically. Notification of changes will be available 30 days prior to the change taking effect.
	Preferred brand drugs	**Retail:** $25/ prescription Deductible does not apply. **Mail order:** $50/ prescription Deductible does not apply.	40% coinsurance	
	Non-preferred brand drugs	**Retail:** $50/ prescription Deductible does not apply. **Mail order:** $100/ prescription Deductible does not apply.	40% coinsurance	
	Specialty drugs	**Preferred:** $25 copay/ prescription. Deductible does not apply. **Non-Preferred:** $50 copay/ prescription. 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	40% coinsurance	---none---
	Physician/surgeon fees	20% coinsurance	40% 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.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	---none---
	Physician/surgeon fees	20% coinsurance	40% coinsurance	---none---
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	---none---
	Inpatient services	20% coinsurance	40% coinsurance	Residential treatment is covered as part of inpatient services.
If you are pregnant	Office visits	No charge. Deductible does not apply.	**Prenatal care:** 0% coinsurance. Deductible does not apply. **Postnatal care:** 40% 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	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	120 visits in-network and 60 visits out-of-network, per member per year.
	Rehabilitation services	20% coinsurance	40% 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.
	Habilitation services	20% coinsurance	40% 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.
	Skilled nursing care	20% coinsurance	40% coinsurance	120 day limit combined in and out-of-network per member per year.
	Durable medical equipment	20% coinsurance	40% coinsurance	---none---
	Hospice services	No charge. Deductible does not apply.	40% 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 your child needs dental or eye care	Children's eye exam	No charge. Deductible does not apply.	40% coinsurance	---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 out-of-network.
- Chiropractic care exceeding 15 visits per member per year for out-of-network.
- 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 exceeding $5,000 medical/ $3,000 pharmacy per member per year combined for in-network and out-of-network.
- 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 1-866-882-8493 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 1-866-882-8493 or the Minnesota Department of Commerce at (651) 539-1600 or 1-800-657-3602.

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 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:** $2,000
- **Specialist coinsurance:** 20%
- **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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$1,000
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:** $2,000
- **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	$1,900
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,000**

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

- **The plan's overall deductible:** $2,000
- **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	$2,000
Copayments	$10
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,210**

The plan would be responsible for the other costs of these EXAMPLE covered services.