




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

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$2,500 per person/ \$6,000 per family in-network and \$3,500 per person/ \$10,500 per family for out-of-network services.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care, copayments, hospice, prenatal, postnatal, well child or prescription drugs from in-network providers.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits .
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	\$5,000 per person/ \$15,000 per family in-network. \$6,000 per person/ \$18,000 per family for out-of-network services.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.medica.com or call 952-945-8000 or 1-800-952-3455 or 711 (TTY users) for a list of Medica Essential 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 [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-network (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Primary care: \$40 copay /visit. Deductible does not apply. Chiropractic: \$40 copay /visit. Deductible does not apply. Convenience: \$25 copay /visit. Deductible does not apply.	Primary care: 40% coinsurance Chiropractic: 40% coinsurance Convenience: 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	\$40 copay / visit. Deductible does not apply.	40% coinsurance	---none---
	Preventive care/ screening/ immunization	No charge. Deductible does not apply.	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: 30% coinsurance X-ray: 30% coinsurance	40% coinsurance	---none---
	Imaging (CT/PET scans, MRIs)	30% coinsurance	40% coinsurance	---none---

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-network (You will pay the most)	
<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.medica.com.</p>	Generic drugs	<p>Retail: \$20/ prescription Deductible does not apply. Mail order: \$40/ prescription Deductible does not apply.</p>	40% coinsurance . Mail order not covered	Up to a 31-day supply/ retail or 93-day supply/ mail order prescription.
	Preferred brand drugs	<p>Retail: \$50/ prescription Deductible does not apply. Mail order: \$100/ prescription Deductible does not apply.</p>	40% coinsurance . Mail order not covered	
	Non-preferred brand drugs	<p>Retail: \$100/ prescription Deductible does not apply. Mail order: \$200/ prescription Deductible does not apply.</p>	40% coinsurance . Mail order not covered	
	Specialty drugs	<p>Preferred: 20% coinsurance. No more than \$120 copay/ prescription. Deductible does not apply. Non-Preferred: 50% coinsurance. No more than \$500 copay/ prescription. Deductible does not apply.</p>	Not covered	Up to a 31-day supply per prescription received from a designated specialty pharmacy.
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	40% coinsurance	---none---
	Physician/surgeon fees	30% coinsurance	40% coinsurance	---none---
<p>If you need immediate medical attention</p>	Emergency room care	\$150 copay / visit. Deductible does not apply.	Covered as an in-network benefit.	---none---
	Emergency medical transportation	30% coinsurance	Covered as an in-network benefit.	---none---
	Urgent care	\$40 copay / visit. Deductible does not apply.	Covered as an in-network benefit.	---none---
<p>If you have a hospital stay</p>	Facility fee (e.g., hospital room)	30% coinsurance	40% coinsurance	---none---
	Physician/surgeon fees	30% coinsurance	40% coinsurance	---none---
<p>If you need mental health, behavioral health, or substance abuse needs</p>	Outpatient services	\$40 copay / visit. Deductible does not apply.	40% coinsurance	---none---
	Inpatient services	30% coinsurance	40% coinsurance	---none---

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-network (You will pay the most)	
If you are pregnant	Office visits	No charge. Deductible does not apply.	40% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	30% coinsurance	40% coinsurance	---none---
	Childbirth/delivery facility services	30% coinsurance	40% coinsurance	---none---
If you need help recovering or have other special health needs	Home health care	30% coinsurance	40% coinsurance	120 visits in-network and 60 visits out-of-network per member per year.
	Rehabilitation services	\$40 copay / visit. Deductible does not apply.	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	\$40 copay / visit. Deductible does not apply.	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	30% coinsurance	40% coinsurance	Limited to 120 days combined in and out-of-network per member per year.
	Durable medical equipment	30% coinsurance	40% coinsurance	Limited to 1 wig per person per year combined for in-network and out-of-network .
	Hospice services	No charge. Deductible does not apply.	40% coinsurance	---none---
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 combined for [in-network](#) and [out-of-network](#).
- 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 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact your [plan](#) administrator or you may contact Medica at 1-800-952-3455. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this Coverage Meet the Minimum Value Standard? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

For assistance, call the number included in this document or on the back of your ID card.
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若需要中文协助，请拨打本文件内或您会员卡背面的电话号码。
Para sa tulong sa Tagalog, tawagan ang numerong kabilang sa dokumentong ito o sa likod ng iyong ID card.
Para obtener asistencia en español, llame al número de teléfono que se incluye en este documento o al dorso de su tarjeta de identificación.

----- *To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.* -----

About these Coverage Examples:

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

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

- The [plan's](#) overall [deductible](#): \$2,500
- [Specialist copayment](#): \$40
- [Hospital \(facility\) coinsurance](#): 30%
- [Other coinsurance](#): 30%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
[Specialist](#) visit (*anesthesia*)

Total Example Cost	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,500
Copayments	\$20
Coinsurance	\$2,300
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,880

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

- The [plan's](#) overall [deductible](#): \$2,500
- [Specialist copayment](#): \$40
- [Hospital \(facility\) coinsurance](#): 30%
- [Other coinsurance](#): 30%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
[Durable medical equipment](#) (*glucose meter*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,800
Copayments	\$1,100
Coinsurance	\$40
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$2,940

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

- The [plan's](#) overall [deductible](#): \$2,500
- [Specialist copayment](#): \$40
- [Hospital \(facility\) coinsurance](#): 30%
- [Other coinsurance](#): 30%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)
 Diagnostic test (*x-ray*)
[Durable medical equipment](#) (*crutches*)
[Rehabilitation services](#) (*physical therapy*)

Total Example Cost	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,700

This [plan](#) is a self-funded group health [plan](#) administered by Medica Self Insured. The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

