



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

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$4,000 per person/ \$8,000 per family in-network and \$8,000 per person/ \$16,000 per family for out-of-network services.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> , preventive prescriptions or prenatal care from in-network <u>providers</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits .
Are there other <u>deductibles</u> for specific services?	No	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$4,000 per person/ \$8,000 per family in-network. \$12,000 per person/ \$24,000 per family for out-of-network services.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.medica.com or call 952-945-8000 or 1-800-952-3455 or 711 (TTY users) for a list of Medica Choice with UnitedHealthcare <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No. You don't need a <u>referral</u> to see a <u>specialist</u> .	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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: 0% coinsurance Chiropractic: 0% coinsurance Convenience: 0% coinsurance	Primary care: 20% coinsurance Chiropractic: 20% coinsurance Convenience: 20% coinsurance	Limited to 15 visits per member, per year for out-of-network chiropractic care.
	Specialist visit	0% coinsurance	20% coinsurance	---none---
	Preventive care/ screening/ immunization	No charge. Deductible does not apply.	20% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Routine physicals and eye exams are not covered out-of-network.
If you have a test	Diagnostic test (x-ray, blood work)	Lab: 0% coinsurance X-ray: 0% coinsurance	20% coinsurance	---none---
	Imaging (CT/PET scans, MRIs)	0% coinsurance	20% coinsurance	---none---
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.medica.com/drugcost2	Generic drugs	Retail: 0% coinsurance Mail order: 0% coinsurance Preventive: No charge. Deductible does not apply.	20% coinsurance	Up to a 31-day supply/ retail or 93-day supply/ mail order prescription. Mail order drugs not covered out-of-network.
	Preferred brand drugs	Retail: 0% coinsurance Mail order: 0% coinsurance Preventive: No charge. Deductible does not apply.	20% coinsurance	
	Non-preferred brand drugs	Retail: 0% coinsurance Mail order: 0% coinsurance Preventive: Benefit does not apply.	20% coinsurance	
	Specialty drugs	Preferred: 0% coinsurance Non-Preferred: 0% coinsurance	Not covered	Up to a 31-day supply per prescription received from a designated specialty pharmacy.

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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	20% coinsurance	---none---
	Physician/surgeon fees	0% coinsurance	20% coinsurance	---none---
If you need immediate medical attention	Emergency room care	0% coinsurance	0% coinsurance	In-network deductible and out-of-pocket applies.
	Emergency medical transportation	0% coinsurance	0% coinsurance	In-network deductible and out-of-pocket applies.
	Urgent care	0% coinsurance	0% coinsurance	In-network deductible and out-of-pocket applies.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	20% coinsurance	---none---
	Physician/surgeon fees	0% coinsurance	20% coinsurance	---none---
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance	20% coinsurance	---none---
	Inpatient services	0% coinsurance	20% coinsurance	---none---
If you are pregnant	Office visits	Prenatal care: No charge. Deductible does not apply. Postnatal care: 0% coinsurance	20% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	0% coinsurance	20% coinsurance	---none---
	Childbirth/delivery facility services	0% coinsurance	20% 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 help recovering or have other special health needs	Home health care	0% coinsurance	20% coinsurance	120 visits in-network and 60 visits out-of-network, per member per year.
	Rehabilitation services	0% coinsurance	20% 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	0% coinsurance	20% 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	0% coinsurance	20% coinsurance	120 day limit combined in and out-of-network per member per year.
	Durable medical equipment	0% coinsurance	20% coinsurance	---none---
	Hospice services	0% coinsurance	20% coinsurance	---none---
If your child needs dental or eye care	Children's eye exam	No charge. Deductible does not apply.	Not covered	---none---
	Children's glasses	Not covered	Not covered	Glasses are not covered by the plan .
	Children's dental check-up	Not covered	Not covered	Dental check-ups are not covered by the plan .

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of other excluded services .)		
<ul style="list-style-type: none"> ● Acupuncture exceeding 15 visits per member per year for in-network and out-of-network acupuncture services combined. ● Chiropractic care exceeding 15 visits per member per year out-of-network. ● Cosmetic Surgery ● Dental Care (Adult) 	<ul style="list-style-type: none"> ● Dental check-up ● Glasses ● Hearing aids except for members 18 years of age and younger for hearing loss due to functional congenital malformation of the ears that is not correctable by other covered procedures; coverage is limited to one hearing aid per ear every three years. 	<ul style="list-style-type: none"> ● 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.)		
<ul style="list-style-type: none"> ● Bariatric Surgery ● Infertility treatment limited to \$5,000 medical/ \$3,000 pharmacy per year. 	<ul style="list-style-type: none"> ● Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> ● 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 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 North Dakota Department of Insurance at (701) 328-2440 or 1-800-247-0560.

Does this Plan 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 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, kwijijigo 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](#): \$4,000
- [Specialist coinsurance](#): 0%
- [Hospital \(facility\) coinsurance](#): 0%
- [Other coinsurance](#): 0%

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	\$4,000
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,060

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

- The [plan's](#) overall [deductible](#): \$4,000
- [Specialist coinsurance](#): 0%
- [Hospital \(facility\) coinsurance](#): 0%
- [Other coinsurance](#): 0%

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	\$3,000
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$3,000

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

- The [plan's](#) overall [deductible](#): \$4,000
- [Specialist coinsurance](#): 0%
- [Hospital \(facility\) coinsurance](#): 0%
- [Other coinsurance](#): 0%

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	\$1,900
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,900

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.