Effective January 01, 2026

Medica

your

ENROLLMENT GUIDE

Marsh & McLennan Agency LLC

CMP5635-1-00922

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.

နမ္နာ်လိဉ်ဘဉ်တာ်မၤစၢၤကလီလၢတာ်ကွဲးကျိာ်ထံလံာ်အံၤအဃိ, 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.

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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 Plan Options:

Passport 500-25-25%
Passport 750-35-25%
Passport 1500-35-25%
Passport 3400-0% HSA
Passport 4500-0% HSA

Looking for more information about how insurance works?

Check out the tip sheets and videos at **Medica.com/Membertips**.

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.

Once your plan starts, you can manage your benefits online.

Just log on to **Medica.com/SignIn** to order extra ID cards, track your claims, see what your plan covers and more.

Have questions or need more information?

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

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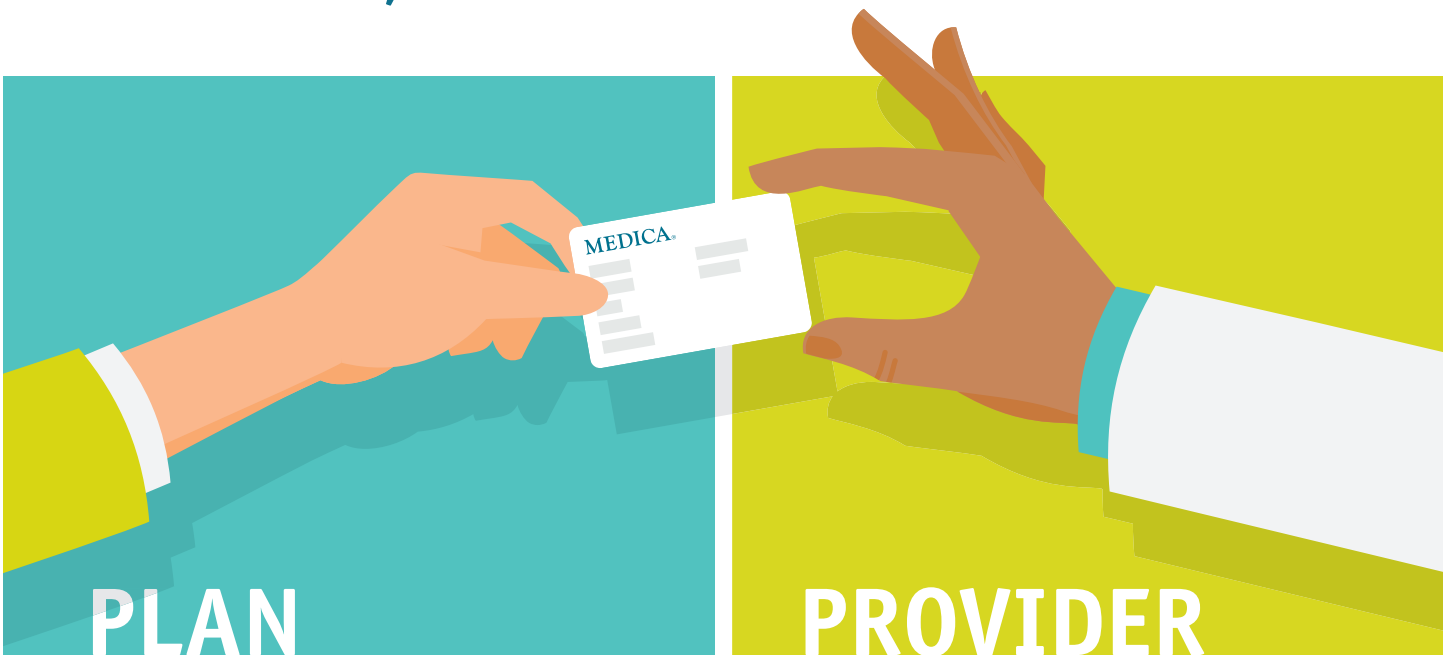
WHICH ONE SHOULD I CHOOSE?

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.

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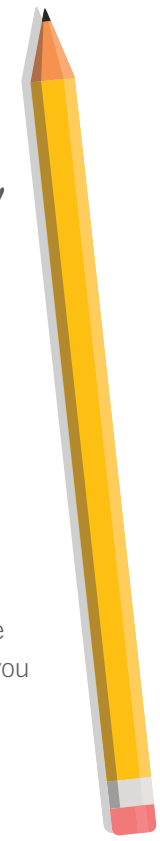
WHICH ONE SHOULD I CHOOSE?

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.

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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**.

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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 **Medica.com/SignIn**.

Once your plan starts, sign in to Medica.com/SignIn 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 at **Medica.com/SignIn**.

- ✓ 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

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

HOW CAN I PAY FOR CARE AND SAVE ON TAXES?

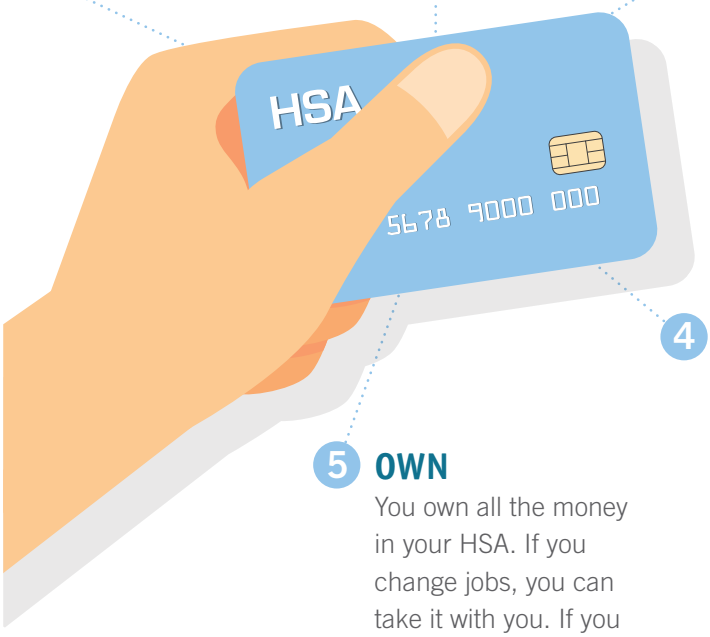
A plan that includes a **health savings account** (HSA) can help you do both. Plans with this type of account will have "HSA" in the name shown at the top of the **benefit summary**.

How it works:

1 SET UP
Depending on your plan, either you or your employer will set up your HSA.

2 DEPOSIT
You'll put money into the account, usually by having money taken out of your paycheck. Or, someone else (like your employer or a relative) can put money into your account.

3 SPEND
You decide when to spend the money – there's no "use it or lose it" rule. If you want your balance to keep growing, you can pay for health care expenses with other money instead.



4 EARN
Some HSAs earn interest and can be invested. Any money you earn is tax free, as long as you spend it on approved expenses.

5 OWN
You own all the money in your HSA. If you change jobs, you can take it with you. If you have money in your account when you die, it goes to your designated beneficiary.

Things to keep in mind:

HSAs can help you save on taxes.
Learn more in Publication 969 on **irs.gov**.

There are limits on how much you can put into your HSA each year.
See the tip sheet at **medica.com/membertips** for more information.

The IRS determines what expenses can be paid for using an HSA.
You'll find the list in Publication 502 on **irs.gov**.

If you use your account for something other than an IRS-approved expense,
you'll pay income taxes on the amount, plus a 20% tax penalty.

After you turn 65, you can use your HSA for any type of expense without the penalty.
But you will pay taxes on money used for non-health care expenses.

To learn more about health savings accounts, see the tip sheet at **medica.com/membertips**.

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BUT WAIT, THERE'S MORE!

Your plan includes some extras at no additional cost that can help you get and stay healthy. Once your coverage starts, we'll send you more information on ways to get the most out of your plan.

Medica® Optum® Emotional Wellbeing Solutions Get help with life's challenges.

Whether it's financial troubles, personal issues, or family problems, we can help. Call **1(800) 626-7944** (TTY: **711**) 25/7/365, to talk with a counselor. They'll help you find the necessary resources to get you back on track.

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 Personify Health app (formerly Virgin Pulse) at no-cost in the App Store and on Google Play.

24-Hour Health Support Trusted answers any time of day or night.

Worried that your stomach bug could be something more serious? Wondering what to do about that cough that won't go away? The advisors and nurses at **Medica CallLink®** can help. They're available 24 hours a day, 365 days a year, to answer your questions and help you make intelligent decisions about your health. Call **1 (800) 962-9497** (TTY: **711**).

Personalized Prevention Program 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 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.

Personalized Family and Women's Health Program Support for your entire parenthood journey.

Ovia Health guides you through your pregnancy, parenting, and reproductive health journey - including trying to conceive and managing menopause. Get clinically-backed content and unlimited support from Ovia's team of health coaches, registered nurses, and certified nurse midwives within Ovia Health's three apps: Ovia (for reproductive health), Ovia Pregnancy, and Ovia Parenting. Download the Ovia app that's right for you for free from the App Store or Google Play. Enter your health plan information to access all the unique tools and features.

Behavioral Health Support On-demand help for stress and emotional well-being.

Access self-care techniques, coping tools, meditations, sleep tracking, and more at no additional cost - anytime, anywhere with **Self Care by AbleTo**. Check-in, track your progress, and explore personalized content that you can move through at your own pace on your mobile device. Build skills you can use for life to feel better. To get started, visit **AbleTo.com/Begin** and select "Medica" when asked for your access code. After you register, download the AbleTo app.

Omada for Joint & Muscle Health A better way to prevent and treat pain.

Omada for Joint & Muscle Health is a virtual program that helps you build muscle to prevent aches and pains, and connects you with a licensed physical therapist to help you treat current muscle or joint pain. All on your mobile device and on your schedule! Available to members enrolled in a Medica Choice Passport plan. Watch for more information about the program from your employer.

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Important Notice from Medica* on behalf of Your Plan Sponsor about Your Prescription Drug Coverage and Medicare ("Medicare Part D")**

Keep this notice if you will become eligible for Medicare Part D within the next 12 months.
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 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) for 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 can also view or download it from their website. You may 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 Section 9 of your copy of the "Medicare & You" handbook for your state's 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.ssa.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, 2024, and forward
Name of Entity/Sender: Medica*
Contact: Customer Service
Address: Route CP555, P.O. Box 9310, Minneapolis, MN 55440-9310
Phone Number: 1-800-952-3455 or 952-945-8000 *(Or refer to number on back of ID card)*

* Medica includes: Medica Insurance Company, Medica Self-Insured, and Medica Services Company, LLC

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

Effective: April 1, 2025
Revised: April 1, 2025

HOW WE[1] PROTECT YOUR PRIVACY

Summary

We are required to protect members' personal *health* information by several state and federal laws. The most comprehensive regulations were issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). HIPAA regulations require entities like us 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, how we must protect this information, and how you can access your protected health information. We must follow the terms of its privacy notice. We may also change or amend its privacy notice as the laws and regulations change. However, if the notice is materially changed, we will make the revised privacy notice available to you.

There are also state and federal laws requiring us to protect your non-public personal *financial* information.[2] The most comprehensive regulations were issued under the Gramm-Leach-Bliley Act ("GLBA"). The GLBA requires us to provide you with a notice about how your non-public personal financial information may be used and disclosed, and to whom.

These duties, responsibilities and rights are described in more detail in the following Privacy Notice.

[1] This Notice of Privacy Practices applies to the following health plans that are affiliated with Medica: Medica Health Plans, Medica Insurance Company, Medica Community Health Plan, Medica Regional Insurance Company, Medica Central Health Plan, Medica Central Insurance Company, Dean Health Plan, Inc., Dean Health Insurance, Inc., and Prevea360 Health Plan. This notice applies to the combined Medica/Dean Health Affiliated Covered Entities (ACE), which are designated as a single HIPAA covered entity as permitted by HIPAA and may be amended from time to time to add new covered entities that are under common control or ownership.

[2] For purposes of the Financial Notice of Privacy Practices, this notice applies to health plans that are affiliated with Medica.

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 MEMBERS OF MEDICA OR ITS AFFILIATES.

What is PHI?

We are 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. We also protect cultural information such as race, ethnicity, language, gender identity, and sexual orientation, the same as all other PHI.

How do we protect your PHI?

We take our responsibility of protecting your PHI seriously. Where possible, we de-identify PHI. We use and disclose only the minimum amount of PHI necessary for treatment, payment and health care operations, or to comply with legal or similar requirements. In addition to physical and technical safeguards, we have also implemented administrative safeguards such as policies and procedures that require our employees to protect your PHI. We also provide training on privacy and security to its employees.

We protect the PHI of former members just as we protect the PHI of current members.

Under what circumstances do we use or disclose PHI?

We receive, maintain, use and share PHI 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[3]
- Health improvement and disease management (for example, sending information on treatment alternatives or other health-related benefits)
- Premium billing and claims administration (for example, your doctor sending us information about your diagnosis and treatment plan so we can pay for those services)
- Complaints and appeals, underwriting, actuarial studies, and premium rating (however, we are 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)

[3] Dean Health Insurance, Inc., along with Dean Health Plan, Medica Central Health Plan, and Medica Central Insurance Company may take part in Organized Health Care Arrangements (OHCAs), including an OHCA with SSM Health and Dean Health System. As part of an OHCA, we may from time to time share your information with other members of the OHCA in order to perform joint health care activities as permitted by HIPAA.

- We 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. However, we will not use cultural information, such as race, ethnicity, language, gender identity, and sexual orientation, for purposes of underwriting, rate setting or denial of coverage or benefits.

With whom do we share PHI?
We share PHI for treatment, payment and health care operations with your health care providers and other businesses that assist it in its operations, or as otherwise permitted by HIPAA and applicable laws. These businesses are called "business associates" in the HIPAA regulations. We require these business associates to follow the same laws and regulations that we follow.

Public Health, Law Enforcement and Health Care Oversight. There are also other activities where the law allows or requires us 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. We have policies that limit the disclosure of PHI to employers. However, we 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. We may use or release PHI for research. We will ensure that only the minimum amount of information that identifies you will be disclosed or used for research. HIPAA allows us 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 us as described below. If we use any identifiers, we will request your permission first.

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

Reproductive Health Care Records.
We are prohibited from using PHI to penalize individuals for providing or obtaining lawful reproductive healthcare. In certain situations, we will be required to obtain a signed attestation that a request for reproductive healthcare PHI is not for a prohibited purpose.

Substance Use Disorder Treatment Records. Substance use disorder treatment records received from federally assisted drug or alcohol abuse programs, ("Part 2 Programs") cannot

be used or disclosed in court proceedings without patient consent or a court order. A court order authorizing use or disclosure must be accompanied by a subpoena or other legal requirement compelling disclosure before Medica would use or disclose records from Part 2 Programs.

When do we need your permission to use or disclose your PHI?
From time to time, we may need to use or disclose PHI where the laws require us to get your permission. We will not be able to release the PHI until you have provided a valid authorization. In this situation, you do not have to allow us to use or disclose your PHI. We 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 we have 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. We must obtain your permission before making most uses and disclosures of psychotherapy notes.
- Marketing. Subject to limited exceptions, we must also obtain your permission before using or disclosing your PHI for marketing purposes.
- Sales. Additionally, we are 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 we have about you. You, or your personal representative on your behalf, may:

Request restrictions of disclosure. You may ask us 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. We are not required to always agree to your restriction. However, if we do agree, we will abide by your request.

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

Inspect or obtain a copy of your PHI. We keep 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 our 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. We will respond to your request within thirty (30) days of receipt. We may charge you a reasonable amount for providing copies. You should know that not all the information we maintain is available to you and there are certain times when other individuals, such as your doctor, may ask us 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 us a written request to make a correction or addition. We may not be able to agree to make the change. For example, if we received the information from a clinic,

we cannot change the clinic information—only the clinic can. If we cannot make the change, we will let you know within thirty (30) days. You may send a statement explaining why you disagree, and we will respond to you. Your request, our disagreement and your statement of disagreement will be maintained in our designated record set.

Request an accounting of disclosures. You have the right to receive a list of disclosures we have made of your PHI. There are certain disclosures we do not have to track. For example, we are not required to list the times we disclosed your PHI when you gave us permission to disclose it. We are also not required to identify disclosures 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. We 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 MEMBER SERVICES AT THE TELEPHONE NUMBER ON THE BACK OF YOUR ID CARD, OR CONTACT MEDICA AT P.O. BOX 9310, MINNEAPOLIS, MN 55440-9310.

File a complaint or grievance about our privacy practices. If you feel your privacy rights have been violated by us, you may file a complaint. You will not be retaliated against for filing a complaint. To file a complaint with us, 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.
We are required by law to maintain the privacy of PHI and to provide this notice. We are required to follow the terms and conditions of this notice. However, we may change this notice and its privacy practices, as long as the change is consistent with state and federal law. If we make a material change to this notice, we 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 MEMBERS OF MEDICA OR ITS AFFILIATES.

How do we protect your information?
We take our responsibility of protecting your information seriously. We maintain 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 do we collect?
We 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 do we collect your information?
We collect information about you in a variety of ways. We obtain such information about you from:

- You, on your application for insurance coverage
- You, concerning your transactions with us, our affiliates or others
- Your physician, health care provider or other participants in the health care system
- Your employer
- Other third parties

Under what circumstances do we use or disclose non-public personal financial information?
We use 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.

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

- To our affiliates to provide certain products and services.
- To our contracted vendors who provide certain products and services on our 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 MEMBER SERVICES AT THE TELEPHONE NUMBER ON THE BACK OF YOUR ID CARD, OR CONTACT MEDICA AT P.O. BOX 9310, MINNEAPOLIS, MN 55440-9310.

Language Assistance (link)

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** (TTY: **711**) **or 1 (800) 952-3455** (TTY: **711**). 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 **(952) 945-8000** (TTY: **711**) **or 1 (800) 952-3455** (TTY: **711**) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$500** per person / **$1,500** per family for in-network services. **$3,000** per person / **$9,000** per family for out-of-network services.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care, copayments, hospice, lab services and prescription drugs 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 for in-network services. **$9,000** per person 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 (unless balanced billing is prohibited), and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.Medica.com/FindCare or call 1-800-952-3455 (TTY:711) for a list of Medica Choice with UnitedHealthcare network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	**Primary care:** $25 copay/visit. Deductible does not apply. **Chiropractic:** $25 copay/visit Deductible does not apply.	**Primary care:** 50% coinsurance **Chiropractic:** 50% coinsurance	In-network primary care visits provided at an outpatient facility may be subject to coinsurance and deductible. Limited to 15 visits per member, per year for out-of-network chiropractic care.
	Specialist visit	$25 copay/visit. Deductible does not apply.	50% coinsurance	In-network specialist visits provided at an outpatient facility may be subject to coinsurance and deductible.
	Preventive care/ screening/ immunization	No charge. Deductible does not apply.	**Well child care:** 0% coinsurance. Deductible does not apply. **Other services:** 50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	**Lab:** No charge. Deductible does not apply. **Xray:** 25% coinsurance	**Lab:** 50% coinsurance **Xray:** 50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	25% coinsurance	50% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.Medica.com/DrugCost1	Generic drugs	**Retail:** $12/prescription. Deductible does not apply. **Mail order:** $24/prescription. Deductible does not apply.	50% coinsurance	Up to a 31-day supply/retail or 93-day supply/mail order prescription. Mail order drugs not covered out-of-network. Insulin: Your cost-share will not exceed $25 per retail prescription unit. 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. ACA preventive drugs covered at no charge. Deductible does not apply.
	Preferred brand drugs	**Retail:** $50/prescription. Deductible does not apply. **Mail order:** $100/prescription. Deductible does not apply.	50% coinsurance	
	Non-preferred brand drugs	**Retail:** $90/prescription. Deductible does not apply. **Mail order:** $180/prescription. Deductible does not apply.	50% coinsurance	
	Specialty drugs	**Preferred:** 20% coinsurance. No more than $200 copay/prescription. Deductible does not apply. **Non-Preferred:** 40% coinsurance. Deductible does not apply.	Not covered	Up to a 31-day supply per prescription received from a designated specialty pharmacy. Drug manufacturer coupon amounts will apply toward your cost share.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	50% coinsurance	None
	Physician/surgeon fees	25% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	25% coinsurance	25% coinsurance	In-network deductible and out-of-pocket applies.
	Emergency medical transportation	25% coinsurance	25% coinsurance	In-network deductible and out-of-pocket applies.
	Urgent care	$25 copay/visit. Deductible does not apply.	$25 copay/visit. Deductible does not apply.	In-network out-of-pocket applies.
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	50% coinsurance	None
	Physician/surgeon fees	25% coinsurance	50% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/office visit. Deductible does not apply. 25% coinsurance for other outpatient services.	50% coinsurance	Other outpatient services include intensive outpatient programs, diagnostic evaluations and psychological testing. *May require prior authorization.
	Inpatient services	25% coinsurance	50% 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:** 50% coinsurance	Cost sharing does not apply to in-network preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., certain ultrasounds.)
	Childbirth/delivery professional services	25% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	25% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	25% coinsurance	50% coinsurance	120 visits per member per year in-network and 60 visits out-of-network, per member per year.
	Rehabilitation services	$25 copay/visit. Deductible does not apply.	50% coinsurance	Out-of-network physical and occupational therapy is limited to a combined limit of 20 visits per member, per year. Out-of-network speech therapy is limited to 20 visits per member, per year. Visit limits are not applicable to behavioral health conditions.
	Habilitation services	$25 copay/visit. Deductible does not apply.	50% coinsurance	Out-of-network physical and occupational therapy is limited to a combined limit of 20 visits per member, per year. Out-of-network speech therapy is limited to 20 visits per member, per year. Visit limits are not applicable to behavioral health conditions.
	Skilled nursing care	25% coinsurance	50% coinsurance	Limited to 120 days combined in and out-of-network providers.
	Durable medical equipment	25% coinsurance	50% coinsurance	None
	Hospice services	No charge. Deductible does not apply.	50% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge. Deductible does not apply.	50% 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
- Chiropractic care exceeding 15 visits per member per year out-of-network
- Cosmetic surgery
- Dental care (Adult)
- Dental check-up
- Glasses
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine foot care except for some conditions
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Abortion
- Hearing aids
- 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** (TTY: **711**) 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** (TTY: **711**) 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 **1 (800) 952-3455** (TTY: **711**).
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1 (800) 952-3455** (TTY: **711**).
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 **1 (800) 952-3455** (TTY: **711**).
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1 (800) 952-3455** (TTY: **711**).

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	$500
Specialist copayment	$25
Hospital (facility) coinsurance	25%
Other coinsurance	25%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$10
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,970**

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

The plan's overall deductible	$500
Specialist copayment	$25
Hospital (facility) coinsurance	25%
Other coinsurance	25%

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	$500
Copayments	$400
Coinsurance	$70
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$970**

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

The plan's overall deductible	$500
Specialist copayment	$25
Hospital (facility) coinsurance	25%
Other coinsurance	25%

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	$500
Copayments	$200
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,100**

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

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

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English: ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-952-3455 (TTY: 711) for Medica, call 1-877-317-2410 (TTY: 711) for Dean Health Plan/Prevea360 Health Plan, or speak to your provider.

Spanish: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia de idiomas. También están disponibles de forma gratuita asistencia y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-952-3455 (TTY: 711) para Medica, llame al 1-877-317-2410 (TTY: 711) para Dean Health Plan/Prevea360 Health Plan o hable con su proveedor de atención médica.

Vietnamese/Việt: LƯU Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-952-3455 (TTY: 711) đối với Medica, gọi theo số 1-877-317-2410 (TTY: 711) đối với Dean Health Plan/Prevea360 Health Plan hoặc trao đổi với nhà cung cấp dịch vụ của quý vị.

Chinese Traditional: 注意：如果您說中文，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-800-952-3455 (TTY: 711) 聯絡 Medica，致電 1-877-317-2410 (TTY: 711) 聯絡 Dean Health Plan/Prevea360 Health Plan，或與您的提供者討論。

Hmong/Lus Hmoob: LUS CEEV: Yog hais tias koj hais Lus Hmoob ces muaj kev pab txhais lus pub dawb rau koj. Muaj khoom siv thiab muaj kev saib xyuas pab uas tsim nyog los npaj kom muaj cov ntaub ntawv uas siv tau dawb. Hu rau 1-800-952-3455 (TTY: 711) rau Medica, hu rau 1-877-317-2410 (TTY: 711) rau Dean Health Plan/Prevea360 Health Plan, los sis tham rau koj tus kws kuaj mob.

German/Deutsch: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-800-952-3455 (TTY: 711) für Medica bzw. 1-877-317-2410 (TTY: 711) für Dean Health Plan/Prevea360 Health Plan oder sprechen Sie mit Ihrem Gesundheitsdienstleister.

Cushitic-Oromo: XIYYEEFFANNOO: Ingiliffaa dubbattu taanaan, tajaajilli deggersa afaan bilisaa ni jira. Tajaajilli deggersa bu'ura dhiheessii odeeffannoo kaffaltii tokko malee ni jira. Lakkoofsa bilbilaa 1-800-952-3455 (TTY: 711) Tajaajila Fayyaaf, lakkoofsa Medica 1-877-317-2410 (TTY: 711), Dean Health Plan/Prevea360 Health Plan, ykn dhiheessaa keessan dubbisaa.

Arabic/العربية

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Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$750** per person / **$2,250** per family for in-network services. **$3,000** per person / **$9,000** per family for out-of-network services.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care, copayments, hospice, lab services and prescription drugs 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?	**$3,500** per person / **$7,000** per family for in-network services. **$9,000** per person 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 (unless balanced billing is prohibited), and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.Medica.com/FindCare or call 1-800-952-3455 (TTY:711) for a list of Medica Choice with UnitedHealthcare network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	**Primary care:** $35 copay/visit. Deductible does not apply. **Chiropractic:** $35 copay/visit. Deductible does not apply.	**Primary care:** 50% coinsurance **Chiropractic:** 50% coinsurance	In-network primary care visits provided at an outpatient facility may be subject to coinsurance and deductible. Limited to 15 visits per member, per year for out-of-network chiropractic care.
	Specialist visit	$35 copay/visit. Deductible does not apply.	50% coinsurance	In-network specialist visits provided at an outpatient facility may be subject to coinsurance and deductible.
	Preventive care/ screening/ immunization	No charge. Deductible does not apply.	**Well child care:** 0% coinsurance. Deductible does not apply. **Other services:** 50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	**Lab:** No charge. Deductible does not apply. **Xray:** 25% coinsurance	**Lab:** 50% coinsurance **Xray:** 50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	25% coinsurance	50% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.Medica.com/DrugCost1	Generic drugs	**Retail:** $12/prescription. Deductible does not apply. **Mail order:** $24/prescription. Deductible does not apply.	50% coinsurance	Up to a 31-day supply/retail or 93-day supply/mail order prescription. Mail order drugs not covered out-of-network. Insulin: Your cost-share will not exceed $25 per retail prescription unit. 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. ACA preventive drugs covered at no charge. Deductible does not apply.
	Preferred brand drugs	**Retail:** $50/prescription. Deductible does not apply. **Mail order:** $100/prescription. Deductible does not apply.	50% coinsurance	
	Non-preferred brand drugs	**Retail:** $90/prescription. Deductible does not apply. **Mail order:** $180/prescription. Deductible does not apply.	50% coinsurance	
	Specialty drugs	**Preferred:** 20% coinsurance. No more than $200 copay/prescription. Deductible does not apply. **Non-Preferred:** 40% coinsurance. Deductible does not apply.	Not covered	Up to a 31-day supply per prescription received from a designated specialty pharmacy. Drug manufacturer coupon amounts will apply toward your cost share.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	50% coinsurance	None
	Physician/surgeon fees	25% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	25% coinsurance	25% coinsurance	In-network deductible and out-of-pocket applies.
	Emergency medical transportation	25% coinsurance	25% coinsurance	In-network deductible and out-of-pocket applies.
	Urgent care	$35 copay/visit. Deductible does not apply.	$35 copay/visit. Deductible does not apply.	In-network out-of-pocket applies.
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	50% coinsurance	None
	Physician/surgeon fees	25% coinsurance	50% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 copay/office visit. Deductible does not apply. 25% coinsurance for other outpatient services.	50% coinsurance	Other outpatient services include intensive outpatient programs, diagnostic evaluations and psychological testing. *May require prior authorization.
	Inpatient services	25% coinsurance	50% 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:** 50% coinsurance	Cost sharing does not apply to in-network preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., certain ultrasounds.)
	Childbirth/delivery professional services	25% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	25% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	25% coinsurance	50% coinsurance	120 visits per member per year in-network and 60 visits out-of-network, per member per year.
	Rehabilitation services	$35 copay/visit. Deductible does not apply.	50% coinsurance	Out-of-network physical and occupational therapy is limited to a combined limit of 20 visits per member, per year. Out-of-network speech therapy is limited to 20 visits per member, per year. Visit limits are not applicable to behavioral health conditions.
	Habilitation services	$35 copay/visit. Deductible does not apply.	50% coinsurance	Out-of-network physical and occupational therapy is limited to a combined limit of 20 visits per member, per year. Out-of-network speech therapy is limited to 20 visits per member, per year. Visit limits are not applicable to behavioral health conditions.
	Skilled nursing care	25% coinsurance	50% coinsurance	Limited to 120 days combined in and out-of-network providers.
	Durable medical equipment	25% coinsurance	50% coinsurance	None
	Hospice services	No charge. Deductible does not apply.	50% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge. Deductible does not apply.	50% 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
- Chiropractic care exceeding 15 visits per member per year out-of-network
- Cosmetic surgery
- Dental care (Adult)
- Dental check-up
- Glasses
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine foot care except for some conditions
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Abortion
- Hearing aids
- 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** (TTY: **711**) 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** (TTY: **711**) 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 **1 (800) 952-3455** (TTY: **711**).
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1 (800) 952-3455** (TTY: **711**).
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 **1 (800) 952-3455** (TTY: **711**).
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1 (800) 952-3455** (TTY: **711**).

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	$750
Specialist copayment	$35
Hospital (facility) coinsurance	25%
Other coinsurance	25%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$750
Copayments	$10
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,120**

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

The plan's overall deductible	$750
Specialist copayment	$35
Hospital (facility) coinsurance	25%
Other coinsurance	25%

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	$750
Copayments	$500
Coinsurance	$10
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,260**

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

The plan's overall deductible	$750
Specialist copayment	$35
Hospital (facility) coinsurance	25%
Other coinsurance	25%

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	$750
Copayments	$200
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,350**

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

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

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English: ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-952-3455 (TTY: 711) for Medica, call 1-877-317-2410 (TTY: 711) for Dean Health Plan/Prevea360 Health Plan, or speak to your provider.

Spanish: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia de idiomas. También están disponibles de forma gratuita asistencia y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-952-3455 (TTY: 711) para Medica, llame al 1-877-317-2410 (TTY: 711) para Dean Health Plan/Prevea360 Health Plan o hable con su proveedor de atención médica.

Vietnamese/Việt: LƯU Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-952-3455 (TTY: 711) đối với Medica, gọi theo số 1-877-317-2410 (TTY: 711) đối với Dean Health Plan/Prevea360 Health Plan hoặc trao đổi với nhà cung cấp dịch vụ của quý vị.

Chinese Traditional: 注意：如果您說中文，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-800-952-3455 (TTY: 711) 聯絡 Medica，致電 1-877-317-2410 (TTY: 711) 聯絡 Dean Health Plan/Prevea360 Health Plan，或與您的提供者討論。

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Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,500** per person / **$4,500** per family for in-network services. **$3,000** per person / **$9,000** per family for out-of-network services.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care, copayments, hospice, lab services and prescription drugs 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?	**$4,500** per person / **$9,000** per family for in-network services. **$9,000** per person 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 (unless balanced billing is prohibited), and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.Medica.com/FindCare or call 1-800-952-3455 (TTY:711) for a list of Medica Choice with UnitedHealthcare network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
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	Specialist visit	$35 copay/visit. Deductible does not apply.	50% coinsurance	In-network specialist visits provided at an outpatient facility may be subject to coinsurance and deductible.
	Preventive care/ screening/ immunization	No charge. Deductible does not apply.	**Well child care:** 0% coinsurance. Deductible does not apply. **Other services:** 50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	**Lab:** No charge. Deductible does not apply. **Xray:** 25% coinsurance	**Lab:** 50% coinsurance **Xray:** 50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	25% coinsurance	50% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.Medica.com/DrugCost1	Generic drugs	**Retail:** $12/prescription. Deductible does not apply. **Mail order:** $24/prescription. Deductible does not apply.	50% coinsurance	Up to a 31-day supply/retail or 93-day supply/mail order prescription. Mail order drugs not covered out-of-network. Insulin: Your cost-share will not exceed $25 per retail prescription unit. 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. ACA preventive drugs covered at no charge. Deductible does not apply.
	Preferred brand drugs	**Retail:** $50/prescription. Deductible does not apply. **Mail order:** $100/prescription. Deductible does not apply.	50% coinsurance	
	Non-preferred brand drugs	**Retail:** $90/prescription. Deductible does not apply. **Mail order:** $180/prescription. Deductible does not apply.	50% coinsurance	
	Specialty drugs	**Preferred:** 20% coinsurance. No more than $200 copay/prescription. Deductible does not apply. **Non-Preferred:** 40% coinsurance. Deductible does not apply.	Not covered	Up to a 31-day supply per prescription received from a designated specialty pharmacy. Drug manufacturer coupon amounts will apply toward your cost share.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	50% coinsurance	None
	Physician/surgeon fees	25% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	25% coinsurance	25% coinsurance	In-network deductible and out-of-pocket applies.
	Emergency medical transportation	25% coinsurance	25% coinsurance	In-network deductible and out-of-pocket applies.
	Urgent care	$35 copay/visit. Deductible does not apply.	$35 copay/visit. Deductible does not apply.	In-network out-of-pocket applies.
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	50% coinsurance	None
	Physician/surgeon fees	25% coinsurance	50% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 copay/office visit. Deductible does not apply. 25% coinsurance for other outpatient services.	50% coinsurance	Other outpatient services include intensive outpatient programs, diagnostic evaluations and psychological testing. *May require prior authorization.
	Inpatient services	25% coinsurance	50% 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:** 50% coinsurance	Cost sharing does not apply to in-network preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., certain ultrasounds.)
	Childbirth/delivery professional services	25% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	25% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	25% coinsurance	50% coinsurance	120 visits per member per year in-network and 60 visits out-of-network, per member per year.
	Rehabilitation services	$35 copay/visit. Deductible does not apply.	50% coinsurance	Out-of-network physical and occupational therapy is limited to a combined limit of 20 visits per member, per year. Out-of-network speech therapy is limited to 20 visits per member, per year. Visit limits are not applicable to behavioral health conditions.
	Habilitation services	$35 copay/visit. Deductible does not apply.	50% coinsurance	Out-of-network physical and occupational therapy is limited to a combined limit of 20 visits per member, per year. Out-of-network speech therapy is limited to 20 visits per member, per year. Visit limits are not applicable to behavioral health conditions.
	Skilled nursing care	25% coinsurance	50% coinsurance	Limited to 120 days combined in and out-of-network providers.
	Durable medical equipment	25% coinsurance	50% coinsurance	None
	Hospice services	No charge. Deductible does not apply.	50% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge. Deductible does not apply.	50% 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
- Chiropractic care exceeding 15 visits per member per year out-of-network
- Cosmetic surgery
- Dental care (Adult)
- Dental check-up
- Glasses
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine foot care except for some conditions
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Abortion
- Hearing aids
- 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** (TTY: **711**) 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** (TTY: **711**) 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.

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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.

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Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1 (800) 952-3455** (TTY: **711**).

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

About these Coverage Examples:

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

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

The plan's overall deductible	$1,500
Specialist copayment	$35
Hospital (facility) coinsurance	25%
Other coinsurance	25%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$10
Coinsurance	$2,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,670**

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

The plan's overall deductible	$1,500
Specialist copayment	$35
Hospital (facility) coinsurance	25%
Other coinsurance	25%

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	$800
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,300**

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

The plan's overall deductible	$1,500
Specialist copayment	$35
Hospital (facility) coinsurance	25%
Other coinsurance	25%

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	$1,500
Copayments	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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

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

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English: ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-952-3455 (TTY: 711) for Medica, call 1-877-317-2410 (TTY: 711) for Dean Health Plan/Prevea360 Health Plan, or speak to your provider.

Spanish: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia de idiomas. También están disponibles de forma gratuita asistencia y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-952-3455 (TTY: 711) para Medica, llame al 1-877-317-2410 (TTY: 711) para Dean Health Plan/Prevea360 Health Plan o hable con su proveedor de atención médica.

Vietnamese/Việt: LƯU Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-952-3455 (TTY: 711) đối với Medica, gọi theo số 1-877-317-2410 (TTY: 711) đối với Dean Health Plan/Prevea360 Health Plan hoặc trao đổi với nhà cung cấp dịch vụ của quý vị.

Chinese Traditional: 注意：如果您說中文，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-800-952-3455 (TTY: 711) 聯絡 Medica，致電 1-877-317-2410 (TTY: 711) 聯絡 Dean Health Plan/Prevea360 Health Plan，或與您的提供者討論。

Hmong/Lus Hmoob: LUS CEEV: Yog hais tias koj hais Lus Hmoob ces muaj kev pab txhais lus pub dawb rau koj. Muaj khoom siv thiab muaj kev saib xyuas pab uas tsim nyog los npaj kom muaj cov ntaub ntawv uas siv tau dawb. Hu rau 1-800-952-3455 (TTY: 711) rau Medica, hu rau 1-877-317-2410 (TTY: 711) rau Dean Health Plan/Prevea360 Health Plan, los sis tham rau koj tus kws kuaj mob.

German/Deutsch: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-800-952-3455 (TTY: 711) für Medica bzw. 1-877-317-2410 (TTY: 711) für Dean Health Plan/Prevea360 Health Plan oder sprechen Sie mit Ihrem Gesundheitsdienstleister.

Cushitic-Oromo: XIYYEEFFANNOO: Ingiliffaa dubbattu taanaan, tajaajilli deggersa afaan bilisaa ni jira. Tajaajilli deggersa bu'ura dhiheessii odeeffannoo kaffaltii tokko malee ni jira. Lakkoofsa bilbilaa 1-800-952-3455 (TTY: 711) Tajaajila Fayyaaf, lakkoofsa Medica 1-877-317-2410 (TTY: 711), Dean Health Plan/Prevea360 Health Plan, ykn dhiheessaa keessan dubbisaa.

Arabic/العربية

كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. تنبيه: (الهاتف النصي: 711) للتواصل مع 1-800-952-3455اتصل على الرقم المعلومات بتنسيقات يمكن الوصول إليها مجانًا. Medica اتصل على الرقم 1-877-317-2410 (الهاتف النصي: 711) بشأن خطة الرعاية الصحية Dean Health Plan/Prevea360 Health Plan

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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** (TTY: **711**) **or 1 (800) 952-3455** (TTY: **711**). 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 **(952) 945-8000** (TTY: **711**) **or 1 (800) 952-3455** (TTY: **711**) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$3,400** per person / **$6,800** per family for in-network services. **$6,800** per person / **$13,600** per family for out-of-network services.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care, preventive prescriptions and prenatal care from in-network providers 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?	**$3,400** per person / **$6,800** per family for in-network services. **$12,000** per person / **$24,000** 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 (unless balanced billing is prohibited), and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.Medica.com/FindCare or call 1-800-952-3455 (TTY:711) for a list of Medica Choice with UnitedHealthcare network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	**Primary care:** 0% coinsurance **Chiropractic:** 0% coinsurance	**Primary care:** 50% coinsurance **Chiropractic:** 50% coinsurance	Limited to 15 visits per member, per year for out-of-network chiropractic care.
	Specialist visit	0% coinsurance	50% coinsurance	None
	Preventive care/ screening/ immunization	No charge. Deductible does not apply.	**Well child care:** 0% coinsurance. Deductible does not apply. **Other services:** 50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	**Lab:** 0% coinsurance **Xray:** 0% coinsurance	**Lab:** 50% coinsurance **Xray:** 50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	50% 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	**Preventive:** Designated preventive drugs: No charge. Deductible does not apply. **Retail:** 0% coinsurance **Mail order:** 0% coinsurance	50% coinsurance	Up to a 31-day supply/retail or 93-day supply/mail order prescription. Mail order drugs not covered out-of-network. Insulin: Your cost-share will not exceed $25 per retail prescription unit. 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. ACA preventive drugs covered at no charge. Deductible does not apply.
	Preferred brand drugs	**Preventive:** Designated preventive drugs: No charge. Deductible does not apply. **Retail:** 0% coinsurance **Mail order:** 0% coinsurance	50% coinsurance	
	Non-preferred brand drugs	**Preventive:** Benefit does not apply. **Retail:** 0% coinsurance **Mail order:** 0% coinsurance	50% 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	50% coinsurance	None
	Physician/surgeon fees	0% coinsurance	50% 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	50% coinsurance	None
	Physician/surgeon fees	0% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance	50% coinsurance	None
	Inpatient services	0% coinsurance	50% coinsurance	Residential treatment is covered as part of inpatient services.
If you are pregnant	Office visits	**Prenatal care:** No charge. Deductible does not apply. **Postnatal care:** 0% coinsurance	**Prenatal care:** 0% coinsurance. Deductible does not apply. **Postnatal care:** 50% coinsurance	Cost sharing does not apply to in-network preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., certain ultrasounds.)
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	Children's glasses	Not covered	Not covered	Glasses are not covered by the plan.
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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** (TTY: **711**) or the Minnesota Department of Commerce at (651) 539-1600 or 1-800-657-3602.

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(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$3,400
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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,400
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,460**

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

The plan's overall deductible	$3,400
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	**$5,600**

In this example, Joe would pay:

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

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

The plan's overall deductible	$3,400
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	**$2,800**

In this example, Mia would pay:

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

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

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

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Arabic/العربية

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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** (TTY: **711**) **or 1 (800) 952-3455** (TTY: **711**). 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 **(952) 945-8000** (TTY: **711**) **or 1 (800) 952-3455** (TTY: **711**) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$4,500** per person / **$9,000** per family for in-network services. **$7,500** per person / **$15,000** per family for out-of-network services.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care, preventive prescriptions and prenatal care from in-network providers 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?	**$4,500** per person / **$9,000** per family for in-network services. **$15,000** per person / **$30,000** 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 (unless balanced billing is prohibited), and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.Medica.com/FindCare or call 1-800-952-3455 (TTY:711) for a list of Medica Choice with UnitedHealthcare network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	**Primary care:** 0% coinsurance **Chiropractic:** 0% coinsurance	**Primary care:** 50% coinsurance **Chiropractic:** 50% coinsurance	Limited to 15 visits per member, per year for out-of-network chiropractic care.
	Specialist visit	0% coinsurance	50% coinsurance	None
	Preventive care/ screening/ immunization	No charge. Deductible does not apply.	**Well child care:** 0% coinsurance. Deductible does not apply. **Other services:** 50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	**Lab:** 0% coinsurance **Xray:** 0% coinsurance	**Lab:** 50% coinsurance **Xray:** 50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	50% 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	**Preventive:** Designated preventive drugs: No charge. Deductible does not apply. **Retail:** 0% coinsurance **Mail order:** 0% coinsurance	50% coinsurance	Up to a 31-day supply/retail or 93-day supply/mail order prescription. Mail order drugs not covered out-of-network. Insulin: Your cost-share will not exceed $25 per retail prescription unit. 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. ACA preventive drugs covered at no charge. Deductible does not apply.
	Preferred brand drugs	**Preventive:** Designated preventive drugs: No charge. Deductible does not apply. **Retail:** 0% coinsurance **Mail order:** 0% coinsurance	50% coinsurance	
	Non-preferred brand drugs	**Preventive:** Benefit does not apply. **Retail:** 0% coinsurance **Mail order:** 0% coinsurance	50% 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	50% coinsurance	None
	Physician/surgeon fees	0% coinsurance	50% 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	50% coinsurance	None
	Physician/surgeon fees	0% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance	50% coinsurance	None
	Inpatient services	0% coinsurance	50% coinsurance	Residential treatment is covered as part of inpatient services.
If you are pregnant	Office visits	**Prenatal care:** No charge. Deductible does not apply. **Postnatal care:** 0% coinsurance	**Prenatal care:** 0% coinsurance. Deductible does not apply. **Postnatal care:** 50% coinsurance	Cost sharing does not apply to in-network preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., certain ultrasounds.)
	Childbirth/delivery professional services	0% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	50% coinsurance	

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	50% coinsurance	120 visits per member per year in-network and 60 visits out-of-network, per member per year.
	Rehabilitation services	0% coinsurance	50% coinsurance	Out-of-network physical and occupational therapy is limited to a combined limit of 20 visits per member, per year. Out-of-network speech therapy is limited to 20 visits per member, per year. Visit limits are not applicable to behavioral health conditions.
	Habilitation services	0% coinsurance	50% coinsurance	Out-of-network physical and occupational therapy is limited to a combined limit of 20 visits per member, per year. Out-of-network speech therapy is limited to 20 visits per member, per year. Visit limits are not applicable to behavioral health conditions.
	Skilled nursing care	0% coinsurance	50% coinsurance	Limited to 120 days combined in and out-of-network providers.
	Durable medical equipment	0% coinsurance	50% coinsurance	None
	Hospice services	0% coinsurance	50% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge. Deductible does not apply.	50% 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
- Chiropractic care exceeding 15 visits per member per year out-of-network
- Cosmetic surgery
- Dental care (Adult)
- Dental check-up
- Glasses
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine foot care except for some conditions
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Abortion
- Hearing aids
- 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** (TTY: **711**) 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** (TTY: **711**) 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 **1 (800) 952-3455** (TTY: **711**).
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1 (800) 952-3455** (TTY: **711**).
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Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1 (800) 952-3455** (TTY: **711**).

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	$4,500
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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$4,500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,560**

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

The plan's overall deductible	$4,500
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	**$5,600**

In this example, Joe would pay:

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

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

The plan's overall deductible	$4,500
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	**$2,800**

In this example, Mia would pay:

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

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