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

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$3,000** per person/ **$6,000** per family in-network and **$6,500** per person/ **$13,000** per family for out-of-network services.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	**Yes.** Preventive care, preventive prescriptions and prenatal care from in-network providers.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits.
Are there other deductibles for specific services?	**No**	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$6,000** per person/ **$12,000** per family in-network. **$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, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count towards the out-of-pocket limit.
Will you pay less if you use a network provider?	**Yes.** See www.medica.com or call 1-800-952-3455 or 711 (TTY users) for a list of Medica Choice with UnitedHealthcare network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	**No.** You don't need a referral to see a specialist.	You can see the specialist you choose without a referral.

All 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 Network Provider (You will pay the least)	 Out-of-network (You will pay the most)	Limitations, Exceptions & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	**Primary care:** 20% coinsurance **Chiropractic:** 20% coinsurance **Convenience:** 20% coinsurance	**Primary:** 50% coinsurance **Chiropractic:** 50% coinsurance **Convenience:** 50% coinsurance	Limited to 15 visits per member, per year for out-of-network chiropractic care.
	Specialist visit	20% coinsurance	50% coinsurance	---none---
	Preventive care/ screening/ immunization	No charge. Deductible does not apply.	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Routine physicals and eye exams are not covered out-of-network.
If you have a test	Diagnostic test (x-ray, blood work)	**Lab:** 20% coinsurance **X-ray:** 20% coinsurance	50% coinsurance	---none---
	Imaging (CT/PET scans, MRIs)	20% 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	**Retail:** 20% coinsurance **Mail order:** 20% coinsurance **Preventive:** No charge. 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.
	Preferred brand drugs	**Retail:** 20% coinsurance **Mail order:** 20% coinsurance **Preventive:** No charge. Deductible does not apply.	50% coinsurance	
	Non-preferred brand drugs	**Retail:** 40% coinsurance **Mail order:** 40% coinsurance **Preventive:** Benefit does not apply.	50% coinsurance	
	Specialty drugs	**Preferred:** 20% coinsurance No more than $200 copay/ prescription. **Non-Preferred:** 40% coinsurance	Not covered	Up to a 31-day supply per prescription received from a designated specialty pharmacy.

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	Out-of-network (You will pay the most)	Limitations, Exceptions & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	---none---
	Physician/surgeon fees	20% coinsurance	50% coinsurance	---none---
If you need immediate medical attention	Emergency room care	20% coinsurance	Covered as an in-network benefit.	---none---
	Emergency medical transportation	20% coinsurance	Covered as an in-network benefit.	---none---
	Urgent care	20% coinsurance	Covered as an in-network benefit.	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	---none---
	Physician/surgeon fees	20% coinsurance	50% coinsurance	---none---
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	50% coinsurance	---none---
	Inpatient services	20% coinsurance	50% coinsurance	---none---
If you are pregnant	Office visits	**Prenatal care:** No charge. Deductible does not apply. **Postnatal care:** 20% coinsurance	50% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	---none---
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	---none---

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	Out-of-network (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Limited to 40 visits per member per year in and out-of-network combined.
	Rehabilitation services	20% coinsurance	50% coinsurance	Physical and occupational therapy combined limited to 20 visits out-of-network per member per year. Out-of-network speech therapy is limited to 20 visits per member per year.
	Habilitation services	20% coinsurance	50% coinsurance	Physical and occupational therapy combined limited to 20 visits out-of-network per member per year. Out-of-network speech therapy is limited to 20 visits per member per year.
	Skilled nursing care	20% coinsurance	50% coinsurance	120 day limit combined in and out-of-network per member per year.
	Durable medical equipment	20% coinsurance	50% coinsurance	---none---
	Hospice services	20% coinsurance	50% coinsurance	---none---
If your child needs dental or eye care	Children's eye exam	No charge. Deductible does not apply.	Not covered	---none---
	Children's glasses	Not covered	Not covered	Glasses are not covered by the plan.
	Children's dental check-up	Not covered	Not covered	Dental check-ups are not covered by the plan.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of other excluded services.)

- Acupuncture exceeding 15 visits per member per year for in-network and out-of-network acupuncture services combined
- Bariatric Surgery
- Chiropractic care exceeding 15 visits per member per year for out-of-network chiropractic care.
- Cosmetic Surgery
- Dental Care (Adult)
- Dental check-up
- Glasses
- Hearing aids and cochlear implants except for members 17 years of age and younger who are certified as deaf or hearing impaired if prescribed by a physician or licensed audiologist; coverage is limited to one hearing aid every three years.
- Infertility treatment
- Long Term Care
- Private-duty nursing
- Routine foot care except for specified conditions
- Weight Loss programs

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

- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)

Your Rights to Continue Coverage:
There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: for group health coverage subject to ERISA, Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; for all other group health coverage, Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

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

Does this Plan Provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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

For assistance, call the number included in this document or on the back of your ID card.

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若需要中文协助，请拨打本文件内或您会员卡背面的电话号码。

Para sa tulong sa Tagalog, tawagan ang numerong kabilang sa dokumentong ito o sa likod ng iyong ID card.

Para obtener asistencia en español, llame al número de teléfono que se incluye en este documento o al dorso de su tarjeta de identificación.

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

About these Coverage Examples:

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

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

- **The plan's overall deductible:** $3,000
- **Specialist coinsurance:** 20%
- **Hospital (facility) coinsurance:** 20%
- **Other coinsurance:** 20%

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

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$0
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,560**

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

- **The plan's overall deductible:** $3,000
- **Specialist coinsurance:** 20%
- **Hospital (facility) coinsurance:** 20%
- **Other coinsurance:** 20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$0
Coinsurance	$800
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$3,800**

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

- **The plan's overall deductible:** $3,000
- **Specialist coinsurance:** 20%
- **Hospital (facility) coinsurance:** 20%
- **Other coinsurance:** 20%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$1,900**

In this example, Mia would pay:

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

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