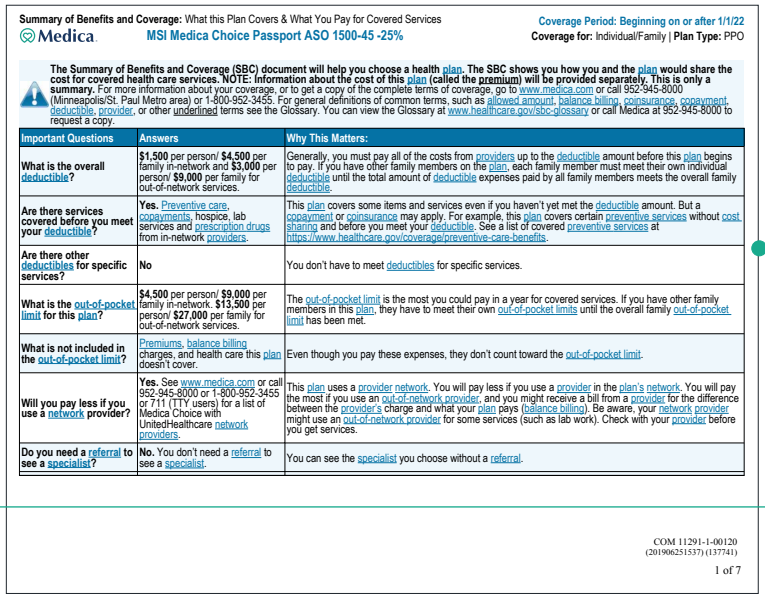
Summary of benefits + coverage (SBC)

How to read — and use — your SBC

An SBC document lays out details about your health plan's benefits and coverage in a question-and-answer format. It also lets you easily compare plans, which can help you find the plan that works best for you and your family.



Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
Medica. MSI Medica Choice Passport ASO 1500-45 -25%
Coverage Period: Beginning on or after 1/1/22
Coverage for: Individual/Family | **Plan Type:** PPO

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

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,500** per person/ **$4,500** per family in-network and **$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.	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 in-network. **$13,500** per person/ **$27,000** per family for out-of-network services.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	**Yes.** See www.medica.com or call 952-945-8000 or 1-800-952-3455 or 711 (TTY users) for a list of Medica 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.

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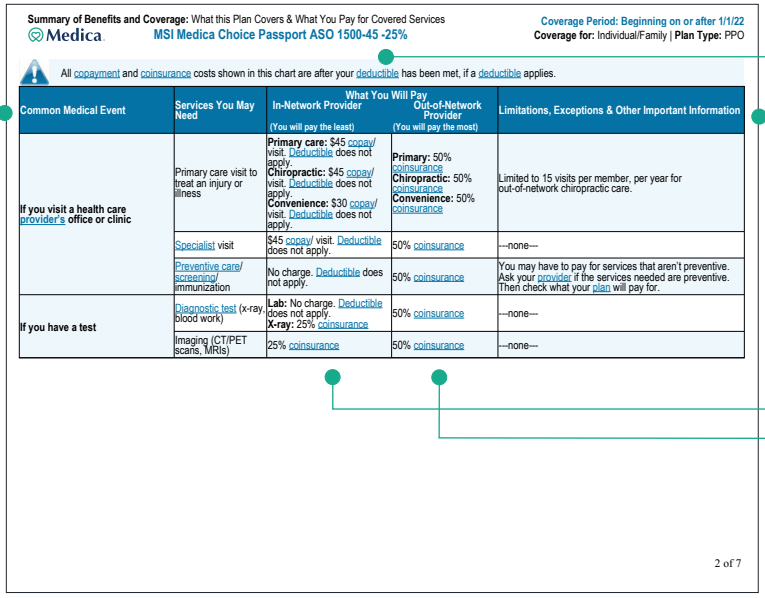

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All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay: In-Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (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:** $45 copay/ visit. Deductible does not apply. **Chiropractic:** $45 copay/ visit. Deductible does not apply. **Convenience:** $30 copay/ visit. Deductible does not apply.	**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	$45 copay/ visit. Deductible does not apply.	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.
If you have a test	Diagnostic test (x-ray, blood work)	**Lab:** No charge. Deductible does not apply. **X-ray:** 25% coinsurance	50% coinsurance	---none---
	Imaging (CT/PET scans, MRIs)	25% coinsurance	50% coinsurance	---none---

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Deductible and out-of-pocket limit.

See page 1 of your plan's SBC to view your deductible(s) and out-of-pocket limit(s).

Common medical event and services you may need.

Look here for a list of common health care services.

What you'll pay.

These columns show how the service is covered when you use an in-network vs. an out-of-network provider.

Limits, exceptions, and other important information.

This column shows any limits or exceptions that apply to a service.

Deductible does not apply.

Your plan may cover some items and services even if you haven't met your deductible.

Coinsurance.

After you've met your deductible, coinsurance applies (unless otherwise noted).

Note: Your insurance benefits and cost sharing may vary from the examples above. See your coverage document on your secure member site (listed on the back of your Medica ID card) for specific details.

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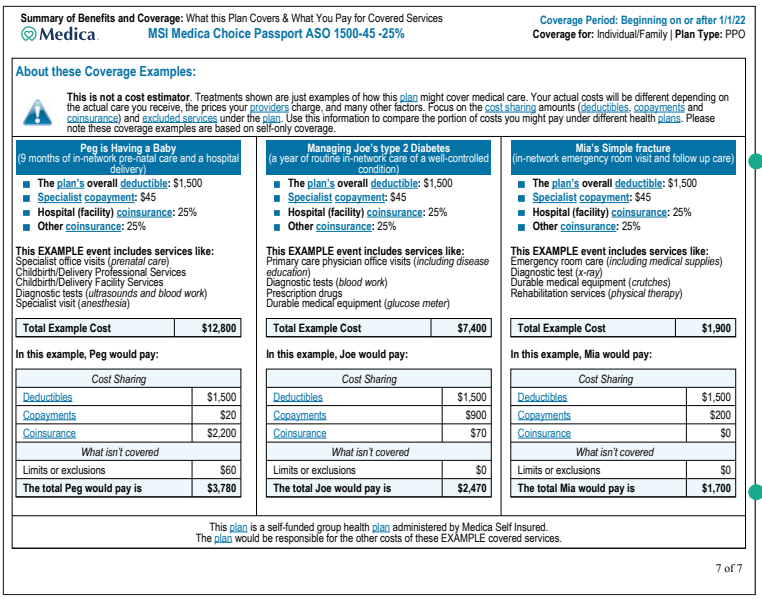

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About these Coverage Examples:

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: $45
- 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	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$20
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,780**

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: $45
- 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	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$900
Coinsurance	$70
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,470**

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

- The plan's overall deductible: $1,500
- Specialist copayment: $45
- 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	$1,900

In this example, Mia would pay:

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

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

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Coverage examples.

Use these examples to understand how you and your plan might share costs for certain services. Remember that the amounts you see aren't your actual costs.

Total you pay.

The amounts listed here are an example. Your costs will vary based on your plan and where you get care.

How to view your SBC

You can view or print your coverage document and SBC on your secure member site (listed on the back of your Medica ID card). You can also request a copy by calling Customer Service at the number on the back of your Medica ID card or by ordering online at **Medica.com/OrderPlanMaterials.**

Key terms to know

DEDUCTIBLE

The amount you pay each year before your insurance starts to pay.

OUT-OF-POCKET MAXIMUM

The most you'll pay in a year for health care services covered by your insurance.

COINSURANCE

Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%). If your plan also has a deductible, coinsurance applies after you've met the deductible.

COPAYMENT (COPAY)

A set amount you pay up front for some services or prescriptions. Depending on your plan, copays may or may not count toward your deductible.

NETWORK

A group of doctors, clinics, hospitals, pharmacies, or other health care providers that contract with your health insurer to provide services to its members, generally at discounted rates.

You can find definitions of other key terms at **Healthcare.gov/SBC-Glossary.**

Have a question?

Call Customer Service at the number on the back of your Medica ID card. (TTY: **711**).

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