MEDICA®

# Medica Choice Passport MN 1650-0% HSA Gold

**Coverage Period: Beginning on or after 1/1/2015**

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage for:** Individual/Family | **Plan Type:** PPO

**This is only a summary:** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.medica.com** or by calling 952-945-8000 (Minneapolis/St. Paul Metro area) or 1-800-952-3455.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | **$1,650** per person/ **$3,000** per family for **in-network** services. **$4,000** per person/ **$8,000** per family for **out-of-network** services. **Deductible** does not apply to preventive care, preventive prescriptions or prenatal care from **in-network providers** or well child or prenatal care from **out-of-network providers**. Family contracts have no member **deductible** maximum. | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. |
| **Are there other deductibles for specific services?** | **No.** | You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| **Is there an out-of-pocket limit on my expenses?** | **Yes. $1,650** per person/ **$3,000** per family for **in-network** services. **$9,000** per person/ **$18,000** per family for **out-of-network** services. Family contracts have no member **out-of-pocket** maximum. | The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| **What is not included in the out-of-pocket limit?** | **Premiums, balance-billed** 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**. |
| **Is there an overall annual limit on what the plan pays?** | **No.** | The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits. |
| **Does this plan use a network of providers?** | **Yes.** For a list of Medica Choice with UnitedHealthcare **providers** see **www.medica.com** or call 952-945-8000 or 800-952-3455 or 800-855-2880 (individuals with hearing impairments). | If you use an **in-network** doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your **in-network** doctor or hospital may use an **out-of-network provider** for some services. Plans use the term **in-network**, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**. |
| **Do I 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 permission from this plan. |
| **Are there services this plan doesn't cover?** | **Yes.** | Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**. |

**Questions:** Call 1-800-952-3455 or visit us at **www.medica.com**.
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at **http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf** or call 1-800-952-3455 to request a copy.

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- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an **out-of-network provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an **out-of-network** hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **in-network providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

| Common Medical Event | Services You May Need | Your cost if you use an In-network Provider | Your cost if you use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | 0% co-insurance after deductible. | 50% co-insurance after deductible. | ---none--- |
| | Specialist visit | 0% co-insurance after deductible. | 50% co-insurance after deductible. | ---none--- |
| | Other practitioner office visit | 0% co-insurance after deductible for chiropractic care. 0% co-insurance after deductible for convenience care. | 50% co-insurance after deductible. | Limited to 15 visits per member, per year for out-of-network chiropractic care. |
| | Preventive care/ screening/ immunization | No charge | No charge for well child care. 50% co-insurance after deductible for other services. | ---none--- |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 0% co-insurance after deductible. | 50% co-insurance after deductible. | ---none--- |
| | Imaging (CT/PET scans, MRIs) | 0% co-insurance after deductible. | 50% co-insurance after deductible. | ---none--- |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at **www.medica.com**. | Tier 1 | 0% co-insurance after deductible. No charge for preventive drugs. | 50% co-insurance after deductible. | Up to a 31-day supply per prescription |
| | Tier 2 | 0% co-insurance after deductible. No charge for preventive drugs. | 50% co-insurance after deductible. | Up to a 31-day supply per prescription |
| | Tier 3 | 0% co-insurance after deductible. Preventive drug benefit does not apply. | 50% co-insurance after deductible. | Up to a 31-day supply per prescription |
| | Specialty Tier 1<br><br>Specialty Tier 2 | Tier 1/ 0% co-insurance after deductible. Tier 2/ 0% co-insurance after deductible. | Not covered | Up to a 31-day supply per prescription received from a designated specialty pharmacy. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 0% co-insurance after deductible. | 50% co-insurance after deductible. | ---none--- |
| | Physician/surgeon fees | 0% co-insurance after deductible. | 50% co-insurance after deductible. | ---none--- |

| Common Medical Event | Services You May Need | Your cost if you use an In-network Provider | Your cost if you use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need immediate medical attention** | Emergency room services | 0% co-insurance after deductible. | Covered as an in-network benefit. | ---none--- |
| | Emergency medical transportation | 0% co-insurance after deductible. | Covered as an in-network benefit. | ---none--- |
| | Urgent care | 0% co-insurance after deductible. | Covered as an in-network benefit. | ---none--- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 0% co-insurance after deductible. | 50% co-insurance after deductible. | ---none--- |
| | Physician/surgeon fee | 0% co-insurance after deductible. | 50% co-insurance after deductible. | ---none--- |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | 0% co-insurance after deductible. | 50% co-insurance after deductible. | ---none--- |
| | Mental/Behavioral health inpatient services | 0% co-insurance after deductible. | 50% co-insurance after deductible. | ---none--- |
| | Substance use disorder outpatient services | 0% co-insurance after deductible. | 50% co-insurance after deductible. | ---none--- |
| | Substance use disorder inpatient services | 0% co-insurance after deductible. | 50% co-insurance after deductible. | ---none--- |
| **If you are pregnant** | Prenatal and postnatal care | No charge for prenatal care. 0% co-insurance after deductible for postnatal care. | No charge for prenatal care. 50% co-insurance after deductible for postnatal care. | ---none--- |
| | Delivery and all inpatient services | 0% co-insurance after deductible. | 50% co-insurance after deductible. | ---none--- |

| Common Medical Event | Services You May Need | Your cost if you use an In-network Provider | Your cost if you use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need help recovering or have other special health needs** | Home health care | 0% co-insurance after deductible. | 50% co-insurance after deductible. | 120 visits per year per member in-network and 60 visits out-of-network combined, per member per year. |
| | Rehabilitation services | 0% co-insurance after deductible. | 50% co-insurance after deductible. | 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. |
| | Habilitation services | 0% co-insurance after deductible. | 50% co-insurance after deductible. | 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. |
| | Skilled nursing care | 0% co-insurance after deductible. | 50% co-insurance after deductible. | Limited to 120 days combined in- and out-of-network providers. |
| | Durable medical equipment | 0% co-insurance after deductible. | 50% co-insurance after deductible. | ---none--- |
| | Hospice service | 0% co-insurance after deductible. | 50% co-insurance after deductible. | ---none--- |
| **If your child needs dental or eye care** | Eye exam | No charge | 50% co-insurance after deductible. | ---none--- |
| | Glasses | 0% co-insurance after deductible. | 50% co-insurance after deductible. | For members under 19 years old. Limited to one pair of glasses or contacts per year. |
| | Dental check-up | Not covered | Not covered | Dental check-ups are not covered by the plan. |

## Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture
- 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
- Hearing aids except for members 18 years of age and younger for hearing loss that is not correctable by other covered procedures; coverage is limited to one hearing aid per ear every three years.
- Infertility treatment
- Long Term Care
- Private-duty nursing
- Routine foot care except for specified conditions
- Weight Loss programs

**Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Glasses or contacts for members under age 19 when prescribed for vision correction.
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at 952-945-8000 or 1-800-952-3455. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or **www.dol.gov/ebsa**, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or **www.cciio.cms.gov**.

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact your plan administrator or you may also contact Medica. For group health coverage subject to ERISA, you may contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or **www.dol.gov/ebsa/healthreform**. You may also contact the Minnesota Department of Commerce at (651) 539-1600 or 1-800-657-3602.

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act required most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Provide Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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

Dine k'ehji shich'i' hadoodzih ninizingo, beesh bee hane'e binumber naaltsoos bikaahigii bich'i' hodiilnih ei doodaii bee neehozin biniiye nanitinigii bine'dee bikaa doo aldo'.

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 page.* ----------

## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,890
- **Patient pays** $2,650

**Sample care costs:**

| | |
|---|---|
| Hospital charges (mother) | $2,700 |
| Routine obstetric care | $2,100 |
| Hospital charges (baby) | $900 |
| Anesthesia | $900 |
| Laboratory tests | $500 |
| Prescriptions | $200 |
| Radiology | $200 |
| Vaccines, other preventive | $40 |
| **Total** | **$7,540** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $1,650 |
| Co-pays | $0 |
| Co-insurance | $0 |
| Limits or exclusions | $1,000 |
| **Total** | **$2,650** |

**Limits or exclusions** include Hospital charges (Baby) and non-covered drugs. Baby costs would be covered separately if enrolled.

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,750
- **Patient pays** $1,650

**Sample care costs:**

| | |
|---|---|
| Prescriptions | $2,900 |
| Medical Equipment and Supplies | $1,300 |
| Office Visits and Procedures | $700 |
| Education | $300 |
| Laboratory tests | $100 |
| Vaccines, other preventive | $100 |
| **Total** | **$5,400** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $1,650 |
| Co-pays | $0 |
| Co-insurance | $0 |
| Limits or exclusions | $0 |
| **Total** | **$1,650** |

## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- **Out-of-pocket** expenses are based only on treating the condition in the example.
- The patient received all care from **in-network providers**. If the patient had received care from **out-of-network providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in **out-of-pocket** costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay **out-of-pocket** expenses.

**Questions:** Call 1-800-952-3455 or visit us at **www.medica.com**.
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