MEDICA® **MN Applause Bronze HSA**

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

**Coverage Period: Beginning on or after 01/01/2014**

**Coverage for:** Individual or 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 888-592-8211.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | **$6,300** Individual/ **$12,700** Family for **in-network** services, **$10,000** Individual/ **$20,000** Family **out-of-network**. Family contracts have no individual **deductible** maximum. **Deductible** does not apply to preventive care from **in-network providers**. **Deductible** does not apply to prenatal care from **in-network** or **out-of-network providers**. | 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. $6,300** Individual/ **$12,700** Family for **in-network** services. | 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, health care this plan doesn't cover, **out-of-network deductible** and **co-insurance**. | 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 **in-network providers**, see **www.medica.com** or call 888-592-8211 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**. |

- **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 | No charge | 50% co-insurance | ---none--- |
| | Specialist visit | No charge | 50% co-insurance | ---none--- |
| | Other practitioner office visit | No charge for chiropractic care.<br>No charge for convenience care. | 50% co-insurance for chiropractic care or convenience care | Coverage is limited to 20 visits per member per year for out-of-network chiropractic care. |
| | Preventive care/ screening/ immunization | No charge | 50% co-insurance | Immunizations for children under age 18 or well child care for children under age 6 from out-of-network providers covered at 0% co-insurance. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No charge | 50% co-insurance | ---none--- |
| | Imaging (CT/PET scans, MRIs) | No charge | 50% co-insurance | ---none--- |
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available at **www.medica.com**. | Tier 1 | No charge | Not covered | Up to a 31-day supply per prescription. |
| | Tier 2 | No charge | Not covered | Up to a 31-day supply per prescription. |
| | Tier 3 | No charge | Not covered | Up to a 31-day supply per prescription. |
| | Specialty Tier 1<br>Specialty Tier 2 | Tier 1: No charge<br>Tier 2: No charge | 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) | No charge | 50% co-insurance | ---none--- |
| | Physician/surgeon fees | No charge | 50% co-insurance | ---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 | No charge | Covered as an in-network benefit | ---none--- |
| | Emergency medical transportation | No charge | Covered as an in-network benefit | ---none--- |
| | Urgent care | No charge | Covered as an in-network benefit | ---none--- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | No charge | 50% co-insurance | Coverage is limited to a 365 day maximum per period of confinement for in-network and out-of-network combined subject to the combined day limit. |
| | Physician/surgeon fee | No charge | 50% co-insurance | ---none--- |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | No charge | 50% co-insurance | ---none--- |
| | Mental/Behavioral health inpatient services | No charge | 50% co-insurance | Coverage is limited to a 365 day maximum per period of confinement for in-network and out-of-network combined subject to the combined day limit. |
| | Substance use disorder outpatient services | No charge | 50% co-insurance | ---none--- |
| | Substance use disorder inpatient services | No charge | 50% co-insurance | Coverage is limited to a 365 day maximum per period of confinement for in-network and out-of-network combined subject to the combined day limit. |

| 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 are pregnant** | Prenatal and postnatal care | Prenatal: No charge<br>Postnatal: No charge | Prenatal: 0% co-insurance<br>Postnatal: 50% co-insurance | ---none--- |
| | Delivery and all inpatient services | No charge | 50% co-insurance | Coverage is limited to a 365 day maximum per period of confinement for in-network and out-of-network combined subject to the combined day limit. |
| **If you need help recovering or have other special health needs** | Home health care | No charge | Not covered | Coverage is limited to 120 visits per member per year. |
| | Rehabilitation services | No charge | 50% co-insurance | Coverage is limited to 15 visits per member per year for out-of-network services. |
| | Habilitation services | No charge | 50% co-insurance | Coverage is limited to 15 visits per member per year for out-of-network services. |
| | Skilled nursing care | No charge | 50% co-insurance | Coverage is limited to 120 days per member per year for in-network and out-of-network services combined. |
| | Durable medical equipment | No charge | 50% co-insurance | ---none--- |
| | Hospice service | No charge | Not covered | ---none--- |
| **If your child needs dental or eye care** | Eye exam | No charge | 50% co-insurance | Coverage is limited to one refractive eye exam per member per year for in-network and out-of-network services combined for members 18 years of age and younger. |
| | Glasses | No charge | 50% co-insurance | Coverage is limited to one pair of frames and lenses every calendar year for members 18 years of age and younger. |
| | Dental check-up | Not covered | Not covered | No coverage for dental check-ups. |

## 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
- Cosmetic Surgery
- Dental Care (Adult)
- 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 eye care (Adult)
- 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.)**

- Chiropractic Care
- Non-emergency care when traveling outside the U.S.

## Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if: •You commit fraud •The insurer stops offering services in the State •You move outside the coverage area.
For more information on your rights to continue coverage, contact the insurer at 888-592-8211. You may also contact your state insurance department at 651-296-2488 or 1-800-657-3602.

## 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: Minnesota Department of Commerce at 651-296-2488 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.

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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 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** $1,740
- **Patient pays** $5,800

**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 | $4,800 |
| Co-pays | $0 |
| Co-insurance | $0 |
| Limits or exclusions | $1,000 |
| **Total** | **$5,800** |

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

- **Amount owed to providers:** $5,400
- **Plan pays** $100
- **Patient pays** $5,300

**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 | $5,300 |
| Co-pays | $0 |
| Co-insurance | $0 |
| Limits or exclusions | $0 |
| **Total** | **$5,300** |

## 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 or preexisting 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 888-592-8211 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 888-592-8211 to request a copy.