MEDICA®
Personalize. Empower. Improve.

Your Guide to Enrollment

Hamline University

Effective January 01, 2016

Your choices. Your life. Your plan.

CMP5635-10211

Welcome!

Your employer is offering you one or more benefit plan options from Medica. Use this guide to learn about these options and things to consider as you make your coverage choices for the coming year. When you have questions, answers are just a phone call or mouse click away.

News and Notes

> Welcome to Medica! Medica is pleased to be offering you health care coverage options, and is providing this information to help you select the very best plan for your needs. Put Medica to work for you — we want to support you in improving your health and getting the most out of your health care benefits.

> We're here to help! If you have questions after you reviewed this information, please call Medica Customer Service at 952-945-8000 or 1-800-952-3455.

> Your group number for Plan A - Medica Choice Passport $5000-0% HSA is 13374.

> Your group number for Plan A - Medica Elect $5000-0% HSA is 13375.

> Your group number for Plan A - Medica Essential $5000-0% HSA is 13376.

> Your group number for Plan B - Medica Choice Passport $2600-10% HSA is 13377.

> Your group number for Plan B - Medica Elect $2600-10% HSA is 13378.

> Your group number for Plan B - Medica Essential $2600-10% HSA is 13379.

> Your group number for Plan C - Medica Choice Passport $1000-$35-25% is 13380.

> Your group number for Plan C - Medica Elect $1000-$35-25% is 13381.

> Your group number for Plan C - Medica Essential $1000-$35-25% is 13382.

> Your group number for Plan D - Medica Choice Passport $300-$35-20% is 13383.

> Your group number for Plan D - Medica Elect $300-$35-20% is 13384.

> Your group number for Plan D - Medica Essential $300-$35-20% is 13385.

Things to Consider

When you have more than one plan to pick from, it can be hard to know which one to choose. Plus, you may have the option of choosing your plan benefits (how health care services are covered) and your provider network (the health care providers you'll see when you need care). The information in this guide shows which options are available to you. The following can help as you weigh your choices.

Choosing your provider network

A provider network is a group of doctors, hospitals and other health care providers contracted to provide services to Medica members for less than their usual fees. You receive your highest level of benefits when you see providers in your plan's network. Your network options are described on the following page(s).

If you have a choice of networks, consider the following:

- **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). Other networks don't require a referral as long as you stay in the network.
- **What size network do you need?**
  Plans with a smaller network generally have lower premiums. Accountable Care Organizations (ACOs) have a more focused 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 your plan benefits

Your plan benefits determine how things are covered and what your share of the costs will be. For example, whether the plan has a deductible and/or coinsurance. To see what a plan covers, check the plan's Summary of Benefits and Coverage, available in this guide.

If you have a choice of benefits, consider the following:

- **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.
- **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 (or 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.

Medica Choice® Passport

National network

Your employer is offering you a Medica Choice Passport benefit plan. This plan features:

- One of the largest networks in the nation
- Nationwide in-network coverage when you travel
- No referrals needed

What is a provider network?

A provider network is a group of physicians, hospitals and other health care providers that has agreed to deliver care to Medica members.

- Medica selects providers to be in its networks based on the quality of care they provide and their proximity to places where Medica members live, work or travel.
- Network providers have a contract with Medica to care for you at discounted prices negotiated on your behalf.
- Network providers can't bill you for more than the discounted amounts allowed by Medica's contract.

Is your doctor in the Medica Choice Passport network?

There are two easy ways to find out:

1. Go to **mymedica.com**
   - Choose **Find Physician or Facility** (in the "Links and Tools" box)
   - Select Medica Choice with UnitedHealthcare Choice Plus
2. Call Medica Customer Service

   1-800-952-3455; TTY users, call 711

Why is it important to see network providers?

If you see a provider that is not in your plan's network, your costs will be *significantly* higher because you will receive a lower coverage amount under your benefit plan, and your share of the costs will be based on the provider's full charges rather than the discounted rate Medica negotiates with network providers. Plus, Medica may pay the provider a fee that is less than the amount billed, and you'll be responsible for paying the difference.

Medica Elect®

Care system network

Your employer is offering you a benefit plan or plans featuring the Medica Elect provider network. Consider a Medica Elect plan if you and your family members live or work within the Elect service area and you want to save money on monthly premium costs. This plan features:

- A mid-size regional network
- National in-network coverage when you travel
- A medical home – you choose a primary care clinic/care system

About Medica Elect

With Medica Elect, you enroll in a primary care clinic that's affiliated with a care system. Each family member can choose a different care system within the Medica Elect network.

- Whenever you need care, you'll always start at your primary care clinic (PCC).
- For your best benefits, get all of your care from providers in your care system.
- If you can't get the care you need within your care system, you can ask for a referral to see a provider in another care system.

Medica Elect Care Systems

- Allina Health (includes Aspen Medical Group)
- Children's Health Network
- Hennepin Health
- Integrity Health Network
- Lakeview Medical Group
- Minnesota HealthCare Network
- Park Nicollet Health Services
- RiverWay/North Suburban Clinics
- St. Luke's Care System

Is your doctor in a Medica Elect care system?

There are two easy ways to find out:

1. Go to **mymedica.com**
   - Choose **Find Physician or Facility** (in the "Links and Tools" box)
   - Select Medica Elect
   - Search for a provider or get more information about how Medica Elect works, including how to choose and enroll in a PCC
2. Call Medica Customer Service
   - 1-800-952-3455; TTY users, call 711

Why is it important to see providers in your care system?

If you see a provider outside your care system without a referral, your costs will be significantly higher. This is also the case if you see a provider outside of the Medica Elect network. That's because you receive a lower coverage amount under your benefit plan, and your share of the costs will be based on the provider's full charges rather than the discounted rate Medica negotiates with network providers. Plus, Medica may pay the provider a fee that is less than the amount billed, and you'll be responsible for paying the difference.

CMP5640-1-01015

Medica Essential℠

Care system network

Your employer is offering you a benefit plan or plans featuring the Medica Essential provider network. Consider a Medica Essential plan if you and your family members live or work within the Essential service area and you want to save money on monthly premium costs. This plan features:

- A mid-size regional network
- National in-network coverage when you travel
- A medical home – you choose a primary care clinic/care system

About Medica Essential

With Medica Essential, you enroll in a primary care clinic that's affiliated with a care system. Each family member can choose a different care system within the Medica Essential network.

- Whenever you need care, you'll always start at your primary care clinic (PCC).
- For your best benefits, get all of your care from providers in your care system.
- If you can't get the care you need within your care system, you can ask for a referral to see a provider in another care system.

Medica Essential Care Systems

- Altru Health System
- Children's Health Network
- Essentia Health West
- Fairview Physician Associates
- HealthEast Care System
- Integrity Health Network
- St. Luke's Care System

Is your doctor in a Medica Essential care system?

There are two easy ways to find out:

1. Go to **mymedica.com**
   - Choose **Find Physician or Facility** (in the "Links and Tools" box)
   - Select Medica Essential
   - Search for a provider or get more information about how Medica Essential works, including how to choose and enroll in a PCC
2. Call Medica Customer Service
   - 1-800-952-3455; TTY users, call 711

Why is it important to see providers in your care system?

If you see a provider outside your care system without a referral, your costs will be significantly higher. This is also the case if you see a provider outside of the Medica Essential network. That's because you receive a lower coverage amount under your benefit plan, and your share of the costs will be based on the provider's full charges rather than the discounted rate Medica negotiates with network providers. Plus, Medica may pay the provider a fee that is less than the amount billed, and you'll be responsible for paying the difference.

CMP5641-1-01015

Health Savings Account (HSA)

One or more of your benefit plan choices qualifies for a health savings account, or HSA, which is described in more detail below.

What is an HSA?

A savings account used to pay for current and future health care expenses.

What are some advantages?

- HSA payroll contributions lower your payroll taxes.
- You get tax-deferred earnings from interest-bearing and invested funds.
- The money is yours. Change employers? Take it with you.
- You can use it or save it. Balances roll over from year to year.
- After age 65, use the funds for any purpose without penalty. (You will, however, pay taxes on funds withdrawn.)
- If you die, remaining funds go to your beneficiary.

How does it work?

Your HSA can be used to pay for deductibles, copayments, coinsurances, and other qualified expenses. After you reach the out-of-pocket maximum (or limit), the plan pays 100% of covered expenses. Learn more about health savings accounts in the tip sheet at **medica.com/membertips**.

This page intentionally left blank.

Your Plan Benefits: Summary of Benefits and Coverage Overview

You will share in the cost of your health care. This packet includes an overview of costs and coverage for your benefit plan called a Summary of Benefits and Coverage. If you have more than one plan to choose from, you will have a Summary for each plan. Your Summary can help you estimate and compare what your costs are likely to be under each plan option.

Reviewing your Summary of Benefits and Coverage

There are two basic ways you will share in your health care costs. There are "up-front" costs (monthly premiums), and "pay as-you-go" (out-of-pocket) costs.

Premiums are the set amount you pay for coverage, paid to Medica through payroll deduction. See your employer for your premium amounts.

Out-of-pocket costs can include the following (not all of these costs may apply to your specific plan; check the Summary of Benefits and Coverage in this guide to see which costs are relevant):

- **Copayments –** a set amount you pay the provider when you use services.
- **Coinsurance –** a percentage of provider charges that you pay.
- **Deductible –** a set amount you must pay before your plan will pay for covered services. You pay providers for the full cost of your care, until you reach your deductible amount for the year. Once you reach the deductible, Medica will pay for covered services. The deductible may not apply to all services.
- **Out-of-pocket maximum (or limit) –** this is the most you would pay out of your pocket per year for covered services under your plan.

Out-of-network Costs

Many plans (though not all) have out-of-network benefits. Depending on your plan, your Summary of Benefits and Coverage shows your benefits when you see providers in the plan network, and how that coverage is reduced if you go to providers outside the network. Remember, if you see providers outside your network, your costs will be significantly higher. For more information, see the out-of-network care tip sheet at **medica.com/membertips**.

(continued on back)

Your Plan Benefits: Summary of Benefits and Coverage Overview
(continued)

What about my prescriptions?

Medica's Preferred Drug List contains thousands of drugs to help meet your needs. These drugs have been thoroughly evaluated for safety, effectiveness and value.

- Look up drugs on the Preferred Drug List by going to **mymedica.com** and selecting **Pharmacy Information** (in the "Links and Tools" box), or call Medica Customer Service.
- Find your share of prescription costs in the Summary of Benefits and Coverage in this guide.
- Fill your prescriptions at a retail pharmacy in Medica's large pharmacy network. Many plans also offer options to receive a three-month supply of maintenance medications.
- Once you're a member, log in to **mymedica.com** and you'll be able to see pricing specific to your benefits, including suggested ways to save on your prescriptions.

Find the information you need on mymedica.com

When you get your ID card, be sure to register for your member website, **mymedica.com**. This one-stop resource provides all the information you need to help you manage your health plan benefits and improve your health.

With **mymedica.com**, you can:

- Print a temporary ID card or order extra cards
- Look up your specific benefits and see what's covered
- Track your claims
- See what doctors and other health care providers are in your plan's network
- Find cost information for prescription drugs
- Chat with a nurse online
- Learn about and participate in health and wellness programs

Medica Choice Passport MN 5000-0% HSA

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

Coverage Period: Beginning on or after 1/1/2016
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?	**$5,000** per person/ **$10,000** per family for **in-network** services. **$6,000** per person/ **$12,000** per family for **out-of-network** services. **Deductible** does not apply to preventive care, or prenatal care from **in-network providers** or well child or prenatal care from **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. $5,000** per person/ **$10,000** per family for **in-network** services. **$10,200** per person/ **$19,400** per family for **out-of-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, 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 1-800-952-3455 or 711 (TTY users).	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.

- **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.	25% co-insurance after deductible.	---none---
	Specialist visit	0% co-insurance after deductible.	25% 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.	25% co-insurance after deductible.	Limited to 15 visits per member, per year for out-of-network chiropractic care.
	Preventive care/ screening/ immunization	No charge	0% co-insurance for well child care. 25% co-insurance after deductible for other services.	---none---
If you have a test	Diagnostic test (x-ray, blood work)	0% co-insurance after deductible.	25% co-insurance after deductible.	---none---
	Imaging (CT/PET scans, MRIs)	0% co-insurance after deductible.	25% co-insurance after deductible.	---none---
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.medica.com**.	Tier 1	0% co-insurance after deductible.	25% co-insurance after deductible.	Up to a 31-day supply per prescription
	Tier 2	0% co-insurance after deductible.	25% co-insurance after deductible.	Up to a 31-day supply per prescription
	Tier 3	0% co-insurance after deductible.	25% co-insurance after deductible.	Up to a 31-day supply per prescription
	Specialty Tier 1 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.	25% co-insurance after deductible.	---none---
	Physician/surgeon fees	0% co-insurance after deductible.	25% 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.	25% co-insurance after deductible.	---none---
	Physician/surgeon fee	0% co-insurance after deductible.	25% 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.	25% co-insurance after deductible.	---none---
	Mental/Behavioral health inpatient services	0% co-insurance after deductible.	25% co-insurance after deductible.	---none---
	Substance use disorder outpatient services	0% co-insurance after deductible.	25% co-insurance after deductible.	---none---
	Substance use disorder inpatient services	0% co-insurance after deductible.	25% 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.	0% co-insurance for prenatal care. 25% co-insurance after deductible for postnatal care.	---none---
	Delivery and all inpatient services	0% co-insurance after deductible.	25% 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.	25% co-insurance after deductible.	120 visits per year per member in-network and 60 visits out-of-network, per member per year.
	Rehabilitation services	0% co-insurance after deductible.	25% 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.	25% 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.	25% co-insurance after deductible.	Limited to 120 days combined in- and out-of-network providers.
	Durable medical equipment	0% co-insurance after deductible.	25% co-insurance after deductible..	---none---
	Hospice service	0% co-insurance after deductible.	25% co-insurance after deductible..	---none---
If your child needs dental or eye care	Eye exam	No charge	25% co-insurance after deductible.	---none---
	Glasses	Not covered	Not covered	Glasses are not covered by the plan.
	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.)

- 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 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.
- 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.)

- Acupuncture
- Bariatric Surgery
- Infertility treatment
- 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** $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**

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** $400
- **Patient pays** $5,000

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	$5,000
Co-pays	$0
Co-insurance	$0
Limits or exclusions	$0
Total	**$5,000**

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**.
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.

Medica Choice Passport MN 2600-10% HSA

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

Coverage Period: Beginning on or after 1/1/2016
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?	**$2,600** per person/ **$5,200** per family for **in-network** services. **$4,800** per person/ **$9,600** per family for **out-of-network** services. **Deductible** does not apply to preventive care, or prenatal care from **in-network providers** or well child or prenatal care from **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. $3,100** per person/ **$6,200** per family for **in-network** services. **$10,200** per person/ **$19,400** per family for **out-of-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, 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 1-800-952-3455 or 711 (TTY users).	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.

- **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	10% co-insurance after deductible.	25% co-insurance after deductible.	---none---
	Specialist visit	10% co-insurance after deductible.	25% co-insurance after deductible.	---none---
	Other practitioner office visit	10% co-insurance after deductible for chiropractic care. 10% co-insurance after deductible for convenience care.	25% co-insurance after deductible.	Limited to 15 visits per member, per year for out-of-network chiropractic care.
	Preventive care/ screening/ immunization	No charge	0% co-insurance for well child care. 25% co-insurance after deductible for other services.	---none---
If you have a test	Diagnostic test (x-ray, blood work)	10% co-insurance after deductible.	25% co-insurance after deductible.	---none---
	Imaging (CT/PET scans, MRIs)	10% co-insurance after deductible.	25% co-insurance after deductible.	---none---
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.medica.com**.	Tier 1	10% co-insurance after deductible.	25% co-insurance after deductible.	Up to a 31-day supply per prescription
	Tier 2	10% co-insurance after deductible.	25% co-insurance after deductible.	Up to a 31-day supply per prescription
	Tier 3	10% co-insurance after deductible.	25% co-insurance after deductible.	Up to a 31-day supply per prescription
	Specialty Tier 1 Specialty Tier 2	Tier 1/ 10% co-insurance after deductible. Tier 2/ 10% 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)	10% co-insurance after deductible.	25% co-insurance after deductible.	---none---
	Physician/surgeon fees	10% co-insurance after deductible.	25% 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	10% co-insurance after deductible.	Covered as an in-network benefit.	---none---
	Emergency medical transportation	10% co-insurance after deductible.	Covered as an in-network benefit.	---none---
	Urgent care	10% co-insurance after deductible.	Covered as an in-network benefit.	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	10% co-insurance after deductible.	25% co-insurance after deductible.	---none---
	Physician/surgeon fee	10% co-insurance after deductible.	25% co-insurance after deductible.	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% co-insurance after deductible.	25% co-insurance after deductible.	---none---
	Mental/Behavioral health inpatient services	10% co-insurance after deductible.	25% co-insurance after deductible.	---none---
	Substance use disorder outpatient services	10% co-insurance after deductible.	25% co-insurance after deductible.	---none---
	Substance use disorder inpatient services	10% co-insurance after deductible.	25% co-insurance after deductible.	---none---
If you are pregnant	Prenatal and postnatal care	No charge for prenatal care. 10% co-insurance after deductible for postnatal care.	0% co-insurance for prenatal care. 25% co-insurance after deductible for postnatal care.	---none---
	Delivery and all inpatient services	10% co-insurance after deductible.	25% 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	10% co-insurance after deductible.	25% co-insurance after deductible.	120 visits per year per member in-network and 60 visits out-of-network, per member per year.
	Rehabilitation services	10% co-insurance after deductible.	25% 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	10% co-insurance after deductible.	25% 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	10% co-insurance after deductible.	25% co-insurance after deductible.	Limited to 120 days combined in- and out-of-network providers.
	Durable medical equipment	10% co-insurance after deductible.	25% co-insurance after deductible.	---none---
	Hospice service	10% co-insurance after deductible.	25% co-insurance after deductible.	---none---
If your child needs dental or eye care	Eye exam	No charge	25% co-insurance after deductible.	---none---
	Glasses	Not covered	Not covered	Glasses are not covered by the plan.
	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.)

- 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 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.
- 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.)

- Acupuncture
- Bariatric Surgery
- Infertility treatment
- 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** $3,740
- **Patient pays** $3,800

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	$2,600
Co-pays	$0
Co-insurance	$200
Limits or exclusions	$1,000
Total	**$3,800**

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** $2,500
- **Patient pays** $2,900

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	$2,600
Co-pays	$0
Co-insurance	$300
Limits or exclusions	$0
Total	**$2,900**

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**.
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.

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?	**$1,000** per person/ **$2,750** per family for **in-network** services. **$2,500** per person/ **$7,000** per family for **out-of-network** services. **Deductible** does not apply to preventive care, co-pay services, hospice, lab, or prescription drugs from **in-network providers** or well child or prenatal care from **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. $3,500** per person/ **$7,000** per family for **in-network** services. **$6,000** per person/ **$12,000** per family for **out-of-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, 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 1-800-952-3455 or 711 (TTY users).	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	$35 co-pay/ visit	50% co-insurance after deductible.	---none---
	Specialist visit	$35 co-pay/ visit	50% co-insurance after deductible.	---none---
	Other practitioner office visit	$35 co-pay/ visit for chiropractic care. $15 co-pay/ visit 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	0% co-insurance for well child care. 50% co-insurance after deductible for other services.	---none---
If you have a test	Diagnostic test (x-ray, blood work)	No charge for lab services. 25% co-insurance after deductible for x-ray services.	50% co-insurance after deductible.	---none---
	Imaging (CT/PET scans, MRIs)	25% 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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.medica.com**.	Tier 1	$11/ prescription	Greater of 40% co-insurance or $60 co-pay/ prescription after deductible.	Up to a 31-day supply per prescription
	Tier 2	$45/ prescription	Greater of 40% co-insurance or $60 co-pay/ prescription after deductible.	Up to a 31-day supply per prescription
	Tier 3	$60/ prescription	Greater of 40% co-insurance or $60 co-pay/ prescription after deductible.	Up to a 31-day supply per prescription
	Specialty Tier 1 Specialty Tier 2	Tier 1/ 20% co-insurance. No more than $200 co-pay/ prescription. Tier 2/ 40% co-insurance.	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)	25% co-insurance after deductible.	50% co-insurance after deductible.	---none---
	Physician/surgeon fees	25% co-insurance after deductible.	50% co-insurance after deductible.	---none---
If you need immediate medical attention	Emergency room services	$75 co-pay/ visit	Covered as an in-network benefit.	---none---
	Emergency medical transportation	25% co-insurance after deductible.	Covered as an in-network benefit.	---none---
	Urgent care	$35 co-pay/ visit	Covered as an in-network benefit.	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	25% co-insurance after deductible.	50% co-insurance after deductible.	---none---
	Physician/surgeon fee	25% 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	$35 co-pay/ visit	50% co-insurance after deductible.	---none---
	Mental/Behavioral health inpatient services	25% co-insurance after deductible.	50% co-insurance after deductible.	---none---
	Substance use disorder outpatient services	$35 co-pay/ visit	50% co-insurance after deductible.	---none---
	Substance use disorder inpatient services	25% 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 are pregnant	Prenatal and postnatal care	No charge. 20% co-insurance after deductible for postnatal care.	0% co-insurance for prenatal care. 50% co-insurance after deductible for postnatal care.	---none---
	Delivery and all inpatient services	25% co-insurance after deductible.	50% co-insurance after deductible.	---none---
If you need help recovering or have other special health needs	Home health care	25% co-insurance after deductible.	50% co-insurance after deductible.	120 visits per year per member in-network and 60 visits out-of-network, per member per year.
	Rehabilitation services	$35 co-pay/ visit	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	$35 co-pay/ visit	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	25% co-insurance after deductible.	50% co-insurance after deductible.	Limited to 120 days combined in- and out-of-network providers.
	Durable medical equipment	25% co-insurance after deductible.	50% co-insurance after deductible.	---none---
	Hospice service	No charge	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	Not covered	Not covered	Glasses are not covered by the plan.
	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.)

- 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 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.
- 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.)

- Acupuncture
- Bariatric Surgery
- Infertility treatment
- 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** $4,620
- **Patient pays** $2,920

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	$1,000
Co-pays	$20
Co-insurance	$900
Limits or exclusions	$1,000
Total	**$2,920**

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** $3,520
- **Patient pays** $1,880

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	$1,000
Co-pays	$800
Co-insurance	$80
Limits or exclusions	$0
Total	**$1,880**

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**.
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.

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?	**$300** per person/ **$600** per family for **in-network** services. **$500** per person/ **$1,000** per family for **out-of-network** services. **Deductible** does not apply to preventive care, co-pay services, hospice, lab, or prescription drugs from **in-network providers** or well child or prenatal care from **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. $2,000** per person/ **$4,000** per family for **in-network** services. **$3,500** per person/ **$5,000** per family for **out-of-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, 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 1-800-952-3455 or 711 (TTY users).	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	$35 co-pay/ visit	40% co-insurance after deductible.	---none---
	Specialist visit	$35 co-pay/ visit	40% co-insurance after deductible.	---none---
	Other practitioner office visit	$35 co-pay/ visit for chiropractic care. $15 co-pay/ visit for convenience care.	40% co-insurance after deductible.	Limited to 15 visits per member, per year for out-of-network chiropractic care.
	Preventive care/ screening/ immunization	No charge	0% co-insurance for well child care. 40% co-insurance after deductible for other services.	---none---
If you have a test	Diagnostic test (x-ray, blood work)	No charge for lab services. 20% co-insurance after deductible for x-ray services.	40% co-insurance after deductible.	---none---
	Imaging (CT/PET scans, MRIs)	20% co-insurance after deductible.	40% 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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.medica.com**.	Tier 1	$11/ prescription	Greater of 40% co-insurance or $60 co-pay/ prescription after deductible.	Up to a 31-day supply per prescription
	Tier 2	$45/ prescription	Greater of 40% co-insurance or $60 co-pay/ prescription after deductible.	Up to a 31-day supply per prescription
	Tier 3	$60/ prescription	Greater of 40% co-insurance or $60 co-pay/ prescription after deductible.	Up to a 31-day supply per prescription
	Specialty Tier 1 Specialty Tier 2	Tier 1/ 20% co-insurance. No more than $200 co-pay/ prescription. Tier 2/ 40% co-insurance.	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)	20% co-insurance after deductible.	40% co-insurance after deductible.	---none---
	Physician/surgeon fees	20% co-insurance after deductible.	40% co-insurance after deductible.	---none---
If you need immediate medical attention	Emergency room services	$75 co-pay/ visit	Covered as an in-network benefit.	---none---
	Emergency medical transportation	20% co-insurance after deductible.	Covered as an in-network benefit.	---none---
	Urgent care	$35 co-pay/ visit	Covered as an in-network benefit.	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance after deductible.	40% co-insurance after deductible.	---none---
	Physician/surgeon fee	20% co-insurance after deductible.	40% co-insurance after deductible.	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$35 co-pay/ visit	40% co-insurance after deductible.	---none---
	Mental/Behavioral health inpatient services	20% co-insurance after deductible.	40% co-insurance after deductible.	---none---
	Substance use disorder outpatient services	$35 co-pay/ visit	40% co-insurance after deductible.	---none---
	Substance use disorder inpatient services	20% co-insurance after deductible.	40% 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 are pregnant	Prenatal and postnatal care	No charge. 20% co-insurance after deductible for postnatal care.	0% co-insurance for prenatal care. 40% co-insurance after deductible for postnatal care.	---none---
	Delivery and all inpatient services	20% co-insurance after deductible.	40% co-insurance after deductible.	---none---
If you need help recovering or have other special health needs	Home health care	20% co-insurance after deductible.	40% co-insurance after deductible.	120 visits per year per member in-network and 60 visits out-of-network, per member per year.
	Rehabilitation services	$35 co-pay/ visit	40% 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	$35 co-pay/ visit	40% 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	20% co-insurance after deductible.	40% co-insurance after deductible.	Limited to 120 days combined in- and out-of-network providers.
	Durable medical equipment	20% co-insurance after deductible.	40% co-insurance after deductible.	---none---
	Hospice service	No charge	40% co-insurance after deductible.	---none---
If your child needs dental or eye care	Eye exam	No charge	40% co-insurance after deductible.	---none---
	Glasses	Not covered	Not covered	Glasses are not covered by the plan.
	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.)

- 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 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.
- 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.)

- Acupuncture
- Bariatric Surgery
- Infertility treatment
- 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** $5,320
- **Patient pays** $2,220

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	$300
Co-pays	$20
Co-insurance	$900
Limits or exclusions	$1,000
Total	**$2,220**

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** $4,100
- **Patient pays** $1,300

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	$300
Co-pays	$800
Co-insurance	$200
Limits or exclusions	$0
Total	**$1,300**

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 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**.
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.

Put Medica to Work For You 

More than any other health plan, Medica responds to your needs with tailor-made services and resources that support you in improving your health and making the most of your benefits. Best of all, these are all part of your benefit plan once you become a member. Call Customer Service for details on any of the resources below.

Health Rewards Program | *Get inspired to make positive changes*

Improving your health and maintaining healthy habits can be fun and rewarding with My Health Rewards by Medica®. Earn gift cards as you complete activities personalized just for you: take an interactive health assessment, set goals and get help reaching them, track your daily activity, and engage in healthy competition with your friends and coworkers. To find your own path to better health, log on to mymedica.com and choose the Health & Wellness tab.

Health Club Reimbursement Program | *Does it really pay to exercise?*

We'll give you a $20 credit toward your monthly dues when you meet your monthly workout requirement at any network fitness club. That's just a few workouts a week, for money in your pocket. View the complete list of Fit Choices SM by Medica network fitness centers at medica.com/fitchoices.

Employee Assistance Program | *Where can I get help with life's challenges?*

Medica offers a toll-free hotline 24 hours a day, 365 days a year with counselors who can help resolve personal and work concerns, family problems and financial difficulties. Call 1-800-626-7944 and our counselors will help you identify, understand, and cope with problems.

Healthy Savings Program | *Bag some healthy savings today*

Save money every month on all kinds of qualified foods with the Healthy Savings program. It's almost like getting a free trip to the grocery store every month. Medica members who live near participating stores are automatically enrolled in the program, and receive a Healthy Savings member card.

24-Hour Nurse Line | *How can I get fast answers to health care questions?*

Call Medica CallLink® to speak to an experienced nurse for information and advice about general health issues, self-care for minor injuries and illnesses, or finding a network provider. The nurse line is open all day, every day, all year at 1-800-962-9497 (TTY, call 711).

Please note that the benefits described here may be subject to change.
Coverage documents describing your final benefits will be available after enrollment.

MEDICA®

PO Box 9310, Minneapolis, MN 55440-9310

CMP5647-11014

This page intentionally left blank.

This coverage notice applies to the following plans:

MIC PP MN 2600-10% HSA, MIC PP MN 1000-35 Rx 11/45/60, MIC PP MN 300-35 Rx 11/45/60, MIC ME MN 2600-10% HSA, MIC MES MN 2600-10% HSA, MIC ME MN 1000-35 Rx 11/45/60, MCI MES MN 1000-35 Rx 11/45/60, MIC ME MN 300-35 Rx 11/45/60, MIC MES MN 300-35 Rx 11/45/60

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

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 or not 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*

* "Medica" refers to the family of health plan businesses that includes Medica Health Plans, Medica Health Plans of Wisconsin, Medica Insurance Company and Medica Self-Insured.

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

Medicare Part D Creditable Coverage Notice

***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) 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 may also 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 the inside back cover of your copy of the Medicare & You handbook for their 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.socialsecurity.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, 2015 forward
Name of Entity/Sender: Medica*
Contact--Position/Office: Customer Service
Address: Route CP 555, P.O. Box 9310, Minneapolis, MN 55440-310
Phone Number: 1-800-952-3455 or 952-945-8000 *(Or refer to number on back of ID card)*

COM3302-10915

This coverage notice applies to the following plans:
MIC PP MN 5000-0% HSA, MIC ME MN 5000-0% HSA, MIC MES MN 5000-0% HSA

Medicare Part D Non-Creditable Coverage Notice

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

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 or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three 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 current benefit plan is, on average for all plan participants, NOT expected to pay out as much as the standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. <u>This is important, because most likely, you will get more help with your drug costs if you join a Medicare drug plan than if you only have prescription drug coverage from your current Plan Sponsor's benefit plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.</u>**
3. **You can keep your current coverage from your Plan Sponsor. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully – it explains your options.**

Medica currently has a number of Medicare Part D product offerings. Please contact Medica's Center for Healthy Aging at 1-800-906-5432 or (952)992-2345 for more information.

<u>When Can You Join a Medicare Drug Plan?</u>
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

* "Medica" refers to the family of health plan businesses that includes Medica Health Plans, Medica Health Plans of Wisconsin, Medica Insurance Company and Medica Self-Insured.
** Your Plan Sponsor is the entity that established your benefit plan, and is typically your employer (or former employer).

However, if you decide to drop your current coverage, since it is employer/union sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan. If your prior coverage was not creditable, you may pay a higher premium (a penalty), but if your prior coverage was creditable, you will not pay a higher premium. This is addressed in detail in the next section.

Your current coverage pays for other health expenses, in addition to prescription drugs. You will still be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

Since your coverage is not creditable, depending on how long you go without creditable prescription drug coverage, you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that is creditable, 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 (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your coverage with your Plan Sponsor will not be affected. Your current coverage pays for other health expenses, in addition to prescription drugs. You will still be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.

If you do decide to join a Medicare drug plan and drop your current Medica coverage, be aware that you and your dependents may not be able to get this coverage back.

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 will 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 may also 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 the inside back cover of your copy of the Medicare & You handbook for their 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.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Date: September 1, 2015 forward ***Contact--Position/Office:*** Customer Service
Name of Entity/Sender: Medica ***Address:*** Route CP 555, P.O. Box 9310, Minneapolis, MN 55440-9310
Phone Number: 1-800-952-3455 or 952-945-8000 *(Or refer to the number on the back of your ID card).*

COM3303-10915

PRIVACY NOTICE

Effective: June 11, 2003
Revised: September 23, 2013

HOW MEDICA PROTECTS YOUR PRIVACY

Summary

There are several state and federal laws requiring Medica Health Plans, Medica Health Plans of Wisconsin and Medica Insurance Company (collectively, "Medica") to protect its members' personal *health* information. The most comprehensive regulations were issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). These regulations have been updated from time to time. Essentially, HIPAA regulations require entities like Medica 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. Regulations also describe how Medica must protect this information and how you can access your protected health information. Medica must follow the terms of its privacy notice. Medica may also change or amend its privacy notice as the laws and regulations change. However, if the notice is materially changed, Medica will make the revised privacy notice available to you.

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

When the law permits use and disclosure

The law permits Medica to use and disclose your personal health information for purposes of treatment, payment and health care operations without first obtaining your authorization. There are other limited circumstances when Medica may use and disclose your personal health information without your authorization, such as public health, regulatory and law enforcement activities. Whether personal health information is used or disclosed with or without your authorization, Medica uses and discloses personal health information only to those persons who need to know and only the minimum amount necessary to perform the required activity.

Your privacy rights

The law also gives you rights to access, copy and amend your personal health information. You have the right to request restrictions on certain uses and disclosures of your personal health information. You also have the right to obtain information about how and when your personal health information has been used and disclosed.

These duties, responsibilities and rights are described in more detail below.

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 MEDICA MEMBERS.

What is PHI?

Medica is 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.

How does Medica protect your PHI?

Medica takes its responsibility of protecting your PHI seriously. Where possible, Medica de-identifies PHI. Medica uses and discloses only the minimum amount of PHI necessary for treatment, payment and operations, or to comply with legal or similar requirements. In addition to physical and technical safeguards, Medica has administrative safeguards such as policies and procedures that require Medica's employees to protect your PHI. Medica also provides training on privacy and security to its employees.

Medica protects the PHI of former members just as it protects the PHI of current members.

Under what circumstances does Medica use or disclose PHI?

Medica receives, maintains, uses and shares PHI only 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
- Health improvement and disease management (for example, sending information on treatment alternatives or other health-related benefits)
- Premium billing and claims administration
- Complaints and appeals, underwriting, actuarial studies, and premium rating (however, Medica is 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)
- Medica 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.

With whom does Medica share PHI?

Medica shares PHI for treatment, payment and health care operations with your health care providers and other businesses that assist it in its operations. These businesses are called "business associates" in the HIPAA regulations. Medica requires these business associates to follow the same laws and regulations that Medica follows.

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

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

When does Medica need your permission to use or disclose your PHI?

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

Request restrictions of disclosure. You may ask Medica 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. Medica is not required to always agree to your restriction. However, if Medica does agree, Medica will abide by your request.

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

Inspect or obtain a copy of your PHI. Medica keeps 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 Medica's 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. Medica will respond to your request within thirty (30) days of receipt. Medica may charge you a reasonable amount for providing copies. You should know that not all the information Medica maintains is available to you and there are certain times when other individuals, such as your doctor, may ask Medica 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 Medica a written request to make a correction or addition. Medica may not be able to agree to make the change. For example, if Medica received the information from a clinic, Medica cannot change the clinic information—only the clinic can. If Medica cannot make the change, it will let you know within thirty (30) days. You may send a statement explaining why you disagree, and Medica will respond to you. Your request, Medica's disagreement and your statement of disagreement will be maintained in Medica's designated record set.

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

File a complaint or grievance about Medica's privacy practices. If you feel your privacy rights have been violated by Medica, you may file a complaint. You will not be retaliated against for filing a complaint. To file a complaint with Medica, 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
Medica is required by law to maintain the privacy of PHI and to provide this notice. Medica is required to follow the terms and conditions of this notice. However, Medica may change this notice and its privacy practices, as long as the change is consistent with state and federal law. If Medica makes a material change to this notice, it 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 MEDICA MEMBERS.

How does Medica protect your information?
Medica takes its responsibility of protecting your information seriously. Medica maintains 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 does Medica collect?
Medica 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 does Medica collect your information?
Medica collects information about you in a variety of ways. Medica obtains such information about you from:

- You, on your application for insurance coverage
- You, concerning your transactions with Medica, its affiliates or others
- Your physician, healthcare provider or other participants in the healthcare system
- Your employer
- Other third parties

Under what circumstances does Medica use or disclose non-public personal financial information?
Medica uses 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.

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

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