MAYO CLINIC

Benefits Legal Notices

2025

Notice Of Privacy Practices

Mayo Medical Plan, Mayo Dental Plan, Mayo Flexible Spending Account Plan, Mayo Clinic Employee Assistance Plan and Mayo Clinic Retiree Health Reimbursement Arrangement

November 1, 2024

NOTICE OF PRIVACY PRACTICES
Mayo Medical Plan, Mayo Dental Plan, Mayo Flexible Spending Account Plan, Mayo Clinic Employee Assistance Plan and Mayo Clinic Retiree Health Reimbursement Arrangement

Updated November 1, 2024

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO MAYO.

Mayo's Legal Duty

This notice is for participants enrolled in the following group health plans sponsored by Mayo Clinic:

Mayo Medical Plan

Mayo Dental Plan

Mayo Flexible Spending Account Plan

Mayo Clinic Employee Assistance Plan

Mayo Clinic Retiree Health Reimbursement Arrangement

These plans (collectively referred to as the Plans in this notice) participate in an organized health care arrangement (OHCA) under the Health Insurance Portability and Accountability Act, as amended (HIPAA). An OHCA is an arrangement that allows these plans to share protected health information about their plan members to promote the joint operations of the participating entities. In addition, the Plans participate in an OHCA with Mayo Clinic and its affiliate hospitals and clinics noted below in the Mayo Affiliates section of this notice (collectively referred to as the Practice in this notice). This means that these plans may share your medical information with each other as needed for the purposes of payment and health care operations, as further described in this notice. The Plans may also share plan member information with the Practice for joint health care operations such as population health and quality improvement activity. If you receive medical care from Mayo Clinic or an affiliate hospital, or Mayo Clinic as a health care provider, your Mayo provider has separate privacy obligations.

We are required by applicable federal law (the HIPAA Privacy Rules) and state law to maintain the privacy of your medical information. For purposes of this notice, your medical information is information collected, maintained, used and/or disclosed by the Plans, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition; the provision of health care to you; or the past, present, or future payment for health care furnished to you. It includes genetic information as defined under Title I of the Genetic Information Nondiscrimination Act of 2008. Under the HIPAA Privacy Rules, we are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your medical information. We must follow the privacy practices that are described in this notice while it is in effect. This notice has been updated as of September 1, 2022, and will remain in effect, subject to further revisions, as described further below.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the

changes in our privacy practices and the new terms of our notice effective for all medical information that we maintain, including medical information we created or received before we made the changes. A copy of our most current notice is posted on the Mayo intranet location.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed in the Questions and Complaints section of this notice.

Uses and Disclosures of Medical Information

We use and disclose medical information about you for treatment, payment and health care operations. For example:

Treatment: We may use or disclose your medical information to a physician or other health care provider in order to provide treatment to you.

Payment: We may use and disclose your medical information to pay claims from physicians, hospitals and other providers for services delivered to you that are covered by the Plans, to determine your eligibility for benefits, to coordinate benefits, to examine medical necessity, to obtain premiums, to issue explanations of benefits to the person who subscribes to the Plans and the like. We may disclose your medical information to a health care provider or other entity so they can obtain payment or engage in these payment activities. We may not, however, use or disclose any medical information that is genetic information for underwriting purposes.

Health Care Operations: We may use and disclose your medical information in connection with our health care operations. However, we may not, and do not, use or disclose any medical information that is genetic information for underwriting purposes. Health care operations include, but are not limited to:

- rating our risk and determining our premiums for the Plans;
- quality assessment and improvement activities;
- reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities;
- medical review, legal services, and auditing, including fraud and abuse detection and compliance;
- business planning and development; and
- business management and general administrative activities, including management activities relating to privacy, customer service, resolution of internal grievances, and creating de-identified medical information or a limited data set.

We may disclose your medical information to another entity which has a relationship with you and is subject to the federal privacy rules, for their health care operations relating to quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, or detecting or preventing health care fraud and abuse.

On Your Authorization: You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your medical information for any reason except those described in this notice. Your written authorization will be required for most uses and disclosures of psychotherapy notes (to the extent that any of the Plans maintain such records), uses and disclosures of medical information for marketing purposes and disclosures that constitute sale of medical information.

To Your Family and Involved Individuals: We may disclose your medical information to your family and certain others in limited circumstances and only to the extent necessary

for them to assist with your health care or with payment for your health care.

To Plan Sponsor: We may disclose your medical information to certain employees of the plan sponsor (Mayo Clinic) and affiliated entities participating in the Plans so that they can perform plan administration functions, as permitted by the HIPAA Privacy Rules. The official plan documents for the Plans explain the limited uses and disclosures that the plan sponsor/your employer may make of your medical information in providing plan administration functions for the Plans. Neither Mayo Clinic nor its affiliates can use medical information received by us for employment purposes, unless you provide written authorization.

To Business Associates: We may contract with certain business associates to perform functions on our behalf. These contracts will limit the uses and disclosures of your medical information. For example, we have hired Mayo Clinic Health Solutions to assist us in administering the Mayo Medical Plan. Accordingly, we entered into a contract with Mayo Clinic Health Solutions to limit its uses and disclosures of your medical information.

Disaster Relief: We may use or disclose your medical information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- as required by law (e.g., when required to do so by the Secretary of HHS);
- for public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- to report reasonably suspected adult abuse, neglect, or domestic violence;
- to health oversight agencies;
- in response to court and administrative orders and other lawful processes;
- to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- to coroners, medical examiners, and funeral directors;
- to organ procurement organizations;
- to avert a serious threat to health or safety;
- in connection with certain research activities if the requirements of the HIPAA Privacy Rules are satisfied;
- to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- to correctional institutions regarding inmates; and
- as authorized by state worker's compensation laws.

Health Related Services: We may use your medical information to contact you with information about health-related benefits and services or about treatment alternatives that may be of interest to you. We may disclose your medical information to a business associate to assist us in these activities.

Individual Rights

Access: You (or another person named by you) have the right to look at or get copies of your medical information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. If your medical information is maintained electronically, you have the right to obtain a copy in electronic format. When possible, we will provide you with a copy in the format you request. If it is not possible, we will work with you to determine a mutually agreeable format. If we cannot agree on a format, you (or another person named by you) will receive a paper copy.

You must make a request in writing to obtain access to your medical information. We may charge a reasonable, cost-based fee to cover the expense of providing copies in paper and/or electronic form. If you would like to direct us to send a copy of your medical information to a third party, please contact us using the information listed in the Questions and Complaints section of this notice.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your medical information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your medical information, a description of the medical information we disclosed, the reason for the disclosure, and certain other information. You must make a request in writing to obtain an accounting. Your request must include a start and end date. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but such requests will be considered and honored when reasonable and practicable. You must make a request for a restriction in writing.

A health care provider must comply with a requested restriction if the disclosure is related to one of the Plans for purposes of payment or health care operations, and the medical information relates to a health care item or service for which you paid in full. For example, if you receive medical care and choose to pay the provider for the entire amount of care in full out-of-pocket, you can request that the provider not disclosure such information to the Plans, and the provider must agree to such a request.

Confidential Communication: You have the right to request that we communicate with you about your medical information by alternative means or to alternative locations**.** You must make your request in writing, and you must state that the information could endanger you if it is not communicated in confidence. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to collect premiums and pay claims under the health plan.

Breach Notification: You have a right to receive notice following discovery of any "breach" of your unsecured protected health information (Breach Notice). This right includes any breach that may occur at one of our business associates. In the event a breach occurs, the Breach Notice will include a description of the breach, the steps you should take to protect yourself from potential harm, if any, and what we are doing to investigate the breach, mitigate the harm and to prevent further breaches.

Amendment: You have the right to request that we amend your medical information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if the information is accurate and complete or for other certain permissible reasons.

Electronic Notice: If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed in the Questions and Complaints section of this notice to obtain this notice in written form.

Fundraising: The Plans do not contact plan members to raise funds for the Plans.

Mayo Affiliates

This notice applies to the Mayo Clinic entities and health care practice locations (collectively referred to as the Practice in this notice) specifically referenced in the Notice of Privacy Practices for the Practice, which is accessible here:

http://www.mayo.edu/pmts/mc5200-mc5299/mc5256-01.pdf

Note that the list of Practice locations may be updated from time to time. If you have any questions regarding the list of Practice locations, please contact us using the information listed in the Questions and Complaints section of this notice.

Questions and Complaints

If you want to submit a request under the Individual Rights section of this notice or want more information about our privacy practices, please contact us using the information listed below.

If you are concerned that we may have violated your privacy rights pursuant to a request under the Individual Rights section of this notice, or you disagree with a decision we made, you may complain to us using the contact information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

The Plans are obligated to notify you if unsecured medical information is breached (as defined by HIPAA Privacy Rules). The Plans have policies and procedures designed to address such situations. If your complaint relates to the breach notification policies and procedures in place for the Plans, or the Plans' compliance with such breach notification policies and procedures, use the information below to send your complaint.

We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the United States Department of Health and Human Services.

Contact:	Privacy Officer for the Plans
E-mail:	DLRSTMayoMedicalPlanHIPAA@mayo.edu
Telephone:	(507) 284-5487 Internal: 4-5487
Fax:	(507) 538-1856 Internal: 8-1856
Address:	200 First Street SW
	Rochester, MN 55905

Health Insurance Marketplace

Section 1512 of the Affordable Care Act creates the Fair Labor Standards Act section 18B which requires Mayo Clinic to provide all employees with the enclosed information.

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1][2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact

Mayo Clinic HR Connect 507-266-0440 or 888-266-0440

_____.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)
Mayo Clinic	**41-6011702**
5. Employer address	6. Employer phone number
200 First Street SW	**507-266-0440 or 888-266-0440**

7. City	8. State	9. ZIP code
Rochester	**MN**	**55905**

10. Who can we contact about employee health coverage at this job?	
Mayo Clinic HR Connect	
11. Phone number (if different from above)	12. Email address

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☑ Some employees. Eligible employees are:

    Eligible employees are classified by the employer for payroll and personnel purposes to be regularly scheduled to work at least half-time as determined by the employer. More specific eligibility requirements are defined in your summary plan description. In the event of a conflict between what is stated in this document and the governing plan document(s), the Plan document(s) will control.

- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are:

    Eligible family members include your spouse, biological or legally adopted children and stepchildren who are under age 26, and children age 26 or older who have qualified for Social Security Disability Insurance (SSDI) prior to age 26 (contact HR Connect for more information).

  - ☐ We do not offer coverage.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Summary of Benefits and Coverage

Under Section 2715 of the Public Health Services Act and by the Patient Protection Act, Mayo Clinic is required to provide the enclosed information.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to www.Medica.com/SignIn or call **(866) 839-4015** (TTY: **711**). For general definitions of common terms, such as allowed amount, balanced billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call **(866) 839-4015** (TTY: **711**) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	(In-Network) **$600** per person / **$1,200** per family. (Out-of-Network) **$1,300** per person / **$2,600** per family. Deductible amounts incurred will cross over and count in the other network.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care, primary care services, prescription drugs, emergency medical transportation, emergency room facility, urgent care, prenatal and postnatal office visits in-network are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	(In-Network) **$2,600** per person / **$5,200** per family. (Out-of-Network) **$4,600** per person / **$9,200** per family. Combined medical and pharmacy out-of-pocket.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges (unless balanced billing is prohibited), coinsurance for certain speciality prescription drugs considered non-essential health benefits under the plan, health care this plan doesn't cover, Non-Preferred and Fertility drugs.	Even though you pay these expenses, they don't count towards the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.Medica.com/SignIn or call **(866) 839-4015** (TTY: **711**) for a list of Mayo Medical Plan network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balanced billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	**Primary care:** No charge. Deductible does not apply. **Chiropractic:** 20% coinsurance **Retail Health:** No charge. Deductible does not apply. **Virtual:** No charge. Deductible does not apply.	**Primary care:** 50% coinsurance **Chiropractic:** 50% coinsurance **Retail Health:** 50% coinsurance **Virtual:** 50% coinsurance	Chiropractic care-20 spinal manipulations per calendar year for in-network and out-of-network benefits combined.
	Specialist visit	20% coinsurance	50% coinsurance	None
	Preventive care/ screening/ immunization	No charge. Deductible does not apply.	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Out-of-network preventive services are not covered by the plan. Refractive eye exams not covered.
If you have a test	Diagnostic test (x-ray, blood work)	**Lab:** 20% coinsurance **X-ray:** 20% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	*May require prior authorization.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.allumaco.com	Formulary Generic drugs (Tier 1)	Mayo Clinic Mail Service/Mayo Clinic Outpatient/Alluma: $10 maximum. Deductible does not apply.	Not covered	Mayo Clinic Mail Service, Mayo Clinic Outpatient pharmacy up to 90-day supply, Alluma pharmacy up to 34-day supply. $25 minimum for Tier 2 & 3. *May require prior authorization. $20k lifetime limit to prescription medications for weight loss.
	Formulary Preferred Brand or injectable drugs (Tier 2)	Mayo Clinic Mail Service: 25% coinsurance Mayo Clinic Outpatient: 30% coinsurance Alluma: 40% coinsurance. Deductible does not apply.	Not covered	
	Formulary Non-Preferred drugs (Tier 3)	Mayo Clinic Mail Service/Mayo Clinic Outpatient: 50% coinsurance Alluma: 60% coinsurance. Deductible does not apply.	Not covered	
	Specialty drugs	Covered under Tier 1, 2 or 3	Not covered	Specialty drug information, including formulary tiers, is available at www.allumaco.com. Please see "Important Questions" regarding the plan's out-of-pocket limit. *May require prior authorization.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	*May require prior authorization.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	*May require prior authorization.
If you need immediate medical attention	Emergency room care	Facility: $100 copay/visit. Deductible does not apply. Other: 20% coinsurance	Facility: $100 copay/visit. Deductible does not apply. Other: 20% coinsurance	In-network out-of-pocket applies to out-of-network Emergency room care.
	Emergency medical transportation	No charge. Deductible does not apply.	No charge. Deductible does not apply.	To nearest qualified facility. In-network out-of-pocket applies to out-of-network emergency medical transportation.
	Urgent care	No charge. Deductible does not apply.	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	*Prior authorization is required for out-of-network inpatient admissions. Failure to comply will result in no coverage.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	*Prior authorization is required for out-of-network inpatient admissions. Failure to comply will result in no coverage.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge for office visits for evaluation and diagnosis. Deductible does not apply. For other outpatient services, 20% coinsurance.	**Mental Health:** No charge for office visits for evaluation and diagnosis. Deductible does not apply. For other outpatient services, 20% coinsurance after deductible. **Substance Use Disorders:** No charge for office visits for evaluation and diagnosis. Deductible does not apply. For other outpatient services, 20% coinsurance.	Out-of-network claims will process at in-network benefits, but you might receive a bill from an out-of-network provider for the difference between the provider's charge and what your plan pays (balanced billing).
	Inpatient services	20% coinsurance	**Mental Health:** 20% coinsurance after In-Network deductible **Substance Use Disorders:** 20% coinsurance	Out-of-network claims will process at in-network benefits, but you might receive a bill from an out-of-network provider for the difference between the provider's charge and what your plan pays (balanced billing)

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	No charge. Deductible does not apply.	50% coinsurance	Cost sharing does not apply to in-network preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., certain ultrasounds.)
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	90-day limit per year
	Rehabilitation services	20% coinsurance	50% coinsurance	Limited to 20 physical therapy/year out of network. Visit limits are not applicable to behavioral health conditions.
	Habilitation services	20% coinsurance	50% coinsurance	Limited to 20 physical therapy/year out of network. Visit limits are not applicable to behavioral health conditions.
	Skilled nursing care	20% coinsurance	50% coinsurance	30-day limit per year. *Prior authorization required.
	Durable medical equipment	20% coinsurance	50% coinsurance	*May require prior authorization.
	Hospice services	20% coinsurance	50% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge. Deductible does not apply.	Not covered	Limit of one exam per member per year.
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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

- Dental care (Adult)
- Dental check-up
- Glasses
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs

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- Acupuncture (20 visits/calendar year)
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- Chiropractic care (20 spinal manipulations visits/calendar year)
- Cosmetic surgery (medically necessary only)
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- Hearing aids ($5,000 every three years)
- Non-emergency care when traveling outside the U.S.
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Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: your plan administrator or you may contact Medica at **(866) 839-4015** (TTY: **711**). You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

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

The plan's overall deductible	$600
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$600
Copayments	$10
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,570**

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

The plan's overall deductible	$600
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$600
Copayments	$300
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,000**

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

The plan's overall deductible	$600
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$600
Copayments	$100
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$800**

Note: The amount the patient pays assumes the patient is not participating in a Flexible Spending Account (FSA), a Health Savings Account (HSA), or a Health Reimbursement Arrangement (HRA), including an HRA funded through a Voluntary Employee Beneficiary Association (VEBA-HRA). If you have a FSA, HSA, HRA, or VEBA-HRA, then you may have additional funds that could help cover certain out-of-pocket expenses such as deductibles, copayments, coinsurance, and benefits otherwise not covered.

This self-insured health care plan is sponsored by your employer and administered by Medica Health Plan Solutions (MHPS).
The plan would be responsible for the other costs of these EXAMPLE covered services.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to www.Medica.com/SignIn or call **(866) 839-4015** (TTY: **711**). For general definitions of common terms, such as allowed amount, balanced billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call **(866) 839-4015** (TTY: **711**) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	(In-Network) **$1,100** per person / **$2,200** per family. (Out-of-Network) **$2,300** per person / **$4,600** per family. Deductible amounts incurred will cross over and count in the other network.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care, primary care services, prescription drugs, emergency medical transportation, emergency room facility, urgent care, copayments, prenatal and postnatal office visits in-network are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	(In-Network) **$4,100** per person / **$8,200** per family. (Out-of-Network) **$6,100** per person / **$12,200** per family. Combined medical and pharmacy out-of-pocket.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges (unless balanced billing is prohibited), coinsurance for certain speciality prescription drugs considered non-essential health benefits under the plan, health care this plan doesn't cover, Non-Preferred and Fertility drugs.	Even though you pay these expenses, they don't count towards the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.Medica.com/SignIn or call **(866) 839-4015** (TTY: **711**) for a list of Mayo Medical Plan network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balanced billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	**Primary care:** No charge. Deductible does not apply. **Chiropractic:** 20% coinsurance **Retail Health:** No charge. Deductible does not apply. **Virtual:** No charge. Deductible does not apply.	**Primary care:** 50% coinsurance **Chiropractic:** 50% coinsurance **Retail Health:** 50% coinsurance **Virtual:** 50% coinsurance	Chiropractic care-20 spinal manipulations per calendar year for in-network and out-of-network benefits combined.
	Specialist visit	20% coinsurance	50% coinsurance	None
	Preventive care/ screening/ immunization	No charge. Deductible does not apply.	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Out-of-network preventive services are not covered by the plan. Refractive eye exams not covered.
If you have a test	Diagnostic test (x-ray, blood work)	**Lab:** 20% coinsurance **X-ray:** 20% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	*May require prior authorization.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.allumaco.com**	Formulary Generic drugs (Tier 1)	Mayo Clinic Mail Service/Mayo Clinic Outpatient/Alluma: $10 maximum. Deductible does not apply.	Not covered	Mayo Clinic Mail Service, Mayo Clinic Outpatient pharmacy up to 90-day supply, Alluma pharmacy up to 34-day supply. $25 minimum for Tier 2 & 3. *May require prior authorization. $20k lifetime limit to prescription medications for weight loss.
	Formulary Preferred Brand or injectable drugs (Tier 2)	Mayo Clinic Mail Service: 25% coinsurance Mayo Clinic Outpatient: 30% coinsurance Alluma: 40% coinsurance. Deductible does not apply.	Not covered	
	Formulary Non-Preferred drugs (Tier 3)	Mayo Clinic Mail Service/Mayo Clinic Outpatient: 50% coinsurance Alluma: 60% coinsurance. Deductible does not apply.	Not covered	
	Specialty drugs	Covered under Tier 1, 2 or 3	Not covered	Specialty drug information, including formulary tiers, is available at www.allumaco.com. Please see "Important Questions" regarding the plan's out-of-pocket limit. *May require prior authorization.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	*May require prior authorization.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	*May require prior authorization.
If you need immediate medical attention	Emergency room care	Facility: $100 copay/visit. Deductible does not apply. Other: 20% coinsurance	Facility: $100 copay/visit. Deductible does not apply. Other: 20% coinsurance	In-network out-of-pocket applies to out-of-network Emergency room care.
	Emergency medical transportation	No charge. Deductible does not apply.	No charge. Deductible does not apply.	To nearest qualified facility. In-network out-of-pocket applies to out-of-network emergency medical transportation.
	Urgent care	No charge. Deductible does not apply.	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	*Prior authorization is required for out-of-network inpatient admissions. Failure to comply will result in no coverage.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	*Prior authorization is required for out-of-network inpatient admissions. Failure to comply will result in no coverage.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge for office visits for evaluation and diagnosis. Deductible does not apply. For other outpatient services, 20% coinsurance.	**Mental Health:** No charge for office visits for evaluation and diagnosis. Deductible does not apply. For other outpatient services, 20% coinsurance after deductible. **Substance Use Disorders:** No charge for office visits for evaluation and diagnosis. Deductible does not apply. For other outpatient services, 20% coinsurance.	Out-of-network claims will process at in-network benefits, but you might receive a bill from an out-of-network provider for the difference between the provider's charge and what your plan pays (balanced billing).
	Inpatient services	20% coinsurance	**Mental Health:** 20% coinsurance after In-Network deductible **Substance Use Disorders:** 20% coinsurance	Out-of-network claims will process at in-network benefits, but you might receive a bill from an out-of-network provider for the difference between the provider's charge and what your plan pays (balanced billing).
If you are pregnant	Office visits	No charge. Deductible does not apply.	50% coinsurance	Cost sharing does not apply to in-network preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., certain ultrasounds.)
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	90-day limit per year
	Rehabilitation services	20% coinsurance	50% coinsurance	Limited to 20 physical therapy/year out of network. Visit limits are not applicable to behavioral health conditions.
	Habilitation services	20% coinsurance	50% coinsurance	Limited to 20 physical therapy/year out of network. Visit limits are not applicable to behavioral health conditions.
	Skilled nursing care	20% coinsurance	50% coinsurance	30-day limit per year. *Prior authorization required.
	Durable medical equipment	20% coinsurance	50% coinsurance	*May require prior authorization.
	Hospice services	20% coinsurance	50% coinsurance	None

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge. Deductible does not apply.	Not covered	Limit of one exam per member per year.
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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

The plan's overall deductible	$1,100
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,100
Copayments	$10
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,970**

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

The plan's overall deductible	$1,100
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,100
Copayments	$300
Coinsurance	$20
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,420**

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

The plan's overall deductible	$1,100
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,100
Copayments	$100
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,400**

Note: The amount the patient pays assumes the patient is not participating in a Flexible Spending Account (FSA), a Health Savings Account (HSA), or a Health Reimbursement Arrangement (HRA), including an HRA funded through a Voluntary Employee Beneficiary Association (VEBA-HRA). If you have a FSA, HSA, HRA, or VEBA-HRA, then you may have additional funds that could help cover certain out-of-pocket expenses such as deductibles, copayments, coinsurance, and benefits otherwise not covered.

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Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,100
Copayments	$10
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,970**

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

The plan's overall deductible	$1,100
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,100
Copayments	$300
Coinsurance	$20
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,420**

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

The plan's overall deductible	$1,100
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,100
Copayments	$100
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,400**

Note: The amount the patient pays assumes the patient is not participating in a Flexible Spending Account (FSA), a Health Savings Account (HSA), or a Health Reimbursement Arrangement (HRA), including an HRA funded through a Voluntary Employee Beneficiary Association (VEBA-HRA). If you have a FSA, HSA, HRA, or VEBA-HRA, then you may have additional funds that could help cover certain out-of-pocket expenses such as deductibles, copayments, coinsurance, and benefits otherwise not covered.

This self-insured health care plan is sponsored by your employer and administered by Medica Health Plan Solutions (MHPS).
The plan would be responsible for the other costs of these EXAMPLE covered services.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to www.Medica.com/SignIn or call **(866) 839-4015** (TTY: **711**) . For general definitions of common terms, such as allowed amount, balanced billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call **(866) 839-4015** (TTY: **711**) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	(In-Network) **$1,650** per person / **$3,300** per family. (Out-of-Network) **$3,000** per person / **$6,000** per family. Deductible amounts incurred will cross over and count in the other network tiers.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care and emergency medical transportation are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	(In-Network) **$5,000** per person / **$10,000** per family. (Out-of-Network) **$7,000** per person / **$14,000** per family. Combined medical and pharmacy out-of-pocket.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges (unless balanced billing is prohibited), health care this plan doesn't cover.	Even though you pay these expenses, they don't count towards the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.Medica.com/SignIn or call **(866) 839-4015** (TTY: **711**) for a list of Mayo Medical Plan network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balanced billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	**Primary care:** 20% coinsurance **Chiropractic:** 20% coinsurance **Retail Health:** 20% coinsurance **Virtual Care:** 20% coinsurance	50% coinsurance	Chiropractic care-20 spinal manipulations per calendar year for in-network and out-of-network benefits combined.
	Specialist visit	20% coinsurance	50% coinsurance	None
	Preventive care/ screening/ immunization	No charge. Deductible does not apply.	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Out-of-network preventive services are not covered by the plan. Refractive eye exams not covered.
If you have a test	Diagnostic test (x-ray, blood work)	**Lab:** 20% coinsurance **X-ray:** 20% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	*May require prior authorization.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.allumaco.com**	Formulary Generic drugs (Tier 1)	Mayo Clinic Mail Service: 5% coinsurance Mayo Clinic Outpatient: 10% coinsurance Alluma: 25% coinsurance	Not covered	Mayo Clinic Mail Service, Mayo Clinic Outpatient pharmacy up to 90-day supply, Alluma pharmacy up to 34-day supply. *May require prior authorization. $20k lifetime limit to prescription medications for weight loss.
	Formulary Preferred Brand or injectable drugs (Tier 2)	Mayo Clinic Mail Service: 25% coinsurance Mayo Clinic Outpatient: 30% coinsurance Alluma: 40% coinsurance	Not covered	
	Formulary Non-Preferred drugs (Tier 3)	Mayo Clinic Mail Service/Mayo Clinic Outpatient: 50% coinsurance Alluma: 60% coinsurance	Not covered	
	Specialty drugs	Covered under Tier 1, 2 or 3	Not covered	Specialty drug information available at www.allumaco.com *May require prior authorization.

* For more information about limitations and exceptions see the plan or policy document at www.Medica.com/SignIn or call **(866) 839-4015** (TTY: **711**).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	*May require prior authorization.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	*May require prior authorization.
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	In-network out-of-pocket applies to out-of-network Emergency room care.
	Emergency medical transportation	No charge. Deductible does not apply.	No charge. Deductible does not apply.	To nearest qualified facility. In-network out-of-pocket applies to out-of-network emergency medical transportation.
	Urgent care	20% coinsurance	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	*Prior authorization is required for out-of-network inpatient admissions. Failure to comply will result in no coverage.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	*Prior authorization is required for out-of-network inpatient admissions. Failure to comply will result in no coverage.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance after deductible for office visits for evaluation and diagnosis. For other outpatient services, 20% coinsurance after deductible.	**Mental Health:** 20% coinsurance after deductible for office visits for evaluation and diagnosis. For other outpatient services, 20% coinsurance after deductible. **Substance Use Disorders:** 20% coinsurance after deductible for office visits for evaluation and diagnosis. For other outpatient services, 20% coinsurance.	Out-of-network claims will process at in-network benefits, but you might receive a bill from an out-of-network provider for the difference between the provider's charge and what your plan pays (balanced billing).
	Inpatient services	20% coinsurance	**Mental Health:** 20% coinsurance after In-Network deductible **Substance Use Disorders:** 20% coinsurance	Out-of-network claims will process at in-network benefits, but you might receive a bill from an out-of-network provider for the difference between the provider's charge and what your plan pays (balanced billing).
If you are pregnant	Office visits	20% coinsurance	50% coinsurance	Cost sharing does not apply to in-network preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., certain ultrasounds.)
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	

*For more information about limitations and exceptions see the plan or policy document at www.Medica.com/SignIn or call **(866) 839-4015** (TTY: **711**).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	90-day limit per year
	Rehabilitation services	20% coinsurance	50% coinsurance	Limited to 20 physical therapy/year out of network. Visit limits are not applicable to behavioral health conditions.
	Habilitation services	20% coinsurance	50% coinsurance	Limited to 20 physical therapy/year out of network. Visit limits are not applicable to behavioral health conditions.
	Skilled nursing care	20% coinsurance	50% coinsurance	30-day limit per year. *Prior authorization required.
	Durable medical equipment	20% coinsurance	50% coinsurance	*May require prior authorization.
	Hospice services	20% coinsurance	50% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge. Deductible does not apply.	Not covered	Limit of one exam per member per year.
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

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

- Dental care (Adult)
- Dental check-up
- Glasses
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs

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

- Acupuncture (20 visits/calendar year)
- Bariatric surgery (*prior authorization may be required)
- Chiropractic care (20 spinal manipulations visits/calendar year)
- Cosmetic surgery (medically necessary only)
- Fertility treatment (20%, In-Network only, $25,000 lifetime limit; *prior authorization may be required)
- Hearing aids ($5,000 every three years)
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult) (excluding refractive eye exam)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: your plan administrator or you may contact Medica at **(866) 839-4015** (TTY: **711**). You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Plan Provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al **1 (800) 952-3455** (TTY: **711**).
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1 (800) 952-3455** (TTY: **711**).
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 **1 (800) 952-3455** (TTY: **711**).
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1 (800) 952-3455** (TTY: **711**).

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

About these Coverage Examples:

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

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

The plan's overall deductible	$1,650
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,600
Copayments	$0
Coinsurance	$1,700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,360**

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

The plan's overall deductible	$1,650
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,600
Copayments	$30
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,030**

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

The plan's overall deductible	$1,650
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,300
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,300**

Note: The amount the patient pays assumes the patient is not participating in a Flexible Spending Account (FSA), a Health Savings Account (HSA), or a Health Reimbursement Arrangement (HRA), including an HRA funded through a Voluntary Employee Beneficiary Association (VEBA-HRA). If you have a FSA, HSA, HRA, or VEBA-HRA, then you may have additional funds that could help cover certain out-of-pocket expenses such as deductibles, copayments, coinsurance, and benefits otherwise not covered.

This self-insured health care plan is sponsored by your employer and administered by Medica Health Plan Solutions (MHPS).
The plan would be responsible for the other costs of these EXAMPLE covered services.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to www.Medica.com/SignIn or call **(866) 839-4015** (TTY: **711**). For general definitions of common terms, such as allowed amount, balanced billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call **(866) 839-4015** (TTY: **711**) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0** in-network services. **$50** person or **$100** family for out-of-network.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	Yes. Durable medical equipment: **$50** for in-network and **$50** for out-of-network.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Medical: **$0** for in-network services. **$1,000** per person or **$2,000** per family for out-of-network. Pharmacy out-of-pocket: **$1,500** per person / **$3,000** per family combined for in-network and out-of-network.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges (unless balanced billing is prohibited), health care this plan doesn't cover, Non-Preferred & Fertility drugs.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.Medica.com/SignIn or call **(800) 952-3455** (TTY: **711**) for a list of Mayo Medical Plan network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balanced billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	**Primary care:** No charge **Chiropractic:** Not covered **Retail Health:** No charge **Virtual:** No charge	**Primary care:** 20% coinsurance **Chiropractic:** Not covered **Retail Health:** 20% coinsurance **Virtual:** 20% coinsurance	Chiropractic services, including but not limited to x-rays, office visits and evaluations is not covered.
	Specialist visit	No charge	20% coinsurance	None
	Preventive care/ screening/ immunization	No charge	20% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Out-of-network preventive services with a maximum of $1,000 per person per year.
If you have a test	Diagnostic test (x-ray, blood work)	**Lab:** No charge **X-ray:** No charge	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	*May require prior authorization.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.allumaco.com	Formulary Generic drugs (Tier 1)	Mayo Clinic Mail Service/Mayo Clinic Outpatient/Alluma: $10 maximum	Not covered	Mayo Clinic Mail Service, Mayo Clinic Outpatient pharmacy up to 100-day supply, Alluma pharmacy, up to 34-day supply. $15 minimum for Alluma Tier 2 & 3. $10 minimum for Mayo Clinic Mail Service/Mayo Clinic Outpatient pharmacy Tier 2 & 3. *May require prior authorization. $20k lifetime limit to prescription medications for weight loss.
	Formulary Preferred Brand or injectable drugs (Tier 2)	Mayo Clinic Mail Service: 25% coinsurance Mayo Clinic Outpatient: 30% coinsurance Alluma: 40% coinsurance	Not covered	
	Formulary Non-Preferred drugs (Tier 3)	Mayo Clinic Mail Service/Mayo Clinic Outpatient: 50% coinsurance Alluma: 60% coinsurance	Not covered	
	Specialty drugs	Covered under Tier 1, 2 or 3	Not covered	Specialty drug information available at www.allumaco.com *May require prior authorization.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	*May require prior authorization.
	Physician/surgeon fees	No charge	20% coinsurance	*May require prior authorization.

*For more information about limitations and exceptions see the plan or policy document at www.Medica.com/SignIn or call **(866) 839-4015** (TTY: **711**).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	No charge	0% coinsurance. Deductible does not apply.	In-Network out-of-pocket applies to out-of-network Emergency room care.
	Emergency medical transportation	No charge	No charge. Deductible does not apply.	To nearest qualified facility. In-Network out-of-pocket applies to out-of-network emergency medical transportation.
	Urgent care	No charge	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	*Prior authorization is required for out-of-network inpatient admissions. Failure to comply will resolve in no coverage.
	Physician/surgeon fees	No charge	20% coinsurance	*Prior authorization is required for out-of-network inpatient admissions. Failure to comply will resolve in no coverage.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	20% coinsurance	*Prior authorization is required for out-of-network inpatient admissions. Failure to comply will resolve in no coverage.
	Inpatient services	No charge	20% coinsurance	*Prior authorization is required for out-of-network inpatient admissions. Failure to comply will resolve in no coverage.
If you are pregnant	Office visits	No charge	20% coinsurance	Cost sharing does not apply to in-network preventive services. Depending on the types of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., certain ultrasounds.)
	Childbirth/delivery professional services	No charge	20% coinsurance	
	Childbirth/delivery facility services	No charge	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	90-day limit per year
	Rehabilitation services	No charge	20% coinsurance	Limited to 20 physical therapy/year out of network. Visit limits are not applicable to behavioral health conditions.
	Habilitation services	No charge	20% coinsurance	Limited to 20 physical therapy/year out of network. Visit limits are not applicable to behavioral health conditions.
	Skilled nursing care	No charge	20% coinsurance	30-day limit per year. *Prior authorization required.
	Durable medical equipment	20% coinsurance	20% coinsurance	$50 deductible applies separately for in-network and out-of-network. *May require prior authorization.
	Hospice services	No charge	20% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Limit of one exam per member per year.
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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Excluded Services & Other Covered Services:

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

- Chiropractic care
- Glasses
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs

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

- Acupuncture (20 visits/calendar year)
- Bariatric surgery (*prior authorization may be required)
- Cosmetic surgery (medically necessary only)
- Dental care (Adult)
- Dental check-up
- Fertility treatment (20%, In-Network only, $25,000 lifetime limit; *prior authorization may be required)
- Hearing aids ($5,000 every three years)
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)

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Does this Plan Provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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Chinese (中文): 如果需要中文的帮助，请拨打这个号码 **1 (800) 952-3455** (TTY: **711**).
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1 (800) 952-3455** (TTY: **711**).

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

About these Coverage Examples:

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

The plan's overall deductible	$0
Specialist copayment	$0
Hospital (facility) copayment	$0
Other coinsurance	$0

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$70**

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

The plan's overall deductible	$0
Specialist copayment	$0
Hospital (facility) copayment	$0
Other coinsurance	$0

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$300**

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

The plan's overall deductible	$0
Specialist copayment	$0
Hospital (facility) copayment	$0
Other coinsurance	$0

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$10**

Note: The amount the patient pays assumes the patient is not participating in a Flexible Spending Account (FSA), a Health Savings Account (HSA), or a Health Reimbursement Arrangement (HRA), including an HRA funded through a Voluntary Employee Beneficiary Association (VEBA-HRA). If you have a FSA, HSA, HRA, or VEBA-HRA, then you may have additional funds that could help cover certain out-of-pocket expenses such as deductibles, copayments, coinsurance, and benefits otherwise not covered.

This self insured health care plan is sponsored by your employer and administered by Medica Health Plan Solutions (MHPS).
This plan is a grandfathered plan; refer to the plan document for more information.
The plan would be responsible for the other costs of these EXAMPLE covered services.

Other Legal Notices

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

GRANDFATHERED HEALTH PLAN STATUS

Mayo Clinic has maintained the Mayo Medicare Supplement option under the Mayo Medical Plan as a "grandfathered health plan" under the Patient Protection and Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. As a grandfathered health plan, your coverage under the Mayo Medical Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on essential health benefits. Please note that all other options under the Mayo Medical Plan are non-grandfathered plans.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Human Resources at 507-266-0440 or 1-888-266-0440. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866- 444-3272 or dol.gov/ebsa/healthreform. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans. You may also contact the U.S. Department of Health and Human Services at healthcare.gov.

HIPAA NOTICE OF PRIVACY PRACTICES AVAILABLE ONLINE

The Health Insurance Portability and Accountability Act ("HIPAA") is a federal law that requires covered entities to notify you of the availability of our Notice of Privacy Practices (the "Notice"). Mayo Clinic sponsored group health plans (the "plans") are covered entities under HIPAA. The Notice describes the plans' privacy practices and legal duties, and your rights concerning your protected health information. The plans follow the privacy practices described in the Notice while it is in effect. The plans, other than the EAP, participate in an organized health care arrangement (OHCA) under HIPAA. An OHCA is an arrangement that allows the plans to share protected health information about their plan members to promote the joint operations of the OHCA participating entities. In addition, the plans participate in an OHCA with Mayo Clinic and affiliate hospitals and clinics ("Practice"), as detailed within the Notice. This means that the plans may share your medical information with each other as needed for the purposes of payment and health care operations, as described in the Notice. The plans may also share plan member information with the Practice for joint health care operations such as population health and quality improvement activity. The EAP and the EAP service provider do not share health information with the other plans, the Practice or your employer.

Women's Health and Cancer Rights Act Medical and surgical benefits for women who have undergone or will undergo a mastectomy, a surgical procedure to remove the breast or breast tissue, were expanded under the federal Women's Health and Cancer Rights Act of 1998. The bill has a provision that requires health plans to provide coverage for certain mastectomy-related procedures. As a member of Mayo Medical Plan, you receive coverage for all stages of reconstruction of the breast on which the mastectomy was performed, breast prosthesis (artificial substitute), surgery of the other breast to produce a symmetrical appearance, and physical complications resulting from a mastectomy including but not limited to lymphedemas. Please refer to the online Summary Plan Description for a description of mastectomy-related benefits available under the Mayo Medical Plan.

SPD REFERENCE

You may access an online version of the Summary Plan Descriptions. Go to HR Connect on the Mayo intranet and search "Summary Plan Description", or visit jobs.mayoclinic.org and follow this path: Benefits, Legal Notices.

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