MAYO CLINIC

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 1-866-839-4015. 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 1-866-839-4015 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Tier 1 (In-Network) **$600** per person/ **$1,200** per family. Tier 2 (Expanded In-Network) **$900** per person/ **$1,800** per family. Tier 3 (Out-of-Network) **$1,300** per person/ **$2,600** 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 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?	Tier 1 (In-Network) **$2,600** per person/ **$5,200** per family. Tier 2 (Expanded In-Network) **$3,600** per person/ **$7,200** per family. Tier 3 (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), 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 1-866-839-4015 (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
		Tier 1 In-Network and Tier 2 Expanded In-Network Provider (You will pay the least)	Tier 3 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 year
	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
		Tier 1 In-Network and Tier 2 Expanded In-Network Provider (You will pay the least)	Tier 3 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 *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
		Tier 1 In-Network and Tier 2 Expanded In-Network Provider (You will pay the least)	Tier 3 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 Tier 2 deductible **Substance Use Disorders:** No charge for office visits for evaluation and diagnosis. Deductible does not apply. For other outpatient services, 20% coinsurance	Tier 3 out-of-network claims will process at Tier 2 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 Tier 2 deductible **Substance Use Disorders:** 20% coinsurance	Tier 3 out-of-network claims will process at Tier 2 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	Physical therapy-20 visit limit out-of-network
	Habilitation services	20% coinsurance	50% coinsurance	None
	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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Tier 1 In-Network and Tier 2 Expanded In-Network Provider (You will pay the least)	Tier 3 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	1 pediatric vision screening per year, Birth-6 years
	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/year, Tier 1 & 2 only)
- Bariatric surgery (*prior authorization may be required)
- Chiropractic care (20 spinal manipulations)
- Cosmetic surgery (medically necessary only)
- Fertility treatment (50%, Tier 1 & 2 only, $15,000 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: Medica at 866-839-4015 or the 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 1-866-839-4015. 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.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-952-3455.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-952-3455.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-952-3455.

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	$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 patient pays amounts assume 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 1-866-839-4015. 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 1-866-839-4015 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Tier 1 (In-Network) **$1,100** per person/ **$2,200** per family. Tier 2 (Expanded In-Network) **$1,850** per person/ **$3,700** per family. Tier 3 (Out-of-Network) **$2,300** per person/ **$4,600** 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 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?	Tier 1 (In-Network) **$4,100** per person/ **$8,200** per family. Tier 2 (Expanded In-Network) **$5,100** per person/ **$10,200** per family. Tier 3 (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), 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 1-866-839-4015 (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
		Tier 1 In-Network and Tier 2 Expanded In-Network Provider (You will pay the least)	Tier 3 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 year
	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
		Tier 1 In-Network and Tier 2 Expanded In-Network Provider (You will pay the least)	Tier 3 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** *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
		Tier 1 In-Network and Tier 2 Expanded In-Network Provider (You will pay the least)	Tier 3 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 Tier 2 deductible **Substance Use Disorders:** No charge for office visits for evaluation and diagnosis. Deductible does not apply. For other outpatient services, 20% coinsurance	Tier 3 out-of-network claims will process at Tier 2 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 Tier 2 deductible **Substance Use Disorders:** 20% coinsurance	Tier 3 out-of-network claims will process at Tier 2 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	Physical therapy-20 visit limit out-of-network
	Habilitation services	20% coinsurance	50% coinsurance	None
	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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Tier 1 In-Network and Tier 2 Expanded In-Network Provider (You will pay the least)	Tier 3 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	1 pediatric vision screening per year, Birth-6 years
	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/year, Tier 1 & 2 only)
- Bariatric surgery (*prior authorization may be required)
- Chiropractic care (20 spinal manipulations)
- Cosmetic surgery (medically necessary only)
- Fertility treatment (50%, Tier 1 & 2 only, $15,000 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: Medica at 866-839-4015 or the 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 1-866-839-4015. 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.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-952-3455.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-952-3455.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-952-3455.

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	$1,100
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	$100
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,500**

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	$10
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,210**

Note: The patient pays amounts assume 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 1-866-839-4015. 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 1-866-839-4015 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Tier 1 (In-Network) **$1,600** per person/ **$3,200** per family. Tier 2 (Expanded In-Network) **$2,000** per person/ **$4,000** per family. Tier 3 (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?	Tier 1 (In-Network) **$5,000** per person/ **$10,000** per family. Tier 2 (Expanded In-Network) **$6,000** per person/ **$12,000** per family. Tier 3 (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, 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 1-866-839-4015 (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
		Tier 1 In-Network and Tier 2 Expanded In-Network Provider (You will pay the least)	Tier 3 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	50% coinsurance	Chiropractic care- 20 spinal manipulations per year
	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.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Tier 1 In-Network and Tier 2 Expanded In-Network Provider (You will pay the least)	Tier 3 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	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 Tier 2 deductible **Substance Use Disorders:** No charge for office visits for evaluation and diagnosis. Deductible does not apply. For other outpatient services, 20% coinsurance	Tier 3 out-of-network claims will process at Tier 2 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 Tier 2 deductible **Substance Use Disorders:** 20% coinsurance	Tier 3 out-of-network claims will process at Tier 2 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).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Tier 1 In-Network and Tier 2 Expanded In-Network Provider (You will pay the least)	Tier 3 Out-of-Network Provider (You will pay the most)	
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	
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	Physical therapy-20 visit limit out-of-network
	Habilitation services	20% coinsurance	50% coinsurance	None
	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	1 pediatric vision screening per year, Birth-6 years
	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/year, Tier 1 & 2 only)
- Bariatric surgery (*prior authorization may be required)
- Chiropractic care (20 spinal manipulations)
- Cosmetic surgery (medically necessary only)
- Fertility treatment (50%, Tier 1 & 2 only, $15,000 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: Medica at 866-839-4015 or the 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 1-866-839-4015. 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.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-952-3455.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-952-3455.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-952-3455.

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	$1,600
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	$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	$1,600
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	$1,600
Copayments	$30
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,130**

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

The plan's overall deductible	$1,600
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	$1,600
Copayments	$0
Coinsurance	$50
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,650**

Note: The patient pays amounts assume 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 1-866-839-4015. 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 1-866-839-4015 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 1-866-839-4015 (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 **Chiropractic:** Not covered **Retail Health:** No charge **Virtual:** No charge	**Primary care:** 20% coinsurance **Chiropractic:** Not covered **Retail Health:** 20% coinsurance **Virtual:** 20% coinsurance	None
	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 $500 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	*Prior authorization may be required
	Physician/surgeon fees	No charge	20% coinsurance	*Prior authorization may be required

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 result in no coverage.
	Physician/surgeon fees	No charge	20% coinsurance	None
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 result in no coverage.
	Inpatient services	No charge	20% coinsurance	*Prior authorization is required for out-of-network inpatient admissions. Failure to comply will result 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	Physical therapy-20 visit limit out-of-network
	Habilitation services	No charge	20% coinsurance	None
	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	1 pediatric vision screening per year, Birth-6 years only
	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.)

- 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/year, In-Network only)
- Bariatric surgery (*prior authorization may be required)
- Cosmetic surgery (medically necessary only)
- Dental care (Adult)
- Dental check-up
- Fertility treatment (50%, In-Network only, $15,000 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)

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 1-866-839-4015. 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.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-952-3455.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-952-3455.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-952-3455.

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	$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**

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.

Discrimination is Against the Law

Medica complies with applicable Federal civil rights laws and will not discriminate against any person on the basis of race, color, national origin, age, disability or sex. Medica:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: TTY communication and written information in other formats (large print, audio, other formats).
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters and information written in other languages.

If you need these services, call the number included in this document or on the back of your Medica ID card. If you believe that Medica has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Civil Rights Coordinator, Mail Route CP250, PO Box 9310, Minneapolis, MN 55443-9310, 952-992-3422 (phone/fax), TTY 711, civilrightscoordinator@medica.com.

You can file a grievance in person or by mail, fax, or email. You may also contact the Civil Rights Coordinator if you need assistance with filing a complaint.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

If you want free help translating this information, call the number included in this document or on the back of your Medica ID card.

Si desea asistencia gratuita para traducir esta información, llame al número que figura en este documento o en la parte posterior de su tarjeta de identificación de Medica.

Yog koj xav tau kev pab dawb kom txhais daim ntawv no, hu rau tus xov tooj nyob hauv daim ntawv no los yog nyob nraum qab ntawm koj daim npav Medica ID.

如果您需要免費翻譯此資訊，請致電本文檔中或者在您的Medica ID卡背面包含的號碼。

Nếu quý vị muốn trợ giúp dịch thông tin này miễn phí, hãy gọi vào số có trong tài liệu này hoặc ở mặt sau thẻ ID Medica của quý vị.

Odeeffannoo kana gargaarsa tolaan akka isinii hiikamu yoo barbaaddan, lakkoobsa barruu kana keessatti argamu ykn ka dugda kaardii Waraqaa Eenyummaa Medica irra jiruun bilbila’a.

اذا كنت تريد مساعدة مجانية في ترجمة هذه المعلومات، فاتصل على الرقم الوارد في هذه الوثيقة أو على ظهر بطاقة تعريف ميديكا الخاصة بك.

Если Вы хотите получить бесплатную помощь в переводе этой информации, позвоните по номеру телефона, указанному в данном документе и на обратной стороне Вашей индентификационной карты Medica.

ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປຂໍ້ມູນນີ້ຟຣີ, ໃຫ້ໂທຫາເລກໝາຍທີ່ມີຢູ່ໃນເອກະສານນີ້ ຫຼື ຢູ່ດ້ານຫຼັງຂອງບັດ Medica ຂອງທ່ານ.

이 정보를 번역하는 데 무료로 도움을 받고 싶으시면, 이 문서에 포함된 전화번호나 Medica ID 카드 뒷면의 전화번호로 전화하십시오.

Si vous voulez une assistance gratuite pour traduire ces informations, appelez le numéro indiqué dans ce document ou au dos de votre carte d’identification Medica.

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Díí t’áá jíík’e shá ata’ hodoonih nínízingo éí ninaaltsoos Medica bee néího’dílzinígí bine’déé’ námboo biká’ígíijį’ béésh bee hodíílnih.

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