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 or call 1-866-428-7427. For general definitions of common terms, such as allowed amount, balance 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 1-866-428-7427 to request a copy.

### Important Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>$3,000 per person/ $6,000 per family in-network and $6,750 per person/ $13,500 per family for out-of-network services.</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes. Preventive care, preventive prescriptions and prenatal care from in-network providers and well child and prenatal care from out-of-network providers.</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits">https://www.healthcare.gov/coverage/preventive-care-benefits</a>.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>$5,500 per person/ $11,000 per family in-network. $20,000 per person/ $40,000 per family for out-of-network services.</td>
<td>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.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Premiums, balance-billing charges (unless balanced billing is prohibited), health care this plan doesn’t cover, out-of-network deductible and coinsurance.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td><strong>Will you pay less if you use a network provider?</strong></td>
<td>Yes. See <a href="http://www.Medica.com/FindCare">www.Medica.com/FindCare</a> or call 1-866-428-7427 (TTY: 711) for a list of Essentia Choice Care with Medica network providers.</td>
<td>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 (balance 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.</td>
</tr>
<tr>
<td><strong>Do you need a referral to see a specialist?</strong></td>
<td>No. You don’t need a referral to see a specialist.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
### Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

**Coverage Period:** Beginning on or after 1/1/2023

**MSI Essentia Choice Care with Medica ASO 3000-20% HSA**

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

---

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

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td><strong>In-Network Provider:</strong> Primary care: 20% coinsurance, Chiropractic: 20% coinsurance, Retail Health: 20% coinsurance, Virtual: 20% coinsurance</td>
<td><strong>Out-of-Network Provider:</strong> Primary: 50% coinsurance, Chiropractic: 50% coinsurance, Retail Health: 50% coinsurance, Virtual: 50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Preventive care/ screening/ immunization</td>
<td>No charge. Deductible does not apply.</td>
<td>Well child care: 0% coinsurance, Deductible does not apply. Other services: 50% coinsurance</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td><strong>Lab:</strong> 20% coinsurance, <strong>X-ray:</strong> 20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
</tbody>
</table>
### Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

**Coverage Period:** Beginning on or after 1/1/2023

**MSI Essentia Choice Care with Medica ASO 3000-20% HSA**

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

#### Common Medical Event

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<tr>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Generic drugs | **Preventive:** Designated preventive drugs: No charge. [Deductible](#) does not apply.  
**Retail:** 20% [coinsurance](#)  
**Mail order:** 20% [coinsurance](#) | 50% [coinsurance](#) | Up to a 31-day supply/ retail or 93-day supply/ mail order prescription. Mail order drugs not covered out-of-network. Insulin: Your cost-share will be $0 per retail prescription unit. Some Over the Counter drugs can be obtained with a prescription at the preventive level of coverage. The list of covered drugs changes periodically. Notification of changes will be available 30 days prior to the change taking effect. ACA preventive drugs covered at no charge. [Deductible](#) does not apply. |
| Preferred brand drugs | **Preventive:** Designated pre-ventive drugs: No charge. [Deductible](#) does not apply.  
**Retail:** 20% [coinsurance](#)  
**Mail order:** 20% [coinsurance](#) | 50% [coinsurance](#) | |
| Non-preferred brand drugs | **Preventive:** Benefit does not apply.  
**Retail:** 20% [coinsurance](#)  
**Mail order:** 20% [coinsurance](#) | 50% [coinsurance](#) | |
| Specialty drugs | **Preferred:** 20% [coinsurance](#)  
**Non-Preferred:** 20% [coinsurance](#) | Not covered | Up to a 31-day supply per prescription received from a designated specialty pharmacy. Amounts reimbursed or paid by a [provider](#) or manufacturer, on your behalf for a product or service, will not apply toward your cost share. |
| **If you have outpatient surgery** | | |
| Facility fee (e.g., ambulatory surgery center) | 20% [coinsurance](#) | 50% [coinsurance](#) | ---none--- |
| Physician/surgeon fees | 20% [coinsurance](#) | 50% [coinsurance](#) | ---none--- |
| **If you need immediate medical attention** | | |
| [Emergency room care](#) | 20% [coinsurance](#) | 20% [coinsurance](#) | In-network [deductible](#) and out-of-pocket applies. |
| [Emergency medical transportation](#) | 20% [coinsurance](#) | 20% [coinsurance](#) | In-network [deductible](#) and out-of-pocket applies. |
| Urgent care | 20% [coinsurance](#) | 50% [coinsurance](#) | ---none--- |
| **If you have a hospital stay** | | |
| Facility fee (e.g., hospital room) | 20% [coinsurance](#) | 50% [coinsurance](#) | ---none--- |
| Physician/surgeon fees | 20% [coinsurance](#) | 50% [coinsurance](#) | ---none--- |
| **If you need mental health, behavioral health, or substance abuse services** | | |
| Outpatient services | 20% [coinsurance](#) | 50% [coinsurance](#) | Relationship and family therapy is covered only if there is a clinical diagnosis. |
| Inpatient services | 20% [coinsurance](#) | 50% [coinsurance](#) | Residential treatment is covered as part of inpatient services. |
### Summary of Benefits and Coverage

**What this Plan Covers & What You Pay for Covered Services**

**Coverage Period:** Beginning on or after 1/1/2023

**Plan Type:** PPO

#### MSI Essentia Choice Care with Medica ASO 3000-20% HSA

**Coverage for:** Individual/Family

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>Prenatal care: No charge. <strong>Deductible</strong> does not apply.</td>
<td>Prenatal care: 0% <strong>coinsurance</strong>, <strong>Deductible</strong> does not apply.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Postnatal care: 20% <strong>coinsurance</strong></td>
<td>Postnatal care: 50% <strong>coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>20% <strong>coinsurance</strong></td>
<td>50% <strong>coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>20% <strong>coinsurance</strong></td>
<td>50% <strong>coinsurance</strong></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>20% <strong>coinsurance</strong></td>
<td>50% <strong>coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>20% <strong>coinsurance</strong></td>
<td>50% <strong>coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>20% <strong>coinsurance</strong></td>
<td>50% <strong>coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>20% <strong>coinsurance</strong></td>
<td>50% <strong>coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% <strong>coinsurance</strong></td>
<td>50% <strong>coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>20% <strong>coinsurance</strong></td>
<td>Not covered</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>No charge. <strong>Deductible</strong> does not apply.</td>
<td>0% <strong>coinsurance</strong>, <strong>Deductible</strong> does not apply.</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

**Summary of Benefits and Coverage:**

- **What this Plan Covers & What You Pay for Covered Services**
- **Coverage Period:** Beginning on or after 1/1/2023
- **Plan Type:** PPO
- **Coverage for:** Individual/Family

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**Note:**

- **Deductible** refers to the amount you pay out-of-pocket before the plan starts to cover services.
- **Coinsurance** is a percentage of the costs that you pay for covered services after you meet your deductible.
- **Copayments** are a flat fee you pay for services, regardless of the costs.
- **Preventive services** may include tests, procedures, and care to help prevent or catch health problems early.
- **Home health care** may not be covered by some plans.
- **Hospice services** may be covered separately from other medical care.
- **Children’s eye exam** may not be covered if the plan does not require eye exams for children.
- **Children’s glasses** may not be covered if the plan does not require glasses for children.
- **Children’s dental check-up** may not be covered if the plan does not require dental check-ups for children.

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**End of Summary of Benefits and Coverage**
### 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.)**

- Acupuncture exceeding 20 visits per member per year for in-network and out-of-network acupuncture services combined.
- Bariatric surgery out-of-network
- Cosmetic surgery
- Dental care (Adult)
- Dental check-up
- Glasses
- Hearing aids except for members 18 years of age and younger for hearing loss that is not correctable by other covered procedures; coverage is limited to one hearing aid per ear every three years.
- Infertility treatment exceeding $5,000 medical/$3,000 pharmacy per member per calendar year combined for in-network and out-of-network.
- Long-term care
- Private-duty nursing
- Routine foot care except for specified conditions
- Weight loss programs

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

- Chiropractic care
- 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 Minnesota Department of Commerce at (651) 539-1600 or 1-800-657-3602 or the U.S. Department Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 1-800-952-3455.

**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.
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, kwiijigoh holne’ 1-800-952-3455.

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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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)</th>
<th>Managing Joe’s type 2 Diabetes (a year of routine in-network care of a well-controlled condition)</th>
<th>Mia’s Simple fracture (in-network emergency room visit and follow up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- The plan’s overall deductible $3,000</td>
<td>- The plan’s overall deductible $3,000</td>
<td>- The plan’s overall deductible $3,000</td>
</tr>
<tr>
<td>- Specialist coinsurance 20%</td>
<td>- Specialist coinsurance 20%</td>
<td>- Specialist coinsurance 20%</td>
</tr>
<tr>
<td>- Hospital (facility) coinsurance 20%</td>
<td>- Hospital (facility) coinsurance 20%</td>
<td>- Hospital (facility) coinsurance 20%</td>
</tr>
<tr>
<td>- Other coinsurance 20%</td>
<td>- Other coinsurance 20%</td>
<td>- Other coinsurance 20%</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles $3,000</th>
<th>Copayments $0</th>
<th>Coinsurance $1,400</th>
</tr>
</thead>
<tbody>
<tr>
<td>What isn’t covered</td>
<td>Limits or exclusions $60</td>
<td>The total Peg would pay is $4,460</td>
<td></td>
</tr>
</tbody>
</table>

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)

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles $2,200</th>
<th>Copayments $0</th>
<th>Coinsurance $0</th>
</tr>
</thead>
<tbody>
<tr>
<td>What isn’t covered</td>
<td>Limits or exclusions $0</td>
<td>The total Joe would pay is $2,200</td>
<td></td>
</tr>
</tbody>
</table>

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

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles $2,800</th>
<th>Copayments $0</th>
<th>Coinsurance $0</th>
</tr>
</thead>
<tbody>
<tr>
<td>What isn’t covered</td>
<td>Limits or exclusions $0</td>
<td>The total Mia would pay is $2,800</td>
<td></td>
</tr>
</tbody>
</table>

This self-funded group health plan is sponsored by your employer and administered by Medica Self Insured (MSI). The plan would be responsible for the other costs of these EXAMPLE covered services.
Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

MSI Essentia Choice Care with Medica ASO 3000-20% HSA

Coverage Period: Beginning on or after 1/1/2023
Coverage for: Individual/Family | Plan Type: PPO

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 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.


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