MEDICA®

Beginning on or after 1/1/2019

Medica Elect MN 350-30-20% BENEFIT SUMMARY All coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.		
Partial listing of covered services	**Your cost if you visit a:**	
	Network provider	**Non-Network provider**
Annual Deductible *The amount paid per year before the health plan starts to pay.*	$350 per person $700 per family	$700 per person $1,500 per family
Annual Out-of-Pocket Maximum *The most you pay in a year for health care services covered by your insurance.*	$1,500 per member $3,000 per family	$2,250 per member $5,000 per family
Office visits ● Primary care ● Specialist visits ● Chiropractic care ● Convenience/Virtual care	$30 copay/visit $30 copay/visit $30 copay/visit $15 copay/visit	40% coinsurance 40% coinsurance 40% coinsurance *Chiropractic care is limited to 20 visits per member per year out-of-network.*
Preventive care ● Routine Physical & Eye Exams ● Immunizations & Cancer Screenings ● Well Child Care	No charge No charge No charge	40% coinsurance 40% coinsurance Well child: 0% coinsurance
Lab and Pathology	No charge	Covered as an in-network benefit
X-Ray and Other Imaging ● X-rays ● CT, MRI, PET scans	No charge	Covered as an in-network benefit Covered as an in-network benefit
Prescription Drugs *Up to a 31-day supply per prescription.*	**Generic:** Greater of 20% coinsurance, minimum $10/prescription, maximum $25/prescription **Preferred:** Greater of 20% coinsurance, minimum $10/prescription, maximum $25/prescription **Non-preferred:** Greater of 30% coinsurance, minimum $40/prescription, maximum $55/prescription	40% coinsurance
Specialty Prescription Drugs *Up to a 31-day supply per prescription received from a designated specialty pharmacy.*	**Preferred & Non-preferred:** Greater of 20% coinsurance, minimum $10/ prescription, maximum $25/ prescription	Not covered
Outpatient Hospital Services ● Facility ● Physician/surgeon fees	20% coinsurance 20% coinsurance	40% coinsurance 40% coinsurance
Emergency Services ● Emergency room services ● Emergency medical transportation ● Urgent care	$75 copay/visit. No charge $30 copay/visit.	Covered as an in-network benefit Covered as an in-network benefit Covered as an in-network benefit

Inpatient Hospital Services ● Facility ● Physician	 20% coinsurance 20% coinsurance	 40% coinsurance 40% coinsurance
Behavioral Health/Mental Health & Substance Abuse Care ● Outpatient services ● Inpatient hospital services	 $30 copay/visit. 20% coinsurance	 40% coinsurance 40% coinsurance
Maternity Benefits ● Prenatal care ● Postnatal care ● Delivery & inpatient services	 No charge No charge 20% coinsurance	 Prenatal: 0% coinsurance 40% coinsurance 40% coinsurance
Durable Medical Equipment & Prosthetics	20% coinsurance	40% coinsurance

This health care plan is offered by Medica Insurance Company (MIC). It may not cover all your health care expenses; read your Certificate of Coverage carefully to determine which expenses are covered. This is a benefit summary only and does not outline all of your benefits. If there is a discrepancy between information in this summary and your Certificate of Coverage, the Certificate of Coverage will take precedence in determining your benefits.

This is a high level summary and does not replace your Summary of Benefits and Coverage. Please contact Medica at 1-800-952-3455 to obtain further benefit information.

COM City of Bloomington-BS-1-00119

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.

နမ့်အဲၣ်ဒီးတၢ်ကဟ့ၣ်ထဲစၢၤကလီနၤလၢတၢ်ကွၢ်တၢ်ကျိၤအံၤလၢအကလီန့ၣ်, ကိးလီတဲစိနီၣ်ဂံၢ်လၢအပၣ်ယှာ်လၢလံာ်တီလံာ်မီအပူၤအံၤမ့တမ့ၢ်ဖဲနနီၣ်ငံၤလၢလံာ်အုၣ်သးခိးက့အလီၢ်ခံတကပၤအဖီခိၣ်နူၣ်တက့ၢ်.

Kung nais mo ng libreng tulong sa pagsasalin ng impormasyong ito, tawagan ang numero na kasama sa dokumentong ito o sa likod ng iyong Kard ng Medica ID.

ይህን መረጃ ለመተርጎም ነጻ እርዳታ የሚፈልጉ ከሆነ በዚ ህ ሰነድ ውስጥ ያለውን ቁጥር ወይም Medica መታወቅያ ካርድዎ በስተጀርባ ያለውን ይደውሉ።

Ako želite besplatnu pomoć za prijevod ovih informacija, nazovite broj naveden u ovom dokumentu ili na poleđini svoje ID kartice Medica.

Díí t'áá jíík'e shá ata' hodoonih nínízingo éí ninaaltsoos Medica bee néího'dílzinígí bine'déé' námboo biká'ígíįį' béésh bee hodíilnih.

Wenn Sie bei der Übersetzung dieser Informationen kostenlose Hilfe in Anspruch nehmen möchten, rufen Sie bitte die in diesem Dokument oder auf der Rückseite Ihrer Medica-ID-Karte angegebene Nummer an.