

**Medica Essential MN 2700-0% HSA  
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
<b>Annual Deductible</b> <i>The amount paid per year before the health plan starts to pay.</i>	\$2,700 per member \$5,400 per family	\$6,000 per member \$12,000 per family
<b>Annual Out-of-Pocket Maximum</b> <i>The most you pay in a year for health care services covered by your insurance.</i>	\$2,700 per member \$5,400 per family	\$11,000 per member \$22,000 per family
<b>Office visits</b> <ul style="list-style-type: none"> <li>● Primary care</li> <li>● Specialist visits</li> <li>● Chiropractic care</li> <li>● Convenience/Virtual care</li> </ul>	0% coinsurance 0% coinsurance 0% coinsurance 0% coinsurance	50% coinsurance 50% coinsurance 50% coinsurance 50% coinsurance <i>Chiropractic care is limited to 20 visits per member per year out-of-network.</i>
<b>Preventive care</b> <ul style="list-style-type: none"> <li>● Routine Physical &amp; Eye Exams</li> <li>● Immunizations &amp; Cancer Screenings</li> <li>● Well Child Care</li> </ul>	No charge No charge No charge	50% coinsurance 50% coinsurance Well child: 0% coinsurance
<b>Lab and Pathology</b>	0% coinsurance	Covered as an in-network benefit
<b>X-Ray and Other Imaging</b> <ul style="list-style-type: none"> <li>● X-rays</li> <li>● CT, MRI, PET scans</li> </ul>	0% coinsurance 0% coinsurance	Covered as an in-network benefit Covered as an in-network benefit
<b>Prescription Drugs</b> <i>Up to a 31-day supply per prescription.</i>	<b>Generic:</b> 0% coinsurance <i>No charge for preventive drugs.</i> <b>Preferred:</b> 0% coinsurance <i>No charge for preventive drugs.</i> <b>Non-preferred:</b> 0% coinsurance <i>Preventive drug benefit does not apply.</i>	50% coinsurance
<b>Specialty Prescription Drugs</b> <i>Up to a 31-day supply per prescription received from a designated specialty pharmacy.</i>	<b>Preferred:</b> 0% coinsurance <b>Non-preferred:</b> 0% coinsurance	Not covered
<b>Outpatient Hospital Services</b> <ul style="list-style-type: none"> <li>● Facility</li> <li>● Physician/surgeon fees</li> </ul>	0% coinsurance 0% coinsurance	50% coinsurance 50% coinsurance
<b>Emergency Services</b> <ul style="list-style-type: none"> <li>● Emergency room services</li> <li>● Emergency medical transportation</li> <li>● Urgent care</li> </ul>	0% coinsurance 0% coinsurance 0% coinsurance	Covered as an in-network benefit Covered as an in-network benefit Covered as an in-network benefit

<b>Inpatient Hospital Services</b> <ul style="list-style-type: none"> <li>● Facility</li> <li>● Physician</li> </ul>	0% coinsurance 0% coinsurance	50% coinsurance 50% coinsurance
<b>Behavioral Health/Mental Health &amp; Substance Abuse Care</b> <ul style="list-style-type: none"> <li>● Outpatient services</li> <li>● Inpatient hospital services</li> </ul>	0% coinsurance 0% coinsurance	50% coinsurance 50% coinsurance
<b>Maternity Benefits</b> <ul style="list-style-type: none"> <li>● Prenatal care</li> <li>● Postnatal care</li> <li>● Delivery &amp; inpatient services</li> </ul>	No charge 0% coinsurance 0% coinsurance	Prenatal: 0% coinsurance 50% coinsurance 50% coinsurance
<b>Durable Medical Equipment &amp; Prosthetics</b>	0% coinsurance	50% 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, [civilrightscordinator@medica.com](mailto:civilrightscordinator@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.

إذا 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 идентификационной карты Medica.

ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປຂໍ້ມູນນີ້ພຣີ, 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.

ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປຂໍ້ມູນນີ້ພຣີ, ໃຫ້ໂທຫາເລກໝາຍທີ່ມີຢູ່ໃນເອກະສານນີ້ ຫຼື ຢູ່ດ້ານຫຼັງຂອງບັດ Medica ຂອງທ່ານ.

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

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Dii t'áá jii'k'e shá ata' hodoonih nínizingo éi ninaaltsoos Medica bee néiho'dilzinígi bine'déé' námboo biká'ígííji' béésh bee hodílnih.

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