Medica

Beginning on or after 1/1/2022

MSI Medica Elect ASO 350-30-20% BENEFIT SUMMARY All copayment and 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:**	
	In-Network provider	**Out-of-Network provider**
Annual Deductible *The amount paid per year before the health plan starts to pay.*	$350 per member $700 per family	$700 per member $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	$3,000 per member $6,000 per family
Office visits ● Primary care ● Specialist visits ● Chiropractic care ● Retail Health	$30 copay/ visit $30 copay/ visit $30 copay/ visit $15 copay/ visit *The deductible does not apply.*	40% coinsurance 40% coinsurance 40% coinsurance 40% coinsurance
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. The deductible does not apply.
Lab and Pathology	No charge. Deductible does not apply.	40% coinsurance
X-Ray and Other Imaging ● X-rays ● CT, MRI, PET scans	10% coinsurance 10% coinsurance	10% coinsurance 10% coinsurance
Prescription Drugs *Up to a 31-day supply per prescription.*	*The deductible does not apply.* **Generic** 20% coinsurance, minimum $10/ prescription, maximum $25/ prescription. **Preferred:** 20% coinsurance, minimum $20/ prescription, maximum $50/ prescription **Non-Preferred:** 20% coinsurance, minimum $25/ prescription, maximum $40/ prescription.	50% coinsurance
Specialty Prescription Drugs *Up to a 31-day supply per prescription received from a designated specialty pharmacy.*	**Preferred:**20% coinsurance, minimum $10/ prescription, maximum $25/ prescription. **Non-Preferred:** 20% coinsurance, minimum $25/ prescription, maximum $40/ 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. The deductible does not apply. 20% coinsurance $30 copay/ visit. The deductible does not apply.	$75 copay/visit. The deductible does not apply. 20% coinsurance $30 copay/ visit. The deductible does not apply.
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. The deductible does not apply. 20% coinsurance	40% coinsurance 40% coinsurance
Maternity Benefits • Prenatal care • Postnatal care • Delivery & inpatient services	No charge No charge. 20% coinsurance	Prenatal: 0% coinsurance. The deductible does not apply. 40% coinsurance 40% coinsurance
Durable Medical Equipment & Prosthetics	20% coinsurance	40% coinsurance

This health care plan is administered by Medica Self Insured (MSI). It may not cover all your health care expenses; read your Plan Document 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 Plan Document, the Plan Document 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.

BS-1-00122

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.

နမ့်အဲၣ်ဒိးတၢ်ကိးထံစၢၤကလီနၤတၢ်ဂ့ၢ်တၢ်ကျိၤအံၤလၢအကလီနှၣ်,ကိးလီတဲစိနီၣ်ဂံၢ်လၢအပာ်ယှာ်လၢလံာ်တီလံာ်မီအပူၤအံၤမ့တမ့ၢ်ဖဲနနီၣ်ငစေလံာ်အှၣ်သးခးက့အလိၢ်ခံတကပၤအဖီခိၣ်နှၣ်တက့ၢ်.

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 መታወቂያ 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'ígíįjį' 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.