TWIN CITIES German Immersion SCHOOL

BENEFITS OVERVIEW

Prepared by Kraus-Anderson Insurance

PLAN YEAR: 2023/2024

Address
1031 Como Ave
St. Paul, MN 55103

Phone
Main: 651-492-7106

Online
Website: www.tcgis.com

WELCOME NOTE

At Twin Cities German Immersion School, we are committed to providing you a comprehensive employee benefits program that helps our employees stay healthy, feel secure, and maintain a work/life balance.

EXISTING EMPLOYEES

Please review these materials and enroll in your benefits through EASE during your scheduled open enrollment period.

NEW HIRES

Welcome to Twin Cities German Immersion School! As part of your on-boarding, you'll need to select your benefits through your online benefits program called EASE. You must enroll online during this time in order to receive benefits.

ELIGIBILITY

You are eligible to enroll in your company's available benefits if you are a regular full-time employee scheduled to work at least 30 hours per week. For existing employees, coverage will run from July 1 – June 30. If you're a new hire, benefits start on the date of hire. Eligible dependents include:

- Your legally married spouse
- Your children up to age 26

QUALIFYING EVENTS

IRS regulations restrict your ability to change your elections during the year unless you experience a qualifying life event such as:

- Marriage
- Divorce
- Birth or adoption of a child
- Death of a dependent
- Changes in your or your spouse's employment status
- An involuntary loss of coverage under another plan

You have **30 days** from the date of the qualifying event to make changes to your coverage, as long as the changes are consistent with the qualifying event. Be sure to notify your plan administrator, then you will be provided the opportunity to make your changes using the EASE enrollment portal. You can make changes to your HSA contributions at any time during the year—you just can't exceed the annual limits.

CONTACTS

Refer to this list when you need to contact one of our benefit partners. For general information contact your Plan Administrator.

Member Service Contact Information

	MEDICAL: Medica	952-945-8000	www.medica.com
	HEALTH SAVINGS ACCOUNT (HSA): Further by HealthEquity	651-662-5065	www.hellofurther.com
	FLEXIBLE SPENDING ACCOUNT (FSA): Further by HealthEquity	651-662-5065	www.hellofurther.com
	DENTAL: Lincoln Financial Group	952-883-5000	www.healthpartners.com
	VISION: MetLife	800-942-0854	www.metlife.com
	LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D): Lincoln Financial Group	800-872-1414	www.lincolnfinancial.com
	SHORT-TERM & LONG-TERM DISABILITY: Lincoln Financial Group	800-872-1414	www.lincolnfinancial.com
	CRITICAL ILLNESS & ACCIDENT: MetLife	800-638-5000	www.metlife.com
	PLAN ADMINISTRATOR: Kimberly Reid	651-492-7106 ext. 297	kreid@tcgis.com

MEDICAL

Who is eligible and when:

All active full-time employees working 30 or more hours per week are eligible for medical coverage on the date of hire.

If you are an active employee and elect medical coverage for yourself, you may also cover your eligible dependents. Eligible dependents include your spouse and dependent children under the age of 26.

Plan Information

Carrier: Medica

Group Number:		
	MSI PP MN $850-$40-15% Passport	TBD
	MSI PP MN $850-$40-15% VantagePlus	TBD
	MSI PP MN $850-$40-15% Park Nicollet	TBD
	MSI PP MN $400-$35-10% Passport	TBD
	MSI PP MN $400-$35-10% VantagePlus	TBD
	MSI PP MN $400-$35-10% Park Nicollet	TBD
	MSI PP MN $2000-$25% HSA + Rx Copays Passport	TBD
	MSI PP MN $2000-$25% HSA + Rx Copays VantagePlus	TBD
	MSI PP MN $2000-$25% HSA + Rx Copays Park Nicollet	TBD

Plan Year: July 1, 2023 through June 30, 2024

Deductible Year: Calendar, deductible accumulates January through December

Plan Network: Current provider listings are available at www.medica.com

Plan Options	MN $850-$40-15% Passport, VantagePlus, Park Nicollet		MN $400-$35-10% Passport, VantagePlus, Park Nicollet		MN $2,000-25% HSA + Rx Passport, VantagePlus, Park Nicollet	
	Individual	Family	Individual	Family	Individual	Family
Deductible	$850	$1,700	$400	$800	$2,000	$4,000
Preventive Care www.healthcare.gov for covered screenings	No charge		No charge		No charge	
Coinsurance	15% after deductible		10% after deductible		25% after deductible	
Out of Pocket Maximum	$2,600	$5,200	$1,700	$3,400	$3,000	$6,000
Office Visit	$40 copay		$35 copay		25% after deductible	
Prescription Drug Coverage	Generic: $25 copay Preferred: $45 copay Non-preferred: $70 copay		Generic: $18 copay Preferred: $30 copay Non-preferred: $55 copay		Generic: $30 copay Preferred: $50 copay Non-preferred: $75 copay	
	Check member services for pharmacies within your network					

Refer to the carrier Summary Benefits of Coverage (SBC) for specific details.

PLAN COST

Your employer contributes 90% to the employee's monthly medical premiums. Eligible dependents may participate in the plan and those costs are the responsibility of the employee.

MSI PP MN $850-$40-15% Plan

Plan Options	Passport		VantagePlus, Park Nicollet	
	Total Monthly Cost	Monthly Employee Cost	Total Monthly Cost	Monthly Employee Cost
Employee	$567.70	$56.77	$482.54	$48.25
Employee + 1	$1,245.14	$734.21	$1,058.36	$624.07
Family	$1,440.24	$929.31	$1,224.20	$789.91

MSI PP MN $400-$35-10% Plan

Plan Options	Passport		VantagePlus, Park Nicollet	
	Total Monthly Cost	Monthly Employee Cost	Total Monthly Cost	Total Employee Cost
Employee	$600.00	$60.00	$510.00	$51.00
Employee + 1	$1,315.98	$775.98	$1,118.58	$659.58
Family	$1,522.18	$982.18	$1,293.86	$834.86

MSI PP MN $2,000-25% HSA + Rx Copays Plan

Plan Options	Passport		VantagePlus, Park Nicollet	
	Total Monthly Cost	Monthly Employee Cost	Total Monthly Cost	Total Employee Cost
Employee	$504.42	$50.44	$428.76	$42.87
Employee + 1	$1,106.34	$652.36	$940.38	$554.50
Family	$1,279.68	$825.70	$1,087.72	$701.84

Refer to the carrier Summary Benefits of Coverage (SBC) for specific details.

HEALTH SAVINGS ACCOUNT (HSA)

Who is eligible and when:

All active full-time employees working 30 or more hours per week are eligible for HSA on the date of hire.

Plan Information

Carrier: Further by HealthEquity

What is a HSA?

- Health Savings Account is a tax favored account which allows you and your employer to make contributions to pay for qualified medical expenses for you and your dependents.
- The account is owned by you, the employee, and stays in your name regardless of your employment status.
- Available when you are covered under a qualified high deductible health plan (HDHP).
- Contributions to the account are made pre-tax via payroll deduction, direct deposit, or lump sum.
- Funds roll over from year to year, no use it or lose it provision!
- Investment opportunities are available.
- Contributions can be changed throughout the year, subject to the annual contribution limits.

Eligible expenses:

- Deductible, coinsurance, prescription drugs, dental and vision services.
- COBRA premiums, some Medicare premiums and portions of long-term care insurance premiums.
- For additional information regarding health care expenses recognized by Section 213(d) of the Internal Revenue Code can be found at www.irs.gov.

Tax benefits (three ways to receive tax savings):

- HSA contributions are excluded from federal income tax.
- Interest earnings are tax free.
- Withdrawals for eligible expenses are exempt from federal income tax.

2023 Maximum Contributions:	2024 Maximum Contributions:
Individual: $3,850 per calendar year	Individual: $4,150 per calendar year
Family: $7,750 per calendar year	Family: $8,300 per calendar year
55+ may contribute an additional $1,000 per calendar year	55+ may contribute an additional $1,000 per calendar year

Reimbursements for Qualified Medical Expenses:

- Withdrawals are tax free for the member and their dependents (up to age 23, even if not covered by the health plan).
- Expenses must be incurred after the HSA is established.
- Expenses are reimbursed up to the HSA balance.
- There are no time limits on when expenses can be reimbursed after account has been established.
- Member must retain documents to support reimbursement.

Reimbursements for Non-Qualified Medical Expenses:

- Withdrawal amount is counted as income.
- 20% excise tax applies.
- Withdrawals for those 65+ are counted as income and no excise tax applies.

FLEXIBLE SPENDING ACCOUNT (FSA)

Who is eligible and when:

All active full-time employees working 30 or more hours per week are eligible for the FSA on the date of hire.

Plan Information

Carrier: Further by HealthEquity

Flexible Spending Account (FSA):

Under a Section 125 Plan (also referred to as a Flexible Account for FSA), you may pay your portion of the premium for specific employer-sponsored benefit plans with pre-tax dollars. You can also pay for eligible medical, dental, and vision expenses not covered by your (or your spouse's) health, dental, or vision plans; and dependent care expenses with pre-tax dollars under a Section 125 plan. Your choices will depend upon factors such as your marital status, income level, dependent status, and/or duplicate coverage under a spouse's plan.

Health Care Reimbursement FSA:

You can set aside up to $3,050 in a Health Care Reimbursement FSA each year to help pay for out-of-pocket medical, dental, and vision expenses for you, your spouse, and your dependent child(ren). There is a "use it or lose it," unused funds are not rolled over each year. There is a "roll-over" option, unused funds up to $610 may be rolled over to the following year. Below is a brief list of such expenses:

- Deductibles, coinsurance and/or co-pays under a health, dental, or vision plan
- Eye glasses, contact lenses, cleaning & wetting solutions
- Orthodontia expenses
- Lasik eye surgery or radial keratotomy

Dependent Care Reimbursement FSA:

You can set aside up to $5,000 (up to $2,500 if you're married and filing separate tax returns) in a Dependent Care Reimbursement FSA each year to help you pay for your eligible dependent care expenses, such as day care for your child(ren) or elder care.

If, in order to maintain employment, you are paying for childcare or elder care services, you may be eligible to request reimbursement for some or all of those expenses through this program. Childcare or elder care services may qualify for reimbursement if they meet these requirements:

- The child must be under 13 years old or, if older, mentally or physically incapable of caring for him or herself.
- Must be provided by a facility or caretaker with a registered tax ID number.
- The services may be provided inside or outside your home, but not by someone who is your dependent for income tax purposes, such as an older child, your spouse, or a grandparent who lives with you.

Eligible Expenses:

Please refer to section 213(b) of the Internal Revenue Code, can be found at www.irs.gov

DENTAL

Who is Eligible and When:

All active full-time employees working 30 or more hours per week are eligible for dental coverage on the date of hire.

If you are an active employee and elect coverage for yourself, you may also cover your eligible dependents. Eligible dependents include your spouse and dependent children under the age of 26.

Your employer contributes 90% to the employee's monthly premiums. Eligible dependents may participate in the plan and those costs are the responsibility of the employee.

Plan Information

Carrier: Lincoln Financial Group
Group Number: TBD
Plan Year: July 1, 2023 through June 30, 2024
Plan Network: Current provider listings are available at www.lincolnfinancial.com

Dental	Lincoln	
Network	**In Network**	**Out of Network**
Individual Deductible	$25	$25
Family Deductible	$75	$75
Annual Maximum (per person)	$2,000	
Preventive Services	100%	100%
Basic Services	80%	80%
Major Services	50%	50%
Plan Cost	**Total Monthly Premium**	**Employee Monthly Premium**
Employee Only	$35.91	$3.59
Employee + 1 Dependent	$69.30	$36.98
Family	$94.61	$62.29

Refer to the carrier summary for specific details.

VISION

Who is Eligible and When:

All active full-time employees working 30 or more hours per week are eligible for vision coverage on the date of hire.

If you are an active employee and elect coverage for yourself, you may also cover your eligible dependents. Eligible dependents include your spouse and dependent children under the age of 26.

Coverage is voluntary and 100% paid by the employee.

Plan Information

Carrier: MetLife
Group Number: 05980444
Plan Year: July 1, 2023 through June 30, 2024
Plan Network: Current provider listings are available at www.metlife.com.

Vision	MetLife (In-Network)
Eye Examinations (every 12 months)	$10 copay
Frames (every 12 months)	$150 allowance + 20% off remaining balance
Lenses (every 12 months)	$10 copay
Contacts (every 12 months)	$150 allowance
Members can receive benefit for either glasses OR contacts in a 12-month period, not both.	
Plan Cost	**Total Monthly Premium**
Employee Only	$12.12
Employee + Spouse	$24.33
Employee + Child(ren)	$20.59
Family	$33.95

Refer to the carrier summary for specific details.

LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

Who is Eligible and When:

All active full-time employees working 30 or more hours per week are eligible for Life and Voluntary Life and AD&D insurance on the date of hire.

Carrier: Lincoln Financial Group
Group Number: TBD

Life and AD&D:

Twin Cities German Immersion School provides Group Term Life (GTL) through Lincoln Financial Group of $50,000. Eligible employees are automatically enrolled in GTL at no cost and without Evidence of Insurability (EOI).

Basic accidental death and dismemberment (AD&D) insurance of $50,000 is also part of the basic coverage package. Eligible employees are automatically enrolled at no cost and without EOI.

Voluntary Life:

Twin Cities German Immersion School provides Voluntary Life Insurance through Lincoln Financial Group and is 100% paid by the employee.

	Employer Paid Life and AD&D	Voluntary Life and AD&D
Employee Benefit	$50,000	5 times your annual salary ($500,000 maximum in increments of $10,000)
Spouse Benefit	N/A	50% of the employee coverage amount ($100,000 maximum in increments of $5,000)
Child(ren) Benefit	N/A	Flat Amount: $2,000, $4,000, $8,000, $10,000 or $20,000
Accidental Death and Dismemberment (AD&D)	Included	Included
Guarantee Issue	$50,000	Employees: $150,000 Spouse: $50,000 Dependent children: $10,000
Age Reduction	**Employee:** 35% at age 65; Additional 15% of original amount at age 70	**Employee:** 35% at age 65; Additional 15% of original amount at age 70

Refer to the carrier summary for specific details.

DISABILITY

Who is Eligible and When:

All active full-time employees working 30 or more hours per week are eligible for Disability coverage on the date of hire.

Carrier: Lincoln Financial Group
Group Number: TBD

Coverage is designed to protect employees from income loss and other financial hardship associated with absence from work due to injury, illness, or disease.

Your employer offers coverage for those unscheduled life events. Coverage can help you remain financially stable should you become injured or ill and cannot work.

Your employer contributes 100% to the employee's monthly premiums.

	Short Term Disability	Long Term Disability
Elimination period	7 days for accident 7 days for illness Waiting period waived if admitted to hospital	90 days of disability
Percentage of Income Replaced	60% of weekly income	60% of weekly income
Maximum Benefits Payable	$1,250 per week	$6,000 per week
Maternity Maximum Duration	6 weeks for normal delivery 8 weeks for c-section (Includes elimination period)	N/A
Maximum Benefit Duration	13 weeks	Own occupation: 2 years Any occupation: to Social Security Retirement Age
Pre-existing Conditions	N/A	If an insured becomes disabled in the first twelve months of coverage, the claims team will do a pre-existing diagnosis investigation three months prior to the individual's effective date.
Benefit Taxability	Benefit is not taxable	Benefit is not taxable

Refer to the carrier summary for specific details.

VOLUNTARY ACCIDENT & CRITICAL ILLNESS

Who is Eligible and When:

All active full-time employees working 30 or more hours per week are eligible for Voluntary Accident and Critical Illness coverage on the date of hire.

Carrier: MetLife
Group Number: Voluntary Accident: TBD
Voluntary Critical Illness: TBD

Coverage is 100% paid by the employee.

Voluntary Accident:

Accident insurance will deliver a payment to you for various qualifying incidents. Accident injuries can lead to costly medical care, loss of work time and various other related expenses. Accident insurance can help fill in those coverage gaps as you pay out-of-pocket medical bills. Accident insurance does not replace your medical insurance; instead, it offers additional coverage and financial assistance.

Plan Cost	Voluntary Accident Monthly Premium
Employee Only	$8.37
Employee + Spouse	$16.53
Employee + Child(ren)	$18.64
Family	$23.11

Voluntary Critical Illness:

Critical illness insurance provides coverage for acute illnesses that can be financially catastrophic. The plan specifies a distinct list of conditions that will be covered. When faced with a severe illness and the accompanying medical costs, critical illness insurance can help cover out-of-pocket expenses not covered by your medical insurance. Illness can often lead to extended times away from work, and critical illness benefits can offset some of those lost wages and help you pay routine living expenses.

Voluntary Critical Illness Monthly Premium per $1,000 of Coverage				
Attained Age	**Employee Only**	**Employee + Spouse**	**Employee + Child(ren)**	**Family**
Under 25	$0.63	$1.12	$1.09	$1.58
25-29	$0.65	$1.16	$1.11	$1.62
30-34	$0.77	$1.33	$1.23	$1.79
35-39	$0.84	$1.44	$1.30	$1.90
40-44	$0.92	$1.60	$1.38	$2.06
45-49	$1.19	$2.06	$1.66	$2.52
50-54	$1.56	$2.69	$2.02	$3.15
55-59	$2.04	$3.52	$2.50	$3.98
60-64	$2.63	$4.56	$3.09	$5.02
65-69	$3.49	$6.08	$3.95	$6.54

Refer to the carrier summary for specific details.

METLAW

Who is Eligible and When:

All active full-time employees working 30 or more hours per week are eligible for MetLaw on the date of hire.

Carrier: MetLife
Group Number: 05980444

Coverage is 100% paid by the employee.

MetLaw:

MetLaw provides numerous resources for an unlimited number of matters with an attorney of your choice. MetLaw provides a consultation with an attorney in person or over the phone. They will discuss your rights and responsibilities, review the law and will help you know your options and their recommended course of action.

For more information:

Please visit infolegalplans.com and enter access code GETLAW or call the client service center at 800-821-6400 (Monday – Friday, 8 am to 7 pm EST/EDT).

Plan Costs:

MetLaw covers the employee, spouse and dependents. The premium is taken post tax from your paycheck.

Additional Plan Features:

- Reduced Fees
- Family Matters
- E-Services

Refer to the carrier summary for specific details.

GLOSSARY

Glossary is for benefit general terms and may not all apply to your plan(s).

Allowed Amount - The highest amount that will cover (pay) a service.

Benefit Period - When services are covered under your plan. It also defines the time when benefit maximums, deductibles and coinsurance limits build up. It has a start and end date. It is often one calendar year for health insurance plans. *Example: You may have a plan with a benefit period of January 1 through December 31 that covers 10 physical therapy visits. The 11th or more session will not be covered.*

Brand - A prescription drug product which is manufactured and marketed under a trademark or name by a specific drug manufacturer, or that is identify as a brand name product.

Coinsurance - A certain percent you must pay each benefit period after you have paid your deductible. This payment is for covered services only. You may still have to pay a copay. *Example: Your plan might cover 80 percent of your medical bill. You will have to pay the other 20 percent. The 20 percent is the coinsurance.*

Coinsurance Limit (or Maximum) - The most you will pay in coinsurance costs during a benefit period.

Condition - An injury, ailment, disease, illness or disorder.

Contract - The agreement between an insurance company and the policyholder.

Coordination of Benefits (COB) – A process to determine who pays first when two or more health insurance plans are responsible for paying the same medical claim. You may be required to complete a form from the insurer(s) to help with this determination. Claims are typically held until COB is established.

Copayment (Copay) - The amount you pay to a healthcare provider at the time you receive services. You may have to pay a copay for each covered visit to your doctor, depending on your plan. Not all plans have a copay.

Covered Charges - Charges for covered services that your health plan paid for. There may be a limit on covered charges if you receive services from providers outside your plan's network of providers.

Covered Person - Any person covered under the plan.

Covered Service - A healthcare provider's service or medical supplies covered by your health plan. Benefits will be given for these services based on your plan.

Creditable Coverage - Coverage of a person under any of these:
A group health plan. This includes church and governmental plans.
Health insurance coverage.
Medicare (Part A or Part B of Title XVIII of the Social Security Act).
Medicaid (Title XIX of the Social Security Act, other than coverage consisting only of benefits under Section 1928).
The health plan for active military personnel. This includes TRICARE.
The Indian Health Service or other tribal organization program.
A state health benefits risk pool.
The Federal Employees Health Benefits Program.
A public health plan (as defined in federal regulations).
A health benefit plan under section 5 (c) of the Peace Corps Act.
Any other plan which gives complete hospital, medical and surgical services.

Deductible - The amount you pay for your healthcare services before your health insurer pays. Deductibles are based on your benefit period (typically a year at a time). *Example: If your plan has a $2,000 annual deductible, you will be expected to pay the first $2,000 toward your healthcare services. After you reach $2,000, your health insurer will cover the rest of the costs.*
Dependent Coverage - Coverage for your dependents who qualify.

Emergency Medical Condition - A medical problem with sudden and severe symptoms that must be treated quickly. In an emergency, a person with no medical training and an average knowledge of health/medicine could reasonably expect the problem could:
Put a person's health at serious risk.
Put an unborn child's health at serious risk.
Result in serious damage to the person's body and how his or her body works.
Result in serious damage of a person's organ or any part of the person.

Experimental or Investigational Drug, Device, Medical Treatment or Procedure - These are not approved by the U.S. Food and Drug Administration (FDA) or are not considered the standard of care

Explanation of benefits - the health insurance company's written explanation of how a medical claim was paid. It contains detailed information about what the company paid and what portion of the costs you are responsible for.

Generic - A prescription drug product that is chemically equivalent to a brand-name drug; or that the claims administrator identifies as a generic product based on available data resources.

Health Assessment - A health survey that measures your current health, health risks and quality of life.

Inpatient Services - Services received when admitted to a hospital and a room and board charge is made.

Institution (Institutional) - A hospital or certain other facility.

Legal Guardian - The person who takes care of a child and makes healthcare decision for the child. This person is the natural parent or was made caretaker by a court of law.

Medical Care - Medical services received from a healthcare provider or facility to treat a condition.

Medically Necessary (or Medical Necessity) - Services, supplies or prescription drugs that are needed to diagnose or treat a medical condition. Also, an insurer must decide if this care is:
Accepted as standard practice. It can't be experimental or investigational.
Not just for your convenience or the convenience of a provider.
The right amount or level of service that can be given to you.
Example: Inpatient care is medically necessary if your condition can't be treated properly as an outpatient service.

Medicare - A federal program for people age 65 or older that pays for certain healthcare expenses.

Network Provider/In-network Provider - A healthcare provider who is part of a plan’s network.

Non-covered Charges - Charges for services and supplies that are **not** covered under the health plan. Examples of non-covered charges may include things like acupuncture, weight loss surgery or marriage counseling. Consult your plan for more information.

Non-network Provider/Out-of-network Provider - A healthcare provider who is **not** part of a plan’s network. Costs associated with out-of-network providers may be higher or not covered by your plan. Consult your plan for more information.

Outpatient Services - Services that do not need an overnight stay in a hospital. These services are often provided in a doctor's office, hospital or clinic.

Out-of-pocket Cost - Cost you must pay. Out-of-pocket costs vary by plan and each plan has a maximum out of pocket (MOOP) cost. Consult your plan for more information.

Per Member Per Month (PMPM) - The average cost or quantity per month based on active membership.

Pre-existing condition - a health problem that has been diagnosed, or for which you have been treated, before buying a health insurance plan.

Preventive Care - Regular care that is generally performed by a primary care physician (e.g. physicals, health screenings).

Primary Care Provider - A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider (Healthcare Provider) - A hospital, facility, physician or other licensed healthcare professional.

Urgent Care Provider - A provider of services for health problems that need medical help right away but are not emergency medical conditions.

Specialist - A physician that specializes in a specific area of medicine.

Waiting period - the period of time that an employer makes a new employee wait before he or she becomes eligible for coverage under the company's health plan. Also, the period of time beginning with a policy's effective date during which a health plan may not pay benefits for certain pre-existing conditions.

ADDITIONAL INFORMATION AND 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 or call 952-945-8000 (Minneapolis/St. Paul Metro area) or 1-800-952-3455. 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 1-800-952-3455 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$400** per person/ **$800** per family in-network and **$1,000** per person/ **$2,000** per family for out-of-network services.	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, copayments, hospice, lab services and prescription drugs from in-network providers and prescription drugs, well child and prenatal care out of network.	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?	**$1,700** per person/ **$3,400** per family in-network. **$4,000** per person/ **$8,000** per family for out-of-network services. Pharmacy out-of-pocket: **$1,050** per person/ **$2,100** 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, out-of-network deductible and coinsurance.	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/FindCare or call 952-945-8000 or 1-800-952-3455 (TTY: 711) for a list of Medica Choice with UnitedHealthcare 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 (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.
Do you need a referral to see a specialist?	No. You don't need a referral to see a specialist.	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:** $35 copay/ visit. Deductible does not apply. **Chiropractic:** $35 copay/ visit. Deductible does not apply. **Retail Health:** $20 copay/ visit. Deductible does not apply. **Virtual:** $20 copay/ visit. Deductible does not apply.	**Primary:** 40% coinsurance **Chiropractic:** 40% coinsurance **Retail Health:** 40% coinsurance **Virtual:** 40% coinsurance	In-network primary care visits provided at an outpatient facility may be subject to coinsurance and deductible. Limited to 15 visits per member, per year for out-of-network chiropractic care.
	Specialist visit	$35 copay/ visit. Deductible does not apply.	40% coinsurance	In-network specialist visits provided at an outpatient facility may be subject to coinsurance and deductible.
	Preventive care/ screening/ immunization	No charge. Deductible does not apply.	**Well child care:** 0% coinsurance Deductible does not apply. **Other services:** 40% 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.
If you have a test	Diagnostic test (x-ray, blood work)	**Lab:** No charge. Deductible does not apply. **X-ray:** 10% coinsurance	40% coinsurance	---none---
	Imaging (CT/PET scans, MRIs)	10% coinsurance	40% coinsurance	---none---

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.Medica.com/DrugCost1	Generic drugs	**Retail:** $18/ prescription Deductible does not apply. **Mail order:** $36/ prescription Deductible does not apply.	40% coinsurance. Deductible does not apply.	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	**Retail:** $30/ prescription Deductible does not apply. **Mail order:** $60/ prescription Deductible does not apply.	40% coinsurance. Deductible does not apply.	
	Non-preferred brand drugs	**Retail:** $55/ prescription Deductible does not apply. **Mail order:** $110/ prescription Deductible does not apply.	40% coinsurance. Deductible does not apply.	
	Specialty drugs	**Preferred:** 20% coinsurance. No more than $200 copay/ prescription. Deductible does not apply. **Non-Preferred:** 40% coinsurance. Deductible does not apply.	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)	$120 copay/ visit. Deductible does not apply.	40% coinsurance	---none---
	Physician/surgeon fees	10% coinsurance	40% coinsurance	---none---
If you need immediate medical attention	Emergency room care	$100 copay/ visit. Deductible does not apply.	$100 copay/ visit. Deductible does not apply.	In-network out-of-pocket applies.
	Emergency medical transportation	10% coinsurance	10% coinsurance	In-network deductible and out-of-pocket applies.
	Urgent care	$35 copay/ visit. Deductible does not apply.	$35 copay/ visit. Deductible does not apply.	In-network out-of-pocket 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 have a hospital stay	Facility fee (e.g., hospital room)	$200 copay/ visit. Deductible does not apply.	40% coinsurance	---none---
	Physician/surgeon fees	10% coinsurance	40% coinsurance	---none---
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 copay/ visit. Deductible does not apply.	40% coinsurance	Coinsurance may apply for some in-network outpatient services such as intensive outpatient programs.
	Inpatient services	$200 copay/ visit. Deductible does not apply.	40% coinsurance	Residential treatment is covered as part of inpatient services.
If you are pregnant	Office visits	No charge. Deductible does not apply.	**Prenatal care:** 0% coinsurance. Deductible does not apply. **Postnatal care:** 40% 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	10% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	$200 copay/ visit. Deductible does not apply.	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	40% coinsurance	120 visits in-network and 60 visits out-of-network per member per year.
	Rehabilitation services	$35 copay/ visit. Deductible does not apply.	40% coinsurance	Physical and occupational therapy combined limited to 20 visits out-of-network per member per year. Out-of-network speech therapy is limited to 20 visits per member per year. Visit limits are not applicable to behavioral health conditions.
	Habilitation services	$35 copay/ visit. Deductible does not apply.	40% coinsurance	Physical and occupational therapy combined limited to 20 visits out-of-network per member per year. Out-of-network speech therapy is limited to 20 visits per member per year. Visit limits are not applicable to behavioral health conditions.
	Skilled nursing care	10% coinsurance	40% coinsurance	120 day limit combined in and out-of-network per member per year.
	Durable medical equipment	10% coinsurance	40% coinsurance	---none---
	Hospice services	No charge. Deductible does not apply.	40% coinsurance	---none---

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 your child needs dental or eye care	Children's eye exam	No charge. Deductible does not apply.	40% coinsurance	---none---
	Children's glasses	Not covered	Not covered	Glasses are not covered by the plan.
	Children's dental check-up	Not covered	Not covered	Dental check-ups are not covered by the plan.

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 15 visits per member per year for in-network and out-of-network acupuncture services combined
- Bariatric surgery
- Chiropractic care exceeding 15 visits per member per year 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
- 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.)

- 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.

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	$400
Specialist coinsurance	10%
Hospital (facility) copayment	$200
Other coinsurance	10%

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	$400
Copayments	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$860**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$400
Specialist coinsurance	10%
Hospital (facility) copayment	$200
Other coinsurance	10%

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	$400
Copayments	$400
Coinsurance	$70
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$870**

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

The plan's overall deductible	$400
Specialist coinsurance	10%
Hospital (facility) copayment	$200
Other coinsurance	10%

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	$400
Copayments	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$800**

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.

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 ألرقم 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.

နမ့်အဲၣ်ဒိးတၢ်ကိုးထံစၢၤကလီနှုံနၤတၢ်ဂ့ၢ်တၢ်ကျိၤအံၤလၢအကလီနှၣ်,ကိးလီတဲစိနီၣ်ဂံၢ်လၢအပၣ်ယှာ်လၢလံာ်တီလံာ်မီအပူၤအံၤမ့တမ့ၢ်ဖဲနနီၣ်ငၢ်ခၢၣ်လံာ်အှၣ်သးခးက့အလီၢ်ခံတကပၤအဖီခိၣ်နှၣ်တက့ၢ်.

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 በዝ 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'ígíijį' 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.

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 952-945-8000 (Minneapolis/St. Paul Metro area) or 1-800-952-3455. 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 1-800-952-3455 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$850** per person/ **$1,700** per family in-network and **$1,700** per person/ **$3,400** per family for out-of-network services.	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, copayments, hospice, lab services and prescription drugs from in-network providers and prescription drugs, well child and prenatal care out of network.	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?	**$2,600** per person/ **$5,200** per family in-network. **$5,200** per person/ **$10,400** per family for out-of-network services. Pharmacy out-of-pocket: **$1,250** per person/ **$2,500** 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, out-of-network deductible and coinsurance.	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/FindCare or call 952-945-8000 or 1-800-952-3455 (TTY: 711) for a list of Medica Choice with UnitedHealthcare 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 (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.
Do you need a referral to see a specialist?	No. You don't need a referral to see a specialist.	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:** $40 copay/ visit. Deductible does not apply. **Chiropractic:** $40 copay/ visit. Deductible does not apply. **Retail Health:** $25 copay/ visit. Deductible does not apply. **Virtual:** $25 copay/ visit. Deductible does not apply.	**Primary:** 40% coinsurance **Chiropractic:** 40% coinsurance **Retail Health:** 40% coinsurance **Virtual:** 40% coinsurance	In-network primary care visits provided at an outpatient facility may be subject to coinsurance and deductible. Limited to 15 visits per member, per year for out-of-network chiropractic care.
	Specialist visit	$40 copay/ visit. Deductible does not apply.	40% coinsurance	In-network specialist visits provided at an outpatient facility may be subject to coinsurance and deductible.
	Preventive care/ screening/ immunization	No charge. Deductible does not apply.	**Well child care:** 0% coinsurance Deductible does not apply. **Other services:** 40% 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.
If you have a test	Diagnostic test (x-ray, blood work)	**Lab:** No charge. Deductible does not apply. **X-ray:** 15% coinsurance	40% coinsurance	---none---
	Imaging (CT/PET scans, MRIs)	15% coinsurance	40% coinsurance	---none---

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.Medica.com/DrugCost1	Generic drugs	**Retail:** $25/ prescription Deductible does not apply. **Mail order:** $50/ prescription Deductible does not apply.	40% coinsurance. Deductible does not apply.	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	**Retail:** $45/ prescription Deductible does not apply. **Mail order:** $90/ prescription Deductible does not apply.	40% coinsurance. Deductible does not apply.	
	Non-preferred brand drugs	**Retail:** $70/ prescription Deductible does not apply. **Mail order:** $140/ prescription Deductible does not apply.	40% coinsurance. Deductible does not apply.	
	Specialty drugs	**Preferred:** 20% coinsurance. No more than $200 copay/ prescription. Deductible does not apply. **Non-Preferred:** 40% coinsurance. Deductible does not apply.	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)	$150 copay/ visit. Deductible does not apply.	40% coinsurance	---none---
	Physician/surgeon fees	15% coinsurance	40% coinsurance	---none---
If you need immediate medical attention	Emergency room care	$125 copay/ visit. Deductible does not apply.	$125 copay/ visit. Deductible does not apply.	In-network out-of-pocket applies.
	Emergency medical transportation	15% coinsurance	15% coinsurance	In-network deductible and out-of-pocket applies.
	Urgent care	$40 copay/ visit. Deductible does not apply.	$40 copay/ visit. Deductible does not apply.	In-network out-of-pocket 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 have a hospital stay	Facility fee (e.g., hospital room)	$325 copay/ visit. Deductible does not apply.	40% coinsurance	---none---
	Physician/surgeon fees	15% coinsurance	40% coinsurance	---none---
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40 copay/ visit. Deductible does not apply.	40% coinsurance	Coinsurance may apply for some in-network outpatient services such as intensive outpatient programs.
	Inpatient services	$325 copay/ visit. Deductible does not apply.	40% coinsurance	Residential treatment is covered as part of inpatient services.
If you are pregnant	Office visits	No charge. Deductible does not apply.	**Prenatal care:** 0% coinsurance. Deductible does not apply. **Postnatal care:** 40% 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	15% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	$325 copay/ visit. Deductible does not apply.	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	15% coinsurance	40% coinsurance	120 visits in-network and 60 visits out-of-network per member per year.
	Rehabilitation services	$40 copay/ visit. Deductible does not apply.	40% coinsurance	Physical and occupational therapy combined limited to 20 visits out-of-network per member per year. Out-of-network speech therapy is limited to 20 visits per member per year. Visit limits are not applicable to behavioral health conditions.
	Habilitation services	$40 copay/ visit. Deductible does not apply.	40% coinsurance	Physical and occupational therapy combined limited to 20 visits out-of-network per member per year. Out-of-network speech therapy is limited to 20 visits per member per year. Visit limits are not applicable to behavioral health conditions.
	Skilled nursing care	15% coinsurance	40% coinsurance	120 day limit combined in and out-of-network per member per year.
	Durable medical equipment	15% coinsurance	40% coinsurance	---none---
	Hospice services	No charge. Deductible does not apply.	40% coinsurance	---none---

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 your child needs dental or eye care	Children's eye exam	No charge. Deductible does not apply.	40% coinsurance	---none---
	Children's glasses	Not covered	Not covered	Glasses are not covered by the plan.
	Children's dental check-up	Not covered	Not covered	Dental check-ups are not covered by the plan.

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 15 visits per member per year for in-network and out-of-network acupuncture services combined
- Bariatric surgery
- Chiropractic care exceeding 15 visits per member per year 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
- 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.)

- 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.

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	$850
Specialist copayment	$40
Hospital (facility) copayment	$325
Other coinsurance	15%

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	$850
Copayments	$300
Coinsurance	$300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,510**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$850
Specialist copayment	$40
Hospital (facility) copayment	$325
Other coinsurance	15%

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	$800
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,300**

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

The plan's overall deductible	$850
Specialist copayment	$40
Hospital (facility) copayment	$325
Other coinsurance	15%

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	$850
Copayments	$400
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,350**

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.

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.

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 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.

နမ့်အဲၣ်ဒိးတၢ်ကိုးထံစၢၤကလီနၤလၢတၢ်ကွၢ်တၢ်ကျိၤအံၤလၢအကလီနှၤ်,ကိးလီတဲစိနီၣ်ဂံၢ်လၢအပၣ်ယှာ်လၢလံာ်တီလံာ်မီအပူၤအံၤမ့တမ့ၢ်ဖဲနနီၣ်ငၤလေၢ်အှၣ်သးခးက့အလိၢ်ခံတကပၤအဖီခိၣ်နှၤ်တက့ၢ်.

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'ígíijį' béésh bee hodíílnih.

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.

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 952-945-8000 (Minneapolis/St. Paul Metro area) or 1-800-952-3455. 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 1-800-952-3455 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$2,000** per person/ **$4,000** per family in-network and **$4,000** per person/ **$8,000** per family for out-of-network services.	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, preventive prescriptions and prenatal care from in-network providers and well child and prenatal care from out-of-network providers.	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?	**$3,000** per person/ **$6,000** per family in-network. **$6,000** per person/ **$12,000** per family for out-of-network services.	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, the overall family out-of-pocket limit must be 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, out-of-network deductible and coinsurance.	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/FindCare or call 952-945-8000 or 1-800-952-3455 (TTY: 711) for a list of Medica Choice with UnitedHealthcare 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 (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.
Do you need a referral to see a specialist?	No. You don't need a referral to see a specialist.	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:** 25% coinsurance **Chiropractic:** 25% coinsurance **Retail Health:** 25% coinsurance **Virtual:** 25% coinsurance	**Primary:** 50% coinsurance **Chiropractic:** 50% coinsurance **Retail Health:** 50% coinsurance **Virtual:** 50% coinsurance	Limited to 15 visits per member, per year for out-of-network chiropractic care.
	Specialist visit	25% coinsurance	50% coinsurance	---none---
	Preventive care/ screening/ immunization	No charge. Deductible does not apply.	**Well child care:** 0% coinsurance Deductible does not apply. **Other services:** 50% 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.
If you have a test	Diagnostic test (x-ray, blood work)	**Lab:** 25% coinsurance **X-ray:** 25% coinsurance	50% coinsurance	---none---
	Imaging (CT/PET scans, MRIs)	25% coinsurance	50% coinsurance	---none---

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.Medica.com/DrugCost7	Generic drugs	**Preventive:** Designated preventive drugs: No charge. Deductible does not apply. **Retail:** $30/prescription **Mail order:** $60/prescription	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:** $50/prescription **Mail order:** $100/prescription	50% coinsurance	
	Non-preferred brand drugs	**Preventive:** Benefit does not apply. **Retail:** $75/prescription **Mail order:** $150/prescription	50% coinsurance	
	Specialty drugs	**Preferred:** 25% coinsurance. No more than $200 copay/ prescription. **Non-Preferred:** 45% 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)	25% coinsurance	50% coinsurance	---none---
	Physician/surgeon fees	25% coinsurance	50% coinsurance	---none---
If you need immediate medical attention	Emergency room care	25% coinsurance	25% coinsurance	In-network deductible and out-of-pocket applies.
	Emergency medical transportation	25% coinsurance	25% coinsurance	In-network deductible and out-of-pocket applies.
	Urgent care	25% coinsurance	25% coinsurance	In-network deductible and out-of-pocket applies.
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	50% coinsurance	---none---
	Physician/surgeon fees	25% coinsurance	50% coinsurance	---none---

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 mental health, behavioral health, or substance abuse services	Outpatient services	25% coinsurance	50% coinsurance	---none---
	Inpatient services	25% coinsurance	50% coinsurance	Residential treatment is covered as part of inpatient services.
If you are pregnant	Office visits	**Prenatal care:** No charge. Deductible does not apply. **Postnatal care:** 25% coinsurance	**Prenatal care:** 0% coinsurance. Deductible does not apply. **Postnatal care:** 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	25% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	25% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	25% coinsurance	50% coinsurance	120 visits in-network and 60 visits out-of-network per member per year.
	Rehabilitation services	25% coinsurance	50% coinsurance	Physical and occupational therapy combined limited to 20 visits out-of-network per member per year. Out-of-network speech therapy is limited to 20 visits per member per year. Visit limits are not applicable to behavioral health conditions.
	Habilitation services	25% coinsurance	50% coinsurance	Physical and occupational therapy combined limited to 20 visits out-of-network per member per year. Out-of-network speech therapy is limited to 20 visits per member per year. Visit limits are not applicable to behavioral health conditions.
	Skilled nursing care	25% coinsurance	50% coinsurance	120 day limit combined in and out-of-network per member per year.
	Durable medical equipment	25% coinsurance	50% coinsurance	---none---
	Hospice services	25% coinsurance	50% coinsurance	---none---
If your child needs dental or eye care	Children's eye exam	No charge. Deductible does not apply.	50% coinsurance	---none---
	Children's glasses	Not covered	Not covered	Glasses are not covered by the plan.
	Children's dental check-up	Not covered	Not covered	Dental check-ups are not covered by the plan.

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 15 visits per member per year for in-network and out-of-network acupuncture services combined
- Bariatric surgery
- Chiropractic care exceeding 15 visits per member per year 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
- 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.)

- 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.

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	$2,000
Specialist coinsurance	25%
Hospital (facility) coinsurance	25%
Other coinsurance	25%

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	$2,000
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,060**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$2,000
Specialist coinsurance	25%
Hospital (facility) coinsurance	25%
Other coinsurance	25%

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	$2,000
Copayments	$0
Coinsurance	$50
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,050**

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

The plan's overall deductible	$2,000
Specialist coinsurance	25%
Hospital (facility) coinsurance	25%
Other coinsurance	25%

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	$2,000
Copayments	$0
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,200**

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.

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.

နမ့ၢ်အဲၣ်ဒိးတၢ်ကဟ့ၣ်ထံဝဲၤကလီနၤတၢ်ကွၢ်ကျိၤအံၤလၢအကလီန့ၣ်,ကိးလီတဲစိနီၣ်ဂံၢ်လၢအပၣ်ယှာ်လၢလံာ်တီလံာ်မီအပူၤအံၤမ့တမ့ၢ်ဖဲနနီၣ်ငံခဲလံာ်အှၣ်သးခးကူအလိၢ်ခံတကပၤအဖီခိၣ်န့ၣ်တက့ၢ်.

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'ígíijí' béésh bee hodíílnih.

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.

COMIFB-0119-I

Medica Choice® Passport

THE RIGHT CARE FOR YOU. WHEREVER YOU GO.

Medica Choice Passport gives you access to a large, national network. No matter if you're in your hometown or in another location across the country, you can connect with providers and a system you know and trust.

Features you'll love

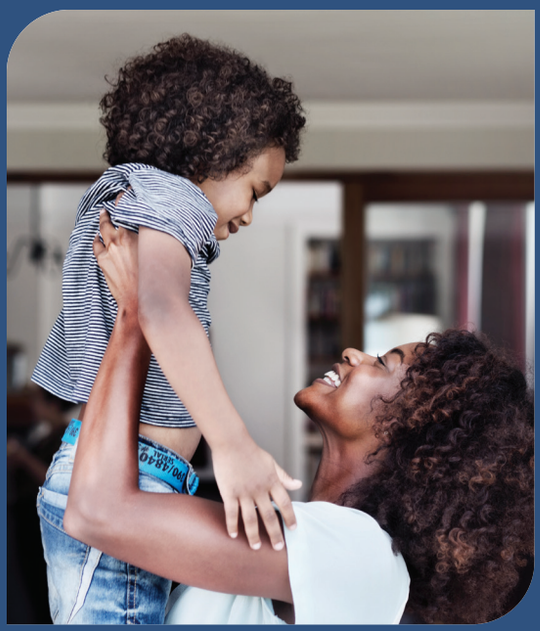
- Choose from any doctor, clinic, or facility in the easy-to-use, nationwide Medica Choice Passport networks.
- Exceptional network discounts and a member experience that's focused squarely on you.
- Travel with peace of mind. You'll find in-network providers in every corner of the country.

Need help? We're here.

Want to know more about your benefits? Have another question? Call Customer Service at the number on the back of your Medica ID card (TTY: **711**). You can reach us Monday-Friday, 7 a.m.-8 p.m. CT (closed 8 a.m.-9 a.m. Thursdays), and Saturday 9 a.m.-3 p.m. CT. To get information about your benefits or care online, go to **Medica.com/Members** and select *Medica Choice Passport*.

- To get the highest level of benefits and pay the lowest costs, see network providers. And while you don't need a referral to see a specialist, it's a good idea to work closely with your primary care doctor to coordinate your health care needs.

Medica



VantagePlus with Medica℠

JUST WHAT THE DOCTOR ORDERED. EASY.

VantagePlus with Medica lets you connect with providers you know and trust. The network includes M Health Fairview, North Memorial Health, and many popular independent clinics. As a member of the VantagePlus network, you'll have in-network access to academic medicine and providers at the University of Minnesota. Plus, high-level trauma care from providers at North Memorial Health.

This unique partnership is called an accountable care organization. Your provider team will help you get the care you need when you need it — and make it as easy as possible. And if you're new to the plan, we'll give you a call to help you get off to a good start.

Features you'll love

- **One phone number** for questions about care, coverage, and more 24/7/365: **1 (866) 882-8493**.
- **Access to any primary or specialty care provider** in the VantagePlus network, including providers at the University of Minnesota, and high-level trauma care at North Memorial Health. Some specialty clinics require that you see a primary care provider first to help guide your care.
- **Pharmacy perks** that include a three-month supply of medication for only two copays when filled at a Fairview or North Memorial Health pharmacy (for members with a copay pharmacy plan).
- **A specially trained pharmacist** who'll make sure your medications are right for your conditions, lifestyle, and budget. This is called Medication Therapy Management.
- **MyChart, a secure online portal** that lets you schedule appointments, pay bills, see test results, request prescription refills, and more. Access MyChart here: **VantagePlusWithMedica.com**.
- **Multiple virtual care options available with M Health Fairview and North Memorial Health providers, including:**
  - 24/7/365 eVisits for many common health conditions. Answer questions about your symptoms through an online tool and providers will respond with a diagnosis and a prescription, if needed.
  - Schedule a phone or video visit with your primary or specialty care provider.
  - Send an online message to your care team through MyChart, anytime. A response is typically available within two business days, often sooner.
  - Virtual care options are available for medical and mental health services.

Medica | HEALTH FAIRVIEW | NORTH MEMORIAL HEALTH

Get the care you need — when and where you need it

- **Direct access** to more than 4,800 providers, 650 clinics, and 11 hospitals.
- **Same-day and virtual appointments** with primary care providers. Many clinics also offer walk-in care, along with early-morning, evening, and weekend hours.
- **Nurse advisors** you can reach 24/7/365.
- **Urgent Care** for issues that aren't life threatening but need attention right away. Open weeknights and often weekends, and/or holidays. No appointment needed.
- **A Travel Program Network** you can use when outside the service area (Minnesota, North Dakota, South Dakota, and western Wisconsin). The program's network is one of the largest in the country. And if you're a parent, even better: It covers your children when they're away at school. If your student is seeking care outside the VantagePlus with Medica service area but within Medica's service area of Minnesota, North Dakota, South Dakota, and western Wisconsin, emergency care services will be covered at the in-network benefit level. For other health care services, they will need to access care from a VantagePlus with Medica network partner for in-network benefits to apply.

Built-in accountability

VantagePlus with Medica is an accountable care organization (ACO). What that means is simple: We partner with a group of doctors, hospitals, and other health care providers to give you high-quality care at a lower cost.

In-network vs. out-of-network

To get the most out of your benefits, remember to see providers in the VantagePlus with Medica network. If you get care outside the network, your costs will be much higher. You can find network providers here: **VantagePlusWithMedica.com**.

Need help? We're here.

Want to know more about your benefits? Have another question? Call **1 (866) 882-8493** (TTY: **711**) 24/7/365. You can also check out **VantagePlusWithMedica.com**.

Medica

Park Nicollet and HealthPartners Medical Group First with Medica℠

A HEALTH PLAN DESIGNED FOR YOU & YOUR FAMILY.

Park Nicollet and HealthPartners Medical Group First with Medica connects you with the providers you know and trust from your neighborhood clinics, specialty centers, and hospitals. We're here for you when you need a well exam, health screenings, immunizations, or an immediate medical need. You can count on us to help you live well at every stage of life.

Features you'll love

- **Access to any Park Nicollet and HealthPartners Medical Group First primary or specialty care provider** without a referral.
- **Direct access to Park Nicollet and HealthPartners specialty centers,** including:
  - Bariatric Surgery & Weight Center
  - Burnsville Same Day Surgery Center
  - Child & Family Behavioral Health (formerly Alexander Center)
  - Family Birth Center
  - Frauenshuh Cancer Center
  - HealthPartners Neuroscience Center
  - HealthPartners Same Day Surgery Center
  - Heart and Vascular Center
  - Jane Brattain Breast Center
  - Joint Replacement Institute
  - Maple Grove Same Day Surgery Center
  - Melrose Center (for eating disorders)
  - Regions Hospital Burn Center
  - Sleep Center
  - St. Louis Park Same Day Surgery Center
  - Struthers Parkinson's Center
  - Women's Center
  - TRIA Orthopedic Center, featuring our Neck and Back Strengthening Program
- **24/7 online care** for diagnosis and treatment of 60 common health conditions at **Virtuwell.com.**

Medica | HealthPartners Park Nicollet

Get the care you need — when and where you need it

- **Direct access** to more than 55 medical and surgical specialties, 50 neighborhood clinics, 18 specialty care centers, 20 urgent care locations, and hospitals recognized as leaders in cancer care, cardiovascular services, maternity care, and neuro-rehabilitation medicine.
- **Same-day primary care appointments**, plus evening and weekend hours.
- **SmartCare℠** for time-saving care when and where you need it — at the clinic, on your phone, or online.
- **Urgent Care** for issues that aren't life threatening but need attention right away. Open late seven days a week; check wait times for your specific urgent care online at **HealthPartners.com.**
- **Nurse advisors** you can reach 24/7/365.
- **A Travel Program Network** you can use when outside the service area (Minnesota, North Dakota, South Dakota, and western Wisconsin). The program's network is one of the largest in the country. And if you're a parent, even better: It covers your children when they're away at school. If your student is seeking care outside the Park Nicollet and HealthPartners Medical Group First service area but within Medica's service area of Minnesota, North Dakota, South Dakota, and western Wisconsin, emergency care services will be covered at the in-network benefit level. For other health care services, they will need to access care from a Park Nicollet and HealthPartners First network partner for in-network benefits to apply.

Built-in accountability

Park Nicollet and HealthPartners Medical Group First with Medica is an accountable care organization (ACO). What that means is simple: We partner with a group of doctors, hospitals, and other health care providers to give you high-quality care at a lower cost.

In-network vs. out-of-network

To get the most out of your benefits, remember to see providers in the Park Nicollet and HealthPartners Medical Group First with Medica network. If you get care outside the network, your costs will be much higher. You can find network providers here: **Medica.com/FindCare** and select *Park Nicollet and HealthPartners Medical Group First with Medica.*

Need help? We're here.

Want to know more about your benefits? Have another question? **Call 1 (855) 727-5178** (TTY: **711**). You can reach us Monday-Friday, 7 a.m. - 8 p.m. CT (closed 8 a.m. - 9 a.m. Thursdays), and Saturday 9 a.m. - 3 p.m. CT. You can also go to **Medica.com/FindCare** and select *Park Nicollet and HealthPartners Medical Group First with Medica.*

Medica

HEALTH CLUB REIMBURSEMENT

240 MORE REASONS TO GET FIT

Looking for reasons to go to the gym? Join Fit Choices℠ by Medica and earn up to a $20 credit each month toward your health club dues when you meet your monthly visit requirement. That's up to $240 a year.

Getting started is simple:

- Find a participating health club near you and learn more about Fit Choices at **medica.com/fitchoices**. The program includes many national, regional and local health clubs.
- Visit the health club and present your Medica ID card.
- Work out at your club. The club tracks your visits and notifies Medica.
- Meet your monthly visit requirement and receive up to a $20 credit toward your monthly health club dues.*

To make sure you are eligible or to learn about your monthly visit requirement and credit, call Customer Service. The number is on the back of your ID card.

Go to **medica.com/fitchoices** for more information about Fit Choices.

*If your monthly dues are less than $20, you'll receive credit for the amount of your dues. Up to two members per eligible Medica policy can earn the $20 credit per month with a single or family health club membership. A maximum of two $20 credits per month. Eligible members must be 18 years of age or older to receive the credit.

COM5455-1-0918

MEDICA®

OVIA HEALTH

DAILY SUPPORT FOR FERTILITY, PREGNANCY AND PARENTING

Ovia Health supports you through your entire parenthood journey. The Ovia Health apps offer personalized guidance, support and coaching to help achieve your health goals, from fertility health tracking, to getting pregnant, to navigating pregnancy, postpartum and parental wellness. Ovia Fertility, Ovia Pregnancy and Ovia Parenting app tools include:

- Health and menstrual cycle tracker
- Pregnancy calendar and daily baby updates
- Child's development checklist
- Daily health and wellness content
- Data and symptom feedback

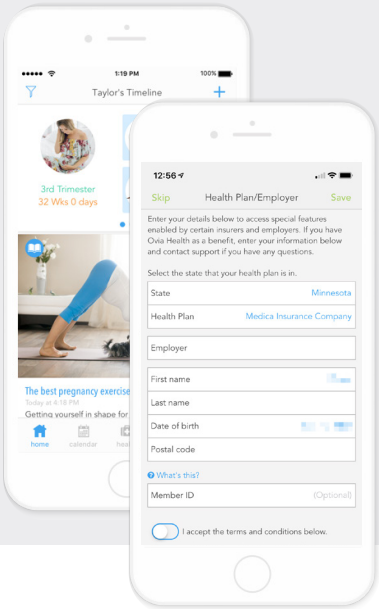
Ovia Fertility

Ovia Pregnancy

Ovia Parenting

Getting started with Ovia

As a Medica member, you'll have access to enhanced and personalized Ovia Health features including one-on-one coaching, symptom tracking, return-to-work tools and more. Simply follow these steps to get started:



1. Download one, or all three Ovia Health apps from the App Store or Google Play: Ovia Fertility, Ovia Pregnancy or Ovia Parenting.

2. When signing up with your email, choose "**I have Ovia Health as a benefit**" before tapping "Sign up".

3. Enter your state, health plan (**Medica**), employer name and personal details.

4. Get started!

oviahealth™

MEDICA®

OVIA FEATURES

Health assessment and symptom tracking
Receive alerts and personal coaching when you need it.

Health and wellness programs
Engage with personalized health and wellness programs to help you navigate infertility, sexual health, birth planning, preterm delivery, mental health, breastfeeding and more.

Unlimited one-on-one coaching
Message instantly with Registered Nurse health coaches to ask all your questions.

Benefits library
Learn about and access your other health care benefits from one centrally located, easy-to-find place.

Career and return-to-work programs
Find coaching and career advice for preparing for maternity leave, returning to work and being a working parent.

GET IT ON Google Play

Download on the App Store

MEDICA®

COM20421-1-00920

Omada for Prevention

Build healthy habits that last

Good news: Changing habits and reducing your risk for chronic disease just got a little easier. Omada for Prevention is a digital lifestyle change program that helps you create healthy routines — and helps you make them stick.* It combines smart health devices with ongoing personal support to help you make the changes that matter most - whether they involve eating, activity, sleep, or stress. Omada offers a better way to lose weight and reduce your risks for type 2 diabetes and heart disease.

Features

Omada can help you learn how to make smart food choices, discover easy ways to boost your activity, and overcome challenges that block you from getting healthier. You'll get support and strategies to help set and reach your goals, including:

- An interactive program with an engaging app to guide your journey anywhere, anytime.
- A wireless smart scale to monitor your progress.
- Weekly online lessons to empower you.
- A professional Omada health coach to keep you on track.
- A small online group of participants to keep you engaged.

If you or your adult dependents are Medica members and are at risk for type 2 diabetes or heart disease, Omada is available at no additional cost. Watch for more program information from your employer when your Medica health plan starts.

*Omada isn't available with all Medica health plans. To check if you're eligible, call our Customer Service team. The number is on the back of your Medica ID card.

Medica | omada

VIRTUAL CARE

SAVE TIME AND CONNECT WITH A PROVIDER ONLINE

Virtual care*, also known as online care or an e-visit, is a convenient way to get care for many common conditions. Connect with a provider from your computer or mobile device to get a diagnosis, treatment plan and prescription (if needed).

Virtual care may be a time-saving option for common conditions like:

- Allergies
- Bladder infection
- Bronchitis
- Cold and cough
- Ear pain
- Flu
- High blood pressure
- Migraines
- Pink eye
- Rashes
- Sinus infection
- Other non-urgent, common health conditions

With a virtual care visit, you:

» Save time — avoid a trip to the doctor's office and get care from the comfort of your home, work or wherever you are.
» Initiate the visit at your convenience — no appointment needed.
» Get care when you need it — visits are often available after clinic hours, sometimes even 24/7.
» May save money — a virtual care visit may cost less than a regular visit to the doctor's office, depending on your plan.

To check your plan's coverage for virtual care, log on to your secure member site (listed on the back of your Medica ID card), select *Look Up My Benefits* and click on *Coverage Documents*. Look for "virtual care" under the Physician Services section. Or call Customer Service at the number on the back of your Medica ID card.

SAVE TIME

» Connect with a provider online.
» Get help for many common conditions.

VIRTUAL CARE OPTIONS

» Many clinics offer options to connect with your provider online.
» Amwell (**Amwell.com/cm**)
» virtuwell® (**Virtuwell.com**)

See the back for more information about these options.

MEDICA®

VIRTUAL CARE OPTIONS

You can access virtual care through providers in your plan's network. Check your virtual care options at **Medica.com/FindaDoctor**. Your virtual care options may include:

YOUR CLINIC	HOW IT WORKS
Many clinics offer virtual care, online care or e-visits. Visit **Medica.com/FindaDoctor** to see which clinics in your plan's network offer virtual care services.	Check with your clinic to see if they offer virtual care and how you can connect with your provider online.

AMWELL	HOW IT WORKS
Amwell is a 24/7 online clinic available in every state. **Services:** ▪ Treatment of common medical conditions. Each visit is $59 or less, depending on your plan's coverage for virtual care. ▪ Behavioral health care services including therapy and psychiatry. Cost per visit may vary depending on your plan and type of service. Eligible services are covered under your plan as a behavioral health office visit.** ▪ Amwell also offers other online services, but is not an in-network provider for those services. You can use those services, but you will pay the full cost. amwell	You have a video visit with a board-certified doctor or nurse practitioner using the web or mobile app. 1. To get started, create an account with Amwell: **Smartphone/tablet**: Download the free Amwell app from the App Store or on Google Play. **Computer**: Go to **Amwell.com/cm**. **Phone**: Call **(844) 733-3627**. 2. Enter your email address, create a password, then add the requested insurance information from your Medica ID card. 3. Select a doctor or nurse practitioner and follow the prompts to start your visit. 4. The provider will review your history, answer questions, diagnose, treat and prescribe medication (if needed). 5. If a prescription is needed, it'll be sent to your pharmacy. The cost of your prescription will be based on your plan's coverage for prescription drugs.

VIRTUWELL	HOW IT WORKS
Virtuwell is a 24/7 online clinic available in select states.*** Virtuwell is not an in-network provider for the following plan networks: Altru and You with Medica℠, Clear Value with Medica℠ and VantagePlus with Medica℠. **Services:** ▪ Treatment of common medical conditions. Check the virtuwell website for the most current pricing. Visits are typically $59 or less, depending on your plan's coverage for virtual care. virtuwell	You have an online visit with a certified nurse practitioner. 1. Go to **Virtuwell.com** and take a quick online interview that checks your medical history and makes sure your problem can be treated online. 2. Once it is determined you can be treated online, you'll create an account including your contact, insurance, pharmacy and payment information. 3. A nurse practitioner will review your case and write a personalized treatment plan. You'll get an email or text when your plan is ready. 4. If a prescription is needed, it'll be sent to your pharmacy. The cost of your prescription will be based on your plan's coverage for prescription drugs.

MEDICA®

***Virtual care is different than receiving care via telemedicine. With telemedicine, you go to a doctor's office or other health care facility and connect with a provider at another location using the phone, internet or another means.**

****To check your plan's coverage for behavioral health, log on to your secure member site (listed on the back of your Medica ID card), select *Look Up My Benefits* and click on *Coverage Documents*. Look for "office visit" under the Behavioral Health — Mental Health section.**

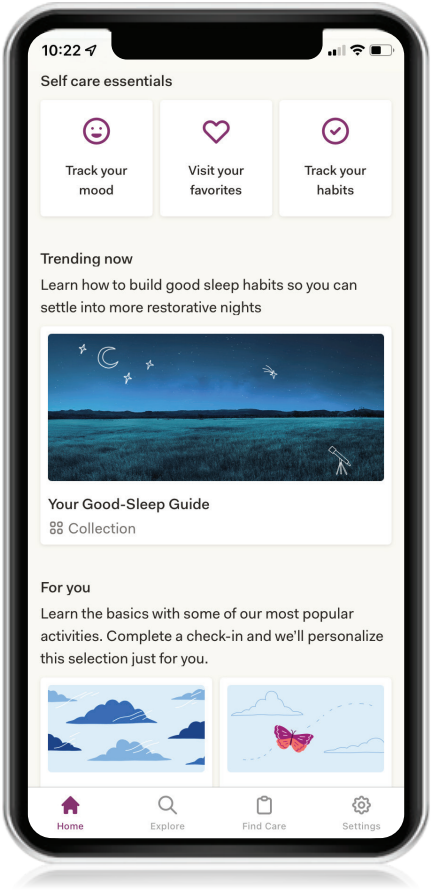
*****Visit virtuwell.com for a list of available states.**

COM9740-1-00221

Self Care by AbleTo

On demand help for stress and emotional well-being

Access self-care techniques, coping tools, meditations, sleep tracking, and more at no additional cost to you — anytime, anywhere with Self Care by AbleTo. Check in and track your progress from your mobile device or computer — then explore personalized content that you can move through at your own pace.



Daily mood tracking

Track your mood, identify patterns, and learn about your progress.

Mental health tools

Learn how to build long-term life skills, like journaling, deep breathing, and positive visualization.

Collections

Feel more in control and get support to cope with stress producing situations — like work, parenting, and social injustice.

Habit tracking

Improve your overall well-being by setting goals and tracking your habits that help identify how your behaviors relate to your emotional health.

AbleTo

Medica | Minnesota Healthcare Consortium

Get started with Self Care

1. Visit **AbleTo.com/Begin** and tap "Get started."
2. When asked for your access code, enter **Medica**. You'll answer a few questions that help us learn more about you and your goals.
3. Set up your account and download the AbleTo app from the App Store or on Google Play.
4. Open the app and select "Log In" to begin your journey.

Get online therapy tailored to your needs

When you need some extra support, you can schedule an online therapy session and talk to a licensed therapist from the comfort of wherever you are. Your therapist will get to know you and work with you on a plan to move forward. It's simple to get started.

1. Set up your account and download the app by following the steps above to get started with Self Care by AbleTo.
2. Open the AbleTo app and tap "Find Care" in the menu.
3. Tap the "Find Care" tile and then tap "Next."
4. Complete the requested information. (If you entered your insurance information when you created your AbleTo account, some of the information will already be populated).
5. Answer a few questions about how you're feeling to find therapists that match your criteria.
6. Select "Schedule Consultation" and follow the prompts to schedule an online visit with a therapist who can help you learn new tools and skills to achieve your goals and help you feel better.

Note: There is a separate cost for online therapy sessions. Sessions are covered under your plan as a behavioral health office visit. Following your visit with a therapist, if you entered your Medica insurance information, AbleTo will send you a bill for any cost share you may have after your plan benefits have been applied.

Have questions? We're here to help.

Call Member Services at the number on the back of your Medica ID card (TTY: **711**).

Self Care by AbleTo should not be used for urgent care needs. If you are experiencing a crisis or need emergency care, call 911 or go to the nearest emergency room. The information contained within Self Care is for educational purposes only; it is not intended to diagnose problems or provide treatment and should not be used on its own as a substitute for care from a provider. Self Care is available to members ages 13+ at no additional cost as part of your benefit plan. Self Care may not be available for all groups in District of Columbia, Maryland, New York, Pennsylvania, Virginia, or West Virginia and is subject to change. Refer to your plan documents for specific benefit coverage and limitations or call Member Services at the number on the back of your Medica ID card. Participation in the program is voluntary and subject to the Self Care terms of use.

Medica

Get online therapy when you need it

When you need some extra support, you can schedule an online therapy session and talk to a licensed therapist from the comfort of wherever you are.* Your therapist will get to know you and work with you on a plan to move forward. It's simple to get started.

1. Open the Sanvello app and tap the therapy scheduling tile.
2. Tap "Get started," select a state, and tap "Next."**
3. Select "I have insurance."
4. At the "Find Your Health Plan" prompt, enter **Medica** and complete the requested information. (If you entered your insurance information when you created your Sanvello account, some of the information will already be populated).
5. Answer a few short questions to find therapists that match your criteria.
6. Choose a therapist who is a good fit for you and select a date and time that works for your schedule.

Note: There is a separate cost for online therapy sessions. Sessions are covered under your plan as a behavioral health office visit. Following your visit with a therapist, if you entered your Medica insurance information, Sanvello will send you a bill for any cost share you may have after your plan benefits have been applied.

Sanvello also offers Coaching that allows you to message with a supportive behavioral health coach and try live, anonymous classes. There is an additional cost for Coaching that it is not covered under your Medica plan. To learn more or to add the Coaching service, tap on the Coaching tile in the Sanvello app.

*The Sanvello mobile application should not be used for urgent care needs. If you are experiencing a crisis or need emergency care, call 911 or go to the nearest emergency room. The information contained in the Sanvello mobile application is for educational purposes only; it is not intended to diagnose problems or provide treatment and should not be used as a substitute for your provider's care. The Sanvello mobile application is available at no out-of-pocket cost to you through your health plan membership. Participation in the program is voluntary and subject to the terms of use contained in the application.

**Online therapy is currently available in select states only. To see a list of states where services are available, go to Sanvello.com.

Medica

Medica Preventive Drug List

(01/01/2023)

Certain health plans provide a specific benefit for preventive outpatient drugs that are considered maintenance drugs used to treat common disease states. Plan terms vary and members should consult their benefit plan documents to determine whether they have coverage for preventive maintenance drugs and, if so, with lower or no member cost sharing. Some strengths or dosage forms, noted with an *, may not be included in the Preventive Drug List, regardless of their appearance in this document. Certain products or categories may not be covered or may be subject to utilization management edits such as step therapy, prior authorization or quantity limits. Please check with your plan provider should you have any questions about coverage. If your benefit includes mail order, please note that some drugs and supplies may not be available through this service.

ANTICOAGULANTS/ ANTIPLATELETS

ANTICOAGULANTS

enoxaparin
fondaparinux
warfarin*
ELIQUIS
XARELTO

PLATELET AGGREGATION INHIBITORS

clopidogrel
dipyridamole
prasugrel
BRILINTA

CORONARY ARTERY DISEASE

ANTIHYPERLIPIDEMICS

atorvastatin
cholestyramine
colesevelam*
colestipol
ezetimibe
fenofibrate*
fenofibric acid*
fenofibric acid delayed-rel
fluvastatin
gemfibrozil
icosapent ethyl
lovastatin
niacin ext-rel
omega-3 acid ethyl esters
pravastatin
rosuvastatin
simvastatin

COMBINATION ANTIHYPERLIPIDEMICS

amlodipine/atorvastatin
ezetimibe/simvastatin

DIABETES

SUPPLIES

INSULIN SYRINGES, AND NEEDLES - BD Products

BLOOD GLUCOSE MONITORS

ACCU-CHEK BLOOD GLUCOSE METER
CONTOUR NEXT BLOOD GLUCOSE METER

INJECTABLE DIABETES AGENTS

HUMULIN R* (U-500 Only)
LEVEMIR
NOVOLIN N, R, 70/30
NOVOLOG
SEMGLEE (YFGN)
TOUJEO
TRESIBA
OZEMPIC
RYBELSUS
TRULICITY
VICTOZA

ORAL DIABETES AGENTS

acarbose
glimepiride
glipizide
glipizide ext-rel
glipizide/metformin
glyburide
glyburide, micronized
glyburide/metformin
metformin
metformin ext-rel
miglitol
nateglinide
pioglitazone
pioglitazone/glimepiride
pioglitazone/metformin
repaglinide
repaglinide/metformin
FARXIGA
JANUMET
JANUMET XR
JANUVIA
JARDIANCE
GLYXAMBI
SEGLUROMET
STEGLATRO
STEGLUJAN
SYNJARDY
SYNJARDY XR
TRIJARDY XR
XIGDUO XR

HYPERTENSION

ACE INHIBITORS/ANGIOTENSIN II RECEPTOR ANTAGONISTS AND COMBINATION AGENTS

amlodipine/benazepril
benazepril
benazepril/hydrochlorothiazide
candesartan
candesartan/hydrochlorothiazide
captopril
captopril/hydrochlorothiazide
enalapril
enalapril/hydrochlorothiazide
eprosartan
fosinopril
fosinopril/hydrochlorothiazide
irbesartan
irbesartan/hydrochlorothiazide
lisinopril
lisinopril/hydrochlorothiazide
losartan
losartan/hydrochlorothiazide
moexipril
moexipril/hydrochlorothiazide

Please note: This list represents brand products in CAPS, branded generics in upper- and lowercase, and generic products in lowercase.
Please check with your plan provider should you have any questions about coverage. Additional medications may be included in this list from time to time in compliance with Affordable Care Act requirements and/or U.S. Internal Revenue Service (IRS) guidance. This list includes medications considered preventive by the IRS; it may not include all preventive medications.

perindopril
quinapril
quinapril/hydrochloro
thiazide
ramipril
telmisartan
telmisartan/hydrochlorothiazide
trandolapril
trandolapril/verapamil ext-rel
valsartan
valsartan/hydrochlorothiazide

BETA-BLOCKERS AND COMBINATION AGENTS
acebutolol
atenolol
atenolol/chlorthalidone
betaxolol
bisoprolol
bisoprolol/hydrochlorothiazide
carvedilol
labetalol
metoprolol
metoprolol succinate ext-rel
metoprolol/hydrochlorothiazide
nadolol
nadolol/bendroflumethiazide
pindolol
propranolol
propranolol ext-rel
propranolol/hydrochlorothiazide
timolol maleate

CALCIUM CHANNEL BLOCKERS AND COMBINATION AGENTS
amlodipine
amiloride/hydrochlorothiazide
diltiazem - select products
felodipine ext-rel
isradipine
nicardipine
nisoldipine ext-rel
verapamil
verapamil ext-rel

DIURETICS
chlorothiazide
chlorthalidone
furosemide
hydrochlorothiazide
indapamide
methyclothiazide
spironolactone
spironolactone/hydrochlorothiazide
torsemide
triamterene/hydrochlorothiazide

OTHER ANTIHYPERTENSIVE AGENTS
amlodipine/telmisartan
amlodipine/valsartan/ hydrochlorothiazide
clonidine
clonidine transdermal
guanfacine
hydralazine
methyldopa
minoxidil

MENTAL HEALTH

ANTIDEPRESSANTS
amitriptyline
amoxapine
bupropion
bupropion ext-rel
citalopram
clomipramine
desipramine
desvenlafaxine succinate ext-rel
doxepin
duloxetine delayed-rel
escitalopram
fluoxetine
fluoxetine delayed-rel
fluvoxamine
imipramine HCl
imipramine pamoate
maprotiline
mirtazapine
nortriptyline
paroxetine HCl
paroxetine HCl ext-rel
phenelzine
protriptyline
sertraline
tranylcypromine
trazodone
trimipramine
venlafaxine
venlafaxine ext-rel

ANTIPSYCHOTICS
aripiprazole
chlorpromazine
clozapine
fluphenazine
haloperidol
loxapine
olanzapine
olanzapine orally disintegrating tabs
paliperidone
perphenazine
quetiapine
quetiapine ext-rel
risperidone
thioridazine
thiothixene
trifluoperazine
ziprasidone
LATUDA

OSTEOPOROSIS

BONE RESORPTION THERAPY
alendronate
ibandronate
raloxifene
risedronate

RESPIRATORY DISORDERS

RESPIRATORY AGENTS
albuterol inhaler*
albuterol nebulizer solution
budesonide inhalation suspension
cromolyn sodium
fluticasone/salmeterol diskus inhaler*
ipratropium nebulizer solution
ipratropium/albuterol nebulizer solution
levalbuterol nebulizer solution
montelukast
theophylline
zafirlukast
zileuton ER
ADVAIR HFA
ARNUITY
ASMANEX HFA
ASMANEX TWISTHALER
BREO ELLIPTA
DULERA
FLOVENT DISKUS
FLOVENT HFA
QVAR REDIHALER
SEREVENT DISKUS
SPIRIVA
SPIRIVA RESPIMAT
SYMBICORT

Over-the-counter (OTC) products require a prescription. Coverage may vary by plan.

Please note: This list represents brand products in CAPS, branded generics in upper- and lowercase, and generic products in lowercase.

Please check with your plan provider should you have any questions about coverage. Additional medications may be included in this list from time to time in compliance with Affordable Care Act requirements and/or U.S. Internal Revenue Service (IRS) guidance. This list includes medications considered preventive by the IRS; it may not include all preventive medications.

Lincoln Financial Group®

All Full-Time Employees of Twin Cities German Immersion School

Benefits At-A-Glance

Dental Insurance

The *Lincoln DentalConnect*® PPO Plan:

- Covers many preventive, basic, and major dental care services
- Features group coverage for Twin Cities German Immersion School employees
- Allows you to choose any dentist you wish, though you can lower your out-of-pocket costs by selecting a network provider
- Does not make you and your loved ones wait six months between routine cleanings

	In-Network	Out-of-Network
Calendar (Annual) Deductible	Individual: $25 Family: $75 Waived for: Preventive	Individual: $25 Family: $75 Waived for: Preventive
Deductibles are combined for basic and major In-Network services. Deductibles are combined for basic and major Out-of-Network services.		
Annual Maximum	$2,000	$2,000
Annual Maximums are combined for preventive, basic, and major services.		
Waiting Period	This plan includes an additional waiting period if you do not enroll within the defined timeframe when it is first offered to you or within an annual open enrollment period. ●0 months for basic services This plan includes an additional waiting period if you do not enroll within the defined timeframe when it is first offered to you or within an annual open enrollment period. ●0 months for basic services	

The Lincoln National Life Insurance Company

Preventive Services	In-Network	Out-of-Network
Routine oral exams Bitewing X-rays Full-mouth or panoramic X-rays Other dental X-rays (including periapical films) Routine cleanings Fluoride treatments	100% No Deductible	100% No Deductible
Basic Services	**In-Network**	**Out-of-Network**
Space maintainers for children Sealants Problem focused exams Palliative treatment (including emergency relief of dental pain) Injections of antibiotics and other therapeutic medications Fillings Prefabricated stainless steel and resin crowns Simple extractions Surgical extractions Oral surgery Biopsy and examination of oral tissue (including brush biopsy) Non-surgical periodontal therapy Periodontal surgery	80% After Deductible	80% After Deductible
Major Services	**In-Network**	**Out-of-Network**
Consultations General anesthesia and I.V. sedation Prosthetic repair and recementation services Bridges Full and partial dentures Denture reline and rebase services Crowns, inlays, onlays and related services TMJ Implants & implant related services	50% After Deductible	50% After Deductible
In-Network/Out-of-Network Dentists	**In-Network**	**Out-of-Network**
To find an in-network dentist near you, visit www.LincolnFinancial.com/FindADentist. This plan lets you choose any dentist you wish. However, your out-of-pocket costs are likely to be lower when you choose an in-network dentist. For example, if you need a crown…	…you pay a deductible (if applicable), then 50% of the remaining discounted fee for PPO members. This is known as a PPO contracted fee.	… you pay a deductible (if applicable), then 50% of the usual and customary fee, which is the maximum expense covered by the plan. You are responsible for the difference between the usual and customary fee and the dentist's billed charge.

With the Lincoln Dental Mobile App

- Find a network dentist near you in minutes
- Have an ID card on your phone
- Customize the app to get details of your plan
- Find out how much your plan covers for checkups and other services
- Keep track of your claims

Lincoln DentalConnect® Online Health Center

- Determine the average cost of a dental procedure
- Have your questions answered by a licensed dentist
- Learn all about dental health for children, from baby's first tooth to dental emergencies
- Evaluate your risk for oral cancer, periodontal disease and tooth decay

Covered Family Members

When you choose coverage for yourself, you can also provide coverage for:

- Your spouse.
- Dependent children, up to age 26.

Benefit Exclusions

Like any coverage, this dental coverage does have some exclusions.

- The plan does not cover services started before coverage begins or after it ends. Benefits are limited to appropriate and necessary procedures listed in the summary plan description. Benefits are not payable for duplication of services. Covered expenses will not exceed the summary plan description's usual and customary allowances.
- Plan benefits are not payable for a condition that is covered under Workers' Compensation or a similar law; that occurs during the course of employment or military service or involvement in an illegal occupation, felony, or riot; or that results from a self-inflicted injury.
- In certain situations, there may be more than one method of treating a dental condition. This summary plan description includes an alternative benefits provision that may reduce benefits to the lowest-cost, generally effective, and necessary form of treatment.
- Certain conditions, such as age and frequency limitations, may impact your coverage. See the summary plan description for details.
- This plan includes continuation of coverage for employees with dental coverage from a previous employer. The member is required to complete the Continuity of Coverage form located on www.lfg.com. The form must be provided to us prior to the effective date to be eligible for continuation of coverage.

A complete list of benefit exclusions is included in the summary plan description.

This is not intended as a complete description of the coverage offered. Controlling provisions are provided in the summary plan description, and this summary does not modify coverage. A summary plan description will be made available to you that describes the benefits in greater detail. Refer to your summary plan description for your maximum benefit amounts.

Lincoln DentalConnect® health center Web content is provided by go2dental.com, Santa Clara, CA. Go2dental.com is not a Lincoln Financial Group® company. Coverage is subject to actual summary plan description language. Each independent company is solely responsible for its own obligations.

The Lincoln National Life Insurance Company (Fort Wayne, IN), does not conduct business in New York, nor is it licensed to do so. In New York, business is conducted by Lincoln Life & Annuity Company of New York (Syracuse NY). Both are Lincoln Financial Group Companies.

Lincoln Financial Group®

Lincoln Financial Group®

Twin Cities German Immersion School provides this valuable benefit at no cost to you.

All Full-Time Employees

Term Life and AD&D Insurance

Safeguard the most important people in your life.

Think about what your loved ones may face after you're gone. Term life insurance can help them in so many ways, like covering everyday expenses, paying off debt, and protecting savings. AD&D provides even more coverage if you die or suffer a covered loss in an accident.

AT A GLANCE:

- A cash benefit of $50,000 to your loved ones in the event of your death, plus a matching cash benefit if you die in an accident
- A cash benefit to you if you suffer a covered loss in an accident, such as losing a limb or your eyesight
- *LifeKeys*® services, which provide access to counseling, financial, and legal support
- *TravelConnect*® services, which give you and your family access to emergency medical assistance when you're on a trip 100+ miles from home

You also have the option to increase your cash benefit by securing additional coverage at affordable group rates. See the enclosed life insurance information for details.

ADDITIONAL DETAILS

Conversion: You can convert your group term life coverage to an individual life insurance policy without providing evidence of insurability if you lose coverage due to leaving your job or for another reason outlined in the plan contract. AD&D benefits cannot be converted.

Continuation of Coverage: You may be able to continue your coverage if you leave your job for any reason other than sickness, injury, or retirement.

Benefit Reduction: Coverage amounts begin to reduce at age 65 and benefits terminate at retirement. See the plan certificate for details.

For complete benefit descriptions, limitations, and exclusions, refer to the certificate of coverage.

Lincoln Financial Group®

Twin Cities German Immersion School provides this valuable benefit at no cost to you.

All Full-Time Employees

Short-term Disability Insurance

Protect your paycheck when you can't work.

Many medical conditions can keep you out of work. Short-term disability insurance helps you meet your financial obligations while you're recovering from an injury, illness, surgery, or childbirth.

AT A GLANCE:

- A cash benefit of 60% of your weekly salary (up to $1,250) when you are out of work for up to 13 weeks due to injury, illness, surgery, or recovery from childbirth
- A partial cash benefit if you can only do part of your job or work part time
- A prompt, responsive claims process

ADDITIONAL DETAILS

Sickness Elimination Period: You must be out of work for 7 days due to an illness before you can collect disability benefits. You can begin collecting benefits on day 8.

Accident Elimination Period: You must be out of work for 7 days due to an accidental injury before you can collect disability benefits. You can begin collecting benefits on day 8.

First Day Hospitalization: The elimination period is reduced if you are hospitalized due to an illness or accidental injury. You can begin collecting benefits on the first day of hospitalization.

Benefits Integration: Your short-term disability benefits can coordinate with income from other sources, such as continued income or sick pay from your employer, during your disability. This allows you to receive up to 100% of your pre-disability income.

For complete benefit descriptions, limitations, and exclusions, refer to the certificate of coverage.

Lincoln Financial Group®

Twin Cities German Immersion School provides this valuable benefit at no cost to you.

All Full-Time Employees

Long-term Disability Insurance

Keep getting a check when you're hurt or sick.

You always have bills to pay, even when you can't get to work due to injury, illness, or surgery. Long-term disability insurance helps you make ends meet during this difficult time.

AT A GLANCE:

- A cash benefit of 50% of your monthly salary (up to $5,000) starting 90 days after you are out of work and continuing up to age 65 or Social Security Normal Retirement Age (SSNRA), whichever is later
- *EmployeeConnect*SM services, which give you and your family confidential access to counselors as well as personal, legal, and financial assistance.
    - Program Services include:
    - Unlimited, 24/7 access to information and referrals
    - In-person help for short-term issues; up to five sessions with a counselor per person, per issue, per year.
    - One free consultation with a network attorney (with subsequent meetings at a reduced fee)
    - Online tools, tutorials, videos and much more

ADDITIONAL DETAILS

Coverage Period for Your Occupation: 24 months. After this initial period, you may be eligible to continue receiving benefits if your disability prohibits you from performing any employment for which you are reasonably suited through your training, education, and experience. In this case, your benefits may be extended through the end of your maximum coverage period (benefit duration).

Pre-existing Condition: If you have a medical condition that begins before your coverage takes effect, and you receive treatment for this condition within the 3 months leading up to your coverage start date, you may not be eligible for benefits for that condition until you have been covered by the plan for 12 months.

For complete benefit descriptions, limitations, and exclusions, refer to the certificate of coverage.

Lincoln Financial Group®

All Full-Time Employees of Twin Cities German Immersion School

Benefits At-A-Glance

Voluntary Term Life and AD&D Insurance

The Lincoln Term Life and AD&D Insurance Plan:

- Provides a cash benefit to your loved ones in the event of your death
- Provides an additional cash benefit to your loved ones if you die — or to you if you lose a limb or your eyesight — in a covered accident when you add optional AD&D insurance
- Features group rates for Twin Cities German Immersion School employees
- Includes *LifeKeys*® services, which provide access to counseling, financial, and legal support services
- Also includes *TravelConnect*® services, which give you and your family access to emergency medical assistance when you're on a trip 100+ miles from home

Employee	
Newly hired employee guaranteed coverage amount	$150,000
Continuing employee guaranteed coverage annual increase amount	Choice of $10,000 or $20,000
Maximum coverage amount	5 times your annual salary ($500,000 maximum in increments of $10,000)
Minimum coverage amount	$10,000
Optional AD&D coverage amount	Equal to the life insurance amount chosen
Spouse	
Newly hired employee guaranteed coverage amount	$50,000
Continuing employee guaranteed coverage annual increase amount	Choice of $5,000 or $10,000
Maximum coverage amount	50% of the employee coverage amount ($100,000 maximum in increments of $5,000)
Minimum coverage amount	$5,000
Optional AD&D coverage amount	Equal to the life insurance amount chosen
Dependent Children	
6 months but less than 26 years (or 26 years if unmarried, & a full-time student) guaranteed coverage amount	$2,000, $4,000, $8,000, $10,000 or $20,000
14 Days but less than 6 months	$2,000, $4,000, $8,000, $10,000 or $20,000
Age 1 day to 14 days guaranteed coverage amount	$2,000

What your benefits cover

Employee Coverage

Guaranteed Life and Optional AD&D Insurance Coverage Amount

- Initial Open Enrollment: When you are first offered this coverage, you can choose a coverage amount up to $150,000 without providing evidence of insurability.
- Annual Limited Enrollment: If you are a continuing employee, you can increase your coverage amount by $10,000 or $20,000 without providing evidence of insurability . If you submitted evidence of insurability in the past and were declined for medical reasons, you may be required to submit evidence of insurability.
- If you decline this coverage now and wish to enroll later, evidence of insurability may be required and may be at your own expense.
- You can increase this amount by up to $20,000 during the next limited open enrollment period.

Maximum Life Insurance Coverage Amount

- You can choose a coverage amount up to 5 times your annual salary ($500,000 maximum) with evidence of insurability. See the Evidence of Insurability page for details.
- The maximum coverage amount for employees 70 and older who are electing coverage for the first time is $50,000.
- Your coverage amount will reduce by 35% when you reach age 65 and an additional 15% of the original amount when you reach age 70.

Spouse Coverage - You can secure term life and AD&D insurance for your spouse if you select coverage for yourself.

Guaranteed Life and Optional AD&D Insurance Coverage Amount

- Initial Open Enrollment: When you are first offered this coverage, you can choose a coverage amount up to 50% of your coverage amount ($50,000 maximum) for your spouse without providing evidence of insurability.
- Annual Limited Enrollment: If you are a continuing employee, you can increase the coverage amount for your spouse by $5,000 or $10,000 without providing evidence of insurability. If you submitted evidence of insurability in the past and were declined for medical reasons, you may be required to submit evidence of insurability.
- If you decline this coverage now and wish to enroll later, evidence of insurability may be required and may be at your own expense.
- You can increase this amount by up to $10,000 during the next limited open enrollment period.

Maximum Life Insurance Coverage Amount

- You can choose a coverage amount up to 50% of your coverage amount ($100,000 maximum) for your spouse with evidence of insurability.
- Coverage amounts are reduced by 35% when an employee reaches age 65 and an additional 15% when an employee reaches age 70.

Dependent Children Coverage - You can secure term life insurance for your dependent children when you choose coverage for yourself.

Guaranteed Life Insurance Coverage Options: $2,000, $4,000, $8,000, $10,000, and $20,000.

Additional Plan Benefits

Accelerated Death Benefit	Included
Premium Waiver	Included
Conversion	Included
Portability	Included
Seat Belt & Airbag	Included with AD&D
Common Carrier	Included with AD&D

Benefit Exclusions

Like any insurance, this term life and AD&D insurance policy does have exclusions.

For life insurance, a suicide exclusion may apply.

For AD&D, benefits will not be paid if death results from suicide, or death/dismemberment occurs while:

- Inflicting or attempting to inflict injury to one's self
- Participating in a riot or as a result of war or act of war
- Serving as a member of the military, including the Reserves and National Guard
- Committing or attempting to commit a felony
- Deliberately inhaling gas (such as carbon monoxide) or using drugs other than those prescribed by a physician and administered as prescribed
- Flying in a non-commercial airplane or aircraft, such as a balloon or glider
- Driving while intoxicated (with a blood alcohol level of .08 grams or more per 100 milliliters of blood)

In addition, the AD&D insurance policy does not cover sickness or disease, including the medical and surgical treatment of a disease.

A complete list of benefit exclusions is included in the policy. State variations apply.

Monthly Voluntary Life and AD&D Insurance Premium
Here's how little you pay with group rates.

Employee Age Range	Life Premium Rate Factor	Life & AD&D Premium Rate Factor
0 - 24	0.0000600	0.0000780
25 - 29	0.0000600	0.0000780
30 - 34	0.0000800	0.0000980
35 - 39	0.0000900	0.0001080
40 - 44	0.0001080	0.0001260
45 - 49	0.0001700	0.0001880
50 - 54	0.0002680	0.0002860
55 - 59	0.0004300	0.0004480
60 - 64	0.0006000	0.0006180
65 - 69	0.0012700	0.0012880
70 - 74	0.0020600	0.0020780
75 - 79	0.0020600	0.0020780
80 - 99	0.0020600	0.0020780

Group Rates for You

The estimated monthly premium for life insurance only or life and optional AD&D insurance is determined by multiplying the desired amount of coverage (in increments of $10,000) by the employee age-range premium factor.

$_____ X _____ = $_____
coverage amount premium factor monthly premium

Note: Rates are subject to change and can vary over time.

Employee Age Range	Life Only Premium Rate Factor	Life & AD&D Premium Rate Factor
0 - 24	0.0000600	0.0000780
25 - 29	0.0000600	0.0000780
30 - 34	0.0000800	0.0000980
35 - 39	0.0000900	0.0001080
40 - 44	0.0001080	0.0001260
45 - 49	0.0001700	0.0001880
50 - 54	0.0002680	0.0002860
55 - 59	0.0004300	0.0004480
60 - 64	0.0006000	0.0006180
65 - 69	0.0012700	0.0012880
70 - 74	0.0020600	0.0020780
75 - 79	0.0020600	0.0020780
80 - 99	0.0020600	0.0020780

Group Rates for Your Spouse

The estimated monthly premium for life insurance only or life and optional AD&D insurance is determined by multiplying the desired amount of coverage (in increments of $5,000) by the employee age-range premium factor.

$_____ X _____ = $_____
coverage amount premium factor monthly premium

Note: Rates are subject to change and can vary over time.

Dependent Children Monthly Premium for Life Insurance Coverage

Coverage Amount	Monthly Premium
$2,000	$0.58
$4,000	$1.17
$8,000	$2.34
$10,000	$2.92
$20,000	$5.84

Group Rates for Your Dependent Children

One affordable monthly premium covers all of your eligible dependent children.

Note: You must be an active Twin Cities German Immersion School employee to select coverage for a spouse and/or dependent children. To be eligible for coverage, a spouse or dependent child cannot be confined to a health care facility or unable to perform the typical activities of a healthy person of the same age and gender.

Because life doesn't always go as planned.

No matter how well you plan, unexpected challenges arise. When they do, help and support are nearby—thanks to *LifeKeys*® services from Lincoln Financial Group.

LifeKeys services include:

Discounts on shopping and entertainment

GuidanceResources® includes 24/7 online access to the Working Advantage discount network. You can save up to 60% on a variety of products and services, including electronics, health and fitness, Broadway shows, and much more. Discounts are also available in the GuidanceNow mobile app, available in the Apple App Store and on Google Play.

Help with important life matters

You'll find support tools and advice on a wide range of topics, including legal, financial, family, and career, on GuidanceResources online. Stay in the know on matters that impact your personal and professional life.

Protection against identity theft

Identity theft is widespread, and everyone is vulnerable. *LifeKeys* includes an online resource for information that can help you recognize and prevent identity theft — and restore your good name should your identity be compromised.

Online will preparation

Creating a will allows you to make vital decisions ahead of time, including naming a guardian for your children or designating who will receive your property and assets after you pass away. Without a will, state officials will distribute your estate. *EstateGuidance*® offers a secure, efficient way to create and execute a will so you can rest easy knowing you've planned ahead for your family.

Guidance and support for your beneficiaries

LifeKeys is a comprehensive program that offers resources to help your loved ones address a range of common concerns should they experience a loss. Services include grief counseling, financial and legal advice, and support when coping with the challenges of day-to-day life. Services are detailed on page 2.

Your life and accidental death and dismemberment (AD&D) insurance policies include access to a wide range of services to help you and your loved ones navigate life's most important matters.

Help, guidance, and support for beneficiaries following a loss

The emotional impact of losing a loved one can be deep and long-lasting. All too often, financial or legal issues can add to the stress. *LifeKeys* services can be a welcome resource for your beneficiaries.

Your beneficiaries will have access to six in-person sessions for grief counseling, legal or financial information, and unlimited phone counseling. Services are available for up to one year after a loss.

Grief counseling — advice, information, and referrals on:

- Coping with loss
- Stress, anxiety, and depression
- Memorial planning information
- Concerns about family, including children and teens

Legal support — access to legal information on:

- Estate and probate law
- Real estate transactions
- Social Security survivor and child benefits
- Important documents for beneficiaries

Financial services — online resources and advice from financial specialists on:

- Estate planning
- Budgeting
- Overcoming debt
- Bankruptcy
- Investments

Help with everyday life — comprehensive information on:

- Finding child care or elder care
- Financing a home
- Moving and relocation
- Making major purchases

Access *LifeKeys* services. Visit GuidanceResources.com, download the GuidanceNow mobile app, or call 855-891-3684. First-time users: enter web ID: LifeKeys.

LincolnFinancial.com

Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates.

Affiliates are separately responsible for their own financial and contractual obligations.

LCN-3985132-121521
MAP 1/22 **Z04**
Order code: LFE-LKEYE-FLI001

Lincoln Financial Group®

LifeKeys® services are provided by ComPsych® Corporation, Chicago, IL. ComPsych® is not a Lincoln Financial Group® company. Coverage is subject to actual contract language. Each independent company is solely responsible for its own obligations. GuidanceResources® is a trademark of ComPsych® Corporation.

State limitations apply. Beneficiary grief counseling is the only benefit available to a beneficiary(ies) of policies issued in the state of New York. Online will prep is the only benefit available to insured employee and dependents of policies issued in the state of Washington.

Lincoln FuneralPrep: Help when you need it most

With many details to manage and decisions to make, the funeral planning process can be overwhelming. To help you every step of the way, we've partnered with **FuneralDecisions.com** to provide Lincoln FuneralPrep, a comprehensive planning service.

What is Lincoln FuneralPrep?

An online portal that provides a breadth of resources, Lincoln FuneralPrep can help with at-need planning or pre-planning — 24 hours a day.

At-need planning

When grieving the loss of a loved one, you're dealing with far more than a life insurance claim. Lincoln FuneralPrep helps you reduce the stress and uncertainty of making urgent decisions during an emotional time.

Pre-planning

Being prepared is one of the best things you can do for your family. In addition to providing pre-planning resources, Lincoln FuneralPrep can direct you to funeral professionals who can provide expert guidance and advice.

How to access Lincoln FuneralPrep

You can access Lincoln FuneralPrep in two ways.

1 Visit the self-service online portal: LincolnFuneralPrep.com/GPLife.

The online portal at LincolnFuneralPrep.com/GPLife includes a wealth of online funeral planning resources and services, including the ability to:

Search for funeral homes

Access an interactive list of funeral homes and cemeteries around the country. You can filter by location, service, and budget.

Access market information

Review price ranges and service options in your selected geographic location.

View guides and checklists

Organize your priorities, consider your options, and make informed decisions based on your preferences with our handy online guides and checklists.

2 Connect with a funeral planning consultant

Work with a funeral planning expert who can guide you through the pre-planning process and:

Help compare options

Get help comparing pre-planning options, even if you don't have a specific funeral home in mind.

Provide personalized service

Work with our experts to ensure your plans reflect your wishes and meet your objectives.

Offer objective guidance

Get guidance on planning options and various funding strategies.

LincolnFinancial.com

Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates.

Affiliates are separately responsible for their own financial and contractual obligations.

LCN-3795167-092721
ADA 1/23 **Z08**
Order code: LFE-FNPRP-FLI001

During difficult times, we're here for you and your loved ones.

To learn more, visit LincolnFuneralPrep.com/GPlife.

Lincoln Financial Group®

Group insurance products and services described herein are issued by The Lincoln National Life Insurance Company.

Not available in New York.

Caring support and assistance when you travel

Lincoln *TravelConnect*® services offer security and reassurance – helping make travel less stressful. If you're enrolled in life and/or accidental death and dismemberment insurance, you and your loved ones can count on *TravelConnect*® services 24 hours a day, 7 days a week.

Services you can count on during an emergency

You'll have dedicated support if you face an emergency when you're 100 or more miles from home. *TravelConnect*® helps with:

- Arranging travel if you're injured and need emergency evacuation to a medical facility
- Managing travel for a companion and/or your dependent children, including transportation expenses and accommodations of a qualified escort
- Planning and paying for a safe evacuation because of a natural disaster or a political or security threat
- Arranging transportation of a deceased traveler
- Securing emergency pet boarding and/or return and vehicle return

Ongoing support when you're far from home

From planning the trip until you're home, these *TravelConnect*® services can help you on your way.

- Medical record requests
- Medication and vaccine delivery
- Medical, dental, and pharmacy referrals
- Corrective lenses and medical device replacement
- Legal consultation
- Recovering lost or stolen documents or luggage
- ID recovery assistance
- Language translation services
- Destination information

TravelConnect®

Lincoln Financial Group®

GLOBAL ASSISTANCE PROGRAM

Provided by On Call International
Medical, security, and travel assistance services for participants traveling 100+ miles from home

Visit MyOnCallPortal.com and enter Group ID: **LFGTravel123** for access to plan documents, international calling instructions, and destination information.

For a complete list of *TravelConnect*® services, go to **MyOnCallPortal.com** and enter Group ID **LFGTravel123.**

TravelConnect® services are provided by On Call International, Salem, NH. On Call International is not a Lincoln Financial Group® company and Lincoln Financial Group does not administer these services. Each independent company is solely responsible for its own obligations. On Call International must coordinate and provide all arrangements in order for eligible services to be covered. Coverage is subject to contract language that contains specific terms, conditions, and limitations, which can be found in the program description.

The *TravelConnect*® program is not available to insured employees and dependents of policies issued in the states of New York and Washington. Access Only program available to insured employees and dependents of policies issued in the state of Missouri and Texas. Benefits provided under the Access Only program exclude payment for paid services.

Not available in New York and Washington.

LincolnFinancial.com

Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates.

Affiliates are separately responsible for their own financial and contractual obligations.

LCN-3885715-102621
MAP 12/21 **Z03**
Order code: LFE-TRVFE-FLI001

Lincoln Financial Group®

If you need medical, security, or travel assistance, regardless of the nature or severity of your situation, contact On Call International 24 hours a day:

Call collect from anywhere in the world:
603-328-1955
Call toll free from U.S. or Canada:
866-525-1955
Email: mail@OnCallInternational.com

Global assistance services must be coordinated and approved by On Call in order to be covered.

See your plan description for full terms and conditions of the services offered in your plan.

On Call International
A member of the **Tokio Marine HCC** group of companies

The resources you need to meet life's challenges

EmployeeConnect℠ offers professional, confidential services to help you and your loved ones improve your quality of life.

In-person guidance

Some matters are best resolved by meeting with a professional in person. With *EmployeeConnect*, you and your family get:

- In-person help for short-term issues (up to five sessions with a counselor per person, per issue, per year)
- In-person consultations with network lawyers, including one free 30-minute in-person consultation per legal issue, and **25% off** subsequent meetings

Unlimited 24/7 assistance

You and your family can access the following services any time — online, on the mobile app, or with a toll-free call:

- Information and referrals on family matters, such as child and elder care, pet care, vacation planning, moving, car buying, college planning, and more
- Legal information and referrals for family law, estate planning, and consumer and civil law
- Financial guidance on household budgeting and short- and long-term planning

Online resources

EmployeeConnect offers a wide range of information and resources you can research and access on your own. Expert advice and support tools are just a click away when you visit **GuidanceResources.com** or download the **GuidanceNow**℠ mobile app. You'll find:

- Articles and tutorials
- Videos
- Interactive tools, including financial calculators, budgeting worksheets, and more

EmployeeConnect℠

EMPLOYEE ASSISTANCE PROGRAM SERVICES

Confidential help 24 hours a day, seven days a week for employees and their family members. Get help with:

- Family
- Parenting
- Addictions
- Emotional
- Legal
- Financial
- Relationships
- Stress

LTD-EAPEE-FLI001_Z03

We partner with your employer to offer this service at no additional cost to you!

EmployeeConnect counselors are experienced and credentialed.

When you call the toll-free line, you'll talk to an experienced professional who will provide counseling, work-life advice, and referrals. All counselors hold master's degrees, with broad-based clinical skills, and at least three years of experience in counseling on a variety of issues. For face-to-face sessions, you'll meet with a credentialed, state-licensed counselor.

You'll receive customized information for each work-life service you use.

Take advantage of *EmployeeConnect*

For more information about the program, visit **GuidanceResources.com**, download the **GuidanceNow** mobile app, or call **888-628-4824**.

GuidanceResources.com login credentials:
Username: LFGSupport Password: LFGSupport1

LincolnFinancial.com

LCN-2836182-112019
MAP 9/21 **Z03**
Order code: LTD-EAPEE-FLI001

Lincoln Financial Group®

*EmployeeConnect*SM

EMPLOYEE ASSISTANCE PROGRAM SERVICES

To find out more:

- Visit GuidanceResources.com
  username: LFGSupport password: LFGSupport1
- Download the GuidanceNow℠ mobile app
- Call 888-628-4824

Lincoln Financial Group® | ComPsych® GuidanceResources® Worldwide

Lincoln Financial Group®

LOGO

Lincoln VisionConnect® and EPIC Hearing Service Plan

Enjoy discounted rates on vision and hearing care

As the cost of health care rises, so does the cost of vision and hearing care. But did you know that your dental insurance also includes discounts on glasses, hearing aids, and more? The *Lincoln VisionConnect* program and EPIC Hearing Service Plan can help you save on the vision and hearing services and products you need.

See the savings

The *Lincoln VisionConnect* discount vision program provides savings on eye care, eyewear, WellVision® exams, retinal screenings, lens enhancements, and laser vision correction. Through the program, you'll receive:

- **Discounts** through a trusted network of eye doctors
- **One rate of $50** for an eye exam[1]
- **15% savings** on a contact lens exam[2]
- **Special pricing** on complete pairs of eyeglasses and sunglasses
- **Reduced pricing** on laser vision correction through contracted providers

Hear the difference

Lincoln's EPIC Hearing Service Plan provides access to a network of more than 7,000 credentialed professionals who provide comprehensive services and products — including the most advanced hearing aid technology. And thanks to specially negotiated rates, you pay less for routine hearing tests and hearing aids and can receive:

- **50% to 80% off standard industry prices** on 2,000+ top brand hearing aids
- **Free charging case or one-year supply of batteries** with hearing aid purchase
- **No-cost hearing test** with your hearing aid evaluation
- **Three-year warranty** on all hearing aids covers repair, damage, and one-time loss
- **Virtual care with hearing aids** delivered directly to your door or in-person care through the largest hearing care provider network in the country

[1] This cost is only available with the purchase of a complete pair of prescription glasses. Otherwise, you'll receive 20% savings on an eye exam only.
[2] Applies only to contact lens exam, not materials. You're responsible for 100% of the contact lens material cost.

Lincoln VisionConnect discount vision program

Lincoln Financial Group®

Name _____

Discount program only. Not an insurance program.

Save today

Visit disvis.LFG.com or call **800-877-7195** for more information about your **vision benefits**.

Visit epichearing.com or call **888-899-1459** to learn more about your **hearing benefits**.

Insurance products marketed by:
The Lincoln National Life Insurance Company
Lincoln Life & Annuity Company of New York

Visit disvis.LFG.com or call 800-877-7195 for more information.

Critical Illness Insurance Plan Summary

COVERAGE OPTIONS

Critical Illness Insurance		
Eligible Individual	**Initial Benefit**	**Requirements**
Employee	**$5,000, $10,000, $15,000 or $20,000**	Coverage is guaranteed provided you are actively at work.[3]
Spouse/Domestic Partner[1]	**50% of the employee's Initial Benefit**	Coverage is guaranteed provided the employee is actively at work and the spouse/domestic partner is not subject to a medical restriction as set forth on the enrollment form and in the Certificate.[3]
Dependent Child(ren)[2]	**50% of the employee's Initial Benefit**	Coverage is guaranteed provided the employee is actively at work and the dependent is not subject to a medical restriction as set forth on the enrollment form and in the Certificate.[3]

BENEFIT PAYMENT

Your **Initial Benefit** provides a lump-sum payment upon the first diagnosis of a Covered Condition. Your plan pays a Recurrence Benefit[4] for the following Covered Conditions: Heart Attack, Stroke, Coronary Artery Bypass Graft, Full Benefit Cancer and Partial Benefit Cancer. A Recurrence Benefit is only available if an Initial Benefit has been paid for the Covered Condition. There is a Benefit Suspension Period between Recurrences.

The maximum amount that you can receive through your Critical Illness Insurance plan is called the **Total Benefit** and is 3 times the amount of your Initial Benefit. This means that you can receive multiple Initial Benefit and Recurrence Benefit payments until you reach the maximum of 300% or $15,000, $30,000, $45,000 or $60,000.

Please refer to the table below for the percentage benefit amount for each Covered Condition.

Covered Conditions	Initial Benefit	Recurrence Benefit
Full Benefit Cancer[5]	100% of Initial Benefit	50% of Initial Benefit
Partial Benefit Cancer[5]	25% of Initial Benefit	12.5% of Initial Benefit
Heart Attack	100% of Initial Benefit	50% of Initial Benefit
Stroke[6]	100% of Initial Benefit	50% of Initial Benefit
Coronary Artery Bypass Graft[7]	100% of Initial Benefit	50% of Initial Benefit
Kidney Failure	100% of Initial Benefit	Not applicable
Alzheimer's Disease[8]	100% of Initial Benefit	Not applicable
Major Organ Transplant Benefit	100% of Initial Benefit	Not applicable
22 Listed Conditions	25% of Initial Benefit	Not applicable

22 Listed Conditions
MetLife Critical Illness Insurance will pay 25% of the Initial Benefit Amount when a covered person is diagnosed with one of the 22 Listed Conditions. A Covered Person may only receive one benefit payment for one Listed Condition in his/her lifetime. The Listed Conditions are Addison's disease (adrenal hypofunction); amyotrophic lateral sclerosis (Lou Gehrig's disease); cerebrospinal meningitis (bacterial); cerebral palsy; cystic fibrosis; diphtheria; encephalitis; Huntington's disease (Huntington's chorea); Legionnaire's disease; malaria; multiple sclerosis (definitive diagnosis); muscular dystrophy; myasthenia gravis; necrotizing fasciitis; osteomyelitis; poliomyelitis; rabies; sickle cell anemia (excluding sickle cell trait); systemic lupus erythematosus (SLE); systemic sclerosis (scleroderma); tetanus; and tuberculosis.

Example of Initial & Recurrence Benefit Payments
The example below illustrates an employee who elected an Initial Benefit of $15,000 and has a Total Benefit of 3 times the Initial Benefit Amount or $45,000.

Illness – Covered Condition	Payment	Total Benefit Remaining
Heart Attack – first diagnosis	Initial Benefit payment of $15,000 or 100%	$30,000
Heart Attack – second diagnosis, two years later	Recurrence Benefit payment of $7,500 or 50%	$22,500
Kidney Failure – first diagnosis, three years later	Initial Benefit payment of $15,000 or 100%	$7,500

In most states there is a preexisting condition limitation. If advice, treatment or care was sought, recommended, prescribed or received during the three months prior to the effective date of coverage, we will not pay benefits if the covered condition occurs during the first six months of coverage. The preexisting condition limitation does not apply to heart attack or stroke.

SUPPLEMENTAL BENEFITS

MetLife provides coverage for the Supplemental Benefits listed below. This coverage would be in addition to the Total Benefit Amount payable for the previously mentioned Covered Conditions.

Health Screening Benefit[10]
MetLife will provide an annual benefit of $100 per calendar year for taking one of the eligible screening/prevention measures. MetLife will pay only one health screening benefit per covered person per calendar year.
Eligible screening/prevention measures may include:

• annual physical exam	• flexible sigmoidoscopy
• biopsies for cancer	• hemoccult stool specimen
• blood test to determine total cholesterol	• hemoglobin A1C
• blood test to determine triglycerides	• human papillomavirus (HPV) vaccination
• bone marrow testing	• lipid panel
• breast MRI	• mammogram
• breast ultrasound	• oral cancer screening
• breast sonogram	• pap smears or thin prep pap test
• cancer antigen 15-3 blood test for breast cancer (CA 15-3)	• prostate-specific antigen (PSA) test
• cancer antigen 125 blood test for ovarian cancer (CA 125)	• serum cholesterol test to determine LDL and HDL levels
• carcinoembryonic antigen blood test for colon cancer (CEA)	• serum protein electrophoresis
• carotid doppler	• skin cancer biopsy
• chest x-rays	• skin cancer screening
• clinical testicular exam	• skin exam
• colonoscopy	• stress test on bicycle or treadmill
• digital rectal exam (DRE)	• successful completion of smoking cessation program
• Doppler screening for cancer	• tests for sexually transmitted infections (STIs)
• Doppler screening for peripheral vascular disease	• thermography
• echocardiogram	• two hour post-load plasma glucose test
• electrocardiogram (EKG)	• ultrasounds for cancer detection
• endoscopy	• ultrasound screening of the abdominal aorta for abdominal aortic aneurysms
• fasting blood glucose test	• virtual colonoscopy
• fasting plasma glucose test	

INSURANCE RATES

MetLife offers competitive group rates and convenient payroll deduction so you don't have to worry about writing a check or missing a payment! Your employee rates are outlined below.

Monthly Premium/$1,000 of Coverage

Attained Age	Employee Only	Employee + Spouse	Employee + Children	Employee + Spouse / Children
<25	$0.63	$1.12	$1.09	$1.58
25–29	$0.65	$1.16	$1.11	$1.62
30–34	$0.77	$1.33	$1.23	$1.79
35–39	$0.84	$1.44	$1.30	$1.90
40–44	$0.92	$1.60	$1.38	$2.06
45–49	$1.19	$2.06	$1.66	$2.52
50–54	$1.56	$2.69	$2.02	$3.15
55–59	$2.04	$3.52	$2.51	$3.98
60–64	$2.63	$4.56	$3.09	$5.02
65–69	$3.49	$6.08	$3.95	$6.54
70+	$5.07	$8.65	$5.54	$9.11

QUESTIONS & ANSWERS

How do I enroll?
Please contact your benefits administrator.

Who is eligible to enroll?
Regular active full-time employees who are actively at work along with their spouse/domestic partner and dependent children can enroll for MetLife Critical Illness Insurance coverage.[3]

How do I pay for coverage?
Coverage is paid through convenient payroll deduction.

What is the coverage effective date?
The coverage effective date is 07/01/2020.

If I Leave the Company, Can I Keep My Coverage? [11]
Under certain circumstances, you can take your coverage with you if you leave. You must make a request in writing within a specified period after you leave your employer. You must also continue to pay premiums to keep the coverage in force.

Who do I call for assistance?
Contact a MetLife Customer Service Representative at 1 800- GET-MET8 (1-800-438-6388), Monday through Friday from 8:00 a.m. to 8:00 p.m., EST.

Footnotes:

[1] Coverage for Domestic Partners, civil union partners and reciprocal beneficiaries varies by state. Please contact MetLife for more information.
[2] Dependent Child coverage varies by state. Please contact MetLife for more information.
[3] Coverage is guaranteed provided (1) the employee is actively at work and (2) dependents are not subject to medical restrictions as set forth on the enrollment form and in the Certificate. Some states require the insured to have medical coverage. Additional restrictions apply to dependents serving in the armed forces or living overseas.
Coverage is guaranteed provided (1) the employee is performing all of the usual and customary duties of your job at the employer's place of business or at an alternate place approved by your employer (2) dependents are not subject to medical restrictions as set forth on the enrollment form and in the Certificate. Some states require the insured to have medical coverage. Additional restrictions apply to dependents serving in the armed forces or living overseas.
[4] We will not pay a Recurrence Benefit for a Covered Condition that Recurs during a Benefit Suspension Period. We will not pay a Recurrence Benefit for either a Full Benefit Cancer or a Partial Benefit Cancer unless the Covered Person has not had symptoms of or been treated for the Full Benefit Cancer or Partial Benefit Cancer for which we paid an Initial Benefit during the Benefit Suspension Period.
[5] Please review the Disclosure Statement or Outline of Coverage/Disclosure Document for specific information about cancer benefits. Not all types of cancer are covered. Some cancers are covered at less than the Initial Benefit Amount. For NH-situsedcases and NH residents, there is an initial benefit of $100 for All Other Cancers.
[6] In certain states, the covered condition is Severe Stroke.
[7] In NJ situsedcases, the Covered Condition is Coronary Artery Disease.
[8] Please review the Outline of Coverage for specific information about Alzheimer's disease.
[10] The Health Screening Benefit is not available in all states. See your certificate for any applicable waiting periods. There is a separate mammogram benefit for MT residents and for cases situsedin CA and MT.
[11] Eligibility for portability through the Continuation of Insurance with Premium Payment provision may be subject to certain eligibility requirements and limitations. For more information, contact your MetLife representative.

METLIFE'S CRITICAL ILLNESS INSURANCE (CII) IS A LIMITED BENEFIT GROUP INSURANCE POLICY. Like most group accident and health insurance policies, MetLife's CII policies contain certain exclusions, limitations and terms for keeping them in force. Product features and availability vary by state. In most plans, there is a preexisting condition exclusion. After a covered condition occurs, there is a benefit suspension period during which benefits will not be paid for a recurrence, except in the case of individuals covered under a New York certificate. Attained Age rates are based on 5-year age bands and will increase when a Covered Person reaches a new age band. A more detailed description of the benefits, limitations, and exclusions applicable can be found in the applicable Disclosure Statement or Outline of Coverage/Disclosure Document available at time of enrollment. For complete details of coverage and availability, please refer to the group policy form GPNP07-CI, GPNP09-CI or contact MetLife for more information. Benefits are underwritten by Metropolitan Life Insurance Company, New York, New York. MetLife's Critical Illness Insurance is not intended to be a substitute for Medical Coverage providing benefits for medical treatment, including hospital, surgical and medical expenses. MetLife's Critical Illness Insurance does not provide reimbursement for such expenses.

Accident Insurance Plan Summary

ACCIDENT INSURANCE BENEFITS

With MetLife, you'll have a comprehensive plan which provide payments in addition to any other insurance payments you may receive. Here are just some of the covered events/services.

Accidental Injury Benefits	**Low Plan Benefits**
Fracture Benefit*	$100 – $8,000 depending on the fracture and type of repair
Dislocation Benefit*	$100 – $8,000 depending on the dislocation and type of repair
Second or Third Degree Burn Benefit	$75 – $10,000 depending on the degree of the burn and the percentage of burnt skin
Concussion Benefit	$250
Coma Benefit	$7,500
Laceration Benefit	$50 – $400 depending on the length of the cut and type of repair
Broken Tooth Benefit	Crown $200 Filling $25 Extraction $100
Eye Injury Benefit	$300
Accident - Medical Services & Treatment Benefits	**Low Plan Benefits**
Ambulance Benefit	Ground: $300 Air: $1,000
Emergency Care Benefit	$75 – $150 depending on location of care
Non-Emergency Initial Care Benefit	$75
Physician Follow-Up Visit Benefit	$75
Therapy Services Benefit (including physical therapy)	$35
Medical Testing Benefit	$150
Medical Appliance Benefit	$75 – $750 depending on the appliance
Transportation Benefit	$300
Pain Management Benefit (for epidural anesthesia)	$75
Prosthetic Device Benefit	One device: $750 More than one device: $1,500
Modification Benefit	$1,000
Blood/Plasma/Platelets Benefit	$400
Surgical Repair Benefit	$150-$1,500 depending on the type of surgery

Exploratory Surgery Benefit	$150
Other Outpatient Surgery Benefit	$300
Hospital Benefits	**Low Plan Benefits**
Admission Benefit	$1,000 for the day of admission
ICU Supplemental Admission Benefit	$1,000 for the day of admission
Confinement Benefit (paid for up to 15 days per accident)	$200 per day
ICU Supplemental Confinement Benefit (paid for up to 15 days per accident)	$200 per day
Inpatient Rehabilitation Benefit (paid for up to 15 days per accident)	$150 per day
Accidental Death Benefit	**Low Plan Benefits**
Accidental Death Benefit*	$25,000 $75,000 for accidental death on common carrier
Accidental Dismemberment, Functional Loss &Paralysis Benefits	**Low Plan Benefits**
Dismemberment/Functional Loss	$750 – $20,000 depending on the injury
Paralysis	$10,000 - $20,000 depending on the number of limbs
Other Benefits	**Low Plan Benefits**
Lodging Benefit* - for a companion of a covered person who is hospitalized	$100 per day

* Notes Regarding Certain Benefits

- Fracture and Dislocation benefits - Chip fractures are paid at 25% of the applicable fracture benefit and partial dislocations are paid at 25% of the applicable dislocation benefit.
- Accidental Death Benefit – The benefit amount will be reduced by the amount of any accidental dismemberment/functional loss/paralysis benefits and modification benefit paid for injuries sustained by the covered person in the same accident for which the accidental death benefit is being paid.
- Accidental Death Benefit – Common carrier refers to airplanes, trains, buses, trolleys, subways and boats.
- Lodging Benefit - The lodging must be at least 50 miles from the insured's primary residence.

BENEFIT PAYMENT EXAMPLE

Kathy's daughter, Molly, plays soccer on the varsity high school team. During a recent game, she collided with an opposing player, was knocked unconscious and taken to the local emergency room by ambulance for treatment. The ER doctor diagnosed a concussion and a broken tooth. He ordered a CT scan to check for facial fractures too, since Molly's face was very swollen. Molly was released to her primary care physician for follow-up treatment, and her dentist repaired her broken tooth with a crown. Depending on her health insurance, Kathy's out-of-pocket costs could run into hundreds of dollars to cover expenses like insurance co-payments and deductibles. MetLife Group Accident Insurance payments can be used to help cover these unexpected costs.

Covered Event[1]	**Benefit Amount**
Ambulance (ground)	**$300**
Emergency Care	**$100**
Physician Follow-Up ($75 x 2)	**$150**
Medical Testing	**$150**
Concussion	**$250**
Broken Tooth (repaired by crown)	**$200**
Benefits paid by MetLife Group Accident Insurance	**$1,150**

Benefit amount is based on a sample MetLife plan design. Actual plan design and plan benefits may vary.

INSURANCE RATES

MetLife offers competitive group rates and convenient payroll deduction so you don't have to worry about writing a check or missing a payment! Your employee rates are outlined below.

Accident [Off-the-Job] Insurance	**Monthly Cost to You**
Coverage Options	
Employee	$8.37
Employee & Spouse	$16.53
Employee & Child(ren)	$18.64
Employee & Spouse/Child(ren)	$23.11

QUESTIONS & ANSWERS

Who is eligible to enroll for this accident coverage?
You are eligible to enroll yourself and your eligible family members![8] You need to enroll during your Enrollment Period and be actively at work for your coverage to be effective.

How do I pay for my accident coverage?
Premiums will be conveniently paid through payroll deduction, so you don't have to worry about writing a check or missing a payment.

What happens if my employment status changes? Can I take my coverage with me?
Yes, you can take your coverage with you.[9] You will need to continue to pay your premiums to keep your coverage in force. Your coverage will only end if you stop paying your premium or if your employer cancels the group policy or offers you similar coverage with a different insurance carrier.

Who do I call for assistance?
Contact a MetLife Customer Service Representative at 1 800- GET-MET8 (1-800-438-6388), Monday through Friday from 8:00 a.m. to 8:00 p.m., EST.

[1] Covered services/treatments must be the result of an accident or sickness as defined in the group policy/certificate. See your Disclosure Statement or Outline of Coverage/Disclosure Document for more details.
[2] Chip fractures are paid at 25% of Fracture Benefit and partial dislocations are paid at 25% of Dislocation Benefit.
[3] Hospital does not include certain facilities such as nursing homes, convalescent care or extended care facilities. See MetLife's Disclosure Statement or Outline of Coverage/Disclosure Document for full details.
[4] The Hospital Sickness benefit may not be available in the following states: NH, VT and WA. See your Disclosure Statement or Outline of Coverage/Disclosure Document for full details.
[5] Common Carrier refers to airplanes, trains, buses, trolleys, subways and boats. Certain conditions apply. See your Disclosure Statement or Outline of Coverage/Disclosure Document for specific details. Be sure to review other information contained in this booklet for more details about plan benefits, monthly rates and other terms and conditions.
[6] The lodging benefit is not available in all states. It provides a benefit for a companion accompanying a covered insured while hospitalized, provided that lodging is at least 50 miles from insured's primary residence.
[7] The Health Screening Benefit is not available in all states. For Texas situsedpolicies and Texas residents covered under policies situsedin other states, when the Health Screening Benefit is included in an Accident-only plan, the covered screening measures are: physical exam, blood chemistry panel, complete blood count (CBC), chest x-rays, electrocardiogram (EKG), and electroencephalogram (EEG).]
[8] Coverage is guaranteed provided (1) the employee is actively at work and (2) dependents to be covered are not subject to medical restrictions as set forth on the enrollment form and in the Certificate. Some states require the insured to have medical coverage. Additional restrictions apply to dependents serving in the armed forces or living overseas.
[9] Eligibility for portability through the Continuation of Insurance with Premium Payment provision may be subject to certain eligibility requirements and limitations. For more information, contact your MetLife representative.

METLIFE'S ACCIDENT INSURANCE IS A LIMITED BENEFIT GROUP INSURANCE POLICY. The policy is not intended to be a substitute for medical coverage and certain states may require the insured to have medical coverage to enroll for the coverage. The policy or its provisions may vary or be unavailable in some states. There are benefit reductions that begin at age 65, if applicable. Like most group accident and health insurance policies, policies offered by MetLife may include waiting periods and contain certain exclusions, limitations and terms for keeping them in force. For complete details of coverage and availability, please refer to the group policy form GPNP12-AX or contact MetLife. Benefits are underwritten by Metropolitan Life Insurance Company, New York, NY. Hospital does not include certain facilities such as nursing homes, convalescent care or extended care facilities. See MetLife's Disclosure Statement or Outline of Coverage/Disclosure Document for full details.

Legal Plans

Provides access to legal expertise
for both expected and unexpected events.

Legal experts on your side, whenever you need them

For **$19.50 a month** a month, you get legal assistance for some of the most frequently needed personal legal matters —with no waiting periods, no deductibles and no claim forms, when using a Network Attorney for a covered matter.

Money Matters	• Debt Collection Defense • Identity Management Services[1] • Identity Theft Defense	• Negotiations with Creditors • Personal Bankruptcy • Promissory Notes	• Tax Audit Representation • Tax Collection Defense
Home & Real Estate	• Boundary & Title Disputes • Deeds • Eviction Defense • Foreclosure	• Home Equity Loans • Mortgages • Property Tax Assessments • Refinancing of Home	• Sale or Purchase of Home • Security Deposit Assistance • Tenant Negotiations • Zoning Applications
Estate Planning	• Codicils • Complex Wills • Healthcare Proxies • Living Wills	• Powers of Attorney (Healthcare, Financial, Childcare, Immigration)	• Revocable & Irrevocable Trusts • Simple Wills
Family & Personal	• Adoption • Affidavits • Conservatorship • Demand Letters • Garnishment Defense • Guardianship • Immigration Assistance	• Juvenile Court Defense, Including Criminal Matters • Name Change • Parental Responsibility Matters • Personal Property Protection • Prenuptial Agreement	• Protection from Domestic Violence • Review of ANY Personal Legal Document • School Hearings
Civil Lawsuits	• Administrative Hearings • Civil Litigation Defense	• Disputes Over Consumer Goods & Services • Incompetency Defense	• Pet Liabilities • Small Claims Assistance
Elder-Care Issues	Consultation & Document Review for your parents: • Deeds • Leases	• Medicaid • Medicare • Notes • Nursing Home Agreements	• Powers of Attorney • Prescription Plans • Wills
Vehicle & Driving	• Defense of Traffic Tickets[2] • Driving Privileges Restoration	• License Suspension Due to DUI	• Repossession
E-Services	• Attorney Locator • Financial Planning	• Insurance Resources • Law Firm E-Panel	• Self-Help Legal Documents

To learn more, visit **info.legalplans.com** and enter access code **5020000** or call **800.821.6400** Monday – Friday 8:00 am – 8:00 pm (EST/EDT).

1. This benefit provides the Participant with access to LifeStages Identity Management Services provided by CyberScout, LLC. CyberScout is not a corporate affiliate of MetLife Legal Plans.
2. Does not cover DUI.

MetLife Legal Plans, Inc. | 1111 Superior Avenue, Suite 800 | Cleveland, OH 44114

L0220001593[exp0621][All States][DC,PR]

SPECIAL NOTICES

PLAN YEAR: 2023

KRAUS-ANDERSON® *Insurance*

CONTACT INFORMATION

PLAN ADMINISTRATOR	
Contact Name:	Kimberly Reid
Phone Number:	651-492-7106 ext. 297
E-mail:	kreid@tcgis.com
HEALTH INSURANCE PROVIDER	
Health Insurer:	Medica
Customer Service:	952-945-8000
Website:	www.medica.com
PRIVACY OFFICER	
Contact Name:	Kimberly Reid
Business Address:	1031 Como Ave
	St. Paul, MN 55103
Phone Number:	651-492-7106 ext. 297
E-mail:	kreid@tcgis.com
Website:	www.tcgis.com
MEDICARE PART D	
Creditable:	MSI PP MN $850-$40-15% Plan
	MSI PP MN $400-$35-10% Plan
	MSI PP MN 2000-25% HSA + Rx Copays Plan

The information in this Special Notices is presented is based on information required by law. While every effort was taken to accurately report your benefits, discrepancies, or errors are always possible. In case of discrepancy between the Special Notices and the actual plan documents the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this summary, contact your plan administrator.

WHCRA ENROLLMENT NOTICE

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manager determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complication of mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: see your Certificate of Coverage or Summary Plan Description. If you would like more information on WHCRA benefits, call Customer Service at the number on the back of your ID card.

SPECIAL ENROLLMENT NOTICE

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information contact your plan administrator.

NEWBORN'S ACT DISCLOSURE

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not under Federal law, required that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

(expires 6-30-2023)

YOUR INFORMATION, YOUR RIGHTS, OUR RESPONSIBILITIES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims record	• You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records	• You can ask us to correct your health and claims records if you think they are correct or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communication	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will consider all reasonable requests and must say "yes" if you tell us you would be in danger if we do not.
Ask us to limit what we use or share	• You can ask us not to use or share certain health information for treatment, payment, or our operations. • We are not required to agree to your request, and we may say "no" if it would affect your care.
Get a list of these with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive this notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the Privacy Officer contact information. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or other involved in payment for your care • Share information in a disaster relief situations • Contact you for fundraising efforts • If you are not able to tell us your preference, for example if you are unconscious we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
In these cases we never share your information unless you give us written permission:	• Marketing purposes • Sale of your information

Our Uses and Disclosures

How do we typically us or share your health information? We typically use or share your health information in the following ways.

Help manage the health care treatment you receive	• We can use your health information and share it with professionals who are treating you.	Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.
Run our organization	• We can use and disclose your information to run our organization and contract you when necessary. • We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.	Example: We use health information about you to develop better services for you.
Pay for your health services	• We can use and disclose your health information as we pay for yourhealth services	Example: We share information about you with your dental plan to coordinate payment for your dental work.
Administer your plan	• We may disclose your health informationto your health plan sponsor for plan administration.	Example: Your company contacts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information? We are allowed or required to share your information in other ways—usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues	• We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	• We can share health information about you with organ procurement organizations. • We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/oct/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our website, and we will mail a copy to you.

GINA DISCLOSURE

GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008

The Genetic Information Nondiscrimination Act of 2008 ("GINA") protects employees against discrimination based on their genetic information. Unless otherwise permitted, your Employer may not request or require any genetic information from you or your family members.

MODEL GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

MENTAL HEALTH & ADDICTION EQUITY ACT DISCLOSURE

The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For information regarding the criteria for medical necessity determinations made under the company's group health plan with respect to mental health or substance use disorder benefits, pleasecontact the plan administrator.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

Your hours of employment are reduced, or
Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

Your spouse dies;
Your spouse's hours of employment are reduced;
Your spouse's employment ends for any reason other than his or her gross misconduct;
Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

The parent-employee dies;
The parent-employee's hours of employment are reduced;
The parent-employee's employment ends for any reason other than his or her gross misconduct;
The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
The parents become divorced or legally separated; or
The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:
The end of employment or reduction of hours of employment; Death of the employee; or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days the qualifying event occurs. You must provide this notice to the Plan Administrator.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. Contact the COBRA Administrator immediately or as soon as possible to notify them of this qualification.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

ADA WELLNESS PROGRAM NOTICE

Our wellness program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive the incentive.

Additional incentives may be available for employees who participate in certain health-related activities or achieve certain health outcomes. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the plan administrator.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health potential risks and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

PROTECTIONS FROM DISCLOSURE OF MEDICAL INFORMATION

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and our company may use aggregate information it collects to design a program based on identified health risks in the workplace, we will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) [indicate who will receive information such as "a registered nurse," "a doctor," or "a health coach"] in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. [Specify any other or additional confidentiality protections if applicable.] Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the plan administrator.

Wellness Program Disclosure

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact your plan administrator and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your State for more information on eligibility –

ALABAMA-Medicaid	CALIFORNIA-Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA-Medicaid	**COLORADO-Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health- plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance- buy-program HIBI Customer Service: 1-855-692-6442

ARKANSAS-Medicaid	FLORIDA-Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecove ry.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA-Medicaid	MASSACHUSETTS-Medicaid and CHIP
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party- liability/childrens-health-insurance-program- reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
INDIANA-Medicaid	**MINNESOTA-Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and- services/other-insurance.jsp Phone: 1-800-657-3739
IOWA-Medicaid and CHIP (Hawki)	**MISSOURI-Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS-Medicaid	**MONTANA-Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
KENTUCKY-Medicaid	**NEBRASKA-Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

LOUISIANA-Medicaid	NEVADA-Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE-Medicaid	**NEW HAMPSHIRE-Medicaid**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY-Medicaid and CHIP	SOUTH DAKOTA-Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK-Medicaid	**TEXAS-Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA-Medicaid	**UTAH-Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA-Medicaid	**VERMONT-Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA-Medicaid and CHIP	**VIRGINIA-Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OREGON-Medicaid	**WASHINGTON-Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022

PENNSYLVANIA-Medicaid	WEST VIRGINIA-Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND-Medicaid and CHIP	**WISCONSIN-Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA-Medicaid	**WYOMING-Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and- eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE CREDITABLE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. We have determined that the prescription drug coverage offered by the company is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When can you join a Medicare drug plan?

- You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

- However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What happens to your current coverage if you decide to join a Medicare drug plan?

- If you decide to join a Medicare drug plan, your current coverage will not be affected. Please see the Insurance Carrier for additional information regarding plan coverage

- If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will may not be able to get this coverage back.

When will you pay a higher premium (penalty) to join a Medicare drug plan?

- You should also know that if you drop or lose your current coverage and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

- If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or your current prescription drug coverage…

Contact the person listed as the plan administrator for further information NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage…

- More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

- For more information about Medicare prescription drug coverage: Visit www.medicare.gov.

- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

- If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).