



## Plan balances continued

Balances for FAMILY		Maximum amount	Progress so far	Remaining amount
Network	Deductible	\$6,600.00	\$11.11	\$6,588.89
	Out-of-pocket limit	\$6,600.00	\$11.11	\$6,588.89
Out-of-Network	Deductible	\$10,000.00	\$0.00	\$10,000.00
	Out-of-pocket limit	\$20,000.00	\$0.00	\$20,000.00



## Definition of Key Terms

**Allowed Amount:** Maximum amount on which benefits are based for covered services.

**Amount you owe:** The amount of money you pay for the services you receive.

**Charges:** The amount your provider charged for services provided to you.

**Claim Number:** The number the system assigns to your claim. A claim number is assigned to every claim.

**Coinsurance:** Your share of the costs of a covered health care service, calculated as a percentage of the amount for the service.

**Copay:** A fixed amount you pay for a covered health care service, usually when you receive the service or fill a prescription.

**Deductible:** The amount you could owe during a coverage period for services your health benefit plan covers before your plan begins to pay.

**Notes:** The code we assign to describe how we processed a claim line. Generally, the adjustment code shows a correction, adjustment or denial.

**Patient non-covered amount:** A service or expense that you do not have coverage for under your health benefit plan.

**Services Received:** A brief description of the medical service, supply or medication billed along with the procedure code or Revenue Code. A procedure code is an alpha numeric identifier used to define the medical service, supply or medication billed. A Revenue Code is used by hospitals to report services rendered - revenue codes are three digits.

### Got questions?

Get in touch with Member Services at **952-945-8000** or **800-952-3455**

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## Your rights as a member

### Information Related to this Decision

If you have any questions related to this claim, please refer to your Certificate of Coverage or contact Medica Member Services at the phone numbers or address listed below.

### First Level of Review

If you are dissatisfied with Medica's decision, you can call or write us at the phone numbers and address listed below to request a review. You may choose to designate a representative to act on your behalf at any time during the review process or external review process. If you choose to do so, contact Medica to obtain a Release of Information form, which will allow Medica to discuss your case with your designated representative. We will review any testimony, explanation, or other information we receive from you, Medica staff members, providers, or others.

For questions about your rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or for employer group plans not governed by ERISA, you can contact the Health Insurance Assistance Team (HIAT) at the U.S. Department of Health and Human Services at 1-888-393-2789. You also have the right at any time to file a complaint with the Minnesota Department of

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Commerce. They can be reached at: 651-539-1600 or 1-800-657-3602.

At any time and at no cost to you, you may request a written copy from Medica of:

- The rule or guideline used to make our decision,
- The clinical judgment used to apply the terms of your plan to your medical circumstances, and
- Any other document or information related to this review.

To request an appeal, additional information, if you need diagnosis and/or treatment code information regarding the services referenced in this communication or assistance, please contact Medica at the following address and telephone numbers:

MAIL:

Medica Member Services  
Route 0501  
PO Box 9310  
Minneapolis MN 55440-9310

Telephone:

Minneapolis/St Paul area: 952-945-8000  
Outside Minneapolis/St Paul area: 1-800-952-3455



CUSTOMER SERVICE  
ROUTE 0501  
P.O. BOX 9310  
MINNEAPOLIS, MN 55440-9310

## Your rights as a member continued

level of review is required, Medica will notify you of the decision within 30 calendar days of your appeal request. If the second level of review is optional, Medica will notify you of the decision within 45 calendar days of your appeal request. Written reconsideration. Under this process, the committee will review your appeal. Medica will notify you of the decision within 30 calendar days of your appeal request.

### External Review Option

You may choose to have your case reviewed by an external review organization. This process is coordinated by the Minnesota Department of Commerce. The Minnesota Department of Commerce can be reached locally at 651-539-1600 or their toll free number 800-657-3602. You may submit additional information to be reviewed by the external review organization. You must submit your written request for external review within six months from the date you receive Medica's decision. You will be notified of the review organization's decision within 45 days. If an expedited review is requested and approved, a decision will be provided within 72 hours.

The external review organization's decision is not binding on you, but it is binding on Medica. Medica may seek judicial review on

grounds that the decision was arbitrary and capricious or involved an abuse of discretion. To make a request for external review, contact the Minnesota Department of Commerce at the numbers listed above. There is no cost to you except for the required filing fee. You must include a \$25.00 filing fee at the time of the request for external review, unless waived by the Department. The fee will be refunded if Medica's decision is completely overturned.

### Right to Civil Action

If your employer group plan is governed by ERISA and you are not satisfied with Medica's appeal determination, you have the right to file a civil action suit under ERISA section 502(a).

### Right to Civil Action

If you remain dissatisfied with Medica's determination after completing the required appeals process, you have the right to file a civil action suit under Section 502(a) of the Employee Retirement Income Security Act.

### False Claims

"A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a

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We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.

**Online:** [civilrightscordinator@medica.com](mailto:civilrightscordinator@medica.com)

**Mail:** Civil Rights Coordinator, P.O. Box 9310 Minneapolis, MN 55443-9310

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

**Online:** <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

**Phone:** Toll-free 1-800-368-1019, 800-537-7697 (TDD)

**Mail:** U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

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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 qu. vì muốn trợ giúp dịch thông tin này miễn phí, h.y gọi vào số có trong tài liệu này hoặc ở mặt sau thẻ ID Medica của qu. vì.

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.

قۇيۇشۇلۇ مۇدە يىف دۇرۇلۇ قۇرۇلۇ يىلۇ لىصۇتۇف، تۇجۇلۇ عۇمۇلۇ مۇدە قۇمۇرۇتۇ يىف قۇيۇنۇمۇ قۇدۇرۇتۇ تۇنۇكۇ اذۇ لىكۇ قۇسۇخۇلۇ كۇيۇدۇمۇ فۇيۇرۇتۇ قۇقۇطۇ رۇمۇظۇ يىلۇ عۇ وۇ.

Если Вы хотите получить бесплатную помощь в переводе этой информации, позвоните по номеру телефона, указанному в данном документе и на обратной стороне Вашей идентификационной карты Medica.

ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປຂໍ້ມູນນີ້ພຣີ, ໃຫ້ໂທຫາເຈກໝາຍທີ່ມີຢູ່ໃນເອກະສານນີ້ ຫຼື ຢູ່ດ້ານຫຼັງຂອງບັດ Medica ຂອງທ່ານ.