Plan balances

As of 06/17/2025 for plan year 2025

Balances for ANDREW

		Maximum amount	Progress so far	Remaining amount
Network	Deductible	$3,300.00	$1,065.26	**$2,234.74**
	Out-of-pocket limit	$3,300.00	$1,065.26	**$2,234.74**
Out-of-Network	Deductible	$5,000.00	$0.00	**$5,000.00**
	Out-of-pocket limit	$10,000.00	$0.00	**$10,000.00**

Balances for FAMILY

		Maximum amount	Progress so far	Remaining amount
Network	Deductible	$6,600.00	$1,065.26	**$5,534.74**
	Out-of-pocket limit	$6,600.00	$1,065.26	**$5,534.74**
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.

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

Claim detail for ANDREW

Provider: PALO ALTO MEDICAL FOUNDATION
Status: Network

Patient ID: 14773-984567643-00
Claim number: 07737924-00

		Billed	Allowed amounts		Amounts paid		Total you owe	
Services received	**Notes**	**Charges**	**Provider Responsibility**	**Allowed amount**	**Other coverage paid**	**Paid amount**	**Patient non-covered amount**	**Amount you owe****
Laboratory 05/22/2025	0926	$246.00	$49.20	$196.80	$0.00	$196.80	$0.00	$0.00
• **Deductible** $0.00 • **Copay:** $0.00 • **Coinsurance:** $0.00								
Laboratory 05/22/2025	0926	$62.00	$12.40	$49.60	$0.00	$49.60	$0.00	$0.00
• **Deductible** $0.00 • **Copay:** $0.00 • **Coinsurance:** $0.00								
Blood Collection 05/22/2025	0926	$21.00	$4.41	$16.59	$0.00	$16.59	$0.00	$0.00
• **Deductible** $0.00 • **Copay:** $0.00 • **Coinsurance:** $0.00								
Total amount		$329.00	$66.01	$262.99	$0.00	$262.99	$0.00	$0.00

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MEDICA INSURANCE COMPANY
P.O. BOX 30990
SALT LAKE CTY, UT 84130-0990

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 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
TTY users, please call 711

Got questions?
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Your rights as a member continued

- 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).

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 crime. Your assistance in detecting fraudulent claims will help reduce cost of health care for all consumers."

This is a final determination of a claim under the medical plan and HRA account. If you have questions about the extent to which this claim for services has been paid, you should follow the appeal procedure on this document. Deductible and coinsurance amounts have been paid under the HRA account to the extent you have a positive balance in your HRA account. If you dispute or have questions about the amount identified as a deductible or co-pay, please follow the appeal procedure in this document.

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