SUMMARY PLAN DESCRIPTION

OF THE

MEDICA GROUP MEDICARE PLAN

Effective January 1, 2022

TABLE OF CONTENTS

INTRODUCTION 1

SUMMARY OF PLAN INFORMATION 2

PART I. GENERAL INFORMATION ABOUT THE PLAN 3

PART II. STATEMENT OF ERISA RIGHTS 6

EXHIBIT A: Medica Group Prime Solution℠ Evidence of Coverage A-1

EXHIBIT B Medica Group Advantage Solution℠ Evidence of Coverage B-1

INTRODUCTION

Medica Services Company, LLC (the "Plan Sponsor" or "Employer") maintains the Medica Group Medicare Plan (the "Plan") for the exclusive benefit of its employees (current and former) and the employees (current and former) of Medica Health Plans. The Plan is a single plan provided through two Medicare coverage programs referred to herein as "Components." The Plan, including the Components, are subject to Employee Retirement Income Security Act of 1974, as amended ("ERISA"), and certain provisions of the Internal Revenue Code of 1986, as amended ("Code").

This SPD describes the requirements imposed by ERISA and the Code and describes the administrative framework under which the benefits available under the Components are provided. The SPD includes the Evidences of Coverage for each of the Components. They are attached as Exhibits at the end of this SPD. This SPD, its Exhibits, and the documents attached to and/or incorporated into the Exhibits (e.g., evidences of coverage issued by the Insurer) constitute the SPD for the Plan required by § 102 of ERISA.

Important: This SPD is only a summary of the key parts of the Plan, and a brief description of your rights as a Participant and/or a Covered Individual. Be sure to review this SPD carefully.

The following Components are described in this SPD:

- Medica Group Prime Solution℠
- Medica Group Advantage Solution℠

Each of these Components is summarized in an evidence of coverage booklet issued by an insurer. A copy of each evidence of coverage booklet is attached to this document in Exhibits A and B. ***This document, including the Exhibits, are the SPD for the Plan.***

Important: The benefits under this Plan are insured. Insured benefits are provided pursuant to an Insurance Policy(ies) and all benefits are provided pursuant to a governing Plan document adopted by the Plan Sponsor. If the terms of this SPD conflict with the terms of such Insurance Policy(ies) or governing Plan document, then the terms of the Insurance Policy(ies) or governing Plan document control, rather than this SPD, unless otherwise required by law.

SUMMARY OF PLAN INFORMATION

Name of Plan:	Medica Group Medicare Plan
Plan Number	502
Plan Sponsor's Federal Tax Identification Number:	41-1242261
Plan Sponsor:	Medica Services Company, LLC 401 Carlson Parkway Minnetonka, MN 55305 Phone: 952-992-3888
Participating Employers:	Medica Services Company, LLC 401 Carlson Parkway Minnetonka, MN 55305 Phone: 952-992-3888 Medica Health Plans 401 Carlson Parkway Minnetonka, MN 55305 Phone: 952-992-3888
Plan Administrator:	Medica Services Company, LLC c/o Medica's Benefits Manager Mail stop: CP175 401 Carlson Parkway Minnetonka, MN 55305 Phone: 952-992-3888
Agent for Process of Legal Service:	Medica's Benefits Manager 401 Carlson Parkway Minnetonka, MN 55305 Phone: 952-992-3888
Type of Employees who may participate in the Plan:	Active Employees and Former Employees of the Participating Employer(s)
Types of Covered Individuals:	**Through an Active Employee:** Parent, Parent In-Law **Through a Former Employee**: Former Employee, Spouse, Parent, Parent In-Law
Plan modifications:	Any amendments to or termination of the Plan will be accomplished by, or pursuant to, a written resolution of the Plan Sponsor.

Questions: After you have reviewed the information in this SPD, if you have questions, please contact:

Medica's Benefit Manager
952-992-2900
BenefitManagers@medica.com

PART 1
GENERAL INFORMATION ABOUT THE PLAN

1.1 What is the purpose of the Plan and this document?

The purpose of the Plan is to provide certain employees (current and former) with an opportunity to obtain benefits under an employee welfare benefit plan, the Medica Group Medicare Plan ("Plan") as further described herein. You are being provided this SPD to give you an overview of the Plan and to address certain information that may not be addressed in the Exhibits.

1.2 When did the Plan take effect?

Medica Services Company, LLC, as the Plan Sponsor, adopted this Plan effective January 1, 2021. The effective date of this SPD is January 1, 2022 and reflects the benefits as they had been provided beginning January 1, 2021.

1.3 What employees can access coverage through the Plan and for whom?

Active Employees and Former Employees may access coverage through the Plan for a Select Group of individuals. Active Employees and Former Employees who actually secure coverage under the Plan for individuals in the Select Group are called "Participants". Individuals in the Select Group that actually become covered under the Plan are called "Covered Individuals". Covered Individuals other than Former Employees are "beneficiaries" for purposes of ERISA.

Participant	Select Group
Active Employee	Coverage for Parent, Parent In-Law
Former Employee	Coverage for Former Employee, Spouse, Parent, Parent In-Law

"Employee" generally means a person employed by a Participating Employer, except that the term "Employee" does not include any common-law employee who is a leased employee (including, but not limited to, an individual defined in Internal Revenue Code § 414(n)), or any common-law employee who is an individual classified by the Participating Employer as a contract worker, independent contractor, temporary employee or casual employee, whether or not any such person is on the Participating Employer's W-2 payroll. The term "Employee" also does not include any individual who performs services for a Participating Employer but who is paid by a temporary or other employment or staffing agency.

"**Active Employee**" means an Employee who is actively employed by a Participating Employer when the related Covered Individual appropriately enrolls in the Plan. Such employment must be reflected on the Participating Employer's payroll.

"Former Employee" means a person who is no longer an Active Employee but who was an Active Employee within the ten year period immediately preceding the date the related Covered Individual appropriately enrolls in the Plan.

1.4 What are the conditions of participation?

As a condition of participation and receipt of benefits under the Plan, people covered under the Plan agree to:

(a) observe all Plan rules and regulations;

(b) consent to inquiries by the Plan with respect to any claim under the Plan;

(c) submit to the Plan all notifications, reports, bills, and other information that the Plan may reasonably require;

(d) agree to repay any overpayments or incorrect payments received through the Plan; and

(e) agree to provide required proof or documentation regarding eligibility within thirty (30) days of the request.

Failure to comply with these conditions may impact your ability to participate or continue participating in the Plan.

1.5 What coverage is available?

The Plan consists of two "Components." The Component available to you depends on where you reside.

COMPONENT BENEFIT:	DESCRIPTION:
Medica Group Prime Solution^{SM} [*see attached Exhibit A*]	Medical coverage provided through the Plan is described in the evidence of coverage that relates to the Insurance Policy which is attached as Exhibit A and is hereby incorporated by reference.
Medica Group Advantage Solution^{SM} [*see attached Exhibit B*]	Medical coverage provided through the Plan is described in the evidence of coverage that relates to the Insurance Policy which is attached as Exhibit B and is hereby incorporated by reference.

1.6 How does a member of the Select Group obtain coverage?

Medica Services Company, LLC, as the Plan Sponsor, will provide you with a website address and/or forms necessary to enroll and make elections for the Component program available to you, including information about the cost of the Component benefits. For additional information regarding enrollment, see the Evidences of Coverage attached as Exhibits to this SPD.

1.7 Can I change my coverage under a Component during a Plan Year?

In general, coverage can be changed only during a limited period of time at the end of the Plan Year and with respect to coverage for the next Plan Year. The Plan Year for the Plan is the calendar year. Whether a change in coverage can occur during the Plan Year depends upon the terms and conditions of the Insurance Policy and applicable law.

Note: If you are interested in making a change in coverage, it is very important to check the evidence of coverage attached as Exhibits to this SPD and the Insurance Policy.

1.8 When does coverage end?

Coverage under the Plan ends when you are no longer covered under any of the Components, regardless of the reason. In general, coverage under the Plan continues until a Covered Individual decides not to participate, coverage under the Insurance Policy ends, the Covered Individual fails to make contributions in a timely manner, the Covered Individual dies, or coverage is terminated for cause. In most cases, if coverage ends, it ends on the last day of the month.

It is very important to check the Insurance Policy and Evidence of Coverage for additional information regarding termination of coverage.

1.9 Who pays the cost of coverage under the Insurance Policy?

Responsibility for the cost of coverage is shared. The Employer pays a portion of the cost of coverage. The Covered Individual is responsible to pay the portion of the cost of coverage not paid by the Employer. The contribution by the Covered Individual must be made with after-tax dollars. Such contributions are generally due by the first day of each month unless your Employer has agreed to another payment schedule.

	Employer Contribution*
Relations of Active Employee	
Parent of Active Employee	$10 per month
Parent In-Law of Active Employee	$10 per month
Former Employee (and Spouse, if any)	
Former Employee 5+ benefit eligible years	$40 per month
Former Employee less than 5 benefit eligible years	$10 per month

**Portion of the coverage cost not paid by Employer contribution is Covered Individual's responsibility.*

1.10 How long will the Plan remain in effect?

Although the Plan Sponsor expects to maintain the Plan (including each of the Components) indefinitely, the Plan Sponsor has the right to amend or terminate the Plan in whole or in part at any time. It is also possible that future changes in state or federal laws may require that the Plan be amended or terminated accordingly. You will be informed if changes are made to the Plan.

1.11 How are claims determined?

With respect to claims arising under the Insurance Policy(ies) obtained to provide Benefits under the Plan, claims and appeals shall be handled in accordance with the terms and conditions of the Insurance Policy(cies). With respect to other claims relating to Benefits under the Plan including, but not limited to, (1) status as Covered Individual, Participant, or part of a Select Group; and (2) entitlement to an Employer Contribution and the amount, claims and appeals shall be handled in accordance with the rules contained in the separate written document entitled "Claims and Appeals Procedures for Medica Group Medicare Plan" unless required by applicable law to be handled in a different manner. A copy of that document is available upon request at no charge.

PART II.
STATEMENT OF ERISA RIGHTS

As a person covered under this Plan (including any Components), you are entitled to certain rights and protections under ERISA. For purposes of this Statement of ERISA Rights, "participant" also refers to people covered under the Plan.

Receive Information About Your Plans and Benefits. ERISA provides that all participants shall be entitled to:

(a) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

(b) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, if applicable, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

(c) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report ("SAR").

Prudent Actions by Plan Fiduciaries. In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other participants and beneficiaries. No one, including your Employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights. If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions. If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA or HIPAA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

EXHIBIT A: Medica Group Prime Solution^{SM} Evidence of Coverage
Link here:

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