

MEDICA CHOICE SELECT
SUMMARY OF BENEFITS

Partial Listing of Covered Services	In-Network Benefits These benefits apply when services are provided by network providers or for services authorized as in-network benefits by MIC.	Out-of-Network Benefits* These benefits apply when services are provided by non-network providers.
Deductible Per Calendar Year	\$1000/ member \$2000/ family	\$1500/ member \$3000/ family
Out-of-Pocket Maximum Per Calendar Year	\$2750/ member \$5500/ family	\$4500/ member Not applicable
	When you receive covered services after deductible has been met, MIC PAYS:	When you receive covered services after deductible has been met, MIC PAYS:
Preventive Care	<i>The deductible does not apply to these services.</i> 100%	60%
Office Visits Chiropractic Services	<i>The deductible does not apply to these services.</i> 100% after the \$20 copayment 100% after the \$20 copayment	60% 60% Limited to 15 visits per member, per year.
Prescription Drugs Up to a 31-day supply for medications received at a pharmacy	<i>The deductible does not apply to these services.</i> 100% after \$10 copayment per prescription unit or refill for formulary generic drugs. 100% after \$25 copayment per prescription unit or refill for formulary brand name drugs. 100% after \$50 copayment per prescription unit or refill for non-formulary prescription drugs.	60%. Member pays the greater of 40% or a \$50 copayment per prescription unit.
Inpatient Hospital Services • Facility • Physician	80% 80%	Limited to 120 days per member, per year. 60% 60%
Outpatient Hospital Services • Facility • Physician	80% 80%	60% 60%
Lab and Pathology	100% <i>The deductible does not apply.</i>	60%
X-Ray and Other Imaging	80%	60%
Urgent or Emergency Care • Urgent Care Center • Hospital Emergency Room • Emergency Ambulance	100% after the \$20 copayment. <i>The deductible does not apply.</i> 80% 80%	See Below See Below See Below
Emergency Services from Non-Network Providers	80%	

Out of Network Coverage

* Coverage is limited to the non-network provider reimbursement amount (as defined in your Certificate of Coverage) after deductible is met.

* If you decide to utilize your Out-of-Network Benefits, you may pay more than you would for In-Network Benefits. The amount you pay could include a percentage coinsurance, a fixed dollar copayment and/or deductible amount. In addition, if the amount that your non-network provider bills you is more than the non-network provider reimbursement amount (as defined in your Certificate of Coverage) **you are responsible for paying the difference**, and such difference will not be applied toward the Out-of-Pocket Maximum.

Exclusions and Limitations to Coverage

The following is a list of some of the services and supplies that are excluded from coverage. When you enroll, the Certificate of Coverage you receive will provide a more complete and detailed list of exclusions. Please refer to your Certificate of Coverage for specific information about excluded services or supplies.

- Cosmetic Surgery
- Refractive eye surgery.
- Exams for employment, insurance, administrative proceedings, research or licensure.
- Personal convenience items and some non-durable supplies.
- A drug, device or medical treatment or procedure that is investigative or not a covered health service.

- Custodial supportive care and self-care or self-help training.
- Educational classes, programs or seminars.
- Services prohibited by law or regulation.
- Services for which coverage is available under worker's compensation, employer liability or any similar law.

Contact Customer Service at 952-945-8000 (Minneapolis/St. Paul metro area), 952-992-3190 (Minneapolis/St. Paul metro area members with hearing impairments), 800-952-3455 (outside of Minneapolis/St. Paul metro area), or 800-841-6753 (outside of Minneapolis/St. Paul metro area members with hearing impairments) for more information or answers to specific questions.

This health care plan may not cover all your health care expenses; read your Certificate of Coverage carefully to determine which expenses are covered. This is a benefit summary only and does not outline all of your benefits. When you enroll with Medica Insurance Company (MIC), you will receive a Certificate of Coverage. If there is a discrepancy between information in this summary and your Certificate of Coverage, the Certificate of Coverage will take precedence in determining your benefits.