MIC Choice MN 500-15
Rx 3-tier

MEDICA CHOICE SELECT SUMMARY OF BENEFITS

Partial Listing of Covered Services	Medica Choice In-network Benefits	Out-of-Network Benefits*
Deductible Per Calendar Year	$500/member $1,000/family	$1,000/member $2,000/family
Out-of-Pocket Maximum Per Calendar Year	$2,000/member $5,000/family	$3,500/member
Lifetime Maximum	Unlimited	$1,000,000
	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	*The deductible does not apply to these services.*	
• **Routine Physical & Eye Exams, Cancer Screenings and Allergy Shots**	100%	60%
• **Immunizations and Well Child Care**	100%	100% *The deductible does not apply.*
Office Visits	*The deductible does not apply to these services.*	
• **Illness or Injury**	100% after $15 copayment	60%
• **Chiropractic Care**	100% after $15 copayment	60% *Limited to 15 visits per member, per year.*
• **Physical, Occupational & Speech Therapy**	100% after $15 copayment	60%
• **Mental Health and Substance Abuse**	100% after $15 copayment for individual therapy or $10 for group therapy.	60%
Prescription Drugs *Up to a 31-day supply per prescription*	*The deductible does not apply to these services.* Formulary Generic: 100% after $10 copayment Formulary Brand Name: 100% after $25 copayment Non-Formulary: 100% after $50 copayment	60%. Member pays the greater of 40% or a $50 copayment per prescription unit.
Inpatient Hospital Services		*Limited to 120 days per member, per year.*
• **Facility**	80%	60%
• **Physician**	80%	60%
• **Mental Health and Substance Abuse**	80%	60%
Outpatient Hospital Services		
• **Facility**	80%	60%
• **Physician**	80%	60%
Lab and Pathology	100% *The deductible does not apply.*	60%
X-Ray and Other Imaging	80%	60%
Urgent or Emergency Care		
• **Urgent Care Center**	100% after $15 copayment *The deductible does not apply.*	80% after in-network deductible.
• **Hospital Emergency Room**	80%	80% after in-network deductible.
• **Emergency Ambulance**	80%	80% after in-network deductible.
Durable Medical Equipment and Prosthetics	80%	60%
Home Health Care	80%	60%

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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 individuals with hearing impairments), **800-952-3455** (outside of Minneapolis/St. Paul metro area), or **800-841-6753** (outside of Minneapolis/St. Paul metro area individuals 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. 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.

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