

**MEDICA CHOICE SELECT
SUMMARY OF BENEFITS**

Partial Listing of Covered Services	Medica Choice In-Network Benefits	Out-of-Network Benefits*
Deductible Per Calendar Year	\$0/member \$0/family	\$300/member \$600/family
Out-of-Pocket Maximum Per Calendar Year	\$1,500/member \$5,000/family	\$3,000/member
Lifetime Maximum	Unlimited	\$1,000,000
	When you receive covered services, MIC PAYS:	When you receive covered services after deductible has been met, MIC PAYS:
Preventive Care		
<ul style="list-style-type: none"> Routine Physical & Eye Exams, Cancer Screenings and Allergy Shots 	100%	60%
<ul style="list-style-type: none"> Immunizations and Well Child Care 	100%	100% <i>The deductible does not apply.</i>
Office Visits		
<ul style="list-style-type: none"> Illness or Injury 	100% after \$15 copayment.	60%
<ul style="list-style-type: none"> Chiropractic Care 	100% after \$15 copayment.	60% <i>Limited to 15 visits per member, per year.</i>
<ul style="list-style-type: none"> Physical, Occupational & Speech Therapy 	100% after \$15 copayment.	60%
<ul style="list-style-type: none"> Mental Health and Substance Abuse 	100% after \$15 copayment for individual therapy or \$10 for group therapy.	60%
Prescription Drugs <i>Up to a 31-day supply per prescription</i>	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		<i>Limited to 120 days per member, per year.</i>
<ul style="list-style-type: none"> Facility 	80%	60%
<ul style="list-style-type: none"> Physician 	80%	60%
<ul style="list-style-type: none"> Mental Health and Substance Abuse 	80%	60%
Outpatient Hospital Services		
<ul style="list-style-type: none"> Facility 	80%	60%
<ul style="list-style-type: none"> Physician 	80%	60%
Lab and Pathology	100%	60%
X-Ray and Other Imaging	80%	60%
Urgent or Emergency Care		<i>The deductible does not apply to these services.</i>
<ul style="list-style-type: none"> Urgent Care Center 	100% after \$15 copayment.	80%
<ul style="list-style-type: none"> Hospital Emergency Room 	100% after \$75 copayment.	80%
<ul style="list-style-type: none"> Emergency Ambulance 	80%	80%
Durable Medical Equipment and Prosthetics	80%	60%
Home Health Care	80%	60%

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.
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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.
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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.