

MEDICA CHOICE® PASSPORT  
SUMMARY OF BENEFITS

Partial Listing of Covered Services	Medica Choice with UnitedHealthcare In-Network Benefits	Out-of-Network Benefits*
<b>Annual Deductible</b>	\$0 per member \$0 per family	\$3,000 per member \$9,000 per family
<b>Annual Out-of-Pocket Maximum</b>	\$2,000 per member \$5,000 per family	\$9,000 per member
<b>Lifetime Maximum</b>	Unlimited	\$1,000,000
	<b>When you receive covered services, the plan pays:</b>	<b>When you receive covered services after the deductible has been met, the plan pays:</b>
<b>Preventive Care</b> • Routine Physical & Eye Exams • Immunizations, Well Child Care and Cancer Screenings	100% 100%	50% 50%
<b>Office Visits</b> • Illness or Injury • Chiropractic Care • Physical, Occupational & Speech Therapy  • Mental Health and Substance Abuse	100% after \$25 copayment. 100% after \$25 copayment. 100% after \$25 copayment.  100% after \$25 for individual therapy or \$20 for group therapy.	50% 50% <i>Limited to 15 visits per member, per year.</i> 50% <i>Physical and occupational therapy is limited to a combined limit of 20 visits per member, per year.</i> 50% <i>Speech therapy is limited to 20 visits per member, per year.</i> 50%
<b>Convenience Care/ Retail Health Clinic Visits</b>	100% after \$10 copayment.	50%
<b>Prescription Drugs</b> <i>Up to a 31-day supply per prescription</i>	Tier 1: 100% after \$11 copayment Tier 2: 100% after \$40 copayment Tier 3: 100% after \$80 copayment	60%. Member pays the greater of 40% or a \$80 copayment per prescription unit.
<b>Specialty Prescription Drugs</b> <i>Up to a 31-day supply per prescription for specialty prescription drugs received from a designated specialty pharmacy.</i>	Tier 1: 80%. Member does not pay more than \$200 per prescription unit. Tier 2: 60%	No Coverage
<b>Inpatient Hospital Services</b> • Facility • Physician • Mental Health and Substance Abuse	100% 100% 100%	50% 50% 50%
<b>Outpatient Hospital Services</b> • Facility • Physician	100% after \$25 copayment 100% after \$25 copayment	50% 50%
<b>Lab and Pathology</b>	100%	50%
<b>X-Ray and Other Imaging</b>	100%	50%
<b>Urgent or Emergency Care</b> • Urgent Care Center • Hospital Emergency Room • Emergency Ambulance	100% after \$25 copayment 100% after \$95 copayment 100%	Covered as an in- network benefit. Covered as an in- network benefit. Covered as an in-network benefit.
<b>Durable Medical Equipment and Prosthetics</b>	80%	50%
<b>Home Health Care</b> <i>Limited to a combined maximum of 120 visits per member, per year for in-network and 60 visits out-of-network.</i>	80%	50%

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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.

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### Exclusions and Limitation 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), **800-952-3455** (outside of Minneapolis/ St. Paul metro area), or **800-855-2880** (individuals with hearing impairments) for more information or answers to specific questions.

This health care plan is administered by Medica Insurance Company (MIC). It 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.