

MEDICA CHOICE® PASSPORT
SUMMARY OF BENEFITS
OPTIONS PLAN

Partial Listing of Covered Services	Tier 1: HCMC/ HFA/ Fairview In-Network Benefits	Tier 2: Medica Choice with UnitedHealthcare In-Network Benefits	Tier 3: Out-of-Network Benefits*
Annual Deductible	\$0 per member \$0 per family	\$0 per member \$0 per family	\$500 per member \$1,000 per family
Annual Out-of-Pocket Maximum	\$3,000 per member \$5,000 per family		
Lifetime Maximum	Unlimited		
	When you receive covered services, the plan pays:	When you receive covered services, the plan pays:	When you receive covered services after the deductible has been met, the plan pays:
Preventive Care • Routine Physical & Eye Exams • Immunizations, Well Child Care and Cancer Screenings	100% 100%	100% 100%	60% 60%
Office Visits • Illness or Injury • Chiropractic Care • Physical, Occupational & Speech Therapy • Mental Health and Substance Abuse	100% after \$10 copayment. <i>(Copayment waived at HCMC & HFA)</i> 100% after \$10 copayment. <i>(Copayment waived at HCMC & HFA)</i> 100% after \$10 copayment. 100% after \$10 copayment. <i>(Copayment waived at HCMC & HFA)</i>	100% after \$30 copayment. 100% after \$30 copayment. 100% after \$30 copayment. 100% after \$30 copayment.	60% 60% Limited to 20 visits per member, per year. 60% 60%
Convenience Care/ Retail Health Clinic Visits	100% after \$5 copayment. <i>(Copayment waived at HCMC & HFA)</i>	100% after \$5 copayment.	60%
Prescription Drugs <i>Up to a 31-day supply per prescription</i>	Preferred Generic: 100% after \$12 copayment Preferred Brand: 100% after \$35 copayment	Covered as Tier 1	60%
Specialty Prescription Drugs <i>Up to a 31-day supply per prescription for specialty prescription drugs received from a designated specialty pharmacy.</i>	Preferred Generic: 100% after \$12 copayment Preferred Brand: 100% after \$35 copayment	Covered as Tier 1	No Coverage
Inpatient Hospital Services including Mental Health and Substance Abuse • Facility • Physician	100% after \$125 copayment 100%	100% after \$250 copayment 100%	60% 60%
Outpatient Hospital Services • Facility • Physician	100% after \$100 copayment 100%	100% after \$200 copayment 100%	60% 60%
Lab and Pathology	100%	100%	Covered as a Tier 2 in-network benefit
X-Ray and Other Imaging	100%	100%	Covered as a Tier 2 in-network benefit
MRI and CT Scan	80%	80%	60%
Urgent or Emergency Care • Urgent Care Center • Hospital Emergency Room • Emergency Ambulance	100% after \$10 copayment 100% after \$175 copayment 80%	100% after \$30 copayment 100% after \$175 copayment 80%	Covered as a Tier 2 in-network benefit Covered as a Tier 2 in-network benefit Covered as a Tier 2 in-network benefit
Durable Medical Equipment and Prosthetics	80%	80%	60%
Home Health Care	100% after \$10 copayment	100% after \$30 copayment	60%

Out-of-Network Coverage

- Coverage is limited to the non-network provider reimbursement amount (as defined in your Plan Document) 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 Plan Document) **you are responsible for paying the difference**, and such difference will not be applied toward the out-of-pocket maximum.

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 Plan Document you receive will provide a more complete and detailed list of exclusions. Please refer to your Plan Document 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; 800-952-3455 Toll Free**, or **800-855-2880** for individuals with hearing impairments, for more information or answers to specific questions.

This health care plan is administered by Medica-Self-Insured (MSI). It may not cover all your health care expenses; read your Plan Document 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 Plan Document, the Plan Document will take precedence in determining your benefits.