

Medica Choice Select – Minnesota Plans

| | | MCS2 Rx Min/Max | | MCS5 Rx Min/Max | | MCS7 Rx Min/Max | | MCS8 Rx Min/Max | |
|-----------------------------------------------------------------------------|--------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|
| Partial Listing of Covered Services | | In-Network Benefits These benefits apply when services are provided by network providers or for services authorized in advance by Medica Health Plans. | Out-of-Network** Benefits These benefits apply when services are provided by non-network providers. | In-Network Benefits These benefits apply when services are provided by network providers or for services authorized in advance by Medica Health Plans. | Out-of-Network** Benefits These benefits apply when services are provided by non-network providers. | In-Network Benefits These benefits apply when services are provided by network providers or for services authorized in advance by Medica Health Plans. | Out-of-Network** Benefits These benefits apply when services are provided by non-network providers. | In-Network Benefits These benefits apply when services are provided by network providers or for services authorized in advance by Medica Health Plans. | Out-of-Network** Benefits These benefits apply when services are provided by non-network providers. |
| Lifetime Maximum Benefit | | Unlimited. | \$1,000,000. | Unlimited. | \$1,000,000. | Unlimited. | \$1,000,000. | Unlimited. | \$1,000,000. |
| Out-of-Pocket Maximum | Member | \$1000 per calendar yr. | \$3000 per calendar yr. | \$1200 per calendar yr. | \$3000 per calendar yr. | \$1200 per calendar yr. | \$3000 per calendar yr. | \$1500 per calendar yr. | \$3000 per calendar yr. |
| | Family | \$5000 per calendar yr. | Does not apply. | \$5000 per calendar yr. | Does not apply. | \$5000 per calendar yr. | Does not apply. | \$5000 per calendar yr. | Does not apply. |
| Deductible | Member | None. | \$300 per calendar yr. | None. | \$300 per calendar yr. | None. | \$300 per calendar yr. | None. | \$300 per calendar yr. |
| | Family | None. | Maximum \$900 per calendar year. | None. | Maximum \$900 per calendar year. | None. | Maximum \$900 per calendar year. | None. | Maximum \$900 per calendar year. |
| | | When you receive covered services, Medica Health Plans PAYS: | When you receive covered services after deductible has been satisfied, Medica Insurance Company PAYS: | When you receive covered services, Medica Health Plans PAYS: | When you receive covered services after deductible has been satisfied, Medica Insurance Company PAYS: | When you receive covered services, Medica Health Plans PAYS: | When you receive covered services after deductible has been satisfied, Medica Insurance Company PAYS: | When you receive covered services, Medica Health Plans PAYS: | When you receive covered services after deductible has been satisfied, Medica Insurance Company PAYS: |
| PREVENTIVE CARE RECEIVED IN THE PHYSICIAN'S OFFICE OR HOSPITAL | | | | | | | | | |
| • Routine physical exams | | 100%. | No coverage. | 100%. | No coverage. | 100%. | No coverage. | 100%. | No coverage. |
| • Immunizations | | 100%. | 80%* | 100%. | 80%* | 100%. | 80%* | 100%. | 80%* |
| • Well child care | | 100%. | 80%* | 100%. | 80%* | 100%. | 80%* | 100%. | 80%* |
| • Mammograms | | 100%. | 80%* | 100%. | 80%* | 100%. | 80%* | 100%. | 80%* |
| • Pap smears | | 100%. | 80%* | 100%. | 80%* | 100%. | 80%* | 100%. | 80%* |
| • Routine eye exams | | 100%. | No coverage. | 100%. | No coverage. | 100%. | No coverage. | 100%. | No coverage. |
| • Allergy shots | | 100%. | 80%* | 100%. | 80%* | 100%. | 80%* | 100%. | 80%* |
| SERVICES RECEIVED IN THE PHYSICIAN'S OFFICE | | | | | | | | | |
| • Office visits for illness or injury | | 100% after \$10 copayment. | 80%* | 100% after \$10 copayment. | 80%* | 100% after \$15 copayment. | 80%* | 100% after \$15 copayment. | 80%* |
| • Lab and X-ray | | 100%. | 80%* | 100%. | 80%* | 100%. | 80%* | 100%. | 80%* |
| • Surgical services | | 100% after \$10 copayment. | 80%* | 80% | 80%* | 100% after \$15 copayment. | 80%* | 80% | 80%* |
| SERVICES RECEIVED IN A HOSPITAL OR SURGICENTER | | | | | | | | | |
| • Inpatient hospital Facility | | 100%. | 80%*. Limited to 120 days per member, per calendar year for all inpatient services combined. | 80%. | 80%*. Limited to 120 days per member, per calendar year for all inpatient services combined. | 100%. | 80%*. Limited to 120 days per member, per calendar year for all inpatient services combined. | 80%. | 80%*. Limited to 120 days per member, per calendar year for all inpatient services combined. |
| • Outpatient hospital Facility | | 100%. | 80%* | 80%. | 80%* | 100%. | 80%* | 80%. | 80%* |
| • Outpatient hospital Physician surgical | | 100% after \$10 copayment. | 80%* | 80% | 80%* | 100% after \$15 copayment. | 80%* | 80% | 80%* |
| • Lab and X-ray Facility | | 100%. | 80%* | 100%. | 80%* | 100%. | 80%* | 100%. | 80%* |
| • Lab and X-ray Physician | | 100%. | 80%* | 100%. | 80%* | 100%. | 80%* | 100%. | 80%* |
| URGENT OR EMERGENCY CARE | | | | | | | | | |
| • Urgent care center | | 100% after \$10 copayment. | See below. | 100% after \$10 copayment. | See below. | 100% after \$15 copayment. | 80%* | 100% after \$15 copayment. | See below. |
| • Hospital emergency room | | 100% after \$60 copayment. | See below. | 80%. | See below. | 100% after \$60 copayment. | See below. | 80% | See below. |
| • Emergency ambulance | | 80%. | See below. | 80%. | See below. | 80%. | See below. | 80%. | See below. |
| EMERGENCY SERVICES FROM NON-NETWORK PROVIDERS | | 80%. A deductible does not apply to emergency services. Member pays a maximum of \$500 per calendar year. | | 80%. A deductible does not apply to emergency services. Member pays a maximum of \$750 per calendar year. | | 80%. A deductible does not apply to emergency services. Member pays a maximum of \$500 per calendar year. | | 80%. A deductible does not apply to emergency services. Member pays a maximum of \$500 per calendar year. | |
| MATERNITY CARE RECEIVED IN THE PHYSICIAN'S OFFICE OR HOSPITAL | | | | | | | | | |
| • Prenatal services | | 100%. | 80%* | 100%. | 80%* | 100%. | 80%* | 100%. | 80%* |
| • Delivery services Physician | | 100%. | 80%* | 100%. | 80%* | 100%. | 80%* | 100%. | 80%* |
| • Delivery services Hospital | | 100%. | 80%*. Limited to 120 days per member, per calendar year for all inpatient services combined. | 80%. | 80%*. Limited to 120 days per member, per calendar year for all inpatient services combined. | 100%. | 80%*. Limited to 120 days per member, per calendar year for all inpatient services combined. | 80%. | 80%*. Limited to 120 days per member, per calendar year for all inpatient services combined. |
| • Postnatal services | | 100%. | 80%* | 100%. | 80%* | 100%. | 80%* | 100%. | 80%* |
| PRESCRIPTION MEDICATIONS RECEIVED AT A PHARMACY | | <i>Up to a 31-day supply for medications dispensed according to Medica's formulary and received at a network pharmacy.</i> | <i>Up to a 31-day supply for medications received at a non-network pharmacy.</i> | <i>Up to a 31-day supply for medications dispensed according to Medica's formulary and received at a network pharmacy.</i> | <i>Up to a 31-day supply for medications received at a non-network pharmacy.</i> | <i>Up to a 31-day supply for medications dispensed according to Medica's formulary and received at a network pharmacy.</i> | <i>Up to a 31-day supply for medications received at a non-network pharmacy.</i> | <i>Up to a 31-day supply for medications dispensed according to Medica's formulary and received at a network pharmacy.</i> | <i>Up to a 31-day supply for medications received at a non-network pharmacy.</i> |
| | | 80%. Member pays a minimum copayment of \$10 and a maximum copayment of \$25 per prescription unit or refill. | 60%. Member pays the greater of 40% or a \$25 copayment. | 80%. Member pays a minimum copayment of \$10 and a maximum copayment of \$25 per prescription unit or refill. | 60%. Member pays the greater of 40% or a \$25 copayment. | 80%. Member pays a minimum copayment of \$10 and a maximum copayment of \$25 per prescription unit or refill. | 60%. Member pays the greater of 40% or a \$25 copayment. | 80%. Member pays a minimum copayment of \$10 and a maximum copayment of \$25 per prescription unit or refill. | 60%. Member pays the greater of 40% or a \$25 copayment. |
| MENTAL HEALTH CARE | | <i>Care must be provided by a Medica-designated mental health provider. You must receive authorization from Medica's designated mental health provider prior to receiving services.</i> | | <i>Care must be provided by a Medica-designated mental health provider. You must receive authorization from Medica's designated mental health provider prior to receiving services.</i> | | <i>Care must be provided by a Medica-designated mental health provider. You must receive authorization from Medica's designated mental health provider prior to receiving services.</i> | | <i>Care must be provided by a Medica-designated mental health provider. You must receive authorization from Medica's designated mental health provider prior to receiving services.</i> | |
| • Outpatient services | | 100% after \$10 copayment for individual therapy or \$5 copayment for group therapy. | 80%* | 100% after \$10 copayment for individual therapy or \$5 copayment for group therapy. | 80%* | 100% after \$15 copayment for individual therapy or \$10 copayment for group therapy. | 80%* | 100% after \$15 copayment for individual therapy or \$10 copayment for group therapy. | 80%* |
| • Inpatient services | | 100%. | 80%*. Limited to 120 days per member, per calendar year for all inpatient services combined. | 80%. | 80%*. Limited to 120 days per member, per calendar year for all inpatient services combined. | 100%. | 80%*. Limited to 120 days per member, per calendar year for all inpatient services combined. | 80%. | 80%*. Limited to 120 days per member, per calendar year for all inpatient services combined. |
| SUBSTANCE ABUSE CARE | | <i>Care must be provided by a Medica-designated substance abuse provider. You must receive authorization from Medica's designated substance abuse provider prior to receiving services.</i> | | <i>Care must be provided by a Medica-designated substance abuse provider. You must receive authorization from Medica's designated substance abuse provider prior to receiving services.</i> | | <i>Care must be provided by a Medica-designated substance abuse provider. You must receive authorization from Medica's designated substance abuse provider prior to receiving services.</i> | | <i>Care must be provided by a Medica-designated substance abuse provider. You must receive authorization from Medica's designated substance abuse provider prior to receiving services.</i> | |
| • Outpatient services | | 100% after \$10 copayment for individual therapy or \$5 copayment for group therapy. | 80%* | 100% after \$10 copayment for individual therapy or \$5 copayment for group therapy. | 80%* | 100% after \$15 copayment for individual therapy or \$10 copayment for group therapy. | 80%* | 100% after \$15 copayment for individual therapy or \$10 copayment for group therapy. | 80%* |
| • Inpatient services | | 100%. | 80%*. Limited to 120 days per member, per calendar year for all inpatient services combined. | 80%. | 80%*. Limited to 120 days per member, per calendar year for all inpatient services combined. | 100%. | 80%*. Limited to 120 days per member, per calendar year for all inpatient services combined. | 80%. | 80%*. Limited to 120 days per member, per calendar year for all inpatient services combined. |
| REHABILITATIVE THERAPY RECEIVED IN THE PROVIDER'S OFFICE OR HOSPITAL | | | | | | | | | |
| • Physical therapy | | 100% after \$10 copayment. | 80%* | 100% after \$10 copayment. | 80%* | 100% after \$15 copayment. | 80%* | 100% after \$15 copayment. | 80%* |
| • Occupational therapy | | 100% after \$10 copayment. | 80%* | 100% after \$10 copayment. | 80%* | 100% after \$15 copayment. | 80%* | 100% after \$15 copayment. | 80%* |
| • Speech therapy | | 100% after \$10 copayment. | 80%* | 100% after \$10 copayment. | 80%* | 100% after \$15 copayment. | 80%* | 100% after \$15 copayment. | 80%* |
| DURABLE MEDICAL EQUIPMENT AND PROSTHETICS | | 80%. | 80%* | 80%. | 80%* | 80%. | 80%* | 80%. | 80%* |
| CHIROPRACTIC CARE | | 100% after \$10 copayment. | 80%*. Limited to 15 visits per member, per calendar year. | 100% after \$10 copayment. | 80%*. Limited to 15 visits per member, per calendar year. | 100% after \$15 copayment. | 80%*. Limited to 15 visits per member, per calendar year. | 100% after \$15 copayment. | 80%*. Limited to 15 visits per member, per calendar year. |

*Coverage is limited to 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 amounts. 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.

Medica CallLink®:

Answering Your Health Questions, Day or Night

One of Medica's most popular features is Medica CallLink.

This 24-hours-a-day, 365-days-a-year service is staffed by experienced registered nurses who are ready and willing to answer your questions on a variety of medical subjects and situations.

With Medica CallLink, you'll find that quick, sound medical advice is only a phone call away.

Optum® Assistance Services:

Helping You Cope With Any Concern, Day or Night

Another popular feature of Medica is Optum Assistance Services. This 24-hours-a-day, 365-days-a-year service is staffed by trained counselors who can help you sort out personal, family or work concerns facing you and your family.

Working Toward Healthier Members

At Medica, our goal is to help you stay healthy. To that end, we offer a wide variety of innovative health improvement services, programs and informational materials. Here is a sampling:

The *Healthy Lifestyle Kit*.

As part of our medical self-care program, we will be sending you a Healthy Lifestyle Kit. This kit is sent to all newly enrolled, fully-insured members of Medica, as an introduction to health improvement and the importance of being an informed health care consumer. It includes the following resources:

- **The *Medica Health Handbook*.**

This award-winning self-care health manual is designed to help you take a more active role in your health. It covers more than 180 common health topics, such as allergies, back pain, ear infections and rashes. Under each topic you'll find detailed information on home treatments and prevention, as well as information about when to call a health care professional.

- **Your Health Profile.**

This questionnaire is used to assess your health and lifestyle habits. When you complete and return the questionnaire, you'll receive an individual report that will provide ideas for healthy living and reducing your risk of being sick or injured in the future.

Mammography and Early Detection of Breast Cancer

If you are a woman over the age of 40, we will work with you and your physician to remind you to receive regular mammograms.

Prenatal Care

In partnership with our obstetrician/gynecologist providers, we have developed a program that identifies women who might be at risk of complications during their pregnancies. We then support those women with educational resources and nurse case managers to assist each mother to have the healthiest pregnancy possible.

Asthma Program for Children

If you have a child with asthma, we will, at your request, send a specially trained nurse into your home to help you learn how to recognize and respond to the early warning signs of an asthma attack and how to use medications and breathing exercises to keep the illness under control.

Retinal Eye Exams for People with Diabetes

If you are an adult with diabetes, we will work closely with you and your physician to remind you to receive annual retinal eye exams.

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 detailed list of exclusions. Please refer to your Certificate of Coverage for specific information about excluded services or supplies.

- Cosmetic services.
- Reversal of voluntary sterilization, in vitro fertilization, sperm banking and adoption.
- Exams for employment, insurance, administrative proceedings, research or licensure.
- Personal convenience items, some non-durable supplies, eyeglasses, contact lenses, hearing aids and related fittings.
- A drug, device or medical treatment or procedure that is investigative.
- Health services that are not medically necessary.
- Custodial supportive care and self-care or self-help training.
- Educational classes, programs or seminars.
- Services for mental disorders not listed in the most current edition of the *Diagnostic and Statistical Manual of Mental Disorders*.
- Services by persons who are family or of the same legal residence.
- Dental procedures, except accident-related dental.
- Services prohibited by law or regulation.
- Autopsies.
- Injuries that occur while on military duty.
- Enteral feedings except to treat PKU.
- Services that are the primary responsibility of a different carrier (including but not limited to workers' compensation, auto insurance and employer's liability insurance) shall be subject to coordination of benefits.
- Travel, transportation or living expenses.
- Recreational therapy.
- Vocational and job rehabilitation.

MEDICA

Medica Choice Select

Minnesota

Product Comparison

**MCS2, MCS5, MCS7, MCS8
Rx Min/Max**

MEDICA