

Medica Choice Passport

*Certificate of
Coverage*

MEDICA®

**MEDICA CHOICE PASSPORT MN 2000-20%
THE CITY OF MINNEAPOLIS ACTIVES AND
RETIRES PLAN**

BPL 87133

DOC 26767

MEDICA CUSTOMER SERVICE

Minneapolis/St. Paul
Metro Area:
(952) 945-8000

Outside the Metro Area:
1-800-952-3455

More information about the plan can also be obtained by signing in at www.mymedica.com.

Hearing Impaired:
National Relay Center
1-800-855-2880, then
ask them to dial Medica
at **1-800-952-3455**

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UNV1011

If you want free help translating this information, call the number
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Introduction

THIS POLICY IS REGULATED BY MINNESOTA LAW.

The benefits of the policy providing your coverage are governed primarily by the law of a state other than Florida.

Many words in this certificate have specific meanings. These words are identified in each section and defined in *Definitions*.

See *Definitions*. These words have specific meanings: benefits, claim, dependent, medically necessary, member, network, premium, provider.

Medica Insurance Company (Medica) offers Medica Choice Passport. This is a non-qualified plan as set forth under Section 62E.05 of Minnesota law. This plan is not a qualified plan as set forth under the Patient Protection and Affordable Care Act. This Certificate of Coverage (this certificate) describes health services that are eligible for coverage and the procedures you must follow to obtain benefits.

The Contract refers to the Contract between Medica and the employer. You should contact the employer to see the Contract.

Because many provisions are interrelated, you should read this certificate in its entirety. Reviewing just one or two sections may not give you a complete understanding of the coverage described. The most specific and appropriate section will apply for those benefits related to the treatment of a specific condition.

Members are subject to all terms and conditions of the Contract and health services must be medically necessary.

Medica may arrange for various persons or entities to provide administrative services on its behalf, including claims processing, and utilization management services. To ensure efficient administration of your benefits, you must cooperate with them in the performance of their responsibilities.

Additional network administrative support is provided by one or more organizations under contract with Medica.

The employer is responsible for remitting the premium to Medica and notifying you of any changes to this certificate as required by applicable law.

In this certificate, the words *you*, *your*, and *yourself* refer to the member. The word *employer* refers to the organization through which you are eligible for coverage.

Medical Loss Ratio (MLR) standards under the federal Public Health Service Act

Federal law establishes standards concerning the percentage of premium revenue that insurers pay out for claims expenses and health care quality improvement activities. If the amount an insurer pays out for such expenses and activities is less than the applicable MLR standard, the insurer is required to provide a premium rebate. MLR calculations are based on aggregate market data rather than on a group by group basis. In the event Medica is required to pay rebates pursuant to federal law, Medica will pay such rebates to your employer unless prohibited by federal law.

Introduction

To be eligible for benefits

Each time you receive health services, you must:

1. Confirm with Customer Service that your provider is a network provider with Medica Choice Passport to be eligible for in-network benefits; and
2. Identify yourself as a Medica Choice Passport member; and
3. Present your Medica Choice Passport identification card. (If you do not show your Medica Choice Passport identification card, providers have no way of knowing that you are a Medica Choice Passport member and you may receive a bill for health services or be required to pay at the time you receive health services.) However, possession and use of a Medica Choice Passport identification card does not necessarily guarantee coverage.

Network providers are required to submit claims within 180 days from when you receive a service. If your provider asks for your health care identification card and you do not identify yourself as a Medica member within 180 days of the date of service, you may be responsible for paying the cost of the service you received.

Language interpretation

Language interpretation services will be provided upon request, as needed in connection with the interpretation of this certificate. If you would like to request language interpretation services, please call Customer Service at one of the telephone numbers listed inside the front cover.

If you have an impairment that requires alternative communication formats such as Braille, large print, or audiocassettes, please call Customer Service at one of the telephone numbers listed inside the front cover to request these materials.

If this certificate is translated into another language or an alternative communication format is used, this written English version governs all coverage decisions.

Acceptance of coverage

This certificate is not a legal contract between you and Medica. It is simply an explanation of the benefits covered under the Contract that has been issued in Minnesota between Medica and the employer. This certificate is being delivered to you by, or on behalf of, your employer.

By accepting the health care coverage described in this certificate, you, on behalf of yourself and any dependents enrolled under the Contract, authorize the following:

1. The use of a social security number for purpose of identification unless otherwise prohibited by state law; and
2. That the information supplied by you to Medica for purposes of enrollment is accurate and complete.

You understand and agree that any omission or incorrect statement concerning a material fact intentionally made by you in connection with your enrollment under the Contract may invalidate your coverage.

Nondiscrimination policy

Medica's policy is to treat all persons alike, without distinctions based on race, color, creed, religion, national origin, gender, marital status, status with regard to public assistance, disability, sexual orientation, age, genetic information, or any other classification protected by law.

If you have questions, call Customer Service at one of the telephone numbers listed inside the front cover.

A. Member Rights And Responsibilities

See Definitions. These words have specific meanings: benefits, emergency, medically necessary, member, network, provider.

Member bill of rights

As a member of Medica Choice Passport, you have the right to:

1. Available and accessible services, including emergency services (defined in this certificate) 24 hours a day, seven days a week; and
2. Information about your health condition, appropriate or medically necessary treatment options and risks, regardless of cost or benefit coverage, so you can make an informed choice about your health care; and
3. Participate with providers in decision making regarding your health care, including the right to refuse treatment recommended to you by Medica or any provider; and
4. Be treated with respect and recognition of your dignity and privacy, including privacy of your medical and financial records maintained by Medica or any network provider in accordance with existing law; and
5. Contact Customer Service and Minnesota's Commissioner of Commerce to file a complaint about issues related to benefits (see *Complaints*). To file a complaint with the Minnesota Department of Commerce, call (651) 296-2488 and request insurance information. You may begin a legal proceeding if you have a problem with Medica or any provider; and
6. Receive information about Medica, its services, its practitioners and providers, and member rights and responsibilities; and
7. Appeal a decision regarding your health care coverage by calling Customer Service at one of the telephone numbers listed inside the front cover. See *Complaints* for information on your appeal rights; and
8. Make recommendations regarding Medica's member rights and responsibilities statement.

Member responsibilities

To increase the likelihood of maintaining good health and to ensure that the best quality care is received, it is important that you take an active role in your health care by:

1. Establishing a relationship with a network provider before becoming ill, as this allows for continuity of care; and
2. Providing the necessary information to health care professionals or Medica needed to determine the appropriate care. This objective is best obtained when you share:
 - a. Information about lifestyle practices; and
 - b. Personal health history; and
3. Understanding your health problems and agreeing to, and following, the plans and instructions for care given by those providing health care; and

Member Rights And Responsibilities

4. Practicing self-care by knowing:
 - a. How to recognize common health problems and what to do when they occur; and
 - b. When and where to seek appropriate help; and
 - c. How to prevent health problems from recurring; and
5. Practicing preventive health care by:
 - a. Having the appropriate tests, exams, and immunizations recommended for your gender and age as described in this certificate; and
 - b. Engaging in healthy lifestyle choices (such as exercise, proper diet, and rest).

You will find additional information on member responsibilities in this certificate.

B. How To Access Your Benefits

See Definitions. These words have specific meanings: benefits, claim, coinsurance, copayment, deductible, dependent, emergency, enrollment date, hospital, inpatient, late entrant, medically necessary, member, network, non-network, non-network provider reimbursement amount, physician, placed for adoption, premium, prescription drug, provider, qualifying coverage, reconstructive, restorative, skilled nursing facility, subscriber, virtual care, waiting period.

Provider network

In-network benefits are available through the Medica Choice Passport provider network. For a list of the in-network providers, please consult your Medica Choice Passport provider directory by signing in at www.mymedica.com or contacting Customer Service. Out-of-network benefits will apply when you choose to receive eligible health services from providers that are not contracted with Medica. Obstetrics/gynecology services do not require prior authorization and will be covered at the in-network or out-of-network benefit level, as applicable.

1. Important member information about in-network benefits

The information below describes your covered health services and the procedures you must follow to obtain in-network benefits.

To be eligible for in-network benefits, follow-up care or scheduled care after an emergency must be received from a network provider.

Benefits

Medica will cover health services and supplies as in-network benefits only if they are provided by network providers or are authorized by Medica. Prior authorization may be required from Medica for certain in-network benefits. This certificate fully defines your benefits and describes procedures you must follow to obtain in-network benefits.

Decisions about coverage are based on appropriateness of care and service to the member. Medica does not reward providers for denying care, nor does Medica encourage inappropriate utilization of services.

Diagnosed Lyme disease is covered the same as any other illness under this certificate.

Referrals

Certain health services are covered only upon referral; read this certificate carefully for referral requirements. All referrals to non-network providers and certain types of network providers must be prior authorized by Medica to be eligible for coverage at your highest level of benefits.

Emergency services

Emergency services from non-network providers will be covered as in-network benefits.

How To Access Your Benefits

Providers

Enrolling in Medica does not guarantee that a particular provider will remain a network provider or provide you with health services. When a provider no longer participates in the network, you must choose to receive health services from network providers to continue to be eligible for in-network benefits. You must verify that your provider is a network provider each time you receive health services.

Exclusions

Certain health services are not covered. Read this certificate for a detailed explanation of all exclusions.

Mental health and substance abuse

Medica's designated mental health and substance abuse provider will arrange your mental health and substance abuse benefits. Medica's designated mental health and substance abuse provider's hospital network is different from Medica's hospital network. Certain mental health and substance abuse services require prior authorization by Medica's designated mental health and substance abuse provider. Emergency services do not require prior authorization.

Continuation

You may continue coverage under certain circumstances. See *Continuation* for additional information.

Cancellation

Your coverage may be canceled only under certain conditions. This certificate describes all reasons for cancellation of coverage. See *Ending Coverage* for additional information.

Newborn coverage

Your dependent newborn is covered from birth. Medica does not automatically know of a birth or whether you would like coverage for the newborn dependent. Call Customer Service at one of the telephone numbers listed inside the front cover for more information. If additional premium is required, Medica is entitled to all premiums due from the time of the infant's birth until the time you notify Medica of the birth. Medica may reduce payment by the amount of premium that is past due for any health benefits for the newborn infant until any premium you owe is paid. For more information, see *Eligibility And Enrollment*.

Prescription drugs and medical equipment

Enrolling in Medica does not guarantee that a particular prescription drug or piece of medical equipment will continue to be covered, even if the drug or equipment is covered at the start of the calendar year.

Post-mastectomy coverage

Medica will cover all stages of reconstruction of the breast on which the mastectomy was performed and surgery and reconstruction of the other breast to produce a symmetrical appearance. Medica will also cover prostheses and physical complications, including lymphedemas, at all stages of mastectomy.

2. *Important member information about out-of-network benefits*

The information below describes your covered health services and provides important information concerning your out-of-network benefits. Read this certificate for a detailed explanation of both in-network and out-of-network benefits. Please carefully review the general sections of this certificate as well as the section(s) that specifically describe the services you are considering, so you are best able to determine the benefits that will apply to you.

Benefits

Medica pays out-of-network benefits for eligible health services received from non-network providers. Prior authorization may be required from Medica before you receive certain services, in order to determine whether those services are eligible for coverage under your out-of-network benefits. This certificate defines your benefits and describes procedures you must follow to obtain out-of-network benefits.

Decisions about coverage are made based on appropriateness of care and service to the member. Medica does not reward providers for denying care, nor does Medica encourage inappropriate utilization of services.

Emergency services received from non-network providers are covered as in-network benefits and are *not* considered out-of-network benefits.

Additionally, under certain circumstances Medica will authorize your obtaining services from a non-network provider at the in-network benefit level. Such authorizations are generally provided only in situations where the requested services are not available from network providers.

Be aware that if you choose to go to a non-network provider and use out-of-network benefits, you will likely have to pay much more than if you use in-network benefits.

The charges billed by your non-network provider may exceed the non-network provider reimbursement amount, leaving a balance for you to pay in addition to any applicable copayment, coinsurance, and deductible amount. This additional amount you must pay to the provider will not be applied toward the out-of-pocket maximum amount described in *Your Out-Of-Pocket Expenses* and you will owe this amount regardless of whether you previously reached your out-of-pocket maximum with amounts paid for other services. **Please see the example calculation below.**

Because obtaining care from non-network providers may result in significant out-of-pocket expenses, it is important that you do the following *before* receiving services from a non-network provider:

- Discuss the expected billed charges with your non-network provider; and
- Contact Customer Service to verify the estimated non-network provider reimbursement amount for those services, so you are better able to calculate your likely out-of-pocket expenses; and
- If you wish to request that Medica authorize the non-network provider's services be covered at the in-network benefit level, follow the procedure described under *Prior authorization* in *How To Access Your Benefits*.

How To Access Your Benefits

An example of how to calculate your out-of-pocket costs*

You choose to receive non-emergency inpatient care at a non-network hospital provider without an authorization from Medica providing for in-network benefits. The out-of-network benefits described in this certificate apply to the services you receive. For purposes of this example, you have previously satisfied your deductible. The non-network hospital provider bills \$30,000 for your hospital stay. Medica's non-network provider reimbursement amount for those hospital services is \$15,000. You must pay a portion of the non-network provider reimbursement amount, generally as a percentage coinsurance. In addition, the non-network provider will likely bill you for the amount by which the provider's charge exceeds the non-network provider reimbursement amount. If your coinsurance is 40%, you will be required to pay:

- 40% coinsurance (40% of \$15,000 = \$6,000) and
- The billed charges that exceed the non-network provider reimbursement amount (\$30,000 - \$15,000 = \$15,000)
- The total amount you will owe is \$6,000 + \$15,000 = \$21,000.
- The \$6,000 you pay as coinsurance will be applied to the out-of-pocket maximum amount described in *Your Out-Of-Pocket Expenses*. However, the \$15,000 amount you pay for billed charges in excess of the non-network provider reimbursement amount will not be applied toward the out-of-pocket maximum amount described in *Your Out-Of-Pocket Expenses*. You will owe the provider this \$15,000 amount regardless of whether you have previously reached your out-of-pocket maximum with amounts paid for other services.

***Note:** The numbers in this example are used only for purposes of illustrating how out-of-network benefits are calculated. The actual numbers will depend on the services received.

Lifetime maximum amount

Out-of-network benefits are subject to a lifetime maximum amount payable per member. See *Your Out-Of-Pocket Expenses* for a detailed explanation of the lifetime maximum amount.

Exclusions

Some health services are not covered when received from or under the direction of non-network providers. Read this certificate for a detailed explanation of exclusions.

Claims

When you use non-network providers, you will be responsible for filing claims in order to be reimbursed for the non-network provider reimbursement amount. See *How To Submit A Claim* for details.

Post-mastectomy coverage

Medica will cover all stages of reconstruction of the breast on which the mastectomy was performed and surgery and reconstruction of the other breast to produce a symmetrical appearance. Medica will also cover prostheses and physical complications, including lymphedemas, at all stages of mastectomy.

3. *Continuity of care*

To request continuity of care or if you have questions about how this may apply to you, call Customer Service at one of the telephone numbers listed inside the front cover.

In certain situations, you have a right to continuity of care.

- a. If your current provider is terminated without cause, you may be eligible to continue care with that provider at the in-network benefit level.
- b. If you are a new Medica member as a result of your employer changing health plans and your current provider is not a network provider, you may be eligible to continue care with that provider at the in-network benefit level.

This applies only if your provider agrees to comply with Medica's prior authorization requirements, provide all necessary medical information related to your care, and accept as payment in full the lesser of the network provider reimbursement or the provider's customary charge for the service. This does not apply when a provider's contract is terminated for cause.

- i. Upon request, Medica will authorize continuity of care for up to 120 days as described in a. and b. above for the following conditions:

- an acute condition;
- a life-threatening mental or physical illness;
- pregnancy beyond the first trimester of pregnancy;
- a physical or mental disability defined as an inability to engage in one or more major life activities, provided that the disability has lasted or can be expected to last for at least one year, or can be expected to result in death; or
- a disabling or chronic condition that is in an acute phase.

Authorization to continue to receive services from your current provider may extend to the remainder of your life if a physician certifies that your life expectancy is 180 days or less.

- ii. Upon request, Medica will authorize continuity of care for up to 120 days as described in a. and b. above in the following situations:
 - if you are receiving culturally appropriate services and a network provider who has special expertise in the delivery of those culturally appropriate services is not available; or
 - if you do not speak English and a network provider who can communicate with you, either directly or through an interpreter, is not available.

Medica may require medical records or other supporting documentation from your provider to review your request, and will consider each request on a case-by-case basis. If Medica authorizes your request to continue care with your current provider, Medica will explain how continuity of care will be provided. After that time, your services or treatment will need to be transitioned to a network provider to continue to be eligible for in-network benefits. If your request is denied, Medica will explain the criteria used to make its decision. You may appeal this decision.

Coverage will not be provided for services or treatments that are not otherwise covered under this certificate.

How To Access Your Benefits

4. *Prior authorization*

Prior authorization from Medica may be required before you receive certain services or supplies in order to determine whether a particular service or supply is medically necessary and a benefit. Medica uses written procedures and criteria when reviewing your request for prior authorization. To determine whether a certain service or supply requires prior authorization, please call Customer Service at one of the telephone numbers listed inside the front cover or sign in at www.mymedica.com. Emergency services do not require prior authorization.

Your attending provider, you, or someone on your behalf may contact Customer Service to request prior authorization. Your network provider will contact Customer Service to request prior authorization for a service or supply. You must contact Customer Service to request prior authorization for services or supplies received from a non-network provider. If a network provider fails to obtain prior authorization *after* you have consulted with them about services requiring prior authorization, you are not subject to a penalty for failure to obtain prior authorization.

Some of the services that may require prior authorization from Medica include:

- Reconstructive or restorative surgery;
- Certain drugs;
- Home health care;
- Medical supplies and durable medical equipment;
- Outpatient surgical procedures;
- Certain genetic tests; and
- Skilled nursing facility services.

Prior authorization is always required for:

- Organ and bone marrow transplant services; and
- In-network benefits for services from non-network providers, with the exception of emergency services.

This is not an all-inclusive list of all services and supplies that may require prior authorization.

When you, someone on your behalf or your attending provider calls, the following information may be required:

- Name and telephone number of the provider who is making the request;
- Name, telephone number, address, and type of specialty of the provider to whom you are being referred, if applicable;
- Services being requested and the date those services are to be rendered (if scheduled);
- Specific information related to your condition (for example, a letter of medical necessity from your provider); and
- Other applicable member information (i.e., Medica member number).

Medica will review your request and provide a response to you and your attending provider within 10 business days after the date your request was received, provided all information reasonably necessary to make a decision has been made available to Medica.

Both you and your provider will be informed of the decision as soon as the medical condition warrants, not to exceed 72 hours from the time of the initial request if your attending provider believes that an expedited review is warranted, or if it is concluded that a delay could seriously jeopardize your life, health, or ability to regain maximum function, or subject you to severe pain that cannot be adequately managed without the care or treatment you are requesting.

If Medica does not approve your request for prior authorization, you have the right to appeal Medica's decision as described in *Complaints*.

Under certain circumstances, Medica may perform concurrent review to determine whether services continue to be medically necessary. If Medica determines that services are no longer medically necessary, Medica will inform both you and your attending provider in writing of its decision. If Medica does not approve continued coverage, you or your attending provider may appeal Medica's initial decision (see *Complaints*).

5. Certification of qualifying coverage

You have the right to a certification of qualifying coverage when coverage ends. You will receive a certification of qualifying coverage when coverage ends. You may also request a certification of qualifying coverage at any time while you are covered under the Contract or within the 24 months following the date your coverage ends. To request a certification of qualifying coverage, call Customer Service at one of the telephone numbers listed inside the front cover. Upon receipt of your request, the certification of qualifying coverage will be issued as soon as reasonably possible.

How Providers Are Paid By Medica

C. How Providers Are Paid By Medica

This section describes how providers are generally paid for health services.

See Definitions. These words have specific meanings: coinsurance, copayment, deductible, hospital, member, network, non-network, physician, provider.

Network providers

Network providers are paid using various types of contractual arrangements, which are intended to promote the delivery of health care in a cost efficient and effective manner. These arrangements are not intended to affect your access to health care. These payment methods may include:

1. A fee-for-service method, such as per service or percentage of charges; or
2. A risk-sharing arrangement, such as an amount per day, per stay, per episode, per case, per period of illness, per member, or per service with targeted outcome.

The methods by which specific network providers are paid may change from time to time. Methods also vary by network provider. The primary method of payment under Medica Choice Passport is fee-for-service.

Fee-for-service payment means that the network provider is paid a fee for each service provided. If the payment is per service, the network provider's payment is determined according to a set fee schedule. The amount the network provider receives is the lesser of the fee schedule or what the network provider would have otherwise billed. If the payment is percentage of charges, the network provider's payment is a set percentage of the provider's charge. The amount paid to the network provider, less any applicable copayment, coinsurance, or deductible, is considered to be payment in full.

Risk-sharing payment means that the network provider is paid a specific amount for a particular unit of service, such as an amount per day, an amount per stay, an amount per episode, an amount per case, an amount per period of illness, an amount per member, or an amount per service with targeted outcome. If the amount paid is less than the cost of providing or arranging for a member's health services, the network provider may bear some of the shortfall. If the amount paid to the network provider is more than the cost of providing or arranging a member's health services, the network provider may keep some of the excess.

Some network providers are authorized to arrange for a member to receive certain health services from other providers. This decision may result in a network provider keeping more or less of the risk-sharing payment.

Withhold arrangements

For some network providers paid on a fee-for-service basis, some of the payment is held back. This is sometimes referred to as a physician contingency reserve or holdback. The withhold amount generally will not exceed 15 percent of the fee schedule amount. In general, a portion of network hospitals' fee for service payments is not held back. However, when it is, the withhold amount will not usually exceed 5 percent of the fee schedule amount.

How Providers Are Paid By Medica

Network providers may earn the withhold amount based on Medica's performance as determined by Medica's Board of Directors and/or based on the standards identified in the network provider's contract. Based on individual measures, the percentage of the withhold amount paid, if any, can vary among network providers.

Non-network providers

When a service from a non-network provider is covered, the non-network provider is paid a fee for each covered service that is provided. This payment may be less than the charges billed by the non-network provider. If this happens, you are responsible for paying the difference.

Your Out-Of-Pocket Expenses

D. Your Out-Of-Pocket Expenses

This section describes the expenses that are your responsibility to pay. These expenses are commonly called out-of-pocket expenses.

See Definitions. These words have specific meanings: benefits, claim, coinsurance, copayment, deductible, dependent, medically necessary, member, network, non-network, non-network provider reimbursement amount, prescription drug, provider, subscriber.

You are responsible for paying the cost of a service that is not medically necessary or a benefit even if the following occurs:

1. A provider performs, prescribes, or recommends the service; or
2. The service is the only treatment available; or
3. You request and receive the service even though your provider does not recommend it. (Your network provider is required to inform you or in some instances provide a waiver for you to sign.)

If you miss or cancel an office visit less than 24 hours before your appointment, your provider may bill you for the service.

Please see the applicable benefit section(s) of this certificate for specific information about your in-network and out-of-network benefits and coverage levels.

To verify coverage before receiving a particular service or supply, call Customer Service at one of the telephone numbers listed inside the front cover.

Copayments, coinsurance, and deductibles

For *in-network benefits*, you must pay the following:

1. Any applicable copayment, coinsurance, and per member deductible each calendar year as described in this certificate (see the Out-of-Pocket Expenses table in this section).

When members in a family unit (a subscriber and his or her dependents) have together paid the applicable per family deductible for benefits received during a calendar year (see the Out-of-Pocket Expenses table in this section), then all members of the family unit are considered to have satisfied the applicable per member and per family deductible for that calendar year.

Note that applicable deductibles are determined by the Contract between Medica and the employer and may increase when Medica and the employer renew the Contract. If this occurs, the new deductible will apply for the rest of the current calendar year, whether or not you had met the previously applicable deductible. This means that it is possible that your deductible will increase mid-year when your employer's Contract with Medica is renewed and that you may have additional out-of-pocket expenses as a result.

2. Any charge that is not covered under the Contract.

For *out-of-network benefits*, you must pay the following:

1. Any applicable copayment, coinsurance, and per member deductible each calendar year as described in this certificate (see the Out-of-Pocket Expenses table in this section).

Your Out-Of-Pocket Expenses

When members in a family unit (a subscriber and his or her dependents) have together paid the applicable per family deductible for benefits received during a calendar year (see the Out-of-Pocket Expenses table in this section), then all members of the family unit are considered to have satisfied the applicable per member and per family deductible for that calendar year.

Note that applicable deductibles are determined by the Contract between Medica and the employer and may increase when Medica and the employer renew the Contract. If this occurs, the new deductible will apply for the rest of the current calendar year, whether or not you had met the previously applicable deductible. This means that it is possible that your deductible will increase mid-year when your employer's Contract with Medica is renewed and that you may have additional out-of-pocket expenses as a result.

2. Any charge that exceeds the non-network provider reimbursement amount. This means you are required to pay the difference between the payment to the provider and what the provider bills.

If you use out-of-network benefits, you may incur costs in addition to your copayment, coinsurance, and deductible amounts. If the amount that your non-network provider bills you is more than the non-network provider reimbursement amount, *you are responsible for paying the difference*. In addition, the difference will not be applied toward satisfaction of the deductible or the out-of-pocket maximum (described in this section).

To inquire about the non-network provider reimbursement amount for a particular procedure, call Customer Service at one of the telephone numbers listed inside the front cover. When you call, you will need to provide the following:

- The CPT (Current Procedural Terminology) code for the procedure (ask your non-network provider for this); and
- The name and location of the non-network provider.

Customer Service will provide you with an *estimate* of the non-network provider reimbursement amount based on the information provided at the time of your inquiry. The *actual amount paid* will be based on the information received at the time the claim is submitted and subject to all applicable benefit provisions, exclusions and limitations, including but not limited to copayments, coinsurance, and deductibles.

3. Any charge that is not covered under the Contract.

More information concerning deductibles

The time period used to apply the deductible (calendar year or Contract year) is determined by the Contract between Medica and the employer. This time period may change when Medica and the employer renew the Contract. If the time period changes, you will receive a new certificate of coverage that will specify the newly applicable time period. You may have additional out-of-pocket expenses associated with this change.

Out-of-pocket maximum

The out-of-pocket maximum is an accumulation of copayments, coinsurance, and deductibles paid for benefits received during a calendar year. Except as described below or as otherwise specified, you will *not* be required to pay more than the applicable per member out-of-pocket maximum for benefits received during a calendar year (see the Out-of-Pocket Expenses table in

Your Out-Of-Pocket Expenses

this section). **Please note: Charges for services not eligible for coverage and any charge in excess of the non-network provider reimbursement amount are *not* applicable toward the out-of-pocket maximum. Additionally, you will owe these amounts regardless of whether you previously reached your out-of-pocket maximum with amounts paid for other services.**

The time period used to calculate whether you have met the out-of-pocket maximum (calendar year or Contract year) is determined by the Contract between Medica and the employer. This time period may change when Medica and the employer renew the Contract. If the time period changes, you will receive a new certificate of coverage that will specify the newly applicable time period. You may have additional out-of-pocket expenses associated with this change.

When members in a family unit (the subscriber and his or her dependents) have together met the applicable per family out-of-pocket maximum for benefits received during the calendar year, then all members of the family unit are considered to have met the applicable per member and per family out-of-pocket maximum for that calendar year (see the Out-of-Pocket Expenses table in this section).

After an applicable out-of-pocket maximum has been met (as described in the Out-of-Pocket Expenses table in this section), all other covered benefits received during the rest of the calendar year will be covered at 100 percent, except for any charge not covered by Medica or charge in excess of the non-network provider reimbursement amount.

Note that out-of-pocket maximum amounts are determined by the Contract between Medica and the employer and may increase when Medica and the employer renew the Contract. If this occurs, the new out-of-pocket maximum will apply for the rest of the current calendar year, whether or not you had met the previously applicable out-of-pocket maximum. This means that it is possible that your out-of-pocket maximum will increase mid-year when your employer's Contract with Medica is renewed and that you may have additional out-of-pocket expenses as a result.

Medica refunds the amount over the out-of-pocket maximum during any calendar year when proof of excess copayments, coinsurance, and deductibles is received and verified by Medica.

Lifetime maximum amount

The lifetime maximum amount payable per member for out-of-network benefits under the Contract and for out-of-network benefits under any other Medica, Medica Health Plans, or Medica Health Plans of Wisconsin coverage offered through the same employer is described in the Out-of-Pocket Expenses table in this section. Any lifetime maximum dollar limit referenced pertains only to those health care services and supplies that are not essential benefits as defined in the Patient Protection and Affordable Care Act, including any amendments, regulations, rules, or other guidance issued with respect to the Act.

Your Out-Of-Pocket Expenses

Out-of-Pocket Expenses

	In-network benefits	* Out-of-network benefits
* For out-of-network benefits, in addition to the deductible, copayment, and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible or the out-of-pocket maximum.		
Copayment or coinsurance	See specific benefit for applicable copayment or coinsurance.	
Deductible		
Per member	\$2,000	\$3,000
Per family	\$4,000	\$6,000
Out-of-pocket maximum		
Per member	\$3,000	\$6,000
Per family	\$6,000	\$12,000
Lifetime maximum amount payable per member	Unlimited	\$2,000,000. Applies to all benefits you receive under this or any other Medica, Medica Health Plans, or Medica Health Plans of Wisconsin coverage offered through the same employer.

Ambulance Services

E. Ambulance Services

This section describes coverage for ambulance transportation and related services received for covered medical and medical-related dental services (as described in this certificate).

See Definitions. These words have specific meanings: benefits, coinsurance, copayment, deductible, emergency, hospital, network, non-network, non-network provider reimbursement amount, physician, provider, skilled nursing facility.

Prior authorization. Prior authorization from Medica may be required *before* you receive services or supplies. Call Customer Service at one of the telephone numbers listed inside the front cover. See *How To Access Your Benefits* for more information about the prior authorization process.

Covered

For benefits and the amounts you pay, see the table in this section. More than one copayment or coinsurance may be required if you receive more than one service or see more than one provider per visit.

For non-emergency licensed ambulance services described in the table in this section:

- *In-network benefits* apply to ambulance services arranged through a physician and received from a network provider.
- *Out-of-network benefits* apply to non-emergency ambulance services described in this section that are arranged through a physician and received from a non-network provider. In addition to the deductible and coinsurance described for out-of-network benefits, you will be responsible for any charges in excess of the non-network provider reimbursement amount. **The out-of-pocket maximum does not apply to these charges.** Please see *Important member information about out-of-network benefits* in *How To Access Your Benefits* for more information and an example calculation of out-of-pocket costs associated with out-of-network benefits.

Not covered

These services, supplies, and associated expenses are not covered:

1. Ambulance transportation to another hospital when care for your condition is available at the network hospital where you were first admitted.
2. Non-emergency ambulance transportation services, except as described in this section.

See Exclusions for additional services, supplies, and associated expenses that are not covered.

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	* Out-of-network benefits after deductible
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*** For out-of-network benefits, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible or the out-of-pocket maximum.**

- | | | |
|--|-----------------|-----------------------------------|
| 1. Ambulance services or ambulance transportation to the nearest hospital for an emergency | 20% coinsurance | Covered as an in-network benefit. |
| 2. Non-emergency licensed ambulance service that is arranged through an attending physician, as follows: | | |
| a. Transportation from hospital to hospital when: | 20% coinsurance | 40% coinsurance |
| i. Care for your condition is not available at the hospital where you were first admitted; or | | |
| ii. Required by Medica | | |
| b. Transportation from hospital to skilled nursing facility | 20% coinsurance | 40% coinsurance |

Durable Medical Equipment And Prosthetics

F. Durable Medical Equipment And Prosthetics

This section describes coverage for durable medical equipment, certain related supplies, and prosthetics.

See Definitions. These words have specific meanings: benefits, coinsurance, copayment, deductible, medically necessary, network, non-network, non-network provider reimbursement amount, physician, provider.

Prior authorization. Prior authorization from Medica may be required *before* you receive services or supplies. Call Customer Service at one of the telephone numbers listed inside the front cover. See *How To Access Your Benefits* for more information about the prior authorization process.

Covered

For benefits and the amounts you pay, see the table in this section. More than one copayment or coinsurance may be required if you receive more than one service or see more than one provider per visit.

Medica covers only a limited selection of durable medical equipment, certain related supplies, and hearing aids that meet the criteria established by Medica. Medica determines if durable medical equipment will be purchased or rented. Some items ordered by your physician, even if medically necessary, may not be covered. The list of eligible durable medical equipment and certain related supplies is periodically reviewed and modified by Medica. To request a list of Medica's eligible durable medical equipment and certain related supplies, call Customer Service at one of the telephone numbers listed inside the front cover.

If the durable medical equipment, prosthetic device, or hearing aid is covered by Medica, but the model you select is not Medica's standard model, you will be responsible for the cost difference.

- *In-network benefits* apply to durable medical equipment, certain related supplies, and prosthetic services prescribed by a physician and received from a network durable medical equipment provider, and hearing aids as described in 4. in the table in this section when prescribed by a network provider. To request a list of durable medical equipment providers, call Customer Service at one of the telephone numbers listed inside the front cover.
- *Out-of-network benefits* apply to durable medical equipment, certain related supplies, and prosthetic services prescribed by a physician and received from a non-network provider. Out-of-network benefits also apply to hearing aids as described in 4. in the table in this section. In addition to the deductible and coinsurance described for out-of-network benefits, you will be responsible for any charges in excess of the non-network provider reimbursement amount. **The out-of-pocket maximum does not apply to these charges.** Please see *Important member information about out-of-network benefits* in *How To Access Your Benefits* for more information and an example calculation of out-of-pocket costs associated with out-of-network benefits.

Durable Medical Equipment And Prosthetics

Not covered

These services, supplies, and associated expenses are not covered:

1. Durable medical equipment, supplies, prosthetics, appliances, and hearing aids not on the Medica eligible list.
2. Charges in excess of the Medica standard model of durable medical equipment, prosthetics, or hearing aids.
3. Repair, replacement, or revision of durable medical equipment, prosthetics, and hearing aids, except when made necessary by normal wear and use.
4. Duplicate durable medical equipment, prosthetics, and hearing aids, including repair, replacement, or revision of duplicate items.

See Exclusions for additional services, supplies, and associated expenses that are not covered.

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	* Out-of-network benefits after deductible
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*** For out-of-network benefits, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible or the out-of-pocket maximum.**

1. Durable medical equipment and certain related supplies	20% coinsurance	40% coinsurance
2. Repair, replacement, or revision of durable medical equipment made necessary by normal wear and use	20% coinsurance	40% coinsurance
3. Prosthetics		
a. Initial purchase of external prosthetic devices that replace a limb or an external body part, limited to:	20% coinsurance	40% coinsurance
i. Artificial arms, legs, feet, and hands;		
ii. Artificial eyes, ears, and noses;		
iii. Breast prostheses		
b. Scalp hair prostheses due to alopecia areata. Coverage is limited to one hair prosthesis (i.e., wig) per member per calendar year.	20% coinsurance	40% coinsurance

Durable Medical Equipment And Prosthetics

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	* Out-of-network benefits after deductible
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* For out-of-network benefits, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible or the out-of-pocket maximum.

c. Repair, replacement, or revision of artificial arms, legs, feet, hands, eyes, ears, noses, and breast prostheses made necessary by normal wear and use	20% coinsurance	40% coinsurance
4. Hearing aids for members 18 years of age and younger for hearing loss that is not correctable by other covered procedures	20% coinsurance. Coverage is limited to one hearing aid per ear every three years. Related services must be prescribed by a network provider.	40% coinsurance. Coverage is limited to one hearing aid per ear every three years.
5. Breast pumps	Nothing. The deductible does not apply.	40% coinsurance

G. Home Health Care

This section describes coverage for home health care. Home health care must be directed by a physician and received from a home health care agency authorized by the laws of the state in which treatment is received.

See Definitions. These words have specific meanings: benefits, coinsurance, copayment, custodial care, deductible, dependent, hospital, network, non-network, non-network provider reimbursement amount, physician, provider, skilled care, skilled nursing facility.

Prior authorization. Prior authorization from Medica may be required *before* you receive services or supplies. Call Customer Service at one of the telephone numbers listed inside the front cover. See *How To Access Your Benefits* for more information about the prior authorization process.

Covered

For benefits and the amounts you pay, see the table in this section. More than one copayment or coinsurance may be required if you receive more than one service or see more than one provider per visit.

As described under 1. and 2. in the table in this section, Medica (in accordance with Medicare guidelines) considers you *homebound* when it is medically contraindicated for you to leave your home (i.e., when leaving your home would directly and negatively affect your physical health). A dependent child may still be considered "confined to home" when attending school where life support specialized equipment and help are available.

Benefits covered under 1. and 2. in the table in this section are limited to a combined maximum of 120 visits per calendar year for in-network and 60 visits per calendar year for out-of-network benefits. **Please note:** These visit limits include any visits that you pay for in order to satisfy any part of your deductible. You may be eligible for additional intermittent skilled care if you have Medica coverage and are also enrolled in the Medical Assistance Program.

Medica covers up to 120 hours of services provided by a private duty nurse or personal care assistant who has provided home care services to a ventilator-dependent patient for the purpose of assuring adequate training of the hospital staff to communicate with that patient.

- *In-network benefits* apply to home health care services ordered or prescribed by a physician and received from a network home health care agency.
- *Out-of-network benefits* apply to home health care services that are ordered or prescribed by a physician and received from a non-network home health care agency. In addition to the deductible and coinsurance described for out-of-network benefits, you will be responsible for any charges in excess of the non-network provider reimbursement amount. **The out-of-pocket maximum does not apply to these charges.** Please see *Important member information about out-of-network benefits* in *How To Access Your Benefits* for more information and an example calculation of out-of-pocket costs associated with out-of-network benefits.

Home Health Care

Please note: Your place of residence is where you make your home. This may be your own dwelling, a relative's home, an apartment complex that provides assisted living services, or some other type of institution. However, an institution will not be considered your home if it is a hospital or skilled nursing facility.

Not covered

These services, supplies, and associated expenses are not covered:

1. Companion, homemaker, and personal care services.
2. Services provided by a member of your family.
3. Custodial care and other non-skilled services.
4. Physical, speech, or occupational therapy provided in your home for convenience.
5. Services provided in your home when you are not homebound.
6. Services primarily educational in nature.
7. Vocational and job rehabilitation.
8. Recreational therapy.
9. Self-care and self-help training (non-medical).
10. Health clubs.
11. Disposable supplies and appliances, except as described in *Durable Medical Equipment And Prosthetics, Miscellaneous Medical Services And Supplies*, and *Prescription Drug Program*.
12. Physical, speech, or occupational therapy services when there is no reasonable expectation that the member's condition will improve over a predictable period of time according to generally accepted standards in the medical community.
13. Voice training.
14. Home health aide services, except when rendered in conjunction with intermittent skilled care and related to the medical condition under treatment.

See *Exclusions* for additional services, supplies, and associated expenses that are not covered.

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	* Out-of-network benefits after deductible
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*** For out-of-network benefits, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible or the out-of-pocket maximum.**

- | | | |
|--|-----------------|-----------------|
| 1. Intermittent skilled care when you are homebound, provided by or supervised by a registered nurse | 20% coinsurance | 40% coinsurance |
| 2. Skilled physical, speech, or occupational therapy when you are homebound | 20% coinsurance | 40% coinsurance |
| 3. Home infusion therapy | 20% coinsurance | 40% coinsurance |
| 4. Services received in your home from a physician | 20% coinsurance | 40% coinsurance |

Hospice Services

H. Hospice Services

This section describes coverage for hospice services including respite care. Care must be ordered, provided, or arranged under the direction of a physician and received from a hospice program.

See Definitions. These words have specific meanings: benefits, coinsurance, copayment, deductible, member, network, non-network, non-network provider reimbursement amount, physician, skilled nursing facility.

Covered

For benefits and the amounts you pay, see the table in this section. More than one copayment or coinsurance may be required if you receive more than one service or see more than one provider per visit.

Hospice services are comprehensive palliative medical care and supportive social, emotional, and spiritual services. These services are provided to terminally ill persons and their families, primarily in the patients' homes. A hospice interdisciplinary team, composed of professionals and volunteers, coordinates an individualized plan of care for each patient and family. The goal of hospice care is to make patients as comfortable as possible to enable them to live their final days to the fullest in the comfort of their own homes and with loved ones.

Respite care is a form of hospice services that gives your uncompensated primary caregivers (i.e., family members or friends) rest or relief when necessary to maintain a terminally ill member at home. Respite care is limited to not more than five consecutive days at a time.

- *In-network benefits* apply to hospice services arranged through a physician and received from a network hospice program.
- *Out-of-network benefits* apply to hospice services arranged through a physician and received from a non-network hospice program. In addition to the deductible and coinsurance described for out-of-network benefits, you will be responsible for any charges in excess of the non-network provider reimbursement amount. **The out-of-pocket maximum does not apply to these charges.** Please see *Important member information about out-of-network benefits* in *How To Access Your Benefits* for more information and an example calculation of out-of-pocket costs associated with out-of-network benefits.

A plan of care must be established and communicated by the hospice program staff to Medica. To be eligible for coverage, hospice services must be consistent with the hospice program's plan of care.

To be eligible for the hospice benefits described in this section, you must:

1. Be a terminally ill patient; and
2. Have chosen a palliative treatment focus (i.e., one that emphasizes comfort and supportive services rather than treatment attempting to cure the disease or condition).

You will be considered terminally ill if there is a written medical prognosis by your physician that your life expectancy is six months or less if the terminal illness runs its normal course. This certification must be made not later than two days after the hospice care is initiated.

Hospice Services

Members who elect to receive hospice services do so in place of curative treatment for their terminal illness for the period they are enrolled in the hospice program.

You may withdraw from the hospice program at any time upon written notice to the hospice program. You must follow the hospice program's requirements to withdraw from the hospice program.

Not covered

These services, supplies, and associated expenses are not covered:

1. Respite care for more than five consecutive days at a time.
2. Home health care and skilled nursing facility services when services are not consistent with the hospice program's plan of care.
3. Services not included in the hospice program's plan of care.
4. Services not provided by the hospice program.
5. Hospice daycare, except when recommended and provided by the hospice program.
6. Any services provided by a family member or friend, or individuals who are residents in your home.
7. Financial or legal counseling services, except when recommended and provided by the hospice program.
8. Housekeeping or meal services in your home, except when recommended and provided by the hospice program.
9. Bereavement counseling, except when recommended and provided by the hospice program.

See Exclusions for additional services, supplies, and associated expenses that are not covered.

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	* Out-of-network benefits after deductible
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* For out-of-network benefits, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible or the out-of-pocket maximum.

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| 1. Hospice services | Nothing. The deductible does not apply. | 40% coinsurance |
|---------------------|---|-----------------|

Hospital Services

I. Hospital Services

This section describes coverage for use of hospital and ambulatory surgical center services. A physician must direct care.

See Definitions. These words have specific meanings: approved clinical trial, benefits, coinsurance, copayment, deductible, emergency, genetic testing, hospital, inpatient, member, network, non-network, non-network provider reimbursement amount, physician, provider, qualified individual, routine patient costs.

Prior authorization. Prior authorization from Medica may be required *before* you receive services or supplies. Call Customer Service at one of the telephone numbers listed inside the front cover. See *How To Access Your Benefits* for more information about the prior authorization process.

Covered

For benefits and the amounts you pay, see the table in this section. More than one copayment or coinsurance may be required if you receive more than one service or see more than one provider per visit.

- *In-network benefits* apply to hospital services received from a network hospital or ambulatory surgical center.
- *Out-of-network benefits* apply to hospital services received from a non-network hospital or ambulatory surgical center. In addition to the deductible and coinsurance described for out-of-network benefits, you will be responsible for any charges in excess of the non-network provider reimbursement amount. **The out-of-pocket maximum does not apply to these charges.** Please see *Important member information about out-of-network benefits* in *How To Access Your Benefits* for more information and an example calculation of out-of-pocket costs associated with out-of-network benefits. Emergency services from non-network providers will be covered as in-network benefits. If you are confined in a non-network facility as a result of an emergency you will be eligible for in-network benefits until your attending physician agrees it is safe to transfer you to a network facility.

Not covered

1. Drugs received at a hospital on an outpatient basis, except drugs requiring intravenous infusion or injection, intramuscular injection, or intraocular injection, or drugs received in an emergency room or a hospital observation room. Coverage for drugs is as described in *Prescription Drug Program*, *Prescription Specialty Drug Program*, or otherwise described as a specific benefit in this certificate.
2. Transfers and admission to network hospitals solely at the convenience of the member.
3. Admission to another hospital is not covered when care for your condition is available at the network hospital where you were first admitted.

See Exclusions for additional services, supplies, and associated expenses that are not covered.

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	* Out-of-network benefits after deductible
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* For out-of-network benefits, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible or the out-of-pocket maximum.

1. Outpatient services

a. Services provided in a hospital or facility-based emergency room	20% coinsurance	Covered as an in-network benefit.
b. Outpatient lab and pathology	20% coinsurance	40% coinsurance
c. Outpatient x-rays and other imaging services	20% coinsurance	40% coinsurance
d. Genetic testing when test results will directly affect treatment decisions or frequency of screening for a disease, or when results of the test will affect reproductive choices Please note: BRCA testing, if appropriate, is covered as a women's preventive health service.	20% coinsurance	40% coinsurance
e. Other outpatient services	20% coinsurance	40% coinsurance
f. Other outpatient hospital and ambulatory surgical center services received from a physician	20% coinsurance	40% coinsurance
g. Anesthesia services received from a provider during an office visit or an outpatient hospital or ambulatory surgical center visit	20% coinsurance	40% coinsurance

Hospital Services

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	* Out-of-network benefits after deductible
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* For out-of-network benefits, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible or the out-of-pocket maximum.

h. Routine patient costs in connection with a qualified individual's participation in an approved clinical trial	Covered at the corresponding in-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit in-network benefit level and surgical services are covered at the surgical services in-network benefit level.	Covered at the corresponding out-of-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit out-of-network benefit level and surgical services are covered at the surgical services out-of-network benefit level.
2. Services provided in a hospital observation room	20% coinsurance	40% coinsurance
3. Inpatient services	20% coinsurance	40% coinsurance
4. Services received from a physician during an inpatient stay	20% coinsurance	40% coinsurance
5. Anesthesia services received from a provider during an inpatient stay	20% coinsurance	40% coinsurance

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	* Out-of-network benefits after deductible
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*** For out-of-network benefits, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible or the out-of-pocket maximum.**

<p>6. Treatment of temporomandibular joint (TMJ) disorder and craniomandibular disorder</p>	<p>Covered at the corresponding in-network benefit level, depending on type of services provided.</p> <p>For example, office visits are covered at the office visit in-network benefit level and surgical services are covered at the surgical services in-network benefit level. Please note: Dental coverage is not provided under this benefit.</p>	<p>Covered at the corresponding out-of-network benefit level, depending on type of services provided.</p> <p>For example, office visits are covered at the office visit out-of-network benefit level and surgical services are covered at the surgical services out-of-network benefit level. Please note: Dental coverage is not provided under this benefit.</p>
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Infertility Services

J. Infertility Services

This section describes coverage for the diagnosis and treatment of infertility in connection with the voluntary planning of conceiving a child. Coverage includes benefits for professional, hospital, and ambulatory surgical center services. Infertility treatment must be received from or under the direction of a physician. See *Prescription Drug Program* and *Prescription Specialty Drug Program* for coverage of infertility drugs.

See Definitions. These words have specific meanings: benefits, coinsurance, copayment, deductible, hospital, inpatient, member, network, non-network, non-network provider reimbursement amount, physician, provider, virtual care.

Prior authorization. Prior authorization from Medica may be required *before* you receive services or supplies. Call Customer Service at one of the telephone numbers listed inside the front cover. See *How To Access Your Benefits* for more information about the prior authorization process.

Covered

For benefits and the amounts you pay, see the table in this section. More than one copayment or coinsurance may be required if you receive more than one service or see more than one provider per visit.

- *In-network benefits* apply to:
 1. Infertility *treatment* services received from a network provider; and
 2. Services for the *diagnosis* of infertility received from a network or non-network provider.
- *Out-of-network benefits* apply to infertility *treatment* services received from a non-network provider. In addition to the deductible and coinsurance described for out-of-network benefits, you will be responsible for any charges in excess of the non-network provider reimbursement amount. **The out-of-pocket maximum does not apply to these charges.** Please see *Important member information about out-of-network benefits* in *How To Access Your Benefits* for more information and an example calculation of out-of-pocket costs associated with out-of-network benefits.

Coverage for infertility services is limited to a maximum of \$5,000 per member per calendar year for in-network and out-of-network benefits combined.

Not covered

These services, supplies, and associated expenses are not covered:

1. Drugs provided or administered by a physician or other provider on an outpatient basis, except those requiring intravenous infusion or injection, intramuscular injection, or intraocular injection. Coverage for drugs is as described in *Prescription Drug Program*, *Prescription Specialty Drug Program*, or otherwise described as a specific benefit in this certificate.

Infertility Services

2. In vitro fertilization (IVF), gamete and zygote intrafallopian transfer (GIFT and ZIFT) procedures.
3. Services for a condition that a physician determines cannot be successfully treated.
4. Services related to surrogate pregnancy for a person not covered as a member under the Contract.
5. Sperm banking.
6. Adoption.
7. Donor sperm.
8. Donor eggs.
9. Embryo and egg storage.

See *Exclusions* for additional services, supplies, and associated expenses that are not covered.

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	* Out-of-network benefits after deductible
<p>* For out-of-network benefits, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible or the out-of-pocket maximum.</p>		
1. Office visits, including any services provided during such visits	20% coinsurance	40% coinsurance, except that in-network benefits apply to services for the diagnosis of infertility
2. Virtual care	20% coinsurance	No coverage
3. Outpatient services received at a hospital	20% coinsurance	40% coinsurance, except that in-network benefits apply to services for the diagnosis of infertility
4. Inpatient services	20% coinsurance	40% coinsurance, except that in-network benefits apply to services for the diagnosis of infertility
5. Services received from a physician during an inpatient stay	20% coinsurance	40% coinsurance, except that in-network benefits apply to services for the diagnosis of infertility
6. Anesthesia services received from a provider during an inpatient stay	20% coinsurance	40% coinsurance, except that in-network benefits apply to services for the diagnosis of infertility

Maternity Services

K. Maternity Services

This section describes coverage for maternity services. Benefits for maternity services include all medical services for prenatal care, labor and delivery, postpartum care, and related complications.

See Definitions. These words have specific meanings: benefits, coinsurance, copayment, deductible, dependent, hospital, inpatient, member, network, non-network, non-network provider reimbursement amount, physician, prenatal care, provider, skilled care.

Prior authorization. Prior authorization from Medica may be required *before* you receive services or supplies. Call Customer Service at one of the telephone numbers listed inside the front cover. See *How To Access Your Benefits* for more information about the prior authorization process.

Newborns' and Mothers' Health Protection Act of 1996

Generally, Medica may not restrict benefits for any hospital stay in connection with childbirth for the mother or newborn child member to less than 48 hours following a vaginal delivery (or less than 96 hours following a cesarean section). However, federal law generally does not prohibit the mother or newborn child member's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, Medica may not require a provider to obtain prior authorization from Medica for a length of stay of 48 hours or less (or 96 hours, as applicable).

Covered

For benefits and the amounts you pay, see the table in this section. More than one copayment or coinsurance may be required if you receive more than one service or see more than one provider per visit. Each member's admission is separate from the admission of any other member. A separate deductible and copayment or coinsurance will be applied to both you and your newborn child for inpatient services related to maternity labor and delivery. **Please note:** We encourage you to enroll your newborn dependent under the Contract within 30 days from the date of birth, date of placement for adoption, or date of adoption. Please refer to *Eligibility And Enrollment* for additional information.

- *In-network benefits* apply to maternity services received from a network provider.
- *Out-of-network benefits* apply to maternity services received from a non-network provider. In addition to the deductible and coinsurance described for out-of-network benefits, you will be responsible for any charges in excess of the non-network provider reimbursement amount. **The out-of-pocket maximum does not apply to these charges.** Please see *Important member information about out-of-network benefits* in *How To Access Your Benefits* for more information and an example calculation of out-of-pocket costs associated with out-of-network benefits.

Additional information about coverage of maternity services

Not all services that are received during your pregnancy are considered prenatal care. Some of the services that are not considered prenatal care include (but are not limited to) treatment of the following:

1. Conditions that existed prior to (and independently of) the pregnancy, such as diabetes or lupus, even if the pregnancy has caused those conditions to require more frequent care or monitoring.
2. Conditions that have arisen concurrently with the pregnancy but are not directly related to care of the pregnancy, such as back and neck pain or skin rash.
3. Miscarriage and ectopic pregnancy.

Services that are not considered prenatal care may be eligible for coverage under the most specific and appropriate section of this certificate. Please refer to those sections for coverage information.

Not covered

These services, supplies, and associated expenses are not covered:

1. Health care professional services for maternity labor and delivery in the home.
2. Services from a doula.
3. Childbirth and other educational classes.

See Exclusions for additional services, supplies, and associated expenses that are not covered.

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	* Out-of-network benefits after deductible
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*** For out-of-network benefits, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible or the out-of-pocket maximum.**

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| <ol style="list-style-type: none"> 1. Prenatal and postnatal services
 Please note: This 1. describes coverage for prenatal and postnatal services only. Coverage of labor and delivery services is as described elsewhere in this section. <ol style="list-style-type: none"> a. Office visits for prenatal care, including professional services, lab, pathology, x-rays, and imaging | <p>Nothing. The deductible does not apply.</p> | <p>0% coinsurance. The deductible does not apply.</p> |
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Maternity Services

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	* Out-of-network benefits after deductible
<p>* For out-of-network benefits, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible or the out-of-pocket maximum.</p>		
b. Hospital and ambulatory surgical center services for prenatal care, including professional services received during an inpatient stay for prenatal care	Nothing. The deductible does not apply.	0% coinsurance. The deductible does not apply.
c. Intermittent skilled care or home infusion therapy when you are homebound due to a high risk pregnancy	Nothing. The deductible does not apply.	0% coinsurance. The deductible does not apply.
d. Supplies for gestational diabetes	Nothing. The deductible does not apply.	0% coinsurance. The deductible does not apply.
e. Postnatal services	Nothing. The deductible does not apply.	40% coinsurance
2. Inpatient hospital stay for labor and delivery services Please note: Maternity labor and delivery services are considered inpatient services regardless of the length of hospital stay.	20% coinsurance	40% coinsurance
3. Professional services received during an inpatient stay for labor and delivery	Nothing. The deductible does not apply.	40% coinsurance
4. Anesthesia services received during an inpatient stay for labor and delivery	20% coinsurance	40% coinsurance
5. Labor and delivery services at a free-standing birth center		
a. Facility services for labor and delivery	20% coinsurance	40% coinsurance
b. Professional services received for labor and delivery	Nothing. The deductible does not apply.	40% coinsurance

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	* Out-of-network benefits after deductible
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* For out-of-network benefits, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible or the out-of-pocket maximum.

6. Home health care visit following delivery Please note: One home health care visit is covered if it occurs within 4 days of discharge. If services are received after 4 days, please refer to <i>Home Health Care</i> for benefits.	Nothing. The deductible does not apply.	40% coinsurance
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Medical-Related Dental Services

L. *Medical-Related Dental Services*

This section describes coverage for medical-related dental services. Services must be received from a physician or dentist.

This section does not describe coverage for comprehensive dental procedures. Comprehensive dental procedures are services rendered by a dentist to treat teeth, their supporting soft tissue and bony structure, or the alignment or occlusion of the teeth. These services are not covered under any section of this certificate.

See Definitions. These words have specific meanings: benefits, coinsurance, copayment, deductible, dependent, hospital, member, network, non-network, non-network provider reimbursement amount, physician, provider.

Prior authorization. Prior authorization from Medica may be required *before* you receive services or supplies. Call Customer Service at one of the telephone numbers listed inside the front cover. See *How To Access Your Benefits* for more information about the prior authorization process.

Covered

For benefits and the amounts you pay, see the table in this section. More than one copayment or coinsurance may be required if you receive more than one service or see more than one provider per visit.

- *In-network benefits* apply to medical-related dental services received from a network provider.
- *Out-of-network benefits* apply to medical-related dental services received from a non-network provider. In addition to the deductible and coinsurance described for out-of-network benefits, you will be responsible for any charges in excess of the non-network provider reimbursement amount. **The out-of-pocket maximum does not apply to these charges.** Please see *Important member information about out-of-network benefits* in *How To Access Your Benefits* for more information and an example calculation of out-of-pocket costs associated with out-of-network benefits.

Not covered

These services, supplies, and associated expenses are not covered:

1. Dental services to treat an injury from biting or chewing.
2. Osteotomies and other procedures associated with the fitting of dentures or dental implants.
3. Dental implants (tooth replacement), except as described in this section for the treatment of cleft lip and palate.
4. Any other dental procedures or treatment, whether the dental treatment is needed because of a primary dental problem or as a manifestation of a medical treatment or condition.
5. Any orthodontia, except as described in this section for the treatment of cleft lip and palate.
6. Tooth extractions, except as described in this section.

Medical-Related Dental Services

7. Any dental procedures or treatment related to periodontal disease.
8. Endodontic procedures and treatment, including root canal procedures and treatment, unless provided as accident-related dental services as described in this section.
9. Routine diagnostic and preventive dental services.

See Exclusions for additional services, supplies, and associated expenses that are not covered.

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	* Out-of-network benefits after deductible
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*** For out-of-network benefits, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible or the out-of-pocket maximum.**

<ol style="list-style-type: none"> 1. Charges for medical facilities and general anesthesia services that are: <ol style="list-style-type: none"> a. Recommended by a physician; and b. Received during a dental procedure; and c. Provided to a member who: <ol style="list-style-type: none"> i. Is a child under age five; or ii. Is severely disabled; or iii. Has a medical condition and requires hospitalization or general anesthesia for dental care treatment 	20% coinsurance	40% coinsurance
<ol style="list-style-type: none"> 2. For a dependent child, orthodontia, dental implants, and oral surgery treatment related to cleft lip and palate 	20% coinsurance	40% coinsurance

Medical-Related Dental Services

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	* Out-of-network benefits after deductible
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* For out-of-network benefits, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible or the out-of-pocket maximum.

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| <p>3. Accident-related dental services to treat an injury to sound, natural teeth and to repair (not replace) sound, natural teeth. The following conditions apply:</p> <ul style="list-style-type: none"> a. Coverage is limited to services received <i>within 24 months from the later of</i>: <ul style="list-style-type: none"> i. The date you are first covered under the Contract; or ii. The date of the injury b. A sound, natural tooth means a tooth (including supporting structures) that is free from disease that would prevent continual function of the tooth for at least one year.

In the case of primary (baby) teeth, the tooth must have a life expectancy of one year. | 20% coinsurance | 40% coinsurance |
| <p>4. Oral surgery for:</p> <ul style="list-style-type: none"> a. Partially or completely unerupted impacted teeth; or b. A tooth root without the extraction of the entire tooth (this does not include root canal therapy); or c. The gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth | 20% coinsurance | 40% coinsurance |

M. Mental Health

This section describes coverage for services to diagnose and treat mental disorders listed in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders*. For a description of coverage for the diagnosis and primary treatment of substance abuse disorders, see *Substance Abuse*.

See Definitions. These words have specific meanings: benefits, claim, coinsurance, copayment, deductible, emergency, hospital, inpatient, medically necessary, member, mental disorder, network, non-network, non-network provider reimbursement amount, physician, provider.

Prior authorization. For prior authorization requirements of *in-network* and *out-of-network benefits*, call Medica's designated mental health and substance abuse provider at 1-800-848-8327 or for Hearing Impaired members, please contact: National Relay Center 1-800-855-2880, then ask them to dial Medica Behavioral Health at 1-866-567-0550.

For purposes of this section:

1. Outpatient services include:
 - a. Diagnostic evaluations and psychological testing.
 - b. Psychotherapy and psychiatric services.
 - c. Intensive outpatient programs, including day treatment, meaning time limited comprehensive treatment plans, which may include multiple services and modalities, delivered in an outpatient setting (up to 19 hours per week).
 - d. Treatment for a minor, including family therapy.
 - e. Treatment of serious or persistent disorders.
 - f. Diagnostic evaluation for attention deficit hyperactivity disorder (ADHD) or pervasive development disorders (PDD).
 - g. Services, care, or treatment described as benefits in this certificate and ordered by a court on the basis of a behavioral health care evaluation performed by a physician or licensed psychologist and that includes an individual treatment plan.
 - h. Treatment of pathological gambling.
 - i. Intensive behavioral and developmental therapy for the treatment of autism spectrum disorders for members 17 years of age and younger when provided in accordance with an individualized treatment plan prescribed by the member's treating physician or mental health professional.
2. Inpatient services include:
 - a. Room and board.
 - b. Attending psychiatric services.
 - c. Hospital or facility-based professional services.

Mental Health

- d. Partial program. This may be in a freestanding facility or hospital based. Active treatment is provided through specialized programming with medical/psychological intervention and supervision during program hours. Partial program means a treatment program of 20 hours or more per week and may include lodging.
- e. Services, care, or treatment described as benefits in this certificate and ordered by a court on the basis of a behavioral health care evaluation performed by a physician or licensed psychologist and that includes an individual treatment plan.
- f. Residential treatment services. These services include either:
 - i. A residential treatment program serving children and adolescents with severe emotional disturbance, certified under Minnesota Rules parts 2960.0580 to 2960.0700; or
 - ii. A licensed or certified mental health treatment program providing intensive therapeutic services. In addition to room and board, at least 30 hours a week per individual of mental health services must be provided, including group and individual counseling, client education, and other services specific to mental health treatment. Also, the program must provide an on-site medical/psychiatric assessment within 48 hours of admission, psychiatric follow-up visits at least once per week, and 24-hour nursing coverage.

Covered

For benefits and the amounts you pay, see the table in this section. More than one copayment or coinsurance may be required if you receive more than one service or see more than one provider per visit.

- For *in-network benefits*:

Medica's designated mental health and substance abuse provider arranges in-network mental health benefits. If you require hospitalization, Medica's designated mental health and substance abuse provider will refer you to one of its hospital providers (Medica and Medica's designated mental health and substance abuse provider hospital networks are different).

For claims questions regarding *in-network benefits*, call Medica's designated mental health and substance abuse provider Customer Service at 1-866-214-6829.

- For *out-of-network benefits*:

1. Mental health services from a non-network provider listed below will be eligible for coverage under out-of-network benefits provided that the health care professional or facility is licensed, certified, or otherwise qualified under state law to provide the mental health services and practice independently:
 - a. Psychiatrist
 - b. Psychologist
 - c. Registered nurse certified as a clinical specialist or as a nurse practitioner in psychiatric and mental health nursing
 - d. Mental health clinic
 - e. Mental health residential treatment center
 - f. Independent clinical social worker
 - g. Marriage and family therapist

- h. Hospital that provides mental health services
 - i. Licensed professional clinical counselor
2. Emergency mental health services are eligible for coverage under in-network benefits.

In addition to the deductible and coinsurance described for out-of-network benefits, you will be responsible for any charges in excess of the non-network provider reimbursement amount. **The out-of-pocket maximum does not apply to these charges.** Please see *Important member information about out-of-network benefits* in *How To Access Your Benefits* for more information and an example calculation of out-of-pocket costs associated with out-of-network benefits.

Not covered

These services, supplies, and associated expenses are not covered:

1. Services for mental disorders not listed in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders*.
2. Services, care, or treatment that is not medically necessary, unless ordered by a court as specifically described in this section.
3. Relationship counseling.
4. Family counseling services, except as specifically described in this certificate as treatment for a minor.
5. Services for telephone psychotherapy.
6. Services beyond the initial evaluation to diagnose mental retardation or learning disabilities, as those conditions are defined in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders*.
7. Services, including room and board charges, provided by health care professionals or facilities that are not appropriately licensed, certified, or otherwise qualified under state law to provide mental health services. This includes, but is not limited to, services provided by mental health providers who are not authorized under state law to practice independently, and services received from a halfway house, housing with support, therapeutic group home, boarding school, or ranch.
8. Services to assist in activities of daily living that do not seek to cure and are performed regularly as a part of a routine or schedule.
9. Room and board charges associated with mental health residential treatment services providing less than 30 hours a week per individual of mental health services, or lacking an on-site medical/psychiatric assessment within 48 hours of admission, psychiatric follow-up visits at least once per week, and 24-hour nursing coverage.

See Exclusions for additional services, supplies, and associated expenses that are not covered.

Mental Health

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	* Out-of-network benefits after deductible
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* For out-of-network benefits, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible or the out-of-pocket maximum.

1. Office visits, including evaluations, diagnostic, and treatment services	20% coinsurance	40% coinsurance
2. Intensive outpatient programs	20% coinsurance	40% coinsurance
3. Intensive behavioral and developmental therapy for the treatment of autism spectrum disorders for members 17 years of age and younger when provided in accordance with an individualized treatment plan prescribed by the member's treating physician or mental health professional. Examples of such therapy include applied behavioral analysis, intensive early intervention behavior therapy, and intensive behavioral intervention.	20% coinsurance	40% coinsurance
4. Inpatient services (including residential treatment services)		
a. Room and board	20% coinsurance	40% coinsurance
b. Hospital or facility-based professional services	20% coinsurance	40% coinsurance
c. Attending psychiatrist services	20% coinsurance	40% coinsurance
d. Partial program	20% coinsurance	40% coinsurance

N. Miscellaneous Medical Services And Supplies

This section describes coverage for miscellaneous medical services and supplies prescribed by a physician. Medica covers only a limited selection of miscellaneous medical services and supplies that meet the criteria established by Medica. Some items ordered by a physician, even if medically necessary, may not be covered.

See Definitions. These words have specific meanings: benefits, coinsurance, copayment, deductible, medically necessary, network, non-network, non-network provider reimbursement amount, physician, provider.

Prior authorization. Prior authorization from Medica may be required *before* you receive services or supplies. Call Customer Service at one of the telephone numbers listed inside the front cover. See *How To Access Your Benefits* for more information about the prior authorization process.

Covered

For benefits and the amounts you pay, see the table in this section. More than one copayment or coinsurance may be required if you receive more than one service or see more than one provider per visit.

- *In-network benefits* apply to miscellaneous medical services and supplies received from a network provider.
- *Out-of-network benefits* apply to miscellaneous medical services and supplies received from a non-network provider. In addition to the deductible and coinsurance described for out-of-network benefits, you will be responsible for any charges in excess of the non-network provider reimbursement amount. **The out-of-pocket maximum does not apply to these charges.** Please see *Important member information about out-of-network benefits* in *How To Access Your Benefits* for more information and an example calculation of out-of-pocket costs associated with out-of-network benefits.

Not covered

Other disposable supplies and appliances, except as described in *Durable Medical Equipment And Prosthetics*, *Miscellaneous Medical Services And Supplies*, and *Prescription Drug Program*.

See Exclusions for additional services, supplies, and associated expenses that are not covered.

Miscellaneous Medical Services And Supplies

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	* Out-of-network benefits after deductible
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* For out-of-network benefits, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible or the out-of-pocket maximum.

1. Blood clotting factors	20% coinsurance	40% coinsurance
2. Dietary medical treatment of phenylketonuria (PKU)	20% coinsurance	40% coinsurance
3. Amino acid-based elemental formulas for the following diagnoses: a. cystic fibrosis; b. amino acid, organic acid, and fatty acid metabolic and malabsorption disorders; c. IgE mediated allergies to food proteins; d. food protein-induced enterocolitis syndrome; e. eosinophilic esophagitis; f. eosinophilic gastroenteritis; and g. eosinophilic colitis. Coverage for the diagnoses in 3.c.-g. above is limited to members five years of age and younger.	20% coinsurance	40% coinsurance
4. Total parenteral nutrition	20% coinsurance	40% coinsurance
5. Eligible ostomy supplies	20% coinsurance. The deductible does not apply.	40% coinsurance
6. Insulin pumps and other eligible diabetic equipment and supplies	20% coinsurance. The deductible does not apply.	40% coinsurance

O. Organ And Bone Marrow Transplant Services

This section describes coverage for certain organ and bone marrow transplant services. Services must be provided under the direction of a network physician and received at a designated transplant facility. This section also describes benefits for professional, hospital, and ambulatory surgical center services.

Coverage is provided for certain types of organ transplants and related services (including organ acquisition and procurement) and for certain bone marrow transplant services that are medically necessary, appropriate for the diagnosis, without contraindications, and non-investigative.

See Definitions. These words have specific meanings: benefits, coinsurance, copayment, deductible, hospital, inpatient, investigative, medically necessary, member, network, non-network, non-network provider reimbursement amount, physician, provider, virtual care.

Prior authorization. Prior authorization from Medica is required *before* you receive services or supplies. Call Customer Service at one of the telephone numbers listed inside the front cover. See *How To Access Your Benefits* for more information about the prior authorization process.

Covered

For benefits and the amounts you pay, see the table in this section. More than one copayment or coinsurance may be required if you receive more than one service or see more than one provider per visit.

Medica uses specific medical criteria to determine benefits for organ and bone marrow transplant services. Because medical technology is constantly changing, Medica reserves the right to review and update these medical criteria. Benefits for each individual member will be determined based on the clinical circumstances of the member according to Medica's medical criteria.

Coverage is provided for the following human organ transplants, if appropriate, under Medica's medical criteria and not otherwise excluded from coverage (see *Not covered* below): cornea, kidney, lung, heart, heart/lung, pancreas, liver, allogeneic, autologous, and syngeneic bone marrow. Bone marrow transplants include the transplant of stem cells from bone marrow, peripheral blood, and umbilical cord blood.

The preceding is not a comprehensive list of eligible organ and bone marrow transplant services.

- *In-network benefits* apply to transplant services provided by a network provider and received at a designated transplant facility. A designated transplant facility means a hospital that has entered into a separate contract with Medica to provide certain transplant-related health services to members receiving transplants. You may be evaluated and listed as a potential recipient at multiple designated facilities for transplant services.

Medica requires that all pre-transplant, transplant, and post-transplant services, from the time of the initial evaluation through no more than one year after the date of the transplant, be received at one designated transplant facility. Based on the type of transplant you

Organ And Bone Marrow Transplant Services

receive, Medica will determine the specific time period medically necessary for these services.

Not covered

These services, supplies, and associated expenses are not covered:

1. Organ and bone marrow transplant services except as described in this section.
2. Supplies and services related to transplants that would not be authorized by Medica under the medical criteria referenced in this section.
3. Chemotherapy, radiation therapy, drugs, or any therapy used to damage the bone marrow and related to transplants that would not be authorized by Medica under the medical criteria referenced in this section.
4. Living donor transplants that would not be authorized by Medica under the medical criteria referenced in this section.
5. Services required to meet the patient selection criteria for the authorized transplant procedure. This includes treatment of nicotine or caffeine addiction, services and related expenses for weight loss programs, nutritional supplements, appetite suppressants, and supplies of a similar nature not otherwise covered under this certificate.
6. Mechanical, artificial, or non-human organ implants or transplants and related services that would not be authorized by Medica under the medical criteria referenced in this section.
7. Transplants and related services that are investigative.
8. Private collection and storage of umbilical cord blood for directed use.
9. Drugs provided or administered by a physician or other provider on an outpatient basis, except those requiring intravenous infusion or injection, intramuscular injection, or intraocular injection. Coverage for drugs is as described in *Prescription Drug Program*, *Prescription Specialty Drug Program*, or otherwise described as a specific benefit in this certificate.

See Exclusions for additional services, supplies, and associated expenses that are not covered.

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	* Out-of-network benefits after deductible
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* For out-of-network benefits, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible or the out-of-pocket maximum.

1. Office visits	20% coinsurance	No coverage
2. Virtual care	20% coinsurance	No coverage

Organ And Bone Marrow Transplant Services

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	* Out-of-network benefits after deductible
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* For out-of-network benefits, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible or the out-of-pocket maximum.

3. Outpatient services

a. Professional services

i. Surgical services (as defined in the <i>Physicians' Current Procedural Terminology</i> code book) received from a physician during an office visit or an outpatient hospital visit	20% coinsurance	No coverage
ii. Anesthesia services received from a provider during an office visit or an outpatient hospital or ambulatory surgical center visit	20% coinsurance	No coverage
iii. Outpatient lab and pathology	20% coinsurance	No coverage
iv. Outpatient x-rays and other imaging services	20% coinsurance	No coverage
v. Other outpatient hospital services received from a physician	20% coinsurance	No coverage
vi. Services related to human leukocyte antigen testing for bone marrow transplants	20% coinsurance	No coverage

b. Hospital and ambulatory surgical center services

i. Outpatient lab and pathology	20% coinsurance	No coverage
ii. Outpatient x-rays and other imaging services	20% coinsurance	No coverage
iii. Other outpatient hospital services	20% coinsurance	No coverage

4. Inpatient services	20% coinsurance	No coverage
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Organ And Bone Marrow Transplant Services

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	* Out-of-network benefits after deductible
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* For out-of-network benefits, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible or the out-of-pocket maximum.

5. Services received from a physician during an inpatient stay	20% coinsurance	No coverage
6. Anesthesia services received from a provider during an inpatient stay	20% coinsurance	No coverage
7. Transportation and lodging <ul style="list-style-type: none"> a. As described below, reimbursement of reasonable and necessary expenses for travel and lodging for you and a companion when you receive approved services at a designated facility for transplant services and you live more than 50 miles from that designated facility <ul style="list-style-type: none"> i. Transportation of you and one companion (traveling on the same day(s)) to and/or from a designated facility for transplant services for pre-transplant, transplant, and post-transplant services. If you are a minor child, transportation expenses for two companions will be reimbursed. 	The deductible does not apply to this reimbursement benefit. You are responsible for paying all amounts not reimbursed under this benefit. Such amounts do not count toward your out-of-pocket maximum or toward satisfaction of your deductible.	No coverage

Organ And Bone Marrow Transplant Services

Your Benefits and the Amounts You Pay

Benefits

In-network benefits after deductible

* Out-of-network benefits after deductible

* For out-of-network benefits, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible or the out-of-pocket maximum.

- ii. Lodging for you (while not confined) and one companion.
Reimbursement is available for a per diem amount of up to \$50 for one person or up to \$100 for two people. If you are a minor child, reimbursement for lodging expenses for two companions is available, up to a per diem amount of \$100.
 - iii. There is a lifetime maximum of \$10,000 per member for all transportation and lodging expenses incurred by you and your companion(s) and reimbursed under the Contract or under any other Medica, Medica Health Plans, or Medica Health Plans of Wisconsin coverage offered through the same employer.
- b. Meals are not reimbursable under this benefit.

Physical, Speech, And Occupational Therapies

P. Physical, Speech, And Occupational Therapies

This section describes coverage for physical therapy, speech therapy, and occupational therapy services provided on an outpatient basis. A physician must direct your care in order for it to be eligible for coverage. Coverage for services provided on an inpatient basis is as described elsewhere in this certificate.

See Definitions. These words have specific meanings: benefits, coinsurance, copayment, deductible, habilitative, inpatient, network, non-network, non-network provider reimbursement amount, physician, provider, rehabilitative.

Prior authorization. Prior authorization from Medica may be required *before* you receive services or supplies. Call Customer Service at one of the telephone numbers listed inside the front cover. See *How To Access Your Benefits* for more information about the prior authorization process.

Covered

For benefits and the amounts you pay, see the table in this section. More than one copayment or coinsurance may be required if you receive more than one service or see more than one provider per visit.

Therapy services described in this section include coverage for the treatment of autism spectrum disorders.

- *In-network benefits* apply to outpatient physical therapy, speech therapy, and occupational therapy services arranged through a physician and received from the following types of network providers: physical therapist, speech therapist, occupational therapist, or physician.
- *Out-of-network benefits* apply to outpatient physical therapy, speech therapy, and occupational therapy services arranged through a physician and received from the following types of non-network providers: physical therapist, speech therapist, occupational therapist, or physician. In addition to the deductible and coinsurance described for out-of-network benefits, you will be responsible for any charges in excess of the non-network provider reimbursement amount. **The out-of-pocket maximum does not apply to these charges.** Please see *Important member information about out-of-network benefits* in *How To Access Your Benefits* for more information and an example calculation of out-of-pocket costs associated with out-of-network benefits.

Not covered

These services, supplies, and associated expenses are not covered:

1. Services primarily educational in nature.
2. Vocational and job rehabilitation.
3. Recreational therapy.
4. Self-care and self-help training (non-medical).
5. Health clubs.

Physical, Speech, And Occupational Therapies

6. Voice training.
7. Group physical, speech, and occupational therapy.
8. Physical, speech, or occupational therapy services (including but not limited to services for the correction of speech impediments or assistance in the development of verbal clarity) when there is no reasonable expectation that the member's condition will improve over a predictable period of time according to generally accepted standards in the medical community.
9. Massage therapy, provided in any setting, even when it is part of a comprehensive treatment plan.

See Exclusions for additional services, supplies, and associated expenses that are not covered.

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	* Out-of-network benefits after deductible
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*** For out-of-network benefits, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible or the out-of-pocket maximum.**

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|--|--|--|
| <ol style="list-style-type: none"> 1. Physical therapy services received outside of your home <ol style="list-style-type: none"> a. Habilitative services b. Rehabilitative services | <ol style="list-style-type: none"> 20% coinsurance 20% coinsurance | <ol style="list-style-type: none"> 40% coinsurance. Coverage for physical and occupational therapy is limited to a combined limit of 20 visits per calendar year.
Please note: This visit limit includes physical and occupational therapy visits that you pay for in order to satisfy any part of your deductible. 40% coinsurance. Coverage for physical and occupational therapy is limited to a combined limit of 20 visits per calendar year.
Please note: This visit limit includes physical and occupational therapy visits that you pay for in order to satisfy any part of your deductible. |
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Physical, Speech, And Occupational Therapies

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	* Out-of-network benefits after deductible
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* For out-of-network benefits, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible or the out-of-pocket maximum.

2. Speech therapy services received outside of your home

a. Habilitative services

20% coinsurance

40% coinsurance. Coverage for speech therapy is limited to 20 visits per calendar year. **Please note:** This visit limit includes speech therapy visits that you pay for in order to satisfy any part of your deductible.

b. Rehabilitative services

20% coinsurance

40% coinsurance. Coverage for speech therapy is limited to 20 visits per calendar year. **Please note:** This visit limit includes speech therapy visits that you pay for in order to satisfy any part of your deductible.

3. Occupational therapy services received outside of your home

a. Habilitative services

20% coinsurance

40% coinsurance. Coverage for physical and occupational therapy is limited to a combined limit of 20 visits per calendar year. **Please note:** This visit limit includes physical and occupational therapy visits that you pay for in order to satisfy any part of your deductible.

Physical, Speech, And Occupational Therapies

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	* Out-of-network benefits after deductible
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* For out-of-network benefits, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible or the out-of-pocket maximum.

b. Rehabilitative services

20% coinsurance

40% coinsurance.

Coverage for physical and occupational therapy is limited to a combined limit of 20 visits per calendar year.

Please note: This visit limit includes physical and occupational therapy visits that you pay for in order to satisfy any part of your deductible.

Prescription Drug Program

Q. Prescription Drug Program

This section describes coverage for prescription drugs and supplies received from a pharmacy or a designated mail order pharmacy. For purposes of this section, the phrase “covered drugs” is meant to include those prescription drugs, over-the-counter (OTC) drugs, and supplies found on the Preferred Drug List (PDL) and prescribed by a provider authorized to prescribe such covered drugs, unless such prescription drugs, OTC drugs, and supplies are identified in this certificate as not covered. The phrase “professionally administered drugs” means drugs requiring intravenous infusion or injection, intramuscular injection, or intraocular injection; the phrase “self-administered drugs” means all other drugs. For the definition and coverage of specialty prescription drugs, see *Prescription Specialty Drug Program*.

See Definitions. These words have specific meanings: benefits, claim, coinsurance, copayment, deductible, emergency, hospital, member, network, non-network, non-network provider reimbursement amount, physician, prescription drug, preventive health service, provider.

Preferred drug list

Medica’s PDL identifies whether a drug is classified by Medica as a Tier 1, Tier 2, or Tier 3 covered drug. In general, only drugs on Medica’s PDL are eligible for benefits under this certificate. The PDL includes the following tiers:

Tier 1 is your lowest copayment or coinsurance option. For the lowest out-of-pocket expense, you should consider a Tier 1 covered drug if you and your physician decide it is appropriate for your treatment.

Tier 2 is your higher copayment or coinsurance option. You may consider a Tier 2 covered drug to treat your condition if you and your physician decide it is appropriate.

Tier 3 is your highest copayment or coinsurance option. The covered drugs in Tier 3 are usually more costly.

If you have questions about Medica’s PDL or whether a specific drug is covered (and/or the PDL tier in which the drug may be covered), or if you would like to request a copy of the PDL at no charge, call Customer Service at one of the telephone numbers listed inside the front cover. The PDL is also available when you sign in at www.mymedica.com.

Medica selects drugs for the PDL based on recommendations of an independent Pharmacy and Therapeutics (P&T) Committee that includes practicing physicians and pharmacists. Placement of a drug on the PDL, and the tier to which a drug is assigned, are based on the drug’s safety, efficacy, uniqueness, and cost.

Exceptions to the preferred drug list

If your physician thinks a non-covered drug is medically necessary, he/she may request an exception. **Please note that exceptions will only be allowed when specific clinical criteria are satisfied.** In the event Medica grants an exception, coverage will be provided at the Tier 3 benefit level. In certain circumstances, your physician may request that Medica make an exception to the coverage rules described under *Preferred drug list* above. **Please note that**

Prescription Drug Program

exceptions will only be allowed when specific clinical criteria are satisfied. Any exception that Medica grants will improve the coverage by only one tier. Exceptions to the PDL can also include antipsychotic drugs prescribed to treat emotional disturbance or mental illness, and certain drugs for diagnosed mental illness or emotional disturbance if removed from the PDL or you change health plans. If you would like to request a copy of Medica's PDL exception process, call Customer Service at one of the telephone numbers listed inside the front cover.

Prior authorization

Certain covered drugs require prior authorization from Medica as indicated on the PDL. The provider who prescribes the drug initiates prior authorization. The PDL is made available to providers, including pharmacies and the designated mail order pharmacies. You are responsible for paying the cost of drugs received if you do not meet Medica's authorization criteria.

Step therapy

Medica requires step therapy prior to coverage of specific drugs as indicated on the PDL. Step therapy involves trying an alternative covered drug first (typically a Tier 1 drug) before moving on to a Tier 2 or Tier 3 covered drug for treatment of the same medical condition. Applicable step therapy requirements must be met before Medica will cover Tier 2 or Tier 3 covered drugs.

Quantity limits

Certain covered drugs are assigned quantity limits as indicated on the PDL. These limits indicate the maximum quantity allowed per prescription over a specific time period. Some quantity limits are based on packaging, FDA labeling, or clinical guidelines.

Covered

The following table provides important general information concerning in-network, out-of-network, and mail order benefits. For specific information concerning benefits and the amounts you pay, see the benefit table at the end of this section. Please note that *Prescription Drug Program* describes your copayment or coinsurance for prescription and OTC drugs themselves. An additional copayment or coinsurance applies for the provider's services if you require that a provider administer self-administered drugs, as described in other applicable sections of this certificate including, but not limited to, *Hospital Services*, *Infertility Services*, and *Professional Services*.

In-network benefits	Out-of-network benefits*	Mail order benefits**
Covered drugs received at a network pharmacy; and	Covered drugs received at a non-network pharmacy; and	Covered drugs received from a designated mail order pharmacy; and

Prescription Drug Program

In-network benefits	Out-of-network benefits*	Mail order benefits**
Covered drugs for family planning services or the treatment of sexually transmitted diseases when prescribed by or received from either a network or a non-network provider; and	See In-network benefits column.	Covered drugs for family planning services or the treatment of sexually transmitted diseases when prescribed by either a network or a non-network provider and received from a designated mail order pharmacy; and
Diabetic equipment and supplies, including blood glucose meters when received from a network pharmacy; and	Diabetic equipment and supplies, including blood glucose meters when received from a non-network pharmacy; and	Diabetic equipment and supplies (excluding blood glucose meters) received from a designated mail order pharmacy.
Tobacco cessation products when prescribed by a provider authorized to prescribe the product and received at a network pharmacy.	Tobacco cessation products when prescribed by a provider authorized to prescribe the product and received at a non-network pharmacy.	Not available.

* When out-of-network benefits are used, in addition to the deductible and copayment or coinsurance, you will be responsible for any charges in excess of the non-network provider reimbursement amount. **The out-of-pocket maximum does not apply to these charges.** Please see *Important member information about out-of-network benefits* in *How To Access Your Benefits* for more information and an example calculation of out-of-pocket costs associated with out-of-network benefits.

** **Please note:** Some drugs and supplies are not available through the designated mail order pharmacy.

See *Miscellaneous Medical Services And Supplies* for coverage of insulin pumps.

See *Prescription Specialty Drug Program* for coverage of growth hormone and other specialty prescription drugs.

Prescription unit

Generally, covered drugs will not be dispensed in excess of one prescription unit except as indicated below. One prescription unit is equal to a 31-consecutive-day supply of a covered drug from your pharmacy (or, in the case of contraceptives, up to a three-cycle supply) or a 93-consecutive-day supply of a covered drug from your designated mail order pharmacy (or, in the case of contraceptives, up to a three-cycle supply), unless limited by drug manufacturer's packaging, dosing instructions, or Medica's medication request guidelines, including quantity limits as indicated on the PDL. Copayment or coinsurance amounts will apply to each prescription unit dispensed.

Three prescription units may be dispensed for covered drugs prescribed to treat chronic conditions that are received at a network pharmacy that Medica has specifically designated to

Prescription Drug Program

dispense multiple prescription units. For the current list of such designated pharmacies, sign in at www.mymedica.com or call Customer Service at one of the telephone numbers listed inside the front cover. When you have used 75 percent of your medication as prescribed, you may refill your prescription.

Not covered

The following are not covered:

1. Any amount above what Medica would have paid when you fail to identify yourself to the pharmacy as a member. (Medica will notify you before enforcement of this provision.)
2. Replacement of a drug due to loss, damage, or theft.
3. Appetite suppressants.
4. Tobacco cessation products or services dispensed through a mail order pharmacy.
5. Drugs prescribed by a provider who is not acting within his/her scope of licensure.
6. Homeopathic medicine.
7. Specialty prescription drugs, except as described in *Prescription Specialty Drug Program*.

See Exclusions for additional drugs, supplies, and associated expenses that are not covered.

Your Benefits and the Amounts You Pay

* For out-of-network benefits, in addition to the deductible, copayment, and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible or the out-of-pocket maximum.

In-network benefits after deductible

*** Out-of-network benefits after deductible**

Mail order benefits after deductible

1. Outpatient covered drugs other than those described below or in *Prescription Specialty Drug Program*

Tier 1: \$10 per prescription unit; or

Tier 2: \$25 per prescription unit; or

Tier 3: \$50 per prescription unit

The deductible does not apply.

\$50 or 40% coinsurance (whichever is greater) per prescription unit

Tier 1: \$20 per prescription unit; or

Tier 2: \$50 per prescription unit; or

Tier 3: \$100 per prescription unit

The deductible does not apply.

Prescription Drug Program

Your Benefits and the Amounts You Pay

* For out-of-network benefits, in addition to the deductible, copayment, and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible or the out-of-pocket maximum.

In-network benefits after deductible	* Out-of-network benefits after deductible	Mail order benefits after deductible
<p>2. Infertility covered drugs</p> <p>Tier 1: \$10 per prescription unit; or</p> <p>Tier 2: \$25 per prescription unit; or</p> <p>Tier 3: \$50 per prescription unit</p> <p>The deductible does not apply.</p>	<p>\$50 or 40% coinsurance (whichever is greater) per prescription unit</p>	<p>Tier 1: \$20 per prescription unit; or</p> <p>Tier 2: \$50 per prescription unit; or</p> <p>Tier 3: \$100 per prescription unit</p> <p>The deductible does not apply.</p>
<p>3. Diabetic equipment and supplies, including blood glucose meters</p> <p>Tier 1: 20% coinsurance per prescription unit; or</p> <p>Tier 2: 20% coinsurance per prescription unit; or</p> <p>Tier 3: 20% coinsurance per prescription unit</p> <p>The deductible does not apply.</p>	<p>40% coinsurance per prescription unit</p>	<p>Tier 1: \$50 per prescription unit; or</p> <p>Tier 2: \$50 per prescription unit; or</p> <p>Tier 3: \$50 per prescription unit</p> <p>The deductible does not apply.</p>
<p>4. Tobacco cessation products</p> <p>Tier 1: Nothing per prescription unit; or</p> <p>Tier 2: Nothing per prescription unit; or</p> <p>Tier 3: Nothing per prescription unit</p> <p>The deductible does not apply.</p>	<p>\$50 or 40% coinsurance (whichever is greater) per prescription unit</p>	<p>Not available through a mail order pharmacy.</p>

Your Benefits and the Amounts You Pay

* For out-of-network benefits, in addition to the deductible, copayment, and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible or the out-of-pocket maximum.

In-network benefits after deductible

*** Out-of-network benefits after deductible**

Mail order benefits after deductible

5. Drugs and other supplies (including women’s contraceptives) considered preventive health services, as specifically defined in *Definitions*, when prescribed by a provider authorized to prescribe such drugs. **This group of drugs and supplies is specific and limited.** For the current list of such drugs and supplies, please refer to the Preventive Drug and Supply List within the PDL or call Customer Service at one of the telephone numbers listed inside the front cover. **Note:** Tobacco cessation products are covered as described in 4. in this benefit table.

Tier 1: Nothing per prescription unit; or

\$50 or 40% coinsurance (whichever is greater) per prescription unit

Tier 1: Nothing per prescription unit; or

Tier 2: Nothing per prescription unit; or

Tier 2: Nothing per prescription unit; or

Tier 3: Nothing per prescription unit

Tier 3: Nothing per prescription unit

The deductible does not apply.

The deductible does not apply.

Prescription Specialty Drug Program

R. Prescription Specialty Drug Program

This section describes coverage for specialty prescription drugs received from a designated specialty pharmacy. Specialty prescription drugs include, but are not limited to, high technology prescription drug products for individuals with diseases that require complex therapies. Such specialty prescription drugs are identified on Medica's Specialty Preferred Drug List (SPDL), as described below. For purposes of this section, the phrase "professionally administered drugs" means drugs requiring intravenous infusion or injection, intramuscular injection, or intraocular injection; the phrase "self-administered drugs" means all other drugs.

See Definitions. These words have specific meanings: benefits, claim, coinsurance, copayment, member, network, physician, prescription drug, provider.

Designated specialty pharmacies

A designated specialty pharmacy means a specialty pharmacy that has entered into a separate contract with Medica to provide specialty prescription drug services to members. For the current list of designated specialty pharmacies, call Customer Service at one of the telephone numbers listed inside the front cover or sign in at www.mymedica.com.

Specialty preferred drug list

Medica has a tiered SPDL that identifies specialty prescription drugs that are covered, unless otherwise listed as not covered in this certificate. The SPDL also identifies whether a drug is classified by Medica as a Tier 1 or Tier 2 specialty prescription drug. In general, only specialty prescription drugs on Medica's SPDL are eligible for benefits under this certificate.

The applicable copayments and coinsurance amounts for coverage of drugs on the SPDL are set forth in the benefit table below.

If you have questions about Medica's SPDL or whether a specific specialty prescription drug is covered (and/or the SPDL tier in which the drug may be covered), or if you would like to request a copy of the SPDL at no charge, call Customer Service at one of the telephone numbers listed inside the front cover. The SPDL is also available by signing in at www.mymedica.com.

Medica selects specialty drugs for the SPDL based on recommendations of an independent Pharmacy and Therapeutics (P&T) Committee that includes practicing physicians and pharmacists. Placement of a specialty drug on the SPDL, and the tier to which a specialty drug is assigned, are based on the specialty drug's safety, efficacy, uniqueness, and cost.

Exceptions to the specialty preferred drug list

If your physician thinks a non-covered specialty drug is medically necessary, he/she may request an exception. **Please note that exceptions will only be allowed when specific clinical criteria are satisfied.** In the event Medica grants an exception, coverage will be provided at the Tier 2 specialty prescription drug benefit level. In certain circumstances your physician may request that Medica make an exception to the coverage rules described under *Specialty preferred drug list* above. **Please note that exceptions will only be allowed when specific clinical criteria are satisfied.** Any exception that Medica grants will improve the

Prescription Specialty Drug Program

coverage by only one tier. Exceptions to the SPDL can also include antipsychotic drugs prescribed to treat emotional disturbance or mental illness, and certain drugs for diagnosed mental illness or emotional disturbance if removed from the SPDL or you change health plans. If you would like to request a copy of Medica's SPDL exception process, call Customer Service at one of the telephone numbers listed inside the front cover.

Prior authorization

Certain specialty prescription drugs require prior authorization from Medica. The provider who prescribes the specialty drug initiates prior authorization. The SPDL is made available to providers, including designated specialty pharmacies. You are responsible for paying the cost of specialty prescription drugs you receive if you do not meet Medica's authorization criteria.

Step therapy

Medica requires step therapy prior to coverage of specific specialty prescription drugs as indicated on the SPDL. Step therapy involves trying an alternative covered specialty prescription drug (typically a Tier 1 specialty prescription drug) before moving on to certain other Tier 1 or Tier 2 specialty prescription drugs for treatment of the same medical condition. Applicable step therapy requirements must be met before Medica will cover certain Tier 1 or Tier 2 specialty prescription drugs.

Quantity limits

Certain specialty prescription drugs are assigned quantity limits as indicated on the SPDL. These limits indicate the maximum quantity allowed per prescription over a specific time period. Some quantity limits are based on packaging, FDA labeling, or clinical guidelines.

Covered

For benefits and the amounts you pay, see the table at the end of this section. Benefits apply to specialty prescription drugs prescribed by a provider authorized to prescribe such drugs and received from a designated specialty pharmacy.

This section describes your copayment or coinsurance for specialty prescription drugs. An additional copayment or coinsurance applies for the provider's services if you require that a provider administer self-administered drugs, as described in other applicable sections of this certificate including, but not limited to, *Hospital Services*, *Infertility Services*, and *Professional Services*.

Prescription unit

Generally, specialty prescription drugs will not be dispensed in excess of one prescription unit. When you have used 65 percent of your medication as prescribed, you may refill your prescription. One prescription unit is equal to a 31-consecutive-day supply of a specialty prescription drug, unless limited by the manufacturer's packaging or Medica's medication request guidelines, including quantity limits as indicated on the SPDL.

Prescription Specialty Drug Program

Not covered

The following are not covered:

1. Any amount above what Medica would have paid when you fail to identify yourself to the designated specialty pharmacy as a member. (Medica will notify you before enforcement of this provision.)
2. Replacement of a specialty drug due to loss, damage, or theft.
3. Specialty prescription drugs prescribed by a provider who is not acting within their scope of licensure.
4. Prescription drugs and OTC drugs, except as described in *Prescription Drug Program*.
5. Specialty prescription drugs received from a pharmacy that is not a designated specialty pharmacy.

See Exclusions for additional drugs, supplies, and associated expenses that are not covered.

Your Benefits and the Amounts You Pay

Benefits	You pay
1. Specialty prescription drugs, other than those described below, received from a designated specialty pharmacy	Tier 1 specialty prescription drugs: \$25 per prescription unit; or Tier 2 specialty prescription drugs: \$50 per prescription unit
2. Specialty infertility prescription drugs received from a designated specialty pharmacy	Tier 1 specialty prescription drugs: \$25 per prescription unit; or Tier 2 specialty prescription drugs: \$50 per prescription unit
3. Specialty growth hormone when prescribed by a physician for the treatment of a demonstrated growth hormone deficiency and received from a designated specialty pharmacy	Tier 1 specialty prescription drugs: \$25 per prescription unit; or Tier 2 specialty prescription drugs: \$50 per prescription unit

S. Professional Services

This section describes coverage for professional services received from or directed by a physician.

See Definitions. These words have specific meanings: approved clinical trial, benefits, coinsurance, convenience care/retail health clinic, copayment, deductible, emergency, genetic testing, hospital, inpatient, member, network, non-network, non-network provider reimbursement amount, physician, preventive health service, provider, qualified individual, routine patient costs, urgent care center, virtual care.

Prior authorization. Prior authorization from Medica may be required *before* you receive services or supplies. Call Customer Service at one of the telephone numbers listed inside the front cover. See *How To Access Your Benefits* for more information about the prior authorization process.

Covered

For benefits and the amounts you pay, see the table in this section. More than one copayment or coinsurance may be required if you receive more than one service or see more than one provider per visit.

- *In-network benefits* apply to:
 1. Professional services received from a network provider;
 2. Professional services for testing and treatment of a sexually transmitted disease and testing for AIDS and other HIV-related conditions received from a network provider or a non-network provider;
 3. Family planning services, for the voluntary planning of the conception and bearing of children, received from a network provider or a non-network provider.
- *Out-of-network benefits* apply to professional services received from a non-network provider. In addition to the deductible and coinsurance, you will be responsible for any charges in excess of the non-network provider reimbursement amount. **The out-of-pocket maximum does not apply to these charges.** Please see *Important member information about out-of-network benefits* in *How To Access Your Benefits* for more information and an example calculation of out-of-pocket costs associated with out-of-network benefits. Emergency services from non-network providers will be covered as in-network benefits.

The most specific and appropriate section of this certificate will apply for professional services related to the treatment of a specific condition. For example, benefits for transplant services are described in *Organ And Bone Marrow Transplant Services*.

For some services, there may be a facility charge resulting in copayment or coinsurance (see *Hospital Services*) in addition to the professional services copayment or coinsurance.

Professional Services

Not covered

These services, supplies, and associated expenses are not covered:

1. Drugs provided or administered by a physician or other provider, except those requiring intravenous infusion or injection, intramuscular injection, or intraocular injection. Coverage for drugs is as described in *Prescription Drug Program*, *Prescription Specialty Drug Program*, or otherwise described as a specific benefit in this certificate.
2. Diagnostic casts, diagnostic study models, and bite adjustments unless related to the treatment of temporomandibular joint (TMJ) disorder and craniomandibular disorder.

See Exclusions for additional services, supplies, and associated expenses that are not covered.

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	* Out-of-network benefits after deductible
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* For out-of-network benefits, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible or the out-of-pocket maximum.

- | | | |
|---|-----------------|-----------------|
| <p>1. Office visits</p> <p>Please note: Some services received during an office visit may be covered under another benefit in this certificate. The most specific and appropriate benefit in this certificate will apply for each service received during an office visit.</p> <p>For example, certain services received during an office visit may be considered surgical or imaging services; see below for coverage of these surgical or imaging services. In such instances, both an office visit copayment or coinsurance and outpatient surgical or imaging services copayment or coinsurance apply.</p> <p>Call Customer Service at one of the telephone numbers listed inside the front cover to determine in advance whether a specific procedure is a benefit and the applicable coverage level for each service that you receive.</p> | 20% coinsurance | 40% coinsurance |
| 2. Virtual care | 20% coinsurance | No coverage |

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	* Out-of-network benefits after deductible
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* For out-of-network benefits, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible or the out-of-pocket maximum.

3. Convenience care/retail health clinic visits	20% coinsurance	40% coinsurance
<p>4. Urgent care center visits</p> <p>Please note: Some services received during an urgent care center visit may be covered under another benefit in this certificate. The most specific and appropriate benefit in this certificate will apply for each service received during an urgent care center visit.</p> <p>For example, certain services received during an urgent care center visit may be considered surgical or imaging services; see below for coverage of these surgical or imaging services. In such instances, both an urgent care center visit copayment or coinsurance and outpatient surgical or imaging services copayment or coinsurance apply.</p> <p>Call Customer Service at one of the telephone numbers listed inside the front cover to determine in advance whether a specific procedure is a benefit and the applicable coverage level for each service that you receive.</p>	20% coinsurance	Covered as an in-network benefit.

Professional Services

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	* Out-of-network benefits after deductible
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* For out-of-network benefits, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible or the out-of-pocket maximum.

5. Preventive health care

Please note: If you receive preventive and non-preventive health services during the same visit, the non-preventive health services may be subject to a copayment, coinsurance, or deductible, as described elsewhere in this certificate. The most specific and appropriate benefit in this certificate will apply for each service received during a visit.

a. Child health supervision services, including well-baby care	Nothing. The deductible does not apply.	0% coinsurance. The deductible does not apply.
b. Immunizations	Nothing. The deductible does not apply.	40% coinsurance
c. Early disease detection services including physicals	Nothing. The deductible does not apply.	40% coinsurance
d. Routine screening procedures for cancer including, but not limited to, screening for ovarian cancer and prostate cancer	Nothing. The deductible does not apply.	40% coinsurance
e. Women's preventive health services including mammograms, screenings for cervical cancer, human papillomavirus (HPV) testing, counseling for sexually transmitted infections, counseling for immunodeficiency virus (HIV), BRCA genetic testing and related genetic counseling (when appropriate), and sterilization	Nothing. The deductible does not apply.	40% coinsurance
f. Other preventive health services	Nothing. The deductible does not apply.	40% coinsurance

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	* Out-of-network benefits after deductible
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* For out-of-network benefits, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible or the out-of-pocket maximum.

6. Allergy shots	Nothing. The deductible does not apply.	40% coinsurance
7. Routine annual eye exams	Nothing. The deductible does not apply.	40% coinsurance
8. Chiropractic services to diagnose and to treat (by manual manipulation or certain therapies) conditions related to the muscles, skeleton, and nerves of the body	20% coinsurance	40% coinsurance. Coverage is limited to a maximum of 15 visits per calendar year. Please note: This visit limit includes chiropractic visits that you pay for in order to satisfy any part of your deductible.
9. Surgical services (as defined in the <i>Physicians' Current Procedural Terminology</i> code book) received from a physician during an office visit or an outpatient hospital or ambulatory surgical center visit	20% coinsurance	40% coinsurance
10. Anesthesia services received from a provider during an office visit or an outpatient hospital or ambulatory surgical center visit	20% coinsurance	40% coinsurance
11. Services received from a physician during an emergency room visit	20% coinsurance	Covered as an in-network benefit.
12. Services received from a physician during an inpatient stay	20% coinsurance	40% coinsurance
13. Anesthesia services received from a provider during an inpatient stay	20% coinsurance	40% coinsurance
14. Outpatient lab and pathology	20% coinsurance	40% coinsurance
15. Outpatient x-rays and other imaging services	20% coinsurance	40% coinsurance

Professional Services

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	* Out-of-network benefits after deductible
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* For out-of-network benefits, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible or the out-of-pocket maximum.

16. Other outpatient hospital or ambulatory surgical center services received from a physician	20% coinsurance	40% coinsurance
17. Treatment to lighten or remove the coloration of a port wine stain	<p>Covered at the corresponding in-network benefit level, depending on type of services provided.</p> <p>For example, office visits are covered at the office visit in-network benefit level and surgical services are covered at the surgical services in-network benefit level.</p>	<p>Covered at the corresponding out-of-network benefit level, depending on type of services provided.</p> <p>For example, office visits are covered at the office visit out-of-network benefit level and surgical services are covered at the surgical services out-of-network benefit level.</p>
18. Treatment of temporomandibular joint (TMJ) disorder and craniomandibular disorder	<p>Covered at the corresponding in-network benefit level, depending on type of services provided.</p> <p>For example, office visits are covered at the office visit in-network benefit level and surgical services are covered at the surgical services in-network benefit level.</p> <p>Please note: Dental coverage is not provided under this benefit.</p>	<p>Covered at the corresponding out-of-network benefit level, depending on type of services provided.</p> <p>For example, office visits are covered at the office visit out-of-network benefit level and surgical services are covered at the surgical services out-of-network benefit level.</p> <p>Please note: Dental coverage is not provided under this benefit.</p>
19. Diabetes self-management training and education, including medical nutrition therapy, received from a provider in a program consistent with national educational standards (as established by the American Diabetes Association)	20% coinsurance	40% coinsurance

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	* Out-of-network benefits after deductible
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* For out-of-network benefits, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible or the out-of-pocket maximum.

20. Neuropsychological evaluations/cognitive testing, limited to services necessary for the diagnosis or treatment of a medical illness or injury	20% coinsurance	40% coinsurance
21. Acupuncture. Limited to 15 visits per calendar year for in-network and out-of-network benefits combined. Please note: This visit limit includes visits that you pay for in order to satisfy any part of your deductible.	20% coinsurance	40% coinsurance
22. Services related to lead testing	20% coinsurance	40% coinsurance
23. Vision therapy and orthoptic and/or pleoptic training, to establish a home program, for the treatment of strabismus and other disorders of binocular eye movements. Coverage is limited to a combined in-network and out-of-network total of 5 training visits and 2 follow-up eye exams per calendar year. Please note: These visit and exam limits include visits and exams that you pay for in order to satisfy any part of your deductible.	20% coinsurance	40% coinsurance
24. Genetic counseling, whether pre- or post-test, and whether occurring in an office, clinic, or telephonically Please note: Genetic counseling for BRCA testing, if appropriate, is covered as a women's preventive health service.	20% coinsurance	40% coinsurance

Professional Services

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	* Out-of-network benefits after deductible
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* For out-of-network benefits, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible or the out-of-pocket maximum.

<p>25. Genetic testing when test results will directly affect treatment decisions or frequency of screening for a disease, or when results of the test will affect reproductive choices Please note: BRCA testing, if appropriate, is covered as a women's preventive health service.</p>	<p>20% coinsurance</p>	<p>40% coinsurance</p>
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<p>26. Routine patient costs in connection with a qualified individual's participation in an approved clinical trial</p>	<p>Covered at the corresponding in-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit in-network benefit level and surgical services are covered at the surgical services in-network benefit level.</p>	<p>Covered at the corresponding out-of-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit out-of-network benefit level and surgical services are covered at the surgical services out-of-network benefit level.</p>
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T. Reconstructive And Restorative Surgery

This section describes coverage for professional, hospital, and ambulatory surgical center services for reconstructive and restorative surgery. To be eligible, reconstructive and restorative surgery services must be medically necessary and not cosmetic.

See Definitions. These words have specific meanings: benefits, coinsurance, copayment, cosmetic, deductible, hospital, inpatient, medically necessary, member, network, non-network, non-network provider reimbursement amount, physician, provider, reconstructive, restorative, virtual care.

Prior authorization. Prior authorization from Medica may be required *before* you receive services or supplies. Call Customer Service at one of the telephone numbers listed inside the front cover. See *How To Access Your Benefits* for more information about the prior authorization process.

Covered

For benefits and the amounts you pay, see the table in this section. More than one copayment or coinsurance may be required if you receive more than one service or see more than one provider per visit.

- *In-network benefits* apply to reconstructive and restorative surgery services received from a network provider.
- *Out-of-network benefits* apply to reconstructive and restorative surgery services received from a non-network provider. In addition to the deductible and coinsurance described for out-of-network benefits, you will be responsible for any charges in excess of the non-network provider reimbursement amount. **The out-of-pocket maximum does not apply to these charges.** Please see *Important member information about out-of-network benefits* in *How To Access Your Benefits* for more information and an example calculation of out-of-pocket costs associated with out-of-network benefits.

Not covered

These services, supplies, and associated expenses are not covered:

1. Revision of blemishes on skin surfaces and scars (including scar excisions) primarily for cosmetic purposes, unless otherwise covered in *Professional Services*.
2. Repair of a pierced body part and surgical repair of bald spots or loss of hair.
3. Repairs to teeth, including any other dental procedures or treatment, whether the dental treatment is needed because of a primary dental problem or as a manifestation of a medical treatment or condition.
4. Services and procedures primarily for cosmetic purposes.
5. Surgical correction of male breast enlargement primarily for cosmetic purposes.
6. Hair transplants.

Reconstructive And Restorative Surgery

7. Drugs provided or administered by a physician or other provider on an outpatient basis, except those requiring intravenous infusion or injection, intramuscular injection, or intraocular injection. Coverage for drugs is as described in *Prescription Drug Program*, *Prescription Specialty Drug Program*, or otherwise described as a specific benefit in this certificate.

See Exclusions for additional services, supplies, and associated expenses that are not covered.

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	* Out-of-network benefits after deductible
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* For out-of-network benefits, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible or the out-of-pocket maximum.

1. Office visits	20% coinsurance	40% coinsurance
2. Virtual care	20% coinsurance	No coverage
3. Outpatient services		
a. Professional services		
i. Surgical services (as defined in the <i>Physicians' Current Procedural Terminology</i> code book) received from a physician during an office visit or an outpatient hospital or ambulatory surgical center visit	20% coinsurance	40% coinsurance
ii. Anesthesia services received from a provider during an office visit or an outpatient hospital or ambulatory surgical center visit	20% coinsurance	40% coinsurance
iii. Outpatient lab and pathology	20% coinsurance	40% coinsurance
iv. Outpatient x-rays and other imaging services	20% coinsurance	40% coinsurance
v. Other outpatient hospital or ambulatory surgical center services received from a physician	20% coinsurance	40% coinsurance

Reconstructive And Restorative Surgery

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	* Out-of-network benefits after deductible
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* For out-of-network benefits, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible or the out-of-pocket maximum.

b. Hospital and ambulatory surgical center services		
i. Outpatient lab and pathology	20% coinsurance	40% coinsurance
ii. Outpatient x-rays and other imaging services	20% coinsurance	40% coinsurance
iii. Other outpatient hospital and ambulatory surgical center services	20% coinsurance	40% coinsurance
4. Inpatient services	20% coinsurance	40% coinsurance
5. Services received from a physician during an inpatient stay	20% coinsurance	40% coinsurance
6. Anesthesia services received from a provider during an inpatient stay	20% coinsurance	40% coinsurance

Skilled Nursing Facility Services

U. Skilled Nursing Facility Services

This section describes coverage for use of skilled nursing facility services. Care must be provided under the direction of a physician. Coverage of the services described in 1. in the table in this section is limited to a combined in-network and out-of-network maximum benefit of 120 days per member per calendar year. Skilled nursing facility services are eligible for coverage only if you are admitted to a skilled nursing facility within 30 days after a hospital admission of at least three consecutive days for the same illness or condition.

See Definitions. These words have specific meanings: benefits, coinsurance, copayment, custodial care, deductible, hospital, inpatient, network, non-network, non-network provider reimbursement amount, physician, skilled care, skilled nursing facility.

Prior authorization. Prior authorization from Medica may be required *before* you receive services or supplies. Call Customer Service at one of the telephone numbers listed inside the front cover. See *How To Access Your Benefits* for more information about the prior authorization process.

Covered

For benefits and the amounts you pay, see the table in this section. More than one copayment or coinsurance may be required if you receive more than one service or see more than one provider per visit. For purposes of this section, *room and board* includes coverage of health services and supplies.

- *In-network benefits* apply to skilled nursing facility services arranged through a physician and received from a network skilled nursing facility.
- *Out-of-network benefits* apply to skilled nursing facility services arranged through a physician and received from a non-network skilled nursing facility. In addition to the deductible and coinsurance described for out-of-network benefits, you will be responsible for any charges in excess of the non-network provider reimbursement amount. **The out-of-pocket maximum does not apply to these charges.** Please see *Important member information about out-of-network benefits* in *How To Access Your Benefits* for more information and an example calculation of out-of-pocket costs associated with out-of-network benefits.

Not covered

These services, supplies, and associated expenses are not covered:

1. Custodial care and other non-skilled services.
2. Self-care or self-help training (non-medical).
3. Services primarily educational in nature.
4. Vocational and job rehabilitation.
5. Recreational therapy.
6. Health clubs.

Skilled Nursing Facility Services

7. Physical, speech, or occupational therapy services when there is no reasonable expectation that the member's condition will improve over a predictable period of time according to generally accepted standards in the medical community.
8. Voice training.
9. Group physical, speech, and occupational therapy.
10. Long-term care.

See Exclusions for additional services, supplies, and associated expenses that are not covered.

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	* Out-of-network benefits after deductible
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*** For out-of-network benefits, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible or the out-of-pocket maximum.**

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|--|-----------------|-----------------|
| 1. Daily skilled care or daily skilled rehabilitation services, including room and board, up to 120 days per member per calendar year for in-network and out-of-network services combined
Please note: Such services are eligible for coverage only if you are admitted to a skilled nursing facility within 30 days after a hospital admission of at least three consecutive days for the same illness or condition. This day limit includes days that you pay for in order to satisfy any part of your deductible. | 20% coinsurance | 40% coinsurance |
| 2. Skilled physical, speech, or occupational therapy when room and board is not eligible to be covered | 20% coinsurance | 40% coinsurance |
| 3. Services received from a physician during an inpatient stay in a skilled nursing facility | 20% coinsurance | 40% coinsurance |

Substance Abuse

V. Substance Abuse

This section describes coverage for the diagnosis and primary treatment of substance abuse disorders listed in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders*.

See Definitions. These words have specific meanings: benefits, claim, coinsurance, copayment, deductible, emergency, hospital, inpatient, medically necessary, member, mental disorder, network, non-network, non-network provider reimbursement amount, physician, provider.

Prior authorization. For prior authorization requirements of *in-network* and *out-of-network benefits*, call Medica's designated mental health and substance abuse provider at 1-800-848-8327 or for Hearing Impaired members, please contact: National Relay Center 1-800-855-2880, then ask them to dial Medica Behavioral Health at 1-866-567-0550.

For purposes of this section:

1. Outpatient services include:
 - a. Diagnostic evaluations.
 - b. Outpatient treatment.
 - c. Intensive outpatient programs, including day treatment and partial programs, which may include multiple services and modalities, delivered in an outpatient setting (up to 19 hours per week).
 - d. Services, care, or treatment for a member that has been placed in the Minnesota Department of Corrections' custody following a conviction for a first-degree driving while impaired offense; to be eligible, such services, care, or treatment must be required and provided by the Minnesota Department of Corrections.
2. Inpatient services include:
 - a. Room and board.
 - b. Attending physician services.
 - c. Hospital or facility-based professional services.
 - d. Services, care, or treatment for a member that has been placed in the Minnesota Department of Corrections' custody following a conviction for a first-degree driving while impaired offense; to be eligible, such services, care, or treatment must be required and provided by the Minnesota Department of Corrections.
 - e. Residential treatment services. These are services from a licensed chemical dependency rehabilitation program that provides intensive therapeutic services following detoxification. In addition to room and board, at least 30 hours (15 hours for children and adolescents) per week per individual of chemical dependency services must be provided, including group and individual counseling, client education, and other services specific to chemical dependency rehabilitation.

Covered

For benefits and the amounts you pay, see the table in this section. More than one copayment or coinsurance may be required if you receive more than one service or see more than one provider per visit.

- For *in-network benefits*:
 1. Medica's designated mental health and substance abuse provider arranges in-network substance abuse benefits. If you require hospitalization, Medica's designated mental health and substance abuse provider will refer you to one of its hospital providers (Medica and Medica's designated mental health and substance abuse provider hospital networks are different).
 2. In-network benefits will apply to services, care or treatment for a member that has been placed in the Minnesota Department of Corrections' custody following a conviction for a first-degree driving while impaired offense. To be eligible, such services, care, or treatment must be required and provided by the Minnesota Department of Corrections.

For claims questions regarding *in-network benefits*, call Medica's designated mental health and substance abuse provider Customer Service at 1-866-214-6829.

- For *out-of-network benefits*:
 1. Substance abuse services from a non-network provider listed below will be eligible for coverage under out-of-network benefits provided that the health care professional or facility is licensed, certified, or otherwise qualified under state law to provide the substance abuse services and practice independently:
 - a. Psychiatrist
 - b. Psychologist
 - c. Registered nurse certified as a clinical specialist or as a nurse practitioner in psychiatric and mental health nursing
 - d. Chemical dependency clinic
 - e. Chemical dependency residential treatment center
 - f. Hospital that provides substance abuse services
 - g. Independent clinical social worker
 - h. Marriage and family therapist
 2. Emergency substance abuse services are eligible for coverage under in-network benefits.

In addition to the deductible and coinsurance described for out-of-network benefits, you will be responsible for any charges in excess of the non-network provider reimbursement amount. **The out-of-pocket maximum does not apply to these charges.** Please see *Important member information about out-of-network benefits* in *How To Access Your Benefits* for more information and an example calculation of out-of-pocket costs associated with out-of-network benefits.

Substance Abuse

Not covered

These services, supplies, and associated expenses are not covered:

1. Services for substance abuse disorders not listed in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders*.
2. Services, care, or treatment that is not medically necessary.
3. Services to hold or confine a person under chemical influence when no medical services are required, regardless of where the services are received.
4. Telephonic substance abuse treatment services.
5. Services, including room and board charges, provided by health care professionals or facilities that are not appropriately licensed, certified, or otherwise qualified under state law to provide substance abuse services. This includes, but is not limited to, services provided by mental health or substance abuse providers who are not authorized under state law to practice independently, and services received from a halfway house, therapeutic group home, boarding school, or ranch.
6. Room and board charges associated with substance abuse treatment services providing less than 30 hours (15 hours for children and adolescents) a week per individual of chemical dependency services, including group and individual counseling, client education, and other services specific to chemical dependency rehabilitation.
7. Services to assist in activities of daily living that do not seek to cure and are performed regularly as a part of a routine or schedule.

See Exclusions for additional services, supplies, and associated expenses that are not covered.

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	* Out-of-network benefits after deductible
<p>* For out-of-network benefits, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible or the out-of-pocket maximum.</p>		
1. Office visits, including evaluations, diagnostic, and treatment services	20% coinsurance	40% coinsurance
2. Intensive outpatient programs	20% coinsurance	40% coinsurance
3. Opiate replacement therapy	20% coinsurance	40% coinsurance
4. Inpatient services (including residential treatment services)		
a. Room and board	20% coinsurance	40% coinsurance
b. Hospital or facility-based professional services	20% coinsurance	40% coinsurance

Your Benefits and the Amounts You Pay

Benefits

**In-network benefits
after deductible**

*** Out-of-network benefits
after deductible**

*** For out-of-network benefits, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible or the out-of-pocket maximum.**

c. Attending physician services 20% coinsurance 40% coinsurance

Surgery For Weight Loss

W. Surgery For Weight Loss

This section describes coverage for surgery for morbid obesity. Services must be provided under the direction of a designated physician and received at a designated facility. This section also describes benefits for professional, hospital, and ambulatory surgical center services.

See Definitions. These words have specific meanings: benefits, coinsurance, copayment, deductible, designated facility, designated physician, hospital, inpatient, investigative, medically necessary, member, network, non-network, non-network provider reimbursement amount, physician, provider, virtual care.

Prior authorization. Prior authorization from Medica is required *before* you receive services or supplies. Call Customer Service at one of the telephone numbers listed inside the front cover. See *How To Access Your Benefits* for more information about the prior authorization process.

Covered

For benefits and the amounts you pay, see the table in this section. More than one copayment or coinsurance may be required if you receive more than one service or see more than one provider per visit.

- *Benefits* apply to surgery for morbid obesity provided by a designated network physician and received at a designated network facility. A designated physician or facility is a network physician or hospital that has been designated by Medica to provide surgery for morbid obesity. To request a list of designated physicians and facilities to provide surgery for morbid obesity, call Customer Service at one of the telephone numbers listed inside the front cover.

Not covered

These services, supplies, and associated expenses are not covered:

1. Surgery for morbid obesity when performed by a network physician that is not a designated physician or received at a network facility that is not a designated facility.
2. Surgery for morbid obesity when performed by a non-network physician or received at a non-network hospital.
3. Surgery for morbid obesity, except as described in this section.
4. Services and procedures primarily for cosmetic purposes.
5. Supplies and services for surgery for morbid obesity that would not be authorized by Medica.
6. Services required to meet the patient selection criteria for an authorized surgery for morbid obesity. This includes services and related expenses for weight loss programs, nutritional supplements, appetite suppressants, and supplies of a similar nature not otherwise covered under this certificate.
7. Drugs provided or administered by a physician or other provider on an outpatient basis, except those requiring intravenous infusion or injection, intramuscular injection, or

Surgery For Weight Loss

intraocular injection. Coverage for drugs is as described in *Prescription Drug Program*, *Prescription Specialty Drug Program*, or otherwise described as a specific benefit in this certificate.

See *Exclusions* for additional services, supplies, and associated expenses that are not covered.

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	* Out-of-network benefits after deductible
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*** For out-of-network benefits, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible or the out-of-pocket maximum.**

1. Office visits	20% coinsurance	No coverage
2. Virtual care	20% coinsurance	No coverage
3. Outpatient hospital services	20% coinsurance	No coverage
4. Outpatient services received from a physician in a hospital	20% coinsurance	No coverage
5. Inpatient services	20% coinsurance	No coverage
6. Services received from a physician during an inpatient stay	20% coinsurance	No coverage

Referrals To Non-Network Providers

X. Referrals To Non-Network Providers

This section describes coverage for referrals from network providers to non-network providers. In-network benefits will apply to referrals from network providers to non-network providers as described in this section. It is to your advantage to seek Medica's authorization for referrals to non-network providers *before* you receive services. Medica can then tell you what your benefits will be for the services you may receive.

See Definitions. These words have specific meanings: benefits, medically necessary, network, non-network, physician, provider.

If you want to apply for a standing referral to a non-network provider, contact Medica for more information. If determined by Medica to be medically necessary, a standing referral may be granted by Medica.

A standing referral is a referral issued by a network provider and authorized by Medica for conditions that require ongoing services from a specialist provider. Standing referrals will only be authorized for the period of time appropriate to your medical condition.

Referrals and standing referrals will not be authorized to accommodate personal preferences, family convenience, or other non-medical reasons. Referrals will also not be authorized for care that has already been provided.

If your request for a standing referral is denied, you have the right to appeal this decision as described in *Complaints*.

What you must do

1. Request a referral or standing referral from a network provider to receive medically necessary services from a non-network provider. The referral will be in writing and will:
 - a. Indicate the time period during which services must be received; and
 - b. Specify the service(s) to be provided; and
 - c. Direct you to the non-network provider selected by your network provider.
2. Seek prior authorization from Medica by calling one of the telephone numbers listed inside the front cover. Medica does not guarantee coverage of services that are received before you obtain prior authorization from Medica.
3. If prior authorization has been obtained from Medica, pay the same amount you would have paid if the services had been received from a network provider.
4. Pay any charges not authorized for coverage by Medica.

What Medica will do

1. May require that you see another network provider selected by Medica before a determination by Medica that a referral to a non-network provider is medically necessary.
2. May require that you obtain a referral or standing referral (as described in this section) from a network provider to a non-network provider practicing in the same or similar specialty.

Referrals To Non-Network Providers

3. Provide coverage for health services that are:
 - a. Otherwise eligible for coverage under this certificate; and
 - b. Recommended by a network physician.
4. Notify you of authorization or denial of coverage within ten days of receipt of your request. Medica will inform both you and your provider of Medica's decision as soon as the medical condition warrants, not to exceed 72 hours from the time of the initial request if your attending provider believes that an expedited review is warranted, or Medica concludes that a delay could seriously jeopardize your life, health, or ability to regain maximum function, or could subject you to severe pain that cannot be adequately managed without the care or treatment you are seeking.

Harmful Use Of Medical Services

Y. Harmful Use Of Medical Services

This section describes what Medica will do if it is determined you are receiving health services or prescription drugs in a quantity or manner that may harm your health.

See *Definitions*. These words have specific meanings: benefits, emergency, hospital, network, physician, prescription drug, provider.

When this section applies

After Medica notifies you that this section applies, you have 30 days to choose one network physician, hospital, and pharmacy to be your coordinating health care providers.

If you do not choose your coordinating health care providers within 30 days, Medica will choose for you. Your in-network benefits are then restricted to services provided by or arranged through your coordinating health care providers.

Failure to receive services from or through your coordinating health care providers will result in a denial of coverage.

You must obtain a referral from your coordinating health care provider if your condition requires care or treatment from a provider other than your coordinating health care provider.

Medica will send you specific information about:

1. How to obtain approval for benefits not available from your coordinating health care providers;
2. How to obtain emergency care; and
3. When these restrictions end.

Z. Exclusions

See Definitions. These words have specific meanings: claim, cosmetic, custodial care, emergency, investigative, medically necessary, member, non-network, physician, provider, reconstructive, routine foot care.

Medica will not provide coverage for any of the services, treatments, supplies, or items described in this section even if it is recommended or prescribed by a physician or it is the only available treatment for your condition.

This section describes additional exclusions to the services, supplies, and associated expenses already listed as *Not covered* in this certificate. These include:

1. Services that are not medically necessary. This includes but is not limited to services inconsistent with the medical standards and accepted practice parameters of the community and services inappropriate—in terms of type, frequency, level, setting, and duration—to the diagnosis or condition.
2. Services or drugs used to treat conditions that are cosmetic in nature, unless otherwise determined to be reconstructive.
3. Refractive eye surgery, including but not limited to LASIK surgery.
4. The purchase, replacement, or repair of eyeglasses, eyeglass frames, or contact lenses when prescribed solely for vision correction, and their related fittings.
5. Services provided by an audiologist when not under the direction of a physician.
6. Hearing aids (including internal, external, or implantable hearing aids or devices) and other devices to improve hearing, and their related fittings, except as described in *Durable Medical Equipment And Prosthetics*.
7. A drug, device, or medical treatment or procedure that is investigative.
8. Genetic testing when performed in the absence of symptoms or high risk factors for a genetic disease; genetic testing when knowledge of genetic status will not affect treatment decisions, frequency of screening for the disease, or reproductive choices; genetic testing that has been performed in response to direct-to-consumer marketing and not under the direction of your physician.
9. Services or supplies not directly related to care.
10. Autopsies.
11. Enteral feedings, unless they are the sole source of nutrition; however, enteral feedings of standard infant formulas, standard baby food, and regular grocery products used in blenderized formulas are excluded regardless of whether they are the sole source of nutrition.
12. Nutritional and electrolyte substances except as specifically described in *Miscellaneous Medical Services And Supplies*.
13. Physical, occupational, or speech therapy or chiropractic services when there is no reasonable expectation that the condition will improve over a predictable period of time.
14. Reversal of voluntary sterilization.

Exclusions

15. Personal comfort or convenience items or services.
16. Custodial care, unskilled nursing, or unskilled rehabilitation services.
17. Respite or rest care, except as otherwise covered in *Hospice Services*.
18. Travel, transportation, or living expenses, except as described in *Organ And Bone Marrow Transplant Services*.
19. Household equipment, fixtures, home modifications, and vehicle modifications.
20. Massage therapy, provided in any setting, even when it is part of a comprehensive treatment plan.
21. Routine foot care, except for members with diabetes, blindness, peripheral vascular disease, peripheral neuropathies, and significant neurological conditions such as Parkinson's disease, Alzheimer's disease, multiple sclerosis, and amyotrophic lateral sclerosis.
22. Services by persons who are family members or who share your legal residence.
23. Services for which coverage is available under workers' compensation, employer liability, or any similar law.
24. Services received before coverage under the Contract becomes effective.
25. Services received after coverage under the Contract ends.
26. Unless requested by Medica, charges for duplicating and obtaining medical records from non-network providers and non-network dentists.
27. Photographs, except for the condition of multiple dysplastic syndrome.
28. Occlusal adjustment or occlusal equilibration.
29. Dental implants (tooth replacement), except as described in *Medical-Related Dental Services*.
30. Dental prostheses.
31. Any orthodontia, except as described in *Medical-Related Dental Services* for the treatment of cleft lip and palate.
32. Treatment for bruxism.
33. Services prohibited by applicable law or regulation.
34. Services to treat injuries that occur while on military duty, and any services received as a result of war or any act of war (whether declared or undeclared).
35. Exams, other evaluations, or other services received solely for the purpose of employment, insurance, or licensure.
36. Exams, other evaluations, or other services received solely for the purpose of judicial or administrative proceedings or research except emergency examination of a child ordered by judicial authorities.
37. Non-medical self-care or self-help training.
38. Educational classes, programs, or seminars, including but not limited to childbirth classes, except as described in *Professional Services*.
39. Coverage for costs associated with translation of medical records and claims to English.

40. Treatment for superficial veins, also referred to as spider veins or telangiectasia.
41. Services not received from or under the direction of a physician, except as described in this certificate.
42. Orthognathic surgery for cosmetic purposes.
43. Sensory integration, including auditory integration training.
44. Services for or related to vision therapy and orthoptic and/or pleoptic training, except as described in *Professional Services*.
45. Services for or related to intensive behavior therapy treatment programs for the treatment of autism spectrum disorders for members 18 years of age and older. Examples of such services include, but are not limited to, Intensive Early Intervention Behavior Therapy Services (IEIBTS), Intensive Behavioral Intervention (IBI), and Lovaas therapy.
46. Health care professional services for home labor and delivery.
47. Surgery for weight loss or morbid obesity, including initial procedures, surgical revisions, and subsequent procedures, except as described in *Surgery For Weight Loss*.
48. Services solely for or related to the treatment of snoring.
49. Interpreter services, except as described in *Home Health Care*.
50. Services provided to treat injuries or illness that are the result of committing a felony or attempting to commit a felony.
51. Services for private duty nursing, except as described in *Home Health Care*. Examples of private duty nursing services include, but are not limited to, skilled or unskilled services provided by an independent nurse who is ordered by the member or the member's representative, and not under the direction of a physician.
52. Laboratory testing that has been performed in response to direct-to-consumer marketing and not under the direction of a physician.
53. Medical devices that are not approved by the U.S. Food and Drug Administration (FDA), other than those granted a humanitarian device exemption.
54. Health clubs.
55. Long-term care.
56. Expenses associated with participation in weight loss programs, including but not limited to membership fees and the purchase of food, dietary supplements, or publications.
57. Charges for mailing, interest, and delivery.

How To Submit A Claim

AA. *How To Submit A Claim*

This section describes the process for submitting a claim.

See Definitions. These words have specific meanings: benefits, claim, dependent, member, network, non-network, non-network provider reimbursement amount, provider.

Claims for benefits from network providers

If you receive a bill for any benefit from a network provider, you may submit the claim following the procedures described below, under *Claims for benefits from non-network providers*, or call Customer Service at one of the telephone numbers listed inside the front cover. Claim forms may also be obtained by signing in at www.mymedica.com.

Network providers are required to submit claims within 180 days from when you receive a service. If your provider asks for your health care identification card and you do not identify yourself as a Medica member within 180 days of the date of service, you may be responsible for paying the cost of the service you received.

Claims for benefits from non-network providers

Claim forms are provided in your enrollment materials. You may request additional claim forms by calling Customer Service at one of the telephone numbers listed inside the front cover. Claim forms may also be obtained by signing in at www.mymedica.com. If the claim forms are not sent to you within 15 days, you may submit an itemized statement without the claim form to Medica. You should retain copies of all claim forms and correspondence for your records.

You must submit the claim in English along with a Medica claim form to Medica no later than 365 days after receiving benefits. Your Medica member number must be on the claim.

Mail to the address identified on the back of your identification card.

Upon receipt of your claim for benefits from non-network providers, Medica will generally pay to you directly the non-network provider reimbursement amount. Medica will only pay the provider of services if:

1. The non-network provider is one that Medica has determined can be paid directly; and
2. The non-network provider notifies Medica of your signature on file authorizing that payment be made directly to the provider.

Medica will notify you of authorization or denial of the claim within 30 days of receipt of the claim.

If your claim does not contain all the information Medica needs to make a determination, Medica may request additional information. Medica will notify you of its decision within 15 days of receiving the additional information. If you do not respond to Medica's request within 45 days, your claim may be denied.

Call Customer Service at one of the telephone numbers listed inside the front cover for a list of non-network providers that Medica will not pay directly.

Claims for services provided outside the United States

Claims for services rendered in a foreign country will require the following additional documentation:

- Claims submitted in English with the currency exchange rate for the date health services were received.
- Itemization of the bill or claim.
- The related medical records (submitted in English).
- Proof of your payment of the claim.
- A complete copy of your passport and airline ticket.
- Such other documentation as Medica may request.

For services rendered in a foreign country, Medica will pay you directly.

Medica will not reimburse you for costs associated with translation of medical records or claims.

Time limits

If you have a complaint or disagree with a decision by Medica, you may follow the complaint procedure outlined in *Complaints* or you may initiate legal action at any point.

However, you may not bring legal action more than six years after Medica has made a coverage determination regarding your claim.

Coordination Of Benefits

BB. Coordination Of Benefits

This section describes how benefits are coordinated when you are covered under more than one plan.

See Definitions. These words have specific meanings: benefits, claim, deductible, dependent, emergency, hospital, medically necessary, member, network, non-network, non-network provider reimbursement amount, provider, subscriber.

1. Applicability

- a. This coordination of benefits (COB) provision applies to this plan when an employee or the employee's covered dependent has health care coverage under more than one plan. *Plan* and *this plan* are defined below.
- b. If this coordination of benefits provision applies, *Order of benefit determination rules* should be looked at first. Those rules determine whether the benefits of this plan are determined before or after those of another plan. Under *Order of benefit determination rules*, the benefits of this plan:
 - i. Shall not be reduced when this plan determines its benefits before another plan; but
 - ii. May be reduced when another plan determines its benefits first. The above reduction is described in *Effect on the benefits of this plan*.

2. Definitions that apply to this section

- a. Plan is any of these which provides benefits or services for, or because of, medical or dental care or treatment:
 - i. Group insurance or group-type coverage, whether insured or uninsured, or individual coverage. This includes prepayment, group practice, or individual practice coverage. It also includes coverage other than school accident-type coverage.
 - ii. Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

Each Contract or other arrangement for coverage under i. or ii. is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

- b. This plan is the part of the Contract that provides benefits for health care expenses.
- c. *Primary plan/secondary plan.* The *Order of benefit determination rules* state whether this plan is a primary plan or secondary plan as to another plan covering the person.

When this plan is a primary plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.

When this plan is a secondary plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

When there are two or more plans covering the person, this plan may be a primary plan as to one or more other plans, and may be a secondary plan as to a different plan or plans.

- d. *Allowable expense* means a necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made. Allowable expense does not include the deductible for members with a primary high deductible plan and who notify Medica of an intention to contribute to a health savings account.

The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an allowable expense under the above definition unless the patient's stay in a private hospital room is medically necessary, either in terms of generally accepted medical practice or as specifically defined in the plan.

The difference between the charges billed by a provider and the non-network provider reimbursement amount is not considered an allowable expense under the above definition.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid.

When benefits are reduced under a primary plan because a member does not comply with the plan provisions, the amount of such reduction will not be considered an allowable expense. Examples of such provisions are those related to second surgical opinions, and preferred provider arrangements.

- e. *Claim determination period* means a calendar year. However, it does not include any part of a year during which a person has no coverage under this plan, or any part of a year before the date this COB provision or a similar provision takes effect.

3. *Order of benefit determination rules*

- a. *General*. When there is a basis for a claim under this plan and another plan, this plan is a secondary plan which has its benefits determined after those of the other plan, unless:
- i. The other plan has rules coordinating its benefits with the rules of this plan; and
 - ii. Both the other plan's rules and this plan's rules, in 3.b. below, require that this plan's benefits be determined before those of the other plan.
- b. *Rules*. This plan determines its order of benefits using the first of the following rules which applies:
- i. *Nondependent/dependent*. The benefits of the plan that covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the plan, which covers the person as a dependent.
 - ii. *Dependent child/parents not separated or divorced*. Except as stated in 3.b.iii. below, when this plan and another plan cover the same child as a dependent of different persons, called *parents*:
 - a) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

Coordination Of Benefits

- b) If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

However, if the other plan does not have the rule described in (a) immediately above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

- iii. *Dependent child/separated or divorced parents.* If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

- a) First, the plan of the parent with custody of the child;
- b) Then, the plan of the spouse of the parent with the custody of the child; and
- c) Finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the secondary plan. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

- iv. *Joint custody.* If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering follow the *Order of benefit determination rules* outlined in 3.b.ii.
- v. *Active/inactive employee.* The benefits of a plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- vi. *Workers' compensation.* Coverage under any workers' compensation act or similar law applies first. You should submit claims for expenses incurred as a result of an on-duty injury to the employer, before submitting them to Medica.
- vii. *No-fault automobile insurance.* Coverage under the No-Fault Automobile Insurance Act or similar law applies first.
- viii. *Longer/shorter length of coverage.* If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member, or subscriber longer are determined before those of the plan which covered that person for the shorter term.

4. Effect on the benefits of this plan

- a. *When this section applies.* This 4. applies when, in accordance with 3. *Order of benefit determination rules*, this plan is a secondary plan as to one or more other plans. In that

event, the benefits of this plan may be reduced under this section. Such other plan or plans are referred to as *the other plans* in b. immediately below.

- b. *Reduction in this plan's benefits.* The benefits of this plan will be reduced when the sum of:
 - i. The benefits that would be payable for the allowable expense under this plan in the absence of this COB provision; and
 - ii. The benefits that would be payable for the allowable expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those allowable expenses in a claim determination period. In that case, the benefits of this plan will be reduced so that they and the benefits payable under the other plans do not total more than those allowable expenses.

When the benefits of this plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this plan.

5. *Right to receive and release needed information*

Certain facts are needed to apply these COB rules. Medica has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. Medica need not tell, or get the consent of, any person to do this. Unless applicable federal or state law prevents disclosure of the information without the consent of the patient or the patient's representative, each person claiming benefits under this plan must give Medica any facts it needs to pay the claim.

6. *Facility of payment*

A payment made under another plan may include an amount, which should have been paid under this plan. If it does, Medica may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this plan. Medica will not have to pay that amount again. The term *payment made* includes providing benefits in the form of services, in which case *payment made* means reasonable cash value of the benefits provided in the form of services.

7. *Right of recovery*

If the amount of the payments made by Medica is more than it should have paid under this COB provision, it may recover the excess from one or more of the following:

- a. The persons it has paid or for whom it has paid; or
- b. Insurance companies; or
- c. Other organizations.

The amount of the *payments made* includes the reasonable cash value of any benefits provided in the form of services.

Please note: See *Right Of Recovery* for additional information.

Right Of Recovery

CC. *Right Of Recovery*

This section describes Medica's right of recovery. Medica's rights are subject to Minnesota and federal law. For information about the effect of applicable state and federal law on Medica's subrogation rights, contact an attorney.

See *Definitions*. This word has a specific meaning: benefits.

1. Medica has a right of subrogation against any third party, individual, corporation, insurer, or other entity or person who may be legally responsible for payment of medical expenses related to your illness or injury. Medica's right of subrogation shall be governed according to this section. Medica's right to recover its subrogation interest applies only after you have received a full recovery for your illness or injury from another source of compensation for your illness or injury.
2. Medica's subrogation interest is the reasonable cash value of any benefits received by you.
3. Medica's right to recover its subrogation interest may be subject to an obligation by Medica to pay a pro rata share of your disbursements, attorney fees and costs, and other expenses incurred in obtaining a recovery from another source unless Medica is separately represented by an attorney. If Medica is represented by an attorney, an agreement regarding allocation may be reached. If an agreement cannot be reached, the matter must be submitted to binding arbitration.
4. By accepting coverage under the Contract, you agree:
 - a. That if Medica pays benefits for medical expenses you incur as a result of any act by a third party for which the third party is or may be liable, and you later obtain full recovery, you are obligated to reimburse Medica for the benefits paid in accordance to Minnesota law.
 - b. To cooperate with Medica or its designee to help protect Medica's legal rights under this subrogation provision and to provide all information Medica may reasonably request to determine its rights under this provision.
 - c. To provide prompt written notice to Medica when you make a claim against a party for injuries.
 - d. To do nothing to decrease Medica's rights under this provision, either before or after receiving benefits, or under the Contract.
 - e. Medica may take action to preserve its legal rights. This includes bringing suit in your name.
 - f. Medica may collect its subrogation interest from the proceeds of any settlement or judgment recovered by you, your legal representative, or the legal representative(s) of your estate or next-of-kin.

DD. Eligibility And Enrollment

This section describes who can enroll and how to enroll.

See Definitions. These words have specific meanings: benefits, continuous coverage, dependent, late entrant, member, placed as a foster child, placed for adoption, premium, qualifying coverage, rescission, subscriber, waiting period.

Who can enroll

To be eligible to enroll for coverage you must meet the eligibility requirements of the Contract and be a subscriber or dependent as defined in this certificate. See *Definitions*.

How to enroll

You must submit an application for coverage for yourself and any dependents to the employer:

1. During the initial enrollment period as described in this section under *Initial enrollment and effective date of coverage*; or
2. During the open enrollment period as described in this section under *Open enrollment and effective date of coverage*; or
3. During a special enrollment period as described in this section under *Special enrollment and effective date of coverage*; or
4. At any other time for consideration as a late entrant as described in this section under *Late enrollment and effective date of coverage*.

Dependents will not be enrolled without the eligible employee also being enrolled. A child who is the subject of a QMCSO can be enrolled as described in this section under *Qualified Medical Child Support Order (QMCSO)* and 6. under *Special enrollment and effective date of coverage*.

Notification

You must notify the employer in writing within 30 days of the effective date of any changes to address or name, addition or deletion of dependents, a dependent child or eligible grandchild reaching the dependent limiting age, or other facts identifying you or your dependents. (For dependent children, including eligible grandchildren, the notification period is not limited to 30 days for newborns or children newly adopted or newly placed for adoption; however, we encourage you to enroll your newborn dependent under the Contract within 30 days from the date of birth, date of placement for adoption, or date of adoption.) Your newborn child, your newly adopted child, a child newly placed for adoption with the subscriber, a child newly placed as a foster child, a newly eligible grandchild, and any child who is a member pursuant to a QMCSO will be covered without application of health screening or waiting periods.

The employer must notify Medica, as set forth in the Contract, of your initial enrollment application, changes to your name or address, or changes to enrollment, including if you or your dependents are no longer eligible for coverage.

Eligibility And Enrollment

Initial enrollment and effective date of coverage

A 30-day time period starting with the date an eligible employee and dependents are first eligible to enroll for coverage under the Contract. An eligible employee must enroll within this period for coverage to begin the date he or she was first eligible to enroll. (The 30-day time period does not apply to newborns or children newly adopted or placed for adoption; see *Special enrollment and effective date of coverage*.) An eligible employee and dependents who do not enroll during the initial enrollment period may enroll for coverage during the next open enrollment, any applicable special enrollment periods, or as a late entrant (if applicable, as described below).

An eligible employee and dependents who do not enroll during the initial enrollment period, an open enrollment period, or during any applicable special enrollment period, as described in this section, will be considered late entrants.

However, an eligible employee or dependent who:

1. does not enroll during the initial enrollment period, an open enrollment period, or any applicable special enrollment period; and
2. is an enrollee of the Minnesota Comprehensive Health Association (MCHA) at the time Medica offers or renews coverage with the employer, provided the eligible employee or dependent maintains continuous coverage, will not be considered a late entrant and will be allowed to enroll. Coverage will be effective as determined by Medica.

A member who is a child entitled to receive coverage through a QMCSO is not subject to any initial enrollment period restrictions, except as noted in this section.

Your coverage begins at 12:01 a.m. on the effective date specified in the Contract.

Open enrollment and effective date of coverage

A minimum 14-day period set by the employer and Medica each year during which eligible employees and dependents who are not covered under the Contract may elect coverage for the upcoming Contract year. An application must be submitted to the employer for yourself and any dependents.

Your coverage begins at 12:01 a.m. on the effective date of your coverage.

For eligible employees and dependents who enroll during the open enrollment period, coverage begins on the first day of the Contract year for which the open enrollment period was held.

Special enrollment and effective date of coverage

Special enrollment periods are provided to eligible employees and dependents under certain circumstances. The effective date of coverage depends upon the type of special enrollment. In all cases, your coverage begins at 12:01 a.m. on the effective date of your coverage.

1. Loss of other coverage
 - a. A special enrollment period will apply to an eligible employee and dependent if the individual was covered under Medicaid or a State Children's Health Insurance Plan and lost that coverage as a result of loss of eligibility. The eligible employee or dependent must present evidence of the loss of coverage and request enrollment within 60 days after the date such coverage terminates.

In the case of the eligible employee's loss of coverage, this special enrollment period applies to the eligible employee and all of his or her dependents. In the case of a dependent's loss of coverage, this special enrollment period applies to both the dependent who has lost coverage and the eligible employee.

- b. A special enrollment period will apply to an eligible employee and dependent if the eligible employee or dependent was covered under qualifying coverage other than Medicaid or a State Children's Health Insurance Plan at the time the eligible employee or dependent was eligible to enroll under the Contract, whether during initial enrollment, open enrollment, or special enrollment, and declined coverage for that reason.

The eligible employee or dependent must present either evidence of the loss of prior coverage due to loss of eligibility for that coverage or evidence that employer contributions toward the prior coverage have terminated, and request enrollment in writing within 30 days of the date of the loss of coverage or the date the employer's contribution toward that coverage terminates.

For purposes of 1.b.:

- i. Prior coverage does not include federal or state continuation coverage;
- ii. Loss of eligibility includes:
 - loss of eligibility as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment;
 - cessation of dependent status;
 - incurring a claim that causes the eligible employee or dependent to meet or exceed the lifetime maximum limit on all benefits
 - for dependents, the eligible employee's enrollment for benefits under Medicare;
 - if the prior coverage was offered through an individual health maintenance organization (HMO), a loss of coverage because the eligible employee or dependent no longer resides or works in the HMO's service area;
 - if the prior coverage was offered through a group HMO, a loss of coverage because the eligible employee or dependent no longer resides or works in the HMO's service area and no other coverage option is available; and
 - the prior coverage no longer offers any benefits to the class of similarly situated individuals that includes the eligible employee or dependent.
- iii. Loss of eligibility occurs regardless of whether the eligible employee or dependent is eligible for or elects applicable federal or state continuation coverage;
- iv. Loss of eligibility does not include a loss due to failure of the eligible employee or dependent to pay premiums on a timely basis or situations allowing for a rescission of coverage;

In the case of the eligible employee's loss of other coverage, the special enrollment period described above applies to the eligible employee and all of his or her dependents. In the case of a dependent's loss of other coverage, the special enrollment period described above applies only to the dependent who has lost coverage and the eligible employee. In the case of the eligible employee's enrollment in Medicare, the special enrollment period described above applies to his or her dependents.

Eligibility And Enrollment

- c. A special enrollment period will apply to an eligible employee and dependent if the eligible employee or dependent was covered under benefits available under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, or any applicable state continuation laws at the time the eligible employee or dependent was eligible to enroll under the Contract, whether during initial enrollment, open enrollment, or special enrollment and declined coverage for that reason.

The eligible employee or dependent must present evidence that the eligible employee or dependent has exhausted such COBRA or state continuation coverage and has not lost such coverage due to failure of the eligible employee or dependent to pay premiums on a timely basis or for cause, and request enrollment in writing within 30 days of the date of the exhaustion of coverage.

For purposes of 1.c.:

- i. Exhaustion of COBRA or state continuation coverage includes:
- losing COBRA or state continuation coverage for any reason other than those set forth in ii. below;
 - losing coverage as a result of the employer's failure to remit premiums on a timely basis; or
 - losing coverage as a result of the eligible employee or dependent incurring a claim that meets or exceeds the lifetime maximum limit on all benefits and no other COBRA or state continuation coverage is available; or
 - if the prior coverage was offered through a health maintenance organization (HMO), losing coverage because the eligible employee or dependent no longer resides or works in the HMO's service area and no other COBRA or state continuation coverage is available.
- ii. Exhaustion of COBRA or state continuation coverage does not include a loss due to failure of the eligible employee or dependent to pay premiums on a timely basis or termination of coverage for cause.
- iii. In the case of the eligible employee's exhaustion of COBRA or state continuation coverage, the special enrollment period described above applies to the eligible employee and all of his or her dependents. In the case of a dependent's exhaustion of COBRA or state continuation coverage, the special enrollment period described above applies only to the dependent who has lost coverage and the eligible employee.

For the special enrollment event described above, coverage is effective on the first day of the first calendar month following the date on which the request for enrollment is received by Medica.

2. The dependent is a new spouse of the subscriber or eligible employee, provided that the marriage is legal and enrollment is requested in writing within 30 days of the date of marriage and provided that the eligible employee also enrolls during this special enrollment period. Coverage is effective on the first day of the following month.
3. The dependent is a new dependent child of the subscriber or eligible employee, provided that enrollment is requested in writing within 30 days of the subscriber or eligible employee acquiring the dependent (for dependent children, the notification period is not limited to 30 days for newborns or children newly adopted or newly placed for adoption) and provided that the eligible employee also enrolls during this special enrollment period. In the case of

birth, coverage is effective on the date of birth; in the case of adoption, placement for adoption or placement as a foster child, coverage is effective the date of adoption or placement. In all other cases, coverage is effective the date the subscriber acquires the dependent child.

4. The dependent is the spouse of the subscriber or eligible employee through whom the dependent child described in 3. above claims dependent status and:
 - a. That spouse is eligible for coverage; and
 - b. Is not already enrolled under the Contract; and
 - c. Enrollment is requested in writing within 30 days of the dependent child becoming a dependent; and
 - d. The eligible employee also enrolls during this special enrollment period.

Coverage is effective on the date coverage for the dependent child is effective, as set forth in 3. above.

5. The dependents are eligible dependent children of the subscriber or eligible employee and enrollment is requested in writing within 30 days of a dependent, as described in 2. or 3. above, becoming eligible to enroll under the coverage provided the eligible employee also enrolls during this special enrollment period. Coverage is effective on the date coverage for the dependent is effective, as set forth in 2. or 3. above (as applicable).
6. When the employer provides Medica with notice of a QMCSO and a copy of the order, as described in this section, Medica will provide the eligible dependent child with a special enrollment period provided the eligible employee also enrolls during this special enrollment period. Coverage is effective on the first day of the first calendar month following the date the completed request for enrollment is received by Medica.
7. When the eligible employee or dependent becomes eligible for group health plan premium assistance provided by Medicaid or a State Children's Health Insurance Plan, the eligible employee must request enrollment within 60 days after the date the employee or dependent is determined to be eligible for premium assistance.

In the case of the eligible employee becoming eligible for premium assistance, this special enrollment period applies to the eligible employee and all of his or her dependents. In the case of a dependent becoming eligible for premium assistance, this special enrollment period applies to both that dependent and the eligible employee. Coverage is effective on the first day of the first calendar month following the date on which the request for enrollment is received by Medica.

Late enrollment and effective date of coverage

An eligible employee or an eligible employee and dependents who do not enroll for coverage offered through the employer during the initial or open enrollment period or any applicable special enrollment period will be considered late entrants.

Late entrants who have maintained continuous coverage may enroll and coverage will be effective the first day of the month following the date of Medica's approval of the request for enrollment. Continuous coverage will be determined to have been maintained if the late entrant requests enrollment within 63 days after prior qualifying coverage ends. Your coverage begins at 12:01 a.m. on the effective date of your coverage.

Individuals who have not maintained continuous coverage may not enroll as late entrants.

Eligibility And Enrollment

An eligible employee or dependent who:

1. does not enroll during an initial or open enrollment period or any applicable special enrollment period; and
2. is an enrollee of MCHA at the time Medica offers or renews coverage with the employer, provided the eligible subscriber or dependent maintains continuous coverage, will not be considered a late entrant and will be allowed to enroll. Coverage will be effective as determined by Medica.

Qualified Medical Child Support Order (QMCSO)

Medica will provide coverage in accordance with a QMCSO pursuant to the applicable requirements under Section 609 of the Employee Retirement Income Security Act (ERISA) and Section 1908 of the Social Security Act. It is the employer's responsibility to determine whether a medical child support order is *qualified*.

Upon receipt of a medical child support order issued by an appropriate court or governmental agency, the employer will follow its established procedures in determining whether the medical child support order is *qualified*. The employer will provide Medica with notice of a QMCSO and a copy of the order, along with an application for coverage, within the greater of 30 days after issuance of the order or the time in which the employer provides notice of its determination to the persons specified in the order.

- Where a QMCSO requires coverage be provided under the Contract for an eligible employee's dependent child who is not already a member, such child will be provided a special enrollment period. If the eligible employee whose dependent child is the subject of the QMCSO is not a subscriber at the time enrollment for the dependent child is requested, the eligible employee must also enroll for coverage under the Contract during the special enrollment period.
- Where a QMCSO requires coverage be provided under the Contract for an eligible employee's dependent child who is already a member, such child will continue to be provided coverage under the Contract pursuant to the terms of the QMCSO.

EE. *Ending Coverage*

This section describes when coverage ends under the Contract. When this happens you may exercise your right to continue your coverage as described in *Continuation*.

See Definitions. These words have specific meanings: certification of qualifying coverage, claim, dependent, member, premium, subscriber.

You have the right to a certification of qualifying coverage when coverage ends. You will receive a certification of qualifying coverage when coverage ends. You may also request a certification of qualifying coverage at any time while you are covered under the Contract or within the 24 months following the date your coverage ends. To request a certification of qualifying coverage, call Customer Service at one of the telephone numbers listed inside the front cover. Upon receipt of your request, the certification of qualifying coverage will be issued as soon as reasonably possible.

When coverage ends

Unless otherwise specified in the Contract, coverage ends the earliest of the following:

1. The end of the month in which the Contract is terminated by the employer or Medica in accordance with the terms of the Contract. If terminated by Medica, Medica will notify each subscriber at least 30 days in advance of the termination.
2. The end of the month for which the subscriber last paid his or her contribution toward the premium.
3. The end of the month in which the subscriber retires or is pensioned, unless Medica and the employer have agreed to provide coverage for retirees under the Contract or a separate Medicare contract.
4. The end of the month in which the subscriber is no longer eligible as determined by the employer. (See *Eligibility And Enrollment* for information on eligibility.)
5. The end of the month in which the subscriber requests that coverage end. You must notify the employer to terminate coverage.
6. The date specified by Medica in written notice to you that coverage ended due to fraud. If coverage ends due to fraud, coverage will be retroactively terminated at Medica's discretion to the original date of coverage or the date on which the fraudulent act took place. Fraud includes but is not limited to:
 - a. Intentionally providing Medica with false material information such as:
 - i. Information related to your eligibility or another person's eligibility for coverage or status as a dependent; or
 - ii. Information related to your health status or that of any dependent; or
 - b. Intentional misrepresentation of the employer-employee relationship; or
 - c. Permitting the use of your member identification card by any unauthorized person; or
 - d. Using another person's member identification card; or

Ending Coverage

- e. Submitting fraudulent claims.

Medica reserves its right to pursue other civil remedies in the event of fraud or intentional misrepresentation with regard to any aspect of coverage under the Contract.

- 7. The end of the month following the date you enter active military duty for more than 31 days. Upon completion of active military duty, contact the employer for reinstatement of coverage.
- 8. The date of the death of the member. In the event of the subscriber's death, coverage for the subscriber's dependents will terminate the end of the month in which the subscriber's death occurred.
- 9. For a spouse, the end of the month following the date of divorce.
- 10. For a dependent child, the end of the month in which the child is no longer eligible as a dependent.
- 11. For a child who is entitled to coverage through a QMCSO, the end of the month in which the earliest of the following occurs:
 - a. The QMCSO ceases to be effective; or
 - b. The child is no longer a child as that term is used in ERISA; or
 - c. The child has immediate and comparable coverage under another plan; or
 - d. The employee who is ordered by the QMCSO to provide coverage is no longer eligible as determined by the employer; or
 - e. The employer terminates family or dependent coverage; or
 - f. The Contract is terminated by the employer or Medica; or
 - g. The relevant premium or contribution toward the premium is last paid.

FF. Continuation

This section describes continuation coverage provisions. When coverage ends, members may be able to continue coverage under state law, federal law, or both. All aspects of continuation coverage administration are the responsibility of the employer.

See Definitions. These words have specific meanings: benefits, dependent, member, placed for adoption, premium, subscriber, total disability.

The paragraph below describes the continuation coverage provisions. State continuation is described in 1. and federal continuation is described in 2.

If your coverage ends, you should review your rights under both state law and federal law with the employer. If you are entitled to continuation rights under both, the continuation provisions run concurrently and the more favorable continuation provision will apply to your coverage.

1. Your right to continue coverage under state law

Notwithstanding the provisions regarding termination of coverage described in *Ending Coverage*, you may be entitled to extended or continued coverage as follows:

a. *Minnesota state continuation coverage.*

Continued coverage shall be provided as required under Minnesota law. Minnesota state continuation requirements apply to all group health plans that are subject to state regulation, regardless of the number of employees in the group. The employer shall, within the parameters of Minnesota law, establish uniform policies pursuant to which such continuation coverage will be provided.

b. *Notice of rights.*

Minnesota law requires that covered employees and their dependents (spouse and/or dependent children) be offered the opportunity to pay for a temporary extension of health coverage (called continuation coverage) at group rates in certain instances where health coverage under an employer sponsored group health plan(s) would otherwise end.

This notice is intended to inform you, in summary fashion, of your rights and obligations under the continuation coverage provision of Minnesota law. It is intended that no greater rights be provided than those required by Minnesota law. Take time to read this section carefully.

Subscriber's loss

The subscriber has the right to continuation of coverage for him or herself and his or her dependents if there is a loss of coverage under the Contract because of the subscriber's voluntary or involuntary termination of employment (for any reason other than gross misconduct) or layoff from employment. In this section, layoff from employment means a reduction in hours to the point where the subscriber is no longer eligible for coverage under the Contract.

Continuation

Subscriber's spouse's loss

The subscriber's covered spouse has the right to continuation coverage if he or she loses coverage under the Contract for any of the following reasons:

- a. Death of the subscriber;
- b. A termination of the subscriber's employment (for any reason other than gross misconduct) or layoff from employment;
- c. Dissolution of marriage from the subscriber;
- d. The subscriber's enrollment for benefits under Medicare.

Subscriber's child's loss

The subscriber's dependent child has the right to continuation coverage if coverage under the Contract is lost for any of the following reasons:

- a. Death of the subscriber if the subscriber is the parent through whom the child receives coverage;
- b. Termination of the subscriber's employment (for any reason other than gross misconduct) or layoff from employment;
- c. The subscriber's dissolution of marriage from the child's other parent;
- d. The subscriber's enrollment for benefits under Medicare if the subscriber is the parent through whom the child receives coverage;
- e. The subscriber's child ceases to be a dependent child under the terms of the Contract.

Responsibility to inform

Under Minnesota law, the subscriber and dependents have the responsibility to inform the employer of a dissolution of marriage or a child losing dependent status under the Contract within 60 days of the date of the event or the date on which coverage would be lost because of the event.

Election rights

When the employer is notified that one of these events has happened, the subscriber and the subscriber's dependents will be notified of the right to continuation coverage.

Consistent with Minnesota law, the subscriber and dependents have 60 days to elect continuation coverage for reasons of termination of the subscriber's employment or the subscriber's enrollment for benefits under Medicare measured from the later of:

- a. The date coverage would be lost because of one of the events described above; or
- b. The date notice of election rights is received.

If continuation coverage is elected within this period, the coverage will be retroactive to the date coverage would otherwise have been lost.

The subscriber and the subscriber's covered spouse may elect continuation coverage on behalf of other dependents entitled to continuation coverage. Under certain circumstances, the subscriber's covered spouse or dependent child may elect continuation coverage even if the subscriber does not elect continuation coverage.

If continuation coverage is not elected, your coverage under the Contract will end.

Type of coverage and cost

If continuation coverage is elected, the subscriber's employer is required to provide coverage that, as of the time coverage is being provided, is identical to the coverage provided under the Contract to similarly situated employees or employees' dependents.

Under Minnesota law, a person continuing coverage may have to make a monthly payment to the employer of all or part of the premium for continuation coverage. The amount charged cannot exceed 102 percent of the cost of the coverage.

Surviving dependents of a deceased subscriber have 90 days after notice of the requirement to pay continuation premiums to make the first payment.

Duration

Under the circumstances described above and for a certain period of time, Minnesota law requires that the subscriber and his or her dependents be allowed to maintain continuation coverage as follows:

- a. For instances where coverage is lost due to the subscriber's termination of or layoff from employment, coverage may be continued until the earliest of:
 - i. 18 months after the date of the termination of or layoff from employment;
 - ii. The date the subscriber becomes covered under another group health plan (as an employee or otherwise) that does not contain any exclusion or limitation with respect to any applicable pre-existing condition; or
 - iii. The date coverage would otherwise terminate under the Contract.
- b. For instances where the subscriber's spouse or dependent children lose coverage because of the subscriber's enrollment under Medicare, coverage may be continued until the earliest of:
 - i. 36 months after continuation was elected;
 - ii. The date coverage is obtained under another group health plan; or
 - iii. The date coverage would otherwise terminate under the Contract.
- c. For instances where dependent children lose coverage as a result of loss of dependent eligibility, coverage may be continued until the earliest of:
 - i. 36 months after continuation was elected;
 - ii. The date coverage is obtained under another group health plan; or
 - iii. The date coverage would otherwise terminate under the Contract.
- d. For instances of dissolution of marriage from the subscriber, coverage of the subscriber's spouse and dependent children may be continued until the earliest of:
 - i. The date the former spouse becomes covered under another group health plan; or
 - ii. The date coverage would otherwise terminate under the Contract.

If a dissolution of marriage occurs during the period of time when the subscriber's spouse is continuing coverage due to the subscriber's termination of or layoff from employment, coverage of the subscriber's spouse may be continued until the earlier of:

- i. The date the former spouse becomes covered under another group health plan; or

Continuation

- ii. The date coverage would otherwise terminate under the Contract.
- e. Upon the death of the subscriber, the coverage of a subscriber's spouse or dependent children may be continued until the earlier of:
 - i. The date the surviving spouse and dependent children become covered under another group health plan; or
 - ii. The date coverage would have terminated under the Contract had the subscriber lived.

Extension of benefits for total disability of the subscriber

Coverage may be extended for a subscriber and his or her dependents in instances where the subscriber is absent from work due to total disability, as defined in *Definitions*. If the subscriber is required to pay all or part of the premium for the extension of coverage, payment shall be made to the employer. The amount charged cannot exceed 100 percent of the cost of the coverage.

2. Your right to continue coverage under federal law

Notwithstanding the provisions regarding termination of coverage described in *Ending Coverage*, you may be entitled to extended or continued coverage as follows:

COBRA continuation coverage

Continued coverage shall be provided as required under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended (as well as the Public Health Service Act (PHSA), as amended). The employer shall, within the parameters of federal law, establish uniform policies pursuant to which such continuation coverage will be provided. See General COBRA information in this section.

USERRA continuation coverage

Continued coverage shall be provided as required under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended. The employer shall, within the parameters of federal law, establish uniform policies pursuant to which such continuation coverage will be provided. See General USERRA information in this section.

General COBRA information

COBRA requires employers with 20 or more employees to offer subscribers and their families (spouse and/or dependent children) the opportunity to pay for a temporary extension of health coverage (called continuation coverage) at group rates in certain instances where health coverage under employer sponsored group health plan(s) would otherwise end. This coverage is a group health plan for purposes of COBRA.

This section is intended to inform you, in summary fashion, of your rights and obligations under the continuation coverage provision of federal law. It is intended that no greater rights be provided than those required by federal law. Take time to read this section carefully.

Qualified beneficiary

For purposes of this section, a qualified beneficiary is defined as:

- a. A covered employee (a current or former employee who is actually covered under a group health plan and not just eligible for coverage);
- b. A covered spouse of a covered employee; or
- c. A dependent child of a covered employee. (A child placed for adoption with or born to an employee or former employee receiving COBRA continuation coverage is also a qualified beneficiary.)

Subscriber's loss

The subscriber has the right to elect continuation of coverage if there is a loss of coverage under the Contract because of termination of the subscriber's employment (for any reason other than gross misconduct), or the subscriber becomes ineligible to participate under the terms of the Contract due to a reduction in his or her hours of employment.

Subscriber's spouse's loss

The subscriber's covered spouse has the right to choose continuation coverage if he or she loses coverage under the Contract for any of the following reasons:

- a. Death of the subscriber;
- b. A termination of the subscriber's employment (for any reason other than gross misconduct) or reduction in the subscriber's hours of employment with the employer;
- c. Divorce or legal separation from the subscriber; or
- d. The subscriber's entitlement to (actual coverage under) Medicare.

Subscriber's child's loss

The subscriber's dependent child has the right to continuation coverage if coverage under the Contract is lost for any of the following reasons:

- a. Death of the subscriber if the subscriber is the parent through whom the child receives coverage;
- b. The subscriber's termination of employment (for any reason other than gross misconduct) or reduction in the subscriber's hours of employment with the employer;
- c. The subscriber's divorce or legal separation from the child's other parent;
- d. The subscriber's entitlement to (actual coverage under) Medicare if the subscriber is the parent through whom the child receives coverage; or
- e. The subscriber's child ceases to be a dependent child under the terms of the Contract.

Responsibility to inform

Under federal law, the subscriber and dependent have the responsibility to inform the employer of a divorce, legal separation, or a child losing dependent status under the Contract within 60 days of the date of the event, or the date on which coverage would be lost because of the event.

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Also, a subscriber and dependent who have been determined to be disabled under the Social Security Act as of the time of the subscriber's termination of employment or reduction of hours or within 60 days of the start of the continuation period must notify the employer of that determination within 60 days of the determination. If determined under the Social Security Act to no longer be disabled, he or she must notify the employer within 30 days of the determination.

Bankruptcy

Rights similar to those described above may apply to retirees (and the spouses and dependents of those retirees), if the subscriber's employer commences a bankruptcy proceeding and these individuals lose coverage.

Election rights

When notified that one of these events has happened, the employer will notify the subscriber and dependents of the right to choose continuation coverage.

Consistent with federal law, the subscriber and dependents have 60 days to elect continuation coverage, measured from the later of:

- a. The date coverage would be lost because of one of the events described above; or
- b. The date notice of election rights is received.

If continuation coverage is elected within this period, the coverage will be retroactive to the date coverage would otherwise have been lost.

The subscriber and the subscriber's covered spouse may elect continuation coverage on behalf of other dependents entitled to continuation coverage. However, each person entitled to continuation coverage has an independent right to elect continuation coverage. The subscriber's covered spouse or dependent child may elect continuation coverage even if the subscriber does not elect continuation coverage.

If continuation coverage is not elected, your coverage under the Contract will end.

Type of coverage and cost

If the subscriber and the subscriber's dependents elect continuation coverage, the employer is required to provide coverage that, as of the time coverage is being provided, is identical to the coverage provided under the Contract to similarly situated employees or employees' dependents.

Under federal law, a person electing continuation coverage may have to pay all or part of the premium for continuation coverage. The amount charged cannot exceed 102 percent of the cost of the coverage. The amount may be increased to 150 percent of the applicable premium for months after the 18th month of continuation coverage when the additional months are due to a disability under the Social Security Act.

There is a grace period of at least 30 days for the regularly scheduled premium.

Duration of COBRA coverage

Federal law requires that you be allowed to maintain continuation coverage for 36 months unless you lost coverage under the Contract because of termination of employment or reduction in hours. In that case, the required continuation coverage period is 18 months.

The 18 months may be extended if a second event (e.g., divorce, legal separation, or death) occurs during the initial 18-month period. It also may be extended to 29 months in the case of an employee or employee's dependent who is determined to be disabled under the Social Security Act at the time of the employee's termination of employment or reduction of hours, or within 60 days of the start of the 18-month continuation period.

If an employee or the employee's dependent is entitled to 29 months of continuation coverage due to his or her disability, the other family members' continuation period is also extended to 29 months. If the subscriber becomes entitled to (actually covered under) Medicare, the continuation period for the subscriber's dependents is 36 months measured from the date of the subscriber's Medicare entitlement even if that entitlement does not cause the subscriber to lose coverage.

Under no circumstances is the total continuation period greater than 36 months from the date of the original event that triggered the continuation coverage.

Federal law provides that continuation coverage may end earlier for any of the following reasons:

- a. The subscriber's employer no longer provides group health coverage to any of its employees;
- b. The premium for continuation coverage is not paid on time;
- c. Coverage is obtained under another group health plan (as an employee or otherwise) that does not contain any exclusion or limitation with respect to any applicable pre-existing condition; or
- d. The subscriber becomes entitled to (actually covered under) Medicare.

Continuation coverage may also end earlier for reasons which would allow regular coverage to be terminated, such as fraud.

General USERRA information

USERRA requires employers to offer employees and their families (spouse and/or dependent children) the opportunity to pay for a temporary extension of health coverage (called continuation coverage) at group rates in certain instances where health coverage under employer sponsored group health plan(s) would otherwise end. This coverage is a group health plan for the purposes of USERRA.

This section is intended to inform you, in summary fashion, of your rights and obligations under the continuation coverage provision of federal law. It is intended that no greater rights be provided than those required by federal law. Take time to read this section carefully.

Employee's loss

The employee has the right to elect continuation of coverage if there is a loss of coverage under the Contract because of absence from employment due to service in the uniformed services, and the employee was covered under the Contract at the time the absence began, and the employee, or an appropriate officer of the uniformed services, provided the employer with advance notice of the employee's absence from employment (if it was possible to do so).

Service in the uniformed services means the performance of duty on a voluntary or involuntary basis in the uniformed services under competent authority, including active duty, active duty for training, initial active duty for training, inactive duty training, full-time National

Continuation

Guard duty, and the time necessary for a person to be absent from employment for an examination to determine the fitness of the person to perform any of these duties.

Uniformed services means the U.S. Armed Services, including the Coast Guard, the Army National Guard, and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty, and the commissioned corps of the Public Health Service.

Election rights

The employee or the employee's authorized representative may elect to continue the employee's coverage under the Contract by making an election on a form provided by the employer. The employee has 60 days to elect continuation coverage measured from the date coverage would be lost because of the event described above. If continuation coverage is elected within this period, the coverage will be retroactive to the date coverage would otherwise have been lost. The employee may elect continuation coverage on behalf of other covered dependents, however, there is no independent right of each covered dependent to elect. If the employee does not elect, there is no USERRA continuation available for the spouse or dependent children. In addition, even if the employee does not elect USERRA continuation, the employee has the right to be reinstated under the Contract upon reemployment, subject to the terms and conditions of the Contract.

Type of coverage and cost

If the employee elects continuation coverage, the employer is required to provide coverage that, as of the time coverage is being provided, is identical to the coverage provided under the Contract to similarly situated employees. The amount charged cannot exceed 102 percent of the cost of the coverage unless the employee's leave of absence is less than 31 days, in which case the employee is not required to pay more than the amount that they would have to pay as an active employee for that coverage. There is a grace period of at least 30 days for the regularly scheduled premium.

Duration of USERRA coverage

When an employee takes a leave for service in the uniformed services, coverage for the employee and dependents for whom coverage is elected begins the day after the employee would lose coverage under the Contract. Coverage continues for up to 24 months.

Federal law provides that continuation coverage may end earlier for any of the following reasons:

- a. The employer no longer provides group health coverage to any of its employees;
- b. The premium for continuation coverage is not paid on time;
- c. The employee loses their rights under USERRA as a result of a dishonorable discharge or other undesirable conduct;
- d. The employee fails to return to work following the completion of his or her service in the uniformed services; or
- e. The employee returns to work and is reinstated under the Contract as an active employee.

Continuation coverage may also end earlier for reasons which would allow regular coverage to be terminated, such as fraud.

COBRA and USERRA coverage are concurrent

If both COBRA and USERRA apply, and you elect COBRA continuation coverage in addition to USERRA continuation coverage, these coverages run concurrently.

Complaints

GG. Complaints

This section describes what to do if you have a complaint or would like to appeal a decision made by Medica.

See Definitions. These words have specific meanings: benefits, claim, complaint, emergency, inpatient, investigative, medical necessity review, network, provider.

You may call Customer Service at one of the telephone numbers listed inside the front cover or by writing to the address below in *First level of review*. You may also contact the Commissioner of Commerce, Minnesota Department of Commerce, at (651) 296-2488 or 1-800-657-3602.

Filing a complaint may require that Medica review your medical records as needed to resolve your complaint.

You may appoint an authorized representative to make a complaint on your behalf. You may be required to sign an authorization which will allow Medica to release confidential information to your authorized representative and allow them to act on your behalf during the complaint process.

Upon request, Medica will assist you with completion and submission of your written complaint. Medica will also complete a complaint form on your behalf and mail it to you for your signature upon request.

At any time during the complaint process, you have a right to submit any information or testimony that you want Medica to consider and to review any information that Medica relied on in making its decision.

In addition to directing complaints to Customer Service as described in this section, you may direct complaints at any time to the Commissioner of Commerce at the telephone number listed at the beginning of this section.

First level of review

You may direct any question or complaint to Customer Service by calling one of the telephone numbers listed inside the front cover or by writing to the address listed below.

1. Complaints that do not involve a medical necessity review by Medica:
 - a. For an oral complaint, if Medica does not communicate a decision within 10 business days from Medica's receipt of the complaint, or if you determine that Medica's decision is partially or wholly adverse to you, Medica will provide you with a complaint form to submit your complaint in writing. Mail the completed form to:

Customer Service
Route 0501
PO Box 9310
Minneapolis, MN 55440-9310

Medica will provide written notice of its first level review decision to you within 30 days from the initial receipt of your complaint.

- b. For a written complaint, Medica will provide written notice of its first level review decision to you within 30 days from initial receipt of your complaint.

- c. If Medica's first level review decision upholds the initial decision made by Medica, you have a right to request a second level review. The second level of review, as described below, must be exhausted before you have the right to submit a request for external review.
2. Complaints that involve a medical necessity review by Medica:
 - a. Your complaint must be made within one year following Medica's initial decision and may be made orally or in writing.
 - b. Medica will provide written notice of its first level review decision to you and your attending provider, when applicable, within 30 calendar days from receipt of your complaint.
 - c. When an initial decision by Medica does not grant a prior authorization request made before or during an ongoing service, and your attending provider believes that Medica's decision warrants an expedited review, you or your attending provider will have the opportunity to request an expedited review by telephone. Alternatively, if Medica concludes that a delay could seriously jeopardize your life, health, or ability to regain maximum function, or could subject you to severe pain that cannot be adequately managed without the care or treatment you are requesting, Medica will process your claim as an expedited review. In such cases, Medica will notify you and your attending provider by telephone of its decision no later than 72 hours after receiving the request.
 - d. If Medica's first level review decision upholds the initial decision made by Medica, you have a right to request a second level review or submit a written request for external review as described in this section. The second level of review is optional and you may submit a request for external review without exhausting the second level of review.
 - e. If your complaint involves Medica's decision to reduce or terminate an ongoing course of treatment that Medica previously approved, the treatment will be covered pending the outcome of the review process.

Second level of review

If you are not satisfied with Medica's first level of review decision, you may request a second level of review through either a written reconsideration or a hearing.

1. Your request can be oral or in writing. It must be provided to Medica within one year following the date of Medica's first level review decision. If your request is in writing, it must be sent to the address listed above in *First level of review*.
2. Regardless of the method chosen for review (hearing or a written reconsideration), testimony, explanation, or other information provided by you, Medica staff, providers, and others is reviewed.
3. Medica will provide written notice of its second level of review decision to you within:
 - a. 30 calendar days from receipt of written notice of your appeal for required second level reviews; or
 - b. 45 calendar days from receipt of written notice of your appeal for optional second level reviews.

For some complaints, the second level of review must be exhausted before you have the right to submit a request for external review. For other complaints, this second level of review is optional before you may submit a request for external review. Generally, a second level review

Complaints

is optional if the complaint requires a medical necessity review. Medica will inform you in writing whether the second level of review is optional or required.

External review

If you consider Medica's decision to be partially or wholly adverse to you, you may submit a written request for external review of Medica's decision to the Commissioner of Commerce at:

Minnesota Department of Commerce
85 7th Place East, Suite 500
St. Paul, MN 55101-2198

You must submit your written request for external review within six months from the date of Medica's decision. You must include a filing fee of \$25 with your written request, unless waived by the Commissioner. An independent review organization contracted with the State Commissioner of Administration will review your request. You may submit additional information that you want the review organization to consider. You will be notified of the review organization's decision within 45 days. The Department of Commerce will refund the filing fee if the review organization completely reverses Medica's decision. The external review decision will not be binding on you but will be binding on Medica. Medica may seek judicial review on grounds that the decision was arbitrary and capricious or involved an abuse of discretion. Contact the Commissioner of Commerce for more information about the external review process.

Under most circumstances, you must complete all required levels of review, described above, before you proceed to external review. You may proceed to external review without completing the required levels of review if Medica agrees that you may do so, or if Medica fails to substantially comply with the complaint and review process described in this section, including meeting any required deadlines. For complaints that involve a medical necessity review, you may request an expedited external review at the same time you request an expedited first level of review. You may also request an expedited external review if Medica's decision involves a medical condition for which the standard external review time would seriously jeopardize your life, health, or ability to regain maximum function, or if Medica's decision concerns an admission, availability of care, continued stay, or health care service for which you received emergency services and you have not been discharged from a facility. If an expedited review is requested and approved, a decision will be provided within 72 hours.

If Medica's decision involves a treatment that Medica considers investigative, the review organization will base its decision on all documents submitted by you and Medica, your provider's recommendation, consulting reports from health care professionals, your benefits under this Certificate of Coverage, federal Food and Drug Administration approval, and medical or scientific evidence or evidence-based standards.

Complaints regarding fraudulent marketing practices or agent misrepresentation cannot be submitted for external review.

Civil action

If you are dissatisfied with Medica's first or second level review decision or the external review decision, you have the right to file a civil action under Section 502(a) of the Employee Retirement Income Security Act (ERISA).

HH. *General Provisions*

This section describes the general provisions of the Contract.

See *Definitions*. These words have specific meanings: benefits, claim, dependent, member, network, premium, provider, subscriber.

Examination of a member

To settle a dispute concerning provision or payment of benefits under the Contract, Medica may require that you be examined or an autopsy of the member's body be performed. The examination or autopsy will be at Medica's expense.

Clerical error

You will not be deprived of coverage under the Contract because of a clerical error. However, you will not be eligible for coverage beyond the scheduled termination of your coverage because of a failure to record the termination.

Relationship between parties

The relationships between Medica, the employer, and network providers are contractual relationships between independent contractors. Network providers are not agents or employees of Medica. The relationship between a provider and any member is that of health care provider and patient. The provider is solely responsible for health care provided to any member.

Assignment

Medica will have the right to assign any and all of its rights and responsibilities under the Contract to any subsidiary or affiliate of Medica or to any other appropriate organization or entity.

Notice

Except as otherwise provided in this certificate, written notice given by Medica to an authorized representative of the employer will be deemed notice to all affected in the administration of the Contract in the event of termination or nonrenewal of the Contract. However, notice of termination for nonpayment of premium shall be given by Medica to an authorized representative of the employer and to each subscriber.

Entire agreement

This certificate, the master group contract and its appendices, and any amendments are the entire Contract between the employer and Medica, and replace all other agreements as of the effective date of the Contract.

Amendment

This certificate may be amended in accordance with the Contract. When this happens, you will receive a new certificate or amendment. No other person or entity has authority to make any changes or amendments to this certificate. All amendments must be in writing.

General Provisions

Discretionary authority

Medica has discretion to interpret and construe all of the terms and conditions of the Contract and make determinations regarding benefits and coverage under the Contract; provided, however, that this provision shall not be construed to specify a standard of review upon which a court may review a claim denial or any other decision made by Medica with respect to a member.

Definitions

In this certificate (and in any amendments), some words have specific meanings. Within each definition, you may note bold words. These words also are defined in this section.

Approved clinical trial. A phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other **life-threatening condition**, is not designed exclusively to test toxicity or disease pathophysiology, and is described in any of the following subparagraphs:

1. The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration.
2. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
3. The study or investigation is approved or funded by one of the following: (i) the National Institutes of Health (NIH), the Centers for Disease Control and Prevention, the Agency for Health Care Research and Quality, the Centers for Medicare and Medicaid Services, or cooperating group or center of any of the entities described in this item; (ii) a cooperative group or center of the United States Department of Defense or the United States Department of Veterans Affairs; (iii) a qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants; or (iv) the United States Departments of Veterans Affairs, Defense, or Energy if the trial has been reviewed or approved through a system of peer review determined by the secretary to: (a) be comparable to the system of peer review of studies and investigations used by the NIH, and (b) provide an unbiased scientific review by **qualified individuals** who have no interest in the outcome of the review.

Benefits. The health services or supplies (described in this certificate and any subsequent amendments) approved by Medica as eligible for coverage.

Certification of qualifying coverage. A written certification that group health plans and health insurance issuers must provide to an individual to confirm the **qualifying coverage** provided to the individual under the group health plan or health insurance.

Claim. An invoice, bill, or itemized statement for **benefits** provided to you.

Coinsurance. The percentage amount you must pay to the **provider** for **benefits** received. Full **coinsurance** payments may apply to scheduled appointments canceled less than 24 hours before the appointment time or to missed appointments.

For in-**network benefits**, the **coinsurance** amount is based on the lesser of the:

1. Charge billed by the **provider** (i.e., retail); or
2. Negotiated amount that the **provider** has agreed to accept as full payment for the **benefit** (i.e., wholesale).

When the wholesale amount is not known nor readily calculated at the time the **benefit** is provided, Medica uses an amount to approximate the wholesale amount. For services from some **network providers**, however, the **coinsurance** is based on the **provider's** retail charge. The **provider's** retail charge is the amount that the **provider** would charge to any patient, whether or not that patient is a Medica **member**.

Definitions

For out-of-**network benefits**, the **coinsurance** will be based on the lesser of the:

1. Charge billed by the **provider** (i.e., retail); or
2. **Non-network provider reimbursement amount**.

For out-of-**network benefits**, in addition to any **copayment**, **coinsurance**, and **deductible** amounts, you will be responsible for any charges billed by the **provider** in excess of the **non-network provider reimbursement amount**.

In addition, for the **network** pharmacies described in *Prescription Drug Program* and *Prescription Specialty Drug Program*, the calculation of **coinsurance** amounts as described above do not include possible reductions for any volume purchase discounts or price adjustments that Medica may later receive related to certain **prescription drugs** and pharmacy services.

The **coinsurance** may not exceed the charge billed by the **provider** for the **benefit**.

Complaint. Any grievance against Medica, submitted by you or another person on your behalf, that is not the subject of litigation. **Complaints** may involve, but are not limited to, the scope of coverage for health care services; retrospective denials or limitations of payment for services; eligibility issues; denials, cancellations, or non-renewals of coverage; administrative operations; and the quality, timeliness, and appropriateness of health care services rendered. If the **complaint** is from an applicant, the **complaint** must relate to the application. If the **complaint** is from a former **member**, the **complaint** must relate to services received during the time the individual was a **member**.

Continuous coverage. The maintenance of continuous and uninterrupted **qualifying coverage** by an eligible employee or **dependent**. An eligible employee or **dependent** is considered to have maintained **continuous coverage** if enrollment is requested under the Contract within 63 days of termination of the previous **qualifying coverage**.

Convenience care/retail health clinic. A health care clinic located in a setting such as a retail store, grocery store, or pharmacy, which provides treatment of common illnesses and certain preventive health care services.

Copayment. The fixed dollar amount you must pay to the **provider** for **benefits** received. Full **copayments** may apply to scheduled appointments canceled less than 24 hours before the appointment time or to missed appointments.

When you receive eligible health services from a **network provider** and a **copayment** applies, you pay the lesser of the charge billed by the **provider** for the **benefit** (i.e., retail) or your **copayment**. Any remaining amount is paid according to the written agreement with the **provider**. The **copayment** may not exceed the retail charge billed by the **provider** for the **benefit**.

For out-of-**network benefits**, in addition to any **copayment**, **coinsurance**, and **deductible** amounts, you will be responsible for any charges in excess of the **non-network provider reimbursement amount**.

Cosmetic. Services and procedures that improve physical appearance but do not correct or improve a physiological function, and that are not medically necessary, unless the service or procedure meets the definition of **reconstructive**.

Custodial care. Services to assist in activities of daily living that do not seek to cure, are performed regularly as a part of a routine or schedule, and, due to the physical stability of the condition, do not need to be provided or directed by a skilled medical professional. These services include help in walking, getting in or out of bed, bathing, dressing, feeding, using the

toilet, preparation of special diets, and supervision of medication that can usually be self-administered.

Deductible. The fixed dollar amount you must pay for eligible services or supplies before **claims** for health services or supplies received from **network** or **non-network providers** are reimbursable as in-**network** or out-of-**network benefits** under this certificate.

Dependent. Unless otherwise specified in the Contract, the following are considered **dependents**:

1. The **subscriber's** spouse.
2. The following **dependent** children up to the **dependent** limiting age of 26:
 - a. The **subscriber's** or **subscriber's** spouse's natural or adopted child;
 - b. A child **placed for adoption** with the **subscriber** or **subscriber's** spouse;
 - c. A child for whom the **subscriber** or the **subscriber's** spouse has been appointed legal guardian; however, upon request by Medica, the **subscriber** must provide satisfactory proof of legal guardianship;
 - d. The **subscriber's** stepchild;
 - e. A child **placed as a foster child** with the **subscriber** or the **subscriber's** spouse; and
 - f. The **subscriber's** or **subscriber's** spouse's grandchild who is dependent upon and resides with the **subscriber** or **subscriber's** spouse continuously from birth.

For residents of a state other than Minnesota, the **dependent** limiting age may be higher if required by applicable state law.

3. The **subscriber's** or **subscriber's** spouse's disabled child who is a **dependent** incapable of self-sustaining employment by reason of developmental disability, mental illness, mental disorder, or physical disability and is chiefly dependent upon the **subscriber** for support and maintenance. An illness that does not cause a child to be incapable of self-sustaining employment will not be considered a physical disability. This **dependent** may remain covered under the Contract regardless of age and without application of health screening or **waiting periods**. To continue coverage for a disabled **dependent**, you must provide Medica with proof of such disability and dependency within 31 days of the child reaching the **dependent** limiting age set forth in 2. above. Beginning two years after the child reaches the **dependent** limiting age, Medica may require annual proof of disability and dependency.
4. The **subscriber's** or **subscriber's** spouse's disabled **dependent** who is incapable of self-sustaining employment by reason of developmental disability, mental illness, mental disorder, or physical disability and is chiefly dependent upon the **subscriber** or **subscriber's** spouse for support and maintenance. For coverage of a disabled **dependent**, you must provide Medica with proof of such disability and dependency at the time of the **dependent's** enrollment.

Designated facility. A **network hospital** that Medica has authorized to provide certain **benefits to members**, as described in this certificate.

Designated physician. A **network physician** that Medica has authorized to provide certain **benefits to members**, as described in this certificate.

Definitions

Emergency. A condition or symptom (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, would believe requires immediate treatment to:

1. Preserve your life; or
2. Prevent serious impairment to your bodily functions, organs, or parts; or
3. Prevent placing your physical or mental health (or, if you are pregnant, the health of your unborn child) in serious jeopardy.

Enrollment date. The date of the eligible employee's or **dependent's** first day of coverage under the Contract or, if earlier, the first day of the **waiting period** for the eligible employee's or **dependent's** enrollment.

Genetic testing. An analysis of human DNA, RNA, chromosomes, proteins, or metabolites if the analysis detects genotypes, mutations, or chromosomal changes. **Genetic testing** includes **pharmacogenetic testing**. **Genetic testing** does not include an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition. For example, an HIV test, complete blood count, or cholesterol test is not a genetic test.

Habilitative. Health care services are considered **habilitative** when they are provided to improve an impairment in physical function or speech due to congenital or developmental conditions, including autism spectrum disorders, that have impeded normal speech and motor development.

Hospital. A licensed facility that provides diagnostic, medical, therapeutic, rehabilitative, and surgical services by, or under the direction of, a **physician** and with 24-hour R.N. nursing services. The **hospital** is not mainly a place for rest or **custodial care**, and is not a nursing home or similar facility.

Inpatient. An uninterrupted stay, following formal admission to a **hospital, skilled nursing facility**, or licensed acute care facility. **Inpatient** services in a licensed residential treatment facility for treatment of emotionally disabled children will be covered as any other health condition.

Investigative. As determined by Medica, a drug, device, diagnostic or screening procedure, or medical treatment or procedure is **investigative** if reliable evidence does not permit conclusions concerning its safety, effectiveness, or effect on health outcomes. Medica will make its determination based upon an examination of the following reliable evidence, none of which shall be determinative in and of itself:

1. Whether there is final approval from the appropriate government regulatory agency, if required, including whether the drug or device has received final approval to be marketed for its proposed use by the United States Food and Drug Administration (FDA), or whether the treatment is the subject of ongoing Phase I, II, or III trials;
2. Whether there are consensus opinions and recommendations reported in relevant scientific and medical literature, peer-reviewed journals, or the reports of clinical trial committees and other technology assessment bodies; and
3. Whether there are consensus opinions of national and local health care **providers** in the applicable specialty or subspecialty that typically manages the condition as determined by a survey or poll of a representative sampling of these **providers**.

Notwithstanding the above, a drug being used for an indication or at a dosage that is an accepted off-label use for the treatment of cancer will not be considered by Medica to be **investigative**. Medica will determine if a use is an accepted off-label use based on published

reports in authoritative peer-reviewed medical literature, clinical practice guidelines, or parameters approved by national health professional boards or associations, and entries in any authoritative compendia as identified by the Medicare program for use in the determination of a medically accepted indication of drugs and biologicals used off-label.

Late entrant. An eligible employee or **dependent** who requests enrollment under the Contract other than during:

1. The initial enrollment period set by the employer; or
2. The open enrollment period set by the employer; or
3. A special enrollment period as described in *Eligibility And Enrollment*.

However, an eligible employee or **dependent** who is an enrollee of the Minnesota Comprehensive Health Association (MCHA) at the time Medica offers or renews coverage with the employer will not be considered a **late entrant**, provided the eligible employee or **dependent** maintains **continuous coverage** as defined in this certificate.

In addition, a **member** who is a child entitled to receive coverage through a QMCSO is not subject to any initial or open enrollment period restrictions.

Life-threatening condition. Any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Medical necessity review. Medica's evaluation of the necessity, appropriateness, and efficacy of the use of health care services, procedures, and facilities, for the purpose of determining the medical necessity of the service or admission.

Medically necessary. Diagnostic testing and medical treatment, consistent with the diagnosis of and prescribed course of treatment for your condition, and preventive services. **Medically necessary** care must meet the following criteria:

1. Be consistent with the medical standards and accepted practice parameters of the community as determined by health care **providers** in the same or similar general specialty as typically manages the condition, procedure or treatment at issue; and
2. Be an appropriate service, in terms of type, frequency, level, setting, and duration, to your diagnosis or condition; and
3. Help to restore or maintain your health; or
4. Prevent deterioration of your condition; or
5. Prevent the reasonably likely onset of a health problem or detect an incipient problem.

Member. A person who is enrolled under the Contract.

Mental disorder. A physical or mental condition having an emotional or psychological origin, as defined in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM).

Network. A term used to describe a **provider** (such as a **hospital, physician**, home health agency, **skilled nursing facility**, or pharmacy) that has entered into a written agreement to provide **benefits** to you. The participation status of **providers** will change from time to time.

The **network provider** directory will be furnished automatically, without charge.

Non-network. A term used to describe a **provider** not under contract as a **network provider**.

Definitions

Non-network provider reimbursement amount. The amount that Medica will pay to a **non-network provider** for each **benefit** is based on one of the following, as determined by Medica:

1. A percentage of the amount Medicare would pay for the service in the location where the service is provided. Medica generally updates its data on the amount Medicare pays within 30-60 days after the Centers for Medicare and Medicaid Services updates its Medicare data; or
2. A percentage of the **provider's** billed charge; or
3. A nationwide provider reimbursement database that considers prevailing reimbursement rates and/or marketplace charges for similar services in the geographic area in which the service is provided; or
4. An amount agreed upon between Medica and the **non-network provider**.

Contact Customer Service for more information concerning which method above pertains to your services, including the applicable percentage if a Medicare-based approach is used.

For certain **benefits**, you must pay a portion of the **non-network provider reimbursement amount** as a **copayment** or **coinsurance**.

In addition, if the amount billed by the **non-network provider** is greater than the **non-network provider reimbursement amount**, *the non-network provider will likely bill you for the difference*. This difference may be substantial, and it is in addition to any **copayment**, **coinsurance**, or **deductible** amount you may be responsible for according to the terms described in this certificate. Furthermore, such difference will not be applied toward the out-of-pocket maximum described in *Your Out-Of-Pocket Expenses*. Additionally, you will owe these amounts regardless of whether you previously reached your out-of-pocket maximum with amounts paid for other services. As a result, the amount you will be required to pay for services received from a **non-network provider** will likely be much higher than if you had received services from a **network provider**.

Pharmacogenetic testing. A type of **genetic testing** that attempts to use personal gene-based information to determine the proper drug and dosage for an individual.

Pharmacogenetic testing seeks to determine how a drug is absorbed, metabolized, or cleared from the body of an individual based on their genetic makeup.

Physician. A Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Optometry (O.D.), or Doctor of Chiropractic (D.C.) practicing within the scope of his or her licensure.

Placed as a foster child. The acceptance of the placement in your home of a child who has been placed away from his or her parents or guardians in 24-hour substitute care and for whom a state agency has placement and care responsibility. Eligibility for a child **placed as a foster child** with the **subscriber** or **subscriber's** spouse ends when such placement is terminated.

Placed for adoption. The assumption and retention of the legal obligation for total or partial support of the child in anticipation of adopting such child.

(Eligibility for a child **placed for adoption** with the **subscriber** ends if the placement is interrupted before legal adoption is finalized and the child is removed from placement.)

Premium. The monthly payment required to be paid to Medica by the employer on behalf of or for you.

Prenatal care. The comprehensive package of medical and psychosocial support provided throughout a pregnancy and related directly to the care of the pregnancy, including risk assessment, serial surveillance, prenatal education, and use of specialized skills and

technology, when needed, as defined by *Standards for Obstetric-Gynecologic Services* issued by the American College of Obstetricians and Gynecologists.

Prescription drug. A drug approved by the FDA for the prescribed use and route of administration.

Preventive health service. The following are considered **preventive health services**:

1. Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force;
2. Immunizations for routine use that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the **member** involved;
3. With respect to **members** who are infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
4. With respect to **members** who are women, such additional preventive care and screenings not described in 1. as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Contact Customer Service for information regarding specific **preventive health services**, services that are rated A or B, and services that are included in guidelines supported by the Health Resources and Services Administration. For a list of **preventive health services** please sign in at www.medicare.com.

Provider. A health care professional or facility licensed, certified, or otherwise qualified under state law to provide health services.

Qualified individual. (1) An individual who is eligible to participate in an **approved clinical trial** according to the trial protocol with respect to treatment of cancer or other **life-threatening conditions**, and (2) either (a) the referring health care professional is a **network provider** and has concluded that the individual's participation in the trial would be appropriate, or (b) the individual provides medical or scientific information establishing that their participation would be appropriate.

Qualifying coverage. Health coverage provided under one of the following plans:

1. A health plan in which a health carrier has issued a policy, contract, or certificate for the coverage of medical and **hospital** benefits, including blanket accident and sickness insurance other than accident only coverage;
2. Part A or Part B of Medicare;
3. A medical assistance medical care plan as defined under Minnesota law;
4. A general assistance medical care plan as defined under Minnesota law;
5. Minnesota Comprehensive Health Association (MCHA);
6. A self-insured health plan;
7. The MinnesotaCare program as defined under Minnesota law;
8. The public employee insurance plan as defined under Minnesota law;
9. The Minnesota employees insurance plan as defined under Minnesota law;

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10. TRICARE or other similar coverage provided under federal law applicable to the armed forces;
11. Coverage provided by a health care network cooperative or by a health **provider** cooperative;
12. The Federal Employees Health Benefits Plan or other similar coverage provided under federal law applicable to government organizations and employees;
13. A medical care program of the Indian Health Service or of a tribal organization;
14. A health benefit plan under the Peace Corps Act;
15. State Children's Health Insurance Program; or
16. A public health plan similar to any of the above plans established or maintained by a state, the U.S. government, a foreign country, or any political subdivision of a state, the U.S. government, or a foreign country.

Coverage of the following types, including any combination of the following types, are *not* **qualifying coverage**:

1. Coverage only for disability or income protection insurance;
2. Automobile medical payment coverage;
3. Liability insurance or coverage issued as a supplement to liability insurance;
4. Coverage for a specified disease or illness or to provide payments on a per diem, fixed indemnity, or non-expense-incurred basis, if offered as independent, non-coordinated coverage;
5. Credit accident and health insurance as defined under Minnesota law;
6. Coverage designed solely to provide dental or vision care;
7. Accident only coverage;
8. Long-term care coverage as defined under Minnesota law;
9. Medicare supplemental health insurance as defined under Minnesota law;
10. Workers' compensation insurance; or
11. Coverage for on-site medical clinics operated by an employer for the benefit of the employer's employees and their **dependents**, in connection with which the employer does not transfer risk.

Reconstructive. Surgery to rebuild or correct a:

1. Body part when such surgery is incidental to or following surgery resulting from injury, sickness, or disease of the involved body part; or
2. Congenital disease or anomaly which has resulted in a functional defect as determined by your **physician**.

In the case of mastectomy, surgery to reconstruct the breast on which the mastectomy was performed and surgery and reconstruction of the other breast to produce a symmetrical appearance shall be considered **reconstructive**.

Rehabilitative. Health care services are considered **rehabilitative** when they are provided to restore physical function or speech that has been impaired due to illness or injury.

Rescission. The cancellation or discontinuance of coverage under a health plan that has a retroactive effect. Coverage will only be rescinded for fraud or intentional misrepresentation of material fact.

Restorative. Surgery to rebuild or correct a physical defect that has a direct adverse effect on the physical health of a body part, and for which the restoration or correction is **medically necessary**.

Routine foot care. Services that are **routine foot care** may require treatment by a professional and include but are not limited to any of the following:

1. Cutting, paring, or removing corns and calluses;
2. Nail trimming, clipping, or cutting; and
3. Debriding (removing toenails, dead skin, or underlying tissue).

Routine foot care may also include hygiene and preventive maintenance such as:

1. Cleaning and soaking the feet; and
2. Applying skin creams in order to maintain skin tone.

Routine patient costs. All items and services that would be covered **benefits** if not provided in connection with a clinical trial. In connection with a clinical trial, **routine patient costs** do not include an **investigative** or experimental item, device, or service; items or services provided solely to satisfy data collection and analysis needs and not used in clinical management; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Skilled care. Nursing or rehabilitation services requiring the skills of technical or professional medical personnel to develop, provide, and evaluate your care and assess your changing condition. Long-term dependence on respiratory support equipment and/or the fact that services are received from technical or professional medical personnel do not by themselves define the need for **skilled care**.

Skilled nursing facility. A licensed bed or facility (including an extended care facility, **hospital** swing-bed, and transitional care unit) that provides skilled nursing care, skilled transitional care, or other related health services including rehabilitative services.

Subscriber. The person:

1. On whose behalf **premium** is paid; and
2. Whose employment is the basis for membership, according to the Contract; and
3. Who is enrolled under the Contract.

Total disability. Disability due to injury, sickness, or pregnancy that requires regular care and attendance of a **physician**, and in the opinion of the **physician** renders the employee unable to perform the duties of his or her regular business or occupation during the first two years of the disability and, after the first two years of the disability, renders the employee unable to perform the duties of any business or occupation for which he or she is reasonably fitted.

Urgent care center. A health care facility distinguishable from an affiliated clinic or **hospital** whose primary purpose is to offer and provide immediate, short-term medical care for minor, immediate medical conditions on a regular or routine basis.

Virtual care. Professional evaluation and medical management services provided to patients through e-mail, telephone, or webcam. **Virtual care** includes interactive audiovisual telehealth

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services. **Virtual care** is used to address non-urgent medical symptoms for patients describing new or ongoing symptoms to which **providers** respond with substantive medical advice. **Virtual care** does not include telephone calls for reporting normal lab or test results, or solely calling in a prescription to a pharmacy.

Waiting period. In accordance with applicable state and federal laws, the period of time that must pass before an otherwise eligible employee and/or **dependent** is eligible to become covered under the Contract (as determined by the employer's eligibility requirements). However, if an eligible employee or **dependent** enrolls as a **late entrant** or through a special enrollment period as set forth in *Eligibility And Enrollment*, any period before such late or special enrollment is not a **waiting period**. Periods of employment in an employment classification that is not eligible for coverage under the Contract do not constitute a **waiting period**.