MEDICA CHOICE PASSPORT

PLAN DOCUMENT

Administered by Medica Self-Insured

HERON LAKE-OKABENA ISD 330

MEDICA CHOICE PASSPORT

6350-0% HSA

BPL 96257/DOC 62848

JULY 1, 2022

Discrimination is Against the Law

Medica complies with applicable Federal civil rights laws and will not discriminate against any person on the basis of race, color, national origin, age, disability or sex. Medica:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: TTY communication and written information in other formats (large print, audio, other formats).
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters and information written in other languages.

If you need these services, call the number included in this document or on the back of your Medica ID card. If you believe that Medica has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Civil Rights Coordinator, Mail Route CP250, PO Box 9310, Minneapolis, MN 55443-9310, 952-992-3422 (phone/fax), TTY 711, civilrightscoordinator@medica.com.

You can file a grievance in person or by mail, fax, or email. You may also contact the Civil Rights Coordinator if you need assistance with filing a complaint.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

If you want free help translating this information, call the number included in this document or on the back of your Medica ID card.

Si desea asistencia gratuita para traducir esta información, llame al número que figura en este documento o en la parte posterior de su tarjeta de identificación de Medica.

Yog koj xav tau kev pab dawb kom txhais daim ntawv no, hu rau tus xov tooj nyob hauv daim ntawv no los yog nyob nraum qab ntawm koj daim npav Medica ID.

如果您需要免費翻譯此資訊，請致電本文檔中或者在您的Medica ID卡背面包含的號碼。

Nếu quý vị muốn trợ giúp dịch thông tin này miễn phí, hãy gọi vào số có trong tài liệu này hoặc ở mặt sau thẻ ID Medica của quý vị.

Odeeffannoo kana gargaarsa tolaan akka isinii hiikamu yoo barbaaddan, lakkoobsa barruu kana keessatti argamu ykn ka dugda kaardii Waraqaa Eenyummaa Medica irra jiruun bilbila'a.

إذا كنت تريد مساعدة مجانية في ترجمة هذه المعلومات، فاتصل على الرقم الوارد في هذه الوثيقة أو على ظهر بطاقة تعريف ميديكا الخاصة بك.

Если Вы хотите получить бесплатную помощь в переводе этой информации, позвоните по номеру телефона, указанному в данном документе и на обратной стороне Вашей индентификационной карты Medica.

ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປຂໍ້ມູນນີ້ຟຣີ, ໃຫ້ໂທຫາເລກໝາຍທີ່ມີຢູ່ໃນເອກະສານນີ້ ຫຼື ຢູ່ດ້ານຫຼັງຂອງບັດ Medica ຂອງທ່ານ.

이 정보를 번역하는 데 무료로 도움을 받고 싶으시면, 이 문서에 포함된 전화번호나 Medica ID 카드 뒷면의 전화번호로 전화하십시오.

Si vous voulez une assistance gratuite pour traduire ces informations, appelez le numéro indiqué dans ce document ou au dos de votre carte d'identification Medica.

နမ့်အဲၣ်ဒိး ဘၣ်တ့ၢ်ကြီၣ်ထံစၢၤကလီနၣ် နၤတၢ်ဂ့ၢ်တၢ်ကျိၤအံၤလၢအကလီဧိၣ်, ကိးလီတဲစိနီၣ်ဂံၢ်လၢအပၣ်ယှာ်လၢလံာ်တီလံာ်မီအပူၤအံၤမ့တမ့ၢ်လၢနနီၣ်ဖးတိၢ်လၢအလိၢ်ခံတကပၤအဖီခိၣ်နၣ်တက့ၢ်.

Kung nais mo ng libreng tulong sa pagsasalin ng impormasyong ito, tawagan ang numero na kasama sa dokumentong ito o sa likod ng iyong Kard ng Medica ID.

ይህን መረጃ ለመተርጎም ነጻ እርዳታ የሚፈልጉ ከሆነ በዚህ ሰነድ ውስጥ ያለውን ቁጥር ወይም Medica መታወቂያ ካርድዎ በስተጀርባ ያለውን ይደውሉ።

Ako želite besplatnu pomoć za prijevod ovih informacija, nazovite broj naveden u ovom dokumentu ili na poleđini svoje ID kartice Medica.

Díí t'áá jíík'e shá ata' hodoonih nínízingo éí ninaaltsoos Medica bee néího'dílzinígí bine'déé' námboo biká'ígíįjį' béésh bee hodíilnih.

Wenn Sie bei der Übersetzung dieser Informationen kostenlose Hilfe in Anspruch nehmen möchten, rufen Sie bitte die in diesem Dokument oder auf der Rückseite Ihrer Medica-ID-Karte angegebene Nummer an.

MEDICA CUSTOMER SERVICE

The specific customer service phone number for your plan is found on the back of your ID card.

General Customer Service:

1-877-347-0282 TTY: **711**

Find more information about your benefits by signing in to your secure member site at **Medica.com/SignIn**.

Welcome!

We're glad you're a covered person under the plan. Health coverage can be complicated. The information found in the pages of this plan can help you better understand your coverage and how it works.

You may need to reference multiple sections to get a complete picture of your coverage and what you will pay when you receive care. If you have more than one service during a visit, you may pay a separate copayment or coinsurance for each service. The most specific section of this plan will apply. Use the **Where to Find It** section to learn about related benefits when you access common services.

Some terms used have specific meanings.

In this plan, the words "you," "your" and "yourself" refer to you, the covered person. The word "plan administrator" means your employer.

The word "employer" refers to the governmental unit that employs you and because of which you are eligible for coverage. See the **Definitions** section at the end of this document for more terms with specific meanings.

Where to Find It

Note: This is a quick guide to some common benefits. For a complete understanding of your coverage, be sure to read any other related sections in this plan.

Do you need…	*Read section(s):*
Immediate medical attention? • Ambulance • Emergency room • Urgent care	Ambulance Emergency Room Care Physician and Professional Services
Quick access to care? • Convenience care • Retail health clinic • Virtual care • Telemedicine	Physician and Professional Services Telemedicine Health Services
To visit a provider or clinic? • Chiropractic care • Office visit	Physician and Professional Services
Preventive care? • Immunizations • Physicals • Women's preventive services	Preventive Health Care
Prescription drugs or supplies? • Diabetic equipment and supplies • Outpatient medications • Preventive medications and products • Specialty medications	Prescription Drugs Prescription Specialty Drugs
A medical test? *Examples: blood work, ultrasounds* • Genetic testing and counseling • Lab and pathology services • X-rays, imaging, MRI, CT and PET CT scans	Genetic Testing and Counseling Lab and Pathology X-Rays and Other Imaging
Outpatient surgery? • Anesthesia services • Outpatient/ambulatory surgical center services (facility charge)	Anesthesia Hospital Services

Do you need…	***Read section(s):***
• Physician services (doctor charge)	Physician and Professional Services
Services provided during a hospital stay? • Anesthesia services • Hospital services (facility charge) • Physician services (doctor charge)	Anesthesia Hospital Services Physician and Professional Services
Mental health or behavioral health services? • Inpatient services • Office visit	Behavioral Health – Mental Health
Substance use disorder services? • Inpatient services • Office visit	Behavioral Health – Substance Use Disorder
Pregnancy care services? • Breast pumps • Inpatient services • Postnatal services • Prenatal services	Durable Medical Equipment, Prosthetics and Medical Supplies Pregnancy – Maternity Care
Medical supplies or equipment? *Examples: crutches, CPAP, wheelchair, oxygen* • Insulin pumps and related supplies • Durable medical equipment and medical supplies • Hearing aids • Prosthetics	Durable Medical Equipment, Prosthetics and Medical Supplies
Medical-related dental care? • Accident-related dental services • Treatment of temporomandibular joint (TMJ) and craniomandibular disorder	Medical-Related Dental Services Temporomandibular Joint (TMJ) and Craniomandibular Disorder
Help recovering? *Example: Help received after a hospital stay, injury or surgery* • Home health care services • Physical, speech and occupational therapies • Skilled nursing facility services	Home Health Care Physical, Speech and Occupational Therapies Skilled Nursing Facility

Table of Contents

Introduction

Group insurance coverage is sponsored by and provided through the Minnesota Healthcare Consortium (MHC), a joint powers entity comprised of seven Minnesota Service Cooperatives. Your employer is a member of a joint powers agreement with one of the seven Minnesota Service Cooperatives and authorizes MHC to arrange group health coverage. MHC performs certain plan administration functions including contracting with Medica Self-Insured (Medica). MHC delegates certain plan administration functions to your employer, including enrollment and compliance with law at the employer level. For purposes of this document, plan administrator means your employer.

Your employer has opted to participate in one of the seven Minnesota Service Cooperatives and MHC (employer member). This plan was originally established January 1, 2018. This restatement of the plan is effective July 1, 2022, unless specifically stated otherwise.

The plan is not an employee welfare benefit plan within the meaning of the Employee Retirement Income Security Act of 1974 (ERISA). The plan is a self-insured medical plan generally intended to meet the requirements of Section 106 and Section 105(h) of the Internal Revenue Code of 1986 (Code) and applicable Minnesota law, including but not limited to Sections 123A.21 and 471.59 of the Minnesota Statutes.

When changes are made to the plan, the plan administrator will notify enrollees or covered persons as required by law and those individuals will receive a new plan or an amendment to this plan.

This plan defines benefits and describes the health services for which you have coverage and the procedures you must follow to obtain in-network coverage. Coverage is subject to all terms and conditions of the plan. As a condition of coverage under the plan, you must consent to the release and re-release of medical information necessary for the administration of this plan. The confidentiality of such information will be maintained in accordance with existing law.

How you accept coverage

When you accept the health care coverage described in this plan, you, on behalf of yourself and any dependents enrolled under the plan:

1. Authorize the use of your Social Security number for purpose of identification unless otherwise prohibited by state law; and
2. Agree that the information you supplied the plan for purposes of enrollment is accurate and complete.

In addition, you understand and agree that if you intentionally omit or incorrectly state any material facts in connection with your enrollment under the plan, the plan administrator may retroactively cancel your coverage.

Covered persons are subject to all terms and conditions of the plan and health services must meet the definition of “medically necessary” (see **Definitions**).

Medica may arrange for others to administer services on its behalf, including arrangement of access to a provider network, claims processing and medical necessity reviews. To ensure that your benefits are managed appropriately, please work with these persons or vendors when needed as they conduct their work for Medica.

The sponsor or its designee is responsible for notifying you of any changes to this plan (as required by applicable law).

If you need language interpretation

Language interpretation services are available to help you understand your benefits under this plan. To request these services, call Customer Service at the telephone number listed at the front of this plan.

If you need alternative formats, such as Braille or large print, call Customer Service at the telephone number listed at the front of this plan to request these materials.

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

Medica's nondiscrimination policy

Medica's policy is to treat all persons alike, without distinctions based on race, color, creed, religion, national origin, gender, gender identity, 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 the telephone number listed at the front of this plan.

Plan Overview

The information contained in this section of the plan provides general information regarding the plan. It is important to remember that this section of the plan is only an overview. You also need to refer to the section that describes a particular plan requirement in detail.

General plan information

Plan Name

Heron Lake-Okabena ISD 330

Plan Administrator, Business Address and Business Telephone Number of Plan Administrator

Heron Lake-Okabena ISD 330
124 North Minnesota Avenue
Okabena, MN 56161
(507) 853-4507

Employer Member

Heron Lake-Okabena ISD 330

Agent for Service of Legal Process

Outside Counsel

Sponsor IRS Employer Identification Number (EIN)

82-3304710

Plan Year

July 1 through June 30

This is also your record-keeping year.

Type of Welfare Plan

Medical

Type of Administration

Self-insured

The sponsor has entered into a service agreement with Medica under which Medica performs a variety of administrative services with respect to the medical benefits provided under the plan. Medica may, from time to time at its sole discretion, contract with other parties, related or unrelated, to arrange for provision of other administrative services including, but not limited to, arrangement of access to a provider network, claims processing services and complaint

resolution assistance. The agreement is for administrative services only. Medica does not insure the provision of benefits under the plan; Medica is not a health insurer. The plan offers Medica Choice Passport.

Name and Address of Claims Administrator

Medica Self-Insured
401 Carlson Parkway
Minnetonka, MN 55305

Funding

This plan is a self-insured medical plan funded by contributions from the employer, members and/or employees. You may be responsible for a portion of the cost of the coverage provided under this plan. The portion of the cost of coverage for which the enrollee is responsible may be paid on a pre-tax basis through a cafeteria plan of employer member if employer member makes such a plan available.

Benefits

Plan benefits are furnished in accordance with this plan, which is issued by the plan administrator. This plan provides an explanation of the benefits offered by the plan. If there is a conflict between any other document and the plan document, the plan document shall govern.

The benefits described in this plan document detail the medical benefits available under the plan. **What's Covered and How Much Will I Pay** describes the copayment, coinsurance and deductible amounts that impact how much the plan pays and how much you pay. The procedures to be followed in obtaining benefits or presenting claims for benefits under the plan and seeking remedies for redress of claims that are denied in whole or in part are described in this plan.

This plan covers medically necessary health services as described throughout the plan. Please pay particular attention to the benefits that have limitations. Some benefits require that certain things be done first (i.e., prior authorization be obtained). Not following these requirements may impact whether benefits are paid under this plan. Additionally, you consent to the release and re-release of medical information necessary for the administration of this plan as a condition of coverage under this plan. Certain services are specifically excluded from coverage under this plan. The fact that a provider recommends or orders services does not always mean the services are covered or medically necessary. For additional details, see **What's Not Covered**. This plan coordinates the benefits it provides with other coverage and/or other sources of payment. For additional details, see **Right to Subrogation and Reimbursement**.

HIPAA compliance

This plan will be administered in a manner consistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and all implementing regulations. The HIPAA privacy

standards address disclosure to a plan sponsor of protected health information (or PHI). With some exceptions, protected health information or PHI is information that: (i) identifies or could reasonably be used to identify you and (ii) relates to your physical or mental health or condition, the provision of your health care or your payment for health care. The sponsor may use or disclose PHI received from the plan or from another party acting on behalf of the plan for certain limited purposes. These include health care operations purposes and health care payment purposes relating to the plan. However, with respect to such PHI, the sponsor agrees as follows:

1. The sponsor will not use or further disclose such PHI other than as permitted or required by this plan or as required by law (as defined in the HIPAA privacy standards).
2. The sponsor will ensure that any agents, including a subcontractor, to whom the sponsor provides PHI received from the plan or from another party acting on behalf of the plan, agree to the same restrictions and conditions that apply to the sponsor with respect to such PHI.
3. The sponsor will not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the sponsor, except under an authorization which meets the requirements of the HIPAA privacy standards.
4. The sponsor will report to the plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the sponsor becomes aware.
5. The sponsor will make available PHI in accordance with your right of access under the HIPAA privacy standards.
6. The sponsor will make available PHI for amendment and incorporate any amendments to PHI in accordance with the HIPAA privacy standards.
7. The sponsor will make available the information required to provide an accounting of certain disclosures of PHI in accordance with the HIPAA privacy standards.
8. The sponsor will make its internal practices, books and records relating to the use and disclosure of PHI received from the plan or another party on behalf of the plan, available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the plan with the HIPAA privacy standards.
9. If feasible, the sponsor will return or destroy all PHI received from the plan, or another party acting on behalf of the plan, that the sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made. If such return or destruction is not feasible, the sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.
10. The sponsor will ensure that adequate separation between the plan and the sponsor is established as follows:
    a. Only the following persons under control of the sponsor may be given access to the PHI that is disclosed:

Director of Finance and Risk Management, Member Services Director, Accountant, Business Office Specialist, Director of Operations

b. The access to and use of PHI by the persons described above is restricted to the plan administration functions that the sponsor performs for the plan.

c. If any of the persons described above do not comply with the above provisions relating to HIPAA compliance, the sponsor will impose sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions may be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate. Sanctions, when imposed, will be commensurate with the severity of the violation.

11. The HIPAA security standards govern the security of electronic protected health information created, received, maintained or transmitted by the plan. The sponsor agrees as follows:

a. The sponsor will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information that it creates, receives, maintains or transmits on behalf of the plan.

b. The sponsor will ensure that the adequate separation required by the HIPAA privacy standard is supported by reasonable and appropriate security measures.

c. The sponsor will ensure that any agent, including a subcontractor, to whom it provides electronic protected health information, agrees to implement reasonable and appropriate security measures to protect the information.

d. The sponsor will report to the plan any security incident of which it becomes aware.

Before You Access Care

This section provides information for you to consider before you access care. More information about when and where to get care can be found at **Medica.com/SignIn**.

What you must do to receive benefits

Each time you receive health services, you must:

1. For your highest level of coverage, confirm that your provider is in your plan's network; and
2. Present your Medica identification (ID) card. Having and using a Medica ID card does not guarantee coverage.

If your provider asks for your ID card information and you do not provide it within 180 days of when you received services, you may be responsible for paying the full cost of those services. (Network providers must submit claims within 180 days from when you receive a service.)

It is your responsibility to alert Medica regarding any discounts, coupons, rebates or financial arrangements between you and a provider or manufacturer for health care items or services, prescribed drugs and/or devices. Discounts, coupons, rebates or similar reimbursement provided to you by providers or manufacturers will not satisfy your out-of-pocket cost-sharing responsibilities. Such amounts will not accumulate toward your deductible and out-of-pocket maximum. You can contact Medica by calling the telephone number on your Medica ID card.

Provider network

In-network benefits are available through your plan's provider network. To see which providers are in your plan's network, check the online search tool at **Medica.com/SignIn** or contact Customer Service. Certain providers may be in other Medica networks, but not in your network.

You may also contact Customer Service for estimates of the amount Medica has contracted to pay a particular network provider for a specific health care service and the amount you will pay as cost-sharing for that service if received from that network provider. Medica will provide you with requested estimates within ten business days from the date Medica receives a request containing all information needed to respond. Please note that the estimates provided are not a final determination of eligibility for coverage or a guarantee of continuing provider network participation or final costs for services you receive.

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

While a particular provider may be in your provider directory at the time you enroll, it is not guaranteed that this provider will be available to provide you with health services or will remain a network provider.

If you access services from providers that are not in your network, your out-of-network benefits will apply. For more information about out-of-network care, see the tip sheet at **Medica.com/SignIn**.

Prior authorization

You may need prior authorization (approval in advance) from Medica before you receive certain services or supplies. When reviewing your request for prior authorization, Medica uses written procedures and criteria to determine whether a particular service or supply is medically necessary and is a covered benefit. To verify whether a specific service or supply requires prior authorization, please call Customer Service at the telephone number listed at the front of this plan.

Emergency services do not require prior authorization.

You do not require prior authorization to obtain access to obstetrical or gynecological care from a network provider who specializes in obstetrics or gynecology. However, certain specific services provided by that network provider may require prior authorization, as described further in this plan.

You, someone on your behalf or your attending provider may contact Customer Service to request prior authorization. Your network provider will contact Medica to request prior authorization for a service or supply. If a network provider fails to request prior authorization after you have consulted with them about services requiring prior authorization, you will not be penalized for this failure.

You must contact Customer Service to request prior authorization for services or supplies received from a non-network provider.

We recommend that you confirm with us that all services and supplies requiring prior authorization, including those received from a network provider, have been prior authorized by Medica. You may contact Customer Service for this confirmation.

Prior authorization is required for the following services and supplies, as described below and in the sections of this plan that discuss the applicable benefit:

- Solid organ and blood and marrow transplant services - this prior authorization must be obtained before the transplant workup is initiated;
- In-network benefits for services from non-network providers, with the exception of emergency services;
- Certain reconstructive or restorative surgery procedures;
- Certain drugs, biologics and biosimilars;
- Certain home health care services;
- Certain medical supplies and durable medical equipment;
- Certain outpatient surgical procedures;
- Certain genetic tests;
- Certain imaging services;
- Non-emergency licensed air ambulance transportation; and

- Skilled nursing facility services.

Pregnancy/maternity care services do not require prior authorization and will be covered at the appropriate in-network or out-of-network benefit level.

This is not a complete 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 making the request;
- Name, telephone number, address and, if applicable, the type of specialty of the provider to whom you are being referred;
- Services being requested and the date those services are to be provided (if scheduled);
- Specific information related to your condition (for example, a letter of medical necessity from your provider); and
- Other applicable covered person information (i.e., Medica identification number).

Medica will review your request for prior authorization and respond to you and your attending provider within a reasonable period of time appropriate to your medical circumstances. Medica will generally respond within 5 business days of the date your request was received electronically (and within 6 business days if received through nonelectronic means), provided all information reasonably necessary to make a decision has been given to Medica.

However, Medica will respond within a time period not exceeding 48 hours (including at least one business day) 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
- you could be subject to severe pain that cannot be adequately managed without the care or treatment you are requesting.

If we do not approve your request for prior authorization, you have the right to appeal Medica's decision as described in **How Do I File a Complaint**.

If you are a new Medica member and have a prior authorization for services from your former health plan, Medica will accept that prior authorization for at least the first 60 days of coverage under this plan. In order to obtain coverage for this 60-day period, you or your provider must send Medica documentation of the previous prior authorization. For coverage to continue after the 60-day period, you, someone on your behalf or your attending provider should submit a request for prior authorization to Medica prior to the end of this 60-day period.

Under certain circumstances, Medica may conduct concurrent reviews to verify whether services are still medically necessary. If we conclude that services are no longer medically necessary, Medica will advise both you and your attending provider in writing of our decision. If we do not approve continuing coverage, you or your attending provider may appeal our initial decision (see **How Do I File a Complaint**).

Referrals to non-network providers

To receive in-network benefits for services received from a non-network provider, you will need to follow the steps described below. If you receive services from a non-network provider without following these steps, your out-of-network benefits will apply. For more information, see the tip sheet at **Medica.com/SignIn**.

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

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 for when 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. Ask your network provider to request prior authorization from Medica. Medica does not guarantee coverage for services that are received before you receive prior authorization.
3. If Medica approves the prior authorization request, your in-network benefit will apply.
4. Pay any amounts that were not approved for coverage 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. Standing referrals will only be authorized for the period of time appropriate to your medical condition. To request a standing referral, contact Customer Service. If Medica denies your request for a standing referral, you have the right to appeal this decision as described in **How Do I File a Complaint**.

Medica:

1. May require that you see another network provider that Medica selects before determining 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.
3. Will provide coverage for health services that are:
    a. Otherwise eligible for coverage under this plan; and
    b. Recommended by a network physician.
4. Will review your request for prior authorization and respond to you and your attending provider within a reasonable period of time appropriate to your medical circumstances. Medica will generally respond within ten business days of receiving your request, provided that all information reasonably necessary to make a decision has been given to Medica.

However, Medica will respond within a time period not exceeding 72 hours from the time of the initial request if: 1) your attending provider believes that an expedited review is warranted, or 2) Medica concludes that a delay could seriously jeopardize your life, health or ability to regain maximum function, or 3) you could be subject to severe pain that cannot be adequately managed without the care or treatment you are seeking.

Visiting non-network providers and why you pay more

In general, eligible health services and supplies are only covered as in-network benefits if they're provided by network providers or if Medica approves them.

If the care you need is not available from a network provider, Medica may authorize non-network provider services at the in-network benefit level.

Be aware that if you use out-of-network benefits, you will likely have to pay much more than if you use in-network benefits. The amounts billed by the non-network provider may be more than what the plan would pay, leaving a balance for you to pay in addition to any coinsurance and deductible amount you owe. This additional amount you must pay the provider will not be counted toward your out-of-pocket maximum amount. You will owe this amount whether or not you previously reached your out-of-pocket maximum. **Please see the example calculation below.**

It is important that you do the following before receiving services from a non-network provider:

- Discuss with the non-network provider what the bill is expected to be; and
- Contact Customer Service to verify the estimated amount the plan would pay for those services; and
- Calculate your likely share of the costs; and
- To request that Medica authorize coverage of the non-network provider's services at the in-network benefit level, follow the prior authorization process described above.

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

Example:

You choose to receive inpatient care (not an emergency) at a non-network hospital without an authorization from Medica. Your out-of-network benefits apply to these services.

Assumptions:

1. You have previously fulfilled your deductible.
2. The non-network hospital bills $30,000 for your hospital stay.
3. The plan's non-network provider reimbursement amount for those hospital services is $15,000.
    a. You must pay a portion of this amount, generally a percentage coinsurance. In this example, we will use 40% coinsurance.

b. In addition, the non-network provider will likely bill you for the difference between what they charge and the amount that the plan pays them.

For this non-network hospital stay, you will be required to pay:

40% coinsurance (40% of $15,000 = $6,000), and

The provider's billed amount that exceeds the non-network provider reimbursement amount ($30,000 - $15,000 = $15,000)

Therefore, the total amount you will owe is $6,000 + $15,000 = $21,000.

The $6,000 amount you pay as coinsurance **will** be applied to your out-of-pocket maximum.

The $15,000 amount you pay for billed amounts in excess of the non-network provider reimbursement amount **will not** be applied toward your out-of-pocket maximum. You will owe the provider this $15,000 amount whether or not you have previously reached your out-of-pocket maximum.

***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 you receive. For more information about out-of-network care, see the tip sheet at **Medica.com/SignIn**.

When do I need to submit a claim

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

Non-network provider services – Additional information

Generally, as described above in **Visiting non-network providers and why you pay more**, you will pay much more for your health care if you receive services from a non-network provider than when you receive services from a network provider. However, please see the public notice at the end of this document for your additional rights and protections against surprise medical bills (**Your Rights and Protections Against Surprise Medical Bills**). The rights and protections in that public notice are as they have been communicated by the U.S. Departments of Health and Human Services, Labor and Treasury.

Additionally, you are not responsible, pursuant to Minnesota Statute 62Q.556, for any amounts above what you would be required to pay for in-network benefits, unless you provide advance written consent, if your network provider sent your lab work to a non-network laboratory for testing.

If you have questions about bills you receive from a non-network provider that provided services under the circumstances described above, please call Customer Service at the telephone number listed at the front of this plan. If you receive a bill that is larger than the applicable in-network copayment, coinsurance or deductible, you may submit the bill for processing to:

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

Continuity of care

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

1. If Medica terminates its contract with your current provider without cause, you may be eligible to continue care with that provider at the in-network benefit level.
2. If you are new to Medica as a result of the sponsor changing third party administrators 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. This includes providing Medica with all necessary medical information related to your care, and accepting as payment in full the lesser of Medica's network provider reimbursement or the provider's customary charge for the service. This does not apply when Medica terminates a provider's contract for cause. If Medica terminates your current provider's contract for cause, we will inform you of the change and how your care will be transferred to another network provider.

Upon request, Medica will authorize continuity of care as described in 1. and 2. above for the following conditions:

- an acute condition;
- a life-threatening mental or physical illness;
- scheduled non-elective surgery, including post-operative care;
- pregnant and undergoing a course of treatment for pregnancy. Health services may continue to be provided through the completion of postpartum care;
- a physical or mental disability defined as an inability to engage in one or more major life activities, provided 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.

Continuity of care, as described above, will continue until the active course of treatment is complete, or 120 days, whichever is shorter.

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

Upon request, Medica will authorize continuity of care for up to 120 days as described in 1. and 2. above in the following situations:

- if you are receiving culturally appropriate services and Medica does not have a network provider who has special expertise in the delivery of those culturally appropriate services; 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 documents from your provider in reviewing your request and will consider each request on a case-by-case basis. If we authorize your request to continue care with your current provider, we 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 our decision. You may appeal this decision.

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

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

What's Covered and How Much Will I Pay

This section describes the services eligible for coverage and any expenses that you will need to pay.

Important information about your benefits

- Before you receive certain services or supplies, you will need to get prior authorization from Medica. To find out when you need to do this, see **What to keep in mind** after each benefit section or call Customer Service at the telephone number listed at the front of this plan. Also refer to **Before You Access Care** for more information about the prior authorization process.
- The plan provides coverage for mental health and substance use disorder services in the same way it provides coverage for other health issues. The Mental Health Parity and Addiction Equity Act, as well as applicable law, requires the plan that offers mental health and substance use disorder benefits, to provide coverage of those benefits in a way that is comparable to coverage for general medical and surgical care. Cost-sharing requirements and limitations on mental health and substance use disorder benefits (such as copayments, visit limits and preauthorization requirements) must generally be comparable to, and no more restrictive than those for medical and surgical benefits.
- When you use out-of-network benefits, in addition to the deductible and coinsurance, you will likely need to pay your provider any billed amount above what the plan pays the provider (the non-network provider reimbursement amount). **These charges are not applied to your deductible or out-of-pocket maximum.** Please see **Visiting non-network providers and why you pay more** in **Before You Access Care** for more information and an example showing out-of-pocket costs associated with out-of-network benefits.
- Certain benefits in this plan have limits. These limits might include day limits, visit limits or dollar limits. These limits are noted in this plan and apply whether or not you have met your deductible.

Key concepts

Deductibles

Your plan may require that you pay a certain dollar amount before your plan starts to pay. This amount is called a deductible. Please note that amounts reimbursed or paid by a provider or manufacturer, including manufacturer coupons, rebates, coupon cards, debit cards or other forms of reimbursement or payment on your behalf for a product or service, will not apply toward your deductible.

The table below shows whether your plan has a deductible, how much it is and whether you have separate deductibles for each family member or a combined deductible for everyone. Each benefit table in this plan shows whether the deductible applies to a particular service.

If you were validly covered by a prior plan that this plan has replaced and were immediately covered under this plan on the original effective date of this plan, amounts paid toward your prior plan's deductible paid within the current calendar year will apply to this plan's deductible for the current calendar year.

For more information about deductibles and other common cost-sharing terms, see the tip sheet at **Medica.com/SignIn**.

Out-of-pocket maximum

Your out-of-pocket maximum is an accumulation of copayments, coinsurance and deductibles that you paid for benefits received during the calendar year. Unless otherwise noted, you won't have to pay more than this amount. Amounts reimbursed or paid by a provider or manufacturer, including manufacturer coupons, rebates, coupon cards, debit cards or other forms of reimbursement or payment on your behalf for a product or service, will not apply toward your out-of-pocket maximum.

If you were validly covered by a prior plan that this plan has replaced and were immediately covered under this plan on the original effective date of this plan, out-of-pocket amounts paid for benefits received under the prior plan within the current calendar year will apply to this plan's out-of-pocket maximum for the current calendar year.

Please note: The following amounts do not apply toward your out-of-pocket maximum:

- **Charges for services that aren't covered; and**
- **Charges a non-network provider bills you that are more than the non-network provider reimbursement amount; and**
- **Charges you pay in addition to your deductible, copayment or coinsurance when you choose to use a preferred brand or non-preferred brand prescription drug when a chemically equivalent generic drug is available.**

You will owe these amounts even if you have already reached your out-of-pocket maximum.

DEDUCTIBLES, OUT-OF-POCKET MAXIMUMS AND LIFETIME MAXIMUM

Deductibles, Out-Of-Pocket Maximums and Lifetime Maximum		
	Your cost if you visit a:	
	Network provider:	**Non-network provider:**
Copayment or coinsurance	See specific benefit for applicable copayment or coinsurance.	
Deductible		
Per covered person	$6,350	$8,250
Per family	$12,700	$16,500
The deductible is the amount you must pay for eligible services each calendar year before the plan will begin to pay claims. If you have family members on the plan, you will each have to meet your own individual deductible before receiving benefits, unless the family deductible is met. Once the family deductible has been met, the plan will pay benefits for all covered family members. Please note that amounts reimbursed or paid by a provider or manufacturer, including manufacturer coupons, rebates, coupon cards, debit cards or other forms of reimbursement or payment on your behalf for a product or service, will not apply toward your deductible.		
Out-of-pocket maximum		
Per covered person	$6,350	$10,000
Per family	$12,700	$20,000
This plan has both a per covered person out-of-pocket maximum and a per family out-of-pocket maximum. The per covered person out-of-pocket maximum applies individually to each family member until the family out-of-pocket maximum is met. Coinsurance, copayments and deductibles paid by each covered family member for covered benefits for the calendar year count toward the individual's annual per covered person out-of-pocket maximum and toward the annual per family out-of-pocket maximum. Please note that amounts reimbursed or paid by a provider or manufacturer, including manufacturer coupons, rebates, coupon cards, debit cards or other forms of reimbursement or payment on your behalf for a product or service, will not apply toward your out-of-pocket maximum.		
Lifetime maximum amount the plan will pay per covered person	Unlimited	Unlimited

AMBULANCE

Ambulance			
		Your cost if you visit a:	
	Benefits	Network provider:	Non-network provider:
1.	Emergency ambulance services or emergency ambulance transportation	Nothing after deductible	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: 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	Nothing after deductible	20% coinsurance after deductible

What's covered

When you use out-of-network benefits, in addition to the deductible and coinsurance, you will likely need to pay your provider any billed amount above what the plan pays the provider (the non-network provider reimbursement amount). **These charges are not applied to your deductible or out-of-pocket maximum.** Please see **Visiting non-network providers and why you pay more** in **Before You Access Care** for more information and an example showing out-of-pocket costs associated with out-of-network benefits.

What to keep in mind

Ambulance services for an emergency are covered when provided by a licensed ambulance service. If you are taken to a non-network hospital, only emergency health services at that hospital are covered as described in **Emergency Room Care**.

Non-emergency ambulance transportation that's arranged through an attending physician is eligible for coverage when certain criteria are met. Prior authorization (approval in advance) is required before you receive non-emergency licensed air ambulance transportation. Pursuant to the Federal No Surprises Act of 2020, when you obtain air ambulance services from certain nonparticipating providers of air ambulance services, your in-network benefit will apply and any copayment, deductible and coinsurance will apply to your in-network deductible and out-of-pocket maximum.

What's 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 above.

ANESTHESIA

Anesthesia			
		Your cost if you visit a:	
	Benefits	Network provider:	Non-network provider:
1.	Anesthesia services received during an office visit	Nothing after deductible	20% coinsurance after deductible
2.	Anesthesia services received during an outpatient hospital or ambulatory surgical center visit	Nothing after deductible	20% coinsurance after deductible
3.	Anesthesia services received during an inpatient stay	Nothing after deductible	20% coinsurance after deductible

What to keep in mind

Anesthesia services can be received from a provider during an office visit, an outpatient hospital visit, an ambulatory surgical center visit or during an inpatient stay.

When you use out-of-network benefits, in addition to the deductible and coinsurance, you will likely need to pay your provider any billed amount above what the plan pays the provider (the non-network provider reimbursement amount). **These charges are not applied to your deductible or out-of-pocket maximum.** Please see **Visiting non-network providers and why you pay more** in **Before You Access Care** for more information and an example showing out-of-pocket costs associated with out-of-network benefits.

BEHAVIORAL HEALTH – MENTAL HEALTH

Behavioral Health – Mental Health			
		Your cost if you visit a:	
	Benefits	**Network provider:**	**Non-network provider:**
1.	Office visits, including evaluations, diagnostic and treatment services **Please note:** Some services received during a mental health office visit may be covered under another benefit in this section. The most specific and appropriate benefit will apply for each service received during a mental health office visit	Nothing after deductible	20% coinsurance after deductible
2.	Intensive outpatient programs	Nothing after deductible	20% coinsurance after deductible

Behavioral Health – Mental Health			
		Your cost if you visit a:	
	Benefits	Network provider:	Non-network provider:
3.	Intensive behavioral and developmental therapy for the treatment of autism spectrum disorders for covered persons 17 years of age and younger when provided in accordance with an individualized treatment plan prescribed by the covered person's treating physician or mental health professional. Examples of such therapy include, but are not limited to, Early Intensive Developmental & Behavioral Intervention (EIDBI), Applied Behavioral Analysis (ABA), Intensive Early Intervention Behavior Therapy (IEIBT), Intensive Behavioral Intervention (IBI) and Lovaas therapy.	Nothing after deductible	20% coinsurance after deductible
4.	Inpatient services (including residential treatment services) **Please note:** Inpatient services in a licensed residential treatment facility for treatment of emotionally disabled children will be covered as any other health condition.		
	a. Room and board	Nothing after deductible	20% coinsurance after deductible
	b. Hospital or facility-based professional services	Nothing after deductible	20% coinsurance after deductible

Behavioral Health – Mental Health			
		Your cost if you visit a:	
	Benefits	Network provider:	Non-network provider:
c.	Attending psychiatrist services	Nothing after deductible	20% coinsurance after deductible
d.	Partial program	Nothing after deductible	20% coinsurance after deductible

What's covered

Outpatient mental health services include:

1. Diagnostic evaluations and psychological testing, including that for attention deficit hyperactivity disorder (ADHD) or autism spectrum disorders.
2. Psychotherapy and psychiatric services.
3. Mental health 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 3 hours per day or 19 hours per week).
4. Relationship and family therapy, including individual, group and multifamily therapy, if there is a clinical diagnosis.
5. Treatment of serious or persistent disorders.
6. Services, care or treatment described as benefits in this plan 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.
7. Treatment of pathological gambling.
8. Intensive behavioral and developmental therapy for the treatment of autism spectrum disorders for covered persons 17 years of age and younger when provided in accordance with an individualized treatment plan prescribed by the covered person's treating physician or mental health professional.

Inpatient mental health services include:

1. Room and board.
2. Attending psychiatric services.
3. Hospital or facility-based professional services.
4. 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 a minimum of 4 hours per day or 20 hours per week of care.

5. Services, care or treatment described as benefits in this plan 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.
6. Mental health residential treatment services. These services include either:
    - A residential treatment program serving children and adolescents with severe emotional disturbance, certified under Minnesota Rules parts 2960.0580 to 2960.0700; or
    - A licensed or certified mental health treatment program providing intensive therapeutic services. In addition to room and board, each individual must receive at least 30 hours of mental health services a week, 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.

When you use out-of-network benefits, in addition to the deductible and coinsurance, you will likely need to pay your provider any billed amount above what the plan pays the provider (the non-network provider reimbursement amount). **These charges are not applied to your deductible or out-of-pocket maximum.** Please see **Visiting non-network providers and why you pay more** in **Before You Access Care** for more information and an example showing out-of-pocket costs associated with out-of-network benefits.

What to keep in mind

Medica offers a 24/7 behavioral health crisis line for covered persons at no additional cost. If you are experiencing a mental health crisis, you may call **1-800-848-8327** to speak with a behavioral health specialist.

Medica requires prior authorization (approval in advance) before you receive certain mental health services or treatment. For non-scheduled inpatient admissions (including emergency admissions), notification by the facility must be provided as soon as reasonably possible after admission. To determine if Medica requires prior authorization for a particular service or treatment, please call your plan's designated mental health and substance use disorder provider at **1-800-848-8327** or TTY users, please contact: National Relay Center **711**, then ask them to dial Medica Behavioral Health at **1-866-567-0550**. Please see **Prior authorization** in **Before You Access Care** for more information about prior authorization requirements and processes.

To be covered, services must diagnose or treat mental disorders listed in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*.

If you have more than one service or modality on the same day, you may pay a separate copayment or coinsurance for each service.

Your plan's designated mental health and substance use disorder provider will coordinate your in-network mental health services. If you require hospitalization, your plan's designated mental health and substance use disorder provider will refer you to one of its hospital providers. **Please note:** The hospital network for medical services and mental health and substance use disorder services is not the same.

Emergency mental health services do not require prior authorization and are eligible for coverage under in-network benefits.

Mental health services from a non-network provider listed below will be eligible for coverage under out-of-network benefits. These services must be obtained from a health care professional or facility that is licensed, certified or otherwise qualified under state law to provide the mental health services and practice independently:

- Psychiatrist
- Psychologist
- Registered nurse certified as a clinical specialist or as a nurse practitioner in psychiatric and mental health nursing
- Mental health clinic
- Mental health residential treatment center
- Independent clinical social worker
- Marriage and family therapist
- Hospital that provides mental health services
- Licensed professional clinical counselor

What's not covered

1. Services for mental disorders not listed in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*.
2. Services, care or treatment that is not medically necessary, unless ordered by a court as specifically described in this section.
3. Relationship and family therapy, including individual, group and multifamily therapy, in the absence of a clinical diagnosis.
4. Services for telephone psychotherapy, however services that are provided in accordance with Medica's telemedicine policies and procedures may be eligible for coverage under **Telemedicine Health Services** in this plan.
5. Services beyond the initial evaluation to diagnose intellectual or learning disabilities.
6. 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 at a halfway house, housing with support, therapeutic group home, boarding school or ranch.
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.
8. Mental health residential treatment services that do not provide all of the following: room and board; group, family and individual counseling; client education; other services specific to mental health treatment; on-site medical/psychiatric assessment within 48

hours of admission; medical/psychiatric follow-up visits at least once per week; and 24-hour nursing coverage.

9. Room and board for outpatient services.

BEHAVIORAL HEALTH – SUBSTANCE USE DISORDER

Behavioral Health – Substance Use Disorder			
		Your cost if you visit a:	
	Benefits	**Network provider:**	**Non-network provider:**
1.	Office visits, including evaluations, diagnostic and treatment services **Please note:** Some services received during a substance use disorder office visit may be covered under another benefit in this section. The most specific and appropriate benefit will apply for each service received during a substance use disorder office visit.	Nothing after deductible	20% coinsurance after deductible
2.	Intensive outpatient programs	Nothing after deductible	20% coinsurance after deductible
3.	Medication-assisted treatment **Please note:** When the prescription drug component of this treatment is received at a pharmacy, your prescription drug benefit will be applied.	Nothing after deductible	20% coinsurance after deductible
4.	Inpatient services (including residential treatment services)		
	a. Room and board	Nothing after deductible	20% coinsurance after deductible
	b. Hospital or facility-based professional services	Nothing after deductible	20% coinsurance after deductible
	c. Attending physician services	Nothing after deductible	20% coinsurance after deductible

Behavioral Health – Substance Use Disorder		
	Your cost if you visit a:	
Benefits	Network provider:	Non-network provider:
d. Partial program	Nothing after deductible	20% coinsurance after deductible

What's covered

Outpatient substance use disorder services include:

1. Diagnostic evaluations.
2. Outpatient treatment.
3. Medication-assisted treatment (the use of medications in conjunction with counseling and behavioral therapies to help maintain sobriety, prevent relapse and reduce craving in order to sustain recovery).
4. Substance use disorder intensive outpatient programs, including day treatment and partial programs, which may include multiple services and modalities, delivered in an outpatient setting (3 or more hours per day, up to 19 hours per week).
5. Services, care or treatment for a covered person that has been placed in any applicable 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 any applicable Department of Corrections.

Inpatient substance use disorder services include:

1. Room and board.
2. Attending physician services.
3. Hospital or facility-based professional services.
4. Services, care or treatment for a covered person that has been placed in any applicable 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 any applicable Department of Corrections.
5. 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 a minimum of 4 hours per day or 20 hours per week of care and may include lodging.
6. Substance use disorder residential treatment services 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.

When you use out-of-network benefits, in addition to the deductible and coinsurance, you will likely need to pay your provider any billed amount above what the plan pays the provider (the non-network provider reimbursement amount). **These charges are not applied to your deductible or out-of-pocket maximum.** Please see **Visiting non-network providers and why you pay more** in **Before You Access Care** for more information and an example showing out-of-pocket costs associated with out-of-network benefits.

What to keep in mind

Medica offers a 24/7 behavioral health crisis line for covered persons at no additional cost. If you are experiencing a substance use disorder crisis, you may call **1-800-848-8327** to speak with a behavioral health specialist.

Medica requires prior authorization (approval in advance) before you receive certain substance use disorder services or treatment. For non-scheduled inpatient admissions (including emergency admissions), notification by the facility must be provided as soon as reasonably possible after admission. To determine if Medica requires prior authorization for a particular service or treatment, please call your plan's designated mental health and substance use disorder provider at **1-800-848-8327** or TTY users, please contact: National Relay Center **711**, then ask them to dial Medica Behavioral Health at **1-866-567-0550**. Please see **Prior authorization** in **Before You Access Care** for more information about prior authorization requirements and processes.

To be covered, services must diagnose or treat substance use disorders listed in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*.

Your plan’s designated mental health and substance use disorder provider arranges in-network substance use disorder benefits. If you require hospitalization, your plan’s designated mental health and substance use disorder provider will refer you to one of its hospital providers. **Please note:** The hospital network for medical services and mental health and substance use disorder services is not the same.

In-network benefits will apply to services, care or treatment for a covered person that has been placed in any applicable 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 any applicable Department of Corrections.

Emergency substance use disorder services do not require prior authorization and are eligible for coverage under in-network benefits.

Substance use disorder services from a non-network provider listed below will be eligible for coverage under out-of-network benefits. These services must be obtained from a health care professional or facility that is licensed, certified or otherwise qualified under state law to provide the substance use disorder services and practice independently:

- Psychiatrist

- Psychologist
- Registered nurse certified as a clinical specialist or as a nurse practitioner in psychiatric and mental health nursing
- Chemical dependency clinic
- Chemical dependency residential treatment center
- Independent clinical social worker
- Marriage and family therapist
- Hospital that provides substance use disorder services

What's not covered

1. Services for substance use disorders not listed in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*.
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 use disorder treatment services, unless such services are provided in accordance with Medica's telemedicine policies and procedures.
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 use disorder services. This includes, but is not limited to, services provided by mental health or substance use disorder providers who are not authorized under state law to practice independently, and services received at a halfway house, therapeutic group home, boarding school or ranch.
6. Substance use disorder residential treatment services that do not provide all of the following: room and board; group, family and individual counseling; client education; other services specific to substance use disorder treatment; on-site medical/psychiatric assessment within 48 hours of admission; medical/psychiatric follow-up visits at least once per week; and 24 hour nursing coverage.
7. Room and board for outpatient services.

CLINICAL TRIALS

Clinical Trials			
		Your cost if you visit a:	
	Benefits	**Network provider:**	**Non-network provider:**
1.	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.

What's covered

Routine patient costs that would be eligible for coverage under this plan, if the services were provided outside of the clinical trial, will be covered.

What to keep in mind

Approved clinical trials are as defined in **Definitions**.

When you use out-of-network benefits, in addition to the deductible and coinsurance, you will likely need to pay your provider any billed amount above what the plan pays the provider (the non-network provider reimbursement amount). **These charges are not applied to your deductible or out-of-pocket maximum.** Please see **Visiting non-network providers and why you pay more** in **Before You Access Care** for more information and an example showing out-of-pocket costs associated with out-of-network benefits.

What's not covered

The item, device or service that is considered investigative is not covered.

DURABLE MEDICAL EQUIPMENT, PROSTHETICS AND MEDICAL SUPPLIES

Durable Medical Equipment, Prosthetics and Medical Supplies		
		Your cost if you visit a:
Benefits	**Network provider:**	**Non-network provider:**
1. Durable medical equipment and certain supplies	Nothing after deductible	20% coinsurance after deductible
2. Prosthetics: a. Initial purchase of external prosthetic devices that replace a limb or an external body part, limited to: i. Artificial arms, legs, feet and hands; ii. Artificial eyes, ears and noses; iii. Breast prostheses b. Scalp hair prosthesis due to alopecia areata Limited to one prosthesis (i.e. wig) per covered person per calendar year. c. Repair, replacement or revision of prostheses made necessary by normal wear and use	Nothing after deductible	20% coinsurance after deductible

Durable Medical Equipment, Prosthetics and Medical Supplies			
		Your cost if you visit a:	
	Benefits	Network provider:	Non-network provider:
3.	Hearing aids for covered persons 18 years of age and younger for hearing loss that is not correctable by other covered procedures **Please note:** Cochlear implants are covered as a surgical service under **Physician and Professional Services**.	Nothing after deductible Coverage is limited to one hearing aid per ear every three years.	20% coinsurance after deductible Coverage is limited to one hearing aid per ear every three years.
4.	Non-investigative bone conduction hearing devices	Nothing after deductible	20% coinsurance after deductible
5.	Breast pumps	Nothing. The deductible does not apply.	20% coinsurance after deductible
6.	Medical supplies: a. Injectable pharmaceutical treatments for hemophilia and bleeding disorders b. Dietary medical treatment of phenylketonuria (PKU) c. Total parenteral nutrition d. Amino acid-based elemental formulas for these diagnoses: i. Cystic fibrosis; ii. Amino acid, organic acid and fatty acid metabolic and malabsorption disorders;	Nothing after deductible	20% coinsurance after deductible

Durable Medical Equipment, Prosthetics and Medical Supplies			
		Your cost if you visit a:	
	Benefits	Network provider:	Non-network provider:
	iii. IgE mediated allergies to food proteins; iv. Food protein induced enterocolitis syndrome; v. Eosinophilic esophagitis; vi. Eosinophilic gastroenteritis; and vii. Eosinophilic colitis Coverage for the diagnoses in iii.–vii. above is limited to covered persons five years of age and younger.		
7.	Eligible ostomy supplies	Nothing after deductible	20% coinsurance after deductible
8.	Insulin pumps and their related supplies	Nothing after deductible	20% coinsurance after deductible

What's covered

Medica covers only a limited selection of durable medical equipment, prosthetics and medical supplies. The repair, replacement or revision of durable medical equipment is covered if it is made necessary by normal wear and use. Hearing aids and certain durable medical equipment, prosthetics and medical supplies must meet specific criteria and some items ordered by your physician, even if they're medically necessary, may not be covered. Medica determines if durable medical equipment will be purchased or rented.

When you use out-of-network benefits, in addition to the deductible and coinsurance, you will likely need to pay your provider any billed amount above what the plan pays the provider (the non-network provider reimbursement amount). **These charges are not applied to your deductible or out-of-pocket maximum.** Please see **Visiting non-network providers and**

why you pay more in **Before You Access Care** for more information and an example showing out-of-pocket costs associated with out-of-network benefits.

What to keep in mind

Medica periodically reviews and modifies the list of eligible durable medical equipment and certain supplies. To request the most up-to-date list, call Customer Service at the telephone number listed at the front of this plan. Medica requires prior authorization (approval in advance) before you receive certain durable medical equipment, prosthetics and/or medical supplies.

To determine if Medica requires prior authorization for a particular piece of equipment, prosthetic or supply, please contact Medica Customer Service at the number listed at the front of this plan, by signing in to **Medica.com/SignIn** or at the number or address listed on the back of your ID card. Please see **Prior authorization** in **Before You Access Care** for more information about prior authorization requirements and processes.

Quantity limits may apply to durable medical equipment, prosthetics and medical supplies.

If the durable medical equipment, prosthetic device or hearing aid is covered by the plan, but the model you choose is not Medica's standard model, you will be responsible for the cost difference. A standard model is defined durable medical equipment that meets the minimum specifications prescribed for your needs.

Diabetic equipment and supplies, other than insulin pumps and the equipment and supplies related to insulin pumps, are covered under the **Prescription Drugs** section of this plan.

In-network benefits apply when eligible equipment, services and supplies are prescribed by a physician and received from a network provider. Hearing aids, when prescribed by a network provider, are covered as described in the table above.

To request a list of durable medical equipment providers and/or hearing aid vendors, call Customer Service at the telephone number listed at the front of this plan.

Out-of-network benefits apply when eligible equipment, services and supplies are prescribed by a physician and received from a non-network provider.

What's 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 properly functioning durable medical equipment, prosthetics and hearing aids, including, but not limited to, due to loss, damage or theft.
4. Duplicate durable medical equipment, prosthetics and hearing aids, including repair, replacement or revision of duplicate items.
5. Other disposable supplies and appliances, except as described in this section and **Prescription Drugs**.

EMERGENCY ROOM CARE

Emergency Room Care			
		Your cost if you visit a:	
	Benefits	**Network provider:**	**Non-network provider:**
1.	Services provided in a hospital or facility-based emergency room	Nothing after deductible	Covered as an in-network benefit.
2.	Other services received during an emergency room visit (for example x-rays, lab, physician)	Nothing after deductible	Covered as an in-network benefit.

What's covered

Emergency services provided in an emergency room of a hospital, whether network or non-network, from non-network providers will be covered as in-network benefits. In the event you receive such services, you will pay the in-network cost-share associated with the services provided. If you receive any other bill from an emergency room provider, please call Customer Service at the telephone number listed at the front of this plan.

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, except as described in **Your Rights and Protections Against Surprise Medical Bills** at the end of this document.

If you receive scheduled or follow-up care after an emergency, you must visit a network provider to receive in-network benefits.

GENETIC TESTING AND COUNSELING

Genetic Testing and Counseling			
		Your cost if you visit a:	
	Benefits	**Network provider:**	**Non-network provider:**
1.	Genetic testing received in an office or outpatient hospital 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.	Nothing after deductible	20% coinsurance after deductible
2.	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.	Nothing after deductible	20% coinsurance after deductible

What to keep in mind

Genetic testing is a complex and rapidly changing field. Many genetic tests require prior authorization (approval in advance) or have criteria that must be met for the test to be covered. To determine if Medica requires prior authorization for a particular genetic test, please call Medica Customer Service at the number listed at the front of this plan. Please see **Prior authorization** in **Before You Access Care** for more information about prior authorization requirements and processes.

To better understand your coverage, please call Customer Service at the number listed at the front of this plan. When you call, it's helpful to have the following information:

- The name of the test;
- The name of the lab performing the test;

- The name of the doctor ordering the test; and
- The reason you are going to have the test.

When you use out-of-network benefits, in addition to the deductible and coinsurance, you will likely need to pay your provider any billed amount above what the plan pays the provider (the non-network provider reimbursement amount). **These charges are not applied to your deductible or out-of-pocket maximum.** Please see **Visiting non-network providers and why you pay more** in **Before You Access Care** for more information and an example showing out-of-pocket costs associated with out-of-network benefits.

What's not covered

1. 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.
2. Laboratory testing (including genetic testing) that has been performed in response to direct-to-consumer marketing and not under the direction of a physician.

HOME HEALTH CARE

Home Health Care			
		Your cost if you visit a:	
	Benefits	Network provider:	Non-network provider:
1.	Home health care services including the following: a. Intermittent skilled care when you are homebound, provided by or supervised by a registered nurse b. Skilled physical, speech or occupational therapy when you are homebound Intermittent skilled care consists of visits of up to two consecutive hours of care per date of service. If you are also enrolled in the Medical Assistance Program, you may be eligible for additional skilled nursing care.	Nothing after deductible	20% coinsurance after deductible
2.	Home infusion therapy	Nothing after deductible	No coverage
3.	Services received in your home from a physician, physician's assistant or advanced practice registered nurse	Nothing after deductible	20% coinsurance after deductible

What's covered

Home health care is covered when ordered by a physician, physician's assistant or advanced practice registered nurse and received from a home health care agency that is authorized by the laws of the state in which treatment is received.

Medica will waive the requirement that you be homebound for a limited number of home visits for palliative care if you have a life-threatening, non-curable condition which has a prognosis of survival of two years or less. If you are eligible to receive palliative care in the home and you are not homebound, there is a maximum of 8 visits per calendar year. Additional palliative care visits are eligible under the home health services benefit if you are homebound and meet all other requirements as defined in this section.

When you use out-of-network benefits, in addition to the deductible and coinsurance, you will likely need to pay your provider any billed amount above what the plan pays the provider (the non-network provider reimbursement amount). **These charges are not applied to your deductible or out-of-pocket maximum.** Please see **Visiting non-network providers and why you pay more** in **Before You Access Care** for more information and an example showing out-of-pocket costs associated with out-of-network benefits.

What to keep in mind

Prior authorization (approval in advance) is required before you receive certain home health care services. Prior authorization is also required before you receive certain biologics, biosimilars and professionally administered drugs. Certain biologics, biosimilars and professionally administered drugs may be subject to step therapy requirements. In certain cases, it is possible to get an exception to step therapy requirements; please see Exceptions to Step Therapy in **Prescription Drugs or Prescription Specialty Drugs**. Please see **Prior authorization** in **Before You Access Care** for more information about prior authorization requirements and processes.

Medica considers you homebound 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.

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, a hospital or skilled nursing facility will not be considered your home.

If you are a ventilator-dependent patient with communication needs and you require home care nursing services in your home, the plan will cover up to 120 hours of interpreter services/communication training provided by a home care nurse during the time you are hospitalized in order to assure adequate training of the hospital staff to communicate with you.

What's 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 or self-help training (non-medical), including but not limited to, educational therapy, aerobic conditioning, therapeutic exercises, work hardening programs, etc., and all related material and products for these programs.
10. Health club memberships.
11. Disposable supplies and appliances, except as described in **Durable Medical Equipment, Prosthetics and Medical Supplies** and **Prescription Drugs** in this section.
12. Physical, speech or occupational therapy services when there is no reasonable expectation that the covered person'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.
15. Extended hours home care, except as described in this section for covered persons who have Medica coverage and are also enrolled in the Medical Assistance Program.
16. Home infusion therapy services received from a non-network provider.

HOSPICE SERVICES

Hospice Services		
	Your cost if you visit a:	
Benefits	Network provider:	Non-network provider:
1. Hospice services	Nothing after deductible	No coverage

What's covered

Hospice services and respite care are covered when ordered, provided or arranged under the direction of a physician and received from a hospice program.

What to keep in mind

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.

Medica contracts with hospice programs to provide hospice services to covered persons. The specific services you receive may vary depending upon which program you select.

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 covered person at home.

Respite care is limited to not more than five consecutive days.

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.

Covered persons 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.

What's not covered

1. Respite care for more than five consecutive days.
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, including room and board charges or fees.
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.

HOSPITAL SERVICES

Hospital Services		
	Your cost if you visit a:	
Benefits	Network provider:	Non-network provider:
1. Outpatient hospital or ambulatory surgical center services	Nothing after deductible	20% coinsurance after deductible
2. Services provided in a hospital observation room	Nothing after deductible	20% coinsurance after deductible
3. Inpatient services For associated physician services, see **Physician and Professional Services** in this section.	Nothing after deductible	20% coinsurance after deductible

What's covered

Hospital and ambulatory surgical center services are covered. They will be covered as in-network benefits if they are:

1. Received from a network hospital or ambulatory surgical center; or
2. Emergency services received from a network provider or a non-network provider. 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.

When you use out-of-network benefits, in addition to the deductible and coinsurance, you will likely need to pay your provider any billed amount above what the plan pays the provider (the non-network provider reimbursement amount). **These charges are not applied to your deductible or out-of-pocket maximum.** Please see **Visiting non-network providers and why you pay more** in **Before You Access Care** for more information and an example showing out-of-pocket costs associated with out-of-network benefits.

What to keep in mind

Prior authorization (approval in advance) is required before you receive certain biologics, biosimilars and professionally administered drugs. Certain biologics, biosimilars and professionally administered drugs may be subject to step therapy requirements. In certain cases, it is possible to get an exception to step therapy requirements; please see Exceptions to Step Therapy in **Prescription Drugs or Prescription Specialty Drugs**. To obtain more

information about the step therapy exception process, call Customer Service at the number on the back of your Medica ID card. Please see **Prior authorization** in **Before You Access Care** for more information about prior authorization requirements and processes.

A physician must direct your care.

If you remain in the hospital overnight, you may be admitted as an inpatient or kept for observation. You can check with your physician to ask which applies to you. The most appropriate benefit will apply, which will impact how much you pay.

For most hospital visits, other charges also will apply. These might include charges for physician services, anesthesia and others.

What's not covered

1. Drugs received at a hospital on an outpatient basis, except drugs that meet the definition of "professionally administered drugs" or drugs received in an emergency room or a hospital observation room. Coverage for drugs is as described in **Prescription Drugs**, **Prescription Specialty Drugs** or otherwise described as a specific benefit elsewhere in this section.
2. Transfers and admissions to network hospitals solely at the convenience of the covered person.
3. Admission to another hospital is not covered when care for your condition is available at the network hospital where you were first admitted.

INFERTILITY DIAGNOSIS

Infertility Diagnosis			
		Your cost if you visit a:	
	Benefits	**Network provider:**	**Non-network provider:**
1.	Office visits, including any services provided during such visits	Nothing after deductible	20% coinsurance after deductible
2.	Outpatient services received at a hospital	Nothing after deductible	20% coinsurance after deductible

What's covered

The diagnosis of infertility is covered. Coverage includes benefits for professional, hospital and ambulatory surgical center services. Services for the diagnosis of infertility must be received from or under the direction of a physician. All services, supplies and associated expenses for the treatment of infertility are not covered.

When you use out-of-network benefits, in addition to the deductible and coinsurance, you will likely need to pay your provider any billed amount above what the plan pays the provider (the non-network provider reimbursement amount). **These charges are not applied to your deductible or out-of-pocket maximum.** Please see **Visiting non-network providers and why you pay more** in **Before You Access Care** for more information and an example showing out-of-pocket costs associated with out-of-network benefits.

What's not covered

1. Physician, hospital and ambulatory surgical center services for the treatment of infertility.
2. Infertility drugs.
3. Assisted reproductive technology services, including but not limited to: in vitro fertilization (IVF); gamete intrafallopian transfer (GIFT); zygote intrafallopian transfer (ZIFT); tubal embryo transfer; intracytoplasmic sperm injection (ICSI); ova or embryo acquisition, retrieval, donation, preservation, and/or storage; and/or any conception that occurs outside the woman's body.
4. Services for intrauterine insemination (IUI).
5. Services for a condition that a physician determines cannot be successfully treated.
6. Services related to surrogate pregnancy for a person not covered as a covered person under the plan.
7. Sperm banking and/or storage.

8. Donor sperm.
9. Donor eggs.
10. Services related to adoption.

LAB AND PATHOLOGY

Lab and Pathology			
		Your cost if you visit a:	
	Benefits	**Network provider:**	**Non-network provider:**
1.	Lab and pathology services received during an office visit	Nothing after deductible	20% coinsurance after deductible
2.	Lab and pathology services received during an outpatient hospital or ambulatory surgical center visit	Nothing after deductible	20% coinsurance after deductible
3.	Lab and pathology services received in an inpatient setting	Nothing after deductible	20% coinsurance after deductible

What's covered

Lab and pathology services ordered or prescribed by a physician will be covered as in-network benefits if they are received from a network provider.

What to keep in mind

When you use out-of-network benefits, in addition to the deductible and coinsurance, you will likely need to pay your provider any billed amount above what the plan pays the provider (the non-network provider reimbursement amount). **These charges are not applied to your deductible or out-of-pocket maximum.** Please see **Visiting non-network providers and why you pay more** in **Before You Access Care** for more information and an example showing out-of-pocket costs associated with out-of-network benefits.

MEDICAL-RELATED DENTAL SERVICES

Medical-Related Dental Services		
	Your cost if you visit a:	
Benefits	**Network provider:**	**Non-network provider:**
1. Charges for medical facilities and general anesthesia services that are recommended by a physician and received during a dental procedure for a covered person who: a. Is a child under age five; or b. Is severely disabled; or c. Has a condition that requires hospitalization or general anesthesia for dental care treatment.	Nothing after deductible	20% coinsurance after deductible
2. For a dependent child, orthodontia, dental implants and oral surgery treatment related to cleft lip and palate	Nothing after deductible	20% coinsurance after deductible

Medical-Related Dental Services		
	Your cost if you visit a:	
Benefits	Network provider:	Non-network provider:
3. Accident-related dental services to treat an injury to and to repair (not replace) sound, natural teeth. The following conditions apply: a. Coverage is limited to services received within 12 months from the later of: i. The date you are first covered under the plan; or ii. The date of the injury **Please note:** Treatment must be completed within 24 months of services being initiated. 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.	Nothing after deductible	20% coinsurance after deductible

What's covered

Medically necessary outpatient dental services are covered as described above. Services must be received from a physician or dentist.

When you use out-of-network benefits, in addition to the deductible and coinsurance, you will likely need to pay your provider any billed amount above what the plan pays the provider (the non-network provider reimbursement amount). **These charges are not applied to your**

deductible or out-of-pocket maximum. Please see **Visiting non-network providers and why you pay more** in **Before You Access Care** for more information and an example showing out-of-pocket costs associated with out-of-network benefits.

What to keep in mind

Comprehensive dental procedures are not considered medical-related dental services and aren't covered under this plan.

What's not covered

1. Dental services to treat an injury from biting or chewing.
2. Diagnostic casts, diagnostic study models and bite adjustments, unless related to the treatment of temporomandibular joint (TMJ) disorder and craniomandibular disorder or cleft lip and palate.
3. Osteotomies and other procedures associated with the fitting of dentures or dental implants.
4. Dental implants (tooth replacement), except as described in this section for the treatment of cleft lip and palate.
5. 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.
6. Any orthodontia, except as described in this section for the treatment of cleft lip and palate and in **Temporomandibular Joint (TMJ) and Craniomandibular Disorder** for the treatment of temporomandibular joint (TMJ) disorder.
7. Tooth extractions, except as described in this section.
8. Any dental procedures or treatment related to periodontal disease.
9. Endodontic procedures and treatment, including root canal procedures and treatment, unless provided as accident-related dental services as described in this section.
10. Routine diagnostic and preventive dental services.
11. Oral surgery, except as specifically described in this section.

PHYSICAL, SPEECH AND OCCUPATIONAL THERAPIES

Physical, Speech and Occupational Therapies		
	Your cost if you visit a:	
Benefits	**Network provider:**	**Non-network provider:**
1. Physical therapy services received outside of your home		
a. Habilitative services	Nothing after deductible	20% coinsurance after deductible
b. Rehabilitative services	Nothing after deductible	20% coinsurance after deductible
2. Speech therapy services received outside of your home		
a. Habilitative services	Nothing after deductible	20% coinsurance after deductible
b. Rehabilitative services	Nothing after deductible	20% coinsurance after deductible
3. Occupational therapy services received outside of your home		
a. Habilitative services	Nothing after deductible	20% coinsurance after deductible
b. Rehabilitative services	Nothing after deductible	20% coinsurance after deductible

What's covered

Physical therapy, speech therapy and occupational therapy services arranged through a physician and provided on an outpatient basis are covered.

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

When you use out-of-network benefits, in addition to the deductible and coinsurance, you will likely need to pay your provider any billed amount above what the plan pays the provider (the non-network provider reimbursement amount). **These charges are not applied to your deductible or out-of-pocket maximum.** Please see **Visiting non-network providers and**

why you pay more in **Before You Access Care** for more information and an example showing out-of-pocket costs associated with out-of-network benefits.

What to keep in mind

A physician must direct your care in order for it to be eligible for coverage.

Coverage for services provided on an inpatient basis is described under **Hospital Services** in this section.

What's not covered

1. Services primarily educational in nature.
2. Vocational and job rehabilitation.
3. Recreational therapy.
4. Self-care or self-help training (non-medical), including but not limited to, educational therapy, aerobic conditioning, therapeutic exercises, work hardening programs, etc., and all related material and products for these programs.
5. Health club memberships.
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 your 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.

PHYSICIAN AND PROFESSIONAL SERVICES

Physician and Professional Services		
	Your cost if you visit a:	
Benefits	**Network provider:**	**Non-network provider:**
1. Office visits **Please note:** Some services received during an office visit may be covered under another benefit in this section. The most specific and appropriate benefit will apply for each service received during an office visit. For example, certain services may be considered surgical or imaging services; see below and in **X-Rays and Other Imaging** for coverage of these services. In such instances, both an office visit copayment or coinsurance and an outpatient surgical or imaging copayment or coinsurance apply.	Nothing after deductible	20% coinsurance after deductible

Physician and Professional Services			
		Your cost if you visit a:	
	Benefits	Network provider:	Non-network provider:
2.	Urgent care center visits **Please note:** Some services received during an urgent care center visit may be covered under another benefit in this section. The most specific and appropriate benefit will apply for each service received during an urgent care center visit. For example, certain services may be considered surgical or imaging services; see below and in **X-Rays and Other Imaging** for coverage of these services. In such instances, both an urgent care center visit copayment or coinsurance and outpatient surgical copayment or coinsurance apply.	Nothing after deductible	20% coinsurance after deductible
3.	Convenience care		
	a. Retail health clinic	Nothing after deductible	20% coinsurance after deductible
	b. Virtual care	Nothing after deductible	20% coinsurance after deductible
4.	Chiropractic services to diagnose and to treat (by manual manipulation or certain therapies) conditions related to the muscles, skeleton and nerves of the body	Nothing after deductible	20% coinsurance after deductible

Physician and Professional Services		
	Your cost if you visit a:	
Benefits	Network provider:	Non-network provider:
5. Surgical services (as defined in the Physicians' Current Procedural Terminology code book):		
a. Received from a physician during an office visit	Nothing after deductible	20% coinsurance after deductible
b. Received from a physician during an urgent care visit or an outpatient hospital or ambulatory surgical center visit	Nothing after deductible	20% coinsurance after deductible
c. Received from a physician in an inpatient setting	Nothing after deductible	20% coinsurance after deductible
6. Non-surgical services received from a physician in an inpatient setting	Nothing after deductible	20% coinsurance after deductible
7. Non-surgical outpatient hospital or ambulatory surgical center services received from or directed by a physician	Nothing after deductible	20% coinsurance after deductible
8. Routine eye exams	Nothing. The deductible does not apply.	20% coinsurance after deductible
9. Allergy shots	Nothing after deductible	20% coinsurance after deductible

Physician and Professional Services			
		Your cost if you visit a:	
	Benefits	Network provider:	Non-network provider:
10.	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)	Nothing after deductible	20% coinsurance after deductible
11.	Acupuncture Limited to 20 visits per calendar year for in-network and out-of-network benefits combined.	Nothing after deductible	20% coinsurance after deductible
12.	Neuropsychological evaluations/cognitive testing, limited to services necessary for the diagnosis or treatment of a medical illness or injury	Nothing after deductible	20% coinsurance after deductible
13.	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.	Nothing after deductible	20% coinsurance after deductible

Physician and Professional Services			
		Your cost if you visit a:	
	Benefits	Network provider:	Non-network provider:
14.	Treatment to lighten or remove the coloration of a port wine stain	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.
15.	Medically necessary treatment recommended by your licensed health care professional for diagnosed pediatric acute-onset neuropsychiatric syndrome (PANS) and pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS), including but not limited to antibiotics, medication and behavioral therapies to manage neuropsychiatric symptoms, plasma exchange and immunoglobulin	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.

What's covered

In-network benefits apply to:

1. Professional services received from a network provider;
2. Emergency services received from network or non-network providers.

3. When required under Federal law, as described in **Your Rights and Protections Against Surprise Medical Bills** at the end of this document, or applicable Minnesota law, certain out-of-network professional and physician services.

When you use out-of-network benefits, in addition to the deductible and coinsurance, you will likely need to pay your provider any billed amount above what the plan pays the provider (the non-network provider reimbursement amount). **These charges are not applied to your deductible or out-of-pocket maximum.** Please see **Visiting non-network providers and why you pay more** in **Before You Access Care** for more information and an example showing out-of-pocket costs associated with out-of-network benefits.

What to keep in mind

Prior authorization (approval in advance) is required before you receive certain outpatient surgical services and certain biologics, biosimilars and professionally administered drugs. Certain biologics, biosimilars and professionally administered drugs may be subject to step therapy requirements. In certain cases, it is possible to get an exception to step therapy requirements; please see Exceptions to Step Therapy in **Prescription Drugs or Prescription Specialty Drugs**.

To determine if Medica requires prior authorization for a particular service or treatment, please call Medica Customer Service at the number listed at the front of this plan. Please see **Prior authorization** in **Before You Access Care** for more information about prior authorization requirements and processes.

Services described in this section must be received from or directed by a physician.

For some services, there may be a facility charge in addition to the physician services copayment or coinsurance.

What's not covered

1. Drugs provided or administered by a physician or other provider, except drugs that meet the definition of "professionally administered drugs." Coverage for drugs is as described in **Prescription Drugs**, **Prescription Specialty Drugs** or otherwise described as a specific benefit elsewhere in this section.

PREGNANCY – MATERNITY CARE

Pregnancy – Maternity Care			
		Your cost if you visit a:	
	Benefits	**Network provider:**	**Non-network provider:**
1.	Prenatal care services that are considered preventive health services	Nothing. The deductible does not apply.	0% coinsurance. The deductible does not apply.
2.	Prenatal care services that are not considered preventive health services	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.
3.	Inpatient stay for labor and delivery services – for the mother **Please note:** Maternity labor and delivery services are considered inpatient services regardless of the length of the hospital stay.	Nothing after deductible	20% coinsurance after deductible
4.	Physician services received during an inpatient stay for labor and delivery – for the mother	Nothing after deductible	20% coinsurance after deductible

Pregnancy – Maternity Care			
		Your cost if you visit a:	
	Benefits	Network provider:	Non-network provider:
5.	Inpatient stay – for your newborn **Please note:** This coverage is separate from the coverage in items 3. and 4. above and applies to newborn dependents.	Nothing after deductible	20% coinsurance after deductible
6.	Physician services received during an inpatient stay – for your newborn **Please note:** This coverage is separate from the coverage in items 3. and 4. above and applies to newborn dependents.	Nothing after deductible	20% coinsurance after deductible
7.	Labor and delivery services at a free-standing birth center		
	a. Facility services for labor and delivery – for the mother **Please note:** Maternity labor and delivery services are considered inpatient services regardless of the length of the hospital stay.	Nothing after deductible	20% coinsurance after deductible
	b. Physician services received for labor and delivery – for the mother	Nothing after deductible	20% coinsurance after deductible
	c. Physician services – for your newborn **Please note:** This coverage is separate from the coverage in item 7.b. above and applies to newborn dependents.	Nothing after deductible	20% coinsurance after deductible

Pregnancy – Maternity Care			
		Your cost if you visit a:	
	Benefits	Network provider:	Non-network provider:
8.	Postnatal services	Nothing after deductible	20% coinsurance after deductible
9.	Home health care visit following delivery	Nothing after deductible	20% coinsurance after deductible

What's covered

Pregnancy services are covered and include medical services for prenatal care, labor and delivery, postnatal care and any related complications. These services will be covered as in-network benefits if they are:

1. Received from a network provider; or
2. Emergency services received from a network or non-network provider. 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.

When you use out-of-network benefits, in addition to the deductible and coinsurance, you will likely need to pay your provider any billed amount above what the plan pays the provider (the non-network provider reimbursement amount). **These charges are not applied to your deductible or out-of-pocket maximum.** Please see **Visiting non-network providers and why you pay more** in **Before You Access Care** for more information and an example showing out-of-pocket costs associated with out-of-network benefits.

What to keep in mind

Enrolling your baby

Newborn infants are eligible for benefits from the moment of birth, including coverage for illness, injury, congenital malformation or premature birth, including birth defects, as specifically described in this plan document. Medica does not automatically know of a birth or whether you would like coverage for your baby. To enroll your newborn as a dependent, see **Who's Eligible for Coverage and How Do They Enroll**.

Please note: We encourage you to enroll your newborn in your plan within 30 days of the date of birth, date of placement for adoption or date of adoption. For more information, see **Who's Eligible for Coverage and How Do They Enroll**.

Prenatal care

Covered prenatal services include:

1. Office visits for prenatal care, including professional services, lab, pathology, x-rays and imaging;

2. Hospital and ambulatory surgery center services for prenatal care, including professional services received during an inpatient stay for prenatal care;
3. Intermittent skilled care or home infusion therapy due to a high-risk pregnancy; and
4. Supplies for gestational diabetes.

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

1. Conditions that existed before (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 during the pregnancy but are not directly related to care of the pregnancy, such as back and neck pain or a 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 plan. Please refer to those sections for coverage information. The **Where to Find It** section can help direct you to the right place.

Labor and delivery

Labor and delivery services are considered inpatient services regardless of the length of hospital stay.

Each covered person's hospital admission is separate from the admission of any other covered person. That means a separate deductible and copayment or coinsurance will be applied to both you and your newborn for inpatient services related to labor and delivery.

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 covered person 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 covered person'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 stay of 48 hours or less (or 96 hours, as applicable).

Postnatal care

Postnatal care includes routine follow-up care from your provider after delivery. Services eligible for coverage include, but are not limited to, parent education, assistance and training in breast and bottle feeding and conducting any necessary and appropriate clinical tests.

Your plan covers one home health care visit if it occurs within 4 days of discharge. For services received after 4 days, please see **Home Health Care** in this section.

For more information about pregnancy care, see the tip sheet at **Medica.com/SignIn**.

What's not covered

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

PRESCRIPTION DRUGS

Prescription Drugs **Your Medica Drug Program: Medica Comprehensive** **A prescription unit is:** **Pharmacy:** 31-consecutive day supply, or in the case of contraceptives, up to a one-cycle supply **Mail order pharmacy:** 93-consecutive day supply, or in the case of contraceptives, up to a three-cycle supply		
Your cost if you visit a:		
Medica Comprehensive Network pharmacy:	**Non-network pharmacy:**	**Medica Comprehensive Network Mail order pharmacy:**
1. Prescription drugs received at a retail pharmacy, other than those described below or in **Prescription Specialty Drugs**		
Generic: Nothing after deductible per prescription unit; or **Preferred brand:** Nothing after deductible per prescription unit; or **Non-preferred brand:** Nothing after deductible per prescription unit	**Generic:** Nothing after deductible per prescription unit; or **Preferred brand:** Nothing after deductible per prescription unit; or **Non-preferred brand:** Nothing after deductible per prescription unit	**Generic:** Nothing after deductible per prescription unit; or **Preferred brand:** Nothing after deductible per prescription unit; or **Non-preferred brand:** Nothing after deductible per prescription unit
2. Diabetic equipment and supplies, including blood glucose meters		
Generic: Nothing after deductible per prescription unit; or **Preferred brand:** Nothing after deductible per prescription unit; or **Non-preferred brand:** Nothing after deductible per prescription unit	**Generic:** Nothing after deductible per prescription unit; or **Preferred brand:** Nothing after deductible per prescription unit; or **Non-preferred brand:** Nothing after deductible per prescription unit	**Generic:** Nothing after deductible per prescription unit; or **Preferred brand:** Nothing after deductible per prescription unit; or **Non-preferred brand:** Nothing after deductible per prescription unit

Prescription Drugs **Your Medica Drug Program: Medica Comprehensive** **A prescription unit is:** **Pharmacy:** 31-consecutive day supply, or in the case of contraceptives, up to a one-cycle supply **Mail order pharmacy:** 93-consecutive day supply, or in the case of contraceptives, up to a three-cycle supply		
Your cost if you visit a:		
Medica Comprehensive Network pharmacy:	**Non-network pharmacy:**	**Medica Comprehensive Network Mail order pharmacy:**
3. FDA-approved drugs (including certain women's contraceptives), tobacco cessation products and other supplies and services that are considered preventive health services		
Generic: Nothing per prescription unit; or **Preferred brand:** Nothing per prescription unit; or **Non-preferred brand:** Nothing per prescription unit The deductible does not apply.	**Generic:** Nothing per prescription unit; or **Preferred brand:** Nothing per prescription unit; or **Non-preferred brand:** Nothing per prescription unit The deductible does not apply.	**Generic:** Nothing per prescription unit; or **Preferred brand:** Nothing per prescription unit; or **Non-preferred brand:** Nothing per prescription unit The deductible does not apply. **Please note:** Tobacco cessation products are not available through a mail order pharmacy.
4. Prescription insulin drugs		
$0 per prescription unit The deductible does not apply.	Covered as an out-of-network benefit under 1. in this table.	$0 per prescription unit The deductible does not apply.

Your cost if you visit a:	
Medica Comprehensive Network pharmacy:	**Non-network pharmacy:**
5. Orally-administered cancer treatment medications	
Generic: Nothing after deductible per prescription unit; or **Preferred brand:** Nothing after deductible per prescription unit; or **Non-preferred brand:** Nothing after deductible per prescription unit	**Generic:** Covered as an out-of-network generic benefit under 1. in this table; or **Preferred brand:** Covered as an out-of-network preferred brand benefit under 1. in this table; or **Non-preferred brand:** Covered as an out-of-network non-preferred brand benefit under 1. in this table.

What's covered

Prescription drugs and certain over-the-counter (OTC) drugs and supplies are covered if they are:

- Prescribed by an authorized provider;
- Included on Medica's Drug List (unless identified as not covered); and
- Received from a pharmacy or a designated mail order pharmacy.

Coverage for specialty prescription drugs (drugs used to treat complex conditions and which may require special handling) is described in the next section, **Prescription Specialty Drugs**.

What is Medica's Drug List

Medica's Drug List (Drug List) is comprised of drugs that meet the medical needs of our covered persons and have proven safety and effectiveness. It includes both brand-name and generic drugs. The drugs on this list have been approved by the Food and Drug Administration (FDA). The Drug List identifies whether a drug is classified by Medica as a generic, preferred brand or non-preferred brand drug.

A team of physicians and pharmacists meets regularly to review and update the Drug List. Your doctor can use this list to select medications for your health care needs, while helping you maximize your prescription drug benefit.

You will be notified in advance if there are any changes to the Drug List that affect medications you are receiving.

The terms "generic" and "brand name" are used in the health care industry in different ways. To better understand your coverage, please review the following:

Generic: A drug: (1) that contains the same active ingredient as a brand name drug and is chemically equivalent to a brand name drug in strength, concentration, dosage form and route of administration; or (2) that Medica identifies as a generic product. Medica uses industry

standard resources to determine a drug's classification as either brand name or generic. Not all products identified as "generic" by the manufacturer, pharmacy or your provider may be classified by Medica as generic.

Generic drugs are your lowest copayment or coinsurance option. For your lowest share of the cost, consider a generic covered drug if you and your provider decide it is appropriate for your treatment.

Preferred brand: A drug: (1) that is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that Medica identifies as a brand name product. Medica uses industry standard resources to determine a drug's classification as either brand name or generic. Not all products identified as "brand name" by the manufacturer, pharmacy or your provider may be classified by Medica as brand name.

Preferred brand drugs have a higher copayment or coinsurance. You may consider a preferred brand covered drug to treat your condition if you and your provider decide it is appropriate.

Non-preferred brand drugs, if covered, may have the highest copayment or coinsurance. The covered non-preferred brand drugs are usually more costly.

If you have questions about Medica's Drug List or whether a specific drug is covered (and/or whether the drug is generic, preferred brand or non-preferred brand), or if you would like to request a copy of the Drug List at no charge, call Customer Service at the telephone number listed at the front of this plan. It is also available on **Medica.com/SignIn**.

What to keep in mind

What is a prescription unit

A prescription unit is the amount that will be dispensed unless it is limited by the drug manufacturer's packaging, dosing instructions or Medica's medication request guidelines. This includes quantity limits that are indicated on the Drug List. Copayment or coinsurance amounts will apply to each prescription unit dispensed.

One prescription unit from a pharmacy is a 31-consecutive-day supply (or, in the case of contraceptives, up to a one-cycle supply).

One prescription unit from a designated mail order pharmacy is a 93-consecutive-day supply (or, in the case of contraceptives, up to a three-cycle supply).

Three prescription units from a pharmacy may be dispensed for covered drugs prescribed to treat chronic conditions. Medica has specifically designated some network pharmacies to dispense multiple prescription units. For the list of these designated pharmacies, visit **Medica.com/SignIn** or call Customer Service.

For some prescriptions there are special requirements that must be met in order to receive coverage. These include:

- Prior authorization (PA)
  Certain drugs require prior authorization (approval in advance) from Medica in order to be covered. These medications are shown on the Drug List with the abbreviation "PA." The

Drug List is available to providers, including pharmacies and the designated mail order pharmacies. Please see **Prior authorization** in **Before You Access Care** for more information about prior authorization requirements and processes. Your network provider who prescribes the drug should initiate the prior authorization process. You must contact Customer Service to request prior authorization for drugs prescribed by a non-network provider. You will pay the entire cost of the drug received if you do not meet Medica's authorization criteria.

- Step therapy (ST)
  Step therapy is a process that involves trying an alternative covered drug first (typically a generic drug) before moving to a preferred brand or non-preferred brand covered drug for treatment of the same medical condition. The medications subject to step therapy are shown on the Drug List with the abbreviation "ST." You must meet applicable step therapy requirements before Medica will cover these preferred brand or non-preferred brand drugs.
- Quantity limits (QL)
  Certain covered drugs have limits on the maximum quantity allowed per prescription over a specific period of time. The medications subject to quantity limits are shown on the Drug List with the abbreviation "QL." Some quantity limits are based on the manufacturer's packaging, FDA labeling or clinical guidelines.

Exceptions to the Drug List

In certain cases, it is possible to get an exception to the coverage rules described under What is Medica's 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 coverage by only one benefit level. However, no covered person cost-sharing will apply for exceptions applicable to preventive health services.

Exceptions 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 Drug List or you change health plans. Antipsychotic drug(s) prescribed to treat emotional disturbance or mental illness will be covered for up to one year if the prescribing provider:

- Certifies to Medica in writing that he/she has considered all equivalent drugs on the Drug List and has determined that the drug prescribed will best treat your condition (unless the drug was removed from Medica's Drug List for safety reasons); or
- Indicates to Medica that drugs on the Drug List cause you to have an adverse reaction, are contraindicated for you or the prescription drug must be dispensed as written to provide maximum medical benefit to you, unless the requested drug was removed from the Drug List for safety reasons.

At the expiration of an antipsychotic medication exception, you may request a renewal of the exception.

If you have a condition that may seriously jeopardize your life, health or ability to regain maximum function or if you are undergoing a current course of treatment with a drug not

included on the Drug List, an expedited review may be requested. Medica will make a determination and provide notification on an expedited review request within 24 hours of receiving the request.

If you would like to request a copy of Medica's Drug List exception process or for more information regarding the expedited review process, call Customer Service at the telephone number listed at the front of this plan.

Exceptions to Step Therapy

In certain cases it is possible to get an exception to step therapy requirements. To obtain more information about the step therapy exception process, please go to **Medica.com/SignIn** or call Customer Service at the telephone number listed at the front of this plan.

Medica will respond to a request for an exception to step therapy requirements within five days of receipt of a complete request. If you have a condition that may seriously jeopardize your life, health or ability to regain maximum function, Medica will respond within 72 hours of receipt of a complete request.

If we do not approve your request for an exception to step therapy requirements, you have the right to appeal Medica's decision. Medica will respond to a request for such an appeal within five days of receipt of a complete request. If you have a condition that may seriously jeopardize your life, health or ability to regain maximum function, Medica will respond within 72 hours of receipt of a complete request. See **How Do I File a Complaint** for more information on your appeal rights.

If Medica's decision on appeal upholds the initial denial of your request for an exception to step therapy requirements, you have a right to request an external review as described in **How Do I File a Complaint.**

Mail order pharmacy

Mail order pharmacy benefits apply when covered drugs are received from a designated mail order pharmacy.

To learn more about how to use mail order pharmacy, sign in to **Medica.com/SignIn**.

Generic requirement

Certain covered preferred brand and non-preferred brand drugs include a chemically equivalent generic drug on the Drug List. If you still choose to use a preferred brand or non-preferred brand prescription drug, the plan will pay the amount that it would have paid had you received the generic drug. You will pay, in addition to the applicable deductible, copayment or coinsurance described in the table, any remaining charges due to the pharmacy in excess of the plan's payment to the pharmacy. **These charges are not applied to your deductible or out-of-pocket maximum.**

If your health care provider requests that a preferred brand or non-preferred brand drug be dispensed as written and there is a chemically equivalent generic drug on the Drug List, the drug will be covered at the non-preferred brand benefit level.

Please note that receiving preferred brand or non-preferred brand drugs when an equivalent generic drug is on the Drug List may result in significantly more out-of-pocket costs.

Investigative

Drugs prescribed for investigative uses are not covered. 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.

Additional considerations

The table above describes your copayment or coinsurance for the prescription drug. An additional copayment or coinsurance will apply for a provider's services if you require that they administer a self-administered drug. For these purposes, "self-administered drugs" are drugs that do not meet the definition of "professionally administered drugs."

Coverage for tobacco cessation includes all FDA-approved tobacco cessation products that are considered preventive health services. This coverage includes up to a 180-day supply of tobacco cessation medication within a 365-day period.

The list of covered Preventive Drugs and Other Services is specific and limited. For a current list sign in to **Medica.com/SignIn** and refer to the Preventive Drug and Supply category on the Drug List or call Customer Service.

While diabetic equipment and supplies, including blood glucose meters, are covered under the diabetic equipment and supplies benefit in this section, coverage for insulin pumps and related supplies is described under **Durable Medical Equipment, Prosthetics and Medical Supplies**.

This section includes coverage for medications used in the treatment of autism spectrum disorders.

What's not covered

1. Drugs and supplies that are not on Medica's Drug List, unless covered through the exception process described in Exceptions to the Drug List in this section, including the exception for antipsychotic drugs.
2. Any amount above what the plan would have paid when you fail to identify yourself as a covered person to the pharmacy. (Medica will notify you before enforcement of this provision.)
3. Drugs that have not been approved by the Food and Drug Administration (FDA).
4. Certain non-preferred brand drugs, as described in the table above.
5. Over-the-counter (OTC) drugs not listed on Medica's Drug List.
6. Replacement of a drug due to loss, damage or theft.
7. Appetite suppressants and other drugs used to assist with weight loss or manage obesity, regardless of the mechanism of action.
8. Sexual dysfunction medications.
9. Tobacco cessation products or services dispensed through a mail order pharmacy.
10. Drugs prescribed by a provider who is not acting within his/her scope of licensure.
11. Homeopathic medicine.
12. Infertility drugs.
13. Specialty prescription drugs, except as described in **Prescription Specialty Drugs**.
14. Bulk powders, chemicals and products used in prescription drug compounding.
15. Products that are duplicative to, or are in the same class and category as products on Medica's Drug List, unless covered through the exception process described under Exceptions to the Drug List in this section.
16. New-to-market drugs: Products recently approved by the FDA and introduced into the market will not be covered until they are reviewed and considered for placement on the Drug List.

PRESCRIPTION SPECIALTY DRUGS

Prescription Specialty Drugs Your Medica Specialty Drug Program: Medica Comprehensive		
	Benefits	**You pay:**
1.	Specialty prescription drugs received from a designated specialty pharmacy	**Preferred specialty prescription drugs:** Nothing after deductible per prescription unit; or **Non-preferred specialty prescription drugs:** Nothing after deductible per prescription unit
2.	Specialty growth hormone when prescribed by a physician for the treatment of a demonstrated growth hormone deficiency and received from a designated specialty pharmacy	**Preferred specialty prescription drugs:** Nothing after deductible per prescription unit; or **Non-preferred specialty prescription drugs:** Nothing after deductible per prescription unit
3.	Orally-administered cancer treatment medications received from a designated specialty pharmacy	**Preferred specialty prescription drugs:** Nothing after deductible per prescription unit; or **Non-preferred specialty prescription drugs:** Nothing after deductible per prescription unit

What's covered

Specialty medications are high-technology, high cost, oral or injectable drugs used for the treatment of certain diseases that require complex therapies. Many specialty medications require special handling and in most cases are prescribed by a specialist.

Specialty prescription drugs are covered if they are:

- Prescribed by an authorized provider;
- Included on Medica's Drug List (unless identified as not covered); and
- Received from a designated specialty pharmacy.

What is Medica's Specialty Drug Program

Medica's Drug List is comprised of drugs that meet the medical needs of our covered persons and have been selected based on their safety, effectiveness, uniqueness and cost. They have been approved by the Food and Drug Administration (FDA). A team of physicians and pharmacists meets regularly to review and update the Drug List. Specialty medications are shown on the Drug List with the abbreviation "SP".

Your doctor can use this list to select medications for your health care needs, while helping you maximize your prescription drug benefit. You will be notified in advance if there are any changes to the Drug List that affect medications you are receiving.

Preferred specialty prescription drugs are your lowest copayment or coinsurance option. For your lowest share of the cost, consider a preferred specialty prescription drug if you and your physician decide it is appropriate for your treatment.

Non-preferred specialty prescription drugs, if covered, may have a higher copayment or coinsurance than preferred specialty prescription drugs. Consider a non-preferred specialty prescription drug if you and your physician decide it is appropriate for your treatment.

If you have questions about Medica's Specialty Drug Program or whether a specific specialty prescription drug is covered (and/or the benefit level at which the drug may be covered), or if you would like to request a copy of the Drug List at no charge, call Customer Service at the telephone number listed at the front of this plan. It is also available on **Medica.com/SignIn**.

What to keep in mind

These benefits apply when covered specialty prescription drugs are received from a designated specialty pharmacy. A current list of designated specialty pharmacies is available on **Medica.com/SignIn**. You can also call Customer Service at the telephone number listed at the front of this plan. Note that certain specialty pharmacies may be in other Medica networks but not in your network.

The table above describes your copayment or coinsurance for the specialty prescription drug. An additional copayment or coinsurance will apply for a provider's services if you require that they administer a self-administered drug. For these purposes, "self-administered drugs" are drugs that do not meet the definition of "professionally administered drugs."

What is a prescription unit

A prescription unit is the amount that will be dispensed unless it is limited by the drug manufacturer's packaging, dosing instructions or Medica's medication request guidelines. This includes quantity limits that are indicated on the Drug List. Copayment or coinsurance amounts will apply to each prescription unit dispensed.

One prescription unit from a designated specialty pharmacy is a 31-consecutive-day supply.

For some prescriptions there are special requirements that must be met in order to receive coverage. These include:

- Prior authorization (PA)
  Certain specialty prescription drugs require prior authorization (approval in advance) from Medica in order to be covered. These medications are shown on the Drug List with the abbreviation "PA." The Drug List is available to providers, including designated specialty pharmacies. Please see **Prior authorization** in **Before You Access Care** for more information about prior authorization requirements and processes. Your network provider who prescribes the drug should initiate the prior authorization process. You must contact Customer Service to request prior authorization for specialty drugs prescribed by a non-

network provider. You will pay the entire cost of the drug received if you do not meet Medica's authorization criteria.

- Step therapy (ST)
  Step therapy is a process that involves trying an alternative covered specialty prescription drug (typically a preferred drug) before moving to certain other preferred or non-preferred drugs. The medications subject to step therapy are shown on the Drug List with the abbreviation "ST." You must meet applicable step therapy requirements before Medica will cover these preferred or non-preferred drugs.
- Quantity limits (QL)
  Certain covered specialty prescription drugs have limits on the maximum quantity allowed per prescription over a specific period of time. These specialty medications are shown on the Drug List with the abbreviation "QL." Some quantity limits are based on the manufacturer's packaging, FDA labeling or clinical guidelines.

Exceptions to the Specialty Drug Program

In certain cases, it is possible to get an exception to the coverage rules described under What is Medica's Specialty Drug Program above. **Please note that exceptions will only be allowed when specific clinical criteria are satisfied.** Any exception that Medica grants will improve the coverage by only one benefit level.

Exceptions 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 Drug List or you change health plans. Antipsychotic drug(s) prescribed to treat emotional disturbance or mental illness will be covered for up to one year if the prescribing provider:

- Certifies to Medica in writing that he/she has considered all equivalent drugs on the Drug List and has determined that the drug prescribed will best treat your condition (unless the drug was removed from the Drug List for safety reasons); or
- Indicates to Medica that drugs on the Drug List cause you to have an adverse reaction, are contraindicated for you or the prescription drug must be dispensed as written to provide maximum medical benefit to you, unless the requested drug was removed from the Drug List for safety reasons.

At the expiration of an antipsychotic medication exception, you may request a renewal of the exception.

If you have a condition that may seriously jeopardize your life, health or ability to regain maximum function or if you are undergoing a current course of treatment with a drug not included on the Drug List, an expedited review may be requested. Medica will make a determination and provide notification on an expedited review request within 24 hours of receiving the request.

If you would like to request a copy of Medica's Drug List exception process or for more information regarding the expedited review process, call Customer Service at the telephone number listed at the front of this plan.

Exceptions to Step Therapy

In certain cases it is possible to get an exception to step therapy requirements. To obtain more information about the step therapy exception process, please go to **Medica.com/SignIn** or call Customer Service at the telephone number listed at the front of this plan.

Medica will respond to a request for an exception to step therapy requirements within five days of receipt of a complete request. If you have a condition that may seriously jeopardize your life, health or ability to regain maximum function, Medica will respond within 72 hours of receipt of a complete request.

If we do not approve your request for an exception to step therapy requirements, you have the right to appeal Medica's decision. Medica will respond to a request for such an appeal within five days of receipt of a complete request. If you have a condition that may seriously jeopardize your life, health or ability to regain maximum function, Medica will respond within 72 hours of receipt of a complete request. See **How Do I File a Complaint** for more information on your appeal rights.

If Medica's decision on appeal upholds the initial denial of your request for an exception to step therapy requirements, you have a right to request an external review as described in **How Do I File a Complaint.**

Preferred requirement for specialty prescription drugs

Certain covered non-preferred specialty drugs include a chemically equivalent preferred specialty drug on the Drug List. If you still choose to use a non-preferred specialty prescription drug, the plan will pay the amount that it would have paid had you received the preferred specialty drug. You will pay, in addition to the applicable deductible, copayment or coinsurance described in the table, any remaining charges due to the pharmacy in excess of the plan's payment to the pharmacy. **These charges are not applied to your deductible or out-of-pocket maximum.**

If your health care provider requests that a non-preferred specialty drug be dispensed as written and there is a chemically equivalent preferred specialty drug on the Drug List, the drug will be covered at the preferred specialty drug benefit level.

Please note that receiving non-preferred specialty drugs when an equivalent preferred specialty drug is on the Drug List may result in significantly more out-of-pocket costs.

Investigative

Drugs prescribed for investigative uses are not covered. 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.

What's not covered

1. Specialty prescription drugs that are not on Medica's Drug List, unless covered through the exception process described in Exceptions to the Specialty Drug Program in this section.
2. Any amount above what the plan would have paid when you fail to identify yourself as a covered person to the designated specialty pharmacy. (Medica will notify you before enforcement of this provision.)
3. Specialty drugs that have not been approved by the Food and Drug Administration (FDA).
4. Certain non-preferred specialty drugs, as described in the table above.
5. Appetite suppressants and other drugs used to assist with weight loss or manage obesity, regardless of the mechanism of action.
6. Replacement of a specialty prescription drug due to loss, damage or theft.
7. Specialty prescription drugs prescribed by a provider who is not acting within his/her scope of licensure.
8. Prescription drugs and certain OTC drugs, except as described in **Prescription Drugs** in this plan.
9. Specialty prescription drugs received from a pharmacy that is not a designated specialty pharmacy.
10. Infertility drugs.
11. Growth hormone, except as specifically described in the benefit table above.
12. New-to-market drugs: Products recently approved by the FDA and introduced into the market will not be covered until they are reviewed and considered for placement on the Drug List.

PREVENTIVE HEALTH CARE

Preventive Health Care			
		Your cost if you visit a:	
	Benefits	**Network provider:**	**Non-network provider:**
1.	Child health supervision services including well-baby care, pediatric preventive services, appropriate immunizations up to age 18, developmental assessments and appropriate laboratory services	Nothing. The deductible does not apply.	0% coinsurance. The deductible does not apply.
2.	Adult immunizations	Nothing. The deductible does not apply.	20% coinsurance after deductible
3.	Early disease detection services including physicals	Nothing. The deductible does not apply.	20% coinsurance after deductible
4.	Routine screening procedures for cancer including, but not limited to, screening for prostate cancer (including prostate-specific antigen blood test and a digital rectal exam and without age limitation), ovarian cancer and colorectal cancer	Nothing. The deductible does not apply.	20% coinsurance after deductible

Preventive Health Care		
	Your cost if you visit a:	
Benefits	Network provider:	Non-network provider:
5. Women's preventive health services including mammograms (including digital breast tomosynthesis), screenings for cervical cancer (including pap smears), human papillomavirus (HPV) testing, counseling for sexually transmitted infections, counseling for human immunodeficiency virus (HIV), BRCA genetic testing and related genetic counseling (when appropriate) and sterilization **Please Note**: Preventive mammogram screenings include, but are not limited to, coverage for women at risk for breast cancer. "At risk for breast cancer" means 1) having a family history with one or more first- or second-degree relatives with breast cancer; 2) testing positive for BRCA1 or BRCA2 mutations; 3) having heterogeneously dense breasts or extremely dense breasts based on the Breast Imaging Reporting and Data System established by the American College of Radiology; or 4) having a previous diagnosis of breast cancer.	Nothing. The deductible does not apply.	20% coinsurance after deductible
6. Tobacco use counseling and intervention	Nothing. The deductible does not apply.	20% coinsurance after deductible

Preventive Health Care			
		Your cost if you visit a:	
	Benefits	Network provider:	Non-network provider:
7.	Obesity-related chronic disease prevention, including digitally delivered counseling for covered persons 18 years of age and older that are at-risk for obesity related chronic disease using Medica's designated prevention program. Contact Medica Customer Service to access Medica's designated prevention program.	Nothing. The deductible does not apply.	No coverage
8.	Diabetes management services for covered persons who have been diagnosed with diabetes and meet the criteria of Medica's designated diabetes management service. Diabetes management services include digitally delivered coaching and devices for tracking and monitoring progress. Contact Medica Customer Service to access Medica's designated diabetes management service	Nothing. The deductible does not apply.	No coverage
9.	Other preventive health services	Nothing. The deductible does not apply.	20% coinsurance after deductible

What to keep in mind

Routine preventive services are as defined by state and federal law.

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 section. The most specific and appropriate benefit will apply for each service you receive during a visit. For example:

- Your plan covers routine mammograms as described above. However, if your doctor recommends additional tests, such as a breast ultrasound or MRI, your x-ray or other imaging benefits will apply. For most plans, that means you'll incur costs for those tests.

When you use out-of-network benefits, in addition to the deductible and coinsurance, you will likely need to pay your provider any billed amount above what the plan pays the provider (the non-network provider reimbursement amount). **These charges are not applied to your deductible or out-of-pocket maximum.** Please see **Visiting non-network providers and why you pay more** in **Before You Access Care** for more information and an example showing out-of-pocket costs associated with out-of-network benefits.

For more information about preventive care, see the tip sheet at **Medica.com/SignIn**.

RECONSTRUCTIVE AND RESTORATIVE SURGERY

Reconstructive and Restorative Surgery		
	Your cost if you visit a:	
Benefits	**Network provider:**	**Non-network provider:**
1. Reconstructive and restorative surgery	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.

What's covered

Professional, hospital and ambulatory surgical center services for reconstructive and restorative surgery are covered. To be eligible, reconstructive and restorative surgery services must be medically necessary and not cosmetic.

When you use out-of-network benefits, in addition to the deductible and coinsurance, you will likely need to pay your provider any billed amount above what the plan pays the provider (the non-network provider reimbursement amount). **These charges are not applied to your deductible or out-of-pocket maximum.** Please see **Visiting non-network providers and why you pay more** in **Before You Access Care** for more information and an example showing out-of-pocket costs associated with out-of-network benefits.

What to keep in mind

Prior authorization (approval in advance) is required before you receive certain reconstructive and/or restorative surgery services. Please see **Prior authorization** in **Before You Access Care** for more information about prior authorization requirements and processes.

After a mastectomy, the plan 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 if the mastectomy was medically necessary (as determined by the attending physician). The plan will also cover prostheses and physical complications, including lymphedemas, at all stages of mastectomy.

Gender Reassignment Surgery

Prior authorization is required for these services. For more information on gender reassignment services, go to **Partner.Medica.com/-/media/documents/provider/utilization-management-policies/iii-sur-20-um-policy.pdf** or contact Customer Service at the telephone number listed inside the front cover.

Benefit Considerations

1. Hormonal treatments for gender reassignment **do not require prior authorization**.
2. All services related to surgical gender reassignment **require prior authorization** by Medica, and review by a Medica medical director.
    - The member must meet **all** medical necessity requirements for genital surgical gender reassignment for services to be authorized.
    - Please see prior authorization list for product specific prior authorization requirements.
3. Services eligible for coverage paid according to the appropriate medical section of the member's coverage document.
    - Pre-gender assignment medical evaluation
    - Hormonal gender assignment medical services. Includes all medical services directly related to the administration and monitoring of hormonal therapy
    - Genital surgical gender reassignment medical services
    - Pre-operation physical examination
    - Genital surgical gender reassignment inpatient and outpatient stays for eligible procedures
    - Includes all ambulatory follow-up care directly related to the genital surgical gender reassignment
    - Breast augmentation for male to female reassignment when all medical necessity criteria have been met
    - Mastectomy for female to male reassignment when all medical necessity criteria have been met.
    - Pre-gender assignment counseling services
    - Services of a licensed psychiatrist, or psychologist to diagnose and counsel the patient in the area of gender dysphoria
    - Psychological/psychiatric evaluation
    - Hormonal and genital gender assignment counseling services (includes all counseling services immediately preceding and following surgical gender reassignment as well as the psychology consult for the second letter of recommendation)
    - All mental health services provided to the member before, during and after initiation of hormonal therapy.

4. Covered secondary sexual characteristic (masculinizing or feminizing) gender affirming procedures, when medically necessary and supported by required documentation:

    - Electrolysis or laser treatment for facial hair removal;
    - Voice therapy;
    - Voice modification surgery when voice/speech therapy has been ineffective;
    - Reduction thyroid chondroplasty or trachea shaving (reduction of Adam's apple);
    - Facial feminization or masculinization surgery on a case-by-case basis, including the following procedures:
        - Hairline advancement
        - Forehead contouring/reconstruction;
        - Implant augmentation/reduction of the forehead and brow;
        - Blepharoplasty;
        - Brow lift;
        - Cheek augmentation with implants or autologous fat grafting;
        - Rhinoplasty;
        - Upper lip lift;
        - Lip augmentation with tissue augmentation or fat graft;
        - Implant augmentation/reduction of the mandible and chin;
        - Neck lift;
        - Facelift or liposuction (only as needed in conjunction with the above facial procedures).

5. Services not eligible for coverage:

    a. Secondary sex change procedures, not listed above, are generally considered cosmetic services and subject to the cosmetic surgery exclusion in this plan document.

    b. Services for the purpose of research or experimentation.

6. If the medical necessity and coverage criteria are met, the plan will authorize benefits within the limits in the member's plan document.

If it appears that the medical necessity and coverage criteria are not met, the individual's case will be reviewed by the medical director or an external reviewer.

What's not covered

1. Revision of blemishes on skin surfaces and scars (including scar excisions) primarily for cosmetic purposes, unless otherwise covered in **Physician and Professional Services** in this section.
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.
7. Drugs provided or administered by a physician or other provider on an outpatient basis, except drugs that meet the definition of “professionally administered drugs.” Coverage for drugs is as described in **Prescription Drugs**, **Prescription Specialty Drugs**.

SKILLED NURSING FACILITY

Skilled Nursing Facility			
		Your cost if you visit a:	
	Benefits	**Network provider:**	**Non-network provider:**
1.	Daily skilled care or daily skilled rehabilitation services, including room and board	Nothing after deductible	20% coinsurance after deductible
2.	Skilled physical, speech or occupational therapy when room and board is not eligible to be covered	Nothing after deductible	20% coinsurance after deductible
3.	Services received from a physician during an inpatient stay in a skilled nursing facility	Nothing after deductible	20% coinsurance after deductible

What's covered

Skilled nursing facility services are covered. Care must be provided under the direction of a physician.

When you use out-of-network benefits, in addition to the deductible and coinsurance, you will likely need to pay your provider any billed amount above what the plan pays the provider (the non-network provider reimbursement amount). **These charges are not applied to your deductible or out-of-pocket maximum.** Please see **Visiting non-network providers and why you pay more** in **Before You Access Care** for more information and an example showing out-of-pocket costs associated with out-of-network benefits.

What to keep in mind

Prior authorization (approval in advance) is required before you receive skilled nursing facility services. Please see **Prior authorization** in **Before You Access Care** for more information about prior authorization requirements and processes.

In this section, room and board includes coverage of health services and supplies.

What's not covered

1. Custodial care and other non-skilled services.

2. Self-care or self-help training (non-medical), including but not limited to, educational therapy, aerobic conditioning, therapeutic exercises, work hardening programs, etc., and all related material and products for these programs.
3. Services primarily educational in nature.
4. Vocational and job rehabilitation.
5. Recreational therapy.
6. Health club memberships.
7. Physical, speech or occupational therapy services when there is no reasonable expectation that the covered person'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.
11. Charges to hold a bed during a skilled nursing facility absence due to hospitalization or any other reason.

TELEMEDICINE HEALTH SERVICES

Telemedicine Health Services		
	Your cost if you visit a:	
Benefits	**Network provider:**	**Non-network provider:**
1. Health services delivered by means of telemedicine	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, inpatient services are covered at the inpatient services in-network benefit level and behavioral health services are covered at the corresponding behavioral health 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, inpatient services are covered at the inpatient services out-of-network benefit level and behavioral health services are covered at the corresponding behavioral health services out-of-network benefit level.

What to keep in mind

When you use out-of-network benefits, in addition to the deductible and coinsurance, you will likely need to pay your provider any billed amount above what the plan pays the provider (the non-network provider reimbursement amount). **These charges are not applied to your deductible or out-of-pocket maximum.** Please see **Visiting non-network providers and why you pay more** in **Before You Access Care** for more information and an example showing out-of-pocket costs associated with out-of-network benefits.

TEMPOROMANDIBULAR JOINT (TMJ) AND CRANIOMANDIBULAR DISORDER

Temporomandibular Joint (TMJ) and Craniomandibular Disorder			
		Your cost if you visit a:	
	Benefits	**Network provider:**	**Non-network provider:**
1.	Surgical and non-surgical treatment of temporomandibular joint (TMJ) disorder and craniomandibular disorder	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.	Orthodontia for temporomandibular joint (TMJ) disorder	Nothing after deductible	20% coinsurance after deductible

What to keep in mind

When you use out-of-network benefits, in addition to the deductible and coinsurance, you will likely need to pay your provider any billed amount above what the plan pays the provider (the non-network provider reimbursement amount). **These charges are not applied to your deductible or out-of-pocket maximum.** Please see **Visiting non-network providers and why you pay more** in **Before You Access Care** for more information and an example showing out-of-pocket costs associated with out-of-network benefits.

TRANSPLANT SERVICES

Transplant Services			
		Your cost if you visit a:	
	Benefits	**Network provider:**	**Non-network provider:**
1.	Solid organ and blood and marrow transplant services **Prior authorization is required for all transplant services; this prior authorization must be obtained before the transplant workup is initiated.**	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.	No coverage
2.	Transportation and lodging reimbursement, as described below, is available for expenses primarily for and essential to the receipt of transplant services. Reimbursement will be for you and a companion or companions whose presence with you is necessary and essential in order for you to receive transplant services, when you receive approved transplant services at a designated facility selected exclusively for medical reasons and you live more than 50 miles from that facility, and will include: a. Transportation for 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, provided that the presence of both companions is necessary for you to receive transplant services. Airfare is reimbursable only if the travel distance from your home to the designated transplant facility is 200 miles or more.		Reimbursement of expenses for out-of-network services is not covered.

Transplant Services		
	Your cost if you visit a:	
Benefits	Network provider:	Non-network provider:
b. Lodging that is not lavish or extravagant under the circumstances for you (while not confined) and one companion (whose presence is necessary in order for you to receive transplant services). If you are a minor child, reimbursement for lodging expenses for two companions is available (provided that the presence of both companions is necessary in order for you to receive transplant services). Reimbursement is available for a per diem amount of up to $50 per person or up to $100 for two people. There is a lifetime maximum of $10,000 per covered person for all transportation and lodging expenses incurred by you and your companion(s). Meals are not reimbursable under this 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.		

What's covered

Certain solid organ and blood and marrow transplant services are covered if provided under the direction of a network physician and received at a designated transplant facility. These transplant and related services (including organ acquisition and procurement) must be medically necessary, appropriate for the diagnosis, without contraindications and be non-investigative.

What to keep in mind

Prior authorization (approval in advance) from Medica is required before you receive transplant services or supplies. This prior authorization must be obtained before the transplant workup is initiated. Please see **Prior authorization** in **Before You Access Care** for more information about prior authorization requirements and processes.

Benefits for each individual covered person will be determined based on their clinical circumstances according to medical criteria used by Medica. Because medical technology is constantly changing, Medica reserves the right to review and update these medical criteria.

Coverage is provided for the following human organ transplants, if appropriate, and those that are not otherwise excluded from coverage:

- Kidney
- Lung
- Heart
- Heart/lung
- Pancreas
- Pancreas/kidney
- Intestinal
- 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 list above is not a comprehensive list of eligible 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 facility that has entered into a separate contract with Medica to provide certain transplant-related health services. You may be evaluated and listed as a potential transplant recipient at multiple designated transplant facilities. Contact Customer Service to be connected with a Medica case manager for your transplant care.

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 facility. Based on the type of transplant you receive, Medica will determine the specific time period medically necessary.

There is no coverage for out-of-network transplant services.

What's not covered

1. Supplies and services related to transplants that would not be authorized by Medica under the medical criteria referenced in this section.
2. 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.
3. Living donor transplants that would not be authorized by Medica under the medical criteria referenced in this section.
4. 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 plan.
5. 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.

6. Transplants and related services that are investigative.
7. Private collection and storage of umbilical cord blood for directed use.
8. Drugs provided or administered by a physician or other provider on an outpatient basis, except drugs that meet the definition of “professionally administered drugs.” Coverage for drugs is as described in **Prescription Drugs**, **Prescription Specialty Drugs**.

X-RAYS AND OTHER IMAGING

X-Rays and Other Imaging			
		Your cost if you visit a:	
	Benefits	Network provider:	Non-network provider:
1.	X-rays and other imaging services received during an office visit	Nothing after deductible	20% coinsurance after deductible
2.	X-rays and other imaging services received during an outpatient hospital or ambulatory surgical center visit **Note:** For these services received during an emergency room visit, see **Emergency Room Care**.	Nothing after deductible	20% coinsurance after deductible
3.	X-rays and other imaging services received in an inpatient setting	Nothing after deductible	20% coinsurance after deductible
4.	MRI, CT and PET CT scans **Note:** Some types of scans may require prior authorization.	Nothing after deductible	20% coinsurance after deductible

What to keep in mind

Prior authorization (approval in advance) is required before you receive certain imaging services. To determine if Medica requires prior authorization for a particular service or treatment, please call Medica Customer Service at the number listed at the front of this plan. Please see **Prior authorization** in **Before You Access Care** for more information about prior authorization requirements and processes.

When you use out-of-network benefits, in addition to the deductible and coinsurance, you will likely need to pay your provider any billed amount above what the plan pays the provider (the non-network provider reimbursement amount). **These charges are not applied to your deductible or out-of-pocket maximum.** Please see **Visiting non-network providers and why you pay more** in **Before You Access Care** for more information and an example showing out-of-pocket costs associated with out-of-network benefits.

What's Not Covered

The plan 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 **What's not covered** in this plan. 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. However, emergency treatment of complications from cosmetic surgery is covered as described in the **Emergency Room Care** section of this document.
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. Hearing aids (including internal, external or implantable hearing aids or devices) and other devices to improve hearing and their related fittings, except cochlear implants and their related fittings and except as described in **Durable Medical Equipment, Prosthetics and Medical Supplies** in **What's Covered and How Much Will I Pay**.
6. A drug, device or medical treatment or procedure that is investigative.
7. Services or supplies not directly related to your care.
8. Autopsies.
9. 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.
10. Nutritional and electrolyte substances, except as specifically described in **Durable Medical Equipment, Prosthetics and Medical Supplies** in **What's Covered and How Much Will I Pay**.
11. 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.
12. Reversal of voluntary sterilization.
13. Personal comfort or convenience items or services.
14. Custodial care, unskilled nursing or unskilled rehabilitation services.

15. Respite or rest care, except as otherwise covered in **Hospice Services** in **What's Covered and How Much Will I Pay**.
16. Travel, transportation or living expenses, except as described in **Transplant Services** in **What's Covered and How Much Will I Pay**.
17. Household equipment, fixtures, home modifications and vehicle modifications.
18. Charges billed by a non-network provider that are not in compliance with generally accepted coding and reimbursement guidelines, including those of the American Medical Association (AMA), the Centers for Medicare and Medicaid Services (CMS) and the community.
19. Massage therapy, provided in any setting, even when it is part of a comprehensive treatment plan.
20. Routine foot care, except for covered persons 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 (ALS).
21. Services by persons who are family members or who share your legal residence.
22. Claims for benefits to the extent such claims have been paid under workers' compensation, employer liability or any similar law, auto insurance or any other coverage or plan that is required to pay before this plan pays. In other words, the plan will not make a duplicate payment on claims that have been paid previously by another payer.
23. Services received before coverage under the plan becomes effective.
24. Services received after coverage under the plan ends.
25. Unless requested by Medica, charges for duplicating and obtaining medical records from non-network providers and non-network dentists.
26. Occlusal adjustment or occlusal equilibration.
27. Dental implants (tooth replacement), except as described in **Medical-Related Dental Services** in **What's Covered and How Much Will I Pay**.
28. Dental prostheses.
29. Any orthodontia, except as described in **Medical-Related Dental Services** for the treatment of cleft lip and palate and **Temporomandibular Joint (TMJ) and Craniomandibular Disorder** for the treatment of temporomandibular joint (TMJ) disorder, under **What's Covered and How Much Will I Pay**.
30. Treatment for bruxism.
31. Services prohibited by applicable law or regulation.
32. 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). This exclusion does not apply if you are a civilian.

33. Exams, other evaluations or other services received solely for the purpose of employment, insurance or licensure.
34. 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.
35. Self-care or self-help training (non-medical), including but not limited to, educational therapy, aerobic conditioning, therapeutic exercises, work hardening programs, etc., and all related material and products for these programs.
36. Educational classes, programs or seminars, including but not limited to childbirth classes, except as described in **Physician and Professional Services** in **What's Covered and How Much Will I Pay**.
37. Coverage for costs associated with translation of medical records and claims to English.
38. Treatment for superficial veins, also referred to as telangiectasia, thread, reticular or spider veins.
39. Orthognathic surgery for cosmetic purposes.
40. Sensory integration, including auditory integration training.
41. Services for or related to vision therapy and orthoptic and/or pleoptic training, except as described in **Physician and Professional Services** in **What's Covered and How Much Will I Pay**.
42. Services for or related to intensive behavior therapy treatment programs for the treatment of autism spectrum disorders for covered persons 18 years of age and older. Examples of such services include, but are not limited to, Early Intensive Developmental and Behavioral Intervention (EIDBI), Applied Behavioral Analysis (ABA), Intensive Early Intervention Behavior Therapy (IEIBT), Intensive Behavioral Intervention (IBI) and Lovaas therapy.
43. Health care professional services for home labor and delivery.
44. Weight loss or morbid obesity surgery, including initial procedures, surgical revisions and subsequent procedures.
45. Services for the treatment of infertility.
46. Infertility drugs.
47. Assisted reproductive technology services, including but not limited to: in vitro fertilization (IVF); gamete intrafallopian transfer (GIFT); zygote intrafallopian transfer (ZIFT); tubal embryo transfer; intracytoplasmic sperm injection (ICSI); ova or embryo acquisition, retrieval, donation, preservation, and/or storage; and/or any conception that occurs outside the woman's body.
48. Services for intrauterine insemination (IUI).
49. Services related to surrogate pregnancy for a person not covered as a covered person under the plan.

50. Sperm banking and/or storage.
51. Donor sperm.
52. Donor eggs.
53. Services related to adoption.
54. Any form, mixture or preparation of cannabis for medical or therapeutic use and any device or supplies related to its administration.
55. Appetite suppressants and other drugs used to assist with weight loss or manage obesity, regardless of the mechanism of action.
56. Services solely for or related to the treatment of snoring.
57. Interpreter services, except as described in **Home Health Care** in **What's Covered and How Much Will I Pay**.
58. Services provided to treat injuries or illnesses that are the result of committing a felony or attempting to commit a felony.
59. Extended hours home care, except as described in Home Health Care in What's **Covered and How Much Will I Pay** for covered persons who have Medica coverage and are also enrolled in the Medical Assistance Program.
60. Services for private duty nursing. 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 covered person or the covered person's representative and not under the direction of a physician.
61. Laboratory testing (including genetic testing) that has been performed in response to direct-to-consumer marketing and not under the direction of a physician.
62. Medical devices that have not been approved by the U.S. Food and Drug Administration (FDA), other than those granted a humanitarian device exemption.
63. Drugs, supplies, biologics and biosimilars that have not been approved by the U.S. Food and Drug Administration (FDA).
64. New-to-market biologics, biosimilars and professionally administered drugs. Biologics, biosimilars and professionally administered drugs recently approved by the FDA (including approval for a new indication) will not be covered until they are reviewed and approved for coverage by Medica.
65. Health club memberships.
66. Long-term care.
67. Expenses associated with participation in weight loss programs, including but not limited to membership fees and the purchase of food, dietary supplements or publications.
68. Any charges for mailing, interest and delivery, such as the cost for mailing medical records.

69. Animals and any service or treatment related to animals.

70. Charges incurred if you fail to keep a scheduled visit.

71. Conversion therapy, which is any practice by a mental health practitioner or mental health professional that seeks to change a person's sexual orientation or gender identity, including efforts to change behaviors or gender expressions or to eliminate or reduce sexual or romantic attractions or feelings toward people regardless of gender. Conversion therapy does not include counseling that provides assistance to a person undergoing gender transition. It also does not include counseling that provides acceptance, support, and understanding of a person or facilitates a person's coping, social support, and identity exploration and development, including sexual-orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, as long as the counseling does not seek to change the person's sexual orientation or gender identity.

What if I Have More Than One Insurance Plan

This section describes how benefits are coordinated when you are covered under more than one plan. **However, when your other plan is Medicare or TRICARE, Medica will coordinate benefits in accordance with the Medicare Secondary Payer or TRICARE provisions of Federal law.** If you have questions about how these rules apply to you or a covered family member, contact Customer Service at the number listed at the front of this plan.

Coordination for Medicare-eligible individuals

The benefits under this plan are not intended to duplicate any benefits to which covered persons are eligible for under Medicare. If we have covered a service under this plan, any sums payable under Medicare for that service must be paid to the plan. If we need any consents, releases, assignments and other documents, complete and return to us those documents to make sure we receive reimbursement by Medicare.

The provisions of this section will apply to the maximum extent permitted by federal or state law. We will not reduce the benefits due any covered person where federal law requires that we determine our benefits for that covered person without regard to the benefits available under Medicare.

When coordination of benefits applies

1. 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.
2. 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:
    a. Shall not be reduced when this plan determines its benefits before another plan; but
    b. May be reduced when another plan determines its benefits first. The above reduction is described in **Effect on the benefits of this plan**.

Definitions that apply to this section

1. A “*plan*” is any of these which provides benefits or services for, or because of, medical or dental care or treatment:
    a. 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.
    b. 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 a. or b. 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.

2. "*This plan*" is the part of the plan that provides benefits for health care expenses.

3. "*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.

4. *"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 covered persons 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 covered person 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.

5. "*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.

Order of benefit determination rules

1. *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:

   a. The other plan has rules coordinating its benefits with the rules of this plan; and

   b. Both the other plan's rules and this plan's rules, in 2. below, require that this plan's benefits be determined before those of the other plan.

2. *Rules.* This plan determines its order of benefits using the first of the following rules which applies:

   a. *Nondependent/dependent.* The benefits of the plan that covers the person as an employee, covered person or enrollee (that is, other than as a dependent) are determined before those of the plan, which covers the person as a dependent.

   b. *Dependent child/parents not separated or divorced*. Except as stated in c. below, when this plan and another plan cover the same child as a dependent of different persons, called “parents”:

      i. 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

      ii. 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 i. 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.

   c. *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:

      i. First, the plan of the parent with custody of the child;

      ii. Then, the plan of the spouse of the parent with the custody of the child; and

      iii. 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.

d. *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 b. above.

e. *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.

f. *Workers' compensation*. You should submit claims incurred as a result of a work-related sickness or injury to the employer for workers' compensation coverage, before submitting them to Medica.

g. *No-fault automobile insurance*. You should submit claims incurred as a result of an automobile accident or injury to the responsible automobile insurance carrier, before submitting them to Medica.

h. *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, covered person or enrollee longer are determined before those of the plan which covered that person for the shorter term.

Effect on the benefits of this plan

1. *When this section applies*. This section applies when, in accordance with *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 2. immediately below.

2. *Reduction in this plan's benefits*. The benefits of this plan will be reduced by the benefits that would be payable for the allowable expenses under the other plans, whether or not a claim is made. In no event will this plan pay benefits which, combined with the benefits of the other plans, total more than the allowable expense under this plan.

   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.

Right to receive and release needed information

Certain facts are needed to apply these COB rules. The plan has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. The plan need not tell or get the consent of, any person to do this, unless applicable 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 the plan any facts it needs to pay the claim.

Facility of payment

A payment made under another plan may include an amount, which should have been paid under this plan. If it does, the plan 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. The plan 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.

Right of recovery

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

1. The persons it has paid or for whom it has paid; or
2. Insurance companies; or
3. 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 to Subrogation and Reimbursement** for additional information.

Right to Subrogation and Reimbursement

This section describes this plan's right of recovery. This plan's rights are subject to Minnesota and federal law. References to "you" or "your" in this section shall include you, your legal representatives, your estate and your heirs and next of kin and beneficiaries, unless otherwise stated. For information about the effect of Minnesota and federal law on the plan's subrogation rights, contact an attorney.

1. This plan 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. This plan's right of subrogation shall be governed according to this section. This plan'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. This plan's subrogation interest is the reasonable cash value of any benefits received by you.
3. This plan's right to recover its subrogation interest may be subject to an obligation by the plan to pay from any recovery 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 the plan 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 plan, you agree:
    a. That if the plan 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 legally responsible and you later obtain full recovery, you are obligated to reimburse the plan for the benefits paid in accordance to Minnesota law.
    b. To cooperate with the plan administrator, sponsor or plan or its designee to help protect the plan's legal rights under this subrogation and reimbursement provision and to provide all information the plan may reasonably request to determine its rights under this provision.
    c. To provide prompt written notice to the plan administrator when you make a claim against a party for injuries.
    d. To do nothing to decrease or limit the plan's rights under this provision, either before or after receiving benefits, or under the plan.
    e. The plan may take action to preserve its legal rights. This includes bringing suit in your name.
    f. Subject to the full recovery requirement set forth in paragraph 1. above, the plan may collect its subrogation interest from the proceeds of any settlement or judgment that includes or otherwise is related to payment of medical expenses recovered by you, your legal representative or the legal representative(s) of your estate or next-of-kin.

g. You will cooperate with the plan in protecting our legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:

   i. Signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim.

   ii. Responding to requests for information about any accident or injuries.

   iii. Making court appearances.

   iv. Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.

   v. Complying with the terms of this section.

h. To hold in trust the proceeds of any settlement or judgment for the plan's benefit under this provision.

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.

When this applies

If it is determined that you are receiving certain prescription drugs in a quantity or manner that may harm your health, benefits for these medications will be restricted to medications that are both prescribed by one specific network physician and dispensed by one specific network pharmacy. Failure to receive these medications in this manner will result in a denial of coverage. Medica will notify you regarding the specific physician and pharmacy assigned for you.

If you have questions about how this provision applies to you, including the specific physician or pharmacy assigned for you, you may call Customer Service at the telephone number listed at the front of this plan. Additionally, you have the right to appeal Medica's decision concerning the application of this section or the particular physician or pharmacy assigned for you. See **How Do I File a Complaint** for more information on your appeal rights.

How Do I Submit a Claim

This section describes the process for submitting a claim.

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 the telephone number listed at the front of this plan.

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 covered person 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 the Document Center at **Medica.com/SignIn**. You may also request claim forms by calling Customer Service at the telephone number listed at the front of this plan. 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 identification 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, the plan will generally pay to you directly the non-network provider reimbursement amount. The plan will only pay the provider of services if:

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

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 proof of travel.
- Such other documentation as Medica may request.

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

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

Time limits

No action at law or in equity shall be brought to recover on this plan prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this plan. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

How Do I File a Complaint

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

You may call Customer Service at the telephone number listed at the front of this plan 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 **651-539-1600** 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 the telephone number listed at the front of this plan 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 calendar 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:

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

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

c. If Medica's first level of 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 of review decision to you and your attending provider within 15 days from receipt of your complaint. If Medica cannot provide its determination within 15 days, Medica may take an additional 4 days and will notify you of the extension and the reason relating to it.

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 of review decision upholds the initial decision made by Medica, you have a right to request a second level of 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 of review regardless of the method chosen for review (hearing or a written reconsideration); or
    b. 45 calendar days from receipt of written notice of your appeal for optional second level of review (if reviewed by hearing) or 30 calendar days from receipt of written notice of your appeal for optional second level of review (if reviewed by written reconsideration).

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 of review 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 280
St. Paul, MN 55101

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 plan, 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. If you have a complaint regarding fraudulent marketing practices or agent misrepresentation, you may contact the Commissioner of Commerce at the Minnesota Department of Commerce.

Who's Eligible for Coverage and How Do They Enroll

This section describes who can enroll and how to enroll.

Who can enroll

To be eligible to enroll for coverage you must meet the eligibility requirements of the plan and be an enrollee or dependent as defined in this plan.

How to enroll

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

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**.

Dependents will not be enrolled without the qualified employee also being enrolled. A child who is the subject of a medical support order can be enrolled as described in this section under **Medical Support Order** and 6. under **Special enrollment and effective date of coverage**.

Initial enrollment and effective date of coverage

Initial enrollment is a time period starting with the date a qualified employee and dependents are first eligible to enroll for coverage under the plan. A qualified employee must enroll within this period for coverage to begin the date he or she was first eligible to enroll. (The time period does not apply to newborns or children newly adopted or newly placed for adoption; see **Special enrollment and effective date of coverage**.) A qualified employee and dependents who do not enroll during the initial enrollment period may enroll for coverage during the next open enrollment period or any applicable special enrollment periods.

A covered person who is a child entitled to receive coverage through a medical support order is not subject to any initial enrollment period restrictions, except as noted in this section.

For qualified employees and dependents who enroll during the initial enrollment period, coverage begins on the first day of the first calendar month following the date the employee first meets the definition of a qualified employee and satisfies any applicable waiting period.

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

Open enrollment and effective date of coverage

A period communicated by the plan administrator each year during which qualified employees and dependents who are not covered under the plan may elect coverage for the upcoming plan year. An application must be submitted to the plan administrator for yourself and any dependents.

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

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

Special enrollment and effective date of coverage

Special enrollment periods are provided to qualified 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 a qualified employee and dependent if the individual was covered under Medicaid or a State Children's Health Insurance Plan (SCHIP) and lost that coverage as a result of loss of eligibility. The qualified 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 qualified employee's loss of coverage, this special enrollment period applies to the qualified 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 qualified employee.

    b. A special enrollment period will apply to a qualified employee and dependent if the qualified employee or dependent was covered under a group health plan or health insurance coverage with benefits consisting of medical care at the time the qualified employee or dependent was eligible to enroll under the plan, whether during initial enrollment, open enrollment or special enrollment and declined coverage for that reason.

    The qualified 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;
- if the prior coverage was offered through an individual health maintenance organization (HMO), a loss of coverage because the qualified 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 qualified 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 qualified employee or dependent.

iii. Loss of eligibility occurs regardless of whether the qualified 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 qualified employee or dependent to pay premiums on a timely basis, termination of coverage for cause.

In the case of the qualified employee's loss of other coverage, the special enrollment period described above applies to the qualified 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 that has lost coverage and the qualified employee.

c. A special enrollment period will apply to a qualified employee and dependent if the qualified 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 qualified employee or dependent was eligible to enroll under the plan, whether during initial enrollment, open enrollment or special enrollment and declined coverage for that reason.

The qualified employee or dependent must present evidence that the qualified employee or dependent has exhausted such COBRA or state continuation coverage and has not lost such coverage due to failure of the qualified 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;
- losing coverage as a result of the qualified 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 qualified 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 qualified employee or dependent to pay premiums on a timely basis; termination of coverage for cause; or voluntary termination of coverage prior to exhaustion.

In the case of the qualified employee's exhaustion of COBRA or state continuation coverage, the special enrollment period described above applies to the qualified 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 qualified employee, dependents will not be enrolled without the qualifying employee also being enrolled.

For the special enrollment events described in 1.a., 1.b. and 1.c. 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 the plan administrator.

2. The dependent is a new spouse of the enrollee or qualified employee, provided the marriage is legal and enrollment is requested in writing within 30 days of the date of marriage and provided the qualified employee also enrolls during this special enrollment period. Coverage is effective on the date of the marriage.

3. The dependent is a new dependent child of the enrollee or qualified employee, provided enrollment is requested in writing within 30 days of the enrollee or qualified 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 the qualified 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 enrollee acquires the dependent child.

4. The dependent is the spouse of the enrollee or qualified 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 plan; and

c. Enrollment is requested in writing within 30 days of the dependent child becoming a dependent; and

d. The qualified 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 enrollee or qualified 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 qualified 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 member is provided with notice of a medical support order and a copy of the order, as described in this section, the employer member will provide the eligible dependent child with a special enrollment period provided the qualified 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 the plan administrator. Any child who is a covered person pursuant to a medical support order will be covered without application of waiting periods.

7. The dependent is a new domestic partner of the enrollee or qualified employee, provided the domestic partnership is registered and enrollment is requested in writing within 30 days of the date of registration, and the qualified employee also enrolls during the special enrollment period.

Medical Support Order

The plan is intended to comply with the requirements of applicable Minnesota law regarding medical support orders. This may result in the delay of a termination of coverage as described in **When Does My Coverage End and What Are My Options for Continuing Coverage**. Notwithstanding any provision of this plan to the contrary, this plan shall recognize support orders that address medical coverage for dependent children and former spouses in accordance with the requirements under Section 518A.41 of the Minnesota Statutes as determined by the plan administrator according to its policy relating to the plan established for the purpose of complying with these requirements.

When Does My Coverage End and What Are My Options for Continuing Coverage

This section describes when coverage ends under the plan. When this happens you may exercise your right to continue your coverage as is also described in this section.

When your coverage ends

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

1. The date on which this plan terminates. If the relationship between the plan administrator and Medica ends, coverage under the plan will not necessarily end. Only the sponsor determines when this plan terminates.
2. The effective date of a plan amendment terminating coverage for the class to which a covered person belongs.
3. The end of the month for which the enrollee or covered person last paid his or her contribution toward the premium.
4. The end of the month in which the covered person is no longer eligible as determined by the plan administrator. (See **Who's Eligible for Coverage and How Do They Enroll** for information on eligibility.)
5. The end of the month following the date the plan administrator approves the enrollee's or covered person's request to end his or her coverage.
6. The date specified by the plan administrator in written notice to you that coverage ended due to fraud. If coverage ends due to fraud, coverage may be retroactively terminated at the plan administrator'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 the plan administrator 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 Medica identification card by any unauthorized person; or
    d. Using another person's Medica identification card; or
    e. Submitting fraudulent claims.
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 plan administrator to discuss reinstatement of coverage.
8. For a dependent domestic partner, the end of the month in which the individual no longer meets the criteria to be a dependent domestic partner.

Continuing your coverage

This section describes continuation coverage provisions. When coverage ends, covered persons may be able to continue coverage under state law, federal law or both. If you are eligible under both state and federal law, the more generous provisions will generally apply.

Please note: All aspects of continuation coverage administration are the responsibility of the plan administrator.

You may have other options available to you when you lose group health coverage. You and your family may have coverage options through the Marketplace, Medicaid or other group health plan coverage options (such as a spouse's plan). Some of these options may cost less than continuation coverage. For example, you may be eligible to buy an individual or family plan through the Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees. You can learn more about many of these options at **Healthcare.gov.**

The paragraph below describes the continuation coverage provisions. State continuation is described in **Your right to continue coverage under state law** and federal continuation is described in **Your right to continue coverage under federal law**.

If your coverage ends, you should review your rights under both state law and federal law with the plan administrator. 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 this section, 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 plan administrator 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.

Enrollee’s loss

The enrollee 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 plan because of the enrollee’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 enrollee is no longer eligible for coverage under the plan.

Enrollee’s spouse's loss

The enrollee’s covered spouse has the right to continuation coverage if he or she loses coverage under the plan for any of the following reasons:

a. Death of the enrollee;

b. A termination of the enrollee’s employment (for any reason other than gross misconduct) or layoff from employment;

c. Dissolution of marriage from the enrollee;

d. The enrollee’s enrollment for benefits under Medicare.

Enrollee’s child's loss

The enrollee’s dependent child has the right to continuation coverage if coverage under the plan is lost for any of the following reasons:

a. Death of the enrollee if the enrollee is the parent through whom the child receives coverage;

b. Termination of the enrollee’s employment (for any reason other than gross misconduct) or layoff from employment;

c. The enrollee’s dissolution of marriage from the child's other parent;

d. The enrollee’s enrollment for benefits under Medicare if the enrollee is the parent through whom the child receives coverage;

e. The enrollee’s child ceases to be a dependent child under the terms of the plan.

Responsibility to inform

Under Minnesota law, the enrollee and dependents have the responsibility to inform the plan administrator of a dissolution of marriage or a child losing dependent status under the plan 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 plan administrator is notified that one of these events has happened, the enrollee and the enrollee's dependents will be notified of the right to continuation coverage.

Consistent with Minnesota law, the enrollee and dependents have 60 days to elect continuation coverage for reasons of termination of the enrollee's employment or the enrollee'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 enrollee and the enrollee's covered spouse may elect continuation coverage on behalf of other dependents entitled to continuation coverage. Under certain circumstances, the enrollee's covered spouse or dependent child may elect continuation coverage even if the enrollee does not elect continuation coverage.

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

Type of coverage and cost

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

Under Minnesota law, a person continuing coverage may have to make a monthly payment to the employer member or its designee 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 enrollee 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 enrollee and his or her dependents be allowed to maintain continuation coverage as follows:

a. For instances where coverage is lost due to the enrollee'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 enrollee 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 plan.

b. For instances where the enrollee's spouse or dependent children lose coverage because of the enrollee'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 plan.

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 plan.

d. For instances of dissolution of marriage from the enrollee, coverage of the enrollee'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 plan.

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

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

   ii. The date coverage would otherwise terminate under the plan.

e. Upon the death of the enrollee, the coverage of a enrollee'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 plan had the enrollee lived.

Extension of benefits for total disability of the enrollee

Coverage may be extended for an enrollee and his or her dependents in instances where the enrollee is absent from work due to total disability, as defined in **Definitions**. If the enrollee is required to pay all or part of the premium for the extension of coverage, payment shall be made to the employer member. 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 this section, you may be entitled to extended or continued coverage under COBRA and/or USERRA 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 plan administrator shall, within the parameters of federal law, establish uniform policies pursuant to which such continuation coverage will be provided.

General COBRA information

COBRA, as it applies to state governmental entities through the PHSA, requires employers with 20 or more employees to offer enrollees 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 available because of an employment relationship 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 covered 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.)

Enrollee’s loss

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

Enrollee’s spouse’s loss

The enrollee’s covered spouse has the right to choose continuation coverage if he or she loses coverage under the plan for any of the following reasons:

a. Death of the enrollee;

b. A termination of the enrollee’s employment (for any reason other than gross misconduct) or reduction in the enrollee’s hours of employment;

c. Divorce or legal separation from the enrollee; or

d. The enrollee’s entitlement to (actual coverage under) Medicare.

Enrollee’s child’s loss

The enrollee’s dependent child has the right to continuation coverage if coverage under the plan is lost for any of the following reasons:

a. Death of the enrollee if the enrollee is the parent through whom the child receives coverage;

b. The enrollee’s termination of employment (for any reason other than gross misconduct) or reduction in the enrollee’s hours of employment;

c. The enrollee’s divorce or legal separation from the child's other parent;

d. The enrollee’s entitlement to (actual coverage under) Medicare if the enrollee is the parent through whom the child receives coverage; or

e. The enrollee’s child ceases to be a dependent child under the terms of the plan.

Responsibility to inform

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

Also, an enrollee and dependent who have been determined to be disabled under the Social Security Act as of the time of the enrollee's termination of employment or reduction of hours or within 60 days of the start of the continuation period must notify the plan administrator 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 plan administrator 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 enrollee’s employer commences a bankruptcy proceeding and these individuals lose coverage.

Election rights

When notified that one of these events has happened, the plan administrator will notify the enrollee and covered dependents of the right to choose continuation coverage.

Consistent with federal law, the enrollee 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 enrollee and the enrollee'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 enrollee's covered spouse or dependent child may elect continuation coverage even if the enrollee does not elect continuation coverage.

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

Type of coverage and cost

If the enrollee and the enrollee's dependents elect continuation coverage, the employer member is required to provide coverage that, as of the time coverage is being provided, is identical to the coverage provided under the plan 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 plan 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 enrollee becomes entitled to (actually covered under)

Medicare, the continuation period for the enrollee's dependents is 36 months measured from the date of the enrollee's Medicare entitlement even if that entitlement does not cause the enrollee 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 enrollee'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 enrollee 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.

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 plan administrator shall, within the parameters of federal law, establish uniform policies pursuant to which such continuation coverage will be provided.

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 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 plan because of absence from employment due to service in the uniformed services, and the employee was covered under the plan at the time the absence began, and the employee or an appropriate officer of the uniformed services, provided the employer member 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 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 plan by making an election on a form provided by the plan administrator. 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 plan upon reemployment, subject to the terms and conditions of the plan.

Type of coverage and cost

If the employee elects continuation coverage, the employer member is required to provide coverage that, as of the time coverage is being provided, is identical to the coverage provided under the plan 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 plan. Coverage continues for up to 24 months.

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

a. The enrollee'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. 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 plan 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.

3. Other continuation coverage

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

Retiree coverage

Retiree coverage shall be provided in accordance with the Minnesota Statutes for a retiree and his or her dependents enrolled under the plan immediately preceding the enrollee's retirement. Employer member may pay a portion of the premium for such coverage. Eligibility with respect to the availability of continuation coverage beyond the requirements of the Minnesota Statutes shall be determined by employer member, pursuant to its Policy and Procedure. The retiree coverage may run concurrently with any available COBRA or state continuation coverage or the retiree coverage may be offered in lieu of the COBRA or state continuation coverage.

Domestic partner

If coverage for domestic partners is available under the plan, an enrolled dependent domestic partner and domestic partner's child who lose eligibility due to termination of the domestic partner relationship may be entitled to continuation coverage. Eligibility, as it pertains to the availability of continuation coverage for domestic partners, shall be determined by the employer member, in accordance with its domestic partner coverage policy.

How Providers are Paid

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: a fee-for-service method, such as per service or percentage of charges; a per episode arrangement, such as an amount per day, per stay, per case, or per period of illness; or a risk sharing/value based arrangement.

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 your plan is fee-for-service.

Under fee-for-service and per episode arrangement, the network provider is paid a fee for each service or episode of care provided. These payments are 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 billed charge. The amount paid to the network provider, less any applicable copayment, coinsurance or deductible is considered to be payment in full.

Medica also has risk sharing/value-based contracting arrangements with a number of providers. These contracts include various quality and efficiency measures designed to encourage high quality and efficient total care for covered persons. Such arrangements may involve claims withhold and gain-sharing or risk-sharing arrangements between Medica and such providers. Amounts paid or returned under these arrangements are not considered when determining the amounts you must pay for health services under this plan.

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, in addition to any applicable copayment, coinsurance or deductible amounts.

Additional Terms of Your Coverage

This section describes the general provisions of the plan.

Applicable law

This plan is intended to be construed, and all rights and duties hereunder are to be governed in accordance with the laws of the State of Minnesota, except to the extent such laws are preempted by the laws of the United States of America.

Examination of a covered person

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

Clerical error and misstatements

You will not be deprived of coverage under the plan because of a clerical error or misstatement by the plan or plan administrator. However, you will not be eligible for coverage beyond the scheduled termination of your coverage because of a failure to record the termination. If there is a clerical error or any misstatement of relevant facts pertaining to coverage under the plan, the plan administrator reserves the right to investigate the matter and determine the existence or amount of coverage.

Plan amendment and termination

Any change or amendment to or termination of the plan, its benefits or its terms and conditions, in whole or in part, whether prospective or retroactive, shall be made solely in a written amendment (in the case of a change or amendment) or in written resolution (in the case of termination) to the plan, approved by the Board of Directors (if a corporation), the general partner(s) (if a partnership), the proprietor (if a sole proprietorship) or similar governing body (in all other cases) of the sponsor or any of their designees to whom such Board of Directors, general partner(s), proprietor or similar body has delegated in writing the foregoing authority. You will receive notice of any amendment to the plan in accordance with applicable law. No one has the authority to make any oral modification to the plan.

Enrollee rights

The action of the sponsor in creating this plan shall not be construed to constitute and shall not be evidence of any contractual relationship between the sponsor and any enrollee, or as a right of any enrollee to continue in the employment of the sponsor, or as a limitation of the right of the sponsor to discharge any of its employees, with or without cause.

Family and Medical Leave Act of 1993 (FMLA)

The Family and Medical Leave Act of 1993 (FMLA) imposes certain obligations on employers with fifty (50) or more employees. This plan shall be administered in a manner consistent with the FMLA and the applicable employer member's FMLA policy.

Relationship between parties

The relationships between Medica, the sponsor 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 covered person is that of health care provider and patient. The provider is solely responsible for health care provided to any covered person.

Discretionary authority

The plan administrator and its delegate have the full discretionary power to interpret and apply the terms of the plan, and its components (including, without limitation, supplying omissions from, correcting deficiencies in or resolving inconsistencies or ambiguities in the language of the plan and its underlying documents) as they relate to matters for which the named fiduciary has responsibility. All decisions of the plan administrator and its delegate as to the facts of the case, interpretation of any provisions of the plan or its application to any case and any other interpretative matter, determination or question under the plan will be final and binding on all affected parties.

Health Savings Accounts (HSA)

This coverage is designed to comply with the requirements of the Internal Revenue Code Section 223 for a federally qualified high-deductible health plan. This coverage may qualify you to make a pre-tax contribution to a health savings account. You are responsible for the cost of all health services, other than preventive care, up to your deductible amount.

For more information about health savings accounts, see the tip sheet at **Medica.com/SignIn**.

Definitions

Words and phrases with specific meanings 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 plan and any subsequent amendments) approved by Medica as eligible for coverage.

Biologics. Any of a wide range of products designed to replicate natural substances in the body, including, but not limited to, products produced using biotechnology. Biologics include, but are not limited to, vaccines, blood and blood components or products, cellular and gene therapy products, tissue and tissue products, allergenics, recombinant therapeutic proteins, monoclonal antibodies, cytokines, growth factors, immunomodulators, and additional biological products regulated by the U.S. Food and Drug Administration and related agencies.

Biosimilar. A biological product that is highly similar to and has no clinically meaningful differences from an existing FDA-approved reference product.

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.

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 covered person.

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 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 Drugs** and **Prescription Specialty Drugs** in **What's Covered and How Much Will I Pay**, 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 covered person, the complaint must relate to services received during the time the individual was a covered person.

Copayment. The fixed dollar amount you must pay to the provider for benefits received.

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.

Covered person. A person who is enrolled under the plan.

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 plan.

Amounts reimbursed or paid by a provider or manufacturer, including manufacturer coupons, rebates, coupon cards, debit cards or other forms of reimbursement or payment on your behalf for a product or service, will not apply toward your deductible.

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

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

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

4. The enrollee's or enrollee'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 enrollee 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. A disabled child may remain covered under the plan regardless of age and without application of health screening or waiting periods. To continue coverage for a disabled child, you must provide the plan with proof of such disability and dependency within 31 days of the child reaching the dependent

limiting age set forth in 3. above. Beginning two years after the child reaches the dependent limiting age, the plan may require annual proof of disability and dependency.

5. The enrollee's or enrollee's spouse's disabled dependent, over the limiting age, 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 enrollee or enrollee's spouse for support and maintenance. For coverage of a disabled dependent, you must provide the plan with proof of such disability at the time of the dependent's enrollment. You must also provide the plan with proof of dependency at the time of enrollment.

Designated facility. A network hospital that Medica has authorized to provide certain benefits to covered persons, as described in this plan.

Designated mental health and substance use disorder provider. An organization, entity or individual selected by Medica to provide or arrange for the mental health and substance use disorder services covered under this plan.

Domestic partner. An adult who the employer member determines:

1. Is in a committed and mutually exclusive relationship, jointly responsible for the enrollee's welfare and financial obligations; and
2. Resides with the enrollee in the same principal residence and intends to do so permanently; and
3. Is at least 18 years of age and unmarried; and
4. Is not a blood relative of the enrollee; and
5. Is mentally competent.

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.

Employee. Any person employed by the employer member on or after the effective date of this plan, except that it shall not include a self-employed individual as described in Section 401(c) of the Code. All employees who are treated as employed by a single employer under Subsections (b), (c) or (m) of Section 414 of the Code are treated as employed by a single employer for purposes of this plan. Employee does not include any of the following:

1. Any employee included within a unit of employees covered under a collective bargaining unit unless such agreement expressly provides for coverage of the employee under this plan;
2. Any employee who is a nonresident alien and receives no earned income from the employer member from sources within the United States; and

3. Any employee who is a leased employee as defined in Section 414(n)(2) of the Code.

Enrollee. A qualified employee who the plan administrator determines is enrolled under the plan.

Extended hours home care. The provision of skilled nursing services for greater than two consecutive hours per day provided in the covered person's home.

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 help a person who has not learned or acquired a particular skill or function for daily living to learn, improve or keep such skill or function, as long as measurable progress can be documented.

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.

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. Investigative services may also be referred to as investigational, unproven or experimental. 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.

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.

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 provider (such as a hospital, physician, home health agency, skilled nursing facility or pharmacy) that has entered into a written agreement with Medica or has made other arrangements with Medica to provide benefits to you. The network is identified online in your plan's provider directory. The participation status of providers will change from time to time.

The network provider directory will be furnished automatically, without charge and it may be obtained by signing in to **Medica.com/SignIn** or by contacting Customer Service.

Non-network. A provider not under contract as a network provider.

Non-network provider reimbursement amount. The amount that the plan 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; or

5. An amount required by the No Surprises Act of 2020, when applicable.

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 coinsurance or deductible amount you may be responsible for according to the terms described in this plan. Furthermore, such difference will not be applied toward the out-of-pocket maximum described in **What's Covered and How Much Will I Pay**. 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.

Out-of-pocket maximum. An accumulation of copayments, coinsurance and deductibles paid for benefits received during a calendar year. Unless otherwise specified, you will not be required to pay more than the applicable per covered person out-of-pocket maximum for benefits received during a calendar year.

Amounts reimbursed or paid by a provider or manufacturer, including manufacturer coupons, rebates, coupon cards, debit cards or other forms of reimbursement or payment on your behalf for a product or service, will not apply toward your out-of-pocket maximum.

The time period used to calculate whether you have met the out-of-pocket maximum (calendar year or plan year) is determined by the plan between Medica and the sponsor or its designee. If this time period changes when Medica and the sponsor renews the plan, you will receive a new plan document that will specify the newly applicable time period and may have additional out-of-pocket expenses associated with this change.

After an applicable out-of-pocket maximum has been met, 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 the plan, or charge in excess of the non-network provider reimbursement amount, or charge you pay in addition to your deductible, copayment or coinsurance when you choose to use a preferred brand or non-preferred brand prescription drug when a chemically equivalent generic drug is available.

The plan 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 the plan.

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 enrollee or enrollee'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 enrollee ends if the placement is interrupted before legal adoption is finalized and the child is removed from placement.)

Plan. The plan of health care coverage established by sponsor for its covered persons, as this plan currently exists or may be amended in the future.

Plan administration functions. Administration functions performed by sponsor or plan administrator on behalf of the plan (such as quality assurance, claims processing, auditing and other similar functions). Plan administration functions do not include functions performed by sponsor or plan administrator in connection with any other benefit or benefit plan of sponsor or employer member.

Plan administrator. HERON LAKE-OKABENA ISD 330.

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.

Prescription insulin drugs. Prescription drugs that contain insulin and are used to treat diabetes.

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 covered person involved;
3. With respect to covered persons 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 covered persons 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 (including Food and Drug Administration approved contraceptive methods, sterilization procedures and related patient education and counseling).

Contact Customer Service for information regarding specific preventive health services or visit the Health & Human Services website at **HHS.gov/healthcare** and search for "preventive services" to learn more about what's covered.

Professionally administered drugs. Drugs that require intravenous infusion or injection, intrathecal infusion or injection, intramuscular injection or intraocular injection, as well as drugs that, according to the manufacturer's recommendations, must typically be administered by a health care provider.

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

Qualified employee. The plan administrator determines an employee's status as a qualified employee.

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.

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.

Surgery that is cosmetic is not 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.

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.

Retail health clinic. Professional evaluation and medical management services provided to patients in a health care clinic located in a setting such as a retail store, grocery store or

pharmacy. Services include treatment of common illnesses and certain preventive health care services.

Retiree. A former employee who is an enrollee under the plan immediately preceding retirement and who, upon retirement:

1. Is receiving a disability benefit from a Minnesota public pension plan other than a volunteer firefighter plan or an annuity from a Minnesota public pension plan other than a volunteer firefighter plan; or
2. Has met age and service requirements to receive an annuity from such a plan as described in 1. above.

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. Skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:

1. Care must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient; and
2. Care is ordered by a physician; and
3. Care is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair; and
4. Care requires clinical training in order to be delivered safely and effectively.

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.

Step therapy. A process that involves trying an alternative covered drug first before moving to another covered drug for treatment of the same medical condition.

Telemedicine. Telemedicine is the delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site. An originating site includes a health care facility at which a patient is located at the time the services are provided by means of telemedicine. A distant site means a site at which a licensed health care provider is located while providing health care services or consultations by means of telemedicine. A communication between a licensed health care provider and a patient that consists solely of an email or facsimile transmission does not constitute telemedicine consultations or services.

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:

1. 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
2. Renders the employee unable to perform the duties of any business or occupation for which he or she is reasonably fitted after the first two years of the disability.

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, in locations such as their home or office, through email, telephone or webcam. Virtual care is used to address non-urgent medical symptoms for covered persons 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 qualified employee and/or dependent is eligible to become covered under the plan (as determined by the employer member's eligibility requirements). However, if a qualified employee or dependent enrolls through either an open enrollment period or a special enrollment period as set forth in **Who's Eligible for Coverage and How Do They Enroll**, any period before such open or special enrollment is not a waiting period. Periods of employment in an employment classification that is not eligible for coverage under the plan do not constitute a waiting period.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn’t in your health plan’s network.

“Out-of-network” describes providers and facilities that haven’t signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called “**balance billing**.” This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you can’t control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan’s in-network cost-sharing amount (such as copayments and coinsurance). You **can’t** be balance billed for these emergency services. This includes services you may get after you’re in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan’s in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can’t** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can’t** balance bill you, unless you give written consent and give up your protections.

You’re never required to give up your protections from balance billing. You also aren’t required to get care out-of-network. You can choose a provider or facility in your plan’s network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact *Minnesota Department of Commerce at* **651-539-1600** or **1-800-657-3602**.

Visit **Medica.com/MemberTips** for more information about your rights under federal law.

Signature

IN WITNESS WHEREOF, the _____ of the employer member has executed the foregoing plan on behalf of sponsor on this _____ day of _____ _____, _____.

By: _____
(please print)

_____
(signature)

Its: _____