

Medica Elect And Medica Essential

*Certificate of
Coverage*

MEDICA®

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Introduction

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

See *Definitions*. In this section, these words have specific meanings: benefits, care system, claim, dependent, designated mental health/substance abuse provider, medically necessary, member, network, preferred network, premium, primary care clinic, provider, referral, service area.

Medica Health Plans (Medica), together with its affiliate, Medica Insurance Company (MIC), offers Medica Elect and Medica Essential. Medica provides coverage for your in-network benefits and MIC provides coverage for your out-of-network benefits. This Certificate of Coverage (this certificate) describes health services that are eligible for coverage and the procedures you must follow to obtain benefits.

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

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

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

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

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

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

To be eligible for benefits

Each time you receive health services, you must:

1. Identify yourself as a Medica Elect or Medica Essential member;
2. Present your Medica Elect or Medica Essential identification card. (If you do not show your Medica Elect or Medica Essential identification card, providers have no way of knowing that you are a Medica Elect or Medica Essential member and you may receive a bill for health services or be required to pay at the time you receive health services.) However, possession and use of a Medica Elect or Medica Essential identification card does not necessarily guarantee coverage.

Network providers are required to submit claims within 180 days from when you receive a service. If your provider asks for your health care identification card and you do not identify

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yourself as a Medica member within 180 days of the date of service, you may be responsible for paying the cost of the service you received.

3. Follow the rules described in *How To Access Your Benefits*, which provides important information concerning how to access your in-network and out-of-network benefits.

Language interpretation

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

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

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

Acceptance of coverage

This certificate is not a legal contract between you and Medica. It is simply an explanation of the benefits covered under the Contract between Medica and the employer.

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

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

You understand and agree that any omissions or incorrect statements knowingly made by you in connection with your enrollment under the Contract may invalidate your coverage.

Nondiscrimination policy

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

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

A. *Member Rights And Responsibilities*

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

Member bill of rights

As a member of Medica Elect or Medica Essential, you have the right to:

1. Available and accessible services, including emergency services (defined in this certificate) 24 hours a day, seven days a week; and
2. Information about your health condition, appropriate or medically necessary treatment options and risks, regardless of cost or benefit coverage, so you can make an informed choice about your health care; and
3. Participate with providers in decision making regarding your health care, including the right to refuse treatment recommended to you by Medica or any provider; and
4. Be treated with respect and recognition of your dignity and privacy; including privacy of your medical and financial records maintained by Medica or any network provider in accordance with existing law; and
5. Contact Medica and Minnesota's Commissioner of Health to file a complaint about issues related to in-network benefits or Minnesota's Commissioner of Commerce to file a complaint about issues related to out-of-network benefits (see *Complaints*). To file a complaint with the Minnesota Department of Health, call (651) 201-5100 or 1-800-657-3916 and request HMO information. To file a complaint with the Minnesota Department of Commerce, call (651) 296-2488 and request insurance information. You may begin a legal proceeding if you have a problem with Medica or any provider; and
6. Receive information about Medica, its services, its practitioners and providers, and member rights and responsibilities; and
7. Appeal a decision regarding your health care coverage by calling Customer Service at one of the telephone numbers listed inside the front cover. See *Complaints* for more information on your appeal rights; and
8. Make recommendations regarding Medica's member rights and responsibilities statement.

Member responsibilities

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

1. Establishing a relationship with a primary care clinic before becoming ill, as this allows for continuity of care; and
2. Providing the necessary information to health care professionals or Medica needed to determine the appropriate care. This objective is best obtained when you share:
 - a. Information about lifestyle practices; and
 - b. Personal health history; and

Member Rights And Responsibilities

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

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

B. How To Access Your Benefits

See Definitions. These words have specific meanings: benefits, care system, claim, coinsurance, convenience care/retail health clinic, copayment, deductible, dependent, designated mental health/substance abuse provider, emergency, enrollment date, e-visits, hospital, inpatient, late entrant, medically necessary, member, network, non-network, non-network provider reimbursement amount, physician, placed for adoption, preferred network, premium, prescription drug, primary care clinic, provider, qualifying coverage, reconstructive, referral, restorative, skilled nursing facility, standing referral, subscriber, travel program, urgent care center, waiting period.

1. Important member information about in-network benefits

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

Benefits

Medica will cover health services and supplies as in-network benefits only if they are:

- a. provided by your primary care clinic; or
- b. provided by a network provider and referred by your primary care clinic or accessed through the procedures required by your care system; or
- c. provided by your designated mental health/substance abuse provider; or
- d. provided by a preferred network convenience care/retail health clinic or urgent care center; or
- e. provided by a network chiropractor; or
- f. provided by a network Ob/Gyn physician within your care system; or
- g. specifically authorized by Medica as in-network benefits.

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

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

Coverage for diagnosed Lyme disease is covered the same as any other illness under this certificate.

Referrals

Certain health services are covered only upon referral; read this certificate carefully for referral requirements. *With the exception of open access services as described in this certificate, all referrals to non-network providers and certain types of network providers must be prior authorized by Medica to be eligible for coverage at the in-network benefit level.*

How To Access Your Benefits

Emergency services

Emergency services from non-network providers will be covered as in-network benefits only if you follow required procedures. This certificate explains these procedures and the covered health services associated with emergency care. See *Emergency Services From Non-Network Providers* for more detailed instructions on emergency health services received from non-network providers. To be eligible for in-network benefits, follow-up care or scheduled care after an emergency must be received from a network provider.

Providers

Enrolling in Medica Elect or Medica Essential does not guarantee that a particular provider or primary care clinic (in the Medica Elect or Medica Essential provider directory) will remain a Medica Elect or Medica Essential network provider or provide you with health services. When a provider no longer participates with Medica Elect or Medica Essential, you must choose to receive health services from Medica Elect or Medica Essential network providers, to continue to be eligible for in-network benefits. (You will also have to select a new primary care clinic *if* your primary care clinic no longer participates with Medica Elect or Medica Essential.)

Not all Medica providers are Medica Elect or Medica Essential providers. See your Medica Elect or Medica Essential provider directory for a listing of Medica Elect or Medica Essential providers.

You must verify that your provider is a Medica Elect and Medica Essential network provider each time you receive health services.

Exclusions

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

Mental health and substance abuse

Your designated mental health/substance abuse provider will arrange your mental health and substance abuse benefits. Your designated mental health/substance abuse provider uses a limited network of hospitals for the provision of mental health and substance abuse benefits. Except for emergencies:

- All mental health and substance abuse services must be arranged by your designated mental health/substance abuse provider; and
- A treatment plan, including any inpatient services, must be prior authorized by your designated mental health/substance abuse provider to be eligible for coverage.

Continuation/conversion

You may continue coverage or convert to an individual conversion plan under certain circumstances. See *Continuation* and *Conversion* for additional information.

Cancellation

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

Newborn coverage

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

Prescription drugs and medical equipment

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

Post-mastectomy coverage

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

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

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

Benefits

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

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

MIC pays out-of-network benefits for eligible health services that are:

- a. received from a network provider other than your primary care clinic, designated mental health/substance abuse provider, a network chiropractor, or network Ob/Gyn physician within your care system without having been referred by your primary care clinic or without following the access procedures required by your care system; or
- b. received from a non-network provider. **Please note:** MIC will only pay for services received from non-network providers at the in-network benefit level if you have both: (1) a referral from your primary care clinic or appropriate care system provider, and (2) a specific authorization from MIC for payment of those services at the in-network benefit

How To Access Your Benefits

level. Medica or MIC generally provides such authorizations only in situations where the requested services are not available from network providers.

Emergency services received from (and prior authorized referrals to) non-network providers are covered as in-network benefits and are *not* considered out-of-network benefits (provided you follow proper procedures).

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

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

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

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

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

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

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

you have previously reached your out-of-pocket maximum with amounts paid for other services.

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

Coverage for diagnosed Lyme disease is covered the same as any other illness under this certificate.

Travel program

Medica has made arrangements for you to receive medically necessary services at the in-network benefit level when you are traveling outside the service area and do not have access to a network provider. Travel program coverage is subject to all of the terms and conditions set forth in this certificate. Call Customer Service at one of the telephone numbers listed inside the front cover to confirm that your provider is a travel program provider, and present your identification card at the time of service. This program is not available for all services (i.e., e-visits or chiropractic services) and may not be available in all areas.

Lifetime maximum amount

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

Exclusions

Some health services, such as preventive care (described in *Professional Services*), are not covered as out-of-network benefits. Read this certificate for a detailed explanation of exclusions.

Claims

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

Post-mastectomy coverage

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

3. *Selecting a primary care clinic*

You must select a primary care clinic from the list of providers designated by Medica as primary care clinics. You may select the same or a different primary care clinic for yourself and each of your dependents. If you do not select a primary care clinic, Medica will designate one for you. For any questions regarding the selection of a primary care clinic, contact Customer Service at one of the telephone numbers listed inside the front cover.

- Selection of your primary care clinic determines your care system.

How To Access Your Benefits

- Before selecting a primary care clinic, you must notify the selected primary care clinic(s) of the selection, and confirm that each primary care clinic is participating with Medica Elect or Medica Essential, and is accepting new Medica Elect or Medica Essential members.
- You may change your primary care clinic once in any calendar month. You may change your primary care clinic by notifying Medica at least 10 days *before* the first day of the next month, on which date the change will take effect.
- If you change your primary care clinic and are receiving services through a referral from your previous primary care clinic, you must obtain a new referral from your new primary care clinic. If a new referral is not obtained, services will be processed as out-of-network benefits, or may not be covered, as appropriate. There is no assurance that your new primary care clinic will refer you to the same provider.

There is no assurance that a particular primary care clinic will remain a primary care clinic or continue to be available to accept you as a patient.

You will be notified by Medica if your primary care clinic no longer participates with Medica Elect or Medica Essential. At that time, you must then choose a new primary care clinic from the list of providers designated by Medica as primary care clinics.

4. Referrals

Certain health services require a referral from your primary care clinic to be eligible for in-network benefits. Contact your primary care clinic or care system to determine the health services that require a referral.

If your network Ob/Gyn physician recommends that you seek specialized services from another provider, you must obtain a referral from your primary care clinic.

If you wish to apply for a standing referral to a provider who is a specialist, contact your primary care clinic. Under certain circumstances, your primary care clinic or care system may grant a standing referral.

A referral from your primary care clinic is not required for the following:

- a. Preferred network convenience care/retail health clinic or urgent care center visits.
- b. Health services provided by a network chiropractor.
- c. Health services provided by a network Ob/Gyn physician within your care system.
- d. You are not required to designate a network Ob/Gyn physician nor are you required to obtain a referral from your primary care clinic to receive services from your network Ob/Gyn physician.
- e. Mental health or substance abuse services provided by your designated mental health/substance abuse provider.

If you would like to receive benefits that are identified in this certificate as requiring prior authorization from Medica, you must obtain this prior authorization regardless of whether you have already obtained a referral.

Referrals to network providers

You must follow the access procedures established by your care system, which may or may not include a referral from your primary care clinic.

If a referral from your primary care clinic is required, before you receive services, you must obtain a written referral (on a Medica form) from your primary care clinic indicating the provider from whom you will receive the referral health services.

If your referral provider recommends health services not specifically identified in the original referral, you must obtain a *new* written referral (on a Medica form) from your primary care clinic prior to receiving additional or other health services.

Certain services also require prior authorization from Medica *before* you receive health services, whether or not you have already obtained a referral from your primary care clinic or followed your care system's access procedures. (See 6. *Prior authorization* below for more information.)

In addition, if you change primary care clinics, you must obtain a referral from your new primary care clinic before obtaining referral health services.

Referrals to non-network providers

Referrals from your primary care clinic or care system to a non-network provider may be eligible for coverage as in-network benefits.

To ensure that you receive your highest level of benefits for referrals to non-network providers, you must:

- i. Obtain a written referral (on a Medica form) from your primary care clinic or care system.
- ii. Call Medica to request authorization to obtain services from the non-network provider at the in-network benefit level (see 6. *Prior authorization* below). Note that such authorizations are generally provided only in situations where the requested services are not available from network providers.
- iii. Obtain a *new* written referral (on a Medica form) from your primary care clinic or care system prior to receiving additional or other health services if your referral provider recommends health services not specifically identified in the original referral.
- iv. Obtain a *new* written referral (on a Medica form) from your new primary care clinic before receiving referral health services, if you change primary care clinics.

Medica provides coverage for services that are otherwise eligible for coverage under this certificate and determined by Medica not to be available from your primary care clinic, care system, or other network providers. Medica will notify you of approval or denial of coverage. (See 6. *Prior authorization* below for more information.)

5. Continuity of care

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

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

- a. If Medica terminates its contract with your current primary care provider, specialist or hospital without cause, you may be eligible to continue care with that provider at the in-network benefit level.

How To Access Your Benefits

- b. If you are a new Medica member as a result of your employer changing health plans and your current primary care provider, specialist or hospital is not a network provider, you may be eligible to continue care with that provider at the in-network benefit level.

This applies only if your provider agrees to comply with Medica's prior authorization requirements, provide Medica with all necessary medical information related to your care, and accept 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, Medica 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 for up to 120 days as described in a. and b. above for the following conditions:

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

Authorization to continue to receive services from your current primary care provider, specialist or hospital may extend to the remainder of your life if a physician 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 a. and b. 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 within the time and distance requirements defined in Minnesota law; or
- if you do not speak English and Medica does not have a network provider who can communicate with you, either directly or through an interpreter, within the time and distance requirements defined in Minnesota law.

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

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

6. Prior authorization

Prior authorization from Medica may be required before you receive certain services or supplies in order to determine whether a particular service or supply is medically necessary

and a benefit. This applies even when services are provided or referred by your primary care clinic or care system.

Medica uses written procedures and criteria when reviewing your request for prior authorization.

To request prior authorization for a service or supply, either you, someone on your behalf or your attending provider must call Medica.

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

- Reconstructive or restorative surgery;
- Treatment of a diagnosed temporomandibular joint disorder or craniomandibular disorder;
- Organ and bone marrow transplant;
- Home health care;
- Medical supplies and durable medical equipment;
- Outpatient surgical procedures;
- Certain genetic tests;
- Skilled nursing facility services; and
- In-network benefits for services from non-network providers.

This is not an all-inclusive list of all services and supplies that may require prior authorization. To determine whether a certain service or supply requires prior authorization or to obtain a current list of services and supplies that require prior authorization, please call Medica at one of the telephone numbers listed inside the front cover.

If a network provider fails to obtain prior authorization *after* you have consulted with them about services requiring prior authorization, you are not subject to a penalty for failure to obtain prior authorization.

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

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

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

Medica will inform both you and your provider of Medica's decision within 72 hours from the time of the initial request if your attending provider believes that an expedited review is warranted, or Medica concludes that a delay could seriously jeopardize your life, health, or ability to regain maximum function.

How To Access Your Benefits

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

If Medica fails to respond within the required timeframe, benefits will be covered unless excluded in this certificate.

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

7. Certification of qualifying coverage

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

C. How Providers Are Paid By Medica And MIC

This section describes how Medica and MIC generally pay providers for health services.

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

Network providers

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

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

The methods by which specific network providers are paid may change from time to time. Methods also vary by network provider. The primary method of payment under Medica Elect and Medica Essential is an amount per service with a targeted outcome.

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

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

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

Non-network providers

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

Your Out-Of-Pocket Expenses

D. *Your Out-Of-Pocket Expenses*

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

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

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

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

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

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

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

Copayments, coinsurance, and deductibles

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

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

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

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

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

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

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

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

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

2. For out-of-network benefits received from a non-network provider, any charge that exceeds the non-network provider reimbursement amount. This means you are required to pay the difference between what Medica or MIC pays to the provider and what the provider bills.

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

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

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

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

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

More information concerning deductibles

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

Your Out-Of-Pocket Expenses

If you were enrolled under a Medica Elect and Medica Essential contract during the last three months of a calendar year, deductibles paid for eligible benefits during that period will apply to the deductible for the next calendar year.

Out-of-pocket maximum

The out-of-pocket maximum is an accumulation of copayments, coinsurance, and deductibles paid for benefits received during a calendar year. Except as described below or as otherwise specified, you will *not* be required to pay more than the applicable per member out-of-pocket maximum for benefits received during a calendar year (see the Out-of-Pocket Expenses table in this section). **Please note: Charges for services not eligible for coverage and any charge in excess of the non-network provider reimbursement amount are *not* applicable toward the out-of-pocket maximum. Additionally, you will owe these amounts regardless of whether you previously reached your out-of-pocket maximum with amounts paid for other services.**

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

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

After an applicable out-of-pocket maximum has been met for a particular type of benefit (as described in the Out-of-Pocket Expenses table in this section), all other covered benefits of the same type received during the rest of the calendar year will be covered at 100 percent, except for any charge not covered by Medica or charge in excess of the non-network provider reimbursement amount. However, you will still be required to pay any applicable copayments, coinsurance and deductibles for other types of benefits received.

After you satisfy the out-of-pocket maximum for any calendar year, some providers may require that you continue to pay a copayment, coinsurance, or deductible amount. If this happens, Medica or the provider will refund the amount over the out-of-pocket maximum when proof of excess copayments, coinsurance, and deductibles is received and verified by Medica.

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

Lifetime maximum amount

The lifetime maximum amount payable per member for out-of-network benefits under the Contract and for out-of-network benefits under any other Medica, MIC or Medica Health Plans of

Your Out-Of-Pocket Expenses

Wisconsin coverage offered through the same employer is described in the Out-of-Pocket Expenses table in this section. You should monitor the amount paid for out-of-network benefits and contact Medica when you are close to reaching your lifetime maximum amount.

Out-of-Pocket Expenses

	In-network benefits	* Out-of-network benefits
<p>* For out-of-network benefits, in addition to the deductible, copayment, and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible or the out-of-pocket maximum.</p>		
Copayment or coinsurance	See specific benefit for applicable copayment or coinsurance.	
Deductible		
Per member	\$1,000	\$1,500
Per family	\$2,000	\$3,000
Out-of-pocket maximum		
Per member	\$2,000	\$3,000
Per family	\$4,000	\$6,000
Lifetime maximum amount payable per member	Unlimited	\$2,000,000
		Applies to all benefits you receive under this or any other Medica, MIC, or Medica Health Plans of Wisconsin coverage offered through the same employer

Professional Services

E. Professional Services

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

See Definitions. These words have specific meanings: benefits, care system, claim, coinsurance, convenience care/retail health clinic, copayment, deductible, emergency, e-visits, hospital, inpatient, member, network, non-network, non-network provider reimbursement amount, physician, preferred network, prenatal care, provider, referral, urgent care center.

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

Covered

For benefits and the amounts you pay, see the table in this section.

- *In-network benefits* apply to:
 1. Professional services received from your primary care clinic; or
 2. Professional services received from a network Ob/Gyn physician within your care system; or
 3. Professional services provided by a network provider and arranged through the access procedures required by your care system; or
 4. Professional services received from a preferred network convenience care/retail health clinic or urgent care center; or
 5. Professional services received from a preferred network chiropractor; or
 6. Professional services for testing and treatment of a sexually transmitted disease and testing for AIDS and other HIV-related conditions received from a network provider or a non-network provider; or
 7. Family planning services, for the voluntary planning of the conception and bearing of children, received from a network provider or a non-network provider.

Refer to *How To Access Your Benefits* for more information.

- *Out-of-network benefits* apply to professional services received other than as described under *In-network benefits* above or as specifically authorized by Medica or MIC as in-network benefits.

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

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

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

Also, more than one copayment or coinsurance may be required if you receive more than one service or see more than one provider per visit.

Not covered

Drugs provided or administered by a physician or other provider, except those requiring intravenous infusion or injection, intramuscular injection, or intraocular injection. Coverage for drugs is as described in *Prescription Drugs And Pharmacy Services*, *Specialty Prescription Drug Program*, and *Mail Service Prescription Drug Program* or otherwise described as a specific benefit in this certificate.

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

Professional Services

Your Benefits and the Amounts You Pay

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

<p>1. Office visits</p> <p>Please note: Some services received during an office visit may be covered under another benefit in this certificate. The most specific and appropriate benefit in this certificate will apply for each service received during an office visit.</p> <p>For example, certain services received during an office visit may be considered surgical services; see 11. below for coverage of these surgical services. In such instances, both an office visit copayment or coinsurance and outpatient surgical services copayment or coinsurance apply.</p> <p>Call Customer Service at one of the telephone numbers listed inside the front cover to determine in advance whether a specific procedure is a benefit and the applicable coverage level for each service that you receive.</p>	20% coinsurance	40% coinsurance
2. E-visits	20% coinsurance	No coverage
3. Convenience care/retail health clinic visits	20% coinsurance	40% coinsurance
4. Urgent care center visits	20% coinsurance	Covered as an in-network benefit.
5. Prenatal care services received from a physician during an office visit or an outpatient hospital visit	Nothing. The deductible does not apply.	Nothing. The deductible does not apply.

Your Benefits and the Amounts You Pay

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

- | | | |
|--|---|--|
| <p>6. Preventive health care
Please note: This only applies when the claim from your provider does not identify an existing condition or complaint about your health, regardless of the reasons that you scheduled your office visit.</p> | | |
| <p>a. Child health supervision services, including well-baby care</p> | Nothing. The deductible does not apply. | Nothing. The deductible does not apply. |
| <p>b. Immunizations</p> | Nothing. The deductible does not apply. | Nothing. The deductible does not apply. |
| <p>c. Early disease detection services including physicals</p> | Nothing. The deductible does not apply. | Nothing. The deductible does not apply. |
| <p>d. Routine screening procedures for cancer</p> | Nothing. The deductible does not apply. | Nothing. The deductible does not apply. |
| <p>7. Allergy shots</p> | Nothing. The deductible does not apply. | Nothing. The deductible does not apply. |
| <p>8. Refractive eye exams. Coverage is limited to one visit per calendar year for in-network and out-of-network benefits combined.</p> | Nothing. The deductible does not apply. In-network benefits will apply to one visit per calendar year without a referral from your primary care clinic for services received from a preferred network provider. | Nothing. The deductible does not apply. |
| <p>9. Chiropractic services to diagnose and to treat (by manual manipulation or certain therapies), conditions related to the muscles, skeleton, and nerves of the body</p> | 20% coinsurance | 40% coinsurance. Coverage is limited to a maximum of 15 visits per calendar year.
Please note: This visit limit includes chiropractic visits that you pay for in order to satisfy any part of your deductible. |

Professional Services

Your Benefits and the Amounts You Pay

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

10. Professional sign language interpreter services in a physician's office (Call Customer Service to arrange such services.)	Nothing. The deductible does not apply.	Nothing. The deductible does not apply.
11. Surgical services (as defined in the <i>Physicians' Current Procedural Terminology</i> code book) received from a physician during an office visit or an outpatient hospital or ambulatory surgical center visit	20% coinsurance	40% coinsurance
12. Anesthesia services received from a provider during an office visit or an outpatient hospital or ambulatory surgical center visit	20% coinsurance	Covered as an in-network benefit.
13. Services received from a physician during an emergency room visit	20% coinsurance	Covered as an in-network benefit.
14. Services received from a physician during an inpatient stay	20% coinsurance	40% coinsurance
15. Anesthesia services received from a provider during an inpatient stay, including maternity labor and delivery	20% coinsurance	Covered as an in-network benefit.
16. Services received from a physician during an inpatient stay for prenatal care and labor and delivery	Nothing. The deductible does not apply.	Nothing. The deductible does not apply.
17. Outpatient lab and pathology	20% coinsurance	Covered as an in-network benefit.
18. Outpatient x-rays and other imaging services	20% coinsurance	Covered as an in-network benefit.

Your Benefits and the Amounts You Pay

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

19. Other outpatient hospital or ambulatory surgical center services received from a physician	20% coinsurance	40% coinsurance
20. Treatment to lighten or remove the coloration of a port wine stain	20% coinsurance	40% coinsurance
21. Diabetes self-management training and education, including medical nutrition therapy, received from a provider in a program consistent with national educational standards (as established by the American Diabetes Association)	20% coinsurance	40% coinsurance
22. Neuropsychological evaluations/cognitive testing, limited to services necessary for the diagnosis or treatment of a medical illness or injury	20% coinsurance	40% coinsurance
23. Vision therapy and orthoptic and/or pleoptic training, to establish a home program, for the treatment of strabismus and other disorders of binocular eye movements. Coverage is limited to a combined in-network and out-of-network total of 10 training visits and 2 follow-up eye exams per calendar year. Please note: These visit and exam limits include visits and exams that you pay for in order to satisfy any part of your deductible.	20% coinsurance	40% coinsurance
24. Genetic counseling, whether pre- or post-test, and whether occurring in an office, clinic, or telephonically	20% coinsurance	40% coinsurance

Professional Services

Your Benefits and the Amounts You Pay

Benefits

In-network benefits after deductible

* Out-of-network benefits after deductible

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

25. Genetic testing when test results will directly affect treatment decisions or frequency of screening for a disease, or when results of the test will affect reproductive choices

20% coinsurance

Covered as an in-network benefit.

F. Prescription Drugs And Pharmacy Services

This section describes coverage for prescription drugs, some over-the-counter (OTC) drugs, and supplies received from a pharmacy. For purposes of this section, the word supplies means eligible diabetic equipment and supplies. For purposes of this section, the phrase “professionally administered drugs” means drugs requiring intravenous infusion or injection, intramuscular injection, or intraocular injection, and the phrase “self-administered drugs” means all other drugs. For coverage of specialty prescription drugs, see *Specialty Prescription Drug Program*.

See Definitions. These words have specific meanings: benefits, care system, claim, coinsurance, copayment, deductible, emergency, hospital, medically necessary, member, network, non-network, non-network provider reimbursement amount, physician, prescription drug, provider, urgent care center.

Preferred products

Medica has a list of drugs and supplies that identifies prescription drugs, some OTC drugs, and supplies that are preferred by Medica for dispensing to members. Where appropriate, Medica’s list of preferred drugs includes generic equivalents of brand name drugs and supplies. The list of preferred drugs also identifies whether a drug is classified by Medica as a preferred generic or preferred brand name drug. You will have your lowest copayment or coinsurance when you use preferred generic products.

The terms "generic" and "brand name" are used in the health care industry in different ways. To be sure that you know whether a drug is classified by Medica as generic or brand name, please review the following definitions:

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 resources that determine a drug’s classification as either brand name or generic. Not all products identified as a “generic” by the manufacturer, pharmacy, or your physician are classified by Medica as generic.

Brand name – 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 resources that determine a drug’s classification as either brand name or generic. Not all products identified as a “brand name” by the manufacturer, pharmacy, or your physician are classified by Medica as brand name.

If you have questions about the current classification of a drug on the list of preferred drugs, call Customer Service at one of the telephone numbers listed inside the front cover.

If you have questions about Medica’s lists of preferred drugs or whether a specific specialty prescription drug, prescription drug, OTC drug, or supply is covered, or would like to request a copy of the lists of preferred drugs at no charge, call Customer Service at one of the telephone numbers listed inside the front cover. The lists of preferred drugs are also available on www.medica.com or www.mymedica.com.

The list of preferred drugs and appropriate use guidelines are periodically reviewed and modified by Medica. This may mean that a preferred drug or supply may become non-preferred

Prescription Drugs And Pharmacy Services

when a more appropriate generic equivalent becomes available. Your pharmacist will dispense the generic equivalent of drugs or supplies according to the list of preferred drugs.

Medica occasionally adds OTC drugs to the list of preferred drugs. However, these preferred OTC drugs must be prescribed by a provider and dispensed at a pharmacy.

Network providers, network pharmacies, and members have access to Medica's list of preferred drugs.

Medica's appropriate use guidelines are based on United States Food and Drug Administration (FDA) approval, manufacturer's packaging guidelines, and clinical publications.

Non-preferred products

Non-preferred products are prescription drugs and supplies that are not on the list of preferred drugs. These may be brand name prescription drugs or supplies that have a therapeutically equivalent brand name or generically equivalent product on the list of preferred drugs. If you use non-preferred products, you will have a higher copayment or coinsurance.

Exceptions to the list of preferred drugs

Your physician may request that Medica make an exception to allow the preferred copayment or coinsurance for a non-preferred prescription drug or OTC drug. Medica will work with your physician to determine if an exception is appropriate for your medical condition. An exception will be granted if the preferred drug causes an adverse reaction, is contraindicated, or when the prescribing physician demonstrates that a drug must be dispensed as written to provide maximum medical benefit. Exceptions to the list of preferred drugs can 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 list of preferred drugs or you change health plans. If you would like to request a copy of Medica's preferred drug exception process, call Customer Service at one of the telephone numbers listed inside the front cover.

Step therapy

Medica requires step therapy for coverage of specific prescription drugs for certain medical conditions. Step therapy involves trying an alternative prescription drug first (typically a generic drug) before moving on to a second or third level drug (whether preferred or non-preferred) for treatment of the same medical condition. Applicable step therapy requirements must be met before Medica will cover second or third level drugs.

Prior authorization

Certain prescription drugs, preferred OTC drugs, and supplies require prior authorization. The provider who prescribes the drug or supply initiates prior authorization. Network providers, including network pharmacies, are given a list that identifies which preferred drugs and supplies require prior authorization.

You are responsible for paying the cost of prescription drugs, preferred OTC drugs, or supplies you receive if you do not meet Medica's authorization criteria for the drug or supply.

Covered

For benefits and the amounts you pay, see the table in this section.

- *In-network benefits* apply to:
 1. Prescription drugs or preferred OTC drugs, including smoking cessation products, prescribed by a provider (authorized to prescribe the drug) and received at a network pharmacy; and
 2. Prescription drugs or preferred OTC drugs prescribed by an Ob/Gyn physician within your care system and received at a network pharmacy; and
 3. Prescription drugs or preferred OTC drugs for family planning services or the treatment of sexually transmitted diseases when prescribed by or received from either a network or a non-network provider; and
 4. Diabetic equipment and supplies, including blood glucose meters (described in this section) ordered or prescribed by a provider when received from a network pharmacy.
- *Out-of-network benefits* apply to:
 1. Prescription drugs or preferred OTC drugs, including smoking cessation products, prescribed by a provider authorized to prescribe the drug and received at a non-network pharmacy; and
 2. Diabetic equipment and supplies, including blood glucose meters (described in this section) ordered or prescribed by a provider when received from a non-network pharmacy.

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

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

See *Specialty Prescription Drug Program* for coverage of specialty prescription drugs.

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

Prescription unit

Prescription drugs, preferred OTC drugs, and supplies will not be dispensed in excess of one prescription unit except as described below. Three prescription units may be dispensed for drugs and supplies prescribed to treat chronic conditions that are received at a network pharmacy that Medica has specifically designated to dispense multiple prescription units. For the current list of such designated pharmacies, call Customer Service at one of the telephone numbers listed inside the front cover. This list is also available on www.medica.com or www.mymedica.com. Copayments or coinsurance amounts will apply to each prescription unit dispensed. When you have used 75 percent of your prescription, you may refill your prescription before your refill date.

Prescription Drugs And Pharmacy Services

1. For prescription drugs and preferred OTC drugs, including smoking cessation products, one prescription unit is equal to:
 - a. Up to a 34-consecutive-day supply (unless limited by the drug manufacturer's packaging or Medica's appropriate use guidelines);
 - b. Up to a 34-consecutive-day supply per type of insulin; or
 - c. A one-cycle supply of oral contraceptives.
2. For diabetic supplies, one prescription unit is equal to the greater of:
 - a. Up to a 34-consecutive-day supply (unless limited by the drug manufacturer's packaging or Medica's appropriate use guidelines); or
 - b. 100 units.

Smoking cessation products may be limited by the drug manufacturer's dosing instructions for appropriate use or Medica's appropriate use guidelines.

Not covered

The following are not covered:

1. Any amount above what Medica would have paid when you fail to identify yourself to the pharmacy as a member. (Medica will notify you before enforcement of this provision.)
2. OTC drugs that by federal or state law do not require a prescription order or refill and any medication that is equivalent to an OTC drug (except OTC drugs that are on the list of preferred drugs and that are received as described in this section).
3. Replacement of a drug or supply due to loss, damage, or theft.
4. Appetite suppressants.
5. Drugs and supplies prescribed by a provider who is not acting within their scope of licensure.
6. Specialty prescription drugs, except as described in *Specialty Prescription Drug Program*.
7. Homeopathic medicine.

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

Prescription Drugs And Pharmacy Services

Your Benefits and the Amounts You Pay

Benefits

**In-network benefits
after deductible**

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

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

- | | | |
|--|---|---|
| <p>1. Outpatient prescription drugs and preferred OTC drugs, including smoking cessation products, other than those described below or in <i>Specialty Prescription Drug Program</i></p> | <p>Preferred generic: \$10 per prescription unit; or
Preferred brand name: \$25 per prescription unit; or
Non-preferred: \$50 per prescription unit</p> <p>The deductible does not apply.</p> | <p>\$50 or 40% coinsurance (whichever is greater) per prescription unit</p> |
| <p>2. Up to a 24-hour supply of emergency prescription drugs or preferred OTC drugs received from a hospital or urgent care center</p> | <p>Nothing. The deductible does not apply.</p> | <p>Covered as an in-network benefit.</p> |
| <p>3. Diabetic equipment and supplies, including blood glucose meters</p> | <p>Preferred generic: 20% coinsurance per prescription unit; or
Preferred brand name: 20% coinsurance per prescription unit; or
Non-preferred: 20% coinsurance per prescription unit</p> <p>The deductible does not apply.</p> | <p>40% coinsurance per prescription unit</p> |
| <p>4. Infertility prescription drugs</p> | <p>Preferred generic: \$10 per prescription unit; or
Preferred brand name: \$25 per prescription unit; or
Non-preferred: \$50 per prescription unit</p> <p>The deductible does not apply.</p> | <p>\$50 or 40% coinsurance (whichever is greater) per prescription unit</p> |

Specialty Prescription Drug Program

G. Specialty Prescription Drug Program

This section describes coverage for specialty prescription drugs received from a designated specialty prescription drug pharmacy. Specialty prescription drugs include but are not limited to high technology prescription drug products for individuals with diseases that require complex therapies. Such specialty prescription drugs are identified on Medica's list of preferred specialty prescription drugs, as described below. Many of these prescription drugs require special handling and close patient monitoring. For purposes of this section, the phrase "professionally administered drugs" means drugs requiring intravenous infusion or injection, intramuscular injection, or intraocular injection, and the phrase "self-administered drugs" means all other drugs.

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

Designated specialty prescription drug pharmacies

A designated specialty prescription drug pharmacy means a specialty prescription drug pharmacy that has entered into a separate contract with Medica to provide specialty prescription drug services to members.

For the current list of designated specialty prescription drug pharmacies, call Customer Service at one of the telephone numbers listed inside the front cover, or access www.medica.com or www.mymedica.com.

Preferred specialty prescription drugs

Medica has a list of specialty prescription drugs that identifies specialty prescription drugs that are preferred by Medica for dispensing to members. Where appropriate, the list of preferred specialty prescription drugs includes generic equivalents of brand name specialty prescription drugs. You will have your lowest copayment when you use preferred specialty prescription drugs.

The list of preferred specialty prescription drugs also identifies whether a drug is classified by Medica as a preferred generic or preferred brand name specialty prescription drug. You will have your lowest copayment when you use preferred generic products.

The terms "generic" and "brand name" are used in the health care industry in different ways. To be sure that you know whether a drug is classified by Medica as generic or brand name, please review the following definitions:

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 that determine a drug's classification as either brand name or generic. Not all products identified as a "generic" by the manufacturer, pharmacy or your physician are classified by Medica as a generic.

Brand name – 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 that determine a drug's classification as either brand name or

Specialty Prescription Drug Program

generic. Not all products identified as “brand name” by the manufacturer, pharmacy, or your physician are classified by Medica as brand name.

If you have questions about the current classification of a drug on the list of preferred specialty prescription drugs, call Customer Service at one of the telephone numbers listed inside the front cover.

If you have questions about Medica’s lists of preferred drugs or whether a specific specialty prescription drug, prescription drug, OTC drug, or supply is covered, or would like to request a copy of the lists of preferred drugs at no charge, call Customer Service at one of the telephone numbers listed inside the front cover. The lists of preferred drugs are also available on www.medica.com or www.mymedica.com.

The list of preferred specialty prescription drugs and appropriate use guidelines are periodically reviewed and modified by Medica. Designated specialty prescription drug pharmacies will dispense the generic equivalent of specialty prescription drugs according to the list of preferred specialty prescription drugs. Network providers, designated specialty pharmacies, and members have access to Medica’s list of preferred specialty prescription drugs.

Medica's appropriate use guidelines are based on United States Food and Drug Administration (FDA) approval, manufacturer's packaging guidelines, and clinical publications.

Non-preferred specialty prescription drugs

Non-preferred specialty prescription drugs are specialty prescription drugs that are not on the list of preferred specialty prescription drugs. These are generally specialty prescription drugs that have a therapeutically equivalent product on the list of preferred specialty prescription drugs. If you use non-preferred specialty prescription drugs, you will have a higher copayment.

Exceptions to the list of preferred specialty prescription drugs

Your physician may request that Medica make an exception to allow the preferred specialty prescription drug copayment for a non-preferred specialty prescription drug. Medica will work with your physician to determine if an exception is appropriate for your medical condition. An exception will be granted if the preferred drug causes an adverse reaction, is contraindicated, or when the prescribing physician demonstrates that a specialty prescription drug must be dispensed as written to provide maximum medical benefit. Exceptions to the list of preferred specialty prescription drugs can include antipsychotic drugs prescribed to treat emotional disturbance or mental illness, and certain specialty prescription drugs for diagnosed mental illness or emotional disturbance if removed from the list of preferred specialty prescription drugs or you change health plans. If you would like to request a copy of Medica’s preferred specialty prescription drug exception process, call Customer Service at one of the telephone numbers listed inside the front cover.

Prior authorization

Specialty prescription drugs may require prior authorization. The provider who prescribes the specialty prescription drug initiates prior authorization. Network providers, including designated specialty prescription drug pharmacies, are given a list that identifies which preferred specialty prescription drugs require prior authorization.

Specialty Prescription Drug Program

You are responsible for paying the cost of specialty prescription drugs you receive if you do not meet Medica's authorization criteria for the specialty prescription drug.

Covered

For benefits and the amounts you pay, see the table in this section.

- *Benefits* apply to specialty prescription drugs prescribed by a provider authorized to prescribe the specialty prescription drug and received from a designated specialty prescription drug pharmacy.

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

Prescription unit

Specialty prescription drugs will not be dispensed in excess of one prescription unit. However, when you have used 65 percent of your prescription, you may refill your prescription before your refill date.

For specialty prescription drugs, one prescription unit is equal to up to a 34-consecutive-day supply (unless limited by the specialty prescription drug manufacturer's packaging or Medica's appropriate use guidelines).

Not covered

The following are not covered:

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

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

Specialty Prescription Drug Program

Your Benefits and the Amounts You Pay

Benefits

You pay

1. Specialty prescription drugs, other than those described below, received from a designated specialty prescription drug pharmacy
 - Preferred generic specialty prescription drugs:** \$10 per prescription unit; or
 - Preferred brand name specialty prescription drugs:** \$25 per prescription unit; or
 - Non-preferred specialty prescription drugs:** \$50 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 prescription drug pharmacy
 - Preferred generic specialty prescription drugs:** \$10 per prescription unit; or
 - Preferred brand name specialty prescription drugs:** \$25 per prescription unit; or
 - Non-preferred specialty prescription drugs:** \$50 per prescription unit
3. Specialty infertility prescription drugs received from a designated specialty prescription drug pharmacy
 - Preferred generic specialty prescription drugs:** \$10 per prescription unit; or
 - Preferred brand name specialty prescription drugs:** \$25 per prescription unit; or
 - Non-preferred specialty prescription drugs:** \$50 per prescription unit

Mail Service Prescription Drug Program

H. Mail Service Prescription Drug Program

This section describes coverage for prescription drugs, some over-the-counter (OTC) drugs, and supplies received from the designated mail service prescription drug program when prescribed as described in this section. For purposes of this section, the word supplies means certain eligible diabetic equipment and supplies. For purposes of this section, the phrase “professionally administered drugs” means drugs requiring intravenous infusion or injection, intramuscular injection, or intraocular injection, and the phrase “self-administered drugs” means all other drugs. For coverage of specialty prescription drugs, see *Specialty Prescription Drug Program*.

See Definitions. These words have specific meanings: benefits, care system, claim, coinsurance, copayment, member, network, non-network, prescription drug, provider.

Preferred products

Medica has a list of drugs and supplies that identifies prescription drugs, some OTC drugs, and supplies that are preferred by Medica for dispensing to members. Where appropriate, Medica’s list of preferred drugs includes generic equivalents of brand name drugs and supplies. The list of preferred drugs also identifies whether a drug is classified by Medica as a preferred generic or a preferred brand name drug. You will have your lowest copayment or coinsurance when you use preferred generic products.

The terms “generic” and “brand name” are used in the health care industry in different ways. To be sure that you know whether a drug is classified by Medica as generic or brand name, please review the following definitions:

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 that determine a drug’s classification as either brand name or generic. Not all products identified as a “generic” by the manufacturer, pharmacy, or your physician are classified by Medica as generic.

Brand name – 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 that determine a drug’s classification as either brand name or generic. Not all products identified as a “brand name” by the manufacturer, pharmacy, or your physician are classified by Medica as brand name.

If you have questions about the current classification of a drug on the list of preferred drugs, call Customer Service at one of the telephone numbers listed inside the front cover.

If you have questions about Medica’s lists of preferred drugs or whether a specific specialty prescription drug, prescription drug, OTC drug, or supply is covered, or would like to request a copy of the lists of preferred drugs at no charge, call Customer Service at one of the telephone numbers listed inside the front cover. The lists of preferred drugs are also available on www.medica.com or www.mymedica.com.

The list of preferred drugs and appropriate use guidelines are periodically reviewed and modified by Medica. This may mean that a preferred drug or supply may become non-preferred when a more appropriate generic equivalent becomes available. The designated mail service

Mail Service Prescription Drug Program

prescription drug program will dispense the generic equivalent of drugs or supplies according to the list of preferred drugs. The designated mail service prescription drug program and members have access to Medica's list of preferred drugs.

Medica occasionally adds OTC drugs to the list of preferred drugs. However, these preferred OTC drugs must be prescribed by a provider and received from the designated mail service prescription drug program.

Medica's appropriate use guidelines are based on FDA approval, manufacturer's packaging guidelines, and clinical publications.

Non-preferred products

Non-preferred products are prescription drugs and supplies that are not on the list of preferred drugs. These may be brand name prescription drugs and supplies that have a therapeutically equivalent brand name or generically equivalent product on the list of preferred drugs. If you use non-preferred products, you will have a higher copayment or coinsurance.

Prior authorization

Certain prescription drugs, preferred OTC drugs, and supplies require prior authorization. The provider who prescribes the drug or supply initiates prior authorization. Network providers and the designated mail service prescription drug program are given a list of preferred drugs and supplies that require prior authorization.

You are responsible for paying the cost of prescription drugs, preferred OTC drugs, or supplies you receive if you do not meet Medica's authorization criteria for the prescription drug or supply.

Covered

Benefits apply to the following when received from the designated mail service prescription drug program:

1. Prescription drugs or preferred OTC drugs prescribed by a provider (authorized to prescribe the drug); and
2. Prescription drugs or preferred OTC drugs prescribed by an Ob/Gyn physician within your care system; and
3. Prescription drugs for family planning services or the treatment of sexually transmitted diseases when prescribed by either a network or a non-network provider; and
4. Diabetic equipment and supplies (described in this section).

See *Specialty Prescription Drug Program* for coverage of growth hormone.

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

Mail Service Prescription Drug Program

Prescription unit

Prescription drugs, preferred OTC drugs, and supplies will not be dispensed in excess of one prescription unit. However, when you have used 70 percent of your prescription, you may refill your prescription before your refill date.

1. For prescription drugs and preferred OTC drugs, one prescription unit is equal to:
 - a. Up to a 93-consecutive-day supply (unless limited by the drug manufacturer's packaging or Medica's appropriate use guidelines); or
 - b. Up to a 93-consecutive-day supply per type of insulin; or
 - c. A three-cycle supply of oral contraceptives.
2. For diabetic equipment and supplies, one prescription unit is equal to the greater of:
 - a. Up to a 93-consecutive-day supply (unless limited by the drug manufacturer's packaging or Medica's appropriate use guidelines); or
 - b. 100 units.

For prescription drugs and preferred OTC drugs, if less than one prescription unit (as described in this section) is requested, see *Prescription Drugs And Pharmacy Services* to determine your benefits.

Not covered

The following are not covered:

1. Any amount above what Medica would have paid when you fail to identify yourself to the designated mail service prescription drug program as a member. (Medica will notify you before enforcement of this provision.)
2. OTC drugs that by federal or state law do not require a prescription order or refill and any medication that is equivalent to an OTC drug (except OTC drugs that are on the list of preferred drugs and that are received as described in this section).
3. Replacement of a drug or supply due to loss, damage, or theft.
4. Appetite suppressants.
5. Smoking cessation products or services.
6. Drugs and supplies prescribed by a provider who is not acting within their scope of licensure.
7. Specialty prescription drugs, except as described in *Specialty Prescription Drug Program*.
8. Homeopathic medicine.

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

Mail Service Prescription Drug Program

Your Benefits and the Amounts You Pay

Benefits	You pay
1. Outpatient prescription drugs and preferred OTC drugs other than those described below or in <i>Specialty Prescription Drug Program</i>	Preferred generic: \$20 per prescription unit; or Preferred brand name: \$50 per prescription unit; or Non-preferred: \$100 per prescription unit
2. Diabetic equipment and supplies	Preferred generic: \$50 per prescription unit; or Preferred brand name: \$50 per prescription unit; or Non-preferred: \$50 per prescription unit
3. Infertility prescription drugs	Preferred generic: \$20 per prescription unit; or Preferred brand name: \$50 per prescription unit; or Non-preferred: \$100 per prescription unit

Hospital Services

I. Hospital Services

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

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

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

Newborns' and Mothers' Health Protection Act of 1996

Generally, Medica may not restrict benefits for any hospital stay in connection with childbirth for the mother or newborn child member to less than 48 hours following a vaginal delivery (or less than 96 hours following a cesarean section).

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

Covered

For benefits and the amounts you pay, see the table in this section.

- *In-network benefits* apply to hospital and ambulatory surgical center services:
 1. Arranged through your primary care clinic or through the access procedures required by your care system and received from a network hospital or ambulatory surgical center; or
 2. Arranged through a network Ob/Gyn physician within your care system and received from a network hospital or ambulatory surgical center; or
 3. That are outpatient services for an emergency provided in a network hospital emergency room. A referral is not required.

Arranging services through a network provider does not guarantee in-network benefits. Refer to *How To Access Your Benefits* for more information.

- *Out-of-network benefits* apply to hospital and ambulatory surgical center services received other than as described under *In-network benefits* above or as specifically authorized by Medica or MIC as in-network benefits.

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

calculation of out-of-pocket costs associated with out-of-network benefits. When out-of-network benefits are received from network providers, the non-network provider reimbursement amount does not apply.

More than one copayment or coinsurance may be required if you receive more than one service or see more than one provider per visit.

Each member's admission is separate from the admission of any other member. A separate deductible and copayment or coinsurance will be applied to both you and your newborn child for inpatient services related to maternity labor and delivery.

Not covered

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

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

Your Benefits and the Amounts You Pay

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

1. Outpatient services		
a. Services provided in a hospital emergency room	20% coinsurance	Covered as an in-network benefit.
b. Outpatient lab and pathology	20% coinsurance	Covered as an in-network benefit.
c. Outpatient x-rays and other imaging services	20% coinsurance	Covered as an in-network benefit.
d. Prenatal care services	Nothing. The deductible does not apply.	Nothing. The deductible does not apply.

Hospital Services

Your Benefits and the Amounts You Pay

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

e. Genetic testing when test results will directly affect treatment decisions or frequency of screening for a disease, or when results of the test will affect reproductive choices	20% coinsurance	Covered as an in-network benefit.
f. Other outpatient services	20% coinsurance	40% coinsurance
g. Other outpatient hospital and ambulatory surgical center services received from a physician	20% coinsurance	40% coinsurance
h. Anesthesia services received from a provider during an office visit or an outpatient hospital or ambulatory surgical center visit	20% coinsurance	Covered as an in-network benefit.
2. Services provided in a hospital observation room	20% coinsurance	40% coinsurance
3. Inpatient services, including inpatient maternity labor and delivery services	20% coinsurance except you pay nothing for inpatient services related to prenatal care services that do not result in a delivery	40% coinsurance
4. Services received from a physician during an inpatient stay	20% coinsurance	40% coinsurance
5. Anesthesia services received from a provider during an inpatient stay, including maternity labor and delivery	20% coinsurance	Covered as an in-network benefit.

J. Ambulance Services

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

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

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

Covered

For benefits and the amounts you pay, see the table in this section.

For non-emergency licensed ambulance services described in 2. in the table in this section:

- *In-network benefits* apply to ambulance services provided by a network provider and:
 1. Arranged through your primary care clinic; or
 2. Arranged through a network Ob/Gyn physician within your care system; or
 3. Arranged through the access procedures required by your care system.
- *Out-of-network benefits* apply to ambulance services received other than as described under *In-network benefits* above or as specifically authorized by Medica or MIC as in-network benefits.

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

Not covered

These services, supplies and associated expenses are not covered:

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

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

Ambulance Services

Your Benefits and the Amounts You Pay

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

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|---|-----------------|-----------------------------------|
| 1. Ambulance services or ambulance transportation to the nearest hospital for an emergency | 20% coinsurance | Covered as an in-network benefit. |
| 2. Non-emergency licensed ambulance service that is arranged through an attending physician, as follows: | | |
| a. Transportation from hospital to hospital when: <ul style="list-style-type: none"> i. Care for your condition is not available at the hospital where you were first admitted; or ii. Required by Medica | 20% coinsurance | 40% coinsurance |
| b. Transportation from hospital to skilled nursing facility | 20% coinsurance | 40% coinsurance |

K. Home Health Care

This section describes coverage for home health care. Home health care must be directed by a physician and received from a home health care agency authorized by the laws of the state in which treatment is received. Such services will be eligible for coverage if they are provided through Medica's managed care procedures.

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

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

Covered

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

Benefits covered under 1. and 2. in the table in this section are limited to a combined maximum of 56 hours of care per week. **Please note:** This hour limit includes any hours that you pay for in order to satisfy any part of your deductible.

- *In-network benefits* apply to home health care services:
 1. Arranged through your primary care clinic or through the access procedures required by your care system and received from a network home health care agency; or
 2. Arranged through a network Ob/Gyn physician within your care system and received from a network home health care agency.

Arranging services through a network provider does not guarantee in-network benefits. Refer to *How To Access Your Benefits* for more information.

- *Out-of-network benefits* apply to home health care services received other than as described under *In-network benefits* above or as specifically authorized by Medica or MIC as in-network benefits.

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

Home Health Care

network benefits are received from network providers, the non-network provider reimbursement amount does not apply.

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

Not covered

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

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

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

Your Benefits and the Amounts You Pay

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

- | | | |
|--|---|-----------------|
| 1. Intermittent skilled care when you are homebound, provided by or supervised by a registered nurse | 20% coinsurance except you pay nothing for high-risk prenatal care services | 40% coinsurance |
| 2. Skilled physical, speech, or occupational therapy when you are homebound | 20% coinsurance | 40% coinsurance |
| 3. Home infusion therapy | 20% coinsurance except you pay nothing for high-risk prenatal care services | 40% coinsurance |
| 4. Services received in your home from a physician | 20% coinsurance | 40% coinsurance |

Outpatient Rehabilitation

L. Outpatient Rehabilitation

This section describes coverage for both professional and outpatient health care facility services. A physician must direct your care.

See Definitions. These words have specific meanings: benefits, care system, coinsurance, copayment, deductible, network, non-network, non-network provider reimbursement amount, physician, primary care clinic, recreational therapy.

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

Covered

For benefits and the amounts you pay, see the table in this section.

- *In-network benefits* apply to outpatient rehabilitation services:

Arranged through your primary care clinic or through the access procedures required by your care system and received from a network physical therapist, a network occupational therapist, a network speech therapist, or a network physician.

Arranging services through a network provider does not guarantee in-network benefits. Refer to *How To Access Your Benefits* for more information.

- *Out-of-network benefits* apply to outpatient rehabilitation services arranged other than as described under *In-network benefits* above or as specifically authorized by Medica or MIC as in-network benefits.

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

Not covered

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

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

6. Correction of speech impediments and assistance in the development of verbal clarity when there is no reasonable expectation that the condition will improve over a predictable period of time according to generally accepted standards in the medical community.
7. Voice training.
8. Outpatient rehabilitation services when no medical diagnosis is present.
9. Group physical, speech, and occupational therapy.

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

Your Benefits and the Amounts You Pay

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

1. Physical therapy received outside of your home	20% coinsurance	40% coinsurance
2. Speech therapy received outside of your home when speech is impaired due to a medical illness or injury, or congenital or developmental conditions that have delayed speech development	20% coinsurance	40% coinsurance
3. Occupational therapy received outside of your home when physical function is impaired due to a medical illness or injury, or congenital or developmental conditions that have delayed motor development	20% coinsurance	40% coinsurance

M. Mental Health

This section describes coverage for services to diagnose and treat mental disorders listed in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders*.

See Definitions. These words have specific meanings: benefits, claim, coinsurance, copayment, custodial care, deductible, designated mental health/substance abuse provider, emergency, hospital, inpatient, medically necessary, member, mental disorder, network, non-network, physician, primary care clinic, provider.

Prior authorization is required. For prior authorization requirements of *in-network* and *out-of-network benefits*, call your designated mental health/substance abuse provider. To determine your designated mental health/substance abuse provider, contact your primary care clinic or refer to your Medica Elect or Medica Essential provider directory.

For purposes of this section:

1. Outpatient services include:
 - a. Diagnostic evaluations and psychological testing.
 - b. Psychotherapy and psychiatric services.
 - c. Intensive outpatient programs, including day treatment, meaning time limited comprehensive treatment plans, which may include multiple services/modalities and lodging, delivered in an outpatient setting (up to 19 hours per week).
 - d. Treatment for a minor, including family therapy.
 - e. Treatment of serious or persistent disorders.
 - f. Diagnostic evaluation for attention deficit hyperactivity disorder (ADHD) or pervasive development disorders (PDD).
 - g. Services, care, or treatment described as benefits in this certificate and ordered by a court on the basis of a behavioral health care evaluation performed by a physician or licensed psychologist and that includes an individual treatment plan.
 - h. Treatment of pathological gambling.
2. Inpatient services include:
 - a. Semi-private room and board.
 - b. Attending psychiatric services.
 - c. Hospital or facility-based professional services.
 - d. Partial program. This may be in a freestanding facility or hospital based. Active treatment is provided through specialized programming with medical/psychological intervention and supervision during program hours. Partial program means a treatment program of 20 hours or more per week and may include lodging.
 - e. Services, care, or treatment described as benefits in this certificate and ordered by a court on the basis of a behavioral health care evaluation performed by a physician or licensed psychologist and that includes an individual treatment plan.

- f. Residential treatment services. These services include either:
 - i. A residential treatment program serving children and adolescents with severe emotional disturbance, certified under Minnesota Rules parts 2960.0580 to 2960.0700; or
 - ii. A licensed or certified mental health treatment program providing intensive therapeutic services. In addition to room and board, at least 30 hours a week per individual of mental health services must be provided, including group and individual counseling, client education, and other services specific to mental health treatment. Also, the program must provide an on-site medical/psychiatric assessment within 48 hours of admission, psychiatric follow-up visits at least once per week, and 24-hour nursing coverage.

Covered

For benefits and the amounts you pay, see the table in this section.

- For *in-network benefits*:
 1. Your designated mental health/substance abuse provider arranges in-network mental health benefits.
 2. Notify your designated mental health/substance abuse provider as soon as reasonably possible after receiving any emergency mental health inpatient services.
 3. Second opinions from a qualified provider are covered under in-network benefits only if your primary care clinic or designated mental health/substance abuse provider determines that no treatment is necessary. Your designated mental health/substance abuse provider will consider the second opinion but is not required to accept it.

If you are seeking mental health benefits, you must contact your primary care clinic or refer to your Medica Elect or Medica Essential provider directory to determine your designated mental health/substance abuse provider.

- For *out-of-network benefits*:
 1. Out-of-network benefits apply to mental health services received other than as described under *in-network benefits* above or as specifically authorized by Medica or MIC as in-network benefits.
 2. Mental health services from a non-network provider listed below will be eligible for coverage under out-of-network benefits provided that the health care professional or facility is licensed, certified, or otherwise qualified under state law to provide the mental health services and practice independently:
 - a. Psychiatrist
 - b. Psychologist
 - c. Registered nurse certified as a clinical specialist or as a nurse practitioner in psychiatric and mental health nursing
 - d. Mental health clinic
 - e. Mental health residential treatment center
 - f. Independent clinical social worker

Mental Health

- g. Marriage and family therapist
- h. Hospital that provides mental health services

3. Emergency mental health services are eligible for coverage under in-network benefits.

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

Not covered

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

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

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

Your Benefits and the Amounts You Pay

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

- | | | |
|---|--|-----------------|
| 1. Outpatient services | | |
| a. Evaluations, diagnostic and treatment services | 10% coinsurance-group;
20% coinsurance-individual | 40% coinsurance |
| b. Intensive outpatient programs | 20% coinsurance | 40% coinsurance |
| 2. Inpatient services | | |
| a. Semi-private room and board | 20% coinsurance | 40% coinsurance |
| b. Hospital or facility-based professional services | 20% coinsurance | 40% coinsurance |
| c. Attending psychiatrist services | Nothing. The deductible does not apply. | 40% coinsurance |
| d. Partial program | 20% coinsurance | 40% coinsurance |

Substance Abuse

N. Substance Abuse

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

See Definitions. These words have specific meanings: benefits, claim, coinsurance, copayment, custodial care, deductible, designated mental health/substance abuse provider, emergency, hospital, inpatient, medically necessary, member, mental disorder, network, non-network, physician, primary care clinic, provider.

Prior authorization. For prior authorization requirements of *in-network* and *out-of-network benefits*, call your designated mental health/substance abuse provider. To determine your designated mental health/substance abuse provider, contact your primary care clinic or refer to your Medica Elect or Medica Essential provider directory.

For purposes of this section:

1. Outpatient services include:
 - a. Diagnostic evaluations.
 - b. Outpatient treatment.
 - c. Intensive outpatient programs, including day treatment and partial programs which may include multiple services/modalities and lodging delivered in an outpatient setting (between 9 and 19 hours per week).
 - d. Services, care, or treatment for a member that has been placed in the Minnesota Department of Corrections' custody following a conviction for a first-degree driving while impaired offense; to be eligible, such services, care, or treatment must be required and provided by the Minnesota Department of Corrections.
2. Inpatient services include:
 - a. Semi-private room and board.
 - b. Attending physician services.
 - c. Hospital or facility-based professional services.
 - d. Services, care, or treatment for a member that has been placed in the Minnesota Department of Corrections' custody following a conviction for a first-degree driving while impaired offense; to be eligible, such services, care, or treatment must be required and provided by the Minnesota Department of Corrections.
 - e. Substance abuse residential treatment services. These are services from a licensed chemical dependency rehabilitation program that provides intensive therapeutic services following detoxification. In addition to room and board, at least 30 hours per week per individual of chemical dependency services must be provided, including group and individual counseling, client education, and other services specific to chemical dependency rehabilitation.

Covered

For benefits and the amounts you pay, see the table in this section.

- For *in-network benefits*:
 1. Your designated mental health/substance abuse provider arranges in-network substance abuse benefits.
 2. In-network benefits will apply to services, care, or treatment for a member that has been placed in the Minnesota Department of Corrections' custody following a conviction for a first-degree driving while impaired offense. To be eligible, such services, care, or treatment must be required and provided by the Minnesota Department of Corrections.
 3. Notify your designated mental health/substance abuse provider as soon as reasonably possible after receiving any emergency substance abuse inpatient services.
 4. Second opinions from a qualified provider are covered under in-network benefits only if your primary care clinic or designated mental health/ substance abuse provider determines that no treatment is necessary. Your designated mental health/substance abuse provider will consider the second opinion but is not required to accept it.

If you are seeking substance abuse benefits, you must contact your primary care clinic or refer to your Medica Elect or Medica Essential provider directory to determine your designated mental health/substance abuse provider.

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

When out-of-network benefits are received from non-network providers: in addition to the applicable deductible and copayment or coinsurance, you will be responsible for any charges in excess of the non-network provider reimbursement amount. **The out-of-pocket**

Substance Abuse

maximum does not apply to these charges. Please see *Important member information about out-of-network benefits* in *How To Access Your Benefits* for more information and an example calculation of out-of-pocket costs associated with out-of-network benefits. When out-of-network benefits are received from network providers, the non-network provider reimbursement amount does not apply.

Not covered

These services, supplies and associated expenses are not covered:

1. Services for substance abuse disorders not listed in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders*.
2. Services from a network provider for a condition that cannot be improved with treatment.
3. Services, care, or treatment that is not medically necessary, unless ordered by a court as specifically described in this section.
4. Services to hold or confine a person under chemical influence when no medical services are required, regardless of where the services are received.
5. Telephonic substance abuse treatment services.
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 substance abuse services. This includes, but is not limited to, services provided by mental health or substance abuse providers who are not authorized under state law to practice independently, and services received from a halfway house, therapeutic group home, boarding school, or ranch.
7. Room and board charges associated with substance abuse treatment services providing less than 30 hours a week per individual of chemical dependency services, including group and individual counseling, client education, and other services specific to chemical dependency rehabilitation.
8. Services to assist in activities of daily living that do not seek to cure and are performed regularly as a part of a routine or schedule.

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

Your Benefits and the Amounts You Pay

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

1. Outpatient services		
a. Evaluations, diagnostic, and treatment services	10% coinsurance-group; 20% coinsurance-individual	40% coinsurance
b. Intensive outpatient programs	20% coinsurance	40% coinsurance
2. Methadone maintenance therapy	20% coinsurance	40% coinsurance
3. Inpatient services		
a. Semi-private room and board	20% coinsurance	40% coinsurance
b. Hospital or facility-based professional services	20% coinsurance	40% coinsurance
c. Attending physician services	Nothing. The deductible does not apply.	40% coinsurance
d. Residential treatment services	20% coinsurance	40% coinsurance

Durable Medical Equipment And Prosthetics

O. Durable Medical Equipment And Prosthetics

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

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

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

Covered

For benefits and the amounts you pay, see the table in this section. Medica covers only a limited selection of durable medical equipment, certain related supplies, and hearing aids that meet the criteria established by Medica. Some items ordered by your physician, even if medically necessary may not be covered. The list of eligible durable medical equipment and certain related supplies is periodically reviewed and modified by Medica. To request a list of Medica's eligible durable medical equipment and certain related supplies, call Customer Service at one of the telephone numbers listed inside the front cover.

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

Medica determines if durable medical equipment will be purchased or rented. Medica's approval of rental of durable medical equipment is limited to a specific period of time. To request approval for an extension of the rental period, call Customer Service at one of the telephone numbers listed inside the front cover.

- *In-network benefits* apply to durable medical equipment and certain related supplies and prosthetic services:
 1. Arranged through your primary care clinic or accessed through the access procedures required by your care system and received from a network durable medical equipment provider; or
 2. Arranged through a network Ob/Gyn physician within your care system, and received from a network durable medical equipment provider.

In-network benefits also apply to hearing aids as described in 4. in the table in this section when prescribed by a network provider. To request a list of network durable medical equipment providers, call Customer Service at one of the telephone numbers listed inside the front cover.

Arranging services through a network provider does not guarantee in-network benefits. Refer to *How To Access Your Benefits* for more information.

- *Out-of-network benefits* apply to durable medical equipment, certain related supplies, and prosthetic services received other than as described under *In-network benefits* above or as specifically authorized by Medica or MIC as in-network benefits. *Out-of-network benefits* also

Durable Medical Equipment And Prosthetics

apply to hearing aids as described in 4. in the table in this section when prescribed by a non-network physician and received from a non-network hearing aid vendor.

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

Not covered

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

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

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

Your Benefits and the Amounts You Pay

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

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|--|-----------------|-----------------|
| 1. Durable medical equipment and certain related supplies | 20% coinsurance | 40% coinsurance |
| 2. Repair, replacement, or revision of durable medical equipment made necessary by normal wear and use | 20% coinsurance | 40% coinsurance |

Durable Medical Equipment And Prosthetics

Your Benefits and the Amounts You Pay

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

3. Prosthetics

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|--|--|--|
| a. Initial purchase of external prosthetic devices that replace a limb or an external body part, limited to: <ul style="list-style-type: none"> i. Artificial arms, legs, feet, and hands; ii. Artificial eyes, ears, and noses; iii. Breast prostheses | 20% coinsurance | 40% coinsurance |
| b. Scalp hair prostheses due to alopecia areata
Please note: The benefit maximum includes amounts you pay for scalp hair prostheses in order to satisfy any part of your deductible. | 20% coinsurance. Medica pays up to \$350. This is calculated each calendar year. | 40% coinsurance. Medica pays up to \$350. This is calculated each calendar year. |
| c. Repair, replacement, or revision of artificial arms, legs, feet, hands, eyes, ears, noses, and breast prostheses made necessary by normal wear and use | 20% coinsurance | 40% coinsurance |

- | | | |
|--|---|--|
| 4. Hearing aids for members 18 years of age and younger for hearing loss that is not correctable by other covered procedures | 20% coinsurance. Limited to one hearing aid per ear every three years. Related services must be prescribed by a network provider. | 40% coinsurance. Limited to one hearing aid per ear every three years. |
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P. *Miscellaneous Medical Services And Supplies*

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

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

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

Covered

For benefits and the amounts you pay, see the table in this section.

- *In-network benefits* apply to:
 1. Miscellaneous medical services and supplies arranged through your primary care clinic or through the access procedures required by your care system and received from a network provider; or
 2. Miscellaneous medical services and supplies arranged through a network Ob/Gyn physician within your care system and received from a network provider.

Arranging services through a network provider does not guarantee in-network benefits. Refer to *How To Access Your Benefits* for more information.

- *Out-of-network benefits* apply to miscellaneous medical services and supplies received other than as described under *In-network benefits* above or as specifically authorized by Medica or MIC as in-network benefits.

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

Not covered

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

Miscellaneous Medical Services And Supplies

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

Your Benefits and the Amounts You Pay

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

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

Q. Organ And Bone Marrow Transplant Services

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

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

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

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

Covered

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

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

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

- *In-network benefits* apply to transplant services:
 1. Provided by or arranged through your care system and received at a designated facility for transplant services; or
 2. Arranged through the access procedures required by your care system and authorized by Medica to be received at a transplant facility other than a designated transplant facility.

Medica has entered into separate contracts to provide certain transplant-related health services to members receiving transplants. Designated transplant facilities are identified on a list of transplant facilities that Medica provides to members receiving transplants.

Organ And Bone Marrow Transplant Services

You may be evaluated and listed as a potential recipient at multiple designated facilities for transplant services.

For in-network benefits, 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 for these services.

- *Out-of-network benefits* apply to organ and bone marrow transplant services arranged other than as described under *In-network benefits* above and received at a transplant facility.

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

Coverage for out-of-network benefits listed in this section is limited to a maximum of \$35,000 per transplant per calendar year. **Please note:** This benefit maximum includes amounts you pay for transplant services in order to satisfy any part of your deductible.

More than one copayment or coinsurance may be required if you receive more than one service, or see more than one provider per visit.

Not covered

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

1. Organ and bone marrow transplant services except as described in this section.
2. Supplies and services related to transplants that would not be authorized by Medica under medical criteria referenced in this section.
3. Chemotherapy, radiation therapy, drugs, or any therapy used to damage the bone marrow and related to transplants that would not be authorized by Medica under the medical criteria referenced in this section.
4. Living donor transplants that would not be authorized by Medica under the medical criteria referenced in this section.
5. Islet cell transplants, except for autologous islet cell transplants associated with pancreatectomy.
6. Services required to meet the patient selection criteria for the authorized transplant procedure. This includes treatment of nicotine or caffeine addiction, services and related expenses for weight loss programs, nutritional supplements, appetite suppressants, and supplies of a similar nature not otherwise covered under this certificate.
7. 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.
8. Transplants and related services that are investigative.

Organ And Bone Marrow Transplant Services

9. Private collection and storage of umbilical cord blood for directed use.
10. Drugs provided or administered by a physician or other provider on an outpatient basis, except those requiring intravenous infusion or injection, intramuscular injection, or intraocular injection. Coverage for drugs is as described in *Prescription Drugs And Pharmacy Services*, *Specialty Prescription Drug Program*, and *Mail Service Prescription Drug Program* or otherwise described as a specific benefit in this certificate.

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

Your Benefits and the Amounts You Pay

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

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

Organ And Bone Marrow Transplant Services

Your Benefits and the Amounts You Pay

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

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

Organ And Bone Marrow Transplant Services

Your Benefits and the Amounts You Pay

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

- | | | |
|--|--|--------------------|
| <p>7. Transportation and lodging</p> <p style="margin-left: 20px;">a. As described below, reimbursement of reasonable and necessary expenses for travel and lodging for you and a companion when you receive approved services at a designated facility for transplant services and you live more than 50 miles from that designated facility</p> <p style="margin-left: 20px;">i. Transportation of you and one companion (traveling on the same day(s)) to and/or from a designated facility for transplant services for pre-transplant, transplant, and post-transplant services. If you are a minor child, transportation expenses for two companions will be reimbursed.</p> <p style="margin-left: 20px;">ii. Lodging for you (while not confined) and one companion. Reimbursement is available for a per diem amount of up to \$50 for one person or up to \$100 for two people. If you are a minor child, reimbursement for lodging expenses for two companions is available, up to a per diem amount of \$100.</p> | <p>The deductible does not apply to this reimbursement benefit. You are responsible for paying all amounts not reimbursed under this benefit. Such amounts do not count toward your out-of-pocket maximum or toward satisfaction of your deductible.</p> | <p>No coverage</p> |
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Organ And Bone Marrow Transplant Services

Your Benefits and the Amounts You Pay

Benefits

In-network benefits
after deductible

* Out-of-network benefits
after deductible

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

- iii. There is a lifetime maximum of \$10,000 per member for all transportation and lodging expenses incurred by you and your companion(s) and reimbursed under the Contract or under any other Medica, MIC, or Medica Health Plans of Wisconsin coverage offered through the same employer.
- b. Meals are not reimbursable under this benefit.

R. Surgery For Weight Loss

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

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

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

Covered

For benefits and the amounts you pay, see the table in this section.

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

Not covered

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

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

Surgery For Weight Loss

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

Your Benefits and the Amounts You Pay

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

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

S. Infertility Services

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

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

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

Covered

For benefits and the amounts you pay, see the table in this section.

- *In-network benefits* apply to:
 1. Infertility *treatment* services provided by or arranged through your primary care clinic and received from a network provider; or
 2. Infertility *treatment* services provided by a network Ob/Gyn physician within your care system; or
 3. Infertility *treatment* services arranged through the access procedures required by your care system and provided by a network provider; or
 4. Services for the *diagnosis* of infertility received from a network or non-network provider.

Arranging services through a network provider does not guarantee in-network benefits. Refer to *How To Access Your Benefits* for more information.

- *Out-of-network benefits* apply to infertility *treatment* services received other than as described under *In-network benefits* above or as specifically authorized by Medica or MIC as in-network benefits.

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

Coverage for infertility services is limited to a maximum of \$5,000 per member per calendar year for in-network and out-of-network benefits combined. **Please note:** This benefit maximum includes amounts you pay for infertility services in order to satisfy any part of your deductible.

Infertility Services

More than one copayment or coinsurance may be required if you receive more than one service, or see more than one provider per visit.

Not covered

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

1. Drugs provided or administered by a physician or other provider on an outpatient basis, except those requiring intravenous infusion or injection, intramuscular injection, or intraocular injection. Coverage for drugs is as described in *Prescription Drugs And Pharmacy Services*, *Specialty Prescription Drug Program*, and *Mail Service Prescription Drug Program* or otherwise described as a specific benefit in this certificate.
2. In vitro fertilization, gamete and zygote intrafallopian transfer (GIFT and ZIFT) procedures.
3. Services related to surrogate pregnancy for a person not covered as a member under the Contract.
4. Sperm banking.
5. Adoption.
6. Donor sperm.
7. Embryo and egg storage.

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

Your Benefits and the Amounts You Pay

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

1. Office visits, including any services provided during such visits	20% coinsurance	40% coinsurance
2. E-visits	20% coinsurance	No coverage
3. Outpatient services received at a hospital	20% coinsurance	40% coinsurance
4. Inpatient services	20% coinsurance	40% coinsurance

T. Reconstructive And Restorative Surgery

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

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

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

Covered

For benefits and the amounts you pay, see the table in this section.

- *In-network benefits* apply to reconstructive and restorative surgery services:
 1. Provided by or arranged through your primary care clinic and received at a network provider; or
 2. Arranged through the access procedures required by your care system and received at a network provider.

Arranging services through a network provider does not guarantee in-network benefits. Refer to *How To Access Your Benefits* for more information.

- *Out-of-network benefits* apply to reconstructive and restorative surgery services received other than as described under *In-network benefits* above or as specifically authorized by Medica or MIC as in-network benefits.

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

More than one copayment or coinsurance may be required if you receive more than one service, or see more than one provider per visit.

Not covered

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

1. Revision of blemishes on skin surfaces and scars (including scar excisions) primarily for cosmetic purposes, unless otherwise covered in *Professional Services*.

Reconstructive And Restorative Surgery

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 those requiring intravenous infusion or injection, intramuscular injection, or intraocular injection. Coverage for drugs is as described in *Prescription Drugs And Pharmacy Services*, *Specialty Prescription Drug Program*, and *Mail Service Prescription Drug Program* or otherwise described as a specific benefit in this certificate.

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

Your Benefits and the Amounts You Pay

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

1. Office visits	20% coinsurance	40% coinsurance
2. E-visits	20% coinsurance	No coverage
3. Outpatient services		
a. Professional services		
i. Surgical services (as defined in the <i>Physicians' Current Procedural Terminology</i> code book) received from a physician during an office visit or an outpatient hospital or ambulatory surgical center visit	20% coinsurance	40% coinsurance

Reconstructive And Restorative Surgery

Your Benefits and the Amounts You Pay

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

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

Skilled Nursing Facility Services

U. Skilled Nursing Facility Services

This section describes coverage for use of skilled nursing facility services. Care must be provided under the direction of a physician. Skilled nursing facility services are eligible for coverage only if they are provided through Medica's managed care procedures.

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

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

Covered

For benefits and the amounts you pay, see the table in this section.

- *In-network benefits* apply to skilled nursing facility services:
 1. Provided by or arranged through your primary care clinic and received from a network facility; or
 2. Arranged through the access procedures required by your care system and provided by a network provider.

Arranging services through a network provider does not guarantee in-network benefits. Refer to *How To Access Your Benefits* for more information.

- *Out-of-network benefits* apply to skilled nursing facility services received other than as described under *In-network benefits* above or as specifically authorized by Medica or MIC as in-network benefits.

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

For purposes of this section, *room and board* includes coverage of health services and supplies.

Not covered

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

1. Custodial care and other non-skilled services.
2. Self-care or self-help training (non-medical).

Skilled Nursing Facility Services

3. Services primarily educational in nature.
4. Vocational and job rehabilitation.
5. Recreational therapy.
6. Health clubs.
7. Correction of speech impediments and assistance in the development of verbal clarity when there is no reasonable expectation that the condition will improve over a predictable period of time according to generally accepted standards in the medical community.
8. Voice training.
9. Outpatient rehabilitation services when no medical diagnosis is present.
10. Group physical, speech, and occupational therapy.

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

Your Benefits and the Amounts You Pay

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

1. Daily skilled care or daily skilled rehabilitation services, including room and board	20% coinsurance	40% coinsurance. Services are covered only after transfer to a skilled nursing facility within 30 calendar days of discharge from a hospital in which you were confined for not less than three consecutive calendar days.
2. Skilled physical, speech, or occupational therapy when room and board is not eligible to be covered	20% coinsurance	40% coinsurance
3. Services received from a physician during an inpatient stay in a skilled nursing facility	20% coinsurance	40% coinsurance

V. Hospice Services

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

See Definitions. These words have specific meanings: benefits, care system, coinsurance, deductible, member, network, physician, primary care clinic, skilled nursing facility.

Covered

For benefits and the amounts you pay, see the table in this section.

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.

A hospice program means a hospice program that has entered into a separate contract with Medica to provide hospice services to members. The specific services you receive may vary depending upon which program you select.

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

- *In-network benefits* apply to hospice services:
 1. Provided by or arranged through your primary care clinic and received from a hospice program; or
 2. Arranged through the access procedures required by your care system and received from a hospice program.
- *Out-of-network benefits* apply to hospice services arranged through a physician and received from a non-network hospice program. In addition to the deductible and copayment or coinsurance described for out-of-network benefits, you will be responsible for any charges in excess of the non-network provider reimbursement amount. **The out-of-pocket maximum does not apply to these charges.** Please see *Important member information about out-of-network benefits* in *How To Access Your Benefits* for more information and an example calculation of out-of-pocket costs associated with out-of-network benefits. When out-of-network benefits are received from network providers, the non-network provider reimbursement amount does not apply.

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.

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

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

Not covered

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

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

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

Hospice Services

Your Benefits and the Amounts You Pay

Benefits

In-network benefits
after deductible

* Out-of-network benefits
after deductible

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

1. Hospice services

Nothing. The deductible
does not apply.

40% coinsurance

W. Temporomandibular Joint (TMJ) Disorder

This section describes coverage for the evaluation(s) to determine whether you have TMJ disorder and the surgical and non-surgical treatment of a diagnosed TMJ disorder. Services must be received from (or under the direction of) physicians or dentists. Coverage for treatment of TMJ disorder includes coverage for the treatment of craniomandibular disorder.

This section also describes benefits for professional, hospital, and ambulatory surgical center services.

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

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

Covered

For benefits and the amounts you pay, see the table in this section.

- *In-network benefits* apply to TMJ services:
 1. Provided by or arranged through your primary care clinic and received from a network provider; or
 2. Arranged through the access procedures required by your care system and received from a network provider.

Arranging services through a network provider does not guarantee in-network benefits. Refer to *How To Access Your Benefits* for more information.

- *Out-of-network benefits* apply to TMJ services received other than as described under *In-network benefits* above or as specifically authorized by Medica or MIC as in-network benefits.

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

More than one copayment or coinsurance may be required if you receive more than one service or see more than one provider per visit.

Temporomandibular Joint (TMJ) Disorder

Not covered

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

Bite adjustment.

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

Your Benefits and the Amounts You Pay

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

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

Temporomandibular Joint (TMJ) Disorder

Your Benefits and the Amounts You Pay

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

b. Hospital and ambulatory surgical center services		
i. Outpatient lab and pathology	20% coinsurance	Covered as an in-network benefit.
ii. Outpatient x-rays and other imaging services	20% coinsurance	Covered as an in-network benefit.
iii. Other outpatient hospital and ambulatory surgical center services	20% coinsurance	40% coinsurance
4. Physical therapy received outside of your home	20% coinsurance	40% coinsurance
5. Inpatient services	20% coinsurance	40% coinsurance
6. Services received from a physician or dentist during an inpatient stay	20% coinsurance	40% coinsurance
7. Anesthesia services received from a provider during an inpatient stay	20% coinsurance	Covered as an in-network benefit.
8. TMJ splints and adjustments if your primary diagnosis is joint disorder	20% coinsurance	40% coinsurance

Medical-Related Dental Services

X. *Medical-Related Dental Services*

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

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

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

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

Covered

For benefits and the amounts you pay, see the table in this section.

- *In-network benefits* apply to medical-related dental services:
 1. Provided by or arranged through your primary care clinic and received from a network provider; or
 2. Arranged through the access procedures required by your care system and received from a network provider.

Arranging services through a network provider does not guarantee in-network benefits. Refer to *How To Access Your Benefits* for more information.

- *Out-of-network benefits* apply to medical-related dental services received other than as described under *In-network benefits* above or as specifically authorized by Medica or MIC as in-network benefits.

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

Not covered

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

1. Dental services to treat an injury from biting or chewing.

Medical-Related Dental Services

2. Osteotomies and other procedures associated with the fitting of dentures or dental implants.
3. Dental implants (tooth replacement), except as described in this section for the treatment of cleft lip and palate.
4. Any other dental procedures or treatment, whether the dental treatment is needed because of a primary dental problem or as a manifestation of a medical treatment or condition.
5. Any orthodontia, except as described in this section for the treatment of cleft lip and palate.
6. Tooth extractions, except as described in this section.
7. Any dental procedures or treatment related to periodontal disease.
8. Endodontic procedures and treatment, including root canal procedures and treatment, unless provided as accident-related dental services as described in this section.
9. Routine diagnostic and preventive dental services.

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

Your Benefits and the Amounts You Pay

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

1. Charges for medical facilities and general anesthesia services that are: <ol style="list-style-type: none"> a. Recommended by a physician; and b. Received during a dental procedure; and c. Provided to a member who: <ol style="list-style-type: none"> i. is a child under age five (prior authorization is <i>not</i> required); or ii. is severely disabled; or 	20% coinsurance	40% coinsurance
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Medical-Related Dental Services

Your Benefits and the Amounts You Pay

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

- | | | |
|--|-----------------|-----------------|
| <ul style="list-style-type: none"> iii. has a medical condition and requires hospitalization or general anesthesia for dental care treatment.
Please note: Age, anxiety, and behavioral conditions are not considered medical conditions. | | |
| 2. For a dependent child, orthodontia, dental implants and oral surgery treatment related to cleft lip and palate | 20% coinsurance | 40% coinsurance |
| 3. Accident-related dental services to treat an injury to sound, natural teeth and to repair (not replace) sound, natural teeth. The following conditions apply: <ul style="list-style-type: none"> a. Coverage is limited to services received <i>within 12 months from the later of:</i> <ul style="list-style-type: none"> i. the date you are first covered under the Contract; or ii. the date of the injury b. A sound, natural tooth means a tooth (including supporting structures) that is free from disease that would prevent continual function of the tooth for at least one year. In the case of primary (baby) teeth, the tooth must have a life expectancy of one year. | 20% coinsurance | 40% coinsurance |

Your Benefits and the Amounts You Pay

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

- | | | |
|--|-----------------|-----------------|
| 4. Oral surgery for: | 20% coinsurance | 40% coinsurance |
| a. Partially or completely unerupted impacted teeth; or | | |
| b. A tooth root without the extraction of the entire tooth (this does not include root canal therapy); or | | |
| c. The gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth | | |

Emergency Services From Non-Network Providers

Y. *Emergency Services From Non-Network Providers*

This section describes coverage for emergency services from non-network providers. In-network benefits will apply to emergency services as described in this section.

See *Definitions*. These words have specific meanings: benefits, claim, coinsurance, deductible, emergency, hospital, inpatient, member, network, non-network, physician, primary care clinic, provider.

Covered

For benefits and the amounts you pay, see the table in this section. To be eligible for coverage, services must be due to an emergency.

You must notify Medica of emergency inpatient services as soon as reasonably possible after receiving inpatient services. Call Customer Service at one of the telephone numbers listed inside the front cover.

For emergency mental health or substance abuse inpatient services, you must notify your designated mental health and substance abuse provider as soon as reasonably possible after the emergency services begin.

If the health services that you require do not meet the definition of emergency, you should refer to the remainder of this certificate for a description of your out-of-network benefits.

For information on submitting claims for emergency services received in a foreign country, refer to *How To Submit A Claim*.

Emergency services ordered, provided, or arranged by your primary care clinic are eligible for coverage as described in *Professional Services* and *Hospital Services*.

If you are confined in a non-network facility as a result of an emergency, your coverage under this section of this certificate continues until your attending physician agrees it is safe to transfer you to a network facility.

Not covered

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

1. Non-emergency care from non-network providers except as described elsewhere in this certificate.
2. Unauthorized continued inpatient services in a non-network facility once the attending physician agrees it is safe to transfer you to a network facility.
3. Follow-up care or scheduled care from a non-network provider except as described elsewhere in this certificate.
4. Transfers and admissions to network hospitals solely at the convenience of the member.

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

Emergency Services From Non-Network Providers

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible
1. Emergency services that are: <ul style="list-style-type: none">a. Administered under the direction of a physician; andb. Received from a non-network provider; andc. Otherwise eligible for coverage in this certificate	20% coinsurance
2. Ambulance service or ambulance transportation to the nearest hospital for an emergency	20% coinsurance

Harmful Use Of Medical Services

Z. Harmful Use Of Medical Services

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

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

When this section applies

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

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

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

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

Medica will send you specific information about:

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

AA. Exclusions

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

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

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

1. Services that are not medically necessary. This includes but is not limited to services inconsistent with the medical standards and accepted practice parameters of the community and services inappropriate—in terms of type, frequency, level, setting, and duration—to the diagnosis or condition.
2. Services or drugs used to treat conditions that are cosmetic in nature, unless otherwise determined to be reconstructive.
3. Refractive eye surgery.
4. The purchase, replacement, or repair of eyeglasses, eyeglass frames, or contact lenses when prescribed solely for vision correction, and their related fittings.
5. Services provided by an audiologist when not under the direction of a physician, air and bone conduction 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 related fittings and except as described in *Durable Medical Equipment And Prosthetics*.
6. A drug, device, or medical treatment or procedure that is investigative.
7. Genetic testing when performed in the absence of symptoms or high risk factors for a heritable 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.
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 *Miscellaneous Medical Services And Supplies*.
11. Physical, occupational or speech therapy when there is no reasonable expectation that the condition will improve over a predictable period of time according to generally accepted standards in the medical community.
12. Reversal of voluntary sterilization.

Exclusions

13. Personal comfort or convenience items or services, including but not limited to breast pumps except when the pump is medically necessary.
14. Custodial care, unskilled nursing, or unskilled rehabilitation services.
15. Respite or rest care except as otherwise covered in *Hospice Services*.
16. Travel, transportation, or living expenses, except as described in *Organ And Bone Marrow Transplant Services*.
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 members with diabetes, peripheral vascular disease, peripheral neuropathies, or blindness.
21. Services by persons who are family members or who share your legal residence.
22. Services for which coverage is available under workers' compensation, employer liability or any similar law.
23. Services received before coverage under the Contract becomes effective.
24. Services received after coverage under the Contract ends.
25. Unless requested by Medica, charges for duplicating and obtaining medical records from non-network providers and non-network dentists.
26. Photographs, except for the condition of multiple dysplastic syndrome.
27. Occlusal adjustment or occlusal equilibration.
28. Dental implants (tooth replacement), except as described in *Medical-Related Dental Services*.
29. Dental prostheses.
30. Any orthodontia including that associated with orthognathic procedures, accident-related dental injuries, or temporomandibular joint (TMJ) disorder. However, this exclusion does not apply when orthodontia is used as secondary treatment for TMJ disorder in cases where primary treatment has been completed and lack of orthopedic (tooth) support has caused additional episodes of TMJ disorder, or as described in *Medical-Related Dental Services* (for cleft lip and palate).
31. Treatment for bruxism.
32. Services prohibited by law or regulation, or illegal under Minnesota law.
33. Services to treat injuries that occur while on military duty to the extent that such care is otherwise covered or available in another program of coverage.
34. Exams, other evaluations, or other services solely for the purpose of employment, insurance, or licensure, unless otherwise covered under this certificate.
35. 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).

36. Non-medical self-care or self-help training.
37. Educational classes, programs or seminars, including but not limited to childbirth classes, except as described in *Professional Services*.
38. Coverage for costs associated with translation of medical records and claims to English.
39. Treatment for spider veins.
40. Services not received from or under the direction of a physician, except as described in this certificate.
41. Services for or related to intensive behavior therapy treatment programs for the treatment of autism spectrum disorders. Examples of such services include, but are not limited to, Intensive Early Intervention Behavior Therapy Services (IEIBTS), Intensive Behavioral Intervention (IBI), and Lovaas therapy.
42. Sensory Integration including Auditory Integration Training.
43. Services for or related to vision therapy and orthoptic and/or pleoptic training except as described in *Professional Services*.
44. Health care professional services for maternity labor and delivery in the home.
45. Surgery for morbid obesity, except as described in *Surgery For Weight Loss*.
46. Services for or related to snoring unaccompanied by sleep apnea.

How To Submit A Claim

BB. How To Submit A Claim

This section describes the process for submitting a claim.

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

Claims for benefits from network providers

If you receive a bill for any benefit from a network provider, you may submit the claim following the procedures described below, under *Claims for benefits from non-network providers* or call Customer Service at one of the telephone numbers listed inside the front cover.

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

Claims for benefits from non-network providers

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

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

Mail to: Medica
PO Box 30990
Salt Lake City, UT 84130

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

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

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

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 receipt of 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 airline ticket.
- Such other documentation as Medica may request.

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

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

Time limits

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

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

Coordination Of Benefits

CC. Coordination Of Benefits

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

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

1. Applicability

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

2. Definitions that apply to this section

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

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

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

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

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

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

- d. *Allowable expense* means a necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made.

The difference between the cost of a private hospital room and the cost of a semiprivate 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.

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

3. Order of benefit determination rules

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

Coordination Of Benefits

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

- iii. *Dependent child/separated or divorced parents.* If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - a) First, the plan of the parent with custody of the child;
 - b) Then, the plan of the spouse of the parent with the custody of the child; and
 - c) Finally, the plan of the parent not having custody of the child.

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

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

4. Effect on the benefits of this plan

- a. *When this section applies.* This 4. applies when, in accordance with *Order of benefit determination rules*, this plan is a secondary plan as to one or more other plans. In that event, the benefits of this plan may be reduced under this section. Such other plan or plans are referred to as *the other plans* in b. immediately below.

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

For non-emergency services received from a non-network provider, and determined to be out-of-network benefits, the following reduction of benefits will apply:

When this plan is a secondary plan, this plan will pay the balance of any remaining expenses determined to be eligible under the Contract, according to the out-of-network benefits described in this certificate. Most out-of-network benefits are covered at 60 percent of the non-network provider reimbursement amount, after you pay the applicable deductible amount. In no event will this plan provide duplicate coverage.

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

5. *Right to receive and release needed information*

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

6. *Facility of payment*

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

7. *Right of recovery*

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

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

Coordination Of Benefits

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

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

DD. Right Of Recovery

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

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

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

Eligibility And Enrollment

EE. Eligibility And Enrollment

This section describes who can enroll and how to enroll.

See Definitions. These words have specific meanings: continuous coverage, dependent, late entrant, member, mental disorder, physician, placed for adoption, premium, qualifying coverage, service area, subscriber, waiting period.

Who can enroll

To be eligible to enroll for coverage you must reside or work in the service area, meet the eligibility requirements of the Contract and be a subscriber or dependent as defined in this certificate. See *Definitions*. (A child who is the subject of a qualified medical child support order (QMCSO) and is otherwise eligible for coverage does not have to reside in the service area.)

How to enroll

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

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

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

Notification

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

The employer must notify Medica within 30 days of the effective date of your initial enrollment application, changes to your name or address, or changes to enrollment, including if you or your dependents are no longer eligible for coverage.

Initial enrollment

A 30-day time period starting with the date an eligible employee and dependents are first eligible to enroll for coverage under the Contract. An eligible employee must apply within this period for coverage to begin the date he or she was first eligible to enroll. (The 30-day time period does not apply to newborns or children newly adopted or placed for adoption; see *Special enrollment*.) An eligible employee and dependents that enroll during the initial enrollment period are accepted without application of health screening or affiliation periods. An eligible employee and dependents who do not enroll during the initial enrollment period may enroll for coverage during the next open enrollment, any applicable special enrollment periods or as a late entrant as described below.

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

Open enrollment

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

Special enrollment

Special enrollment periods are provided to eligible employees and dependents under certain circumstances.

1. Loss of other coverage

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

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

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

The eligible employee or dependent must present either evidence of the loss of prior coverage due to loss of eligibility for that coverage or evidence that employer contributions toward the prior coverage have terminated; and request enrollment in writing within 30 days of the date of the loss of coverage or the date the employer's contribution toward that coverage terminates, or the date on which a claim is denied due to the operation of a lifetime maximum limit on all benefits.

Eligibility And Enrollment

For purposes of 1.b.:

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

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

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

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

For purposes of 1.c.:

- a. 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 eligible employee or dependent incurring a claim that meets or exceeds the lifetime maximum limit on all benefits and no other COBRA or state continuation coverage is available; or
 - if the prior coverage was offered through a health maintenance organization (HMO), losing coverage because the eligible employee or dependent no longer resides or works in the HMO's service area and no other COBRA or state continuation coverage is available.
- b. Exhaustion of COBRA or state continuation coverage does not include a loss due to failure of the eligible employee or dependent to pay premiums on a timely basis or termination of coverage for cause.
 - iii. In the case of the eligible employee's exhaustion of COBRA or state continuation coverage, the special enrollment period described above applies to the eligible employee and all of his or her dependents. In the case of a dependent's exhaustion of COBRA or state continuation coverage, the special enrollment period described above applies only to the dependent who has lost coverage and the eligible employee.
2. The dependent is a new spouse of the subscriber or eligible employee, provided that the marriage is legal and enrollment is requested in writing within 30 days of the date of marriage and provided that the eligible employee also enrolls during this special enrollment period;
 3. The dependent is a new dependent child of the subscriber or eligible employee, provided that enrollment is requested in writing within 30 days of the subscriber or eligible employee acquiring the dependent (for dependent children, the notification period is not limited to 30 days for newborns or children newly adopted or newly placed for adoption) and provided that the eligible employee also enrolls during this special enrollment period;
 4. The dependent is the spouse of the subscriber or eligible employee through whom the dependent child described in 3. above claims dependent status and:
 - a. That spouse is eligible for coverage; and
 - b. Is not already enrolled under the Contract; and
 - c. Enrollment is requested in writing within 30 days of the dependent child becoming a dependent; and
 - d. The eligible employee also enrolls during this special enrollment period; or
 5. The dependents are eligible dependent children of the subscriber or eligible employee and enrollment is requested in writing within 30 days of a dependent, as described in 2. or 3. above, becoming eligible to enroll under the coverage provided the eligible employee also enrolls during this special enrollment period.
 6. When the employer provides Medica with notice of a QMCSO and a copy of the order, as described in this section, Medica will provide the eligible dependent child with a special enrollment period provided the eligible employee also enrolls during this special enrollment period.
 7. When the eligible employee or dependent becomes eligible for group health plan premium assistance provided by Medicaid or a State Children's Health Insurance Plan. The eligible employee must request enrollment within 60 days after the date the employee or dependent is determined to be eligible for premium assistance.

Eligibility And Enrollment

In the case of the eligible employee becoming eligible for premium assistance, this special enrollment period applies to the eligible employee and all of his or her dependents. In the case of a dependent becoming eligible for premium assistance, this special enrollment period applies to both that dependent and the eligible employee.

Late enrollment

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

Late entrants who have maintained continuous coverage may enroll and coverage will be effective the first day of the month following date of approval by Medica. Continuous coverage will be determined to have been maintained if the late entrant requests enrollment within 63 days after prior qualifying coverage ends.

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

An eligible employee or dependent who:

1. does not enroll during an initial or open enrollment period or any applicable special enrollment period; and
2. is an enrollee of MCHA at the time Medica offers or renews coverage with the employer, provided the eligible subscriber or dependent maintains continuous coverage,

will not be considered a late entrant and will be allowed to enroll. Coverage will be effective as determined by Medica.

Qualified Medical Child Support Order (QMCSO)

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

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

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

The date your coverage begins

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

1. For eligible employees and dependents who enroll during the initial enrollment period, coverage begins on the effective date specified in the Contract.
2. For eligible employees and dependents who enroll during the open enrollment period, coverage begins on the first day of the Contract year for which the open enrollment period was held.
3. For eligible employees and/or dependents who enroll during a special enrollment period, coverage begins on the date indicated below for the particular special enrollment. In the case of:
 - a. Numbers 1., 2., or 7. under *Special enrollment*, coverage begins on the first day of the first calendar month following the date on which the request for enrollment is received by Medica;
 - b. Number 3. under *Special enrollment*, in the case of birth, the date of birth; in the case of adoption or placement for adoption, date of adoption or placement. In all other cases, the date the subscriber acquires the dependent child;
 - c. Number 4. under *Special enrollment*, the date coverage for the dependent child is effective, as set forth in 3.b. above;
 - d. Number 5. under *Special enrollment*, the date coverage for the dependent identified in 2. or 3. under *Special enrollment* becomes effective;
 - e. Number 6. under *Special enrollment*, the first day of the first calendar month following the date the completed request for enrollment is received by Medica.
4. For eligible employees and/or dependents who enroll during late enrollment, coverage begins on the date specified in the Contract.

Ending Coverage

FF. *Ending Coverage*

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

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

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

When coverage ends

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

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

- d. Using another person's member identification card; or
- e. Submitting fraudulent claims.

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

- 7. The end of the month following the date 31 days after we notify you that coverage will end because you did not pay a copayment or coinsurance for in-network benefits.
- 8. The end of the month following the date 31 days after we notify you that coverage will end because you do not live in the service area, provided the notification is made within one year following the date Medica was provided written notification of your address change. However, Medica may approve other arrangements.
- 9. The end of the month following the date you enter active military duty for more than 31 days. Upon completion of active military duty, contact the employer for reinstatement of coverage.
- 10. The end of the month following the date the subscriber's coverage ends.
- 11. The date of the death of the member. In the event of the subscriber's death, coverage for the subscriber's dependents will terminate the end of the month in which the subscriber's death occurred.
- 12. For a spouse, the end of the month following the date of divorce.
- 13. For a dependent child, the end of the month in which the child is no longer eligible as a dependent.
- 14. For a child who is entitled to coverage through a QMCSO, the end of the month in which the earliest of the following occurs:
 - a. The QMCSO ceases to be effective; or
 - b. The child is no longer a child as that term is used in ERISA; or
 - c. The child has immediate and comparable coverage under another plan; or
 - d. The employee who is ordered by the QMCSO to provide coverage is no longer eligible as determined by the employer; or
 - e. The employer terminates family or dependent coverage; or
 - f. The Contract is terminated by the employer or Medica; or
 - g. The relevant premium or contribution toward the premium is last paid.

GG. Continuation

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

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

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

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

1. *Your right to continue coverage under state law*

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

a. *Minnesota state continuation coverage.*

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

b. *Notice of rights.*

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

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

Subscriber's loss

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

Subscriber's spouse's loss

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

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

Subscriber's child's loss

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

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

Responsibility to inform

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

Election rights

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

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

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

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

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

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

Continuation

Type of coverage and cost

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

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

Duration

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

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

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

 - i. The date the former spouse becomes covered under another group health plan or Medicare; or
 - ii. The date coverage would otherwise terminate under the Contract.

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

When your continuation coverage under this section ends, you have the option to enroll in an individual conversion health plan (as described in *Conversion*).

Extension of benefits for total disability of the subscriber

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

2. Your right to continue coverage under federal law

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

COBRA continuation coverage

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

USERRA continuation coverage

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

General COBRA information

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

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

Continuation

Qualified beneficiary

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

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

Subscriber's loss

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

Subscriber's spouse's loss

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

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

Subscriber's child's loss

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

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

Responsibility to inform

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

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

Bankruptcy

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

Election rights

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

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

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

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

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

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

Type of coverage and cost

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

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

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

Duration of COBRA coverage

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

Continuation

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

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

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

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

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

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

General USERRA information

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

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

Employee's loss

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

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

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

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

Election rights

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

Type of coverage and cost

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

Duration of USERRA coverage

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

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

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

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

Continuation

COBRA and USERRA coverage are concurrent

If the employer is subject to COBRA and USERRA, and you elect COBRA continuation coverage in addition to USERRA continuation coverage, these coverages run concurrently.

HH. Conversion

See Definitions. These words have specific meanings: continuous coverage, dependent, premium, service area, waiting period.

Your conversion plan coverage may not provide the same coverage as your previous group health plan. Benefits and provider networks may be different.

Minnesota residents

This section describes your right to convert to an individual conversion plan if you are a resident of Minnesota on the day that you submit an enrollment form to Medica or Medica's designated conversion vendor.

If you are a Minnesota resident, you may be eligible to obtain coverage from 1) other private sources of health coverage, or 2) the Minnesota Comprehensive Health Association, without a pre-existing condition limitation. Contact the Minnesota Comprehensive Health Association for further information:

- For deductible plan options call 1-866-894-8053 or TTY: 1-800-841-6753.
- For Medicare supplement plan options call 1-800-325-3540 or TTY: 1-800-234-8819.

Overview

1. You may convert to an HMO individual conversion plan through Medica or Medica's designated conversion vendor without proof of good health or waiting periods at the following times:
 - a. Your continuation coverage with Medica, as described in *Continuation*, is exhausted.
 - b. Your coverage or continuation coverage ends because the Contract is terminated and the Contract is not replaced with other continuous group coverage.
 - c. Your coverage ends under the Contract and you do *not* have the right to continue coverage as described in *Continuation*.
2. If you move from the service area you may convert to an insurance conversion plan without proof of good health or waiting periods.
3. *Your conversion plan goes into effect the day following the date your other coverage ends.* You may select a qualified 1, 2 or 3 conversion plan. You must maintain continuous coverage when applying for conversion coverage.
4. Conversion coverage is not available:
 - a. When continuous coverage is not maintained; or
 - b. If your coverage terminates due to nonpayment of premium; or
 - c. If you have exhausted your right to continue coverage as described in *Continuation*; or
 - d. If your coverage or continuation coverage ends because the Contract is terminated and the Contract is replaced with other continuous group coverage; or

Conversion

- e. If you commit fraud or material misrepresentation in applying for continuation or conversion of coverage.

For purposes of 3. and 4.a. above, continuous coverage will be determined to have been maintained if you request enrollment for conversion within 63 days after your coverage ends or within 31 days of the date you were notified of the right to convert coverage, whichever is later.

What you must do

1. For conversion coverage information, call Customer Service at one of the telephone numbers listed inside the front cover.
2. Pay premiums to Medica or Medica's designated conversion vendor within 63 days after your coverage ends or within 31 days of the date you were notified of your right to convert coverage, whichever is later. You will be required to include your first month premium payment with your enrollment form for conversion coverage.
3. Submit an enrollment form to Medica or Medica's designated conversion vendor within 63 days after your coverage ends or within 31 days of the date you were notified of your right to convert, whichever is later. You may include only those dependents who were enrolled under the Contract at the time of conversion.

What the employer must do

The employer is required to notify you of your right to convert coverage.

Residents of a state other than Minnesota

This section describes your right to convert to an individual conversion plan if other group coverage is unavailable and if you are a resident of a state other than Minnesota on the day that you submit an enrollment form to Medica or Medica's designated conversion vendor.

Overview

You may convert to an individual conversion plan through Medica or Medica's designated conversion vendor without proof of good health or waiting periods, in accordance with the laws of the state in which you reside on the day that you submit an enrollment form to Medica or Medica's designated conversion vendor.

What you must do

1. For conversion coverage information, call Customer Service at one of the telephone numbers listed inside the front cover.
2. Pay premiums to Medica or Medica's designated conversion vendor within 31 days after your coverage ends or such other period of time as provided under applicable state law. You will be required to include your first month premium payment with your enrollment form for conversion coverage.
3. Submit an enrollment form to Medica or Medica's designated conversion vendor within 31 days after your coverage ends or such other period of time as provided under applicable state law. You may include only those dependents who were enrolled under the Contract at the time of conversion.

II. Complaints

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

See Definitions. These words have specific meanings: benefits, claim, inpatient, member, network, provider.

You may call Customer Service at one of the telephone numbers listed inside the front cover or by writing to the address below in *First level of review*, 2. You also may contact the Commissioner of Health, Minnesota Department of Health, at (651) 201-5100 or 1-800-657-3916, regarding complaints about in-network benefits, or the Commissioner of Commerce, Minnesota Department of Commerce, at (651) 296-2488 or 1-800-657-3602, regarding complaints about out-of-network benefits.

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

Medical Necessity Review: Means 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.

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.

First level of review

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

Complaints

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

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

Medica will provide written notice of its first level review decision to you within 30 calendar days from the initial receipt of your complaint or request.
 - b. For a written complaint, Medica will provide written notice of its first level review decision to you within 30 calendar days from initial receipt of your complaint.
 - c. If Medica's first level review decision upholds the initial decision made by Medica, you have a right to request a second level review. The second level of review, as described in 2. below, must be exhausted before you have the right to submit a request for external review.
2. Complaints that involve a medical necessity review by Medica:
 - a. Your complaint must be made within one year following Medica's initial decision and may be made orally or in writing.
 - b. Medica will provide written notice of its first level review decision to you and your attending provider, when applicable, within 30 calendar days from receipt of your complaint.
 - c. When an initial decision by Medica does not grant a prior authorization request made before or during an ongoing service, and your attending provider believes that Medica's decision warrants an expedited review you or your attending provider will have the opportunity to request an expedited review by telephone. Alternatively, if Medica concludes that a delay could seriously jeopardize your life, health, or ability to regain maximum function, 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.
3. If Medica's first level review decision upholds the initial decision made by Medica, you have a right to request a second level review or submit a written request for external review as described in this section. The second level of review is optional and you may submit a request for external review without exhausting the second level of review.

Second level of review

If you are not satisfied with Medica's first level 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:

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

2. Testimony, explanation or other information provided by you, Medica staff, providers and others is reviewed, regardless of the method chosen for review (hearing or a written reconsideration).
3. For required second level reviews, Medica will provide written notice of its second level review decision to you within 30 calendar days from receipt of your request for written reconsideration or a hearing.

For optional second level reviews, Medica will provide written notice of its second level review decision to you within 30 calendar days from receipt of your request for written reconsideration or 45 calendar days from receipt of your request for a hearing.

External review

If you consider Medica's decision to be partially or wholly adverse to you, you have a right to submit a written request for external review to the Commissioner of Health for issues related to in-network benefits or the Commissioner of Commerce for issues related to out-of-network benefits. Please contact the Commissioner at:

Minnesota Department of Health
PO Box 64975
St. Paul, MN 55164-0975
(651) 201-5100 or 1-800-657-3916

Minnesota Department of Commerce
85 7th Place East, Suite 500
St. Paul, MN 55101-2198
(651) 296-2488 or 1-800-657-3602

An independent entity contracted with the State Commissioner of Administration will review your request. The external review decision will not be binding on you but will be binding on Medica. Contact the Commissioner of Health or the Commissioner of Commerce for more information about the external review process.

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

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

Complaints

Civil action

If you remain dissatisfied with Medica's determination after completing the required appeals process, you have the right to file a civil action under Section 502(a) of the Employee Retirement Income Security Act (ERISA).

JJ. General Provisions

This section describes the general provisions of the Contract.

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

Examination of a member

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

Clerical error

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

Relationship between parties

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

Assignment

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

Notice

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

Entire agreement

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

Amendment

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

Definitions

Definitions

In this certificate (and in any amendments), some words have specific meanings.

Within each definition, you may note bold words. These words also are defined in this section.

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

Care system. A **network of providers**, including primary care **physicians**, that assumes responsibility for managing and ensuring the provision, coordination, **referral**, and delivery of health services for **members** who have designated a **primary care clinic** within that **care system**. Each **care system** establishes its own access procedures for seeing all other **providers**. Some **care systems** require a **referral** from your **primary care clinic**; others allow you direct access to a **provider** affiliated with your **care system**. Contact your **primary care clinic** for more information about **care system** access procedures, or see your Medica Elect or Medica Essential **provider** directory for more information.

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

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

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

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

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

For services from some **network providers**, however, the **coinsurance** is based on the **provider's** retail charge. The **provider's** retail charge is the amount that the **provider** would charge to any patient, whether or not that patient is a Medica **member**.

For out-of-**network benefits** received from **network providers**, the **coinsurance** will be 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 out-of-**network benefits**, received from **non-network providers**, 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** received from **non-network providers**, in addition to any **copayment, coinsurance** and **deductible** amounts, you are 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 Pharmacy Services, Specialty Prescription Drug Program, and Mail Service Prescription Drug Program*, the calculation of **coinsurance** amounts as described above do not include possible reductions for any volume purchase discounts or price adjustments that Medica may later receive related to certain **prescription drugs** and pharmacy services.

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

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

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

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

When you receive eligible health services from a **network provider** and a **copayment** applies, you pay the lesser of the charge billed by the **provider** for the **benefit** (i.e., retail) or your **copayment**. Medica pays any remaining amount according to the written agreement between Medica and 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 are responsible for any charges in excess of the **non-network provider reimbursement amount**.

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

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

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

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

1. The **subscriber's** spouse.
2. The following **dependent** children up to the **dependent** limiting age of 26:
 - a. The **subscriber's** or **subscriber's** spouse's unmarried natural or adopted child;

Definitions

- b. An unmarried child **placed for adoption** with the **subscriber** or **subscriber's** spouse;
 - c. An unmarried child for whom the **subscriber** or the **subscriber's** spouse has been appointed legal guardian; however, upon request by Medica, the **subscriber** must provide satisfactory proof of legal guardianship;
 - d. The **subscriber's** unmarried stepchild; and
 - e. The **subscriber's** or **subscriber's** spouse's unmarried grandchild who is dependent upon and resides with the **subscriber** or **subscriber's** spouse continuously from birth.
3. The **subscriber's** or **subscriber's** spouse's unmarried disabled child who is a **dependent** incapable of self-sustaining employment by reason of developmental disability, mental illness, mental disorder, or physical disability and is chiefly dependent upon the **subscriber** for support and maintenance. An illness will not be considered a physical disability. This **dependent** may remain covered under the Contract regardless of age and without application of health screening or **waiting periods**. To continue coverage for a disabled **dependent**, you must provide Medica with proof of such disability and dependency within 31 days of the child reaching the **dependent** limiting age set forth in 2. above. Beginning two years after the child reaches the **dependent** limiting age, Medica will require annual proof of disability and dependency.

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

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

Designated mental health/substance abuse provider. An organization, entity or individual selected by Medica and your **primary care clinic** to provide or arrange for the mental health and substance abuse services covered under this certificate.

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

Emergency. A condition or symptom that a prudent layperson 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 in serious jeopardy.

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

E-visits. A **member**-initiated online evaluation and management service provided to patients via the Internet. **E-visits** are used to address non-urgent medical symptoms for established patients describing new or on-going symptoms to which **providers** respond with substantive medical advice.

Genetic testing. An analysis of human DNA, RNA, chromosomes, proteins, or metabolites if the analysis detects genotypes, mutations, or chromosomal changes. **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.

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

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

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

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

Notwithstanding the above, a drug being used for an indication or at a dosage that is an accepted off-label use for the treatment of cancer will not be considered by Medica to be **investigative**. Medica will determine if a use is an accepted off-label use based on published reports in authoritative peer-reviewed medical literature, clinical practice guidelines or parameters approved by national health professional boards or associations, and entries in any authoritative compendia as identified by the Medicare program for use in the determination of a medically accepted indication of drugs and biologicals used off-label.

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

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

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

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

Definitions

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

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

Member. A person who is enrolled under the Contract.

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

Network. A **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 Medica Elect or Medica Essential **benefits** to you. The participation status of **providers** will change from time to time.

The Medica Elect or Medica Essential **provider** directory will be furnished automatically, without charge.

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

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

1. A percentage of the amount Medicare would pay for the service in the location where the service is provided. MIC 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 MIC and the **non-network provider**.

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

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

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

Preferred network. A term used to describe a **network provider** (such as a **network hospital** or a **network physician**) that has a preferred affiliation with Medica Elect or Medica Essential. **Preferred network providers** are listed in your Medica Elect or Medica Essential **provider** directory.

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

Prenatal care. The comprehensive package of medical and psychosocial support provided throughout a pregnancy and related directly to the care of the pregnancy, including risk assessment, serial surveillance, prenatal education and use of specialized skills and technology, when needed, as defined by *Standards for Obstetric-Gynecologic Services* issued by the American College of Obstetricians and Gynecologists.

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

Primary care clinic. An individual or group of **network providers** practicing in the areas of family practice, general practice, internal medicine, or pediatrics, selected by you to coordinate the health services eligible for coverage under this certificate. You must select a **primary care clinic** from the list of **network providers** designated by Medica as **primary care clinics**.

Your **care system** establishes the access procedures you must follow to obtain in-**network benefits**. Contact your **primary care clinic** for information about these **care system** access procedures, or see your Medica Elect and Medica Essential **provider** directory for more information.

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

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

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

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

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

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

Reconstructive. Surgery to rebuild or correct a:

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

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

Surgery that is cosmetic is not **reconstructive**.

Recreational therapy. Services and recreation activities provided to individuals with disabilities or illnesses. A variety of techniques may be used, including but not limited to, arts and crafts, animals, sports, games, dance and movement, drama, music, and community outings.

Referral. Authorization from your **primary care clinic**, or another primary care **provider** affiliated with your **care system** if allowed under your **care system's** access procedures, for you to receive **medically necessary** services from another **provider** when such **benefits** are not available from your **primary care clinic** or **care system**. The authorization will be in writing and will:

1. Indicate the time period during which services must be received; and
2. Specify the service(s) to be provided; and
3. Direct you to the **provider** selected by the referring **provider**.

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**.

Service area. The geographic area in which Medica is approved to provide coverage for in-**network benefits**. You may contact Customer Service for a current description of the **service area**.

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

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

Standing referral. A **referral** issued by your **primary care clinic** for conditions that require ongoing services from a specialist **provider**. You may apply for, and if appropriate, receive a **standing referral** for: 1) a chronic health condition; 2) a life-threatening mental or physical illness; 3) pregnancy beyond the first trimester of pregnancy; 4) a degenerative disease or disability; or 5) any other condition or disease of sufficient seriousness and complexity to require treatment by a specialist **provider**. You may request an extension of a **standing referral** by contacting your **primary care clinic**. **Standing referrals** will only be authorized for the period of time appropriate to your medical condition. **Standing referrals** will not be issued to accommodate personal preferences, family convenience, or other non-medical reasons. **Standing referrals** will also not be issued for care that has already been provided.

Subscriber. The person:

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

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

Definitions

Travel program. A national program in which you can receive the in-**network benefit** level for most services when traveling outside the **service area** if your **provider** is a **travel program provider**. See *How To Access Your Benefits* for more information about the **travel program**.

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.

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

Ogow. Haddii aad dooneyso in lagaa kaalmeeyo tarjamadda macluumaadkani, oo lacag la'aan ah, wac Medica: 1-800-952-3455.

1-800-952-3455: Medica بالمعلومات، فاتصل بالرقم
ملاحظة: إذا أردت مساعدة مجانية في ترجمة هذه

Внимание: Если Вам нужна бесплатная помощь в переводе этой информации, позвоните по следующему телефону: Medica: 1-800-952-3455.

ລະວັງ. ຖ້າຫາກທ່ານຕ້ອງການ ການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ຟຣີ, ຈົ່ງໂທຫາ Medica: 1-800-952-3455.

Atención. Si desea recibir asistencia gratuita para traducir esta información, llame a Medica: 1-800-952-3455.

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សូមទូរស័ព្ទទៅ Medica: 1-800-952-3455.

Chú Ý. Nếu quý vị cần dịch thông-tin này miễn phí, xin gọi Medica: 1-800-952-3455.

Ceeb toom. Yog koj xav tau kev pab txhais cov xov no rau koj dawb, hu Medica: 1-800-952-3455.

Pažnja. Ako vam je potrebna besplatna pomoć za prevod ove informacije, nazovite Medica: 1-800-952-3455.

Hubaddhu. Yo akka odeeffannoon kun sii hiikamu gargaarsa tolaa feeta ta'e, bilbila kana bilbili Medica: 1-800-952-3455.

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If you want free help translating this information, call 1-800-952-3455.