

**Amendment to be attached to Medica Direct HSA for Individuals
Policy Form CHA2128-10804**

AMENDMENT NON-GRANDFATHERED INDIVIDUAL PLAN

Despite anything in the Policy of Coverage (“Policy”) to the contrary, the following provisions apply under this Policy for plan years beginning on or after September 23, 2010 to ensure compliance with Federal health care reform known as the Patient Protection and Affordable Care Act, including any amendments, regulations, rules or other guidance issued with respect to that law:

Rescissions

Only an act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact may be used to void this Policy.

Emergency Treatment

Emergency services from non-participating providers will be covered at the same benefit and cost sharing level as services provided by participating providers.

Preventive Services

The following services received from a participating provider are covered without regard to any deductible, copayment, or coinsurance requirements that would otherwise apply:

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

Lifetime Dollar Limits

Lifetime maximum dollar limits referenced do not apply to in-network [or out-of-network] benefits.

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Extension of Coverage to Dependents

If coverage includes dependents, dependent children are eligible for coverage until the end of the month the dependent child turns age 26 regardless of the child's marital status, financial dependency, residency, student status or employment status. Coverage does not include the spouse of the dependent child or the child of the dependent child (unless that child meets other eligibility criteria as set forth in the Policy).

Preexisting Conditions

Any preexisting condition exclusions do not apply to a member that has not attained the age of 19.

Annual Dollar Limits

"Per calendar year" or "per Contract year" dollar limits may only be applied to benefits that are not considered essential under Federal health care reform. For information concerning coverage of specific benefits, please contact Medica Customer Service at the numbers listed inside the front cover of the Policy.

Internal Appeals

You have the right to appeal an adverse benefit determination made by MIC through MIC's internal appeals process. An adverse benefit determination includes a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit including any denial, reduction, termination, or failure to provide or make a payment (for pre-service or post service claims) that is based on:

1. A determination that a benefit is not a covered benefit.
2. The imposition of a preexisting condition exclusion, source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits; or
3. A determination that a benefit is experimental, investigational, or not medically necessary or appropriate.

A rescission is also considered an adverse benefit determination.

Once an appeal is filed you will be provided free of charge a copy of "new evidence", if any, that MIC considered and a rationale for the adverse benefit determination. This information will be provided sufficiently in advance of the completion of the appeal so that you have a reasonable opportunity to respond. The claim or appeal decisionmaker assignment will be made so as to avoid conflicts of interest in a manner designed to ensure the independence and impartiality of the persons involved in making a decision. MIC will respond to your request for appeal no later than 72 hours after receipt of your request if it is

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an urgent care situation. A situation is considered urgent if, in the judgment of your provider, applying non-urgent appeal review periods would seriously jeopardize your life, health, or your ability to regain maximum function; or your medical condition would subject you to severe pain that cannot be adequately managed without the health care services or treatment that is the subject of the appeal. You have the right to contact the South Dakota Division of Insurance for additional information or assistance with your claim. MIC will provide you a copy of the complete appeals procedure upon request. If it is a concurrent review you will have continued coverage pending the outcome of an internal appeal.

External Review

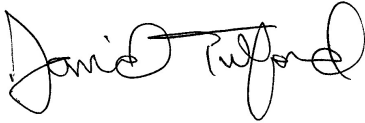
As a member, you have the right to an external review of an adverse benefit determination within 4 months after date of receipt of notice of an adverse benefit determination. An adverse benefit determination is a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated. Additionally, a rescission of coverage is an adverse determination.

The external review will be conducted by an independent review organization with health care professionals that have no conflict of interest with respect to the benefit determination. Except for approved expedited external reviews, an external review is available once you have exhausted the internal grievance process. You may request an external review by completing the request for external review which may be obtained from MIC or from the South Dakota Division of Insurance. The South Dakota Division of Insurance upon application and approval of the request for external review will assign the external review organization. Upon request MIC will provide a copy of the full external review procedure. You may also contact the Division of Insurance for assistance or if you have questions.

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All other terms and conditions of the Policy remain in full force and effect.

By:

Handwritten signature of David Rufford in black ink.

President

Handwritten signature of Jim Jacobson in black ink.

Senior Vice President and Assistant Secretary