

Medica SoloSM

*North Dakota
Policy of
Coverage*

ND-SOLO-PC-10-01

**Medica SoloSM
\$6,100 Deductible
80% Plan
Plan Code SFI-RC**

Notice of Free Examination

If you are not satisfied with this Policy you may return it within 10 days of receipt. Mail or deliver this Policy to the agent who sold it to you or our Home Office. We will refund any premium paid and this Policy will be deemed to never have been issued.

MEDICA CUSTOMER SERVICE

■ Customer Service:

1-866-894-8051

■ Hearing Impaired: National
Relay Center **1-800-855-2880**,
then ask for **1-866-894-8051**

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**MEDICA INSURANCE COMPANY (“MIC”)
INDIVIDUAL POLICY
 (“Policy”)**

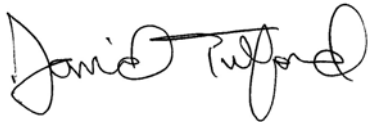
This Policy is a legal contract between the subscriber and Medica Insurance Company (“MIC”) and describes the benefits covered under this Policy. This Policy is issued on a subscriber only basis. There is no coverage for spouses, or other dependents, under this Policy.

We have issued this Policy in consideration of the application and the payment of the first premium on or before delivery of this Policy.

Important Consumer Information

Guarantee Renewal

MIC guarantees to renew this Policy as long as the premium is paid on or before the due date or within the grace period. Renewal is subject to MIC’s right to terminate your Policy due to non-payment of premium or for fraud or intentional misrepresentation of a material fact, or as otherwise described in *Ending Coverage*. MIC has the right to change the benefits and premium as allowed under North Dakota law. This Policy will not be canceled or non-renewed merely because your health deteriorates.



President



Senior Vice President and Assistant Secretary

Introduction

Medica Insurance Company ("MIC") offers Medica SoloSM. This Policy ("Policy") describes health services that are eligible for coverage and the procedures you must follow to obtain benefits.

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

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

Because many provisions are interrelated, you should read this Policy 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 this Policy and health services must be medically necessary.

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

In this Policy, the words *you*, *your* and *yourself* refer to the member.

To be eligible for benefits

Each time you receive health services, you must:

1. Confirm with MIC that your provider is a network provider with Medica Solo to be eligible for in-network benefits;
2. Identify yourself as a Medica Solo member; and
3. Present your Medica Solo identification card. (If you do not show your Medica Solo identification card, providers have no way of knowing that you are a Medica Solo 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 Solo identification card does not necessarily guarantee coverage.

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

Language interpretation

Language interpretation services will be provided upon request, as needed in connection with the interpretation of this Policy. 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 Policy 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.

Term of this Policy

All coverage under this Policy begins and ends at 12:01 a.m. Central Time.

Premiums

Your premiums must be prepaid at the address set forth below:

Medica Insurance Company
NW7105 P.O. Box 1450
Minneapolis, MN 55485-7105

MIC may change the premium with 30 day written notice.

Grace Period.

The grace period for the subscriber's payment of premiums will be 31 days from the date a premium is due. If you pay the premium at any time during this grace period, this Policy shall remain in force. If premium is not paid by the end of the grace period, coverage will end as stated in the *Ending Coverage* section.

Acceptance of coverage

By accepting the health care coverage described in this Policy the subscriber authorizes the use of a social security number for purpose of identification and declares that the information supplied by the subscriber to MIC for purposes of enrollment is accurate and complete.

The subscriber understands and agrees that any omissions or incorrect statements knowingly made by the subscriber in connection with enrollment under this Policy may invalidate coverage.

Nondiscrimination policy

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, provider

Member bill of rights

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

1. Available and accessible services, including emergency services (defined in this Policy) 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 MIC 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 MIC or any network provider in accordance with existing law; and
5. Contact MIC and North Dakota's Commissioner of Insurance to file a complaint about issues related to benefits (see *Complaints*). To file a complaint with the North Dakota Department of Insurance call 1-800-247-0560 and request insurance information. You may begin a legal proceeding if you have a problem with MIC or any provider; and
6. Receive information about MIC, 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 MIC's member rights and responsibilities statement.

Member responsibilities

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

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

Member Rights And Responsibilities

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

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

B. How To Access Your Benefits

See Definitions. These words have specific meanings: benefits, claim, coinsurance, deductible, emergency, enrollment date, genetic testing, hospital, inpatient, medically necessary, member, network, non-network, non-network provider reimbursement amount, physician, pre-existing condition, premium, prescription drug, provider, qualifying coverage, reconstructive, restorative, skilled nursing facility, subscriber

1. Important member information about in-network benefits

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

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

Benefits

MIC will cover health services and supplies as in-network benefits only if they are provided by network providers or are authorized by MIC. Prior authorization may be required from MIC for certain in-network benefits. This Policy 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. MIC does not reward providers for denying care, nor does MIC encourage inappropriate utilization of services.

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

Referrals

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

Emergency services

Emergency services from non-network providers will be covered as in-network benefits only if you follow required procedures. This Policy explains these procedures and the covered health services associated with emergency care.

Providers

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

Exclusions

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

Mental health and substance abuse

MIC's designated mental health and substance abuse provider will arrange your mental health and substance abuse benefits. MIC's designated mental health and 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 MIC's designated mental health and substance abuse provider; and
- A treatment plan, including any inpatient services must be authorized by MIC's designated mental health and substance abuse provider to be eligible for coverage.

Note: Mental health and substance abuse benefits are not included under this Policy if mental health and substance abuse coverage was declined at the time of the initial application. This election may be made only at the time of initial application.

Post-mastectomy coverage

MIC 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. MIC 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 the procedures you must follow to obtain out-of-network benefits.

Benefits

MIC pays out-of-network benefits for eligible health services received from non-network providers. Prior authorization may be required from MIC before you receive certain services, in order to determine whether those services are eligible for coverage under your out-of-network benefits. This Policy 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.

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

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

Be aware that if you choose to 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 coinsurance and deductible amount **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 Policy 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.

***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.

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

Exclusions

Some health services are not covered when received from or under the direction of non-network providers. Read this Policy 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.

3. Cancellation

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

4. Prescription drugs and medical equipment

Enrolling in MIC 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.

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. If MIC 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.

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

- i. Upon request, MIC will authorize continuity of care as described above for up to 120 days 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.

- ii. Upon request, MIC will authorize continuity of care as described above for up to 120 days in the following situations:
 - if you are receiving culturally appropriate services and MIC does not have a *network provider* who has special expertise in the delivery of those culturally appropriate services within MIC's time and distance requirements; or
 - if you do not speak English and MIC does not have a *network provider* who can communicate with you, either directly or through an interpreter, within MIC's time and distance requirements.

MIC 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 MIC authorizes your request to continue care with your current *provider*, MIC 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, MIC 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 Policy.

5. **Prior authorization**

Prior authorization from MIC 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. MIC uses written procedures and criteria when reviewing your request for prior authorization. To determine whether a certain service or supply requires prior authorization, please call Customer Service at one of the telephone numbers listed inside the front cover.

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

Some of the services that may require prior authorization from MIC 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. 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., MIC member number).

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

If the information necessary to make a decision is not provided, additional information may be requested. Upon receipt of the additional information, you, your authorized representative or your attending physician will be notified of the determination within two business days. If the additional information is not received within 45 days, the claim may be denied.

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

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

6. Pre-existing condition limitations

For in-network and out-of-network benefits, you must pay for services you receive to treat a pre-existing condition.

The use of prescription drugs from a pharmacy will be considered in determining whether you have a pre-existing condition limitation; however, such prescription drugs (used in this determination) may be a benefit. See *Prescription Drug Program* and *Specialty Prescription Drug Program* for information.

Length of pre-existing condition limitation

The pre-existing condition limitation applies during the first 12 months following your enrollment date.

However, the length of time that a pre-existing condition limitation may be imposed on a member is reduced by the aggregate of certain periods of qualifying coverage applicable to the member as of the enrollment date.

A period of qualifying coverage will not be counted if, after such period and before the enrollment date, there was a 63-day period during all of which you were not covered under any qualifying coverage. Time spent in a waiting period will not be considered a break in coverage.

MIC may modify your pre-existing condition limitation period if it ascertains that the initial determination of your prior qualifying coverage was inaccurate. If this occurs, MIC will notify you of the correct pre-existing condition limitation period.

When a pre-existing condition limitation does not apply

No pre-existing condition limitation may be applied to an individual who maintains qualifying coverage (without a break of 63 or more days) for 12 months.

A pre-existing condition limitation will *not* apply to a member who is under age 19 when he or she enrolls under the Policy.

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 this Policy 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 MIC

This section describes how MIC generally pays 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 Solo is fee-for-service.

Fee-for-service payment means that MIC 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 MIC 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, in addition to any applicable coinsurance and deductible amount.**

D. Your Out-Of-Pocket Expenses

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

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

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

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

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

Please see the applicable benefit section(s) of this Policy 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 deductible as described in this Policy.
You must pay an annual deductible. (See the Out-of-Pocket Expenses table in this section.) However, the deductible does not apply to outpatient prescription drugs (see Prescription Drug Program and Specialty Prescription Drug Program).
2. Any charge that is not covered under this Policy.

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

1. Any applicable coinsurance and deductible as described in this Policy
You must pay an annual deductible. (See the Out-of-Pocket Expenses table in this section.) However, the deductible does not apply to outpatient prescription drugs (see Prescription Drug Program and Specialty Prescription Drug Program).
2. Any charge that exceeds the non-network provider reimbursement amount. ***This means you are required to pay the difference between what MIC pays to the provider and***

what the provider bills. As a result, you may have substantial out-of-pocket expense when you use a non-network provider.

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 coinsurance and deductible.

3. Any charge that is not covered under this Policy.

If you use out-of-network benefits, you may incur costs in addition to your coinsurance and deductible amount. 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 (described in more detail later in this section). See Important member information about out-of-network benefits in *How To Access Your Benefits*.

In-network Out-of-pocket maximum

The out-of-pocket maximum is an accumulation of the applicable in-network copayments, coinsurance and deductible paid for benefits received during a calendar year. Unless otherwise specified, you will *not* be required to pay more than the applicable in-network out-of-pocket maximum for benefits received during a calendar year (see the Out-of-Pocket Expenses table in this section). Any amount or charge *not* covered, including charges for services not eligible for coverage and any charge in excess of the non-network provider reimbursement amount, is *not* applicable toward the out-of-pocket maximum.

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

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

Lifetime maximum amount

The lifetime maximum amount payable by MIC for out-of-network benefits under this Policy, or any other MIC policy for individuals and families that has a lifetime maximum benefit, is described in the Out-of-Pocket Expenses table in this section. You should monitor the amount

Your Out-Of-Pocket Expenses

paid for out-of-network benefits and contact MIC 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 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.</p>		
Copayment or coinsurance	<p>Copayments may be subject to a “cost of living” increase on a yearly basis. This “cost of living” increase is tied to the Consumer Price Index (CPI) and may be up to, but no greater than, the CPI. You will receive a notice of change 30 days in advance.</p> <p>Copayments do not accumulate to the deductible or out-of-pocket maximum described below.</p> <p>See specific benefit for applicable copayment or coinsurance.</p>	
Deductible	<p>Deductible may be subject to a “cost of living” increase on a yearly basis. This “cost of living” increase is tied to the Consumer Price Index (CPI) and may be up to, but no greater than, the CPI. You will receive a notice of change 30 days in advance.</p>	
	\$6,100	\$12,200
Out-of-pocket maximum	<p>Out-of-pocket maximum may be subject to a “cost of living” increase on a yearly basis. This “cost of living” increase is tied to the Consumer Price Index (CPI) and may be up to, but no greater than, the CPI. You will receive a notice of change 30 days in advance.</p> <p>Copayments are not included in the out-of-pocket maximum</p>	<p>Out-of-pocket maximum does not apply.</p>
	\$7,100	
Lifetime maximum amount payable per member	Unlimited	<p style="text-align: center;">\$1,000,000</p> <p>Applies to all out-of-network benefits you receive under this or any other MIC policy for individuals and families.</p>

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, coinsurance, convenience care/retail health clinic, copayment, deductible, emergency, genetic testing, hospital, inpatient, member, network, non-network, non-network provider reimbursement amount, physician, prenatal care, preventive health services, provider, urgent care center

Prior authorization. Prior authorization from MIC 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 professional services received from a network provider.
- *Out-of-network benefits* apply to professional services received from a non-network provider. **There is not an out-of-pocket maximum that applies to these charges.** In addition to the deductible and coinsurance, you will be responsible for any charges in excess of the non-network provider reimbursement amount. Please see Important member information about out-of-network benefits in *How To Access Your Benefits* for more information.

The most specific and appropriate section of this Policy 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

1. Maternity care services, other than those provided for involuntary complications of pregnancy.
2. Drugs provided or administered by a physician or other provider, except those requiring intravenous infusion or injection, intramuscular injection, or intraocular injection. Coverage for drugs is as described in *Prescription Drug Program and Specialty Prescription Drug Program* or otherwise described as a specific benefit in this Policy.

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

Your Benefits and the Amounts You Pay

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

<p>1. Office visits</p> <p>Please note: Some services received during an office visit may be covered under another benefit in this Policy. The most specific and appropriate benefit in this Policy will apply for each service received during an office visit.</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>	<p>\$40 copayment per visit for the first 3 visits per calendar year.[†] The deductible does not apply for the first 3 visits. Thereafter, you pay 20% coinsurance after deductible.</p>	<p>40% coinsurance</p>
<p>2. Convenience care/ retail health clinic visits</p> <p>Please note: The convenience care/retail health clinic network is a more limited network than our urgent care network. Please contact customer service at one of the telephone numbers listed inside the front cover to verify that your convenience care/retail health clinic is a network provider.</p>	<p>\$20 copayment for the first 3 visits per calendar year. The deductible does not apply for the first 3 visits. Thereafter, you pay 20% coinsurance after deductible.</p>	<p>For emergency services from non-network providers, refer to <i>Emergency Services From Non-Network Providers</i>. 40% coinsurance for non-emergency services received from non-network providers</p>

Your Benefits and the Amounts You Pay

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

3. Urgent care center visits	\$100 copayment per visit for the first visit per calendar year. The deductible does not apply for the first visit. Thereafter, you pay 20% coinsurance after deductible.	For emergency services from non-network providers, refer to <i>Emergency Services From Non-Network Providers</i> . 40% coinsurance for non-emergency services received from non-network providers
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4. Maternity care

a. Prenatal care services, received from a physician during an office visit, an outpatient hospital visit, or an inpatient stay	No coverage	No coverage
b. Services received for labor and delivery	No coverage	No coverage
c. Post partum office visit	No coverage	No coverage

5. Preventive health care

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

a. Child health supervision services, including well-baby care	Nothing. The deductible does not apply.	40% coinsurance
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Your Benefits and the Amounts You Pay

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

b. Immunizations	Nothing. The deductible does not apply.	40% coinsurance
c. Early disease detection services including physicals	Nothing. The deductible does not apply.	40% coinsurance
d. Routine screening procedures for cancer	Nothing. The deductible does not apply.	40% coinsurance
e. Other preventive health services	Nothing. The deductible does not apply.	40% coinsurance
6. Allergy shots	20% coinsurance	40% coinsurance
<p>7. Refractive eye exams</p> <p>Coverage is limited to one visit per calendar year for in-network and out-of-network benefits combined.</p> <p>Please note: This visit limit includes any visits that you pay for in order to satisfy any part of your deductible.</p>	<p>\$40 copayment per visit for the first 3 visits per calendar year.[†] The deductible does not apply for the first 3 visits. Thereafter, you pay 20% coinsurance after deductible.</p>	40% coinsurance

Your Benefits and the Amounts You Pay

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

<p>8. Chiropractic services to diagnose and to treat, (by manual manipulation or certain therapies) conditions related to the muscles, skeleton and nerves of the body</p> <p>Coverage is limited to 15 visits per calendar year for in-network and out-of-network benefits combined.</p> <p>Please note: This visit limit includes any visits that you pay for in order to satisfy any part of your deductible.</p>	<p>\$40 copayment per visit for the first 3 visits per calendar year.[†] The deductible does not apply for the first 3 visits. Thereafter, you pay 20% coinsurance after deductible.</p>	<p>40% coinsurance</p>
<p>9. Genetic counseling, whether pre- or post-test, and whether occurring in an office, clinic, or telephonically.</p>	<p>No coverage during the first 12 months following your enrollment date. Thereafter, you pay a \$40 copayment.</p> <p>The deductible does not apply.</p>	<p>No coverage during the first 12 months following your enrollment date. Thereafter, you pay 40% coinsurance.</p>
<p>10. Surgical services (as defined in the Physicians' Current Procedural Terminology code book) received from a physician during an office visit or an outpatient hospital or ambulatory surgical center visit</p>	<p>20% coinsurance</p>	<p>40% coinsurance</p>
<p>11. Anesthesia services received from a provider during an office visit or an outpatient hospital or ambulatory surgical center visit</p>	<p>20% coinsurance</p>	<p>40% coinsurance</p>

Your Benefits and the Amounts You Pay

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

12. Services received from a physician during an emergency room visit	20% coinsurance	For emergency services from non-network providers, see <i>Emergency Services From Non-Network Providers</i> . 40% coinsurance for non-emergency services provided in a non-network hospital emergency room.
13. Services received from a physician during an inpatient stay	20% coinsurance	40% coinsurance
14. Anesthesia services received from a provider during an inpatient stay.	20% coinsurance	40% coinsurance
15. Outpatient lab and pathology	20% coinsurance	40% coinsurance
16. 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	No coverage during the first 12 months following your enrollment date. Thereafter, you pay nothing	No coverage during the first 12 months following your enrollment date. Thereafter, you pay 40% coinsurance.
17. Outpatient x-rays and other imaging services	20% coinsurance	40% coinsurance
18. Other outpatient hospital or ambulatory surgical center services received from a physician	20% coinsurance	40% coinsurance

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	* Out-of-network benefits after deductible
<p>* For out-of-network benefits, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.</p>		
19. Diabetes self-management training and education, including medical nutrition therapy, received from a provider in a program consistent with national educational standards (as established by the American Diabetes Association)	20% coinsurance	40% coinsurance
20. Neuropsychological evaluations/cognitive testing, limited to services necessary for the diagnosis or treatment of a medical illness or injury	20% coinsurance	40% coinsurance
21. 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 Please note: The visit and exam limits include visits that you pay for in order to satisfy any part of your deductible	20% coinsurance Coverage is limited to a combined in-network and out-of-network total of 5 training visits and 2 follow-up eye exams per calendar year.	40% coinsurance Coverage is limited to a combined in-network and out-of-network total of 5 training visits and 2 follow-up eye exams per calendar year.
22. Eyewear, including eyeglass lenses, frames or contact lenses received from a <i>Medica contracted</i> optical provider.	MIC pays up to \$50 per calendar year for in-network and out-of-network benefits combined. You are responsible for any costs in excess of \$50.	MIC pays up to \$50 per calendar year for in-network and out-of-network benefits combined. You are responsible for any costs in excess of \$50.

⁺ The copayment and per calendar year 3 visit limit for the services identified throughout the policy by the ⁺ symbol apply to any combination of such services received.

F. Prescription Drug Program

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

See Definitions. These words have specific meanings: benefits, claim, coinsurance, copayment, durable medical equipment, emergency, hospital, member, network, non-network, non-network provider reimbursement amount, physician, prescription drug, preventive health services, provider, urgent care center

The in-network deductible and out-of-pocket maximum do not apply to this section.

Preferred drug list

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

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

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

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

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

MIC utilizes medication request guidelines to determine whether a drug should be listed on the PDL. MIC’s medication request guidelines are based on United States Food and Drug Administration (FDA) approval, manufacturers’ packaging guidelines, and clinical publications. These medication request guidelines, as well as the PDL, are periodically reviewed and modified by MIC. In addition to the medication request guidelines, MIC assigns a tier to each drug based on a review of the drug’s cost and effectiveness.

Exceptions to the preferred drug list

In certain circumstances your physician may request that MIC make an exception to the coverage rules described under *Preferred drug list* above. **Please note that exceptions will only be allowed when specific clinical criteria are satisfied.** Any exception MIC grants will improve the coverage by only one tier. If you would like to request a copy of MIC's PDL exception process, call Customer Service at one of the telephone numbers listed inside the front cover.

Prior authorization

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

If prior authorization is not obtained, you are required to pay the cost of the prescription drug and submit a paper claim with supporting documentation.

Step therapy

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

Quantity limits

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

Covered

The following table provides important general information concerning benefits. For specific information concerning benefits and the amounts you pay, see the benefit table at the end of this section. Please note that the Prescription Drug Program section describes your copayment or coinsurance for prescription 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 Policy including, but not limited to, Professional Services and Hospital Services.

Benefits

1. Covered drugs received at a pharmacy; and
2. Diabetic equipment and supplies, including blood glucose meters when received from a pharmacy; and
3. Tobacco cessation products when prescribed by a provider authorized to prescribe the product and received at a pharmacy.

When out-of-network benefits are received from non-network providers, you are responsible for any charges in excess of the non-network provider reimbursement amount in addition to the deductible and coinsurance described for 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.

Prescription unit

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

Three prescription units may be dispensed for covered drugs prescribed to treat chronic conditions that are received at a network pharmacy that MIC has specifically designated to dispense multiple prescription units. For the current list of such designated pharmacies, access mymedica.com or call Customer Service at one of the telephone numbers listed inside the front cover.

Not covered

The following are not covered:

1. Any amount above what MIC would have paid when you fail to identify yourself to the pharmacy as a member. (MIC 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.
3. Replacement of a drug due to loss, damage, or theft.
4. Appetite suppressants.
5. Weight loss medications.
6. Growth hormone.
7. Non-sedating antihistamines and non-sedating antihistamine/decongestant combinations.
8. Proton pump inhibitors
9. Drugs prescribed by a provider who is not acting within his/her scope of licensure.
10. Homeopathic medicine.
11. Drugs and supplies not listed on the PDL.
12. Specialty prescription drugs, except as described in *Specialty Prescription Drug Program*.

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

Your Benefits and the Amounts You Pay

In-network benefits

Out-of-network benefits

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

Tier 1: \$10 copayment per prescription unit or refill; or

Tier 1: 40% coinsurance per prescription unit or refill; or

Tier 2: \$50 copayment per prescription unit or refill; or

Tier 2: 40% coinsurance per prescription unit or refill; or

Tier 3: \$100 copayment per prescription unit or refill

Tier 3: 40% coinsurance per prescription unit or refill

2. Diabetic equipment and supplies, including blood glucose meters

Tier 1: 50% coinsurance per prescription unit or refill; or

Tier 1: 40% coinsurance per prescription unit or refill; or

Tier 2: \$50 copayment per prescription unit or refill; or

Tier 2: 40% coinsurance per prescription unit or refill; or

Tier 3: \$100 copayment per prescription unit or refill

Tier 3: 40% coinsurance per prescription unit or refill

3. Tobacco cessation products

Tier 1: \$10 copayment per prescription unit or refill; or

Tier 1: 40% coinsurance per prescription unit or refill; or

Tier 2: \$50 copayment per prescription unit or refill; or

Tier 2: 40% coinsurance per prescription unit or refill; or

Tier 3: \$100 copayment per prescription unit or refill

Tier 3: 40% coinsurance per prescription unit or refill

G. Specialty Prescription Drug Program

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

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

The in-network deductible and out-of-pocket maximum do not apply to this section. There is no coverage for out-of-network specialty drugs.

Designated specialty pharmacies

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

Specialty preferred drug list

MIC has a tiered SPDL that identifies specialty prescription drugs that are covered, unless otherwise listed as not covered in this Policy. The SPDL also identifies whether a drug is classified by MIC as a Tier 1 or Tier 2 specialty prescription drug. In general, only specialty prescription drugs on MIC's SPDL are eligible for benefits under this Policy. The applicable coinsurance amounts for coverage of drugs on the SPDL are set forth in the benefits table below.

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

MIC utilizes medication request guidelines to determine whether a specialty prescription drug should be covered. MIC's medication request guidelines are based on United States Food and Drug Administration (FDA) approval, manufacturers' packaging guidelines, and clinical publications. These medication request guidelines, as well as the SPDL, are periodically reviewed and modified by MIC. In addition to the medication request guidelines, MIC assigns a tier to each specialty prescription drug based on a review of the drug's cost and effectiveness.

Exceptions to the specialty preferred drug list

In certain circumstances your physician may request that MIC make an exception to the coverage rules described under *Specialty preferred drug list* above. **Please note that exceptions will only be allowed when specific clinical criteria are satisfied.** If you would

Specialty Prescription Drug Program

like to request a copy of MIC SPDL exception process, call Customer Service at one of the telephone numbers listed inside the front cover.

Prior authorization

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

If prior authorization is not obtained, you are required to pay the cost of the prescription drug and submit a paper claim with supporting documentation.

Quantity limits

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

Covered

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

This section describes your coinsurance for specialty prescription drugs. An additional 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 Policy including, but not limited to, *Professional Services* and *Hospital Services*.

Prescription unit

For specialty prescription drugs, one prescription unit is equal to up to a 31 consecutive day supply of a specialty prescription drug unless limited by the manufacturer's packaging or MIC's medication request guidelines, including quantity limits as indicated on the SPDL. Generally, specialty prescription drugs will not be dispensed in excess of one prescription unit.

Not covered

The following are not covered:

1. Any amount above what MIC would have paid when you fail to identify yourself to the designated specialty pharmacy as a member. (MIC will notify you before enforcement of this provision.)
2. Replacement of a specialty drug due to loss, damage, or theft.

Specialty Prescription Drug Program

3. Specialty prescription drugs prescribed by a provider who is not acting within their scope of licensure.
4. Prescription drugs, and OTC drugs, except as described in *Prescription Drug Program*.
5. Specialty prescription drugs received from a pharmacy that is not a designated specialty pharmacy.
6. Growth Hormone.
7. Weight loss medications.
8. Specialty drugs not listed on the SPDL.

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

Your Benefits and the Amounts You Pay

Benefits	You pay
1. Specialty prescription drugs received from a designated specialty pharmacy	Tier 1 specialty prescription drugs: 20% coinsurance up to a maximum of \$200 per prescription unit or refill; or Tier 2 specialty prescription drugs: 40% coinsurance up to a maximum of \$400 per prescription unit or refill.

F. 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, coinsurance, copayment, deductible, emergency, genetic testing, hospital, inpatient, member, network, non-network, non-network provider reimbursement amount, physician, prenatal care, provider

Prior authorization. Prior authorization from MIC 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 hospital services received from a network hospital or ambulatory surgical center.
- *Out-of-network benefits* apply to hospital services received from a non-network hospital or ambulatory surgical center. **There is not an out-of-pocket maximum that applies to these charges.** In addition to the deductible and coinsurance described for out-of-network benefits, you will be responsible for any charges in excess of the non-network provider reimbursement amount. Please see Important member information about out-of-network benefits in *How To Access Your Benefits* for more information.

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

1. Drugs received at a hospital on an outpatient basis, except drugs requiring intravenous infusion or injection, intramuscular injection, or intraocular injection; or drugs received in an emergency room or a hospital observation room. Coverage for drugs is as described in *Prescription Drug Program* and *Specialty Prescription Drug Program*, or otherwise described as a specific benefit in this Policy.
2. Admission to another hospital is not covered when care for your condition is available at the network hospital where you were first admitted.
3. Maternity care services, including all prenatal care, maternity labor and delivery services, other than those provided for involuntary complications of pregnancy.

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

Your Benefits and the Amount You Pay

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

1. Outpatient services:

a. Services provided in a hospital emergency room	\$200 copayment for the first visit per calendar year. The deductible does not apply for the first visit. Thereafter, you pay 20% coinsurance after deductible.	For emergency services from non-network providers, covered as an in-network benefit 40% coinsurance for non-emergency services provided in a non-network hospital emergency room
b. Outpatient lab and pathology	20% coinsurance	40% coinsurance
c. Outpatient x-rays and other imaging services	20% coinsurance	40% coinsurance
d. Prenatal care services	No coverage	No coverage
e. Maternity labor and delivery services	No coverage	No coverage
f. 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	No coverage during the first 12 months following your enrollment date. Thereafter, you pay nothing.	No coverage during the first 12 months following your enrollment date. Thereafter, you pay 40% coinsurance.
g. Other outpatient services	20% coinsurance	40% coinsurance
h. Other outpatient hospital and ambulatory surgical center services received from a physician	20% coinsurance	40% coinsurance

Your Benefits and the Amount You Pay

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

<ul style="list-style-type: none"> i. Anesthesia services received from a provider during an office visit or an outpatient hospital or ambulatory surgical center visit 	20% coinsurance	40% coinsurance
2. Services provided in a hospital observation room	20% coinsurance	40% coinsurance
3. Inpatient services, including semi-private room and board in a hospital and services received from a physician during an inpatient stay:		
<ul style="list-style-type: none"> a. Inpatient services other than for maternity care 	20% coinsurance	40% coinsurance
<ul style="list-style-type: none"> b. Inpatient services related to prenatal care services that do not result in a delivery 	No coverage	No coverage
<ul style="list-style-type: none"> c. Inpatient services related to maternity labor and delivery services 	No coverage	No coverage
4. Anesthesia services received from a provider during an inpatient stay	20% coinsurance	40% coinsurance

G. 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 Policy).

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

Prior authorization. Prior authorization from MIC 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 arranged through a physician and received from a network provider.
- *Out-of-network benefits* apply to ambulance services arranged through a physician and received from a non-network provider (except as described in 1. in the table in this section). **There is not an out-of-pocket maximum that applies to these charges.** In addition to the deductible and coinsurance described for out-of-network benefits, you will be responsible for any charges in excess of the non-network provider reimbursement amount. Please see Important member information about out-of-network benefits in *How To Access Your Benefits* for more information.

Not covered

These services, supplies and associated expenses are not covered:

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

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

Your Benefits and the Amounts You Pay

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

1. Ambulance services or ambulance transportation to the nearest hospital for an emergency	20% coinsurance	See <i>Emergency Services From Non-Network Providers</i> .
2. Non-emergency licensed ambulance service that is arranged through an attending physician, as follows:		
a. Transportation from hospital to hospital when:	20% coinsurance	40% coinsurance
i. Care for your condition is not available at the hospital where you were first admitted; or		
ii. Required by MIC		
b. Transportation from hospital to skilled nursing facility	20% coinsurance	40% coinsurance

H. Home Health Care

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

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

Prior authorization. Prior authorization from MIC 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, MIC (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 child may still be considered "confined to home" when attending school where life support specialized equipment and help are available.

Benefits covered under 1., 2. and 4. in the table in this section are limited to a combined annual benefit maximum each calendar year.

- *In-network benefits* apply to home health care services ordered or prescribed by a physician and received from a network home health care agency.
- *Out-of-network benefits* apply to home health care services that are ordered or prescribed by a physician and received from a non-network home health care agency. **There is not an out-of-pocket maximum that applies to these charges.** In addition to the deductible and coinsurance described for out-of-network benefits, you will be responsible for any charges in excess of the non-network provider reimbursement amount.

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 nonskilled services.
4. Physical, speech or occupational therapy provided in your home for convenience.
5. Services provided in your home when you are not homebound.
6. Services primarily educational in nature.
7. Vocational and job rehabilitation.
8. Recreational therapy.
9. Self-care and self-help training (non-medical).
10. Health clubs.
11. Disposable supplies and appliances, except as described in this Policy.
12. IV therapy.
13. 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.
14. Voice training.
15. Outpatient rehabilitation services when no medical diagnosis is present.

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**

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

- | | | |
|---|-----------------|-----------------|
| 1. Intermittent skilled care when you are homebound, provided by or supervised by a registered nurse. | 20% coinsurance | 40% coinsurance |
|---|-----------------|-----------------|

Coverage is limited to a maximum of 180 visits per calendar year for numbers 1., 2. and 4. in this section combined.

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

Your Benefits and the Amounts You Pay

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

- | | | |
|---|-----------------|-----------------|
| 2. Skilled physical, speech or occupational therapy when you are homebound. | 20% coinsurance | 40% coinsurance |
|---|-----------------|-----------------|

Coverage is limited to a maximum of 180 visits per calendar year for numbers 1., 2. and 4. in this section combined.

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

- | | | |
|--------------------------|-----------------|-----------------|
| 3. Home infusion therapy | 20% coinsurance | 40% coinsurance |
|--------------------------|-----------------|-----------------|

- | | | |
|---|-----------------|-----------------|
| 4. Services received in your home from a physician. | 20% coinsurance | 40% coinsurance |
|---|-----------------|-----------------|

Coverage is limited to a maximum of 180 visits per calendar year for numbers 1., 2. and 4. in this section combined.

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

I. *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, coinsurance, deductible, network, non-network, non-network provider reimbursement amount, physician

Prior authorization. Prior authorization from MIC 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 a physician and received from a network physical therapist, a network occupational therapist, a network speech therapist or a network physician.
- *Out-of-network benefits* apply to outpatient rehabilitation services arranged through a physician and received from a non-network physical therapist, a non-network occupational therapist, a non-network speech therapist or a non-network physician. Out-of-network benefits covered under 1., 2. and 3. in the table in this section are limited to a combined annual benefit maximum each calendar year. **There is not an out-of-pocket maximum that applies to these charges.** In addition to the deductible and coinsurance described for out-of-network benefits, you are responsible for any charges in excess of the non-network provider reimbursement amount. Please see Important member information about out-of-network benefits in *How To Access Your Benefits* for more information.

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
<p>* For out-of-network benefits, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.</p>		
<p>1. Physical therapy received outside of your home</p>	<p>20% coinsurance</p>	<p>40% coinsurance</p> <p>Coverage is limited to an out-of-network combined maximum of 15 visits per calendar year for 1., 2. and 3. in this section combined.</p> <p><i>Please note:</i> This visit limit includes any visits that you pay for in order to satisfy any part of your deductible.</p>
<p>2. 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</p>	<p>20% coinsurance</p>	<p>40% coinsurance</p> <p>Coverage is limited to an out-of-network combined maximum of 15 visits per calendar year for 1., 2. and 3. in this section combined.</p> <p><i>Please note:</i> This visit limit includes any visits that you pay for in order to satisfy any part of your deductible.</p>
<p>3. 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</p>	<p>20% coinsurance</p>	<p>40% coinsurance</p> <p>Coverage is limited to an out-of-network combined maximum of 15 visits per calendar year for 1., 2. and 3. in this section combined.</p> <p><i>Please note:</i> This visit limit includes any visits that you pay for in order to satisfy any part of your deductible.</p>

J. *Mental Health*

Mental health benefits are not included under this Policy if the Mental Health and Substance Abuse Coverage option was declined at the time of initial application. This election may be made only at the time of initial application.

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, emergency, hospital, inpatient, medically necessary, member, mental disorder, network, non-network, physician, provider, residential treatment

Prior authorization. For prior authorization requirements of *in-network* and *out-of-network benefits*, call MIC's designated mental health and substance abuse provider at 1-800-848-8327 or Hearing Impaired: National Relay Center 1-800-855-2880, then ask them to dial 1-800-543-7162.

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 and partial programs, 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. 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. Residential treatment services. Residential treatment only applies to members under the age of 21. These services include either:
 - i. A residential treatment program serving children and adolescents with severe emotional disturbance; 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. MIC's designated mental health and substance abuse provider arranges in-network mental health benefits. MIC's designated mental health and substance abuse provider will refer you to other mental health providers only if network providers cannot provide the services you require. If you require hospitalization, MIC's designated mental health and substance

abuse provider will refer you to one of its hospital providers. (MIC and MIC's designated mental health and substance abuse provider hospital networks are different.)

2. Notify MIC's designated mental health and substance abuse provider as soon as reasonably possible after receiving any emergency mental health inpatient services. Call MIC's designated mental health and substance abuse provider at: 1-800-848-8327 or Hearing Impaired: National Relay Center 1-800-855-2880, then ask them to dial: 1-800-543-7162.
3. Second opinions from a qualified provider are covered under in-network benefits only if MIC's designated mental health and substance abuse provider determines that no treatment is necessary. You must receive your second opinion within 30 calendar days of MIC's designated mental health and substance abuse provider's first evaluation. MIC's designated mental health and substance abuse provider will consider the second opinion but is not required to accept it.

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

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

In addition to the deductible and coinsurance described for out-of-network benefits, you are responsible for any charges in excess of the non-network provider reimbursement amount.

There is not an out-of-pocket maximum that applies to these charges. Please see Important member information about out-of-network benefits in *How To Access Your Benefits* for more information.

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 .
4. Relationship counseling.
5. Family counseling services, except as specifically described in this Policy as treatment for a minor.
6. Services for telephone psychotherapy.
7. Services beyond the initial evaluation to diagnose developmental disability 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, a Rule 36 facility, 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 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.**

Your Benefits and the Amounts You Pay

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

<p>1. Outpatient services</p> <p>a. Evaluations, diagnostic and treatment services</p> <p>b. Intensive outpatient programs</p>	<p>Nothing for the first 5 hours per calendar year and the deductible does not apply. You pay 20% coinsurance after deductible for the remaining hours. Coverage is limited to 40 hours per calendar year combined with out-of-network benefits.</p> <p>Please note: this hour limit includes hours that you pay for in order to satisfy any part of your deductible.</p>	<p>Nothing for the first 5 hours per calendar year and the deductible does not apply. You pay 40% coinsurance after deductible for the remaining hours. Coverage is limited to 40 hours per calendar year combined with in-network benefits.</p> <p>Please note: this hour limit includes hours that you pay for in order to satisfy any part of your deductible.</p>
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2. Inpatient services

Your Benefits and the Amounts You Pay

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

a. Semi-private room and board

20% coinsurance
Coverage is limited to a maximum benefit of 60 days per member per calendar year combined with out-of-network benefits for inpatient mental health covered health services and inpatient substance abuse covered health services combined (see *Substance Abuse*). Up to 23 inpatient services days may be traded for residential treatment services days as described in 4. of this section.

Please note: this day limit includes days that you pay for in order to satisfy any part of your deductible.

40% coinsurance
Coverage is limited to a maximum benefit of 60 days per member per calendar year combined with in-network benefits for inpatient mental health covered health services and inpatient substance abuse covered health services combined (see *Substance Abuse*). Up to 23 inpatient services days may be traded for residential treatment services days as described in 4. of this section.

Please note: this day limit includes days that you pay for in order to satisfy any part of your deductible.

Your Benefits and the Amounts You Pay

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

b. Hospital or facility-based professional services	<p>20% coinsurance Coverage is limited to a maximum benefit of 60 days per member per calendar year combined with out-of-network benefits for inpatient mental health covered health services and inpatient substance abuse covered health services combined (see <i>Substance Abuse</i>). Up to 23 inpatient services days may be traded for residential treatment services days as described in 4. of this section.</p> <p>Please note: this day limit includes days that you pay for in order to satisfy any part of your deductible.</p>	<p>40% coinsurance Coverage is limited to a maximum benefit of 60 days per member per calendar year combined with in-network benefits for inpatient mental health covered health services and inpatient substance abuse covered health services combined (see <i>Substance Abuse</i>). Up to 23 inpatient services days may be traded for residential treatment services days as described in 4. of this section.</p> <p>Please note: this day limit includes days that you pay for in order to satisfy any part of your deductible.</p>
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Your Benefits and the Amounts You Pay

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

c. Attending psychiatrist services

20% coinsurance
 Coverage is limited to a maximum benefit of 60 days per member per calendar year combined with out-of-network benefits for inpatient mental health covered health services and inpatient substance abuse covered health services combined (see *Substance Abuse*). Up to 23 inpatient services days may be traded for residential treatment services days as described in 4. of this section.

Please note: this day limit includes days that you pay for in order to satisfy any part of your deductible.

40% coinsurance
 Coverage is limited to a maximum benefit of 60 days per member per calendar year combined with in-network benefits for inpatient mental health covered health services and inpatient substance abuse covered health services combined (see *Substance Abuse*). Up to 23 inpatient services days may be traded for residential treatment services days as described in 4. of this section.

Please note: this day limit includes days that you pay for in order to satisfy any part of your deductible.

Your Benefits and the Amounts You Pay

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

3. Partial program	<p>20% coinsurance</p> <p>Coverage is limited to a maximum benefit of 120 days per member per calendar year combined with out-of-network benefits for mental health partial program covered health services and substance abuse partial program covered health services combined (see <i>Substance Abuse</i>).</p> <p>Please note: this day limit includes days that you pay for in order to satisfy any part of your deductible.</p>	<p>40% coinsurance</p> <p>Coverage is limited to a maximum benefit of 120 days per member per calendar year combined with in-network benefits for mental health partial program covered health services and substance abuse partial program covered health services combined (see <i>Substance Abuse</i>).</p> <p>Please note: this day limit includes days that you pay for in order to satisfy any part of your deductible.</p>
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Your Benefits and the Amounts You Pay

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

<p>4. Residential treatment services (Residential treatment only applies to members under the age of 21.)</p>	<p>20% coinsurance Coverage is limited to a maximum benefit of 120 days per member per calendar year combined with out-of-network benefits.</p> <p>Please note: this day limit includes days that you pay for in order to satisfy any part of your deductible.</p> <p>Benefits for residential treatment covered health services may be expanded by trading up to 23 unused inpatient services days for residential treatment services days. For purposes of this combination of benefits, each inpatient services day equals two days of residential treatment services.</p>	<p>40% coinsurance Coverage is limited to a maximum benefit of 120 days per member per calendar year combined with in-network benefits.</p> <p>Please note: this day limit includes days that you pay for in order to satisfy any part of your deductible</p> <p>Benefits for residential treatment covered health services may be expanded by trading up to 23 unused inpatient services days for residential treatment services days. For purposes of this combination of benefits, each inpatient services day equals two days of residential treatment services.</p>
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K. Substance Abuse

Substance abuse benefits are not included under this Policy if the Mental Health and Substance Abuse Coverage option was declined at the time of initial application. This election may be made only at the time of initial application.

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

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

Prior authorization. For prior authorization requirements of in-network and out-of-network benefits, call MIC's designated mental health and substance abuse provider at: 1-800-848-8327 or Hearing Impaired: National Relay Center 1-800-855-2880, then ask them to dial: 1-800-543-7162.

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.
2. Inpatient services include:
 - a. Semi-private room and board.
 - b. Attending physician services.
 - c. Hospital or facility-based professional services.
 - d. 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. MIC's designated mental health and substance abuse provider arranges in-network substance abuse benefits. MIC's designated mental health and substance abuse provider will refer you to other substance abuse providers only if network providers cannot provide the services you require. If you require hospitalization, MIC's designated mental health and substance abuse provider will refer you to one of its hospital providers. (MIC and MIC's designated mental health and substance abuse provider hospital networks are different.)
2. Notify MIC's designated mental health and substance abuse provider as soon as reasonably possible after receiving any emergency substance abuse inpatient services. Call MIC's designated mental health and substance abuse provider at 1-800-848-8327 or Hearing Impaired: National Relay Center 1-800-855-2880, then ask them to dial 1-800-543-7162.
3. Second opinions from a qualified provider are covered under in-network benefits only if MIC's designated mental health and substance abuse provider determines that no treatment is necessary. You must receive your second opinion within 30 calendar days of MIC's designated mental health and substance abuse provider's first evaluation. MIC's designated mental health and substance abuse provider will consider the second opinion but is not required to accept it.

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

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

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

There is not an out-of-pocket maximum that applies to these charges. Please see Important member information about out-of-network benefits in *How To Access Your Benefits* for more information.

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.
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 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.**

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	* Out-of-network benefits after deductible
<p>* For out-of-network benefits, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.</p>		
1. Outpatient services		
a. Evaluations, diagnostic and treatment services	Nothing for the first 5 visits per calendar year and the deductible does not apply. You pay 20% coinsurance after deductible for the remaining visits. Coverage is limited to 30 visits per calendar year combined with out-of-network benefits.	Nothing for the first 5 visits per calendar year and the deductible does not apply. You pay 40% coinsurance after deductible for the remaining visits.
b. Intensive outpatient programs	Coverage is limited to 30 visits per calendar year combined with out-of-network benefits. Please note: this visit limit includes visits that you pay for in order to satisfy any part of your deductible.	Coverage is limited to 30 visits per calendar year combined with in-network benefits. Please note: this visit limit includes visits that you pay for in order to satisfy any part of your deductible.
2. Methadone maintenance therapy	20% coinsurance	40% coinsurance

3. Inpatient services:

Your Benefits and the Amounts You Pay

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

<p>a. Semi-private room and board</p>	<p>20% coinsurance Coverage is limited to a maximum benefit of 60 days per member per calendar year combined with out-of-network benefits for inpatient substance abuse covered health services and inpatient mental health covered health services combined (see <i>Mental Health</i>). Up to 23 inpatient services days may be traded for partial program or residential treatment services days as described in 3. and 4. of this section.</p> <p>Please note: this day limit includes days that you pay for in order to satisfy any part of your deductible.</p>	<p>40% coinsurance Coverage is limited to a maximum benefit of 60 days per member per calendar year combined with in-network benefits for inpatient substance abuse covered health services and inpatient mental health covered health services combined (see <i>Mental Health</i>). Up to 23 inpatient services days may be traded for partial program or residential treatment services days as described in 3. and 4. of this section.</p> <p>Please note: this day limit includes days that you pay for in order to satisfy any part of your deductible.</p>
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Your Benefits and the Amounts You Pay

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

b. Hospital or facility-based professional services

20% coinsurance
Coverage is limited to a maximum benefit of 60 days per member per calendar year combined with out-of-network benefits for inpatient substance abuse covered health services and inpatient mental health covered health services combined (see *Mental Health*). Up to 23 inpatient services days may be traded for partial program or residential treatment services days as described in 3. and 4. of this section.

Please note: this day limit includes days that you pay for in order to satisfy any part of your deductible.

40% coinsurance
Coverage is limited to a maximum benefit of 60 days per member per calendar year combined with in-network benefits for inpatient substance abuse covered health services and inpatient mental health covered health services combined (see *Mental Health*). Up to 23 inpatient services days may be traded for partial program or residential treatment services days as described in 3. and 4. of this section.

Please note: this day limit includes days that you pay for in order to satisfy any part of your deductible.

Your Benefits and the Amounts You Pay

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

<p>c. Attending physician services</p>	<p>20% coinsurance Coverage is limited to a maximum benefit of 60 days per member per calendar year combined with out-of-network benefits for inpatient substance abuse covered health services and inpatient mental health covered health services combined (see <i>Mental Health</i>). Up to 23 inpatient services days may be traded for partial program and residential treatment services days as described in 3. and 4. of this section.</p> <p>Please note: this day limit includes days that you pay for in order to satisfy any part of your deductible.</p>	<p>40% coinsurance Coverage is limited to a maximum benefit of 60 days per member per calendar year combined with in-network benefits for inpatient substance abuse covered health services and inpatient mental health covered health services combined (see <i>Mental Health</i>). Up to 23 inpatient services days may be traded for partial program and residential treatment services days as described in 3. and 4. of this section.</p> <p>Please note: this day limit includes days that you pay for in order to satisfy any part of your deductible.</p>
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Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	* Out-of-network benefits after deductible
<p>* For out-of-network benefits, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.</p>		
<p>4. Residential treatment services</p>	<p>20% coinsurance Coverage is limited to a maximum benefit of 60 days per member per calendar year combined with out-of-network benefits.</p> <p>Please note: this day limit includes days that you pay for in order to satisfy any part of your deductible.</p> <p>Benefits for residential treatment covered health services may be expanded by trading up to 23 unused inpatient services days for residential treatment services days. For purposes of this combination of benefits, each inpatient services day equals two days of residential treatment services.</p>	<p>40% coinsurance Coverage is limited to a maximum benefit of 60 days per member per calendar year combined with in-network benefits.</p> <p>Please note: this day limit includes days that you pay for in order to satisfy any part of your deductible.</p> <p>Benefits for residential treatment covered health services may be expanded by trading up to 23 unused inpatient services days for residential treatment services days. For purposes of this combination of benefits, each inpatient services day equals two days of residential treatment services.</p>

L. *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, coinsurance, deductible, medically necessary, network, non-network, non-network provider reimbursement amount, physician, provider

Prior authorization. Prior authorization from MIC 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. Benefits payable for all covered items except prosthetic limbs are limited to \$10,000 per calendar year. MIC covers only a limited selection of durable medical equipment and certain related supplies that meet the criteria established by MIC. 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 MIC. To request a list of MIC's eligible durable medical equipment and certain related supplies, call Customer Service at one of the telephone numbers listed inside the front cover.

MIC determines if durable medical equipment will be purchased or rented. MIC'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.

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

- *In-network benefits* apply to durable medical equipment and certain related supplies and prosthetic services prescribed by a physician and received from a network durable medical equipment 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.
- *Out-of-network benefits* apply to durable medical equipment and certain related supplies and prosthetic services prescribed by a physician and received from a non-network provider. **There is not an out-of-pocket maximum that applies to these charges.** In addition to the deductible and coinsurance described for out-of-network benefits, you are responsible for charges in excess of the non-network provider reimbursement amount. Please see Important member information about out-of-network benefits in *How To Access Your Benefits* for more information.

Durable Medical Equipment And Prosthetics

Not covered

These services, supplies and associated expenses are not covered:

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

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

Your Benefits and the Amounts You Pay

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

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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 |
| 3. Prosthetics: | | |
| a. Initial purchase of external prosthetic devices that replace a limb or an external body part, limited to: | 20% coinsurance | 40% coinsurance |
| i. Artificial arms, legs, feet, and hands; | | |
| ii. Artificial eyes, ears and noses; | | |
| iii. Breast prostheses. | | |

Durable Medical Equipment And Prosthetics

Your Benefits and the Amounts You Pay

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

b. 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
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M. Miscellaneous Medical Services And Supplies

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

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

Prior authorization. Prior authorization from MIC 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 miscellaneous medical services and supplies received from a network provider.
- *Out-of-network benefits* apply to miscellaneous medical services and supplies received from a non-network provider. **There is not an out-of-pocket maximum that applies to these charges.** In addition to the deductible and coinsurance described for out-of-network benefits, you are responsible for any charges in excess of the non-network provider reimbursement amount. Please see Important member information about out-of-network benefits in *How To Access Your Benefits* for more information.

Not covered

1. Other disposable supplies and appliances, except as described in this Policy.
2. Low protein modified food products or medical food to the extent these items are available under a department of health program.

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

Miscellaneous Medical Services And Supplies

Your Benefits and the Amounts You Pay

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

1. Blood clotting factors	20% coinsurance	40% coinsurance
2. Dietary medical treatment of phenylketonuria (PKU) and maple-syrup urine disease	20% coinsurance Coverage for low protein modified food products is limited to a combined maximum benefit of \$3,000 per calendar year for in-network and out-of-network benefits. Please note: this benefit maximum includes amounts you pay for low protein modified food products in order to satisfy any part of your deductible.	40% coinsurance Coverage for low protein modified food products is limited to a combined amount of \$3,000 per calendar year for in-network and out-of-network benefits. Please note: this benefit maximum includes amounts you pay for low protein modified food products in order to satisfy any part of your deductible.

Miscellaneous Medical Services And Supplies

Your Benefits and the Amounts You Pay

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

3. Amino acid-based elemental oral formulas for the following diagnoses: <ul style="list-style-type: none"> a. cystic fibrosis; b. amino acid, organic acid, and fatty acid metabolic and malabsorption disorders; c. IgE mediated allergies to food proteins; d. food protein-induced enterocolitis syndrome; e. eosinophilic esophagitis; f. eosinophilic gastroenteritis; and g. eosinophilic colitis. Coverage for the diagnoses in 3.c.-g. above is limited to members five years of age and younger.	20% coinsurance	40% coinsurance
4. Total parenteral nutrition	20% coinsurance	40% coinsurance
5. Eligible ostomy supplies	20% coinsurance	40% coinsurance
Please note: Eligible ostomy supplies may be received from a pharmacy or a durable medical equipment provider		
6. Insulin pumps and other eligible diabetic equipment and supplies	20% coinsurance	40% coinsurance

N. 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, coinsurance, copayment, deductible, designated facility, hospital, inpatient, investigative, medically necessary, member, network, non-network, non-network provider reimbursement amount, physician, provider

Prior authorization. Prior authorization from MIC 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

MIC uses specific medical criteria to determine benefits for organ and bone marrow transplant services. Because medical technology is constantly changing, MIC 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 MIC's medical criteria.

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

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

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

For in-network benefits, MIC 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 (that you select from among the list of transplant facilities MIC provides). Based on the type of transplant you receive, MIC will determine the specific time period medically necessary for these services.

Organ And Bone Marrow Transplant Services

- *Out-of-network benefits* apply to organ and bone marrow transplant services provided by or at either of the following:
 1. A non-network provider; or
 2. A network facility that is not a designated facility for transplant services.

There is not an out-of-pocket maximum that applies to these charges. In addition to the deductible and coinsurance described for out-of-network benefits, you are responsible for any charges in excess of the non-network provider reimbursement amount. Please see Important member information about out-of-network benefits in *How To Access Your Benefits* for more information.

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.

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 MIC under the medical criteria referenced in this section.
3. Chemotherapy, radiation therapy, drugs or any therapy used to damage the bone marrow and related to transplants that would not be authorized by MIC under the medical criteria referenced in this section.
4. Living donor transplants that would not be authorized by MIC 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 Policy.
7. Mechanical, artificial or non-human organ implants or transplants and related services that would not be authorized by MIC under the medical criteria referenced in this section.
8. Transplants and related services that are investigative.
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 Drug Program and Specialty Prescription Drug Program* or otherwise described as a specific benefit in this Policy.
11. In-network benefits for transplant services provided by a non-designated transplant facility.

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

Organ And Bone Marrow Transplant Services

Your Benefits and the Amounts You Pay

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

1. Office visits	20% coinsurance	40% coinsurance
2. 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	40% coinsurance
iii. Outpatient lab and pathology	20% coinsurance	40% coinsurance
iv. Outpatient x-rays and other imaging services	20% coinsurance	40% coinsurance
v. Other outpatient hospital services received from a physician	20% coinsurance	40% coinsurance
b. Hospital and ambulatory surgical center services		
i. Outpatient lab and pathology	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 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.**

<ul style="list-style-type: none"> ii. Outpatient x-rays and other imaging services 	20% coinsurance	40% coinsurance
<ul style="list-style-type: none"> iii. Other outpatient hospital services 	20% coinsurance	40% coinsurance
3. Inpatient services	20% coinsurance	40% coinsurance
4. Services received from a physician during an inpatient stay	20% coinsurance	40% coinsurance
5. Anesthesia services received from a provider during an inpatient stay	20% coinsurance	40% coinsurance

O. Reconstructive And Restorative Surgery

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

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

Prior authorization. Prior authorization from MIC 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 received from a network provider.
- *Out-of-network benefits* apply to reconstructive and restorative surgery services received from a non-network provider. **There is not an out-of-pocket maximum that applies to these charges.** In addition to the deductible and coinsurance described for out-of-network benefits, you will be responsible for any charges in excess of the non-network provider reimbursement amount. Please see Important member information about out-of-network benefits in *How To Access Your Benefits* for more information.

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*.
2. Repair of a pierced body part and surgical repair of bald spots or loss of hair.
3. Repairs to teeth, including any other dental procedures or treatment, whether the dental treatment is needed because of a primary dental problem or as a manifestation of a medical treatment or condition.
4. Services and procedures primarily for cosmetic purposes.
5. Surgical correction of male breast enlargement primarily for cosmetic purposes.
6. Hair transplants.

Reconstructive And Restorative Surgery

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

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

Your Benefits and the Amounts You Pay

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

- | | | |
|---|---|-----------------|
| 1. Office visits | \$40 copayment per visit for the first 3 visits per calendar year. [†] The deductible does not apply for the first 3 visits. Thereafter, you pay 20% coinsurance after deductible. | 40% coinsurance |
| 2. Outpatient services | | |
| a. Professional services | | |
| i. Surgical services (as defined in the <i>Physicians' Current Procedural Terminology</i> code book) received from a physician during an office visit or an outpatient hospital or ambulatory surgical center visit | 20% coinsurance | 40% coinsurance |
| ii. Anesthesia services received from a provider during an office visit or an outpatient hospital or ambulatory surgical center visit | 20% coinsurance | 40% coinsurance |
| iii. Outpatient lab and pathology | 20% coinsurance | 40% coinsurance |

Reconstructive And Restorative Surgery

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	* Out-of-network benefits after deductible
<p>* For out-of-network benefits, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.</p>		
iv. Outpatient x-rays and other imaging services	20% coinsurance	40% coinsurance
v. Other outpatient hospital or ambulatory surgical center services received from a physician	20% coinsurance	40% coinsurance
b. Hospital and ambulatory surgical center services		
i. Outpatient lab and pathology	20% coinsurance	40% coinsurance
ii. Outpatient x-rays and other imaging services	20% coinsurance	40% coinsurance
iii. Other outpatient hospital and ambulatory surgical center services	20% coinsurance	40% coinsurance
3. Inpatient services	20% coinsurance	40% coinsurance
4. Services received from a physician during an inpatient stay	20% coinsurance	40% coinsurance
5. Anesthesia services received from a provider during an inpatient stay	20% coinsurance	40% coinsurance

⁺ The copayment and per calendar year 3 visit limit for the services identified throughout the policy by the ⁺ symbol apply to any combination of such services received.

P. 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 qualify as reimbursable under Medicare.

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

Prior authorization. Prior authorization from MIC 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. Benefits covered under numbers 1 and 3 in the table in this Section are limited to a combined maximum of 120 days per calendar year.

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

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).
3. Services primarily educational in nature.
4. Vocational and job rehabilitation.
5. Recreational therapy.
6. Health clubs.

Skilled Nursing Facility Services

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 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.**

<p>1. Daily skilled care or daily skilled rehabilitation services, including room and board</p> <p>Benefits are limited to 120 days per calendar year for in-network and out-of-network combined.</p> <p>Please note: This day limit includes any days that you pay for in order to satisfy any part of your deductible.</p>	<p>20% coinsurance</p> <p>Services are covered only after transfer to a skilled nursing facility within 30 days of discharge from a hospital in which you were confined for not less than three consecutive calendar days. Services must begin within 14 days of an inpatient stay of at least three days in a hospital.</p>	<p>40% coinsurance</p> <p>Services are covered only after transfer to a skilled nursing facility within 30 days of discharge from a hospital in which you were confined for not less than three consecutive calendar days. Services must begin within 14 days of an inpatient stay of at least three days in a hospital.</p>
<p>2. Skilled physical, speech or occupational therapy when room and board is not eligible to be covered</p>	<p>20% coinsurance</p>	<p>40% coinsurance</p>
<p>3. Services received from a physician during an inpatient stay in a skilled nursing facility</p> <p>Benefits are limited to services received during 120 days of inpatient stay per calendar year for in-network and out-of-network combined.</p> <p>Please note: This day limit includes any days that you pay for in order to satisfy any part of your deductible</p>	<p>20% coinsurance</p>	<p>40% coinsurance</p>

Q. 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 designated hospice program.

See Definitions. These words have specific meanings: benefits, coinsurance, deductible, member, network, non-network, physician, 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 designated hospice program means a hospice program that has entered into a separate contract with MIC 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 arranged through a physician and received from a designated hospice program.*
- *Out-of-network benefits apply to hospice services arranged through a physician and received from a non-network hospice program.*

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 designated hospice program. You must follow the designated hospice program's requirements to withdraw from the designated 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.
10. In-network benefits for hospice services received from a non-designated hospice program.

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

Your Benefits and the Amounts You Pay

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

1. Hospice services	20% coinsurance	40% coinsurance
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R. 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. TMJ disorder is covered the same as any other joint disorder under this Policy.

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

Prior authorization. Prior authorization from MIC 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.

Benefits payable for surgical treatment are limited to a lifetime maximum benefit of \$10,000. Benefits payable for non-surgical treatment are limited to a lifetime maximum benefit of \$2,500 .

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

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. Diagnostic casts and diagnostic study models.
2. Bite adjustment.

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

Temporomandibular Joint (TMJ) Disorder

Your Expenses and the Amounts You Pay

Benefits	In-network benefits after deductible	* Out-of-network benefits after deductible
<p>* For out-of-network benefits, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.</p>		
1. Office visits	\$40 copayment per visit for the first 3 visits per calendar year. [†] The deductible does not apply for the first 3 visits. Thereafter, you pay 20% coinsurance after deductible.	40% coinsurance
2. 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	40% coinsurance
iii. Outpatient lab and pathology	20% coinsurance	40% coinsurance
iv. Outpatient x-rays and other imaging services	20% coinsurance	40% coinsurance
v. Other outpatient hospital and ambulatory surgical center services received from a physician or dentist	20% coinsurance	40% coinsurance

Temporomandibular Joint (TMJ) Disorder

Your Expenses and the Amounts You Pay

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

b. Hospital and ambulatory surgical center services		
i. Outpatient lab and pathology	20% coinsurance	40% coinsurance
ii. Outpatient x-rays and other imaging services	20% coinsurance	40% coinsurance
ii. 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	40% coinsurance
8. TMJ splints and adjustments if your primary diagnosis is joint disorder	20% coinsurance	40% coinsurance

⁺ The copayment and per calendar year 3 visit limit for the services identified throughout the policy by the ⁺ symbol apply to any combination of such services received.

S. 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 Policy.

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

Prior authorization. Prior authorization from MIC 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 received from a network provider.
- *Out-of-network benefits* apply to medical-related dental services received from a non-network provider. **There is not an out-of-pocket maximum that applies to these charges.** In addition to the deductible and coinsurance described for out-of-network benefits, you will be responsible for any charges in excess of the non-network provider reimbursement amount. Please see Important member information about out-of-network benefits in *How To Access Your Benefits* for more information.

Not covered

These services, supplies and associated expenses are not covered:

1. Dental services to treat an injury from biting or chewing.
2. Osteotomies and other procedures associated with the fitting of dentures or dental implants.
3. Dental implants (tooth replacement).
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 including that associated with orthognathic procedures or accident-related dental injuries.
6. Tooth extractions, except as described in this section.
7. Any dental procedures or treatment related to periodontal disease.

Medical-Related Dental Services

8. Endodontic procedures and treatment, including root canal procedures and treatment.
9. Routine diagnostic and preventive dental services.

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

Your Benefits and the Amounts You Pay

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

<ol style="list-style-type: none"> 1. Charges for medical facilities and general anesthesia services that are: <ol style="list-style-type: none"> a. Recommended by a network 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 nine (prior authorization is <i>not</i> required); or ii. Is severely disabled; or iii. Has a medical condition and requires hospitalization or general anesthesia for dental care treatment. 	<p>20% coinsurance</p>	<p>40% coinsurance</p>
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Please note. Age, anxiety and behavioral conditions are not considered medical conditions.

V. 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, 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 and:

- If there was a delay associated with getting to a network provider, your health would be endangered; or
- Because of your health condition you are unable to request treatment from a network provider.

You must notify MIC 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 MIC's designated mental health and substance abuse provider as soon as reasonably possible. MIC's designated mental health and substance abuse provider can be reached at:

- 1-800-848-8327
- Hearing Impaired: National Relay Center 1-800-855-2880, then ask them to dial 1-800-543-7162.

Important: Mental health and substance abuse benefits are not included under this Policy if the Mental Health and Substance Abuse Coverage option was declined at the time of initial application. This election may be made only at the time of initial application.

If the health services that you require do not meet the definition of emergency, you should refer to the remainder of this Policy 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 from network providers 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 Policy continues until your attending physician agrees it is safe to transfer you to a network facility.

Emergency Services From Non-Network Providers

Not covered

These services, supplies and associated expenses are not covered:

1. Non-emergency care from non-network providers except as described in this Policy.
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 in this Policy.
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.

Your Benefits and the Amounts You Pay

Benefits

In-network benefits after deductible

- | | |
|---|-----------------|
| 1. Emergency services that are: | 20% coinsurance |
| a. Administered under the direction of a physician; <i>and</i> | |
| b. Otherwise eligible for coverage in this Policy. | |
| 2. Ambulance service or ambulance transportation to the nearest hospital for an emergency | 20% coinsurance |

W. Referrals To Non-Network Providers

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

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

If you want to apply for a standing referral to a non-network provider, contact MIC for more information. If determined by MIC to be clinically appropriate, a standing referral may be granted by MIC.

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

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

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

What you must do

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

What MIC will do

1. May require that you see another network provider selected by MIC before a determination by MIC that a referral to a non-network provider is medically necessary.
2. May require that you obtain a referral or standing referral (as described in this section) from a network provider to a non-network provider practicing in the same or similar specialty.
3. Provide coverage for health services that are:
 - a. Otherwise eligible for coverage under this Policy; and
 - b. Recommended by a network physician.
4. Notifies you of coverage or denial of coverage within two business days of receipt of your request, provided all information reasonably necessary to make a decision has been made available. For additional information about prior authorization, see *How To Access Your Benefits*.

X. Harmful Use Of Medical Services

This section describes what MIC 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 MIC 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, MIC 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.

MIC 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.

Y. Exclusions

See Definitions. These words have specific meanings: claim, coinsurance, copayment, cosmetic, custodial care, emergency, genetic testing, investigative, medically necessary, member, non-network, physician, pre-existing condition, provider, reconstructive

MIC 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 Policy. 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 except as stated in *Professional Services*.
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.
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. Services or supplies not directly related to care.
9. Autopsies, except as stated in *General Provisions*.
10. 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.

11. Nutritional and electrolyte substances except as specifically described in *Miscellaneous Medical Services And Supplies*.
12. Physical, occupational or speech therapy when there is no reasonable expectation that the condition will improve over a predictable period of time.
13. Reversal of voluntary sterilization.
14. Neuropsychological evaluations/cognitive testing, except as stated in *Professional Services*.
15. Personal comfort or convenience items or services, including but not limited to breast pumps except when the pump is medically necessary.
16. Custodial care, unskilled nursing or unskilled rehabilitation services.
17. Respite or rest care except as otherwise covered in *Hospice Services*.
18. Travel, transportation or living expenses.
19. Household equipment, fixtures, home modifications and vehicle modifications.
20. Services to treat nicotine addiction except as stated in *Prescription Drug Program*.
21. Massage therapy, provided in any setting, even when it is part of a comprehensive treatment plan.
22. Routine foot care, except for members with diabetes, peripheral vascular disease, peripheral neuropathies or blindness.
23. Services by persons who are family members or who share your legal residence.
24. Services for which coverage is available under workers' compensation, employer liability or any similar law.
25. Services received before coverage under this Policy becomes effective.
26. Services received after coverage under this Policy ends.
27. Unless requested by MIC, charges for duplicating and obtaining medical records from non-network providers and non-network dentists.
28. Photographs, except for the condition of multiple dysplastic syndrome.
29. Occlusal adjustment or occlusal equilibration.
30. Dental implants (tooth replacement).
31. Dental prostheses.
32. Orthodontic treatment, except as described in *Medical-Related Dental Services*.
33. Treatment for bruxism.
34. Services prohibited by law or regulation, or illegal under North Dakota law.
35. Services to treat injuries that occur while on military duty; and any services received as a result of war, or any act of war (whether declared or undeclared).
36. Exams, other evaluations or other services received solely for the purpose of employment, insurance or licensure.
37. 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.

38. Non-medical self-care or self-help training.
39. Educational classes, programs or seminars, including but not limited to childbirth classes, except as described in *Professional Services*.
40. Coverage for costs associated with translation of medical records and claims to English.
41. Treatment for spider veins.
42. Services not received from or under the direction of a physician, except as described in this Policy.
43. Preventive dental services.
44. Elective, induced abortions, except as medically necessary to protect the life or health of the mother.
45. Implants for the purpose of contraception.
46. Therapeutic acupuncture.
47. Services billed by an acupuncturist.
48. Services for or related to vision therapy and orthoptic and/or pleoptic training, except as stated in *Professional Services*.
49. 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 Behavior Intervention (IBI), and Lovaas therapy.
50. Sensory Integration including Auditory Integration Training.
51. Orthognathic surgery.
52. Health care professional services for maternity labor and delivery in the home.
53. Telephone consultations.
54. Surgery for morbid obesity.
55. Growth hormone.
56. Infertility services and services and drugs for or related to assisted reproductive technology (ART).
57. Services to treat a pre-existing condition as described in *How To Access Your Benefits*.
58. Maternity care services, other than those services provided for involuntary complications of pregnancy.
59. Charges that are eligible, paid, or payable under any medical payment, personal injury protection, automobile or other coverage that is payable without regard to fault, including charges that are applied toward any deductible, copayment or coinsurance requirement of such coverage.
60. Services for private-duty nursing.
61. Services for sex transformation surgery, sex hormones related to surgery, related preparation and follow-up treatment, and care and counseling, unless medically necessary and prior authorization is obtained from MIC before you receive services.

62. Functional capacity evaluations and related services for vocational purposes or for determination of disability or pension benefits.
63. Services for chemotherapy, supplies, drugs and aftercare in connection with a human organ transplant that is not covered (see *Organ And Bone Marrow Transplant Services*).
64. Services for systemic candidiasis, homeopathy and immunoaugmentive therapy.
65. Services for or in connection with fetal tissue transplantation.
66. Services which are not within the scope of licensure or certification of the provider.
67. Charges for services by a non-network provider in excess of the non-network provider reimbursement amount.
68. Non-emergency transportation.
69. Non-emergency services received outside the United States.
70. Services solely for or related to the treatment of snoring.
71. Services for mental health and substance abuse disorders if the Mental Health and Substance Abuse Coverage option was declined at the time of initial application.

Z. How To Submit A Claim

This section describes the process for submitting a claim.

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

Claims for benefits from network providers

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

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 MIC 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 can be found at www.medica.com or you may request 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 MIC. You should retain copies of all claim forms and correspondence for your records.

MIC does not accept assignment of benefits to non-network providers.

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

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

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

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

MIC will notify you of authorization or denial of the claim within 15 days of receipt of the claim.

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

Claims for emergency services provided outside the United States

Claims for emergency 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 MIC may request.

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

MIC 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 MIC, 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 three years after MIC has made a coverage determination regarding your claim.

AA. *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, non-network, non-network provider reimbursement amount, provider, subscriber

1. *Applicability*

- a. This coordination of benefits (COB) provision applies to this plan when a member has health care coverage under more than one plan. *Plan* and *this plan* are defined below.
- b. The order of benefits determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans do not exceed 100 percent of the total allowable expense.

2. *Definitions that apply to this section*

- a. Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
 - i. Plan includes: Group and nongroup insurance contracts and health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
 - ii. Plan does not include: Hospital indemnity coverage or other fixed indemnity coverage; accident-only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident-type coverage; benefits for nonmedical components of long-term care policies; Medicare supplement policies; Medicaid policies, or coverage under other federal governmental plans, unless permitted by law.

Each contract of coverage under i. or ii. is a separate plan. Also, if a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

- b. This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan.

A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

- c. *Primary plan/secondary plan.* The *Order of benefit determination rules* determine whether this plan is a primary plan or secondary plan as when the person has health care coverage under more than one plan.

When this plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits.

When this plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits do not exceed 100 percent of the total allowable expense.

- d. *Allowable expense* is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any plan covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the person is not an allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense.

The following are examples of expenses that are not allowable expenses:

- i. The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense unless one of the plans provides coverage for private hospital room expenses.
- ii. If a person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.
- iii. If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.
- iv. If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.
- v. The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

- e. *Closed panel plan* is a plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.
- f. *Custodial parent* is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one-half of the calendar year excluding any temporary visitation.

3. Order of benefit determination rules

When a person is covered by two or more plans, the rules for determining the order of benefits payments are as follows:

- a. The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of any other plan.
 - i. Except as provided in ii. below, a plan that does not contain a COB provision that is consistent with this regulation is always primary unless the provisions of both plans state that the complying plan is primary.
 - ii. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.
- b. A plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that other plan.
- c. Each plan determines its order of benefits using the first of the following rules that apply:
 - i. *Nondependent or dependent*. The plan that covers the person other than as a dependent, for example as an employee, member or subscriber, is the primary plan and the plan that covers the person as a dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (for example, a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, policyholder, subscriber, or retiree is the secondary plan and the other plan is the primary plan.
 - ii. *Dependent child covered under more than one plan*. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one plan the order of benefits is determined as follows:
 - a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
 - i) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or

- ii) If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.
 - b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
 - i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree;
 - ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of a) above shall determine the order of benefits;
 - iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of a) above shall determine the order of benefits; or
 - iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - The plan covering the custodial parent;
 - The plan covering the spouse of the custodial parent;
 - The plan covering the noncustodial parent; and then
 - The plan covering the spouse of the noncustodial parent.
 - c) For a dependent child covered under more than one plan of individuals who are the parents of the child, the provisions of a) or b) above shall determine the order of benefits as if those individuals were the parents of the child.
- iii. *Active employee or retired or laid-off employee.* The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The plan covering that same person as a retired or laid-off employee is the secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if 3.c.i. can determine the order of benefits.
- iv. *COBRA or state continuation coverage.* If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber, or retiree or covering the person as a dependent of an employee, member, subscriber, or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if 3.c.i. can determine the order of benefits.

- v. *Longer or shorter length of coverage.* The plan that covered the person as an employee, member, policyholder, subscriber, or retiree longer is the primary plan and the plan that covered the person the shorter period of time is the secondary plan.
- vi. If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

4. Effect on the benefits of this plan

- a. When this plan is a secondary plan, it may reduce its benefits so that the total benefits paid or provided by all plans during a plan year are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.
- b. If a member is enrolled in two or more closed panel plans and if, for any reasons, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

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 about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. MIC has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. MIC 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 MIC any facts it needs to apply those rules and determine benefits payable.

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, MIC 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. MIC 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 MIC is more than it should have paid under this COB provision, it may recover the excess from one or more of the following:

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

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

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

BB. *Right Of Recovery*

This section describes MIC's right of recovery. MIC's rights are subject to North Dakota and federal law. For information about the effect of North Dakota and federal law on MIC's subrogation rights, contact an attorney.

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

1. MIC 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. MIC's right of subrogation shall be governed according to this section. MIC'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. MIC's subrogation interest is the reasonable cash value of any benefits received by you.
3. MIC's right to recover its subrogation interest may be subject to an obligation by MIC 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 MIC is separately represented by an attorney. If MIC 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 this Policy, you agree:
 - a. To cooperate with MIC or its designee to help protect MIC's legal rights under this subrogation provision and to provide all information MIC may reasonably request to determine its rights under this provision.
 - b. To provide prompt written notice to MIC when you make a claim against a party for injuries.
 - c. To provide prompt written notice of MIC's subrogation rights to any party against whom you assert a claim for injuries.
 - d. To do nothing to decrease MIC's rights under this provision, either before or after receiving benefits, or under this Policy.
 - e. MIC may take action to preserve its legal rights. This includes bringing suit in your name.
 - f. MIC 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 MIC's benefit under this provision.

CC. Eligibility And Enrollment

This section describes who can enroll and how to enroll.

See Definitions. These words have specific meanings: continuous coverage, enrollee, member, mental disorder, physician, placed for adoption, pre-existing condition, premium, qualifying coverage, subscriber

Who can enroll

To be eligible to enroll for coverage under this Policy, you must be a *subscriber* (as defined in **Definitions**) and meet the eligibility requirements stated below.

Subscriber eligibility.

To be eligible to enroll for coverage the *subscriber* must:

1. be a North Dakota resident; and
2. be at least 19 years of age; and
3. complete an application form provided by MIC; and
4. provide MIC certain information regarding his or her health status; and
5. be accepted by MIC for enrollment.

Notification

The subscriber must notify MIC in writing within 30 days of the effective date of any changes to address or name, or other facts identifying you.

The date your coverage begins

Coverage will begin after the application for coverage has been approved by MIC. MIC will notify the subscriber of the approval and the effective date of coverage. Premium must be paid from the date coverage starts.

Coverage begins at 12:01 a.m. on the effective date of enrollment.

DD. *Ending Coverage*

This section describes when coverage ends under this Policy.

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

When coverage ends

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

1. The date MIC notifies you that MIC will cease doing business. Coverage will end on the last day of a month. (To cease doing business means to discontinue issuing new individual health plans and to refuse to renew all of MIC's existing individual health plans.)
2. The end of the month for which the subscriber last paid the premium due.
3. The end of the month following the date the subscriber requests that coverage end. Written request for termination of the subscriber's coverage must be received by MIC at least 31 days before the date of termination. However, the effective date of such termination must be the end of the month. Any refund of premium shall be mailed to the subscriber upon receipt of this notice by MIC.
4. If you terminate this Policy within the first ten days of receiving it, coverage shall terminate retroactive to the effective date of this Policy.
5. The end of the month following the date 31 days after we notify you that coverage will end because you do not reside in a state where MIC is authorized to do business, provided the notification is made within one year following the date MIC was provided written notification of your address change. However, MIC may approve other arrangements.
6. The end of the month following the date you enter active military duty for more than 31 days. Upon completion of active military duty, your coverage will be reinstated if you notify MIC within 90 days after removal from active military duty. Pre existing condition limitations or exclusions will not apply.
7. The date of the death of the member.
8. The date specified by MIC in written notice to you that coverage ended due to fraud or intentional misrepresentation of a material fact. If coverage ends due to fraud or intentional misrepresentation of a material fact, coverage will be retroactively terminated at MIC's discretion to the original date of coverage or the date on which the fraudulent act took place. Fraud and intentional misrepresentation of a material fact include but are not limited to:
 - a. Knowingly providing MIC with false material information such as:
 - i. Information related to your eligibility; or
 - ii. Information related to your health status; or
 - b. Permitting the use of your member identification card by any unauthorized person; or

- c. Using another person's member identification card; or
- d. Submitting fraudulent claims; or
- e. Engaging in any fraudulent activity related to your eligibility for coverage under this Policy.

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.

EE. *Complaints*

This section describes what to do if you have a complaint or would like to appeal a decision made by MIC. You may also have appeal rights under regulations implementing the Patient Protection and Affordable Care Act (PPACA).

See *Definitions*. These words have specific meanings: claim, inpatient, 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 North Dakota Commissioner of Insurance at (701) 328-2440 or 1-800-247-0560 or for hearing impaired members with a TTY phone at 1-800-366-6888.

Filing a complaint may require that MIC 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 MIC to release confidential information to your authorized representative and allow them to act on your behalf during the complaint process. Upon request, MIC will assist you with completion and submission of your written complaint. MIC will also complete a complaint form on your behalf and mail it to you for your signature upon request.

In addition to directing complaints to Customer Service as described in this section, you may direct complaints at any time to the North Dakota Department of Insurance at 1-800-247-0560.

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.

3. If your complaint is regarding an initial decision made by MIC, and your complaint requires a medical determination in its resolution, your complaint must be made within one year following MIC's initial decision.
4. For an oral complaint that does not require a medical determination in its outcome, if MIC does not communicate a decision within 10 business days from MIC's receipt of the complaint, or if you determine that MIC's decision is partially or wholly adverse to you, MIC 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

3. MIC 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 or request.

4. When an initial decision by MIC not to grant a prior authorization request is made before or during an ongoing service requiring MIC's authorization, and your attending *provider* believes that MIC's decision warrants an expedited appeal, you or your attending *provider* will have the opportunity to request an expedited review by telephone. Alternatively, if MIC concludes that a delay could seriously jeopardize your life, health, or ability to regain maximum function, MIC will process your *claim* as an expedited review. In such cases, MIC will notify you and your attending *provider* by telephone of its decision no later than 72 hours after receiving the request.
5. If MIC's first level review decision upholds the initial decision made by MIC, you may have a right to request an external review as described in this section.

External review

If you consider MIC's decision to be partially or wholly adverse to you, you may submit a written request for external review of MIC's decision. This process is coordinated through MIC. An approved independent review organization will conduct the external review. The external review decision will be binding on you and MIC. Costs associated with the independent external review are the responsibility of the nonprevailing party. Requests for independent external review may be submitted to the address listed above in *First level of review, 2*. Complaints regarding fraudulent marketing practices or agent misrepresentation cannot be submitted for external review.

FF. General Provisions

This section describes the general provisions of this Policy.

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

Examination of a member or autopsy

To settle a dispute concerning provision or payment of benefits under this Policy, MIC may require that you be examined or an autopsy of the member's body be performed if the autopsy is not prohibited by law. The examination or autopsy will be at MIC's expense.

Clerical error

You will not be deprived of coverage under this Policy 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 MIC and network providers are contractual relationships between independent contractors. Network providers are not agents or employees of MIC. 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

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

Notice

Except as otherwise provided in this Policy, written notice given by MIC will be deemed notice to all affected in the administration of this Policy in the event of termination or nonrenewal of this Policy.

However, notice of termination for nonpayment of premium shall be given by MIC to the subscriber.

Entire agreement

This Policy, the application, and any amendments are the entire contract between you and MIC. No person other than an executive officer of MIC has the authority to change this Policy or to waive any of its provisions.

MIC may change this Policy at renewal or at any other time when required by federal or state regulatory agencies. When this happens you will receive a new policy or an amendment to this Policy. All amendments must be in writing. No change in this Policy is valid until approved by an executive officer of MIC and unless the approval is endorsed on or attached to this Policy.

Amendment

This Policy may be amended in accordance with this Policy (see *Introduction*). **When this happens, you will receive a new policy or amendment.** No other person or entity has authority to make any changes or amendments to this Policy. All amendments must be in writing.

Time limit on certain defenses

After two years from the date of issue of this Policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such Policy shall be used to void the Policy or to deny a claim for loss incurred after the expiration of such two year period. All statements made by the applicant shall be deemed representations and not warranties.

Reinstatement

If any renewal premium is not paid within the time granted the subscriber for payment, a subsequent acceptance of premium by MIC or by any insurance producer duly authorized by MIC to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the Policy; provided, however, if MIC or such insurance producer requires an application for reinstatement and issues a conditional receipt for the premium paid, the Policy will be reinstated upon approval of such application by MIC, or lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless MIC has previously notified the subscriber in writing of its disapproval of such application. The reinstated Policy will cover only loss resulting from accidental injury that is sustained after the date of reinstatement and loss due to sickness that begins more than ten days after such date. In all other respects the subscriber and MIC will have the same rights under the Policy as they had immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with a reinstatement. Any premium accepted in connection with a reinstatement will be applied to a period of time for which premium has not been previously paid, but not to any period more than sixty days prior to the date of reinstatement.

Conformity with state statutes

Any provision of this Policy which, on its effective date, is in conflict with the statutes of the state in which the member resides on such date, is amended to conform to the minimum requirements of such statutes.

Misstatement of age

If the age of the member has been misstated, all amounts payable under this Policy will be such as the premium paid would have purchased at the correct age.

Discretionary authority

MIC has discretion to interpret and construe all of the terms and conditions of this Policy and make determinations regarding benefits and coverage under this Policy.

Legal Actions

No lawsuit may be brought to recover a claim from MIC until more than 60 days after the date written Proof of Loss is made. Such action cannot be made more than three years after the date written proof of loss is made.

Refund of premium upon death of insured

In the event of the death of the insured, and within 30 days of notice to MIC of the event, MIC will refund the portion of the premium, fees, or other sum paid beyond the month of death after deducting any claim for losses during the current term of the policy. This provision does not apply if MIC has a valid defense to the payment of benefits under the policy.

GG. Definitions

In this Policy (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 Policy and any subsequent amendments) approved by MIC as eligible for coverage.

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

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

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

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

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

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

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

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

For out-of-**network benefits**, in addition to any **coinsurance** and **deductible** amounts, you 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 and *Specialty 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 MIC 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**.

Complications of pregnancy. (1) Conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; (2) Non-elective cesarean section, ectopic pregnancy, which is terminated, and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

Continuous coverage. The maintenance of continuous and uninterrupted **qualifying coverage** by an individual. An individual is considered to have maintained **continuous coverage** if enrollment is requested under this Policy 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**. MIC pays any remaining amount according to the written agreement between MIC 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 **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 you must pay for eligible services or supplies before **claims** for health services or supplies received from **network** or **non-network providers** are reimbursable as in-**network** or out-of-**network benefits** under this Policy.

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

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

Designated provider. A **network provider** that MIC has authorized to provide certain **benefits to members**, as described in this Policy.

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 **member's** first day of coverage under this Policy.

Genetic testing. Genetic testing means 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 MIC, 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. MIC 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 MIC to be **investigative**. MIC 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.

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 this Policy and on whose behalf the premium is being paid. In this Policy, the words you, your or yourself refer to the member.

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

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

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

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

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:

- a. 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
- b. A percentage of the **provider's** billed charge; or
- c. 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
- d. An amount agreed upon between MIC and the **non-network provider**.

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

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

In addition, if the amount billed by the **non-network provider** is greater than the **non-network provider reimbursement amount**, *the non-network provider will likely bill you for the difference*. This difference may be substantial, and it is in addition to any **coinsurance** or **deductible** amount you may be responsible for according to the terms described in this Policy. 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.

Pre-existing condition. A physical or mental condition other than a pregnancy, present before your **enrollment date** under the Policy, for which medical advice, diagnosis, care or treatment (including treatment with **prescription drugs**) was recommended by or received from a **physician** or other **provider** within the six months immediately preceding your **enrollment date**. Genetic information alone, in the absence of any physical or mental condition, is not considered to be a **pre-existing condition**. Refer to *How To Access Your Benefits* for additional information regarding **pre-existing conditions** and the application of a **pre-existing condition** limitation.

Premium. The monthly payment required to be paid by you for coverage under this Policy.

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

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

Preventive Health Services. The following are considered preventive health services:

- (1) evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force;

(2) immunizations for routine use that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved;

(3) with respect to 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 paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Contact Customer Service for information regarding specific preventive health services and services that are rated “A” or “B”.

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 benefit plan or a group health benefit plan as defined under North Dakota law;
2. Medicare;
3. Medicaid;
4. A state health benefit risk pool, including the North Dakota Comprehensive Health Association (CHAND);
5. State Children’s Health Insurance Program;
6. 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;
7. TRICARE or other similar coverage provided under federal law applicable to the armed forces;
8. The Federal Employees Health Benefits Plan or other similar coverage provided under federal law applicable to government organizations and employees;
9. A medical care program of the Indian Health Service or of a tribal organization;
10. A health benefit plan under the Peace Corps Act;

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 North Dakota law;
6. Coverage designed solely to provide dental or vision care;
7. Accident only coverage;
8. Long-term care coverage as defined under North Dakota law;
9. Medicare supplemental health insurance as defined under North Dakota 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.

Any **pre-existing condition** limitation may be affected by your prior **qualifying coverage**. You have the right to prove your prior **qualifying coverage** to MIC. You have the right to obtain a **certification of qualifying coverage** from a prior plan. MIC can assist you in obtaining the **certification of qualifying coverage** from the prior plan.

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**.

Residential treatment. A 24-hour-a-day program under the clinical supervision of a mental health professional, in a community residential setting other than an acute care **hospital**, for the active treatment of persons with mental illness.

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**.

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

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

Subscriber. The person to whom this Policy is issued.

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.

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