Medica Direct HSA℠ for Individuals

SOUTH DAKOTA
Policy of Coverage

Medica Direct℠ HSA for Individuals
$1,500 Individual Deductible
$3,000 Family Deductible
80% Coinsurance
Plan Code IOQ, IOU
CHA2128-10804

- CUSTOMER SERVICE:

  1-866-894-8051

- TTY USERS MAY CALL:

  1-800-855-2880

Table Of Contents

MIC Customer Service iii

Table of Contents iv

Disclosure required by Minnesota law ix

Introduction x
- To be eligible for benefits x
- Definitions xi
- Language interpretation xi
- Term of this Policy xi
- Premiums xi
- Grace Period xii
- Acceptance of coverage xii
- Nondiscrimination policy xii

A. Member Rights And Responsibilities 1
- Member bill of rights 1
- Member responsibilities 1

B. How To Access Your Benefits 3
- Important member information about in-network benefits 3
- Important member information about out-of-network benefits 4
- Cancellation 5
- Newborn coverage 6
- Prescription drugs and medical equipment 6
- Continuity of Care 6
- Prior authorization 8
- Pre-existing condition limitations 11

C. How Providers Are Paid By MIC 13
- Network providers 13
- Withhold arrangements 14
- Non-network providers 14

D. Your Out-Of-Pocket Expenses 15
- Expenses you must pay 15
- Out-of-pocket maximum 17
- Lifetime maximum amount 17
- Out-of-pocket expenses 18

E. Professional Services 19
- Covered 19
- Not covered 20
- Office visits 20
- Convenient/urgent care center visits 20

Maternity care 20
Preventive health care 20
Routine screening procedures for cancer 21
Allergy shots 21
Refractive eye exams 21
Chiropractic services 21
Surgical services 22
Services received from a physician during an emergency room visit 22
Services received from a physician during an inpatient stay 22
Outpatient lab, pathology and x-rays 22
Other outpatient hospital or ambulatory surgical center services 22
Diabetes self-management training and education 22
Neuropsychological evaluations/cognitive testing 23

F. Prescription Drugs And Pharmacy Services 24
Prior authorization 25
Covered 25
Prescription unit 26
Not covered 27
Outpatient prescription drugs 28
Emergency prescription drugs 28
Diabetic supplies and equipment 28
Eligible ostomy supplies 28
Smoking cessation products 29

G. Hospital Services 30
Covered 30
Not covered 30
Outpatient services 31
Services provided in a hospital observation room 31
Inpatient services 32

H. Ambulance Services 33
Covered 33
Not covered 33
Ambulance services or ambulance transportation 34
Non-emergency licensed ambulance service 34

I. Home Health Care 35
Covered 35
Not covered 36
Intermittent skilled care 37
Skilled physical or speech or occupational therapy 37
Home infusion therapy 37
Services received in your home from a physician 37

J. Outpatient Rehabilitation 38
Covered 38
Not covered 38
Physical therapy received outside of your home 39
Occupational therapy received outside of your home 39

Speech therapy received outside of your home 39

K. **Mental Health 41**
Covered 42
Not covered 43
Outpatient services 44
Inpatient services 44

L. **Treatment of Alcoholism 46**
Covered 46
Not covered 47
Inpatient services 48

M. **Durable Medical Equipment And Prosthetics 49**
Covered 49
Not covered 50
Durable medical equipment and certain related supplies 50
Repair, replacement or revision of durable medical equipment 50
Prosthetics 50

N. **Miscellaneous Medical Supplies 52**
Covered 52
Not covered 52
Blood clotting factors 53
Dietary medical treatment of PKU 53
Total parenteral nutrition 53

O. **Organ And Bone Marrow Transplant Services 54**
Covered 54
Not covered 55
Office visits 56
Outpatient services 56
Inpatient services 57
Services received from a physician during an inpatient stay 57

P. **Reconstructive And Restorative Surgery 58**
Covered 58
Not covered 59
Office visits 59
Outpatient services 59
Inpatient services 60
Services received from a physician during an inpatient stay 60

Q. **Skilled Nursing Facility Services 61**
Covered 61
Not covered 61
Daily skilled care or daily skilled rehabilitation services 62
Skilled physical or occupational therapy 62
Services received from a physician during an inpatient stay in a skilled nursing facility 62

R. **Hospice Services 63**

Covered ... 63
Not covered ... 64
Hospice services ... 65

S. Medical-Related Dental Services ... 66
Covered ... 66
Not covered ... 66
Charges for medical facility and general anesthesia services ... 67
Orthodontia related to cleft lip and palate ... 67
Oral surgery ... 67

T. Emergency Services From Non-Network Providers ... 69
Covered ... 69
Not covered ... 69
Emergency services ... 70
Ambulance service or ambulance transportation ... 70

U. Referrals To Non-Network Providers ... 71
What you must do ... 71
What MIC will do ... 71

V. Harmful Use Of Medical Services ... 73
When this section applies ... 73

W. Exclusions ... 74

X. How To Submit A Claim ... 79
Claims for benefits from network providers ... 79
Claims for benefits from non-network providers ... 79

Claims ... 80
Time limits ... 80

Y. Right Of Recovery ... 81

Z. Eligibility And Enrollment ... 83
Who can enroll ... 83
Extending a child's eligibility ... 83
Notification ... 84
The date your coverage begins ... 84
How to add dependents ... 85

AA. Ending Coverage ... 86
When coverage ends ... 86

BB. Continuation ... 88
Your right to continue coverage under state law ... 88
Subscriber's spouse's loss ... 88
What you must do ... 88
What MIC must do ... 89
Duration ... 89

CC. Grievances/Appeals 90

DD. General Provisions 97

EE. Definitions 100

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

This Policy is a legal contract between you and Medica Insurance Company (“MIC”) and we agree to provide the benefits stated in this Policy, subject to the provisions, exceptions, and limitations set forth on this and the following pages, all of which are a part of this contract.

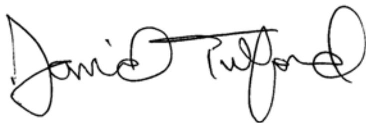
We have issued this Policy in consideration of the application and the payment of the first premium on or before delivery of this Policy.

10 Day Free Look

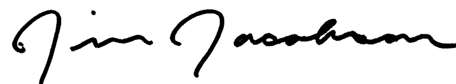
If you are not satisfied with this Policy, you may return it within 10 days of receipt. Mail or deliver the Policy to the agent who sold it to you or our Home Office or the agency office through which it was delivered. We will then refund any premium paid. The Policy will then be deemed never to have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

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 misrepresentation, or as otherwise described in *Ending Coverage*. MIC has the right to change the premium as allowed under South Dakota law. This Policy will not be canceled or non-renewed merely because your health deteriorates.



President



Assistant Secretary

Introduction

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

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.

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

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.

See *Definitions*. These words have specific meanings:

- Benefit
- Claim
- Dependent
- Medically necessary
- Member
- Network
- Premium
- Provider

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 Direct℠ HSA for Individuals to be eligible for in-network benefits;
2. Identify yourself as a Medica Direct℠ HSA for Individuals member; and
3. Present your Medica Direct℠ HSA for Individuals identification card. (If you do not show your Medica Direct℠ HSA for Individuals identification card, providers have no way of knowing that you are a Medica Direct℠ HSA for Individuals 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 Direct℠ HSA for Individuals 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.

Definitions

Many words in this Policy have specific meanings. These words are identified in each section and defined in *Definitions* (at the end of this Policy).

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

Payment of premium is due on the first day of each calendar month 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 days written notice.

Calculation of premium for a newborn child:

1. For a child born on or before the fifteenth day of the month, the premium will be equal to a full month's rate.
2. For a child born after the fifteenth day of the month, the premium will be equal to one half of the regular month's rate.

Grace Period

The grace period for the subscriber's payment of monthly 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, you, on behalf of yourself and any dependents enrolled under this Policy, authorize the following:

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

You understand and agree that any omissions or incorrect statements knowingly made by you in connection with your enrollment under this Policy may invalidate your 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 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*

Member bill of rights

As a member of Medica Direct[SM] HSA for Individuals, 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;
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;
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;
4. Be treated with respect and recognition of your dignity, and privacy of your medical and financial records maintained by MIC or any network provider in accordance with existing law;
5. Contact MIC and the South Dakota Division of Insurance to file a grievance or appeal about issues related to benefits (see *Grievances/Appeals*). You may begin a legal proceeding if you have a problem with MIC or any provider;
6. Receive information about MIC, its services, its practitioners and providers, and members' rights and responsibilities.

See *Definitions*. These words have specific meanings:

- Benefits
- Emergency
- Medically necessary
- Member
- Network
- Provider

To file a complaint with the South Dakota Division of Insurance call 1-605-773-3563 and request insurance information.

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;
2. Providing the necessary information to health care professionals needed to determine the appropriate care. This objective is best obtained when you share:
   a. Information about lifestyle practices; and

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

   b. Personal and family health history;

3. Following the instructions given by those providing health care;
4. Practicing self-care by knowing:
   a. How to recognize common health problems and what to do when they occur;
   b. When and where to seek appropriate help; and
   c. How to prevent health problems from recurring;
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).

B. How To Access Your Benefits

1. *Important member information about in-network benefits*

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

Benefits

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.

Lifetime maximum amount

In-network and out-of-network benefits are subject to a combined lifetime maximum amount payable by MIC. See *Your Out-Of-Pocket Expenses* for a detailed explanation of the lifetime maximum amount.

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.

See *Definitions.* These words have specific meanings:

- Benefits
- Claim
- Coinsurance
- Deductible
- Dependent
- Emergency
- Enrollment date
- Hospital
- Inpatient
- Medically necessary
- Member
- Network
- Non-network
- Non-network provider reimbursement amount
- Placed for adoption
- Pre-existing condition
- Premium
- Prescription drug
- Provider
- Qualifying coverage
- Reconstructive
- Restorative
- Skilled nursing facility
- Subscriber

Providers

Enrolling in Medica Direct℠ HSA for Individuals 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.

> Except for emergencies:
> - All mental health services and services for treatment of alcoholism must be arranged by MIC's designated provider; and
> - A treatment plan, including any inpatient services must be prior authorized by MIC's designated provider to be eligible for coverage.

Mental health and treatment of alcoholism

MIC's designated provider will arrange your benefits for mental health services and treatment of alcoholism. MIC's designated provider uses a limited network of hospitals for the provision of mental health and treatment of alcoholism benefits.

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

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 for certain out-of-network benefits. This Policy defines your benefits and describes procedures you must follow to obtain out-of-network benefits. In addition to the benefits described in this Policy, MIC may authorize more efficient methods of providing services.

> Before receiving services from a non-network provider, you should do the following:
> - Confirm with the non-network provider what the services will be; and
> - Verify with Customer Service the estimated non-network provider reimbursement amount for those services. Refer to *Your Out-Of-Pocket Expenses* for additional information.

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

Read this Policy for a detailed explanation of in-network and out-of-network benefits.

Important: Be aware that if you choose to use out-of-network benefits, you may have to pay more than if you use in-network benefits. The charges billed by your non-network provider may exceed the non-network provider reimbursement amount. You are responsible for payment of any charges billed in excess of the non-network provider reimbursement amount. This is in addition to any applicable coinsurance and deductible amount. The excess charges will not be applied to the out-of-pocket maximum amount described in *Your Out-Of-Pocket Expenses*. This means you may have substantial out-of-pocket expense when you use a non-network provider.

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.

Lifetime maximum amount

In-network and out-of-network benefits are subject to a combined lifetime maximum amount payable by MIC. See *Your Out-Of-Pocket Expenses* for a detailed explanation of the lifetime maximum amount.

Exclusions

Some health services, such as transplant services, hospice services and home infusion therapy, 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. ***Newborn coverage***

MIC does not automatically know of a birth or whether you would like coverage for the newborn dependent. Call Customer Service at one of the telephone numbers listed inside the front cover for more information.

Your dependent newborn is covered from birth, but only if health services, other than emergency services, are provided by a network provider or authorized by MIC. For emergency services from non-network providers, refer to *Emergency Services From Non-Network Providers*. Certain services are covered only upon referral. If additional premium is required, MIC is entitled to all premiums due from the time of the infant's birth until the time you notify MIC of the birth. MIC may reduce payment by the amount of premium that is past due for any health benefits for the newborn infant until any premium you owe is paid. For more information, see *Eligibility And Enrollment.*

5. ***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.

6. ***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, if your course of treatment is maternity care and you are in the second trimester of pregnancy. Health services may be continued to be provided by the provider, through the completion of postpartum care.

iii. 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.

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

If MIC terminates your current *provider's* contract for cause, MIC will inform you of the change and how your care will be transferred to another *network provider*.

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

7. *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 request prior authorization for a service or supply, either you, your representative, or your attending provider must call MIC.

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

- Reconstructive or restorative surgery;
- Organ and bone marrow transplant;
- Home health care;
- Medical supplies and durable medical equipment;
- Outpatient surgical procedures;
- Skilled nursing facility services; and
- In-network benefits for services from non-network providers.

When you, your representative, 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);

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.

This is not an all-inclusive list of all services and supplies that may require prior authorization. Please call Customer Service at one of the telephone numbers listed inside the front cover to obtain the current list of services which require prior authorization.

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.

- Other applicable member information (i.e., MIC member number).

MIC will review your request and provide a response to you or your representative and your attending provider within 15 days after the date your request was received, provided all information reasonably necessary to make a decision was available to MIC.

For information on what is included if our determination is an adverse determination, please see the provision titled "Adverse Determination Notice", appearing in the *Grievances/Appeals* section.

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 you or your representative in writing of its decision. If MIC does not approve continued coverage, you or your representative, may appeal MIC's initial decision (see the *Grievances/Appeals* section).

Notice of a concurrent review determination

If MIC has certified an ongoing course of treatment to be provided over a period of time or a number of treatments, any reduction or termination by MIC during the course of treatment before the end of the period or number of treatments, other than a coverage amendment or termination of coverage , will constitute an adverse determination. MIC will notify you or your representative, if applicable, of the adverse determination at a time sufficiently in advance of the reduction or termination to allow you or your representative to file a grievance to request a review of the adverse determination and obtain a determination with respect to that review of the adverse determination before the benefit is reduced or terminated.

For information on what is included if our determination is an adverse determination please see the provision titled "Adverse Determination Notice", appearing in the *Grievances/Appeals* section.

Until notification of MIC's determination is received with respect to an internal review request, the health care service or treatment that is the subject of the adverse determination will be continued without liability to you.

Urgent care request

You have an urgent care request when your attending provider judges that a delay may seriously jeopardize your life or health or your

ability to regain maximum function; or your medical condition would subject you to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

In these urgent situations:

- You or your attending provider should call us as soon as possible. The request does not need to be submitted in writing.
- MIC will notify you of the decision within 72 hours after the date of the receipt of the request.
- If MIC needs more information from your attending provider to make a decision, this information must be submitted to MIC no later than 48 hours after receipt of MIC's request for the additional information.

The notification will be provided either orally or in writing. If the notice of the adverse determination is provided orally, MIC will provide written notification within 3 days of the date of the oral notification.

For information on what is included if our determination is an adverse determination, please see the provision titled "Adverse Determination Notice", appearing in the *Grievance/Appeals* section.

Concurrent review urgent care request

If you or your representative request to extend the course of treatment beyond the initial period of time or the number of treatments within 24 hours prior to the expiration of the prescribed period of time or number of treatments, MIC will make a determination and notify you or your representative, if applicable, within 24 hours of the receipt of the request.

If you or your representative failed to provide MIC with sufficient information to make a determination, MIC will notify you or your representative, if applicable, either orally or, if requested by you or your representative, in writing of the failure to submit sufficient information, and state what specific information is needed, within 24 hours after receipt of the request. If the benefit request involves a prospective review urgent care request, this provision would only apply in the case of a

failure that is a communication by you or your representative that is received by our designated person or department responsible for handling benefit matters; and is a communication that refers to you, your medical condition or symptom, and the specific health care service, treatment or provider for which the approval is being requested.

MIC will provide you or your authorized representative, if applicable, a reasonable period of time to submit necessary information, but in no event later than 48 hours after the date of notifying you or your representative of the failure to submit sufficient information.

MIC will notify you or your representative, if applicable, of MIC's determination within 48 hours after the earlier of our receipt of the requested specified information; or the end of the period provided for you or your representative to submit the requested specified information. If you or your representative fail to submit the information before the end of the period extension, MIC may deny the certification of the requested benefit.

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 Drugs And Pharmacy Services* for information.

8. *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.

Length of pre-existing condition limitation

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

However, this 12 month period is reduced by the aggregate of certain periods of qualifying coverage applicable to you 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

A pre-existing condition limitation will *not* apply to the following:

a. An individual who maintained 12 months of qualifying coverage (without a break of 63 or more days) as the effective date of his or her coverage under the Policy.

b. Your newborn child, your adopted child, a child placed for adoption with the subscriber, or your handicapped dependent, provided these dependents are enrolled under the Policy as described in *Eligibility And Enrollment;*

c. A dependent child who (i) is covered under prior qualifying coverage as of the last day of the 31-day period beginning with his/her date of birth, the date of the child's adoption or the date the child is placed for adoption and, (ii) has not had a break of 63 days or more in such qualifying coverage at the time he or she enrolls under the Policy; or

d. The condition of pregnancy.

C. *How Providers Are Paid By MIC*

This section describes how MIC generally pays providers for health services.

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 Direct℠ HSA for Individuals 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 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

See *Definitions*. These words have specific meanings:

- Coinsurance
- Deductible
- Hospital
- Member
- Network
- Non-network
- Physician
- Provider

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.

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.

Withhold arrangements

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

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

Non-network providers

When a service from a non-network provider is covered, the non-network provider is paid a fee for each covered service that is provided. This payment is based on the non-network provider reimbursement amount and 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.

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.)

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

- Most in-network benefits are covered at 80% to 100% after you pay a deductible amount for yourself or your family.
- Most out-of-network benefits are covered at 80% to 100% of the non-network provider reimbursement amount after you pay a deductible amount for yourself or your family.

See *Definitions.* These words have specific meanings:

- Benefits
- Claim
- Coinsurance
- Deductible
- Dependent
- Medically necessary
- Member
- Network
- Non-network
- Non-network provider reimbursement amount
- Prescription drug
- Provider
- Subscriber

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

Expenses you must pay

For both in-network and out-of-network benefits, you must pay the following:

1. Any applicable coinsurance or deductible as described in this Policy.
2. 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 amounts. If the amount that your non-network provider bills you is more than the non-network provider reimbursement amount, *you are responsible for paying the difference*. In addition, the difference will not be applied toward the out-of-pocket maximum (described in this section).

IMPORTANT INFORMATION ABOUT HOW COINSURANCE PAYMENTS ARE CALCULATED WHEN BASED ON RETAIL CHARGES

Following is an explanation of how MIC's payments to network providers are determined when the member coinsurance is based on the provider's retail charge, but MIC has negotiated a discount with the network provider.

The amount MIC actually pays a provider may be a discounted amount (i.e., "wholesale"). When a member is asked to pay coinsurance based on the provider's retail charge in these instances, the amount that MIC pays the provider is as described under either 1. or 2. below.

1. The amount that MIC pays the provider is the difference between the wholesale amount that the provider has agreed to accept and what the member pays as coinsurance (based on the retail charge). For example, if a network provider charges $100 for a particular benefit (i.e., retail), and the member is responsible to pay a 20 percent coinsurance based on the provider's retail charge, the member must pay $20 (20 percent of the retail charge). MIC, however, may have negotiated a discount with the provider; for example, a wholesale charge of $60. Less the $20 member coinsurance, MIC would pay the network provider $40, instead of paying 80 percent of the retail charge ($80).

2. The amount that MIC pays the provider is a "per episode" amount agreed upon by MIC and the provider. This amount might not change based on what the member pays as coinsurance.

You may obtain a written Explanation of Benefits (EOB) regarding any claim by calling Customer Service at one of the telephone numbers listed inside the front cover to request one.

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

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 billed to you. 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 your deductible.

Out-of-pocket maximum

The out-of-pocket maximum is an accumulation of in-network and out-of-network coinsurance and your deductible only. Unless otherwise specified, you will *not* be required to pay more than the out-of-pocket maximum of coinsurance and/or your deductible, as described in the Out-of-Pocket Expenses table in this section, for benefits received during any calendar year.

After you satisfy the out-of-pocket maximum, all other *eligible* in-network and out-of-network services 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.

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.

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

Lifetime maximum amount

The lifetime maximum amount payable per member for in-network and out-of-network benefits (combined) under this Policy is described in the Out-of-Pocket Expenses table in this section. You should monitor the amount paid for in-network and out-of-network benefits and contact MIC when you are close to reaching your lifetime maximum amount.

Out-of-Pocket Expenses

Coinsurance	See specific benefit for applicable coinsurance
Calendar Year Deductible	**Each Calendar Year the deductible amount may be subject to a "cost of living increase". If the deductible amount is less than the minimum deductible amount required by the Internal Revenue Service to be a HSA qualified high deductible health plan, the deductible amount will be increased to the minimum required. You will receive a notice of change 30 days in advance of the increase. Any portion of the yearly deductible satisfied during the last three months of a calendar year can be applied toward the next calendar year deductible.**
Individual Coverage	$1,500 Applies to your combined in-network and out-of-network benefits.
Family Coverage	$3,000 Applies to the combined in-network and out-of-network benefits for the subscriber and his/her dependents.
Calendar year Out-of-pocket maximum (for coinsurance and deductible combined)	
Individual Coverage	$2,700 Applies to your combined in-network and out-of-network benefits. The out-of pocket maximum may be subject to a "cost of living increase" based on federal guidelines. You will receive a notice of change 30 days in advance of any increase.
Family Coverage	$4,050 Applies to the combined in-network and out-of-network benefits for the subscriber and his/her dependents. The out-of pocket maximum may be subject to a "cost of living increase" based on federal guidelines. You will receive a notice of change 30 days in advance of any increase.
Lifetime maximum amount payable per member	$5,000,000 Applies to your combined in-network and out-of-network benefits. Applies to all benefits you receive under this or any future MIC policy or contract that has a lifetime maximum benefit.

E. *Professional Services*

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

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

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 reconstructive surgery services are described in *Reconstructive And Restorative Surgery*.

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.

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

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

Not covered

Mental health or treatment of alcoholism services, except as described in *Mental Health* and *Treatment of Alcoholism.*

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

Your Benefits and the Amounts You Pay

Benefits (after $1,500 individual coverage deductible, or $3,000 family coverage deductible)	**In-network benefits** **You pay**	**Out-of-network benefits** **You pay**
1. Office visits	20% coinsurance	20% coinsurance
2. Convenient/urgent care center visits	20% coinsurance	For emergency services from non-network providers, refer to *Emergency Services From Non-Network Providers*. 20% coinsurance for non-emergency services received from non-network providers
3. Maternity care after the first 18 months following your enrollment date.	No coverage during the first 18 months following your enrollment date. Thereafter, 20% coinsurance	No coverage during the first 18 months following your enrollment date. Thereafter, 20% coinsurance
4. Preventive health care (**Please note:** This only applies when there is no existing condition or no complaint about your health, regardless of the reasons that you scheduled your office visit.)		
a. Health education and health supervision services provided during an office visit (including evaluation and follow-up)	20% coinsurance	20% coinsurance

Your Benefits and the Amounts You Pay		
Benefits (after $1,500 individual coverage deductible, or $3,000 family coverage deductible)	**In-network benefits** **You pay**	**Out-of-network benefits** **You pay**
b. Child health supervision services (i.e. pediatric preventive services, developmental assessments and laboratory services) appropriate to the age of a child from birth to age 6. Coverage is limited to: • 5 visits from birth through 11 months • 3 visits from 12 months through 23 months • 1 visit per calendar year from 24 months through 71 months	20% coinsurance	20% coinsurance
c. Immunizations for a dependent child from birth to age 18	20% coinsurance	20% coinsurance
d. Early disease detection services including physicals.	20% coinsurance	20% coinsurance
5. Routine screening procedures for cancer	20% coinsurance	20% coinsurance
6. Allergy shots	20% coinsurance	20% coinsurance
7. Refractive eye exams	20% coinsurance	20% coinsurance
8. Chiropractic services to diagnose and to treat, by manual manipulation or certain therapies, neuromusculoskeletal conditions related to the spine or joint	20% coinsurance	20% coinsurance

Your Benefits and the Amounts You Pay		
Benefits (after $1,500 individual coverage deductible, or $3,000 family coverage deductible)	**In-network benefits** **You pay**	**Out-of-network benefits** **You pay**
9. 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	20% coinsurance	20% coinsurance
10. Services received from a physician during an emergency room visit	20% coinsurance	For emergency services from non-network providers, see *Emergency Services From Non-Network Providers.* 20% coinsurance for non-emergency services provided in a non-network hospital emergency room.
11. Services received from a physician during an inpatient stay	20% coinsurance	20% coinsurance
12. Outpatient lab, pathology and x-rays	20% coinsurance	20% coinsurance
13. Other outpatient hospital or ambulatory surgical center services received from a physician	20% coinsurance	20% coinsurance
14. 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	20% coinsurance

Your Benefits and the Amounts You Pay		
Benefits (after $1,500 individual coverage deductible, or $3,000 family coverage deductible)	**In-network benefits** **You pay**	**Out-of-network benefits** **You pay**
15. Neuropsychological evaluations/cognitive testing, limited to services necessary for the diagnosis or treatment of a medical illness or injury	20% coinsurance	20% coinsurance

F. *Prescription Drugs And Pharmacy Services*

This section describes coverage for prescription drugs, some over-the-counter (OTC) drugs, and supplies received from a pharmacy or the designated mail order drug program. For purposes of this section, the word supplies means eligible diabetic equipment and supplies and ostomy supplies and smoking cessation products.

The MIC drug formulary (formulary) identifies prescription drugs, some OTC drugs, and supplies that are covered. Where appropriate, the formulary includes generic equivalents of brand name prescription drugs and supplies.

Only prescription drugs, OTC drugs, and supplies on MIC's formulary are eligible for benefits under this Policy.

The formulary and appropriate use guidelines are periodically reviewed and modified by MIC. This may mean that a brand name formulary prescription drug or supply may become non-formulary when an appropriate generic equivalent becomes available. Such a change may occur at any time during the calendar year. Your pharmacist will dispense the generic equivalent of prescription drugs or supplies according to the formulary. If you choose to continue to receive a drug which is no longer on the formulary, it will not be covered. Network providers, network pharmacies, the designated mail order drug program and members have access to MIC's drug formulary.

MIC occasionally adds OTC drugs to the formulary. However, these formulary OTC drugs must be prescribed by a provider and dispensed at a pharmacy.

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

Your physician may request that MIC make an exception to allow coverage of a non-formulary prescription drug. MIC will work with your physician to determine if an exception is appropriate for your medical condition. Exceptions to the formulary can include antipsychotic drugs prescribed to treat emotional disturbance or mental illness, and certain drugs for diagnosed mental illness or emotional disturbance if removed from the formulary or you change health plans.

See *Definitions*. These words have specific meanings:

- Benefits
- Claim
- Coinsurance
- Convenient/urgent care center
- Deductible
- Emergency
- Hospital
- Investigative
- Medically necessary
- Member
- Network
- Non-network
- Non-network provider reimbursement amount
- Physician
- Prescription drug
- Provider

If you have questions about the formulary, whether a specific prescription drug, OTC drug, or supply is covered, or would like to request a copy of the formulary at no charge, call Customer Service at one of the telephone numbers listed inside the front cover.

Prior authorization

Certain prescription drugs and supplies require prior authorization. The provider who prescribes the prescription drug or supply initiates prior authorization. Network providers, including network pharmacies and the designated mail order drug program, are given a list of formulary prescription drugs and supplies that require prior authorization.

If prior authorization is not obtained, you are required to pay the cost of the prescription drug or supply and submit a paper claim with supporting documentation. If you do not meet MIC's authorization criteria for the prescription drug or supply, you are responsible for the cost of the prescription drug or supply and will not be reimbursed.

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

Covered

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

- *In-network benefits* apply to:
  1. A prescription drug or formulary OTC drugs prescribed by a provider authorized to prescribe the drug and received at a network pharmacy or from the designated mail order drug program; and
  2. Diabetic equipment and supplies (described in this section) when received from a network pharmacy, the designated mail order drug program or a network durable medical equipment provider (you must provide the name of your prescribing provider to the network pharmacist, designated mail order drug program or network durable medical equipment provider); and
  3. Eligible ostomy supplies (described in this section) when received from a network pharmacy, the designated mail order drug program or a network durable medical equipment provider (you must provide the name of your prescribing provider to the network pharmacist, designated mail order drug program or network durable medical equipment provider); and

See *Miscellaneous Medical Supplies* for coverage of supplies such as dietary medical treatment of phenylketonuria (PKU).

4. Smoking cessation products (described in this section) when prescribed by a provider authorized to prescribe the product and received at a network pharmacy. You must provide the name of your network provider to the network pharmacist.

- *Out-of-network benefits* apply to:

  1. A prescription drug or a formulary OTC drug prescribed by a provider authorized to prescribe the drug and received at a non-network pharmacy; and
  2. Diabetic equipment and supplies and eligible ostomy supplies (described in this section) when received from a non-network pharmacy or a non-network durable medical equipment provider ; and
  3. Smoking cessation products (described in this section) when prescribed by a provider authorized to prescribe the product and received at a non-network pharmacy.

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

Prescription unit

Prescription drugs, formulary OTC drugs, and supplies will not be dispensed in excess of one prescription unit. However, when you have used 80 percent of your prescription, you may refill your prescription before your refill date. (This is generally seven days before your refill date 21 days for prescriptions from the designated mail order drug program.)

1. For prescription drugs and formulary OTC drugs, one prescription unit is equal to :
   a. Up to a 31-consecutive-day supply (93-consecutive-day supply for prescriptions from the designated mail order drug program), unless limited by the drug manufacturer's packaging or MIC's appropriate use guidelines;
   b. Up to a 31-day supply per type of insulin (93-day supply for insulin from the designated mail order drug program); or
   c. A one cycle supply of oral contraceptives.
2. For diabetic supplies, one prescription unit is equal to the greater of:

   a. Up to a 31-consecutive-day supply (93-consecutive-day supply for diabetic supplies from the designated mail order drug program), unless limited by the drug manufacturer's packaging or MIC's appropriate use guidelines; or
   b. 100 units (300 units for diabetic supplies from the designated mail order drug program).
3. For eligible ostomy supplies, one prescription unit is equal to up to a 31-consecutive-day supply (93-consecutive-day supply for ostomy supplies from the designated mail order drug program), unless limited by the drug manufacturer's packaging or MIC's appropriate use guidelines.
4. For smoking cessation products, coverage is limited to nicotine patches, nicotine gum and Zyban. One prescription unit is equal to up to a 30-consecutive-day supply of nicotine patches *or* nicotine gum *or* Zyban (unless limited by the drug manufacturer's packaging) as determined by the manufacturer's dosing instructions for appropriate use.

Amounts less than a 30-consecutive-day supply of smoking cessation products will count as one prescription unit when calculating the annual maximum benefit.

Coverage for smoking cessation products is limited to a maximum benefit of two prescription units per calendar year for in-network and out-of-network benefits combined.

Not covered

These prescription drugs and supplies are not covered:

See *Exclusions* for additional prescription drugs and supplies that are not covered.

1. Any amount above what MIC would have paid when you fail to identify yourself to the pharmacy or designated mail order drug program as a member. (MIC will notify you before enforcement of this provision.)
2. Medications available over-the-counter (OTC) that by federal or state law do not require a prescription order or refill and any medication that is equivalent to an OTC medication (except as described in this section).
3. Replacement of a prescription drug or supply due to loss, damage or theft.
4. Appetite suppressants.
5. Smoking cessation products or services (except as described in this section).
6. Drugs and supplies that are not prescribed by a provider acting within their scope of licensure.
7. Prescription drugs for the treatment of infertility.
8. Drugs and supplies, other than oral contraceptives, when prescribed for purposes of family planning.

9. Prescription drugs and supplies not on MIC's formulary, unless MIC has authorized an exception.
10. Vitamin therapy or dietary supplements.

Your Benefits and the Amounts You Pay

Benefits (after $1,500 individual coverage deductible, or $3,000 family coverage deductible)	**In-network benefits** **You pay**	**Out-of-network benefits** **You pay**
1. Outpatient prescription drugs and formulary OTC drugs other than those described below	The amount you pay per prescription unit or refill is based on cost. 20% coinsurance	The amount you pay per prescription unit or refill is based on the non-network provider reimbursement amount. 20% coinsurance
2. Up to a 24-hour supply of emergency prescription drugs and formulary OTC drugs received from a hospital or convenient/urgent care center	The amount you pay per prescription unit or refill is based on cost. 20% coinsurance	The amount you pay per prescription unit or refill is based on the non-network provider reimbursement amount. 20% coinsurance
3. Diabetic supplies and equipment	The amount you pay per prescription unit or refill is based on cost. 20% coinsurance	The amount you pay per prescription unit or refill is based on the non-network provider reimbursement amount. 20% coinsurance
4. Eligible ostomy supplies	The amount you pay per prescription unit or refill is based on cost. 20% coinsurance	The amount you pay per prescription unit or refill is based on the non-network provider reimbursement amount. 20% coinsurance

Your Benefits and the Amounts You Pay		
Benefits (after $1,500 individual coverage deductible, or $3,000 family coverage deductible)	**In-network benefits** **You pay**	**Out-of-network benefits** **You pay**
5.. Smoking cessation products limited to nicotine replacement therapy (nicotine patch and nicotine gum only) and Zyban. Coverage is limited to an annual maximum benefit of up to two prescription units for Zyban, two prescription units for nicotine patches, and up to two prescription units for nicotine gum for in-network and out-of-network benefits combined. This annual limit is calculated each calendar year.	The amount you pay per prescription unit or refill is based on cost. 20% coinsurance Coverage is limited to an annual maximum benefit of two prescription units for in-network and out-of-network benefits combined. This annual limit is calculated each calendar year.	The amount you pay per prescription unit or refill is based on the non-network provider reimbursement amount. 20% coinsurance Coverage is limited to an annual maximum benefit of two prescription units for in-network and out-of-network benefits combined. This annual limit is calculated each calendar year.

G. *Hospital Services*

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

Newborns and Mother's Health Protection Act of 1996

During the first 18 months following your enrollment date, maternity care is not covered. Thereafter, maternity care benefits are subject to the following:

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

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

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.

See ***Definitions.*** These words have specific meanings:
- Benefits
- Coinsurance
- Deductible
- Emergency
- Hospital
- Inpatient
- Member
- Network
- Non-network
- Non-network provider reimbursement amount
- Physician
- Provider

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. 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.

Not covered

Admission to another hospital is not covered when care for your condition is available at the network hospital where you were first admitted.

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

Your Benefits and the Amount You Pay		
Benefits (after $1,500 individual coverage deductible, or $3,000 family coverage deductible)	**In-network benefits** **You pay**	**Out-of-network benefits** **You pay**
1. Outpatient services		
a. Services provided in a hospital emergency room	20% coinsurance	For emergency services from non-network providers, see *Emergency Services From Non-Network Providers*. 20% coinsurance for non-emergency services provided in a non-network hospital emergency room
b. Outpatient lab, pathology and x-rays	20% coinsurance	20% coinsurance
c. Maternity care services	No coverage during the first 18 months following your enrollment date. Thereafter, 20% coinsurance.	No coverage during the first 18 months following your enrollment date. Thereafter, 20% coinsurance.
d. Other outpatient services	20% coinsurance	20% coinsurance
e. Other outpatient hospital and ambulatory surgical center services received from a physician	20% coinsurance	20% coinsurance
2. Services provided in a hospital observation room	20% coinsurance	20% coinsurance

Your Benefits and the Amount You Pay		
Benefits (after $1,500 individual coverage deductible, or $3,000 family coverage deductible)	**In-network benefits** **You pay**	**Out-of-network benefits** **You pay**
3. Inpatient services, including semi-private room and board in a hospital and services received from a physician during an inpatient stay: A private room is covered only for conditions of preeclampsia, radium implants, contagion or immunosuppression that require isolation		
a. Inpatient services other than for maternity care	20% coinsurance	20% coinsurance
b. Inpatient service for maternity care	No coverage during the first 18 months following your enrollment date. Thereafter, 20% coinsurance.	No coverage during the first 18 months following your enrollment date. Thereafter, 20% coinsurance.

H. *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).

Covered

For benefits and the amounts you pay, see the table in this section. For non-emergency licensed ambulance services described in number 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 number 1 in the table in this section). In addition to the deductible and coinsurance described for out-of-network benefits, you will be responsible for any charges in excess of the non-network provider reimbursement amount.

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.

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

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 (after $1,500 individual coverage deductible, or $3,000 family coverage deductible)	**In-network benefits** **You pay**	**Out-of-network benefits** **You pay**
1. Ambulance services or ambulance transportation to the nearest hospital for an emergency	20% coinsurance	See *Emergency Services From Non-Network Providers*.
2. Non-emergency licensed ambulance service that is arranged through an attending physician, as follows:		
a. Transportation from hospital to hospital when:	20% coinsurance	20% 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	20% coinsurance

I. *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.

Covered

For benefits and the amounts you pay, see the table in this section. As described under numbers 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 dependent child may still be considered "confined to home" when attending school where life support specialized equipment and help are available.

Benefits covered under numbers 1, 2 and 4 in the table in this section are limited to a combined annual benefit maximum each calendar year and to 1 home health care visit per day.

- *In-network benefits* apply to home health care services ordered or prescribed by a physician and received from a network home health care agency.
- *Out-of-network benefits* apply to home health care services that are ordered or prescribed by a physician and received from a non-network home health care agency. In addition to the deductible and coinsurance described for out-of-network benefits, you will be responsible for any charges in excess of the non-network provider reimbursement amount.

Important: Out-of-network benefits are not provided for home infusion therapy. Home infusion therapy is covered only if provided by a network provider.

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.

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.

See ***Definitions***. These words have specific meanings:
- Benefits
- Coinsurance
- Custodial care
- Deductible
- Hospital
- Network
- Non-network
- Non-network provider reimbursement amount
- Physician
- Provider
- Skilled care
- Skilled nursing facility

Not covered

See *Exclusions* for additional services, supplies and associated expenses that are 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. Home infusion therapy provided by a non-network provider.
13. IV therapy.
14. Services to administer home infusion therapy when you or your caregiver can be successfully trained to administer therapy.

Your Benefits and the Amounts You Pay		
Benefits (after $1,500 individual coverage deductible, or $3,000 family coverage deductible)	**In-network benefits** **You pay**	**Out-of-network benefits** **You pay**
1. Intermittent skilled care when you are homebound, provided by or supervised by a registered nurse. Coverage is limited to an annual benefit maximum of $25,000 per calendar year for numbers 1., 2. and 4. of this Section combined. Coverage is limited to 1 visit per day.	20% coinsurance	20% coinsurance
2. Skilled physical or speech or occupational therapy when you are homebound. Coverage is limited to an annual benefit maximum of $25,000 per calendar year for numbers 1., 2. and 4. of this Section combined. Coverage is limited to 1 visit per day.	20% coinsurance	20% coinsurance
3. Home infusion therapy	20% coinsurance	No coverage
4. Services received in your home from a physician. Coverage is limited to an annual benefit maximum of $25,000 per calendar year for numbers 1., 2. and 4. of this Section combined. Coverage is limited to 1 visit per day.	20% coinsurance	20% coinsurance

J. *Outpatient Rehabilitation*

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

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. 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.

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 (stuttering or lisps) and assistance in the development of verbal clarity.
7. Voice training and voice therapy.
8. Outpatient rehabilitation services when no medical diagnosis is present
9. Maintenance therapies.

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.

See *Definitions*. These words have specific meanings:

- Benefits
- Coinsurance
- Deductible
- Network
- Non-network
- Non-network provider reimbursement amount
- Physician

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

Your Benefits and the Amounts You Pay		
Benefits (after $1,500 individual coverage deductible, or $3,000 family coverage deductible)	**In-network benefits** **You pay**	**Out-of-network benefits** **You pay**
1. Physical therapy received outside of your home	20% coinsurance	20% coinsurance
2. Occupational therapy received outside of your home		
a. Initial occupational therapy evaluation to determine if physical function is impaired due to a medical illness or injury or congenital or developmental conditions that have delayed motor development	20% coinsurance	20% coinsurance
b. Occupational therapy when physical function is impaired due to a medical illness or injury or congenital or developmental conditions that have delayed motor development	20% coinsurance	20% coinsurance
3. Speech therapy received outside of your home		
a. Initial speech therapy evaluation to determine if speech is impaired due to a medical illness or injury, or congenital or developmental conditions that have delayed speech development	20% coinsurance	20% coinsurance

Your Benefits and the Amounts You Pay		
Benefits (after $1,500 individual coverage deductible, or $3,000 family coverage deductible)	**In-network benefits** **You pay**	**Out-of-network benefits** **You pay**
b. Speech therapy when speech is impaired due to a medical illness or injury, or congenital or developmental conditions that have delayed speech development	20% coinsurance	20% coinsurance

K. *Mental Health*

This section describes coverage for services to diagnose and treat biologically-based mental illness. Biologically-based mental illness include schizophrenia and other psychotic disorders, bipolar disorder, major depression, and obsessive-compulsive disorders.

For purposes of this section:

1. Outpatient services include:
   a. Evaluations and diagnostic services.
   b. Therapeutic services including psychiatric services.
   c. Relationship and family counseling services.
   d. Intensive outpatient programs, meaning time limited comprehensive treatment plans, which may include multiple services and modalities, delivered in an outpatient setting (this may also include services such as day treatment programs).
   e. Treatment for a minor, including family therapy.
   f. Treatment of serious or persistent disorders.
   g. Diagnostic evaluation for attention deficit hyperactivity disorder (ADHD) or pervasive development disorders (PDD).
   h. Services, care or treatment ordered by a court on the basis of a behavioral health care evaluation performed by a physician or licensed psychologist and that includes an individual treatment plan.
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.)
   e. Services, care or treatment ordered by a court on the basis of a behavioral health care evaluation performed by a physician or licensed psychologist and that includes an individual

Prior authorization.
For prior authorization of *in-network benefits*, call MIC's designated provider at:

- 1-800-848-8327
- TTY: 1-800-543-7162

For prior authorization of *out-of-network benefits*, call Customer Service at one of the telephone numbers listed inside the front cover.

See ***Definitions***. These words have specific meanings:
- Benefits
- Claim
- Coinsurance
- Custodial care
- Deductible
- Emergency
- Hospital
- Inpatient
- Medically necessary
- Member
- Network
- Non-network
- Physician
- Provider

treatment plan. Refer to numbers 2a, b, c and d in the table in this section to determine your benefits.

f. Residential services. (Refer to numbers 2a, b and c in the table in this section to determine your benefits.)

Covered

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

- For *in-network benefits*:
  1. MIC's designated provider arranges in-network mental health benefits. MIC's designated 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 provider will refer you to one of its hospital providers (MIC and MIC's designated provider hospital networks are different).
  2. Notify MIC's designated provider as soon as reasonably possible after receiving any emergency mental health inpatient services. Call MIC's designated provider at: 1-800-848-8327 or TTY: 1-800-843-7162.
  3. Second opinions from a qualified provider are covered under in-network benefits only if MIC's designated provider determines that no treatment is necessary. You must receive your second opinion within 30 calendar days of MIC's designated provider's first evaluation. MIC's designated provider will consider the second opinion but is not required to accept it.
  4.

For claims questions regarding *in-network benefits*, call MIC's designated provider Customer Service at 1-800-557-5745.

- 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. Emergency mental health services are eligible for coverage under in-network benefits.
  2. You must receive services directly from or at any of the following non-network providers to obtain out-of-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.

a. Licensed psychiatrist

b. Licensed psychologist

c. A psychiatric nurse with a master's degree from an accredited education program and two years of supervised clinical experience in a mental health setting.

d. A certified social worker with a master's degree from an accredited training program and two years of supervised clinical experience in a mental health setting.

e. A person who has a master's degree in psychology from an accredited program and two years of supervised clinical mental health experience and who meets the provisions of SDCL 36-27A-2(2).

f. A counselor who is certified under SDCL chapter 36-32 as a licensed professional counselor—mental health.

g. A counselor who is certified under SDCL chapter 36-32 as a licensed professional counselor and has two years of supervised clinical experience in a mental health setting and who is employed by the State of South Dakota or a mental health center.

h. A therapist who is licensed under SDCL chapter 36-33 as a marriage and family therapist with two years of supervised clinical experience in a mental health setting.

i. Licensed mental health clinic

j. Licensed residential treatment center

k. A hospital that provides mental health services

Not covered

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

These services, supplies and associated expenses are not covered:

1. Services for a mental illness that is not a biologically-based mental illness.

2. Services from a network provider for a condition that cannot be improved with treatment.
3. Services, care or treatment that is not medically necessary, unless ordered by a court as specifically described in this section.
4. Relationship counseling beyond initial evaluation and brief intervention services.
5. Services beyond the initial evaluation to diagnose mental retardation or learning disabilities.
6. Telephone consultations.
7. Services, including room and board charges, provided by mental health providers who are not licensed to practice independently or providers who are not certified, such as services received at a halfway house or therapeutic group home, except for outpatient mental health services that are specifically described in this section.
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.

Your Benefits and the Amounts You Pay

Benefits (after $1,500 individual coverage deductible, or $3,000 family coverage deductible)	**In-network benefits** **You pay**	**Out-of-network benefits** **You pay**
1. Outpatient services	20% coinsurance	20% coinsurance
2. Inpatient services		
a. Semi-private room and board	20% coinsurance	20% coinsurance
b. Hospital or facility-based professional services	20% coinsurance	20% coinsurance
c. Attending psychiatrist services	20% coinsurance	20% coinsurance

Your Benefits and the Amounts You Pay		
Benefits (after $1,500 individual coverage deductible, or $3,000 family coverage deductible)	**In-network benefits** **You pay**	**Out-of-network benefits** **You pay**
d. Partial program	20% coinsurance	20% coinsurance

L. *Treatment of Alcoholism*

This section describes coverage for the inpatient treatment of alcoholism in a licensed hospital or residential treatment facility approved by the State of South Dakota, which is carrying out an approved program pursuant to the diagnosis and recommendation of a doctor of medicine.

For purposes of this section inpatient services include:

a. Semi-private room and board.
b. Attending physician 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 may include lodging.)
e. Residential services

Covered

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

- For *in-network benefits*:
  1. MIC's designated provider arranges in-network benefits. MIC's designated provider will refer you to other providers only if network providers cannot provide the services you require. If you require hospitalization, MIC's designated provider will refer you to one of its hospital or residential treatment facility providers (MIC and MIC's designated provider hospital networks are different).
  2. Notify MIC's designated provider as soon as reasonably possible after receiving any emergency inpatient services. Call MIC's designated provider at 1-800-848-8327 or TTY: 1-800-543-7162.
  3. Second opinions from a qualified provider are covered under in-network benefits only if MIC's designated provider determines that no treatment is necessary. You must receive your

Prior authorization.
For prior authorization of *in-network benefits*, call MIC's designated provider at:

- 1-800-848-8327
- TTY: 1-800-543-7162

For prior authorization of *out-of-network benefits*, call Customer Service at one of the telephone numbers listed inside the front cover.

See ***Definitions***. These words have specific meanings:
- Benefits
- Claim
- Coinsurance
- Custodial care
- Deductible
- Emergency
- Hospital
- Inpatient
- Medically necessary
- Member
- Network
- Non-network
- Physician
- Provider

For claims questions regarding *in-network benefits*, call MIC's designated provider Customer Service at 1-800-557-5745.

- For *out-of-network benefits*:
  1. Services from a non-network provider listed below will be eligible for coverage under out-of-network benefits. Emergency services for treatment of alcoholism are eligible for coverage under in-network benefits.
  2. You must receive services directly from or at any of the following non-network providers to obtain out-of-network benefits:
     a. Licensed psychiatrist
     b. Licensed consulting psychologist
     c. Licensed psychologist
     d. Certified clinical nurse specialist in psychiatric and mental health nursing
     e. Licensed chemical dependency clinic
     f. Licensed residential treatment center
     g. A hospital that provides services for treatment of alcoholism.

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.

Not covered

These services, supplies and associated expenses are not covered:

1. Services for disorders other than alcoholism.
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 the influence of alcohol when no medical services are required, regardless of where the services are received.
5. Services beyond the primary treatment of alcoholism.
6. Telephone consultations.
7. Services, including room and board charges, provided by providers who are not licensed to practice independently or providers who are not

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

certified, such as services received at a halfway house or therapeutic group home.

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.

Your Benefits and the Amounts You Pay		
Benefits (after $1,500 individual coverage deductible, or $3,000 family coverage deductible)	**In-network benefits** **You pay**	**Out-of-network benefits** **You pay**
Inpatient services Coverage is limited to a maximum of 30 days care in any 6 consecutive month period and a lifetime maximum of 90 days care:		
a. Semi-private room and board	20% coinsurance	20% coinsurance
b. Hospital or facility-based professional services	20% coinsurance	20% coinsurance
c. Attending physician services	20% coinsurance	20% coinsurance

M. *Durable Medical Equipment And Prosthetics*

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

Covered

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

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.

- *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 the 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. 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.

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.

See *Definitions*. These words have specific meanings:

- Benefits
- Coinsurance
- Deductible
- Medically necessary
- Network
- Non-network
- Non-network provider reimbursement amount
- Physician
- Provider

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.

Not covered

See *Exclusions* for additional services, supplies and associated expenses that are 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.
5. Scalp hair prostheses due to alopecia areata.
6. Hearing aids.

Your Benefits and the Amounts You Pay

Benefits (after $1,500 individual coverage deductible, or $3,000 family coverage deductible)	**In-network benefits** **You pay**	**Out-of-network benefits** **You pay**
1. Durable medical equipment and certain related supplies	20% coinsurance	20% coinsurance
2. Repair, replacement or revision of durable medical equipment made necessary by normal wear and use	20% coinsurance	20% coinsurance
3. Prosthetics:		
a. Initial purchase of breast prostheses	20% coinsurance	20% coinsurance
b. Initial purchase of artificial limbs and eyes	20% coinsurance	20% coinsurance

Your Benefits and the Amounts You Pay		
Benefits (after $1,500 individual coverage deductible, or $3,000 family coverage deductible)	**In-network benefits** **You pay**	**Out-of-network benefits** **You pay**
c. Repair, replacement or revision of artificial limbs, eyes and breast prostheses made necessary by normal wear and use.	20% coinsurance	20% coinsurance

N. *Miscellaneous Medical Supplies*

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

Covered

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

- *In-network benefits* apply to miscellaneous medical supplies received from a network provider.
- *Out-of-network benefits* apply to miscellaneous medical supplies received from a non-network provider. 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.

Not covered

Other disposable supplies and appliances, except as described in this Policy.

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.

See *Definitions*. These words have specific meanings:

- Benefits
- Coinsurance
- Deductible
- Medically necessary
- Network
- Non-network
- Non-network provider reimbursement amount
- Physician
- Provider

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

Your Benefits and the Amounts You Pay		
Benefits (after $1,500 individual coverage deductible, or $3,000 family coverage deductible)	**In-network benefits** **You pay**	**Out-of-network benefits** **You pay**
1. Blood clotting factors	20% coinsurance	20% coinsurance
2. Dietary medical treatment of phenylketonuria (PKU)	20% coinsurance	20% coinsurance
3. Total parenteral nutrition	20% coinsurance	20% coinsurance

O. *Organ And Bone Marrow Transplant Services*

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

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

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.

See *Definitions*. These words have specific meanings:

- Benefits
- Coinsurance
- Deductible
- Hospital
- Inpatient
- Investigative
- Medically necessary
- Member
- Network
- Non-network
- Non-network provider reimbursement amount
- Physician
- Provider

Bone marrow transplants include the transplant of stem cells from bone marrow, peripheral blood and umbilical cord blood.

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.

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

- *In-network benefits* apply to transplant services provided by a network provider and received at a designated transplant facility. A designated transplant facility means a hospital that has entered into a separate contract with MIC to provide certain transplant-related health services to members receiving transplants.

  Once evaluated and listed as a potential recipient at a designated transplant facility, you must remain with that facility, unless it is medically necessary for your transplant to be rendered elsewhere. You cannot be listed at more than one facility. If you independently choose to be listed at additional facilities, any charges for services they provide will not be covered under this Policy.

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 transplant 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.

- **Important:** *Out-of-network benefits* are not provided for transplant services. Transplant services are covered only if provided by a network provider and designated transplant facility.

Not covered

See *Exclusions* for additional services, supplies and associated expenses that are 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 otherwise not 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. Transplant services provided by a non-network provider or non-designated transplant facility.

Your Benefits and the Amounts You Pay

Benefits (after $1,500 individual coverage deductible, or $3,000 family coverage deductible)	In-network benefits You pay	Out-of-network benefits You pay
1. Office visits	20% coinsurance	No coverage
2. Outpatient services		
a. Professional services		
i. Surgical services (as defined in the *Physicians' Current Procedural Terminology* code book) received from a physician during an office visit or an outpatient hospital visit	20% coinsurance	No coverage
ii. Outpatient lab, pathology and x-rays	20% coinsurance	No coverage
iii. Other outpatient hospital services received from a physician	20% coinsurance	No coverage
b. Hospital and ambulatory surgical center services		
i. Outpatient lab, pathology and x-rays	20% coinsurance	No coverage

Your Benefits and the Amounts You Pay		
Benefits (after $1,500 individual coverage deductible, or $3,000 family coverage deductible)	**In-network benefits** **You pay**	**Out-of-network benefits** **You pay**
ii. Other outpatient hospital services	20% coinsurance	No coverage
3. Inpatient services	20% coinsurance	No coverage
4. Services received from a physician during an inpatient stay	20% coinsurance	No coverage

P. *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.

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. 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.

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.

See *Definitions.* These words have specific meanings:
- Benefits
- Coinsurance
- Cosmetic
- Deductible
- Hospital
- Inpatient
- Medically necessary
- Member
- Network
- Non-network
- Non-network provider reimbursement amount
- Physician
- Provider
- Reconstructive
- Restorative

Not covered

See *Exclusions* for additional services, supplies and associated expenses that are 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.

Your Benefits and the Amounts You Pay

Benefits (after $1,500 individual coverage deductible, or $3,000 family coverage deductible)	**In-network benefits** **You pay**	**Out-of-network benefits** **You pay**
1. Office visits	20% coinsurance	20% coinsurance
2. Outpatient services		
a. Professional services i. 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	20% coinsurance	20% coinsurance

Your Benefits and the Amounts You Pay		
Benefits (after $1,500 individual coverage deductible, or $3,000 family coverage deductible)	**In-network benefits** **You pay**	**Out-of-network benefits** **You pay**
ii. Outpatient lab, pathology and x-rays	20% coinsurance	20% coinsurance
iii. Other outpatient hospital or ambulatory surgical center services received from a physician	20% coinsurance	20% coinsurance
b. Hospital and ambulatory surgical center services		
i. Outpatient lab, pathology and x-rays	20% coinsurance	20% coinsurance
ii. Other outpatient hospital and ambulatory surgical center services	20% coinsurance	20% coinsurance
3. Inpatient services	20% coinsurance	20% coinsurance
4. Services received from a physician during an inpatient stay	20% coinsurance	20% coinsurance

Q. *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.

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. 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.

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. Private room, except for conditions of preeclampsia, radium implants, contagion or immunosuppression that require isolation.
4. Services primarily educational in nature.
5. Vocational and job rehabilitation.
6. Recreational therapy.
7. Health clubs.
8. Correction of speech impediments (stuttering or lisps) and assistance in the development of verbal clarity.

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.

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

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

9. Voice training and voice therapy.
10. Outpatient rehabilitation services when no medical diagnosis is present.

Your Benefits and the Amounts You Pay		
Benefits (after $1,500 individual coverage deductible, or $3,000 family coverage deductible)	**In-network benefits** **You pay**	**Out-of-network benefits** **You pay**
1. Daily skilled care or daily skilled rehabilitation services, including room and board Benefits are limited to 120 days per calendar year for in-network and out-of-network combined. This day limitation applies whether or not your deductible has been met.	20% coinsurance Services must begin within 14 days of an inpatient stay of at least three days in a hospital.	20% coinsurance Services must begin within 14 days of an inpatient stay of at least three days in a hospital.
2. Skilled physical or occupational therapy when room and board is not eligible to be covered	20% coinsurance	20% coinsurance
3. Services received from a physician during an inpatient stay in a skilled nursing facility Benefits are limited to services received during 120 days of inpatient stay per calendar year for in-network and out-of-network combined. This day limitation applies whether or not your deductible has been met.	20% coinsurance	20% coinsurance

R. *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.

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.

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

- *In-network benefits apply to* hospice services arranged through a physician and received from a designated hospice program.
- **Important:** *Out-of-network benefits* are not provided for hospice services. Hospice services are covered only if arranged through a physician and received from a designated 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.

See *Definitions*. These words have specific meanings:

- Benefits
- Coinsurance
- Deductible
- Member
- Network
- Physician
- Skilled nursing facility

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.

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.

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.

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.

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. 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 (after $1,500 individual coverage deductible, or $3,000 family coverage deductible)	**In-network benefits** **You pay**	**Out-of-network benefits** **You pay**
Hospice services	20% coinsurance	No coverage

S. *Medical-Related Dental Services*

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

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. 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.

Not covered

These services, supplies and associated expenses are not covered:

1. Accident-related dental services to treat an injury.
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, except as described in number 2 in the table in this section.
6. Tooth extractions, except as described in this section.
7. Any dental procedures or treatment related to periodontal disease.
8. Endodontic procedures and treatment, including root canal procedures and treatment.
9. Routine diagnostic and preventive dental services.

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.

See *Definitions.* These words have specific meanings:

- Benefits
- Coinsurance
- Deductible
- Dependent
- Hospital
- Member
- Network
- Non-network
- Non-network provider reimbursement amount
- Physician
- Provider

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

Your Benefits and the Amounts You Pay		
Benefits (after $1,500 individual coverage deductible, or $3,000 family coverage deductible)	**In-network benefits** **You pay**	**Out-of-network benefits** **You pay**
1. Charges for medical facilities and general anesthesia services that are: a. Recommended by a network physician; and b. Received during a dental procedure; and c. Provided to a member who: i. Is a child under age five (prior authorization is *not* required); or ii. Is severely disabled; or iii. Has a medical condition and requires hospitalization or general anesthesia for dental care treatment. **Please note**. Age, anxiety and behavioral conditions are not considered medical conditions.	20% coinsurance	20% coinsurance
2. For a dependent child, orthodontia related to cleft lip and palate **Please note.** For a dependent child, benefits for oral surgery treatment for cleft lip and palate are covered in *Professional Services* and *Hospital Services*.	20% coinsurance	20% coinsurance
3. Oral surgery for: a. Partially or completely unerupted impacted teeth;	20% coinsurance	20% coinsurance

Your Benefits and the Amounts You Pay		
Benefits (after $1,500 individual coverage deductible, or $3,000 family coverage deductible)	**In-network benefits** **You pay**	**Out-of-network benefits** **You pay**
b. A tooth root without the extraction of the entire tooth (this does not include root canal therapy); or c. The gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth.		

T. *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.

Covered

For benefits and the amounts you pay, see the table in this section. To be eligible for coverage, services must be due to a medical condition that a prudent layperson would have reasonably believed to be an emergency medical condition 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 treatment of alcoholism inpatient services, you must notify MIC's designated provider as soon as reasonably possible. MIC's designated provider can be reached at:

- 1-800-848-8327
- TTY: 1-800-543-7162

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*.

See *Definitions*. These words have specific meanings:

- Benefits
- Claim
- Coinsurance
- Deductible
- Emergency
- Hospital
- Inpatient
- Member
- Network
- Non-network
- Physician
- Provider

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.

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.

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

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.

Your Benefits and the Amounts You Pay

Benefits (after $1,500 individual coverage deductible, or $3,000 family coverage deductible)	**In-network benefits** **You pay**
1. Emergency services that are: a. Administered under the direction of a physician; *and* b. Otherwise eligible for coverage in this Policy.	20% coinsurance
2. Ambulance service or ambulance transportation to the nearest hospital for an emergency	20% coinsurance

U. *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.

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.

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 medically necessary, 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 non-network specialist provider. Standing referrals will only be authorized for the period of time appropriate to your medical condition.

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

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

3. Provide coverage for health services that are:
   a. Otherwise eligible for coverage under this Policy; and
   b. Recommended by a network physician.
4. Notify you of authorization or denial of coverage within ten days of receipt of your request. MIC will inform both you and your provider of MIC's decision within 72 hours from the time of the initial request if your attending provider believes that an expedited appeal is warranted, or MIC concludes that a delay could seriously jeopardize your life, health, or ability to regain maximum function.

V. *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.

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.

MIC will send you specific information about:

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

See *Definitions*. These words have specific meanings:

- Benefits
- Emergency
- Hospital
- Network
- Physician
- Prescription drug
- Provider

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.

W. *Exclusions*

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.
5. Services provided by an audiologist when not under the direction of a physician, 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. Services for genetic screening and testing except when:
   a. Recommended by a genetic counselor as predictive of a disease process, and treatment standards of care exist for the disease process; or
   b. Reproductive choices would be made based on the test findings.
8. Services or supplies not directly related to care.
9. Autopsies.
10. Enteral feedings (unless they are the sole source of nutrition) except for the dietary medical treatment of PKU.
11. Nutritional and electrolyte substances.

See *Definitions*. These words have specific meanings:

- Claim
- Cosmetic
- Custodial care
- Emergency
- 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.

12. Physical or 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.
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. Massage therapy, provided in any setting, even when it is part of a comprehensive treatment plan.
21. Routine foot care, except for members with diabetes, peripheral vascular disease, peripheral neuropathies or blindness.
22. Services by persons who are family members or who share your legal residence. This exclusion does not apply in those areas in which the immediate family member is the only health care professional in the area and is acting within the scope of their normal employment.
23. Services for which benefits have been paid under worker's compensation, employer liability, or any similar law.
24. Services received before coverage under this Policy becomes effective.
25. Services received after coverage under this Policy ends.
26. Unless requested by MIC, charges for duplicating and obtaining medical records from non-network providers and non-network dentists.
27. Photographs, except for the condition of multiple dysplastic syndrome.
28. Occlusal adjustment or occlusal equilibration.
29. Dental implants (tooth replacement).
30. Dental prostheses.

31. Orthodontic treatment, except as stated in *Medical-Related Dental Services.*
32. Treatment for bruxism.
33. Services prohibited by law or regulation, or illegal under South Dakota law.
34. Services to treat injuries that occur while on military duty; and any services received as a result of war, or any act of war (whether declared or undeclared).
35. Exams, other evaluations or other services for employment, insurance or licensure, unless otherwise covered under this Policy.
36. Exams, other evaluations or other services for judicial or administrative proceedings or research, except emergency examination of a child ordered by judicial authorities, or which MIC determines is medically necessary, or as otherwise covered under this Policy.
37. Non-medical self-care or self-help training.
38. Educational classes, programs or seminars, unless otherwise covered under this Policy.
39. Coverage for costs associated with translation of medical records and claims to English.
40. Treatment for spider veins.
41. Services not received from or under the direction of a physician, except as described in this Policy.
42. Preventive dental services.
43. Services for or related to intensive behavior therapy treatment programs for the treatment of autism spectrum disorders. Examples of such services include, but are not limited to, Intensive Early Intervention Behavior Therapy Services (IEIBTS), Intensive Behavioral Intervention (IBI), and Lovaas therapy.
44. Infertility services and services and drugs for or related to assisted reproductive technology (ART), artificial insemination or in vetro fertilization.
45. Charges for services by a non-network provider in excess of the non-network provider reimbursement amount.
46. Maternity care services during the first 18 months following your enrollment date.
47. Treatment by any method for jaw joint problems, including temporomandibular joint dysfunction

(TMJ), TMJ pain syndromes, craniomandibular disorders, myofascial pain dysfunction or other conditions of the joint linking the jaw bone (mandible) and skull and the complex of muscles, nerves and other tissue related to the joint.

48. Services to treat nicotine addiction except as stated in *Prescription Drugs And Pharmacy Services*.
49. Elective, induced abortions, except as *medically necessary* to protect the life or health of the mother.
50. Implants for the purpose of contraception.
51. Therapeutic acupuncture.
52. Services billed by acupuncturist.
53. Visual therapy.
54. Growth hormone
55. Services to treat a pre-existing condition as described in *How To Access Your Benefits*.
56. Services and supplies to they are extent paid or payable under Medicare.
57. Services provided to your dependents if you have subscriber coverage only. (If you need to add coverage for your dependents, see the *Eligibility And Enrollment* section.)
58. 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, or coinsurance requirement of such coverage.
59. Services for private-duty nursing.
60. Functional capacity evaluations and related services for vocational purposes or for determination of disability or pension benefits.
61. 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*).
62. Services for systemic candidiasis, homeopathy and immunoaumentive therapy.
63. Services for or in connection with fetal tissue transplantation.
64. Services which are not within the scope of licensure or certification of the provider.

65. Non-emergency transportation.
66. Non-emergency services received outside the United States.
67. Preventive health care, except as stated in *Professional Services*.
68. Charges made by a provider for telephone consultations.
69. Services needed due to your commission of or attempt to commit a felony, or because you were engaged in an illegal occupation.
70. Charges for giving injections which can be self-administered.
71. Weight loss programs.

X. *How To Submit A Claim*

This section describes the process for submitting a claim.

See *Definitions*. These words have specific meanings:

- Benefits
- Claim
- Dependent
- Member
- Network
- Non-network
- Non-network provider reimbursement amount
- Provider

Claims for benefits from network providers

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

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

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

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 pay the provider of services if:

1. You ask MIC in writing to pay the provider directly; or
2. The non-network provider notifies MIC of your signature on file authorizing that payment be made directly to the provider.

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 30 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 proof of travel.
- 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.

> For 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 grievance or disagree with a decision by MIC, you may follow the grievance procedure outlined in *Grievances/Appeals* 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.

Y. *Right Of Recovery*

This section describes MIC's right of recovery. MIC's rights are subject to South Dakota and federal law.

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 regardless of whether 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.
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.

See *Definitions*. These words have specific meanings:

- Benefits
- Claim

For information about the effect of South Dakota and federal law on MIC's subrogation rights, contact an attorney.

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.

Z. *Eligibility And Enrollment*

This section describes who can enroll and how to enroll.

Who can enroll

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

See *Definitions*. These words have specific meanings:

- Continuous coverage
- Dependent
- Member
- Mental disorder
- Physician
- Placed for adoption
- Pre-existing condition
- Premium
- Qualifying coverage
- Subscriber

Subscriber eligibility.

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

1. be a South Dakota resident and reside in the service area; and
2. be at least 18 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.

Dependent eligibility.

To be eligible to enroll for coverage, the *dependent* must:

1. provide MIC certain information regarding the dependent's health status; and
2. be accepted by MIC for enrollment; and
3. for a legally married spouse, be a South Dakota resident and reside in the *service area;* and
4. for a dependent child, be under the age of 19 (see "Extending a child's eligibility" below).

Extending a child's eligibility

A dependent child is no longer eligible for coverage under this Policy when he or she reaches the dependent limiting age of 19. However, the child's eligibility continues in either of the following situations:

An illness will not be considered a physical handicap.

- *Handicapped dependent.* The child is incapable of self-sustaining employment by reason of mental retardation or physical handicap and is chiefly dependent upon the subscriber for support and maintenance. To continue coverage for a handicapped dependent, you must provide MIC with proof of such handicap and dependency within 31 days of the child reaching the dependent limiting age of 19. Beginning two years after the child reaches the dependent limiting age of 19, MIC will require annual proof of handicap and dependency. Your handicapped dependent is covered under this Policy regardless of age and without application of health screening or pre-existing condition limitations.
- *Full-time student.* The child is eligible up to the student limiting age of 25 if he or she is enrolled full-time in a recognized high school, college, university, trade or vocational school. To continue coverage for a full-time student dependent, you must provide MIC with proof of full-time student status within 31 days of the child reaching the dependent limiting age. If the student is unable to carry a full-time course load due to illness, injury, or a physical or mental disability (as documented by a physician), full-time student status will be granted if the student carries at least 60% of a full-time course load, as determined by the educational institution that they are enrolled in. At a minimum, MIC will require annual proof of full-time student status, and may require such proof on a quarterly basis.

Coverage for a student enrolled in school continues during vacation or between consecutive term periods.

Notification

You must notify MIC in writing within 31 days of the effective date of any changes to address or name, addition or deletion of dependents, change in full-time student status for dependents beyond the dependent limiting age, or other facts identifying you or your dependents.

The date your coverage begins

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

Coverage for a subscriber and enrolled dependents will begin after the application for coverage has been approved by MIC. MIC will notify you of your approval and the effective date of your coverage.

How to add dependents

Coverage for new dependents may be added after the subscriber's coverage begins as follows:

- A newborn dependent is covered under this Policy from the date of birth. You must pay the premium required by MIC for the newborn dependent's coverage, and you must enroll the child under this Policy within 31 days from the date of birth. No evidence of good health will be required.
- A dependent child placed for adoption in the subscriber's home is covered under this Policy from the date of placement. You must pay the premium required by MIC for the dependent child's coverage, and you must enroll the child under this Policy within 31 days of the child's date of placement. No evidence of good health will be required. (Eligibility for a child placed for adoption with the subscriber ends if the placement is interrupted before legal adoption and the child is removed from placement.)
- For all other dependents, the subscriber must make written application for the dependent's coverage, provide evidence of good health and pay the required premium. The dependent's coverage is not effective unless MIC accepts the dependent's evidence of good health. MIC will notify the subscriber of the dependent's approval and the effective date of coverage. If a subscriber applies for coverage for his or her spouse within 31 days after marriage and coverage is approved by MIC, coverage will begin as of the date of marriage.

Premium must be paid from the date coverage starts.

AA. *Ending Coverage*

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

When coverage ends

See *Definitions*. These words have specific meanings:

- Certification of qualifying coverage
- Claim
- Dependent
- Member
- Premium
- Subscriber

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 and/or dependents’ 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. The end of the month following the date 31 days after we notify you that coverage will end because you do not reside in the service area.
5. The end of the month following the date the subscriber becomes eligible for Medicare or social security disability benefits.
6. For a dependent child, the end of the month in which the child is no longer eligible as a dependent as specified in this Policy.
7. For a student, the end of the month in which the earliest of the following occurs:
   a. Graduation or completion of the term;
   b. Termination of full-time registration at the school for reasons other than graduation, except as specified in *Eligibility And Enrollment*; or
   c. Reaching the student limiting age specified in

this Policy.

8. The date specified by MIC in written notice to you that coverage ended due to fraud. Fraud includes but is not limited to:
   a. Knowingly providing MIC with false material information such as:
      i. Information related to your eligibility or another person's eligibility for coverage or status as a dependent; or
      ii. Information related to your health status or that of any dependent; or
   b. 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 within the 24 months following the date your coverage ends.

BB. *Continuation*

This section describes continuation coverage provisions for a subscriber's covered dependent spouse. When the coverage ends, a covered dependent spouse may be able to continue coverage under state law. The paragraphs below describe the continuation coverage provisions.

If your coverage ends, you should review your continuation rights.

See *Definitions*. These words have specific meanings:

- Benefits
- Dependent
- Member
- Premium
- Subscriber

Your right to continue coverage under state law

Notwithstanding the provisions regarding termination of coverage described in *Ending Your Coverage,* you may be entitled to continued coverage. South Dakota law requires that a covered dependent spouse be offered the opportunity to pay for an extension of health coverage (called continuation coverage) in certain instances where health coverage would otherwise end. It is intended that no greater rights be provided than those required by South Dakota law. Take time to read this section carefully.

Subscriber's spouse's loss

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

a. Divorce from the subscriber; or

b. The subscriber's eligibility for Medicare or security disability benefits.

What you must do

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

a. Notify MIC within 31 days of:

   - the subscriber's divorce
   - the subscriber's eligibility for Medicare or social security disability benefits

b. Elect continuation coverage by notifying MIC in writing within 31 days after coverage ends due to divorce or within 60 days after coverage ends

due to eligibility for Medicare or social security disability benefits

c. Pay premiums for the continuation coverage.
   - The premium to continue coverage is the rate charged under the Policy.
   - You must pay the first premium within 45 days after choosing to continue your coverage.
   - You must pay subsequent premiums by the date specified in the Policy.

What MIC must do

a. Notify you of your right to continue coverage and the 31 or 60 day election period.
b. Inform you of the premium required to continue coverage and how to pay the premium.

Duration

Under the circumstances described above coverage will be continued subject to the payment of the required premium until the date coverage would otherwise terminate under the Policy as specified in *Ending Coverage*.

CC. *Grievances/Appeals*

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

You may call Customer Service at one of the telephone numbers listed inside the front cover or by writing to Customer Service, Route CP 320, PO Box 9310, Minneapolis, MN 55440-9310. You may also contact the South Dakota Division of Insurance, Department of Revenue and Regulation at 445 E Capitol Ave, Pierre, SD 57501. Their telephone number is 1-605-773-3563.

Filing a grievance may require that MIC review your medical records as needed to resolve your grievance.

Filing a grievance may require that MIC review your medical records as needed to resolve your grievance.

You may have another person make a grievance on your behalf by telephone or in writing. Before releasing confidential information to a person filing a grievance on your behalf, MIC will require you to sign an authorization form.

Grievance:

Grievance means a written complaint, or oral compliant if the compliant involves an urgent care request, submitted by or on behalf of you regarding: (a) the availability, delivery, or quality of health care services; (b) claims payment, handling, or reimbursement for health care services; or (c) any other matter pertaining to the contractual relationship between a member and MIC.

Adverse determination:

Adverse Determination means: (a) a determination by MIC that, based upon the information provided, a request by you for a benefit under your coverage upon application of any utilization review technique does not meet MIC's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit; (b) the denial, reduction, termination, or failure to provide or make payment in whole or in part, for a benefit based on a determination by MIC or our designee of your eligibility to participate in our plan; or (c) any prospective review or retrospective review

determination that denies, reduces, terminates, or fails to provide or make payment, in whole or in part, for a benefit.

First level standard grievance review

If you have a grievance for any matter that does not involve an adverse determination (a situation that does not require a medical determination) you or your representative should contact MIC. You may call Customer Service at one of the telephone numbers listed inside the front cover or write to Customer Service, Route CP 320, PO Box 9310, Minneapolis, MN 55440-9310. Your grievance must be made within 1 year following MIC's initial decision. MIC will notify you of the name, address and telephone number of the person designated by MIC to coordinate the review within 3 working days of receiving the grievance. Neither you nor your representative may attend the review; however, you are entitled to submit written material for the reviewer(s) designated by MIC to consider when conducting the review. The reviewer(s) evaluating the grievance will not be the same reviewer(s) who initially handled the matter that is the subject of the grievance.

You may have another person make a Grievance on your behalf by telephone or in writing. Before releasing confidential information to a person filing a grievance on your behalf, MIC will require you to sign an authorization form.

A written decision will be sent to you and your representative, if applicable, within 20 working days of MIC's receipt of the grievance. See *Written decision notification* for details on information included in this notification.

The decision will also include a description of the process to obtain a voluntary review of the first-level standard grievance review decision, the written procedures governing the voluntary review, and a notice of your right to contact the South Dakota Division of Insurance.

If, due to circumstances beyond MIC's control, MIC cannot make a decision within 20 working days of MIC's receipt of the grievance, MIC may take up to an additional 10 working days to issue a written decision. You and your representative, if applicable, will be notified in writing if there will be an extension and the reasons for the extension within 20 working days of receiving the grievance.

First level grievance review of an adverse determination

If you have a grievance regarding an adverse determination (a situation that does require a medical decision), you or your representative may notify MIC in writing of the grievance. The grievance must be filed within 1 year after you received notice of an adverse determination. MIC will notify you of the name, address and telephone number of the person designated by MIC to coordinate the review within 3 working days of receiving the grievance.

MIC will designate a health care provider(s) who has the appropriate training and experience in the field of medicine involved in the medical judgment to evaluate the adverse determination. The health care provider(s) will not have been involved in the initial adverse determination. In conducting the review, the reviewer(s) will take into consideration all comments, documents, records, and other information regarding the request for services submitted by you or your representative, without regard to whether the information was submitted or considered in making the initial adverse determination.

Neither you nor your representative may attend the review; however, you are entitled to: (a) submit written comments, documents, records, and other material relating to the request for benefits for the review or reviewers to consider when conducting the review; and (b) receive from MIC, upon request and free of charge, reasonable access to, and copies of all documents, records and other information relevant to your request for benefits.

A document, record or other information will be considered relevant to your request for benefits if the document, record, or other information: 1) was relied upon in making the benefit determination; 2) was submitted, considered, or generated in the course of making the adverse determination, without regard to whether the document, records, or other information was relied upon in making the benefit determination; 3) demonstrates that, in making the benefit determination, MIC, or our designated representatives consistently applied required administrative procedures and safeguards with respect to you as other similarly situated members; or 4) constitutes a statement of policy or guidance with respect to MIC concerning the denied health care service or treatment for your diagnosis, without regard to whether the advice or

statement was relied upon in making the benefit determination.

MIC will provide written notice of its first level grievance review decision to you or your representatives, if applicable, and your attending provider, when applicable, within 30 calendar days from receipt of your grievance or request.

See *Written decision notification* for information on what is included in the notification.

If our initial adverse determination is upheld, the decision will also include items 1., 2., 6., 7., 8. and 9. as stated in *Adverse determination notice* as well as; as statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your benefit request.

The decision will also include a description of the process to obtain a voluntary review of the first-level grievance review decision of an adverse determination and the written procedures governing the voluntary review.

Expedited grievance review of an adverse determination

If you have a situation where the above time frames set out in the first-level grievance review of an adverse determination would, as judged by a prudent person or physician, seriously jeopardize your life or health or your ability of the regain maximum function; or your medical condition would subject you to severe pain that cannot be adequately managed without the health care services or treatment that is the subject of the request, you or your representative may request an expedited review orally or in writing. MIC will notify you or your representative, if applicable, and your attending provider, within 72 hours after receiving your request of MIC's decision by telephone, facsimile or the most expeditious method available and provide all pertinent information.

If the expedited review is a concurrent review determination, the service will be continued without liability to you until you are notified of MIC's determination.

The grievance process for expedited review of adverse determination decisions does not apply to prescheduled treatments, therapies, surgeries or other

procedures that MIC does not consider urgent situations.

See *Written decision notification* for information on what is included in the notification.

If MIC's initial adverse determination is upheld, the decision will also include information as listed in 1., 2., 3., 6., 7., 8. and 9. of *Adverse determination notification*.

The notification will be provided either orally or in writing. If the notice of the adverse determination is provided orally, MIC will provide written notification within 3 days of the date of the oral notification.

Voluntary second level review

If MIC makes a final determination to deny benefits, you may choose to participate in MIC's voluntary second level review. Upon receipt of your request for a voluntary secondary level review, MIC will notify you of your right to:

- Request to appear in person before a review panel of MIC's designated representatives within 5 working days after receipt of your request;
- Receive from MIC, upon request, copies of all documents, records and other information that is not confidential or privileged relevant to your request for benefits;
- Present your case to the review panel;
- Submit written comments, documents, records and other material relating to the request for benefits for consideration both before and during the review meeting;
- Ask questions of any of MIC's representatives of the review panel; and
- Be represented by an individual of your choice. Your right to a fair review will not be made conditional on your appearance at the review.

If you or your representative request the opportunity to appear in person before the review panel, the review panel will be scheduled and held within 45 calendar days of receiving your request for a voluntary review. You will be notified at least 15 working days in advance of the date of your review. You will also be notified in advance if an attorney will represent MIC and a statement that you may wish to obtain legal

representation on your own. If a face-to-face meeting is not practical due to geographic reasons, you have the option to communicate with the review panel via conference call at MIC's expense. If postponement is necessary, MIC will not unreasonably deny your request. The review panel will issue you or your representative, if applicable, a written decision within 5 working days of completing the review meeting.

If a request to appear in person before the review panel is not made within 5 working days of receiving MIC's notice, the review panel will issue you and your representative, if applicable, a written decision within 45 calendar days after the earlier of: (a) the date you or your representative notify MIC of your decision not to request the opportunity to appear in person before the review panel; or (b) the date on which you or your representative's opportunity to request to appear in person before the review panel expires.

The written decision will include items under *Written decision notification* along with a notice of your right to contact the South Dakota Division of Insurance.

The decision of the review panel is legally binding on MIC.

Written decision notification

A written decision will include the following:

- The titles and qualifying credentials of the reviewers participating in the review process;
- A statement of the reviewers' understanding of your grievance;
- The reviewers' decision in clear terms and the coverage basis in sufficient detail for you to respond further to MIC's position; and
- A reference to the evidence or documentation used as the basis for the decision.

Adverse determination notice

If MIC's determination is an adverse determination, the notification of this determination will include the following information:

1. The specific reason or reasons for the adverse determination.

2. A reference to the specific coverage provisions on which the determination is based.
3. A description of any additional material or information necessary for you to complete the request, including an explanation of why the material or information is necessary to complete the request.
4. A description of MIC's grievance procedures, including any time limits applicable to those procedures.
5. If applicable, a description of MIC's expedited review procedures.
6. If MIC relied upon internal rule, guideline, protocol, or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol, or other similar criteria or a statement that a specific rule, guideline, protocol, or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided to you free of charge upon request.
7. If the adverse determination is based on a medical necessity or experimental or investigation treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of your coverage to your medical circumstances or a statement that an explanation will be provided to you free of charge upon request;
8. If applicable, instruction for requesting:
   - A copy of the rule, guidelines, protocol, or other similar criterion relied upon making the adverse determination; or
   - The written statement of the scientific or clinical rational for the adverse determination; and
9. Notice of your right to contact the South Dakota Division of Insurance and notice of your right to file a civil action in a court of competent jurisdiction upon completion of MIC's grievance procedures.

DD. *General Provisions*

This section describes the general provisions of this Policy.

See *Definitions*. These words have specific meanings:

- Benefits
- Claim
- Dependent
- Member
- Network
- Premium
- Provider
- Subscriber

Examination of a member

To settle a dispute concerning provision or payment of benefits under this Policy, MIC may require that you be examined or an autopsy of the member's body be performed. 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 each subscriber.

Entire contract; changes

This Policy, the application, and any amendments are the entire contract between you and MIC, and replace all other agreements as of the effective date of this Policy.

MIC may change this Policy at Policy renewal, or at any time when required by federal or regulatory agencies. When this happens you will receive a new Policy or amendment. All amendments must be in writing. No other person or entity has authority to make any changes or waive any of its provisions.

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.

EE. *Definitions*

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

Term	Definition 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**.

Term	Definition Within each definition, you may note bold words. These words also are defined in this section.
	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 *Prescription Drugs And Pharmacy Services*, 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**.
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**.
Convenient/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.
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 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.
Dependent	Unless otherwise specified in this Policy:

Term	Definition Within each definition, you may note bold words. These words also are defined in this section.
	1. The **subscriber's** legally married spouse 2. An unmarried child of the **subscriber** who is a: a. Natural or adopted child b. Child **placed for adoption** with the **subscriber** c. Stepchild 3. An unmarried grandchild who is dependent upon and resides with the **subscriber** or **subscriber's** legally married spouse continuously from birth. In addition, a child under legal guardianship of the **subscriber** will be considered a **dependent**. However, the **subscriber** must provide satisfactory proof of dependency upon request by MIC. See *Extending a child's eligibility* in *Eligibility And Enrollment* for details regarding **dependent** limiting ages.
Emergency	A medical condition or symptom that a prudent layperson would reasonably believe to be an emergency medical condition that requires immediate treatment to: 1. Preserve your life; or 2. Prevent serious impairment to your bodily functions, organs, or parts; or 3. Prevent placing your physical or mental health in serious jeopardy.
Enrollment date	The date of the eligible employee's or **dependent's** first day of coverage under this Policy.
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.

Term	Definition Within each definition, you may note bold words. These words also are defined in this section.
Inpatient	A stay in a **hospital**, **skilled nursing facility** or licensed acute care facility. **Inpatient** services in a licensed residential treatment facility for treatment of emotionally handicapped 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.** Not withstanding 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 or life threatening condition 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 the following drug compendia: *The American Hospital Formulary Service Drug Information, DRUGDEX,* and the *United States Pharmacopoeia Dispensing Information*.

Term	Definition Within each definition, you may note bold words. These words also are defined in this section.
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.
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 of a **non-network provider's** charge that is eligible for benefits under the Policy. The **non-network provider reimbursement amount** is determined as follows: 1. For **emergency** services and services provided upon referral from a **network provider** (see the sections *Emergency Services From Non-Network Providers* and *Referrals To Non-Network Providers*): The **non-network provider's** charge.

Term	Definition Within each definition, you may note bold words. These words also are defined in this section.
	2. For prescription drugs and pharmacy services: 85% of the **non-network provider's** charge. 3. For all other services: The lesser of: a. the **non-network provider's** charge; or b. the fee maximum amount for the service as determined pursuant to MIC's fee schedule then in effect for the Medica Direct[SM] HSA for Individuals product. If the amount billed by the **non-network provider** is greater than the **non-network provider reimbursement amount**, *you must pay the difference*. Such difference is in addition to any **coinsurance** or **deductible** amount you may be responsible for according to the terms described in this Policy. In addition, such difference will not be applied to the out-of-pocket maximum described in *Your Out-of-Pocket Expenses*.
Physician	A Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Optometry (O.D.) or Doctor of Chiropractic (D.C.) practicing within the scope of his or her licensure.
Placed for adoption	The assumption and retention of the legal obligation for total or partial support of the child in anticipation of adopting such child. (Eligibility for a child **placed for adoption** with the **subscriber** ends if the placement is interrupted before legal adoption is finalized and the child is removed from placement.)
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 12 months immediately preceding your **enrollment date**. 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.

Term	Definition Within each definition, you may note bold words. These words also are defined in this section.
Prescription drug	A drug approved by the FDA for the prescribed use and route of administration. See also Investigative.
Provider	A health care professional or facility licensed, certified or otherwise qualified under state law to provide health services.
Qualifying coverage	Health coverage provided under one of the following plans: 1. A health plan in which a health carrier has issued a policy, contract or policy for the coverage of medical and **hospital** benefits, including blanket accident and sickness insurance other than accident only coverage; 2. Medicare or Medicaid 3. TRICARE or other similar coverage provided under federal law applicable to the armed forces; 4. A medical care program of the Indian Health Service or of a tribal organization; 5. A state health benefits risk pool; 6. The Federal Employees Health Benefits Plan or other similar coverage provided under federal law applicable to government organizations and employees; 7. A public health plan; 8. A health benefit plan under the Peace Corps Act; 9. A church plan; 10. A college plan; or 11. A short term or limited duration plan. Coverage of the following types, including any combination of the following types, are *not* **qualifying coverage**: 1. Coverage only for accident including accidental death and dismemberment; 2. Disability income insurance; 3. Liability insurance including general liability insurance and automobile liability;

Term	Definition Within each definition, you may note bold words. These words also are defined in this section.
	4. Coverage issued as a supplement to liability insurance; 5. Worker's compensation or similar insurance; 6. Automobile medical payment insurance; 7. Credit only insurance including mortgage insurance; 8. Coverage for on-site medical clinics; and 9. Limited scope dental and long-term care insurance, if provided under a separate policy, certificate, or contract of insurance, or not otherwise an integral part of a 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**.
Restorative	Surgery to rebuild or correct a physical defect that has a direct adverse effect on the physical health of a body part, and for which the restoration or correction is **medically necessary.**
Service Area	The geographic area in which MIC is approved to provide coverage for in-network benefits. You may contact Customer Service for a current description of the service area.
Skilled care	Nursing or rehabilitation services requiring the skills of technical or professional medical personnel to develop provide and evaluate your care and assess your changing condition. Long-term dependence on respiratory support equipment and/or the fact that services are received from technical or professional medical personnel do not by themselves define the need for **skilled care.**

Term	Definition Within each definition, you may note bold words. These words also are defined in this section.
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 (you)	The person: 1. On whose behalf **premium** is paid; 2. Who is enrolled under this Policy; and 3. To whom this Policy is issued.