

Medica Direct HSA for Individuals

*Minnesota
Policy of
Coverage*

MN-HSA-PC07-100-01

Medica Direct HSA for Individuals
\$4,600 Individual Deductible
\$8,150 Family Deductible
80% Coinsurance Plan
Plan Code IYI, IYK

Cancellation Within First Ten Days

The subscriber may cancel this Policy by delivering or mailing a written notice or sending a telegram to: **Medica Insurance Company, 401 Carlson Parkway, Attn: Customer Service, Route CP555, Minnetonka, MN 55305**. This Policy must be returned before midnight the tenth day after the date you receive this Policy. Notice given by mail and return of this Policy are effective when postmarked, properly addressed, and postage prepaid. MIC shall return all premiums within ten days after it receives notice of cancellation and the returned Policy. However, the subscriber must then pay any claims incurred prior to such cancellation.

MEDICA CUSTOMER SERVICE

- Minneapolis/St. Paul
Metro Area:
(952) 992-1805 or
- Outside the Metro Area:
1-866-894-8051

- TTY Minneapolis/St. Paul
Metro Area:
1-800-855-2880 or
- TTY Outside the Metro Area:
1-800-855-2880

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

Notice: This disclosure is required by Minnesota law. This Policy is expected to return on average 79.5% of your premium dollar for health care coverage.

The lowest percentage permitted by state law for this Policy is 72% of your premium dollar.

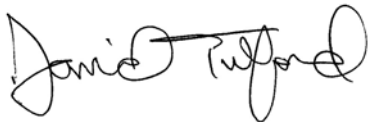
Important Consumer Information

Guarantee Renewal

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

Policy

This Policy is a legal contract between the subscriber and Medica Insurance Company (“MIC”) and describes the benefits covered under this Policy.



President



Senior Vice President and 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.

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.

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.

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

See **Definitions**. These words have specific meanings:

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

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

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

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

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 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.

Changes to this Policy

MIC may change this Policy at Policy renewal, or at any time when required by federal or state regulatory agencies. When this happens, you will receive a new Policy or amendment.

MIC may change the benefits, as described above, or MIC may change the premium with 30 days written notice.

Entire Agreement

The documents below are the entire Policy between you and MIC, and replace all other agreements as of the effective date of this Policy.

1. This Policy and any amendments.
2. The Medica Direct HSA for Individuals Application form.

Acceptance of coverage

By accepting the health care coverage described in this Policy, the subscriber, on behalf of yourself if covered under this Policy, and/or on behalf of the dependents enrolled under this Policy, authorizes the use of a social security number for purpose of identification, and declares that the information supplied by you to MIC for purposes of enrollment is accurate and complete.

The subscriber understands and agrees 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 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 Minnesota's Commissioner of Commerce to file a complaint about issues related to benefits (see *Complaints*). 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 Minnesota Department of Commerce call (651) 296-2488 or 1-800-657-3602 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:

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

Member Rights And Responsibilities

- a. Information about lifestyle practices; and
- 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 the required procedures found in Section U. This Policy explains these procedures and the

See *Definitions*. These words have specific meanings:

- Benefits
- Claim
- Coinsurance
- Copayment
- 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

covered health services associated with emergency care.

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.

Mental health and Substance abuse

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

Note: Mental health benefits are included under this Policy only if the Mental Health Coverage option was elected at the time of initial application (for an additional cost). This election may be made only at the time of initial application.

Except for emergencies:

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

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

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

Benefits

MIC pays out-of-network benefits for eligible health services received from non-network providers. Prior authorization may be required from MIC 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.

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

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 copayment, 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

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.

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**

The covered subscriber's dependent newborn is covered from birth. 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 the covered subscriber notifies 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*.

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

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 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, someone on your behalf or your attending provider must call MIC.

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

- Reconstructive or restorative surgery;
- Temporomandibular joint disorder or craniomandibular disorder;
- 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, someone on your behalf or your attending provider calls, the following information may be required:

- Name and telephone number of the provider who is making the request;
- Name, telephone number, address and type of specialty of the provider to whom you are being referred, if applicable;
- Services being requested and the date those services are to be rendered (if scheduled);

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.

- Specific information related to your condition (for example, a letter of medical necessity from your provider);
- Other applicable member information (i.e., MIC member number).

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

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 review is warranted, or MIC concludes that a delay could seriously jeopardize your life, health, or ability to regain maximum function.

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

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 18 months following your enrollment date.

However, if you have maintained continuous coverage, the pre-existing condition limitation applies during the first 12 months following your enrollment date. In addition, 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

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

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.

determination of your prior qualifying coverage was inaccurate. If this occurs, MIC will notify you of the correct pre-existing condition limitation period.

When a pre-existing condition limitation does not apply

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

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

- a. The subscriber's newborn child, the subscriber's adopted child, a child placed for adoption with the subscriber, the subscriber's disabled dependent, or any child who is a member pursuant to a qualified medical child support order (QMCSO), provided these dependents are enrolled under the Policy as described in *Eligibility And Enrollment*;
- b. A dependent child who (i) is covered under prior qualifying coverage as of the last day of the 30-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
- c. 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 copayment, coinsurance or deductible, is considered to be payment in full.

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

See *Definitions*. These words have specific meanings:

- Coinsurance
- Copayment
- 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.

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

Expenses you must pay

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

1. Any applicable copayment, coinsurance or deductible as described in this Policy.

You must pay an annual deductible. (See the Out-of-Pocket Expenses table in this section.)

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

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***

See **Definitions**. These words have specific meanings:

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

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

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).

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 copayments, coinsurance and your deductible.

Out-of-pocket maximum

The out-of-pocket maximum is an accumulation of in-network and out-of-network copayments, coinsurance and your deductible only. Unless otherwise specified, you will *not* be required to pay more than the out-of-pocket maximum of copayments, 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 copayments, coinsurance and deductible 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

Copayment or Coinsurance	See specific benefit for applicable copayment or coinsurance
Calendar Year Deductible	Deductible is subject to a “cost of living” increase on a yearly basis. This “cost of living” increase is tied to the Consumer Price Index (CPI). You will receive a notice of change 30 days in advance. 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	\$4,600 Applies to your combined in-network and out-of-network benefits.
Family Coverage	\$8,150 Applies to your combined in-network and out-of-network benefits.
Calendar year Out-of-pocket maximum (for copayments, coinsurance and deductible combined)	
Individual Coverage	\$5,900 Applies to your combined in-network and out-of-network benefits. The Out-of-Pocket maximum will be subject to the “cost of living” increase.
Family Coverage	\$9,450 Applies to your combined in-network and out-of-network benefits. The Out-of-Pocket maximum will be subject to the “cost of living” 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:
 1. Professional services received from a network provider;
 2. Professional services for testing and treatment of a sexually transmitted disease and testing for AIDS and other HIV-related conditions received from a network provider or a non-network provider;
 3. Family planning services, for the voluntary planning of the conception and bearing of children, received from a network provider or a non-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.

See **Definitions**. These words have specific meanings:

- Benefits
- Coinsurance
- Convenient/urgent care center
- Deductible
- Emergency
- Hospital
- Inpatient
- Member
- Network
- Non-network
- Non-network provider reimbursement amount
- Physician
- Prenatal care
- Provider

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 substance abuse services, except as described in *Mental Health* and *Substance Abuse*.

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

Your Benefits and the Amounts You Pay

Benefits (after \$4,600 individual coverage deductible, or \$8,150 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 <i>Emergency Services From Non-Network Providers</i> . 20% coinsurance for non-emergency services received from non-network providers
3. Maternity care		
a. Prenatal care services received from a physician during an office visit, an outpatient hospital visit, or an inpatient stay	Nothing. The deductible does not apply.	Nothing. The deductible does not apply.
b. Services received for labor and delivery	No coverage during the first 12 months following your enrollment date. Thereafter, 20% coinsurance	No coverage during the first 12 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.)		

Your Benefits and the Amounts You Pay

Benefits (after \$4,600 individual coverage deductible, or \$8,150 family coverage deductible)	In-network benefits You pay	Out-of-network benefits You pay
a. Health education and health supervision services provided during an office visit (including evaluation and follow-up)	20% coinsurance	20% coinsurance
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: <ul style="list-style-type: none"> • 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 	Nothing. The deductible does not apply.	Nothing. The deductible does not apply.
c. Immunizations for a dependent child from birth to age 18	Nothing. The deductible does not apply.	Nothing. The deductible does not apply.
d. Early disease detection services including physicals.	20% coinsurance	20% coinsurance
5. Routine screening procedures for cancer	20% coinsurance	20% coinsurance
6. Allergy shot	20% coinsurance	20% coinsurance
7. Refractive eye exams	20% coinsurance	20% coinsurance

Your Benefits and the Amounts You Pay

Benefits (after \$4,600 individual coverage deductible, or \$8,150 family coverage deductible)	In-network benefits You pay	Out-of-network benefits You pay
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
9. Professional sign language interpreter services in a physician's office (Call Customer Service to arrange such services.)	20% coinsurance	20% coinsurance
10. Surgical services (as defined in the Physicians' Current Procedural Terminology code book) received from a physician during an office visit or an outpatient hospital or ambulatory surgical center visit	20% coinsurance	20% coinsurance
11. Services received from a physician during an emergency room visit	20% coinsurance	For emergency services from non-network providers, see <i>Emergency Services From Non-Network Providers</i> . 20% coinsurance for non-emergency services provided in a non-network hospital emergency room.
12. Services received from a physician during an inpatient stay	20% coinsurance	20% coinsurance
13. Outpatient lab, pathology and x-rays	20% coinsurance	20% coinsurance
14. Other outpatient hospital or ambulatory surgical center services received from a physician	20% coinsurance	20% coinsurance

Your Benefits and the Amounts You Pay

Benefits (after \$4,600 individual coverage deductible, or \$8,150 family coverage deductible)	In-network benefits You pay	Out-of-network benefits You pay
15. Treatment to lighten or remove the coloration of a port wine stain	20% coinsurance	20% coinsurance
16. 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
17. 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 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, ostomy supplies and smoking cessation products.

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

Only prescription 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'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
- Copayment
- Deductible
- Emergency
- Hospital
- 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 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 products and submit a paper claim with supporting documentation.

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 prescribed by a provider authorized to prescribe the prescription drug and received at a network pharmacy or from the designated mail order drug program; and
 2. Prescription drugs for family planning services or the treatment of sexually transmitted diseases when prescribed by or received from either a network or a non-network provider or received from the designated mail order drug program; and
 3. 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
 4. 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).

5. 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 prescribed by a provider authorized to prescribe the prescription 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 copayment or 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 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, 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.

Using his or her professional judgment, your pharmacist may determine that prescription drugs prescribed to treat certain chronic conditions may be dispensed in up to three prescription units at once.

If multiple prescription units are dispensed, copayments and coinsurance will apply separately to each unit.

Prescription Drugs And Pharmacy Services

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:

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. Prescription drugs and supplies that are not prescribed by a provider acting within their scope of licensure.

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

Prescription Drugs And Pharmacy Services

7. Prescription drugs for the treatment of infertility.
8. Prescription drugs and supplies not on MIC's formulary, unless MIC has authorized an exception.
9. Vitamin therapy or dietary supplements.

Your Benefits and the Amounts You Pay

Benefits (after \$4,600 individual coverage deductible, or \$8,150 family coverage deductible)	In-network benefits You pay	Out-of network benefits You pay
1. Outpatient prescription drugs other than those described below	<p>The amount you pay per prescription unit or refill is based on cost as follows:</p> <p style="padding-left: 20px;">Less than \$15 – you pay the cost</p> <p style="padding-left: 20px;">\$15 to \$75 – you pay a \$15 copayment</p> <p style="padding-left: 20px;">More than \$75 – you pay 20% coinsurance</p>	<p>The amount you pay per prescription unit or refill is based on cost as follows:</p> <p style="padding-left: 20px;">Less than \$15 – you pay the cost</p> <p style="padding-left: 20px;">\$15 to \$75 – you pay a \$15 copayment</p> <p style="padding-left: 20px;">More than \$75 – you pay 20% coinsurance</p>
2. Up to a 24-hour supply of emergency prescription drugs received from a hospital or convenient/urgent care center	<p>The amount you pay per prescription unit or refill is based on cost as follows:</p> <p style="padding-left: 20px;">Less than \$15 – you pay the cost</p> <p style="padding-left: 20px;">\$15 to \$75 – you pay a \$15 copayment</p> <p style="padding-left: 20px;">More than \$75 – you pay 20% coinsurance</p>	<p>The amount you pay per prescription unit or refill is based on cost as follows:</p> <p style="padding-left: 20px;">Less than \$15 – you pay the cost</p> <p style="padding-left: 20px;">\$15 to \$75 – you pay a \$15 copayment</p> <p style="padding-left: 20px;">More than \$75 – you pay 20% coinsurance</p>

Prescription Drugs And Pharmacy Services

Your Benefits and the Amounts You Pay

Benefits (after \$4,600 individual coverage deductible, or \$8,150 family coverage deductible)	In-network benefits You pay	Out-of network benefits You pay
3. Diabetic supplies and equipment	<p>The amount you pay per prescription unit or refill is based on cost as follows:</p> <p>Less than \$15 – you pay the cost</p> <p>\$15 to \$75 – you pay a \$15 copayment</p> <p>More than \$75 – you pay 20% coinsurance</p>	<p>The amount you pay per prescription unit or refill is based on cost as follows:</p> <p>Less than \$15 – you pay the cost</p> <p>\$15 to \$75 – you pay a \$15 copayment</p> <p>More than \$75 – you pay 20% coinsurance</p>
4. Eligible ostomy supplies	<p>The amount you pay per prescription unit or refill is based on cost as follows:</p> <p>Less than \$15 – you pay the cost</p> <p>\$15 to \$75 – you pay a \$15 copayment</p> <p>More than \$75 – you pay 20% coinsurance</p>	<p>The amount you pay per prescription unit or refill is based on cost as follows:</p> <p>Less than \$15 – you pay the cost</p> <p>\$15 to \$75 – you pay a \$15 copayment</p> <p>More than \$75 – you pay 20% coinsurance</p>

Prescription Drugs And Pharmacy Services

Your Benefits and the Amounts You Pay

Benefits (after \$4,600 individual coverage deductible, or \$8,150 family coverage deductible)	In-network benefits You pay	Out-of network benefits You pay
<p>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.</p>	<p>The amount you pay per prescription unit or refill is based on cost as follows:</p> <p style="padding-left: 20px;">Less than \$15 – you pay the cost</p> <p style="padding-left: 20px;">\$15 to \$75 – you pay a \$15 copayment</p> <p style="padding-left: 20px;">More than \$75 – you pay 20% coinsurance</p> <p>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.</p>	<p>The amount you pay per prescription unit or refill is based on cost as follows:</p> <p style="padding-left: 20px;">Less than \$15 – you pay the cost</p> <p style="padding-left: 20px;">\$15 to \$75 – you pay a \$15 copayment</p> <p style="padding-left: 20px;">More than \$75 – you pay 20% coinsurance</p> <p>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.</p>

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 12 months following your enrollment date, maternity care (other than prenatal care services) 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).

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.

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
- Prenatal care
- Provider

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 \$4,600 individual coverage deductible, or \$8,150 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 <i>Emergency Services From Non-Network Providers</i> . 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 labor and delivery services	No coverage during the first 12 months following your enrollment date. Thereafter, 20% coinsurance.	No coverage during the first 12 months following your enrollment date. Thereafter, 20% coinsurance.
d. Prenatal care services	Nothing. The deductible does not apply.	Nothing. The deductible does not apply.
e. Other outpatient services	20% coinsurance	20% coinsurance
f. 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 \$4,600 individual coverage deductible, or \$8,150 family coverage deductible)	In-network benefits You Pay	Out-of-network benefits You pay
<p>3. Inpatient services, including semi-private room and board in a hospital and services received from a physician during an inpatient stay:</p> <p>A private room is covered only for conditions of preeclampsia, radium implants, contagion or immunosuppression that require isolation</p>		
<p>a. Inpatient services other than for maternity care</p>	20% coinsurance	20% coinsurance
<p>b. Inpatient service for maternity care:</p>		
<p>i. For inpatient services related to prenatal care services that do not result in a delivery</p>	Nothing. The deductible does not apply.	Nothing. The deductible does not apply.
<p>ii. For all other inpatient maternity care services</p>	No coverage during the first 12 months following your enrollment date. Thereafter, 20% coinsurance.	No coverage during the first 12 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 \$4,600 individual coverage deductible, or \$8,150 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	<i>See Emergency Services From Non-Network Providers.</i>
2. Non-emergency licensed ambulance service that is arranged through an attending physician, as follows:		
a. Transportation from hospital to hospital when:	20% coinsurance	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.

- *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
- Prenatal care
- Provider
- Skilled care
- Skilled nursing facility

Not covered

These services, supplies and associated expenses are not covered:

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

Your Benefits and the Amounts You Pay

Benefits (after \$4,600 individual coverage deductible, or \$8,150 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.	20% coinsurance except you pay nothing for high-risk prenatal care services. For high-risk prenatal care services, the deductible does not apply.	20% coinsurance except you pay nothing for high-risk prenatal care services. For high-risk prenatal care services, the deductible does not apply.

Your Benefits and the Amounts You Pay

Benefits (after \$4,600 individual coverage deductible, or \$8,150 family coverage deductible)	In-network benefits You pay	Out-of-network benefits You pay
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.	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.	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.

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 \$4,600 individual coverage deductible, or \$8,150 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
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

Important: Mental health benefits are included under this Policy only if the Mental Health Coverage option was elected at the time of initial application (for an additional cost). This election may be made only at the time of initial application.

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

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.)

Prior authorization.

For prior authorization of *in-network benefits*, call MIC's designated mental health and substance abuse 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
- Mental disorder
- Network
- Non-network
- Physician
- Provider

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

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

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.

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:
 - a. Licensed psychiatrist
 - b. Licensed consulting psychologist
 - c. Licensed psychologist
 - d. Certified clinical nurse specialist in psychiatric and mental health nursing
 - e. Licensed mental health clinic.
 - f. Licensed residential treatment center
 - g. Licensed independent clinical social worker
 - h. Licensed marriage and family therapists
 - i. A hospital that provides mental health services

Not covered

These services, supplies and associated expenses are not covered:

1. Services for mental disorders not listed in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders*.
2. Services from a network provider for a condition that cannot be improved with treatment.
3. Services, care or treatment that is not medically necessary, unless ordered by a court as specifically described in this section.
4. Relationship counseling 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 substance abuse providers who are not certified, such as services received at a halfway house or therapeutic

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

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 \$4,600 individual coverage deductible, or \$8,150 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
d. Partial program	20% coinsurance	20% coinsurance

L. Substance Abuse

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

For purposes of this section:

1. Outpatient services include:
 - a. Evaluations, diagnostic services and primary treatment.
 - b. 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 programs such as day treatment or intensive outpatient programs with lodging).
 - c. Services, care or treatment for a member that has been placed in the Minnesota Department of Corrections' custody following a conviction for a first-degree driving while impaired offense; to be eligible, such services, care or treatment must be required and provided by the Minnesota Department of Corrections.
 - d. Services, care or treatment ordered by a court on the basis of a behavioral health care evaluation performed by a physician, licensed psychologist, licensed alcohol and drug dependency counselor or a certified chemical dependency assessor and that includes an individual treatment plan.
2. Inpatient services include:
 - a. Semi-private room and board.
 - b. Attending physician services.
 - c. Hospital or facility-based professional services.
 - d. Services, care or treatment for a member that has been placed in the Minnesota Department of Corrections' custody following a conviction for a first-degree driving while impaired offense; to be eligible, such services, care or treatment must be required and provided by the Minnesota Department of Corrections. (Refer to numbers 2a, b and c in the table in this section to determine your benefits.)

Prior authorization.

For prior authorization of *in-network benefits*, call MIC's designated mental health and substance abuse 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
- Mental disorder
- Network
- Non-network
- Physician
- Provider

- e. 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.) (Refer to numbers 2a, b and c 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.)
- g. Services, care or treatment ordered by a court on the basis of a behavioral health care evaluation performed by a physician, licensed psychologist, licensed alcohol and drug dependency counselor or a certified chemical dependency assessor and that includes an individual treatment plan. (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 mental health and substance abuse provider arranges in-network substance abuse benefits. MIC's designated mental health and substance abuse provider will refer you to other substance abuse providers only if network providers cannot provide the services you require. If you require hospitalization, MIC's designated mental health and substance abuse provider will refer you to one of its hospital providers (MIC and MIC's designated mental health and substance abuse provider hospital networks are different).
 2. In-network benefits will apply to services, care or treatment for a member that has been placed in the Minnesota Department of Corrections' custody following a conviction for a first-degree driving while impaired offense. To be eligible, such services, care or treatment must be required and provided by the Minnesota Department of Corrections.

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

3. Notify MIC's designated mental health and substance abuse provider as soon as reasonably possible after receiving any emergency substance abuse inpatient services. Call MIC's designated mental health and substance abuse provider at 1-800-848-8327 or TTY: 1-800-543-7162.
 4. Second opinions from a qualified provider are covered under in-network benefits only if MIC's designated mental health and substance abuse provider determines that no treatment is necessary. You must receive your second opinion within 30 calendar days of MIC's designated mental health and substance abuse provider's first evaluation. MIC's designated mental health and substance abuse provider will consider the second opinion but is not required to accept it.
- For *out-of-network benefits*:
 1. Substance abuse services from a non-network provider listed below will be eligible for coverage under out-of-network benefits. Emergency substance abuse 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:
 - 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 substance abuse services

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 substance abuse disorders not listed in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders*.
2. Services from a network provider for a condition that cannot be improved with treatment.
3. Services, care or treatment that is not medically necessary, unless ordered by a court as specifically described in this section.
4. Services to hold or confine a person under chemical influence when no medical services are required, regardless of where the services are received.
5. Services beyond the primary treatment of substance abuse.
6. Methadone, Suboxone, Subutex or Cyclazocine maintenance or their equivalents.
7. Telephone consultations.
8. Services, including room and board charges, provided by providers who are not licensed to practice independently or substance abuse providers who are not certified, such as services received at a halfway house or therapeutic group home, except for outpatient substance abuse services that are specifically described in this section.
9. Services to assist in activities of daily living that do not seek to cure and are performed regularly as a part of a routine or schedule.

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

Your Benefits and the Amounts You Pay

Benefits (after \$4,600 individual coverage deductible, or \$8,150 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 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.

Durable Medical Equipment And Prosthetics

Not covered

These services, supplies and associated expenses are not covered:

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

Your Benefits and the Amounts You Pay

Benefits (after \$4,600 individual coverage deductible, or \$8,150 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
c. Scalp hair prostheses due to alopecia areata	20% coinsurance	20% coinsurance
	MIC pays up to \$350. This is calculated each calendar year.	MIC pays up to \$350. This is calculated each calendar year.

Durable Medical Equipment And Prosthetics

Your Benefits and the Amounts You Pay

Benefits (after \$4,600 individual coverage deductible, or \$8,150 family coverage deductible)	In-network benefits You pay	Out-of-network benefits You pay
d. Repair, replacement or revision of artificial limbs, eyes and breast prostheses made necessary by normal wear and use	20% coinsurance	20% coinsurance
4. Hearing aids for members under age 19 for hearing loss that is not correctable by other covered procedures. Coverage is limited to one hearing aid every three years.	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.

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

Not covered

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

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

Miscellaneous Medical Supplies

Your Benefits and the Amounts You Pay

Benefits (after \$4,600 individual coverage deductible, or \$8,150 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. Amino acid-based elemental oral formulas for the following diagnoses:	20% coinsurance	20% coinsurance
a. Cystic fibrosis;		
b. amino acid, organic acid, and fatty acid metabolic and malabsorption disorders;		
c. IgE mediated allergies to food proteins;		
d. food protein-induced enterocolitis syndrome;		
e. eosinophilic esophagitis;		
f. eosinophilic gastroenteritis; and		
g. eosinophilic colitis.		
Coverage for the diagnoses in 3.c.-3.g. above is limited to members five years of age and younger.		
4. 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.

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

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.

Organ And Bone Marrow Transplant Services

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

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

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

Organ And Bone Marrow Transplant Services

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 \$4,600 individual coverage deductible, or \$8,150 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 <i>Physicians' Current Procedural Terminology</i> 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
ii. Other outpatient hospital services	20% coinsurance	No coverage
3. Inpatient services	20% coinsurance	No coverage

Organ And Bone Marrow Transplant Services

Your Benefits and the Amounts You Pay

Benefits (after \$4,600 individual coverage deductible, or \$8,150 family coverage deductible)	In-network benefits You pay	Out-of-network benefits You pay
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

Reconstructive And Restorative Surgery

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.

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

Your Benefits and the Amounts You Pay

Benefits (after \$4,600 individual coverage deductible, or \$8,150 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 <i>Physicians' Current Procedural Terminology</i> code book) received from a physician during an office visit or an outpatient hospital or ambulatory surgical center visit	20% coinsurance	20% coinsurance
ii. Outpatient lab, pathology and x-rays	20% coinsurance	20% coinsurance

Reconstructive And Restorative Surgery

Your Benefits and the Amounts You Pay

Benefits (after \$4,600 individual coverage deductible, or \$8,150 family coverage deductible)	In-network benefits You pay	Out-of-network benefits You pay
<ul style="list-style-type: none"> iii. Other outpatient hospital or ambulatory surgical center services received from a physician 	20% coinsurance	20% coinsurance
<ul style="list-style-type: none"> b. Hospital and ambulatory surgical center services <ul style="list-style-type: none"> i. Outpatient lab, pathology and x-rays 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).

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.

Skilled Nursing Facility Services

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.
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 \$4,600 individual coverage deductible, or \$8,150 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

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.

not later than two days after the hospice care is initiated.

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

Not covered

These services, supplies and associated expenses are not covered:

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

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

Your Benefits and the Amounts You Pay

Benefits (after \$4,600 individual coverage deductible, or \$8,150 family coverage deductible)	In-network benefits You Pay	Out-of-network benefits You Pay
1. Hospice services	20% coinsurance	No coverage

S. Temporomandibular Joint (TMJ) Disorder

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

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

Covered

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

- *In-network benefits* apply to TMJ services received from a network provider.
- *Out-of-network benefits* apply to TMJ services received from a non-network provider. 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
- Hospital
- Inpatient
- Member
- Network
- Non-network
- Non-network provider reimbursement amount
- Physician
- Provider

TMJ disorder is covered the same as any other joint disorder under this Policy.

Temporomandibular Joint (TMJ) Disorder

Not covered

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

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

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

Your Expenses and the Amounts You Pay

Benefits (after \$4,600 individual coverage deductible, or \$8,150 family coverage deductible)	In-network benefits You Pay	Out-of-network benefits You Pay
1. Initial office visit for evaluation	20% coinsurance	20% coinsurance
2. Office visits (including further evaluations)	20% coinsurance	20% coinsurance
3. Outpatient services		
a. Professional services		
i. Surgical services (as defined in the <i>Physicians' Current Procedural Terminology</i> code book) received from a physician or dentist during an office visit or an outpatient hospital or ambulatory surgical center visit	20% coinsurance	20% coinsurance
ii. Outpatient lab, pathology and x-rays	20% coinsurance	20% coinsurance
iii. Other outpatient hospital and ambulatory surgical center services received from a physician or dentist	20% coinsurance	20% coinsurance
b. Hospital and ambulatory surgical center services		
i. Outpatient lab, pathology and x-rays	20% coinsurance	20% coinsurance

Temporomandibular Joint (TMJ) Disorder

Your Expenses and the Amounts You Pay

Benefits (after \$4,600 individual coverage deductible, or \$8,150 family coverage deductible)	In-network benefits You Pay	Out-of-network benefits You Pay
ii. Other outpatient hospital and ambulatory surgical center services	20% coinsurance	20% coinsurance
4. Physical therapy received outside of your home	20% coinsurance	20% coinsurance
5. Inpatient services	20% coinsurance	20% coinsurance
6. Services received from a physician or dentist during an inpatient stay	20% coinsurance	20% coinsurance
7. TMJ splints and adjustments if your primary diagnosis is joint disorder	20% coinsurance	20% coinsurance

T. 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.

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.

Medical-Related Dental Services

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.

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

Your Benefits and the Amounts You Pay

Benefits (after \$4,600 individual coverage deductible, or \$8,150 family coverage deductible)	In-network benefits You pay	Out-of- network benefits You pay
<ol style="list-style-type: none"> 1. Charges for medical facilities and general anesthesia services that are: <ol style="list-style-type: none"> a. Recommended by a network physician; and b. Received during a dental procedure; and c. Provided to a member who: 	20% coinsurance	20% coinsurance

Your Benefits and the Amounts You Pay

Benefits (after \$4,600 individual coverage deductible, or \$8,150 family coverage deductible)	In-network benefits You pay	Out-of- network benefits You pay
<ul style="list-style-type: none"> i. Is a child under age five (prior authorization is <i>not</i> required); or ii. Is severely disabled; or iii. Has a medical condition and requires hospitalization or general anesthesia for dental care treatment. <p>Please note. Age, anxiety and behavioral conditions are not considered medical conditions.</p>		
<p>2. For a dependent child, orthodontia related to cleft lip and palate</p> <p>Please note. For a dependent child, benefits for oral surgery treatment for cleft lip and palate are covered in <i>Professional Services</i> and <i>Hospital Services</i>.</p>	20% coinsurance	20% coinsurance
<p>3. Oral surgery for:</p> <ul style="list-style-type: none"> a. Partially or completely unerupted impacted teeth; 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. 	20% coinsurance	20% coinsurance

U. 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 an emergency and:

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

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

For emergency mental health or substance abuse inpatient services, you must notify MIC's designated mental health and substance abuse provider as soon as reasonably possible. MIC's designated mental health and substance abuse provider can be reached at:

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

Note: Mental health benefits are included under this Policy only if the Mental Health Coverage option was elected at the time of initial application (for an additional cost). This election may be made only at the time of initial application.

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

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

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

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

Your Benefits and the Amounts You Pay

Benefits

(after \$4,600 individual coverage deductible, or \$8,150 family coverage deductible)

In-network benefits

You pay

- | | |
|---|-----------------|
| 1. Emergency services that are:

a. Administered under the direction of a physician; <i>and</i>

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 |

V. 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.
3. Provide coverage for health services that are:

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.

-
- 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.

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

W. 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.

X. 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. However, hearing aids for members under age 19 are covered as stated in *Durable Medical Equipment And Prosthetics*.
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, except as described in General Provisions.

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.

10. Enteral feedings (unless they are the sole source of nutrition) except for the dietary medical treatment of PKU.
11. Nutritional and electrolyte substances, except as Specifically described in Miscellaneous Medical Services and Supplies.
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.
23. Services for which coverage is available 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 Minnesota 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.
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 to treat nicotine addiction except as stated in *Prescription Drugs And Pharmacy Services*.
44. Elective, induced abortions, except as *medically necessary* to protect the life or health of the mother.
45. Implants for the purpose of contraception.
46. Therapeutic acupuncture.
47. Services billed by an acupuncturist.
48. Visual therapy.
49. Growth hormone
50. Infertility services and services and drugs for or related to assisted reproductive technology (ART).
51. Mental health services (except as described in *Prescription Drugs And Pharmacy Services*), unless the Mental Health Coverage option was elected (for an additional cost).

52. Services to treat a pre-existing condition as described in *How To Access Your Benefits*.
53. Maternity care services, other than prenatal care, during the first 12 months following your enrollment date.
54. Services and supplies to the extent they are paid or payable under Medicare.
55. 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.)
56. 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 requirement of such coverage.
57. Services for private-duty nursing.
58. Functional capacity evaluations and related services for vocational purposes or for determination of disability or pension benefits.
59. 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*).
60. Services for systemic candidiasis, homeopathy and immunoaugmentive therapy.
61. Services for or in connection with fetal tissue transplantation.
62. Services which are not within the scope of licensure or certification of the provider.
63. Charges for services by a non-network provider in excess of the non-network provider reimbursement amount.
64. Non-emergency transportation.

65. Non-emergency services received outside the United States.
66. Preventive health care , except as stated in *Professional Services*.

Y. How To Submit A Claim

This section describes the process for submitting a claim.

Claims for benefits from network providers

If you receive a bill for any benefit from a network provider, call Customer Service at one of the telephone numbers listed inside the front cover.

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

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

See *Definitions*. These words have specific meanings:

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

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.

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

decision within 15 days of receiving the additional information. If you do not respond to MIC's request within 45 days, your claim may be denied.

Claims for emergency services provided outside the United States

Claims for emergency services rendered in a foreign country will require the following additional documentation:

- Claims submitted in English with the currency exchange rate for the date health services were received.
- Itemization of the bill or claim.
- The related medical records (submitted in English).
- Proof of your payment of the claim.
- A complete copy of your passport and airline ticket.
- Such other documentation as MIC may request.

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

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

Time limits

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

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

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.

Z. Coordination Of Benefits

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

1. **Applicability**

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

See *Definitions*. These words have specific meanings:

- Benefits
- Claim
- Deductible
- Dependent
- Hospital
- Emergency
- Medically necessary
- Member
- Non-network
- Non-network provider reimbursement amount
- Provider
- Subscriber

2. **Definitions that apply to this section**

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

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

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

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

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

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

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

The difference between the cost of a private hospital room and the cost of a semiprivate hospital room is not considered an allowable expense under the above definition unless the patient's stay in a private hospital room is medically necessary, either in terms of generally accepted medical practice or as specifically defined in the plan.

The difference between the charges billed by a provider and the non-network provider reimbursement amount is not considered an allowable expense under the above definition.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid.

When benefits are reduced under a primary plan because a covered person does not comply with the plan provisions, the amount of such reduction will not be considered an allowable expense. Examples of such provisions are those related to second surgical opinions, and preferred provider arrangements.

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

3. **Order of benefit determination rules**

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

the parent whose birthday falls later in that year; but

- b) If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

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

- iv. *Dependent child/separated or divorced parents.* If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

- a. First, the plan of the parent with custody of the child;
- b. Then, the plan of the spouse of the parent with the custody of the child; and
- c. Finally, the plan of the parent not having custody of the child.

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

- v. *Joint custody.* If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering follow the *Order of benefit*

determination rules outlined in paragraph b(ii).

- vi. *Active/inactive employee.* The benefits of a plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- vii. *Workers' compensation.* Coverage under any workers' compensation act or similar law applies first. You should submit claims for expenses incurred as a result of an on-duty injury to the employer, before submitting them to MIC.
- viii. *No-fault automobile insurance.* Coverage under the No-Fault Automobile Insurance Act or similar law applies first.
- ix. *Longer/shorter length of coverage.* If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member, or subscriber longer are determined before those of the plan which covered that person for the shorter term.

4. ***Effect on the benefits of this plan***

- a. *When this section applies.* This number 4 applies when, in accordance with number 3 *Order of benefit determination rules*, this plan is a secondary plan as to one or more other plans. In that event, the benefits of this plan may be reduced under this section. Such other plan or plans are referred to as *the other plans* in b. immediately below.
- b. *Reduction in this plan's benefits.* The benefits of this plan will be reduced when the sum of:
 - i. The benefits that would be payable for the allowable expense under this plan in the absence of this COB provision; and
 - ii. The benefits that would be payable for the allowable expenses under the other

plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those allowable expenses in a claim determination period. In that case, the benefits of this plan will be reduced so that they and the benefits payable under the other plans do not total more than those allowable expenses.

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

When this plan is a secondary plan, this plan will pay the balance of any remaining expenses determined to be eligible under this Policy, according to the out-of-network benefits described in this Policy. Most out-of-network benefits are covered at 80% of the non-network provider reimbursement amount, after you pay the applicable deductible amount. In no event will this plan provide duplicate coverage.

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

5. *Right to receive and release needed information*

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

6. *Facility of payment*

A payment made under another plan may include an amount, which should have been paid under this plan. If it does, MIC may pay that amount to the organization which made that payment. That

amount will then be treated as though it were a benefit paid under this plan. MIC will not have to pay that amount again. The term *payment made* includes providing benefits in the form of services, in which case *payment made* means reasonable cash value of the benefits provided in the form of services.

7. ***Right of recovery***

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

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

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

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

AA. *Right Of Recovery*

This section describes MIC's right of recovery. MIC's rights are subject to Minnesota 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 only after you have received a full recovery for your illness or injury from another source of compensation for your illness or injury.
2. MIC's subrogation interest is the reasonable cash value of any benefits received by you.
3. MIC's right to recover its subrogation interest may be subject to an obligation by MIC to pay a pro rata share of your disbursements, attorney fees and costs, and other expenses incurred in obtaining a recovery from another source unless MIC is separately represented by an attorney. If MIC is represented by an attorney, an agreement regarding allocation may be reached. If an agreement cannot be reached, the matter must be submitted to binding arbitration.
4. By accepting coverage under this Policy, you agree:
 - a. To cooperate with MIC or its designee to help protect MIC's legal rights under this subrogation provision and to provide all information MIC may reasonably request to determine its rights under this provision.
 - b. To provide prompt written notice to MIC when you make a claim against a party for injuries.
 - c. To provide prompt written notice of MIC's subrogation rights to any party against whom you assert a claim for injuries.
 - d. To do nothing to decrease MIC's rights under this provision, either before or after receiving benefits, or under this Policy.

See *Definitions*. These words have specific meanings:

- Benefits
- Claim

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

- e. MIC may take action to preserve its legal rights. This includes bringing suit in your name.
- f. MIC may collect its subrogation interest from the proceeds of any settlement or judgment recovered by you, your legal representative or the legal representative(s) of your estate or next-of-kin.
- g. To hold in trust the proceeds of any settlement or judgment for MIC's benefit under this provision.

BB. 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.

Subscriber eligibility.

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

1. be a Minnesota resident; 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. be a Minnesota resident; and
2. for a dependent child, be under the age of 25 (see “Extending a child’s eligibility” below); and
3. provide MIC certain information regarding the dependent’s health status; and
4. be accepted by MIC for enrollment.

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 25. However, the child’s eligibility continues in either of the following situations:

- *Disabled dependent.* The child is incapable of self-sustaining employment by reason of developmental disability, mental illness, mental

See *Definitions*. These words have specific meanings:

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

An illness will not be considered a physical disability.

disorder or physical disability and is chiefly dependent upon the subscriber for support and maintenance. To continue coverage for a disabled dependent, you must provide MIC with proof of such disability and dependency within 31 days of the child reaching the dependent limiting age of 25. Beginning two years after the child reaches the dependent limiting age of 25, MIC will require annual proof of disability and dependency. Your disabled dependent is covered under this Policy regardless of age and without application of health screening or pre-existing condition limitations.

Notification

The subscriber must notify MIC in writing within 30 days of the effective date of any changes to address or name, addition or deletion of dependents, or other facts identifying you or your dependents. (The notification period is not limited to 30 days for newborns or children newly placed for adoption; however, we encourage the covered subscriber to enroll a newborn dependent under this Policy within 30 days from the date of birth, date of placement for adoption, or date of adoption.)

The date your coverage begins

Coverage for a subscriber and/or 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.

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

How to add dependents

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

- The covered subscriber's dependent is covered under this Policy from the date of birth. The subscriber must pay the premium required by MIC for the newborn dependent's coverage, and must enroll the child under this Policy. No evidence of good health will be required. We encourage the covered subscriber to enroll the newborn child under this Policy within 30 days from the date of birth.
- A dependent child placed for adoption in the covered subscriber's home is covered under this

Policy from the date of placement. The subscriber must pay the premium required by MIC for the dependent child's coverage, and must enroll the child under this Policy. No evidence of good health will be required. We encourage the covered subscriber to enroll the dependent child under this Policy within 30 days of the child's date of placement. (Eligibility for a child placed for adoption with the covered 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 30 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.

CC. *Ending Coverage*

This section describes when coverage ends under this Policy. When this happens you may exercise your right to continue or convert your coverage as described in *Continuation* or *Your Right To Convert Coverage*.

When coverage ends

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

1. The date MIC notifies you that MIC will cease doing business. Coverage will end on the last day of a month. (To cease doing business means to discontinue issuing new individual health plans and to refuse to renew all of MIC's existing individual health plans.)
2. The end of the month for which the subscriber last paid the premium due.
3. The end of the month following the date the subscriber requests that coverage end. Written request for termination of the subscriber's 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. If you terminate this Policy within the first ten days of receiving it, coverage shall terminate retroactive to the effective date of this Policy.
5. The end of the month following the date you enter active military duty for more than 31 days. Upon completion of active military duty, your coverage will be reinstated if you notify MIC within 90 days after removal from active military duty. Preexisting condition limitations or exclusions will not apply.
6. When the subscriber is enrolled under this Policy, coverage for dependents will end the date the subscriber's coverage ends.
7. The date of the death of the member. When the subscriber is enrolled under this policy and in the event of the subscriber's death, coverage for the subscriber's dependents will terminate the end of

See *Definitions*. These words have specific meanings:

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

If the subscriber and/or dependents become covered under Medicare and chooses to terminate this policy, coverage for the remaining members will continue.

the month in which the subscriber's death occurred.

8. For a spouse, the end of the month following the date of divorce.
9. 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.
10. For a child who is entitled to coverage through a qualified medical child support order (QMCSO), the end of the month in which the earliest of the following occurs:
 - a. The QMCSO ceases to be effective; or
 - b. The child is no longer a child as that term is used in ERISA; or
 - c. The child has immediate and comparable coverage under another plan; or
 - d. The individual who is ordered by the QMCSO to provide coverage is no longer eligible; or
 - e. The Policy is terminated by MIC; or
 - f. The relevant premium is last paid.
11. The end of the month following the date 31 days after MIC notifies you that coverage will end because you did not pay a copayment or coinsurance for in-network benefits.
12. 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.

If coverage ends due to fraud, coverage will be retroactively terminated at MIC's discretion to the original date of coverage or the date on which the fraudulent act took place. No continuation or conversion privilege will be extended.

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.

DD. Continuation

This section describes continuation coverage provisions for a subscriber's covered dependents. When coverage ends, covered dependents 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.

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 as follows:

- a. *Minnesota state continuation coverage.*
Continued coverage shall be provided as required under Minnesota law. Minnesota state continuation requirements apply to health plans that are subject to state regulation.
- b. *Notice of rights.*
Minnesota law requires that covered dependents (spouse and/or dependent children) be offered the opportunity to pay for a temporary extension of health coverage (called continuation coverage) in certain instances where health coverage would otherwise end.

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

Subscriber's spouse's loss

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

- a. Death of the subscriber;
- b. Dissolution of marriage from the subscriber;

See *Definitions*. These words have specific meanings:

- Benefits
- Dependent
- Member
- Premium
- Subscriber

- c. The subscriber's enrollment for benefits under Medicare.

Subscriber's child's loss

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

- a. Death of the subscriber if the subscriber is the parent through whom the child receives coverage;
- b. The subscriber's dissolution of marriage from the child's other parent;
- c. The subscriber's enrollment for benefits under Medicare if the subscriber is enrolled under this policy and is the parent through whom the child receives coverage;
- d. The subscriber's child ceases to be a dependent child under the terms of the Policy.

What you must do

- a. Notify MIC within 30 days of:
 - the subscriber's death
 - the subscriber's dissolution of marriage
 - the subscriber's enrollment for benefits under Medicare
 - the date the subscriber's child ceases to be a dependent child under the terms of the Policy
- b. Elect continuation by notifying MIC in writing within 60 days after coverage ends
- 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. If coverage is terminated due to the subscriber's death, the first payment is due 90 days after the dependents are notified of their right to continue coverage.

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

- 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 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 and for a certain period of time, Minnesota law requires that a subscriber's dependents be allowed to maintain continuation coverage as follows:

- a. Upon the death of the subscriber, the coverage of a subscriber's spouse or dependent children may be continued until the earlier of:
 - i. The date the surviving spouse and dependent children become covered under a group health plan, or
 - ii. The date coverage would have terminated under the Policy had the subscriber lived.
- b. For instances of dissolution of marriage from the subscriber, coverage of the subscriber's spouse and dependent children may be continued until the earliest of:
 - i. The date the former spouse becomes covered under a group health plan; or
 - ii. The date coverage would otherwise terminate under the Policy.
- c. For instances where the subscriber's spouse or dependent children lose coverage because of the subscriber's enrollment under Medicare, coverage may be continued until the earliest of:
 - i. 36 months after continuation was elected;
 - ii. The date coverage is obtained under a group health plan; or
 - iii. The date coverage would otherwise terminate under the Policy.
- d. For instances where dependent children lose coverage as a result of loss of dependent

eligibility, coverage may be continued until the earliest of:

- i. 36 months after continuation was elected;
- ii. The date coverage is obtained under a group health plan; or
- iii. The date coverage would otherwise terminate under the Policy.

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

EE. *Your Right To Convert Coverage*

Introduction

1. You are eligible to convert to a MIC individual conversion policy without proof of good health or waiting periods when your continuation coverage with MIC, as described in Continuation, is exhausted.

Your conversion policy goes into effect the date your coverage ends under this Policy.

2. Conversion coverage is not available if your coverage ended due to:
 - fraud; or
 - non-payment of a copayment or coinsurance for in-network benefits; or
 - non-payment of premium when continuous coverage is not maintained.

For purposes of this section, “continuous coverage” will be determined to have been maintained if you request enrollment for a conversion policy within 31 days after your coverage ends under this Policy or within 31 days of the date you were notified of the right to convert coverage, whichever is later.

What you must do

1. For conversion coverage information, please call Customer Service at one of the telephone numbers listed inside the front cover.
2. Make payment to MIC within 31 days after coverage ends under this Policy or within 31 days of the date you were notified of your right to convert coverage, whichever is later. You will be required to include your first month premium payment with your enrollment form for the conversion coverage.
3. Submit an enrollment form to MIC. Only those individuals who were covered under this Policy may be enrolled.

What MIC must do: Notify you of your right to convert coverage.

FF. *Complaints*

This section describes what to do if you have a complaint 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 the address below in *First level of review*, number 2. You also may contact the Commissioner of Commerce, Minnesota Department of Commerce, at (651) 296-2488 or 1-800-657-3602.

First level of review

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

1. If your complaint is regarding an initial decision made by MIC, and your complaint requires a medical determination in its resolution, your complaint must be made within one year following MIC's initial decision.
2. For an oral complaint that does not require a medical determination in its outcome, if MIC does not communicate a decision within ten business days from MIC's receipt of the complaint, or if you determine that MIC's decision is partially or wholly adverse to you, MIC will provide you with a complaint form to submit your complaint in writing. Mail the completed form to:

Customer Service
Route CP 320
PO Box 9310
Minneapolis, MN 55440-9310
3. MIC will provide written notice of its first level review decision to you and your attending provider, when applicable, within 30 calendar days from receipt of your complaint or request.
4. When an initial decision by MIC not to grant a prior authorization request is made before or during an ongoing service requiring MIC's authorization, and your attending *provider* believes that MIC's decision

See ***Definitions***. These words have specific meanings:

- Inpatient
- Network
- Provider

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

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

Upon request, MIC will assist you with completion and submission of your written complaint. MIC will also complete a complaint form on your behalf and mail it to you for your signature upon request.

warrants an expedited appeal, you or your attending *provider* will have the opportunity to request an expedited review by telephone. Alternatively, if MIC concludes that a delay could seriously jeopardize your life, health, or ability to regain maximum function, MIC will process your *claim* as an expedited review. In such cases, MIC will notify you and your attending *provider* by telephone of its decision no later than 72 hours after receiving the request.

5. If MIC's first level review decision upholds the initial decision made by MIC, you may have a right to request a second level review or submit a written request for external review as described in this section.

NOTE: For some complaints, the second level of review must be exhausted before you have the right to submit a request for external review. For other complaints, this second level of review is optional before you may submit a request for external review. MIC will inform you in writing whether the second level of review is optional or required.

Second level of review

If you are not satisfied with MIC's first level review decision, you may request a second level of review through either a written reconsideration or a hearing.

1. Your request can be oral or in writing. It must be provided to MIC within one year following the date of MIC's first level review decision. If your request is in writing, it must be sent to the address listed above in *First level of review*, number 2.
2. Regardless of the method chosen for review (hearing or a written reconsideration), testimony, explanation or other information provided by you, MIC staff, providers and others is reviewed.
3. MIC will provide written notice of its second level review decision to you within:
 - a. 30 calendar days from receipt of written notice of your appeal for required second level reviews; or
 - b. 45 calendar days from receipt of written notice of your appeal for optional second level reviews.

External review

If you consider MIC's decision to be partially or wholly adverse to you, you may submit a written request for external review of MIC's decision to the Commissioner of Commerce at:

Minnesota Department of Commerce
85 7th Place East, Suite 500
St. Paul, MN 55101-2198

A filing fee of \$25 must accompany your written request, unless waived by the Commissioner. An independent entity contracted with the State Commissioner of Administration will review your request. The external review decision will not be binding on you but will be binding on MIC. Contact the Commissioner of Commerce for more information about the external review process.

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

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

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

GG. General Provisions

This section describes the general provisions of this Policy.

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.

See *Definitions*. These words have specific meanings:

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

Entire agreement

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

Amendment

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

Discretionary Authority

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

HH. Definitions

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

Term	Definition
Benefits	<p>Within each definition, you may note bold words. These words also are defined in this section.</p> <p>The health services or supplies (described in this Policy and any subsequent amendments) approved by MIC as eligible for coverage.</p>
Certification of qualifying coverage	<p>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.</p>
Claim	<p>An invoice, bill or itemized statement for benefits provided to you.</p>
Coinsurance	<p>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.</p> <p>For in-network benefits, the coinsurance amount typically is based on the lesser of the:</p> <ol style="list-style-type: none"> 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). <p>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.</p> <p>For out-of-network benefits, the coinsurance will be based on the lesser of the:</p> <ol style="list-style-type: none"> 1. Charge billed by the provider (i.e., retail) or 2. Non-network provider reimbursement amount.

Term	Definition
	<p>Within each definition, you may note bold words. These words also are defined in this section.</p> <p>For out-of-network benefits, in addition to any copayment, coinsurance and deductible amounts, you are responsible for any charges billed by the provider in excess of the non-network provider reimbursement amount.</p> <p>In addition, for the network pharmacies described in <i>Prescription Drugs And Pharmacy Services</i>, 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.</p> <p>The coinsurance may not exceed the charge billed by the provider for the benefit.</p>
Continuous coverage	<p>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.</p>
Convenient/urgent care center	<p>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.</p>
Copayment	<p>The fixed dollar amount you must pay to the provider for benefits received. Full copayments may apply to scheduled appointments canceled less than 24 hours before the appointment time or to missed appointments.</p> <p>When you receive eligible health services from a network provider and a copayment applies, you pay the lesser of the charge billed by the provider for the benefit (i.e., retail) or your copayment. MIC pays any remaining amount according to the written agreement between MIC and the provider. The copayment may not exceed the retail charge billed by the provider for the benefit.</p> <p>For out-of-network benefits, in addition to any copayment, coinsurance and deductible amounts, you are responsible for any charges in excess of the non-network provider reimbursement amount.</p>

Term	Definition
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	<p>Unless otherwise specified in this Policy:</p> <ol style="list-style-type: none">1. The subscriber's legally married spouse2. An unmarried child of the subscriber who is a:<ol style="list-style-type: none">a. Natural or adopted childb. Child placed for adoption with the subscriberc. Stepchild3. An unmarried grandchild who is dependent upon and resides with the subscriber or subscriber's legally married spouse continuously from birth. <p>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.</p> <p>See <i>Extending a child's eligibility in Eligibility And Enrollment</i> for details regarding dependent limiting ages.</p>

Term	Definition
	Within each definition, you may note bold words. These words also are defined in this section.
	A child who is the subject of a qualified medical child support order (QMCSO) is not considered a dependent for purposes of coverage under this Policy and may not enroll dependents for coverage. See the definition of subscriber .
Emergency	A condition or symptom that requires immediate treatment to: <ol style="list-style-type: none"><li data-bbox="618 573 938 600">1. Preserve your life; or<li data-bbox="618 642 1438 705">2. Prevent serious impairment to your bodily functions, organs, or parts; or<li data-bbox="618 741 1398 804">3. Prevent placing your physical or mental health in serious jeopardy.
Enrollment date	The date of the member's first day of coverage.
Hospital	A licensed facility that provides diagnostic, medical, therapeutic, rehabilitative and surgical services by, or under the direction of, a physician and with 24-hour R.N. nursing services. The hospital is not mainly a place for rest or custodial care , and is not a nursing home or similar facility.
Inpatient	An uninterrupted stay of 24 hours or more in a hospital, skilled nursing facility or licensed acute care facility. Inpatient services in a licensed residential treatment facility for treatment of emotionally disabled children will be covered as any other health condition.
Investigative	As determined by MIC, a drug, device, diagnostic or screening procedure, or medical treatment or procedure is investigative if reliable evidence does not permit conclusions concerning its safety, effectiveness or effect on health outcomes. MIC will make its determination based upon an examination of the following reliable evidence, none of which shall be determinative in and of itself: <ol style="list-style-type: none"><li data-bbox="618 1566 1438 1766">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;

Term

Definition

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

2. Whether there are consensus opinions and recommendations reported in relevant scientific and medical literature, peer-reviewed journals or the reports of clinical trial committees and other technology assessment bodies; and
3. Whether there are consensus opinions of national and local health care **providers** in the applicable specialty or subspecialty that typically manages the condition as determined by a survey or poll of a representative sampling of these **providers**.

Notwithstanding the above, a drug being used for an indication or at a dosage that is an accepted off-label use for the treatment of cancer will not be considered by MIC to be **investigative**. MIC will determine if a use is an accepted off-label use based on published reports in authoritative peer-reviewed medical literature, clinical practice guidelines or parameters approved by national health professional boards or associations and entries in the following drug compendia: *The American Hospital Formulary Service Drug Information* and the *United States Pharmacopoeia Dispensing Information*.

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.

Term	Definition
	Within each definition, you may note bold words. These words also are defined in this section.
Member	A person who is enrolled under this Policy and on whose behalf the premium is being paid. In this Policy the words you, your or yourself refer to the member.
Mental disorder	A physical or mental condition having an emotional or psychological origin, as defined in the current edition of the <i>Diagnostic and Statistical Manual of Mental Disorders (DSM)</i> .
Network	<p>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.</p> <p>The MIC network provider directory will be furnished automatically, without charge.</p>
Non-network	A term used to describe a provider not under contract as a network provider .
Non-network provider reimbursement amount	<p>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:</p> <ol style="list-style-type: none"> 1. For emergency services and services provided upon referral from a network provider (see the sections <i>Emergency Services From Non-Network Providers</i> and <i>Referrals To Non-Network Providers</i>): The non-network provider's charge. 2. For family planning services for the voluntary planning of the conception and bearing of children, services for testing and treatment of a sexually transmitted disease, and testing for AIDs and other HIV-related conditions: The non-network provider's charge. 3. For prescription drugs and pharmacy services: 85% of the non-network provider's charge. 4. For all other services: The lesser of: <ol style="list-style-type: none"> a. the non-network provider's charge; or

Term	Definition
	<p>Within each definition, you may note bold words. These words also are defined in this section.</p> <p style="margin-left: 40px;">b. the fee maximum amount for the service as determined pursuant to MIC's fee schedule then in effect for the Medica Direct HSA for Individuals product.</p> <p>If the amount billed by the non-network provider is greater than the non-network provider reimbursement amount, <i>you must pay the difference</i>. Such difference is in addition to any copayment, 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 <i>Your Out-of-Pocket Expenses</i>.</p>
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	<p>The assumption and retention of the legal obligation for total or partial support of the child in anticipation of adopting such child.</p> <p>(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.)</p>
Pre-existing condition	A physical or mental condition other than a pregnancy, present before your enrollment date under the Policy, for which medical advice, diagnosis, care or treatment (including treatment with prescription drugs) was recommended by or received from a physician or other provider within the six months immediately preceding your enrollment date . Refer to <i>How To Access Your Benefits</i> for additional information regarding pre-existing conditions and the application of a pre-existing condition limitation.
Premium	The monthly payment required to be paid by you for coverage under this Policy.
Prenatal care	The comprehensive package of medical and psychosocial support provided throughout a pregnancy and related directly to the care of the pregnancy, including risk assessment, serial surveillance, prenatal education and use of specialized skills and technology, when needed, as defined by <i>Standards for Obstetric-Gynecologic Services</i> issued by the American College of Obstetricians and Gynecologists.

Term	Definition
Prescription drug	A drug approved by the FDA for the prescribed use and route of administration.
Provider	A health care professional or facility licensed, certified or otherwise qualified under state law to provide health services.
Qualifying coverage	<p data-bbox="618 543 1382 571">Health coverage provided under one of the following plans:</p> <ol data-bbox="618 606 1435 1856" style="list-style-type: none"><li data-bbox="618 606 1435 737">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;<li data-bbox="618 772 1040 800">2. Part A or Part B of Medicare;<li data-bbox="618 835 1406 898">3. A medical assistance medical care plan as defined under Minnesota law;<li data-bbox="618 934 1406 997">4. A general assistance medical care plan as defined under Minnesota law;<li data-bbox="618 1033 1386 1060">5. Minnesota Comprehensive Health Association (MCHA);<li data-bbox="618 1096 1003 1123">6. A self-insured health plan;<li data-bbox="618 1159 1409 1222">7. The MinnesotaCare program as defined under Minnesota law;<li data-bbox="618 1257 1360 1320">8. The public employee insurance plan as defined under Minnesota law;<li data-bbox="618 1356 1435 1419">9. The Minnesota employees insurance plan as defined under Minnesota law;<li data-bbox="618 1455 1425 1518">10. TRICARE or other similar coverage provided under federal law applicable to the armed forces;<li data-bbox="618 1554 1435 1617">11. Coverage provided by a health care network cooperative or by a health provider cooperative;<li data-bbox="618 1652 1406 1757">12. The Federal Employees Health Benefits Plan or other similar coverage provided under federal law applicable to government organizations and employees;<li data-bbox="618 1793 1435 1856">13. A medical care program of the Indian Health Service or of a tribal organization;

Term	Definition
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	14. A health benefit plan under the Peace Corps Act;
	15. State Children's Health Insurance Program; or
	16. A public health plan similar to any of the above plans established or maintained by a state, the U.S. government, a foreign country, or any political subdivision of a state, the U.S. government, or a foreign country.
	<p>Coverage of the following types, including any combination of the following types, are <i>not</i> qualifying coverage:</p>
	1. Coverage only for disability or income protection insurance;
	2. Automobile medical payment coverage;
	3. Liability insurance or coverage issued as a supplement to liability insurance;
	4. Coverage for a specified disease or illness or to provide payments on a per diem, fixed indemnity, or non-expense-incurred basis, if offered as independent, non-coordinated coverage;
	5. Credit accident and health insurance as defined under Minnesota law;
	6. Coverage designed solely to provide dental or vision care;
	7. Accident only coverage;
	8. Long-term care coverage as defined under Minnesota law;
	9. Medicare supplemental health insurance as defined under Minnesota law;
	10. Workers' compensation insurance; or
	11. Coverage for on-site medical clinics operated by an employer for the benefit of the employer's employees and their dependents , in connection with which the employer does not transfer risk.
Reconstructive	Surgery to rebuild or correct a:

Term	Definition
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	<ol style="list-style-type: none">1. Body part when such surgery is incidental to or following surgery resulting from injury, sickness or disease of the involved body part; or2. Congenital disease or anomaly which has resulted in a functional defect as determined by your physician.
	<p>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.</p>
Restorative	<p>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.</p>
Skilled care	<p>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.</p>
Skilled nursing facility	<p>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.</p>
Subscriber	<p>The person to whom this Policy is issued</p> <p>The definition of subscriber may also include a child for whom a member is required to provide health coverage through a qualified medical child support order (QMCSO). The child is considered a subscriber only if:</p> <ol style="list-style-type: none">1. MIC determines that the support order is effective and meets all criteria of a QMCSO, as that term is used in the Employee Retirement Income Security Act (ERISA); and2. the relevant member is eligible to enroll for coverage according to the terms of this Policy.

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

When the **subscriber** is a child who is eligible for coverage as a result of a QMCSO, the child's certain rights and obligations pertaining to other **subscribers** are modified according to the terms of this Policy.

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