

Medica Direct HSASM for Individuals

Bronze

*Minnesota
Policy of
Coverage*

MN-HSA07-PC-19-01

**Medica Direct HSASM for
Individuals**

Bronze

\$6,000 Per Member Deductible

\$12,000 Per Family Deductible

Plan Code 6DHBMH

This is not an HSA-compliant high deductible health plan. Coverage under this plan is not designed to comply with the requirements of the Internal Revenue Code Section 223 for a federally-qualified high-deductible health plan.

Cancellation Within First Ten Days

The subscriber may cancel this Policy by delivering or mailing a written notice to **Medica Insurance Company, 401 Carlson Parkway, Attn: Customer Service, Route CP595, Minnetonka, MN 55305** or an agent of the company. This Policy must be returned before midnight the tenth day after the date you receive this Policy and then this Policy is considered void from the beginning. 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.

Discrimination is Against the Law

Medica complies with applicable Federal civil rights laws and will not discriminate against any person on the basis of race, color, national origin, age, disability or sex. Medica:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: TTY communication and written information in other formats (large print, audio, other formats).
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters and information written in other languages.

If you need these services, call the number included in this document or on the back of your Medica ID card. If you believe that Medica has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Civil Rights Coordinator, Mail Route CP250, PO Box 9310, Minneapolis, MN 55443-9310, 952-992-3422 (phone/fax), TTY 711, civilrightscoordinator@medica.com

You can file a grievance in person or by mail, fax, or email. You may also contact the Civil Rights Coordinator if you need assistance with filing a complaint.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

If you want free help translating this information, call the number included in this document or on the back of your Medica ID card.

Si desea asistencia gratuita para traducir esta información, llame al número que figura en este documento o en la parte posterior de su tarjeta de identificación de Medica.

Yog koj xav tau kev pab dawb kom txhais daim ntawv no. hu rau tus xov tooj nyob hauv daim ntawv no los yog nyob nraum qab ntawm koj daim npav Medica ID.

如果您需要免費翻譯此資訊，請致電本文檔中或者在您的 Medica ID卡背面包含的號碼。

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Odeeffannoo kana gargaarsa tolaan akka isinii hiikamu yoo barbaaddan, lakkoobsa barruu kana keessatti argamu ykn ka dugda kaardii Waraqaa Eenyummaa Medica irra jiruun bilbila'a.

إذا كنت تريد مساعدة مجانية في ترجمة هذه المعلومات،
فأتصل على الرقم الوارد في هذه الوثيقة أو على ظهر بطاقة
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ຫາເລກໝາຍທີມີຢູ່ໃນເອກະສານນີ້ ຫຼື ຢູ່ດ້ານຫຼັງຂອງບັດ Medica
ຂອງທ່ານ.

이 정보를 번역하는 데 무료로 도움을 받고 싶으시면, 이 문서에 포함된 전화번호나 Medica ID 카드 뒷면의 전화번호로 전화하십시오.

Si vous voulez une assistance gratuite pour traduire ces informations, appelez le numéro indiqué dans ce document ou au dos de votre carte d'identification Medica.

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Kung nais mo ng libreng tulong sa pagsasalin ng impormasyong ito, tawagan ang numero na kasama sa dokumentong ito o sa likod ng iyong Kard ng Medica ID.

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Ako želite besplatnu pomoć za prijevod ovih informacija, nazovite broj naveden u ovom dokumentu ili na poledini svoje ID kartice Medica.

Díí t'áá jį́k'e shá'ata' hodoonih nínízingo éí ninaaltsoos Medical Center dóó nísho' dį́lzinígíí bine'déé' námbóó biká'ígíjį́' béésh bee hodoonih.

Wenn Sie bei der Übersetzung dieser Informationen kostenlose Hilfe in Anspruch nehmen möchten, rufen Sie bitte die in diesem Dokument oder auf der Rückseite Ihrer Medica-ID-Karte angegebene Nummer an.

Medica Member Resources



Important Phone Numbers:

- **Medica Customer Service: 1-888-592-8211**

Call Customer Service if you have any questions.

TTY users, call **711**.

- **Nurse Line: 1-866-668-6548**

Available 24 hours every day for you and your family to talk with a nurse for advice on where and when to get care, or how to provide care safely at home. In a medical emergency, please call 911.



Online Resources:

- **Secure Member Site: [Medica.com/IndividualLogin](https://medica.com/IndividualLogin)**

You can view much of the information you may need by logging into your secure member site at **medica.com/IndividualLogin**. The website allows you to view information specific to you and your plan:

- View your ID card
- See what's covered by your plan, including important plan documents
- Track your plan balances, such as your deductible and out-of-pocket maximum
- View your claims and explanations of benefits (EOBs)
- Look up prices for prescriptions and how they're covered by your plan
- Look up providers and pharmacies in your network
- Wellness tools and support
- Forms to help you add dependents, change your address, and submit various claims
- Pay your premium

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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 84.7% of your premium dollar for health care coverage.

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

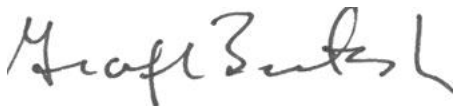
Important Consumer Information

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 intentional misrepresentation of a material fact, 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.



Vice President and General Manager of Individual
and Family Business



Senior Vice President and 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.

What you must do to receive 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. Having and using a Medica Direct HSA for Individuals identification card does not guarantee coverage.

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).

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
- Subscriber

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

Language interpretation

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

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

If you need alternative formats, such as large print or an audio format, 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 by the subscriber from the date coverage starts.

Your premium may change each year as permitted by state and federal law. You will be provided at least 30 days written notice before a change in the premium.

MIC does not accept premium payment directly or indirectly from any third party including, but not limited to, any health care provider, except as stated in this paragraph. MIC will also accept premium payments from the following third parties, to the extent required by law: Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act; Indian tribes, tribal organizations or urban Indian organizations; and state and federal government programs. Premiums paid by you, the subscriber, or the third-parties listed in the prior sentence, will not be reimbursed or contributed to by or on behalf of any other third party including, but not limited to, any health care provider directly or indirectly.

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 not be terminated. If premium is not paid by the end of the grace period,

coverage will end as stated in the *Ending Coverage* section.

If the person obligated to pay premiums under this Policy has not paid the past due premiums by the end of the grace period, and MIC has provided coverage during the grace period, then that person may not be allowed to enroll in any other MIC (or its affiliates) individual or family policies for up to twelve months following the beginning of the grace period. If the subscriber wants to obtain MIC individual or family coverage before the end of the twelve-month period, the subscriber may need to pay the outstanding premium owed under the prior MIC policy consistent under MIC's process.

Changes to this Policy

The coverage provided under this Policy may change each year as permitted or required in compliance with federal or state regulatory requirements, or to ensure that your Policy maintains the actuarial value for the designated metal levels as defined in federal law. Any provision of this Policy which, on its effective date, is in conflict with the law of the federal government or this state is hereby amended to conform to the minimum requirements of such law.

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, gender identity, marital status, status with regard to public assistance, disability, sexual orientation, age, genetic information or any other classification protected by law.

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

A. Member Rights And Responsibilities

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, including 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 member rights and responsibilities;
7. Appeal a decision regarding your health care coverage by calling Customer Service at one of the telephone numbers listed inside the front cover. See *Complaints* for more information on your appeal rights; and
8. Make recommendations regarding MIC's member rights and responsibilities statement.

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;

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

Member Rights And Responsibilities

2. Providing the necessary information to health care professionals or MIC needed to determine the appropriate care. This objective is best obtained when you share:
 - a. Information about lifestyle practices; and
 - b. Personal health history;
3. Understanding your health problems and agreeing to, and following, the plans and instructions for care 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.

MIC provides coverage for mental health and substance abuse services in the same way it provides coverage for other health issues. The Mental Health Parity and Addiction Equity Act, as well as applicable state law, requires MIC, an insurer that offers mental health and substance abuse benefits, to provide coverage of those benefits in a way that is comparable to coverage for general medical and surgical care. Cost-sharing requirements and limitations on mental health and substance abuse benefits (such as copayments, visit limits and preauthorization requirements) must generally be comparable to, and no more restrictive than those for medical and surgical benefits.

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.

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

- Benefits
- Claim
- Coinsurance
- Deductible
- Dependent
- Emergency
- Enrollment date
- Genetic testing
- Hospital
- Inpatient
- Medically necessary
- Member
- Network
- Non-network
- Non-network provider reimbursement amount
- Premium
- Prescription drug
- Provider
- Reconstructive
- Restorative
- Skilled nursing facility
- Subscriber

Emergency services

Emergency services from non-network providers will be covered as in-network benefits. This Policy explains the 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.

Post-mastectomy coverage

MIC will cover all stages of reconstruction of the breast on which the mastectomy was performed and surgery and reconstruction of the other breast to produce a symmetrical appearance if the mastectomy was medically necessary (as determined by the attending physician). MIC will also cover prostheses and physical complications, including lymphedemas, at all stages of mastectomy.

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

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.

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

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.

benefits (provided you follow proper procedures for prior authorizations and referrals).

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

Some benefits are provided only as in-network benefits. 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 leaving a balance for you to pay in addition to any applicable coinsurance and deductible amount. The difference 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.

Generally, as described above, you will pay much more for your health care if you receive services from a non-network provider than when you receive services from a network provider. However, in the following situations, Minnesota law provides that you may not be responsible for any amounts above what you would be required to pay for in-network benefits, unless you provided advance written consent:

1. While you obtained care at an in-network hospital or ambulatory surgical center you also received eligible health care services from a non-network provider (for example: an anesthesiologist or a radiologist) but you did not have the opportunity to select the provider of those services; or
2. Your network provider sent your lab work to a non-network laboratory for testing.

If you have questions about bills you receive from a non-network provider that provided services under the circumstances described above, please call Customer Service at one of the telephone numbers listed at the front of this Policy. If you receive a bill that is larger than the applicable in-network copayment, coinsurance, or deductible, you may submit the bill for processing to:

Customer Service

Route CP595
PO Box 9310
Minneapolis, MN 55440-9310

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

MIC provides coverage for mental health and substance abuse services in the same way it provides coverage for other health issues. The Mental Health Parity and Addiction Equity Act, as well as applicable state law, requires MIC, an insurer that offers mental health and substance abuse benefits, to provide coverage of those benefits in a way that is comparable to coverage for general medical and surgical care. Cost-sharing requirements and limitations on mental health and substance abuse benefits (such as copayments, visit limits and preauthorization requirements) must generally be comparable to, and no more restrictive than those for medical and surgical benefits.

Exclusions

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

Claims

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

Post mastectomy coverage

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

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. Coverage for a newborn or newly adopted child

The covered subscriber's dependent newborn or newly adopted child is covered from date of birth, adoption or placement for adoption. If additional premium is required, MIC is entitled to all premiums due from the time of the child's birth, adoption or placement for adoption until the time the covered subscriber notifies MIC of the birth or adoption. MIC may reduce payment by the amount of premium that is past due for any health benefits for the child until any premium you owe is paid. For more information, see *BB. Eligibility And Enrollment*.

MIC does not automatically know of a birth or whether the covered subscriber would like coverage for the newborn dependent or newly adopted child. 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. Transition of care

If you are a new MIC member as a result of changing health insurance carriers, your current provider is not a network provider, and you are undergoing a current course of treatment, 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. This includes providing MIC with all necessary medical information related to your care, and accepting as payment in full the lesser of MIC's network provider reimbursement or the provider's customary charge for the service.

Upon request, MIC will authorize transition of care as described above for the following conditions:

1. An ongoing course of treatment for a life-threatening condition;
2. An ongoing course of treatment for a serious acute condition, such as chemotherapy;
3. Pregnancy in the second or third trimesters, through the postpartum period; or
4. An ongoing course of treatment for a health condition for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would

worsen the condition or interfere with anticipated outcomes.

Transition of care, as described above, will continue until the active course of treatment is complete, or 90 days, whichever is shorter. 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, advanced practice registered nurse or physician assistant certifies that your life expectancy is 180 days or less.

If your provider agrees to comply with MIC's prior authorization requirements, provides MIC with all necessary medical information related to your care, and accepts as payment in full the lesser of MIC's network provider reimbursement or the provider's customary charge for the service, then the provider will not be permitted to bill you for the amount in excess of your in-network deductible and coinsurance or copay described in this Policy. If your provider does not agree to these terms, in addition to the deductible and coinsurance described in this Policy for in-network benefits, you will be responsible for any charges in excess of the non-network provider reimbursement amount.

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 transition of care will be provided. After that time, your services or treatment will need to be transitioned to a network provider to continue to be eligible for in-network benefits. If your request is denied, MIC will explain the criteria used to make its decision. You may appeal this decision.

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

7. Continuity of care

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

MIC may require medical records or other supporting documentation from your provider to review your request, and will consider each request on a case-by-case basis. If MIC authorizes your request to continue care with your current provider, MIC will explain how continuity of care will be provided. After that time, your services or

treatment will need to be transitioned to a network provider to continue to be eligible for in-network benefits. If your request is denied, MIC will explain the criteria used to make its decision. You may appeal this decision.

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

Continuity of care does not apply when MIC terminates a provider's contract for cause. 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.

If MIC's contract with your primary care provider or specialist ends

If you are currently in an active course of treatment with a treating provider (not a hospital), you have a right to continuity of care. If the contract between MIC and your treating provider terminates without cause, you may be eligible to continue care with that provider at the in-network benefit level. Continuity of care only applies if you are in an active course of treatment with the provider at the time the provider's contract is terminated. This does not apply when the provider's contract is terminated for cause.

Upon request, MIC will authorize continuity of care as described above for the following conditions:

1. An ongoing course of treatment for a life-threatening physical or mental condition;
2. An ongoing course of treatment for a serious acute condition, such as chemotherapy;
3. Pregnancy in the second or third trimesters, through the postpartum period;
4. An ongoing course of treatment for a health condition for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes;
5. 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
6. A disabling or chronic condition that is in an acute phase.

Continuity of care, as described above, will continue until the active course of treatment is complete, or 120 days, whichever is shorter.

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, advanced practice registered nurse or physician assistant certifies that your life expectancy is 180 days or less.

If your provider agrees to comply with MIC's prior authorization requirements, provides MIC with all necessary medical information related to your care, and accepts as payment in full the lesser of MIC's network provider reimbursement or the provider's customary charge for the service, then the provider will not be permitted to bill you for the amount in excess of your in-network deductible and coinsurance or copay described in this Policy. If your provider does not agree to these terms, in addition to the deductible and coinsurance described in this Policy for in-network benefits, you will be responsible for any charges in excess of the non-network provider reimbursement amount.

If MIC's contract with your hospital ends

In certain situations, you have a right to continuity of care with your hospital. If MIC terminates its contract with your current hospital without cause, you may be eligible to continue care with that provider at the in-network benefit level.

Continuity of care at a hospital applies only if your provider agrees to comply with MIC's prior authorization requirements, provides MIC with all necessary medical information related to your care, and accepts 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.

Upon request, MIC will authorize continuity of care as described above for up to 120 days for the following conditions:

1. An acute condition;
2. A life-threatening mental or physical illness;
3. Pregnancy beyond the first trimester of pregnancy;
4. 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

- 5.A disabling or chronic condition that is in an acute phase.

Authorization to continue to receive services from your current hospital may extend to the remainder of your life if a physician, advanced practice registered nurse or physician assistant certifies that your life expectancy is 180 days or less.

If MIC's contract with your primary care provider, specialist or hospital ends

Upon request, MIC will authorize continuity of care as described above for up to 120 days in the following situations:

- 1.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
- 2.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.

Continuity of care for (1) or (2) applies only if your provider agrees to comply with MIC's prior authorization requirements, provides MIC with all necessary medical information related to your care, and accepts as payment in full the lesser of MIC's network provider reimbursement or the provider's customary charge for the service.

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

8. Prior authorization

Note: Prior authorization (approval in advance) is a clinical review that services are medically necessary. Receiving prior authorization is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, your eligibility and the terms and conditions

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.

of this Policy applicable on the date you receive services.

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. This applies even when the services are provided by a network provider or provided as the result of referral or direction by a network provider.

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

Your attending provider, you or someone on your behalf may contact MIC to request prior authorization. Your network provider will contact MIC to request prior authorization for a service or supply. You must contact MIC to request prior authorization for services or supplies received from a non-network provider. If a network provider fails to request 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.

Emergency services do not require prior authorization.

You do not require prior authorization in order to obtain access to obstetrical or gynecological care from a network provider who specializes in obstetrics or gynecology. However, certain of the specific services provided by that network provider may require prior authorization, as described further in this Policy.

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

- Reconstructive or restorative surgery procedures;
- Treatment of a diagnosed temporomandibular joint (TMJ) disorder or craniomandibular disorder;
- Solid organ and bone marrow transplant services – this prior authorization must be obtained before the transplant workup is initiated;
- Treatment at a designated facility for complex medical conditions;
- Home health care services;
- Durable medical equipment;
- Outpatient surgical procedures;
- Certain genetic tests;
- Certain drugs and biologics;
- Inpatient care, including mental health and substance use disorders, skilled nursing facility services, long

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.

term acute hospital (LTAH) and acute inpatient rehab (AIR);

- Certain outpatient mental health and substance use disorder services;
- Certain imaging services;
- Certain professionally administered drugs;
- Non-emergency licensed air ambulance transportation; and
- In-network benefits for services from non-network providers, with the exception of emergency services.

Pregnancy/maternity care services do not require prior authorization or a referral and will be covered at the appropriate in-network or out-of-network benefit level.

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

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

MIC will review your request for prior authorization and provide a response to you and your attending provider within 10 business days after the date your request was received provided all information reasonably necessary to make a decision has been given to MIC.

MIC will respond within a time period not exceeding 72 hours from the time of the initial request if 1) your attending provider believes that an expedited review is warranted, or 2) MIC concludes that a delay could seriously jeopardize your life, health, or ability to regain maximum function, or 3) you could be subject to severe pain that cannot be adequately managed without the care or treatment you are requesting.

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

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

C. How Providers Are Paid By MIC

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

Network providers

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

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

The methods by which specific network providers are paid may change from time to time. Methods also vary by network provider. The primary method of payment under Medica Direct HSA for Individuals is fee-for-service.

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

Risk-sharing payment means that MIC pays the network provider a specific amount for a particular unit of service, such as an amount per day, an amount per stay, an amount per episode, an amount per case, an amount per period of illness, an amount per member, or an amount per service with targeted outcome. If

See *Definitions*. These words have specific meanings:

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

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

the amount paid is less than the cost of providing or arranging for a member's health services, the network provider may bear some of the shortfall. If the amount paid to the network provider is more than the cost of providing or arranging a member's health services, the network provider may keep some of the excess.

Withhold arrangements

For some network providers paid on a fee-for-service basis, including most network physicians and clinics, MIC holds back some of the payment. This is sometimes referred to as a physician contingency reserve or holdback. The withhold amount generally will not exceed 15% of the fee schedule amount.

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

Non-network providers

When a service from a non-network provider is covered, the non-network provider is paid a fee for each covered service that is provided. This payment may be less than the charges billed by the non-network provider. **If this happens, you are responsible for paying the difference, in addition to any applicable coinsurance and deductible amount.**

Payment of claims

MIC will pay or deny clean claims within 30 calendar days after the date upon which MIC received the claim.

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.

- In-network benefits are covered at 80% after you pay a deductible amount.
- Out-of-network benefits are covered at 80% of the non-network provider reimbursement amount after you pay a deductible amount.

Expenses you must pay

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

1. Any applicable coinsurance and deductible as described in this Policy.

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

However, a family deductible also applies. When members in a family unit (a subscriber and his or her dependents) have together paid the family deductible for benefits received during any calendar year (as described in the Out-of-Pocket Expenses table at the end of this section), then all members of the family unit are considered to have satisfied their deductible for that calendar year.

You may contact Customer Service for estimates of the amount Medica has contracted to pay a particular network provider for a specific health care service and

See Definitions. These words have specific meanings:

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

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

If you use out-of-network benefits, you may incur costs in addition to your deductible amount. If the amount that your non-network provider bills you is more than the non-network provider reimbursement amount, *you are responsible for paying the difference*. In addition, the difference will not be applied toward the out-of-pocket maximum (described in this section).

the amount you will pay as cost sharing for that service if received from that network provider. Medica will provide you with requested estimates within ten business days from the date Medica receives a request containing all information needed to respond. Please note that the estimates provided are not a final determination of eligibility for coverage or a guarantee of continuing provider network participation or final costs for services you receive.

Please note that amounts reimbursed or paid by a provider or manufacturer, including manufacturer coupons, point of service rebates, coupon cards, debit cards or other forms of reimbursement or payment on your behalf for a product or service, will not apply toward your deductible.

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

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

1. Any charge that exceeds the non-network provider reimbursement amount. ***This means you are required to pay the difference between what MIC pays to the provider and what the provider bills. As a result, you may have substantial out-of-pocket expense when you use a non-network provider.***

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

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

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

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

Out-of-pocket maximum

The out-of-pocket maximum is an accumulation of the in-network and out-of-network coinsurance and deductible paid for benefits received during a calendar year. Unless otherwise specified, you will *not* be required to pay more than the applicable out-of-pocket maximum for benefits received during a calendar year (see the Out-of-Pocket Expenses table in this section).

Please note that amounts reimbursed or paid by a provider or manufacturer, including manufacturer coupons, point of service rebates, coupon cards, debit cards or other forms of reimbursement or payment on your behalf for a product or service, will not apply toward your out-of-pocket maximum.

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

In addition, a family out-of-pocket maximum also applies to your in-network benefits. When members in a family unit (the subscriber and his or her dependents) have together satisfied the family out-of-pocket maximum of coinsurance and/or deductibles for in-network benefits received during any calendar year (as described in the Out-of-Pocket Expenses table at the end of this Section), then all members of the family unit are considered to have satisfied the family out-of-pocket maximum for that calendar year.

Any amount or charge *not* covered, including charges for services not eligible for coverage and any charge in excess of the non-network provider reimbursement amount, is *not* applicable toward the out-of-pocket maximum.

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

Out-of-Pocket Expenses

Coinsurance

There may be adjustments made to the coinsurance on a yearly basis in order to meet the requirements for the Policy to stay at the same metal level (Platinum, Gold, Silver or Bronze).

You will receive a notice of change 30 days in advance.

See specific benefit for applicable coinsurance.

Calendar year deductible

Deductible may be subject to a “cost of living” increase on a yearly basis. This “cost of living” increase is tied to the Consumer Price Index (CPI) and may be up to, but no greater than, the CPI.

There may also be adjustments made to the deductible on a yearly basis in order to meet the requirements for the Policy to stay at the same metal level (Platinum, Gold, Silver or Bronze).

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.

Per member

\$6,000

Applies to your combined in-network and out-of-network benefits.

Per family

\$12,000

Applies to your combined in-network and out-of-network benefits.

Calendar year out-of-pocket maximum (for coinsurance and deductible)

Out-of-pocket maximum may be subject to a “cost of living” increase on a yearly basis. This “cost of living” increase is tied to the Consumer Price Index (CPI) and may be up to, but no greater than, the CPI.

There may also be adjustments made to the out-of-pocket maximum on a yearly basis in order to meet the requirements for the Policy to stay at the same metal level (Platinum, Gold, Silver or Bronze).

You will receive a notice of change 30 days in advance.

Your Out-Of-Pocket Expenses

Per member	\$7,500
Per family	Applies to your combined in-network and out-of-network benefits.
	\$15,000
	Applies to your combined in-network and out-of-network benefits.
Lifetime maximum amount payable per member	Unlimited

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*.

Not covered

1. Drugs provided or administered by a physician or other provider, except those drugs that meet the definition of “professionally administered drugs.” Coverage for “professionally administered drugs” is as described under *Professionally Administered Drugs*. Coverage for drugs is as described in *Prescription Drugs* or otherwise described as a specific benefit elsewhere in this section.

Prior authorization. Prior authorization from MIC may be required *before* you receive services or supplies. For a list of the specific services and supplies that require MIC’s prior authorization, please 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
- Genetic testing
- Hospital
- Inpatient
- Member
- Network
- Non-network
- Non-network provider reimbursement amount
- Physician
- Prenatal care
- Provider
- Retail health clinic
- Telemedicine
- Urgent care center
- Virtual care

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

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

Your Benefits and the Amounts You Pay

Benefits (after deductible)	In-network benefits You pay	Out-of-network benefits You pay
1. Office visits Please note: This benefit does not include services received from locations using "hospital-based outpatient billing" practices. The most specific and appropriate benefit in this Policy will apply for each service received at that type of provider. If you are unsure if your provider uses these billing practices, please contact them.	20% coinsurance	20% coinsurance
2. Convenience care		
a. Retail health clinic	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.
b. Virtual care	20% coinsurance	No coverage
3. Telemedicine	20% coinsurance	20% coinsurance
4. 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
5. Maternity care		

Your Benefits and the Amounts You Pay

Benefits (after deductible)	In-network benefits You pay	Out-of-network benefits You pay
--------------------------------	--------------------------------	------------------------------------

- | | | |
|---|---|---|
| a. Prenatal care services, including services for prenatal complications without delivery, 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 | 20% coinsurance | 20% coinsurance |
| c. Postpartum office visit | 20% coinsurance | 20% coinsurance |
| d. Home health care visit following delivery | 20% coinsurance | 20% coinsurance |

Please note: One home health visit is covered if it occurs within 4 days of discharge. Services eligible for coverage include but are not limited to, parent education, assistance and training in breast and bottle feeding and conducting any necessary and appropriate clinical tests. If services are received after 4 days, please refer to *Home Health Care* for benefits.

5. Preventive health care

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

Your Benefits and the Amounts You Pay

Benefits (after deductible)	In-network benefits You pay	Out-of-network benefits You pay
a. Child health supervision services, including well-baby care, including well-baby care, pediatric preventive services, appropriate immunizations up to age 18, developmental assessments, and appropriate laboratory services	Nothing. The deductible does not apply.	20% coinsurance Except you pay nothing for these services for members to age 6 and the deductible does not apply
b. Adult immunizations	Nothing. The deductible does not apply.	20% coinsurance Except, for members under age 18, you pay nothing and the deductible does not apply.
c. Early disease detection services including physicals	Nothing. The deductible does not apply.	20% coinsurance
d. Routine screening procedures for cancer including, but not limited to, screening for prostate cancer (including prostate-specific antigen for blood test and a digital rectal exam and without age limitation), ovarian cancer and colorectal cancer	Nothing. The deductible does not apply.	20% coinsurance

Your Benefits and the Amounts You Pay

Benefits (after deductible)	In-network benefits You pay	Out-of-network benefits You pay
e. Women's preventive health services including mammograms, BRCA genetic testing and related genetic counseling (when appropriate), screenings for cervical cancer (including pap smears), human papillomavirus (HPV) testing, counseling for sexually transmitted infections, counseling for immunodeficiency virus (HIV), and sterilization.	Nothing. The deductible does not apply.	20% coinsurance
f. Other preventive health services, including tobacco cessation counseling	Nothing. The deductible does not apply.	20% coinsurance
6. Allergy shots	20% coinsurance	20% coinsurance
7. Refractive eye exams	20% coinsurance Except you pay nothing for these services for members under age 19 and the deductible does not apply	20% coinsurance
8. Chiropractic services to diagnose and to treat, by manual manipulation or certain therapies, neuromusculoskeletal conditions related to the spine or joint	20% coinsurance	20% coinsurance
9. Genetic counseling, whether pre- or post-test, and whether occurring in an office, clinic, or telephonically	20% coinsurance	20% coinsurance
Please note: Genetic counseling for BRCA testing, if appropriate, is covered as a woman's preventive health service.		

Your Benefits and the Amounts You Pay

Benefits (after deductible)	In-network benefits You pay	Out-of-network benefits You pay
10. Professional sign language interpreter services in a physician's office (Call Customer Service to arrange such services.)	20% coinsurance	20% coinsurance
11. 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
12. Anesthesia services received from a provider during an office visit or an outpatient hospital or ambulatory surgical center visit	20% coinsurance	20% coinsurance
13. 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.
14. Services received from a physician during an inpatient stay	20% coinsurance	20% coinsurance
15. Anesthesia services received from a provider during an inpatient stay.	20% coinsurance	20% coinsurance
16. Outpatient and inpatient lab and pathology	20% coinsurance	20% coinsurance

Your Benefits and the Amounts You Pay

Benefits (after deductible)	In-network benefits You pay	Out-of-network benefits You pay
17. Genetic testing when test results will directly affect treatment decisions or frequency of screening for a disease, or when results of the test will affect reproductive choices. Please note: BRCA testing, if appropriate, is covered as a woman's preventive health service	20% coinsurance	20% coinsurance
18. Outpatient and inpatient x-rays and other imaging services	20% coinsurance	20% coinsurance
19. Other outpatient hospital or ambulatory surgical center services received from a physician	20% coinsurance	20% coinsurance
20. Treatment to lighten or remove the coloration of a port wine stain	20% coinsurance	20% coinsurance
21. Diabetes self-management training and education (for Type I and Type II), including medical nutrition therapy, received from a provider in a program consistent with national educational standards (as established by the American Diabetes Association) Please note: Management and supplies for gestational diabetes is covered as a prenatal care benefit in <i>Maternity care</i> .	20% coinsurance	20% coinsurance
22. Neuropsychological evaluations/cognitive testing, limited to services necessary for the diagnosis or treatment of a medical illness or injury	20% coinsurance	20% coinsurance

Your Benefits and the Amounts You Pay

Benefits (after deductible)	In-network benefits You pay	Out-of-network benefits You pay
<p>23. Eyewear, including eyeglass lenses, frames or contact lenses for members 18 years of age and younger received from an optical provider (coverage continues through the end of the month in which the member turns 19)</p> <p>Coverage is limited to one pair of frames and lenses every calendar year. Contact lenses are limited to coverage once every calendar year. Low vision aids which are hand-held lenses, spectacle mounted lenses or telescopic lens systems are limited to one device every calendar year.</p> <p>Please note: This limit includes eyewear that you pay for in order to satisfy any part of your deductible.</p>	<p>20% coinsurance</p>	<p>20% coinsurance</p>
<p>24. Routine patient costs in connection with a qualified individual's participation in an approved clinical trial</p>	<p>Covered at the corresponding in-network benefit level, depending on type of services provided.</p> <p>For example, office visits are covered at the office visit in-network benefit level and surgical services are covered at the surgical services in-network benefit level.</p>	<p>Covered at the corresponding out-of-network benefit level, depending on type of services provided.</p> <p>For example, office visits are covered at the office visit out-of-network benefit level and surgical services are covered at the surgical services out-of-network benefit level.</p>

F. Prescription Drugs

This section describes coverage for prescription drugs and supplies received from a pharmacy.

Prescription drugs and supplies are covered if they are:

- Prescribed by an authorized provider,
- Included on MIC's drug list (unless identified as not covered), and
- Received from a pharmacy.

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

For these purposes, "self-administered drugs" are drugs that do not meet the definition of "professionally administered drugs."

MIC's Drug List

MIC's drug list (Drug List) is comprised of drugs that meet the medical needs of our members and have proven safety and effectiveness. It includes both brand-name and generic drugs. The drugs on this list have been approved by the Food and Drug Administration (FDA). The Drug List identifies whether a drug is classified by MIC as a preferred generic, generic, preferred brand, or non-preferred brand drug. A team of physicians and pharmacists meets regularly to review and update the Drug List. Your doctor can use this list to select medications for your health care needs, while helping you maximize your prescription drug benefit. You will be notified in advance if there are any changes to the Drug List that affect medications you are receiving.

The terms "generic" and "brand name" are used in the health care industry in different ways. To better understand your coverage, please review the following:

Generic: A drug: (1) that contains the same active ingredient as a brand name drug and is chemically equivalent to a brand name drug in strength, concentration, dosage form and route of administration; or (2) that MIC identifies as a preferred generic or generic product. MIC uses industry standard resources to determine a drug's classification as either brand name or generic. Not all products identified as "generic" by the manufacturer, pharmacy or your provider may be classified by MIC as generic.

MIC's Drug List includes **preferred generic** drugs and **generic** drugs. These medications are your lower copayment or coinsurance options. Consider a preferred generic or generic covered drug if you and your provider decide such a drug is appropriate for your treatment. Preferred generic drugs may be identified in the Drug List as Tier 1 and generic drugs may be identified as Tier 2.

Brand: A drug: (1) that is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that MIC identifies as a brand name product. MIC uses industry standard resources to determine a drug's classification as either brand name or generic. Not all products identified as "brand name" by the manufacturer, pharmacy or your provider may be classified by MIC as brand name.

Preferred brand drugs on the Drug List have a higher copayment or coinsurance. You may consider a preferred brand covered drug to treat your condition if you and your provider decide it is appropriate. Preferred brand drugs may be identified in the Drug List as Tier 3.

Non-preferred brand drugs have the highest copayment or coinsurance. The covered non-preferred brand drugs are usually more costly. Non-preferred brand drugs may be identified in the Drug List as Tier 4.

If you have questions about MIC's Drug List or whether a specific drug is covered (and/or whether the drug is preferred generic, generic, preferred brand, or non-preferred brand), or if you would like to request a copy of the Drug List at no charge, call Customer Service at one of the telephone numbers listed inside the front cover. It is also available on medica.com/IndividualLogin.

Exceptions to the Drug List

In certain cases, it is possible to get an exception to the coverage rules described under *MIC's Drug List* above. **Please note that exceptions will only be allowed when specific clinical criteria are satisfied.**

Exceptions 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 Drug List or you change health plans. Antipsychotic drug(s) prescribed to treat emotional disturbance or mental illness will be covered for up to one year if the prescribing provider:

- Certifies to MIC in writing that he/she has considered all equivalent drugs on the Drug List and has determined that the drug prescribed will best treat your condition (unless the drug was removed from MIC's Drug List for safety reasons); or
- Indicates to MIC that drugs on the Drug List cause you to have an adverse reaction, are contraindicated for you, or the prescription drug must be dispensed as written to provide maximum medical benefit to you, unless the requested drug was removed from the Drug List for safety reasons.

If you have a health condition that may seriously jeopardize your life, health, or ability to regain maximum function or if you are undergoing a current course of treatment with a drug not included on the Drug List, an expedited review may be requested. MIC will make a determination and provide notification on an expedited review request within 24 hours of receiving the request. For all other exception requests (standard requests), MIC will make a determination and provide notification within 72 hours of receiving the request.

If MIC denies your request for an exception, you, your provider, or other designee may request an independent review of MIC's decision by an external review organization. To make a request, you may call Customer Service at one of the telephone numbers listed inside the front cover or contact MIC by writing to Customer Service, Route CP595, PO Box 9310, Minneapolis, MN 55440-9310. You will be notified of the external review organization's decision within 72 hours of receipt of the request for external review, unless you are requesting review of a denial that was completed as an expedited review. In that case, you will be notified of the external review organization's decision within 24 hours of receipt of the request for external review.

If you would like to request a copy of MIC's Drug List exception process or for more information regarding the expedited review process, call Customer Service at one of the telephone numbers listed inside the front cover.

Prescription unit

A prescription unit is the amount that will be dispensed unless it is limited by the drug manufacturer's packaging, dosing instructions or MIC's medication request guidelines. This includes quantity limits that are indicated on the Drug List. Copayment or coinsurance amounts will apply to each prescription unit dispensed.

One prescription unit from a pharmacy is a 31-consecutive-day supply (or, in the case of contraceptives, up to a one-cycle supply).

MIC has specifically designated certain network pharmacies to dispense multiple prescription units. These pharmacies may dispense three prescription units for covered drugs prescribed to treat chronic conditions. For the list of these designated pharmacies, visit [medica.com](https://www.medicare.com) or call Customer Service.

Special requirements

For some prescriptions there are special requirements that must be met in order to receive coverage. These include:

Prior authorization (PA)

Certain drugs require prior authorization (approval in advance) from MIC in order to be covered. These medications are shown on the Drug List with the abbreviation “PA.” The Drug List is available to providers, including pharmacies. Please see *Prior authorization* in *How to Access Your Benefits* for more information about prior authorization requirements and processes. Your network provider who prescribes the drug should initiate the prior authorization process. You must contact Customer Service to request prior authorization for drugs prescribed by a non-network provider. You will pay the entire cost of the drug received if you do not meet MIC’s authorization criteria.

Step therapy (ST)

Step therapy is a process that involves trying an alternative covered drug first (typically a generic drug) before moving to a preferred brand or non-preferred brand covered drug for treatment of the same medical condition. The medications subject to step therapy are shown on the Drug List with the abbreviation “ST.” You must meet applicable step therapy requirements before MIC will cover these preferred brand or non-preferred brand drugs.

Quantity limits (QL)

Certain covered drugs have limits on the maximum quantity allowed per prescription over a specific time period. The medications subject to quantity limits are shown on the Drug List with the abbreviation “QL.” Some quantity limits are based on the manufacturer’s packaging, FDA labeling or clinical guidelines.

Pharmacy requirement

Certain self-administered cancer treatment medications must be obtained from a Medica-designated specialty pharmacy in order to be covered.

Covered

The following table provides important general information concerning benefits. For specific information concerning benefits and the amounts you pay, see the benefit table at the end of this section.

Benefits

1. Covered drugs prescribed by a provider authorized to prescribe the drug and received at a network pharmacy; and
2. Prescription drugs or Drug List OTC drugs for family planning services or the treatment of sexually transmitted diseases when prescribed by or received from either a network or a non-network provider; and
3. Diabetic equipment and supplies, including blood glucose meters, (described in this section) when received from a network pharmacy; and
4. All FDA-approved drugs (including women's contraceptives), tobacco cessation products and other supplies and services that are considered preventive health services.

See *Durable Medical Equipment And Prosthetics* for coverage of insulin pumps and their related supplies.

Not covered

The following are not covered:

1. Any amount above what MIC would have paid when you fail to identify yourself to the pharmacy as a member. (MIC will notify you before enforcement of this provision.)
2. Over the counter (OTC) drugs that by federal or state law do not require a prescription order or refill and any medication that is therapeutically equivalent to an OTC drug, except those that are considered preventive health services.
3. Replacement of a drug due to loss, damage, or theft.
4. Appetite suppressants.
5. Weight loss medications.
6. Sexual dysfunction medications.
7. Drugs prescribed by a provider who is not acting within his/her scope of licensure.
8. Homeopathic medicine.
9. Infertility drugs.
10. Prescription drugs, including diabetic equipment and supplies and preventive drugs and other supplies, received at a non-network pharmacy.

11. Drugs and supplies not listed on MIC's Drug List, unless covered through the exception process described in this Policy. Such exclusions are in addition to drugs or classes of drugs excluded under other provisions of this Policy.
12. Bulk powders, chemicals and products used in prescription drug compounding.
13. Products that are duplicative to, or are in the same class and category as, products on MIC's Drug List.
14. New to market drugs: Products recently approved by the FDA and introduced into the market will not be covered until they are reviewed and considered for placement on the Drug List.

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

Your Benefits and the Amounts You Pay (After deductible)

In-network benefits

You pay

Out-of-network benefits

You pay

1. Prescription drugs received at a retail pharmacy, other than those described below.

Preferred generic: 20% coinsurance per prescription unit or refill; or

Preferred generic: 20% coinsurance per prescription unit or refill; or

Generic: 20% coinsurance per prescription unit or refill; or

Generic: 20% coinsurance per prescription unit or refill; or

Preferred brand: 20% coinsurance per prescription unit or refill

Preferred brand: 20% coinsurance per prescription unit or refill

Non-preferred brand: 20% coinsurance per prescription unit or refill

Non-preferred brand: 20% coinsurance per prescription unit or refill

2. Up to a 24-hour supply of emergency prescription drugs received from a hospital or convenient/urgent care center

Preferred generic: 20% coinsurance per prescription unit or refill; or

Preferred generic: 20% coinsurance per prescription unit or refill; or

Generic: 20% coinsurance per prescription unit or refill; or

Generic: 20% coinsurance per prescription unit or refill; or

Your Benefits and the Amounts You Pay

(After deductible)

In-network benefits

Out-of-network benefits

You pay

You pay

Preferred brand: 20% coinsurance per prescription unit or refill

Preferred brand: 20% coinsurance per prescription unit or refill

Non-preferred brand: 20% coinsurance per prescription unit or refill

Non-preferred brand: 20% coinsurance per prescription unit or refill

3. Diabetic equipment and supplies, including blood glucose meters

Preferred generic: 20% coinsurance per prescription unit or refill; or

Preferred generic: 20% coinsurance per prescription unit or refill; or

Generic: 20% coinsurance per prescription unit or refill; or

Generic: 20% coinsurance per prescription unit or refill; or

Preferred brand: 20% coinsurance per prescription unit or refill

Preferred brand: 20% coinsurance per prescription unit or refill

Non-preferred brand: 20% coinsurance per prescription unit or refill

Non-preferred brand: 20% coinsurance per prescription unit or refill

3. All FDA-approved drugs (including women's contraceptives), tobacco cessation products and other supplies and services that are considered preventive health services

Please note: The list of covered preventive drugs and other services is specific and limited. For a current list, go to medica.com/IndividualLogin or call Customer Service

Nothing

No coverage

The deductible does not apply.

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

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.

When an inpatient stay spans an old and new policy year, the benefit for charges billed on the hospital claim will be based on the old policy year provisions. Certain covered services received, such as a physician visit or lab and pathology services, performed during the inpatient stay but billed separately from the hospital, will apply to the benefits in effect on the date the covered service was provided.

If your coverage under a MIC policy ends during your inpatient stay, MIC will not cover the portion of your inpatient stay or other services received after your MIC Policy terminates.

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

Not covered

1. Drugs received at a hospital on an outpatient basis, except drugs that meet the definition of "professionally administered drugs" or drugs received in an emergency

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

room or a hospital observation room. Coverage for “professionally administered drugs” is as described under *Professionally Administered Drugs*. Coverage for drugs is as described in *Prescription Drugs*.

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

Your Benefits and the Amount You Pay

Benefits (after 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 and pathology	20% coinsurance	20% coinsurance
c. Outpatient x-rays and other imaging services	20% coinsurance	20% coinsurance
d. Maternity labor and delivery services	20% coinsurance	20% coinsurance
e. Prenatal care services, including services for prenatal complications without delivery.	Nothing. The deductible does not apply.	Nothing. The deductible does not apply.
f. Other outpatient services	20% coinsurance	20% coinsurance
g. Other outpatient hospital and ambulatory surgical center services received from a physician	20% coinsurance	20% coinsurance

Your Benefits and the Amount You Pay

Benefits (after deductible)	In-network benefits You Pay	Out-of-network benefits You pay
h. Anesthesia services received from a provider during an office visit or an outpatient hospital or ambulatory surgical center visit	20% coinsurance	20% coinsurance
i. Routine patient costs in connection with a qualified individual's participation in an approved clinical trial	Covered at the corresponding in-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit in-network benefit level and surgical services are covered at the surgical services in-network benefit level.	Covered at the corresponding out-of-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit out-of-network benefit level and surgical services are covered at the surgical services out-of-network benefit level.
2. Services provided in a hospital observation room	20% coinsurance	20% coinsurance
3. Inpatient services, including semi-private room and board in a hospital and services received from a physician during an inpatient stay: A private room is covered only for conditions of preeclampsia, radium implants, contagion or immunosuppression that require isolation		
a. Inpatient services other than for maternity care	20% coinsurance	20% coinsurance
b. Inpatient services for maternity care:		

Your Benefits and the Amount You Pay

Benefits (after deductible)	In-network benefits You Pay	Out-of-network benefits You pay
i. For inpatient services related to prenatal care services, including prenatal complications, that do not result in a delivery	Nothing. The deductible does not apply.	Nothing. The deductible does not apply.
ii. For all other inpatient maternity labor and delivery services	20% coinsurance	20% coinsurance
c. Anesthesia services received from a provider during an inpatient stay	20% coinsurance	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 certain 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

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 deductible)	In-network benefits	Out-of-network benefits
	You pay	You pay
1. Ambulance services or ambulance transportation to the nearest hospital for an emergency	20% coinsurance	Covered as an in-network benefit.
2. Non-emergency licensed ambulance service that is arranged through an attending physician, as follows:		
a. Transportation from hospital to hospital when:	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.

Covered

For benefits and the amounts you pay, see the table in this section. MIC covers skilled care in your place of residence for members that are homebound.

(Exception: You are not required to be homebound to be eligible for home infusion therapy or services received in your home from a physician.) Skilled services must be ordered by a physician who has conducted a face-to-face assessment per Medicare guidelines.

To be considered homebound, a doctor must certify that you're homebound. To be homebound means the following:

- Leaving your home isn't recommended because of your condition.
- Your condition keeps you from leaving your home without help (such as using a wheelchair or walker, needing special transportation, of getting help from another person).
- Leaving home takes a considerable and taxing effort.

A person may leave home for a medical treatment or short, infrequent absences for non-medical reasons, such as attending religious services. You can still get home health care if you attend adult day care, but you would get the home care services in your home. A dependent child may still be considered homebound when attending school where life support specialized equipment and help are available.

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.

- *In-network benefits* apply to covered home health care services received from a network home health care agency.
- *Out-of-network benefits* apply to covered home health care services received from a non-network home

Prior authorization. Prior authorization from MIC may be required *before* you receive services or supplies, even if a provider has directed or recommended that you receive the services or supplies. For a list of the specific services and supplies that require MIC's prior authorization, please 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.

health care agency. In addition to the deductible 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.

Not covered

These services, supplies and associated expenses are not covered:

1. Extended hours home care.
2. Companion, homemaker and personal care services.
3. Services provided by a member of your family.
4. Custodial care and other nonskilled services.
5. Physical, speech or occupational therapy provided in your home for convenience.
6. Skilled nursing care, or skilled physical, occupational or speech therapy provided in your home when you are not homebound.
7. Services primarily educational in nature.
8. Vocational and job rehabilitation.
9. Recreational therapy.
10. Self-care and self-help training (non-medical).
11. Health clubs.
12. Disposable supplies and appliances, except as described in this Policy.
13. Home infusion therapy provided by a non-network provider.
14. Voice training and voice therapy
15. Outpatient rehabilitation and habilitative care services when no medical diagnosis is present.
16. Drugs provided or administered by a physician or other provider, except those drugs that meet the definition of “professionally administered drugs.” Coverage for “professionally administered drugs” is as described under *Professionally Administered Drugs*. Coverage for drugs is as described in *Prescription Drugs* or otherwise described as a specific benefit elsewhere 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 deductible)	In-network benefits You pay	Out-of-network benefits You pay
1. Skilled care when you are homebound, provided by or supervised by a registered nurse	20% coinsurance For high-risk prenatal care services, the deductible does not apply.	20% coinsurance For high-risk prenatal care services, the deductible does not apply
2. Skilled physical, speech or occupational therapy when you are homebound	20% coinsurance	20% coinsurance
3. Home infusion therapy	20% coinsurance For high-risk prenatal care services, the deductible does not apply.	No coverage Except you pay nothing for high-risk prenatal care services and the deductible does not apply
4. Services received in your home from a physician	20% coinsurance	20% coinsurance

J. *Physical, Speech And Occupational Therapies*

This section describes coverage for the following rehabilitative and habilitative care: physical therapy, speech therapy, and occupational therapy services provided on an outpatient basis. A physician must direct your care in order for it to be eligible for coverage. Coverage for services provided on an inpatient basis is as described elsewhere in this Policy.

Covered

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

- *In-network benefits* apply to outpatient physical therapy, speech therapy, and occupational therapy 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 physical therapy, speech therapy, and occupational therapy 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 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. Voice training and voice therapy.
7. Outpatient rehabilitation and habilitative care 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
- Habilitative care
- Network
- Non-network
- Non-network provider reimbursement amount
- Physician
- Rehabilitative

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

Physical, Speech And Occupational Therapies

Your Benefits and the Amounts You Pay		
Benefits (after deductible)	In-network benefits You pay	Out-of-network benefits You pay
1. Physical therapy services received outside of your home		
a. Habilitative services	20% coinsurance	20% coinsurance
b. Rehabilitative services	20% coinsurance	20% coinsurance
2. Speech therapy services received outside of your home		
a. Habilitative services	20% coinsurance	20% coinsurance
b. Rehabilitative services	20% coinsurance	20% coinsurance
3. Occupational therapy services received outside of your home		
a. Habilitative services	20% coinsurance	20% coinsurance
b. Rehabilitative services	20% coinsurance	20% coinsurance

K. Mental Health

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

For purposes of this section:

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

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
- Claim
- Coinsurance
- Custodial care
- Deductible
- Emergency
- Hospital
- Inpatient
- Medically necessary
- Member
- Mental disorder
- Network
- Non-network
- Physician

and that includes an individual treatment plan.
(Refer to 2.a., b., c. and d. in the table in this section to determine your benefits.)

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

(Refer to 2.a., b., c. and d. 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. If you require hospitalization, MIC will refer you to one of its hospital providers. Call Customer Service at one of the telephone numbers listed inside the front cover. Emergency mental health services are covered as in-network benefits. After receiving emergency mental health inpatient services please notify Customer Service at one of the telephone numbers listed inside the front cover as soon as reasonably possible.
- For *out-of-network benefits*:
 1. Mental health services from a non-network provider listed below will be eligible for coverage under out-of-network benefits. Emergency mental health services are eligible for coverage under in-network benefits.

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.

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 psychologist
 - c. Licensed registered nurse certified as a clinical specialist or as a nurse practitioner in psychiatric and mental health nursing
 - d. Licensed mental health clinic.
 - e. Licensed residential treatment center
 - f. Licensed independent clinical social worker
 - g. Licensed marriage and family therapists
 - h. 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, care or treatment that is not medically necessary, unless ordered by a court as specifically described in this section.
3. Relationship and family therapy in the absence of a clinical diagnosis.
4. Services beyond the initial evaluation to diagnose developmental disability or learning disabilities, as those conditions are defined in the current edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*.
5. Telephonic psychotherapy treatment services, unless such services are provided in accordance with MIC's telemedicine policies and procedures.
6. 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, housing with support, a Rule 36 facility or therapeutic group home, except for outpatient mental health services that are specifically described in this section.

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

7. 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.
8. Room and board charges associated with mental health residential treatment services providing less than 30 hours a week per individual of mental health services, or lacking an on-site medical/psychiatric assessment within 48 hours of admission, psychiatric follow-up visits at least once per week, and 24-hour nursing coverage, except as described in 2.f.i. in this section.
9. Drugs provided or administered by a physician or other provider, except those drugs that meet the definition of “professionally administered drugs.” Coverage for “professionally administered drugs” is as described under *Professionally Administered Drugs*. Coverage for drugs is as described in *Prescription Drugs* or otherwise described as a specific benefit elsewhere in this section.

Your Benefits and the Amounts You Pay

Benefits (after 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. Diagnostic evaluations.
 - b. Outpatient treatment (structured outpatient services for less than nine hours per week delivered in an outpatient setting).
 - c. Medication-assisted treatment (the use of medications in conjunction with counseling and behavioral therapies to help maintain sobriety, prevent relapse, and reduce craving in order to sustain recovery).
 - d. Intensive outpatient programs, including day treatment, meaning time limited comprehensive treatment plans, which may include multiple services and modalities, delivered in an outpatient setting (between 9 and 19 hours per week).
 - e. 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 1.a. and b. in the table in this section to determine your benefits.)
 - f. 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 1.a. and b. in the table in this section to determine your benefits.)
 - g. Treatment of pathological gambling.
2. Inpatient services include:

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
- Claim
- Coinsurance
- Custodial care
- Deductible
- Emergency
- Hospital
- Inpatient
- Medically necessary
- Member
- Mental disorder
- Network
- Non-network
- Physician

- 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 2.a., b. and c. in the table in this section to determine your benefits.)
- 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 means a treatment program of 20 hours or more per week and may include lodging. (Refer to 2.a., b., c., d. and e. in the table in this section to determine your benefits.)
- f. Substance abuse residential treatment services. These are services from a licensed chemical dependency rehabilitation program that provides intensive therapeutic services following detoxification. In addition to room and board, at least 30 hours per week per individual of chemical dependency services must be provided, including group and individual counseling, client education, and other services specific to chemical dependency rehabilitation. (Refer to 2.a., b. c., d. and e. 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 2.a., 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. If you require hospitalization, MIC will refer you to one of its hospital providers. Call Customer Service at one of the telephone numbers listed inside the front cover. Emergency substance use disorder services are covered as in-network benefits. After receiving emergency substance use disorder inpatient services please notify Customer Service at one of the telephone numbers listed inside the front cover as soon as reasonably possible.
 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 *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 psychologist
 - c. Licensed registered nurse certified clinical specialist or as a nurse practitioner in psychiatric and mental health nursing
 - d. Licensed chemical dependency clinic
 - e. Licensed residential treatment center
 - f. A hospital that provides substance abuse services
 - g. Licensed independent clinical social worker
 - h. Licensed marriage and family therapist

In addition to the deductible 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:

See *Exclusions* for additional services, supplies and associated expenses that 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, care or treatment that is not medically necessary.
3. Services to hold or confine a person under chemical influence when no medical services are required, regardless of where the services are received.
4. Telephonic substance abuse treatment services, unless such services are provided in accordance with MIC's telemedicine policies and procedures.
5. Services beyond the primary treatment of substance abuse.
6. 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 group home, except for outpatient substance abuse services that are specifically described in this section.
7. Room and board charges associated with substance abuse treatment services providing less than 30 hours a week per individual of chemical dependency services, including group and individual counseling, client education, and other services specific to chemical dependency rehabilitation.
8. Services to assist in activities of daily living that do not seek to cure and are performed regularly as a part of a routine or schedule.
9. Drugs provided or administered by a physician or other provider, except those drugs that meet the definition of "professionally administered drugs." Coverage for "professionally administered drugs" is as described under *Professionally Administered Drugs*. Coverage for drugs is as described in *Prescription Drugs* or otherwise described as a specific benefit elsewhere in this section.

Your Benefits and the Amounts You Pay

Benefits (after deductible)	In-network benefits You pay	Out-of-network benefits You pay
1. Outpatient services		
a. Evaluations, diagnostic and primary treatment services	20% coinsurance	20% coinsurance
b. Intensive outpatient programs	20% coinsurance	20% coinsurance
2. Medication-assisted treatment	20% coinsurance	20% coinsurance
Please note: When the prescription drug component of this treatment is received at a pharmacy, your <i>Prescription Drug</i> benefit will be applied.		
3. 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
d. Partial program	20% coinsurance	20% coinsurance
e. Residential treatment 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, and hearing aids that meet the criteria established by MIC. Some items ordered by your physician, even if medically necessary, may not be covered. To request a list of MIC's eligible durable medical equipment and certain related supplies, call Customer Service at one of the telephone numbers listed inside the front cover.

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

Quantity limits may apply to durable medical equipment, prosthetics and medical supplies.

Diabetic equipment and supplies, other than insulin pumps and the equipment and supplies related to insulin pumps, are covered under the *Prescription Drug* section of this Policy.

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

Prior authorization. Prior authorization from MIC may be required *before* you receive certain 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 or hearing aid 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

are responsible for charges in excess of the non-network provider reimbursement amount.

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, appliances and hearing aids not on the MIC eligible list.
2. Charges in excess of the MIC standard model of durable medical equipment, prosthetics or hearing aids.
3. Repair, replacement or revision of properly functioning durable medical equipment and prosthetics, including, but not limited to, due to loss, damage or theft.
4. Duplicate durable medical equipment, prosthetics and hearing aids, including repair, replacement or revision of duplicate items.

Your Benefits and the Amounts You Pay

Benefits (after 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

Durable Medical Equipment And Prosthetics

Your Benefits and the Amounts You Pay		
Benefits (after deductible)	In-network benefits You pay	Out-of-network benefits You pay
<p>c. Scalp hair prosthesis due to alopecia areata</p> <p>Coverage is limited to one prosthesis per calendar year for in-network and out-of-network combined.</p> <p>Please note: The benefit maximum includes amounts you pay for scalp hair prosthesis in order to satisfy any part of your deductible.</p>	20% coinsurance	20% coinsurance
<p>d. Repair, replacement or revision of artificial limbs, eyes and breast prostheses made necessary by normal wear and use</p>	20% coinsurance	20% coinsurance
<p>4. Hearing aids for members 18 years of age and younger for hearing loss that is not correctable by other covered procedures.</p> <p>Limited to one hearing aid per ear every three years.</p>	20% coinsurance	20% coinsurance
<p>5. Insulin pumps and their related supplies</p>	20% coinsurance	20% coinsurance

N. *Miscellaneous Medical Services And Supplies*

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

Covered

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

- *In-network benefits* apply to miscellaneous medical services and supplies received from a network provider.
- *Out-of-network benefits* apply to miscellaneous medical services and supplies received from a non-network provider. In addition to the deductible and coinsurance described for out-of-network benefits, you are responsible for any charges in excess of the non-network provider reimbursement amount.

Not covered

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

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

See *Definitions*. These words have specific meanings:

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

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

Miscellaneous Medical Services And Supplies

Your Benefits and the Amounts You Pay		
Benefits (after deductible)	In-network benefits You pay	Out-of-network benefits You pay
1. Injectable pharmaceutical treatments for hemophilia and bleeding disorders	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.-g. above is limited to members five years of age and younger.		
4. Total parenteral nutrition	20% coinsurance	20% coinsurance
5. Eligible ostomy supplies	20% coinsurance	20% coinsurance

O. **Organ And Bone Marrow Transplants And Other Complex Medical Conditions**

This section describes coverage for certain organ and bone marrow transplant services and services for other complex medical conditions. Not all network hospitals are in-network for organ and bone marrow transplants and other complex medical conditions. Services covered under this section must be provided under the direction of a physician and received at a designated facility. This section also describes benefits for professional, hospital and ambulatory surgical center services.

Coverage under this section is provided for certain medical conditions and certain types of organ or bone marrow transplants and related services (including organ acquisition and procurement) that are:

- medically necessary,
- appropriate for the diagnosis,
- without contraindications, and
- non-investigative.

Covered

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

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

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

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

- *In-network benefits* apply to transplant services provided by a network provider and received at a designated facility for transplant services. MIC has

Prior authorization. Prior authorization from MIC is required *before* you receive services or supplies, even if a provider has directed or recommended that you receive the services or supplies. For a list of the specific services and supplies that require MIC's prior authorization, please 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
- Designated facility
- Hospital
- Inpatient
- Investigative
- Medically necessary
- Member
- Network
- Non-network
- Non-network provider reimbursement amount
- Physician
- Provider

entered into separate contracts to provide certain transplant-related health services to members receiving transplants.

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

For in-network benefits, MIC requires that all pre-transplant, transplant and post-transplant services, from the time of the initial evaluation through no more than one year after the date of the transplant, be received at one designated facility (that you select from among the list of transplant facilities MIC provides). Based on the type of transplant you receive, MIC will determine the specific time period medically necessary for these services.

Other Complex Medical Conditions: MIC uses specific medical criteria to determine benefits for complex medical conditions. Because medical technology is constantly changing, MIC reserves the right to review and update these medical criteria.

- For certain complex medical conditions, benefits are only available under this section if there is no in-network care available under other provisions of this policy for the complex medical condition.
- For certain other complex medical conditions, even if in-network care is available under other provisions of this policy, benefits under this policy for the treatment of the complex medical condition are only available under this section. If you choose not to obtain care from a designated facility, benefits are not available under this policy for treatment of that complex medical condition.
- In-network benefits under this section apply to services for complex medical conditions provided by a network provider and received at a designated facility. MIC has entered into separate contracts to provide certain health services for complex medical conditions to members.

Important: *Out-of-network benefits* are not provided for transplant services or services for other complex medical conditions that are authorized at a designated

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

facility. Services are covered only if provided by a network provider and designated 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. 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 procedure. This includes treatment of nicotine or caffeine addiction, services and related expenses for weight loss programs, nutritional supplements, appetite suppressants and supplies of a similar nature not otherwise covered under this Policy.
7. Mechanical, artificial or non-human organ implants or transplants and related services that would not be authorized by MIC under the medical criteria referenced in this section.
8. Services that are investigative.
9. Private collection and storage of umbilical cord blood for directed use.
10. Drugs provided or administered by a physician or other provider on an outpatient basis, except those drugs that meet the definition of “professionally administered drugs.” Coverage for “professionally administered drugs” is as described under *Professionally Administered Drugs*. Coverage for drugs is as described in *Prescription Drugs* or otherwise described as a specific benefit in this Policy.

Organ And Bone Marrow Transplants

11. Services provided by a non-network provider or non-designated facility.

Your Benefits and the Amounts You Pay		
Benefits (after 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 Transplants

Your Benefits and the Amounts You Pay

Benefits (after 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
5. Anesthesia services received from a provider during an inpatient stay	20% coinsurance	No coverage

P. Professionally Administered Drugs

This section describes coverage for professionally administered drugs.

MIC covers medically necessary professionally administered drugs that are administered, in conjunction with a covered benefit such as an office visit or home health care visit, by a physician acting within the scope of the provider's license, on an outpatient basis in a hospital, physician's office, or in your home.

If you require certain professionally administered drugs, we may direct you to a designated facility with whom we have an arrangement to provide those certain professionally administered drugs. Such designated facilities may include an outpatient pharmacy, specialty pharmacy, home health care agency, home infusion provider, hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy. If you or your provider administering the professionally administered drugs are directed to a designated facility and you or your provider choose not to obtain your professionally administered drug from that designated facility, benefits are not available under this policy for that professionally administered drug.

Prior authorization. Prior authorization from MIC may be required before you receive services or supplies, even if a provider has directed or recommended that you receive the services or supplies. For a list of the specific services and supplies that require MIC's prior authorization, please 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.

Prior authorization. Prior authorization from MIC may be required *before* you receive services or supplies even if a provider has directed or recommended that you receive the services or supplies. For a list of the specific services and supplies that require MIC's prior authorization, please 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
- Designated facility
- Hospital
- Medically necessary
- Member
- Network
- Non-network
- Non-network provider reimbursement amount
- Physician
- Professionally administered drugs
- Provider

Covered

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

- *In-network benefits* apply to professionally administered drugs received from a network provider.
- *Out-of-network benefits* apply to professionally administered drugs 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.

Professionally Administered Drugs

Your Benefits and the Amounts You Pay

Benefits

In-network benefits after deductible

*Out-of-network benefits after deductible

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

1. Professionally administered drugs that are required to be administered at a designated facility

If administered at a designated facility:

Covered at the corresponding in-network benefit level, depending on whether it is administered during a home health care visit, office visit, or outpatient hospital visit.

For example, if the professionally administered drug was administered during an office visit, then the professionally administered drug is covered at the office visit in-network benefit level. If the professionally administered drug was administered during a home health care visit, then the professionally administered drug is covered at the home health care visit in-network benefit level.

If not administered at a designated facility:

No coverage

No coverage

2. Professionally administered drugs that are not required to be administered at a designated facility

Covered at the corresponding in-network benefit level, depending on whether it is administered during a home health care visit, office visit, or outpatient hospital visit.

For example, if the professionally administered drug was administered during an office visit, then the professionally administered drug is covered at the office visit in-network benefit level. If the professionally administered drug was administered during a home health care visit, then the professionally administered drug is covered at the home health care visit in-network benefit level.

Covered at the corresponding out-of-network benefit level, depending on whether it is administered during a home health care visit, office visit, or outpatient hospital visit.

For example, if the professionally administered drug was administered during an out-of-network office visit, then the professionally administered drug is covered at the out-of-network office visit benefit level.

Q. 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

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. 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.
7. Drugs provided or administered by a physician or other provider on an outpatient basis, except those drugs that meet the definition of "professionally administered drugs." Coverage for "professionally administered drugs" is as described under *Professionally Administered Drugs*. Coverage for drugs is as described in *Prescription Drugs* or otherwise described as a specific benefit in this Policy.

Reconstructive And Restorative Surgery

Your Benefits and the Amounts You Pay		
Benefits (after 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. Anesthesia services received from a provider during an office visit or an outpatient hospital or ambulatory surgical center visit	20% coinsurance	20% coinsurance
iii. Outpatient lab and pathology	20% coinsurance	20% coinsurance
iv. Outpatient x-rays and other imaging services	20% coinsurance	20% coinsurance
v. Other outpatient hospital or ambulatory surgical center services received from a physician	20% coinsurance	20% coinsurance
b. Hospital and ambulatory surgical center services		
i. Outpatient lab and pathology	20% coinsurance	20% coinsurance
ii. Outpatient x-rays and other imaging services	20% coinsurance	20% coinsurance
iii. Other outpatient hospital and ambulatory surgical center services	20% coinsurance	20% coinsurance

Reconstructive And Restorative Surgery

Your Benefits and the Amounts You Pay

Benefits (after deductible)	In-network benefits You pay	Out-of-network benefits You pay
3. Inpatient services	20% coinsurance	20% coinsurance
4. Services received from a physician during an inpatient stay	20% coinsurance	20% coinsurance
5. Anesthesia services received from a provider during an inpatient stay	20% coinsurance	20% coinsurance

R. 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 described for out-of-network benefits, you will be responsible for any charges in excess of the non-network provider reimbursement amount.

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

Not covered

These services, supplies and associated expenses are not covered:

1. Custodial care and other non-skilled services.
2. Self-care or self-help training (non-medical).
3. Private room, except for conditions of preeclampsia, radium implants, contagion or immunosuppression that require isolation.
4. Services primarily educational in nature.
5. Vocational and job rehabilitation.
6. Recreational therapy.
7. Health clubs.

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

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

Your Benefits and the Amounts You Pay

Benefits (after deductible)	In-network benefits You Pay	Out-of-network benefits You Pay
<p>1. Daily skilled care or daily skilled rehabilitation and habilitative services, including room and board</p> <p>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.</p>	<p>20% coinsurance</p> <p>Services are covered only after transfer to a skilled nursing facility within 30 days of discharge from a hospital in which you were confined for not less than three consecutive calendar days.</p>	<p>20% coinsurance</p> <p>Services are covered only after transfer to a skilled nursing facility within 30 days of discharge from a hospital in which you were confined for not less than three consecutive calendar days.</p>
<p>2. Skilled physical, speech or occupational therapy when room and board is not eligible to be covered</p>	<p>20% coinsurance</p>	<p>20% coinsurance</p>
<p>3. Services received from a physician during an inpatient stay in a skilled nursing facility</p> <p>Benefits are limited to services received during 120 days of inpatient stay per calendar year for in-network and out-of-network combined. This day limitation applies whether or not your deductible has been met.</p>	<p>20% coinsurance</p>	<p>20% coinsurance</p>

S. 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 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.

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

Not covered

These services, supplies and associated expenses are not covered:

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

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

Your Benefits and the Amounts You Pay

Benefits (after deductible)	In-network benefits	Out-of-network benefits
	You Pay	You Pay
1. Hospice services	20% coinsurance	No coverage

T. 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

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 services, supplies and associated expenses that are not covered.

1. Diagnostic casts, diagnostic study models, and bite adjustments, unless related to the treatment of temporomandibular joint (TMJ) disorder and craniomandibular disorder or cleft lip and palate.

Your Expenses and the Amounts You Pay

Benefits (after 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. Anesthesia services received from a provider during an office visit or an outpatient hospital or ambulatory surgical center visit	20% coinsurance	20% coinsurance
iii. Outpatient lab and pathology	20% coinsurance	20% coinsurance
iv. Outpatient x-rays and other imaging services	20% coinsurance	20% coinsurance

Temporomandibular Joint (TMJ) Disorder

Your Expenses and the Amounts You Pay		
Benefits (after deductible)	In-network benefits You Pay	Out-of-network benefits You Pay
v. 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 and pathology	20% coinsurance	20% coinsurance
ii. Outpatient x-rays and other imaging services	20% coinsurance	20% coinsurance
iii. 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. Anesthesia services received from a provider during an inpatient stay	20% coinsurance	20% coinsurance
8. TMJ splints and adjustments if your primary diagnosis is joint disorder	20% coinsurance	20% coinsurance

U. *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.

Not covered

These services, supplies and associated expenses are not covered:

1. Dental services to treat an injury from biting or chewing.
2. Osteotomies and other procedures associated with the fitting of dentures or dental implants.
3. Dental implants (tooth replacement) except dental implants related to cleft lip and palate for a dependent child as described in your Policy.
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 deductible)

In-network benefits You pay

Out-of- network benefits You pay

- | | | |
|---|-----------------|-----------------|
| 1. Charges for medical facilities and general anesthesia services that are: | 20% coinsurance | 20% coinsurance |
| a. Recommended by a network physician; and | | |
| b. Received during a dental procedure; and | | |
| c. Provided to a member who: | | |
| i. Is a child under age five (prior authorization is <i>not</i> required); or | | |

Your Benefits and the Amounts You Pay

Benefits (after deductible)	In-network benefits You pay	Out-of- network benefits You pay
<ul style="list-style-type: none"> ii. Is severely disabled; or iii. Has a medical condition and requires hospitalization or general anesthesia for dental care treatment. 		
<p>2. For a dependent child, orthodontia related to cleft lip and palate</p> <p><i>Please note.</i> 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; or b. A tooth root without the extraction of the entire tooth (this does not include root canal therapy); or c. The gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth. 	20% coinsurance	20% coinsurance
<p>4. Accident-related dental services to treat an injury to sound, natural teeth and to repair (not replace) sound, natural teeth. The following conditions apply:</p>	20% coinsurance	No coverage

Your Benefits and the Amounts You Pay

Benefits**(after deductible)****In-network benefits****You pay****Out-of- network benefits****You pay**

- a. Coverage is limited to services initiated within 6 months of the date of the injury and received within 24 months from the later of:
 - i. The date you are first covered under the Policy; or
 - ii. The date of the injury
- b. A sound natural tooth means a tooth (including supporting structures) that is free from disease that would prevent continual function of the tooth for at least one year. In case of primary baby teeth, the tooth must have a life expectancy of one year.

V. Emergency Services From Non-Network Providers

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

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, as defined in *Definitions*.

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.

If you are confined in a non-network facility as a result of an emergency, you will be eligible for in-network benefits until your attending physician agrees it is safe to transfer you to a network facility.

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*.

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 *Definitions*. These words have specific meanings:

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

Emergency services from network providers are eligible for coverage as described in *Professional Services* and *Hospital Services*.

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

Emergency Services From Non-Network Providers

Your Benefits and the Amounts You Pay

Benefits**(after deductible)****In-network benefits****You pay**

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

W. Referrals To Non-Network Providers

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

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.

Referrals To Non-Network Providers

- a. Otherwise eligible for coverage under this Policy;
and
 - b. Recommended by a network physician.
4. Review your request for prior authorization and respond within ten business days of receipt of your request provided that all information reasonably necessary to make a decision has been given to MIC. However, MIC will respond within a time period not exceeding 72 hours from the time of the initial request if 1) your attending provider believes that an expedited appeal is warranted, or 2) MIC concludes that a delay could seriously jeopardize your life, health, or ability to regain maximum function, or 3) you could be subject to severe pain that cannot be adequately managed without the care or treatment you are seeking.

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

X. Harmful Use Of Medical Services

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

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; and
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.

Y. 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 low vision aids, eyeglasses, eyeglass frames, or contact lenses when prescribed solely for vision correction, and their related fittings except as stated in *Professional Services*.
5. Services provided by an audiologist when not under the direction of a physician, hearing aids (including internal, external or implantable hearing aids or devices) and other devices to improve hearing, and their related fittings, except cochlear implants and related fittings and except as stated in *Durable Medical Equipment And Prosthetics*.
6. A drug, device or medical treatment or procedure that is investigative.
7. Genetic testing when performed in the absence of symptoms or high risk factors for a heritable disease; genetic testing when knowledge of genetic status will not affect treatment decisions, frequency of screening for the disease, or reproductive choices; genetic testing that has been performed in response to direct to consumer marketing and not under the direction of your physician.
8. Services or supplies not directly related to care.
9. Autopsies, except as stated in *General Provisions*.

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

- Claim
- Cosmetic
- Custodial care
- Emergency
- Genetic testing
- Investigative
- Medically necessary
- Member
- Non-network
- Physician
- 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, occupational or speech therapy when there is no reasonable expectation of improvement.
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. Certain travel or living expenses may be partially reimbursed when approved by MIC and related to transplant services that have been authorized by MIC as described in *Organ And Bone Marrow Transplants And Other Complex Medical Conditions*.
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, blindness and significant neurological conditions such as Parkinson's disease, Alzheimer's disease, multiple sclerosis, and amyotrophic lateral sclerosis (ALS).
22. Services by persons who are family members or who share your legal residence.
23. Services for which benefits have been paid under workers' 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 conditions of dysplastic nevi and melanoma.
28. Occlusal adjustment or occlusal equilibration.
29. Dental implants (tooth replacement) except dental implants related to cleft lip and palate for a dependent child as described in your Policy.
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.
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. Elective, induced abortions, except as *medically necessary* to protect the life of the mother.
44. Therapeutic acupuncture.
45. Services billed by an acupuncturist.

- 46. Services for or related to vision therapy and orthoptic and/or pleoptic training, except as stated in *Professional Services*.
- 47. Services for or related to intensive behavior therapy treatment programs for the treatment of autism spectrum disorders. Examples of such services include, but are not limited to, Early Intensive Developmental & Behavioral Intervention (EIDBI), Applied Behavioral Analysis (ABA), Intensive Early Intervention Behavior Therapy (IEIBT), Intensive Behavior Intervention (IBI), and Lovaas therapy.
- 48. Sensory Integration including Auditory Integration Training.
- 49. Orthognathic surgery for cosmetic purposes.
- 50. Assisted reproductive technology services, including but not limited to: in vitro fertilization (IVF), gamete and zygote intrafallopian transfer (GIFT and ZIFT) procedures; tubal embryo transfer; intracytoplasmic sperm injection (ICSI); ova or embryo acquisition, retrieval, donation, preservation, and/or storage; and/or any conception that occurs outside the woman's body.
- 51. Charges that are paid under any medical payment, personal injury protection, automobile or other coverage that is paid without regard to fault, including charges that are applied toward any deductible, copayment or coinsurance requirement of such coverage.
- 52. Services for private-duty nursing, except as stated in *Home Health Care*.
- 53. Functional capacity evaluations and related services for vocational purposes or for determination of disability or pension benefits.
- 54. Services for chemotherapy, supplies, drugs and aftercare in connection with a human organ transplant that is not covered (see *Organ And Bone Marrow Transplants And Other Complex Medical Conditions*).

- 55. Services for or in connection with fetal tissue transplantation.
- 56. Services which are not within the scope of licensure or certification of the provider.
- 57. Charges for services by a non-network provider in excess of the non-network provider reimbursement amount.
- 58. Non-emergency transportation.
- 59. Non-emergency services received outside the United States.
- 60. Services provided to your dependents if you have subscriber coverage only. (If you need to add coverage for your dependents, see the *BB. Eligibility And Enrollment* section.)
- 61. Out-of-network virtual care.
- 62. Any form, mixture or preparation of cannabis for medical or therapeutic use and any device or supplies related to its administration.
- 63. Animals and any service or treatment related to animals.
- 64. Drugs provided or administered by a physician or other provider on an outpatient basis, except those drugs that meet the definition of “professionally administered drugs.” Coverage for “professionally administered drugs” is as described under *Professionally Administered Drugs*. Coverage for drugs is as described in *Prescription Drugs* or otherwise described as a specific benefit in this Policy.
- 65. Procedures, tests, or other services that are exclusively provided to monitor the effectiveness of non-covered fertilization procedures.
- 66. Physician, hospital and ambulatory surgical center services for the treatment of infertility.
- 67. Services for intrauterine insemination (IUI).
- 68. Sperm banking and/or storage.
- 69. Donor sperm.
- 70. Donor eggs.
- 71. Services related to adoption.
- 72. Drugs, supplies and biologics that have not been approved by the U.S. Food and Drug Administration (FDA).

- 73. Medical devices that have not been approved by the U.S. Food and Drug Administration (FDA), other than those granted a humanitarian device exemption.
- 74. New to market biologics and professionally administered drugs. Biologics and professionally administered drugs recently approved by the FDA (including approval for a new indication) will not be covered until they are reviewed and approved for coverage by MIC.

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

Claims for benefits from non-network providers

Claim forms are provided in your enrollment materials and can also be found at **medica.com/IndividualLogin**. You may request additional claim forms by calling Customer Service at one of the telephone numbers listed inside the front cover. 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 981647
El Paso, TX 79998-1647

Generally, MIC does not accept assignment of benefits to non-network providers. Upon receipt of your claim for benefits from non-network providers, MIC will pay to you directly the non-network provider reimbursement amount. MIC will notify you of authorization or denial of the claim within 30 days of receipt of the claim.

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

See *Definitions*. These words have specific meanings:

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

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.

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

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.

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.

AA. 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
- Emergency
- Hospital
- 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 or non-group insurance or group-type coverage, whether insured or uninsured, or individual coverage. 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. *Allowable expense* does not include the deductible for members with a primary high deductible plan and who notify MIC of an intention to contribute to a health savings account.

The difference between the cost of a private hospital room and the cost of a semi-private 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. *Nondependent/dependent.* The benefits of the plan that covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the plan, which covers the person as a dependent.
 - ii. *Dependent child/parents not separated or divorced.* Except as stated in 3.b.iii. below, when this plan and another plan cover the

same child as a dependent of different persons, called *parents*:

- a. The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but
- b. If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

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

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

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

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

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

4. Effect on the benefits of this plan

- a. *When this section applies.* This 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 other organizations or persons. 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;
or
- b. Insurance companies; or
- c. Other organizations.

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

Please note. See *MIC's Right To Subrogation And Reimbursement* for additional information.

8. Coordination for Medicare-eligible individuals

The benefits under this Policy are not intended to duplicate any benefits to which members are, or would be, eligible for under Medicare Part B. If we have covered a service under this Policy, any sums payable under Medicare Part B for that service must be paid to MIC. If we need any consents, releases, assignments and other documents, complete and return to us those documents to make sure we receive reimbursement by Medicare Part B.

Medicare is primary if you are enrolled in Medicare in the following circumstances:

- You are at least 65 years old;

- You are less than 65 years old, but are covered by Medicare because of disability or end stage renal disease.

If you are eligible for Medicare Part B, we will consider you covered by Medicare Part B, whether or not you are actually enrolled in Medicare Part B. We will reduce your benefits under this Policy by the amount you would have been eligible for under Medicare Part B if you had actually enrolled in Medicare Part B. You should enroll in Medicare Part B when you are eligible to avoid large out of pocket expenses.

The provisions of this section will apply to the maximum extent permitted by federal or state law. We will not reduce the benefits due any insured where federal law requires that we determine our benefits for that insured without regard to the benefits available under Medicare Part B.

BB. MIC's Right To Subrogation And Reimbursement

This section describes MIC's right to subrogation and reimbursement. MIC's rights are subject to Minnesota and federal law. References to "you" or "your" in this section shall include you, your legal representatives, your Estate and your heirs and next of kin, and beneficiaries unless otherwise stated. For information about the effect of Minnesota and federal law on MIC's subrogation rights, contact an attorney.

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 from any recovery 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. That if MIC pays benefits for medical expenses you incur as a result of any act by a third party for which the third party is or may be legally responsible, and you later obtain full recovery, you are obligated to reimburse MIC for the benefits paid in accordance to Minnesota law.
 - b. To cooperate with MIC or its designee to help protect MIC's legal rights under this subrogation and reimbursement provision and to provide all information MIC may reasonably request to determine its rights under this provision.
 - c. To provide prompt written notice to MIC when you make a claim against a party for injuries.

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.

MIC's Right To Subrogation And Reimbursement

- d. To do nothing to decrease or limit MIC's rights under this provision, either before or after receiving benefits, or under this Policy.
- e. MIC may take action to preserve its legal rights. This includes bringing suit in your name.
- f. MIC may collect its subrogation interest from the proceeds of any settlement or judgment recovered by you, your legal representative or the legal representative(s) of your estate or next-of-kin.

CC. 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 *FF. 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. complete an application form provided by MIC; and
3. be accepted by MIC for enrollment; and
4. not have failed to pay premium which you were obligated to pay for individual/family coverage with MIC or its affiliates for any period of coverage in the 12 months prior to your requested effective date under this Policy.

Child only eligibility

Individuals under the age of 21 are eligible to enroll as a subscriber without an adult on the Policy. Siblings of the child subscriber may be added to the child subscriber's Child Only policy. Any newborn or newly adopted child of a subscriber under the age of 21 may be covered through a separate child-only policy or this child only policy.

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 26 (see "Extending a child's eligibility" below); and
3. be accepted by MIC for enrollment; and

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

- Dependent
- Member
- Mental disorder
- Physician
- Placed for adoption
- Premium
- Subscriber

4. not have failed to pay premium which you were obligated to pay for individual/family coverage with MIC or its affiliates for any period of coverage in the 12 months prior to the requested coverage effective date for you under this Policy.

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 26. However, the child's eligibility continues in the following situation:

- *Disabled dependent.* The child is incapable of self-sustaining employment by reason of developmental disability, mental illness, mental disorder or physical disability and is chiefly dependent upon the subscriber for support and maintenance. 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 26. Beginning two years after the child reaches the dependent limiting age of 26, MIC may require annual proof of disability and dependency. Your disabled dependent is covered under this Policy regardless of age.

Enrollment

Open enrollment and effective date of coverage

For subscribers and dependents, the period of time identified each year by MIC for open enrollment, is the period during which subscribers and dependents may elect to enroll in coverage. An application for yourself and any dependents must be submitted to MIC for coverage offered directly through MIC.

Coverage will be effective as determined by MIC in accordance with applicable law.

An illness will not be considered a physical disability.

MIC may ask you for information to confirm your eligibility for coverage. By accepting coverage under this Policy, you agree to cooperate with our reasonable request for information.

Special enrollment and effective date of coverage

Special enrollment periods are provided to subscribers and dependents under certain circumstances. Eligibility for special enrollment will be determined by MIC. MIC requires documentation to be submitted to MIC to demonstrate that there is a current special enrollment period. The effective date of coverage depends upon the type of special enrollment. Unless otherwise stated, the subscriber shall have 60 days following the date of the life event to exercise his or her right for a special enrollment.

MIC may ask you for information to confirm your eligibility for coverage. By accepting coverage under this Policy, you agree to cooperate with our reasonable request for information.

The following are the life events for special enrollment opportunities:

1. The subscriber gains a dependent through marriage, birth, adoption, placement for adoption, or child support order or other court order. If coverage was obtained through MNsure, you must contact MNsure to enroll the dependent and determine what types of plan changes can be made due to this special enrollment. If you obtained coverage directly from Medica, for adding dependent children to this Policy, the notification period is not limited to 60 days for newborns or children newly adopted or newly placed for adoption, although you are encouraged to notify MIC within this time period. If you obtained

coverage through MNSure, for adding dependent children to this Policy, the notification period may be limited to 60 days for newborns or children newly adopted or newly placed for adoption. In the case of marriage, at least one spouse must demonstrate having minimum essential coverage for 1 or more days during the 60 days preceding the date of marriage unless (1) the spouse is moving from a foreign country or US territory, (2) the spouse is an Indian as defined in the Indian Health Care Improvement Act, or (3) the spouse lived for 1 or more days during the 60 days leading up to the event or during the most recent preceding open enrollment in a service area where no qualified health plans were offered through the Exchange. If not, then there is no special enrollment period for either spouse. The subscriber is permitted to either add the dependent to this current policy, or if the dependent is not eligible under this policy, the subscriber and his or her dependents may enroll in another plan within the same metal level. If no plan is available in the same metal level, the subscriber and dependent may enroll in another plan one metal level higher or lower than the current plan. Or, at the option of the subscriber or dependent, the dependent may be enrolled separately in any available plan. In the case of birth, adoption or placement for adoption, child support or other court order, coverage begins on the date of birth, date of adoption, date of placement for adoption, respectively or the first of the month following plan selection if allowed by MIC or MNSure and elected by you, as applicable. In the case of marriage, coverage is generally effective on the first day of the month following plan selection in MNSure or enrollment with Medica, as

applicable. See How to add dependents below for more information. In the case of a child support order or other court order, coverage is generally effective on the date specified in the order.

2. If the subscriber or enrolled dependent loses a dependent or is no longer considered a dependent through divorce or legal separation as defined by State law in the State in which the divorce or legal separation occurs, or if the member, or his or her dependent, dies. In these instances, if the result is a loss of minimum essential coverage for the subscriber or enrolled dependent, the person who lost coverage will have a special enrollment period. Coverage is effective on the date established by MIC.
3. For subscribers currently enrolled through MNsure, the subscriber or dependent enrolled in the same qualified health plan is determined to be newly ineligible for an advance premium tax credit or cost-sharing reductions. Coverage is effective on the date established by MIC.
4. A qualified individual or dependent gains access to a new qualified health plan as a result of a permanent move. The qualified individual or dependent must have had minimum essential coverage for at least one day in the 60 days prior to the permanent move unless (1) the spouse is moving from a foreign country or US territory, (2) the spouse is an Indian as defined in the Indian Health Care Improvement Act, or (3) the spouse lived for 1 or more days during the 60 days leading up to the move or during the most recent preceding open enrollment in a service area where no qualified health plans were offered through the Exchange. The subscriber or dependent has 60 days before or after the life event to exercise his

or her right for a special enrollment.

Moving solely for medical treatment or vacation does not qualify an individual for this special enrollment period. Coverage is effective on the date established by MIC.

5. The dependent loses “minimum essential coverage,” as defined under federal law, is enrolled in a non-calendar year group or individual plan, or loses certain pregnancy-related coverage or coverage for an unborn child, or medically needy coverage as defined under the Social Security Act. Loss of minimum essential coverage under this paragraph does not include voluntary termination of coverage, or loss due to failure to pay premiums or rescission. The subscriber or dependent has 60 days before or after the life event to exercise his or her right for a special enrollment. The date of the loss of coverage for those enrolled in a non-calendar year plan is the last day of the plan or policy year. Coverage is effective on the date established by MIC.
6. The subscriber demonstrates to MIC that the health plan providing coverage to him or her substantially violated a material provision of its contract. Coverage is effective on the date established by MIC.
7. The subscriber demonstrates to MIC that enrollment or non-enrollment in a health plan was unintentional, inadvertent or erroneous and the result of the error, misrepresentation or inaction of MNsure or the United States Department of Health and Human Services, or a non-MNsure entity providing enrollment assistance or conducting enrollment activities. Coverage is effective on the date established by MIC.
8. For subscribers and dependents, in the event of a qualifying event under section 603 of the Employee Retirement Income

Security Act of 1974, as amended.

Coverage is effective on the date established by MIC.

9. For subscribers or dependents, in the event the subscriber or dependent is a victim of domestic abuse or spousal abandonment, including a dependent or unmarried victim within a household, is enrolled in minimum essential coverage and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment. Coverage is effective on the date established by MIC. The dependent of a victim of domestic abuse or spousal abandonment applying for or covered on the same application as the victim, also may enroll in coverage at the same time as the victim.
10. This special enrollment period applies if a qualified individual or dependent applies for coverage on MNsure during annual open enrollment or a special enrollment, and is determined by MNsure as potentially eligible for Medicaid or CHIP, and is later determined ineligible for Medicaid or CHIP after open enrollment ended or more than 60 days after the qualifying event. It also applies if the qualified individual or dependent applies for coverage at the State Medicaid or CHIP agency during annual open enrollment and is determined ineligible for Medicaid or CHIP after open enrollment has ended. Coverage is effective on the date established by MIC.

Notification

Unless a longer period is provided in this Policy, the subscriber must notify MIC in writing within 30 days of the effective date of any changes to home 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 coverage. Premium must be paid from the date coverage starts.

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

How to add dependents

Except for policies issued to individual under age of 21, coverage for new dependents may be added after the subscriber's coverage begins as described in Open enrollment and Special enrollment above. Please note that with regard to births and adoptions: MIC does not automatically know of a birth or adoption or whether the subscriber would like coverage for the newborn or newly adopted dependent. You must, therefore, request that the newborn or newly adopted dependent be added. If additional premium is required, MIC is entitled to all premiums due from the time of the child's birth, adoption or placement for adoption until the time the covered subscriber notifies MIC of the birth or adoption. MIC may reduce payment by the amount of premium that is past due for any health benefits for the child until any premium you owe is paid.

Premium must be paid from the date coverage starts.

DD. Ending Coverage

This section describes when coverage ends under this Policy.

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 the subscriber terminates this Policy within the first ten days of receiving it, coverage shall terminate retroactive to the effective date of this Policy.
5. The end of the month following the date 31 days after we notify you that coverage will end because you do not reside in your plan's service area, provided the notification is made within one year following the date MIC was provided written notification of your address change. However, MIC may approve other arrangements.
6. The end of the month following the date you enter active military duty for more than 31 days. Upon completion of active military duty, your coverage will be reinstated if you notify MIC within 90 days after removal from active military duty.
7. When the subscriber is enrolled under this Policy, coverage for dependents will end the date the subscriber's coverage ends.

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

- Claim
- Dependent
- Member
- Premium
- Subscriber

Upon the death of the subscriber or if the subscriber and/or member terminates this policy due to eligibility for Medicare, dissolution of marriage, or for a child that is no longer eligible as a dependent as specified in this Policy, or for any other reason, the remaining members may choose to continue coverage under this plan.

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.

8. 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 the month in which the subscriber's death occurred. The dependents may have continuation rights stated at the end of this *Ending Coverage* section.
9. For a spouse, the end of the month following the date of divorce.
10. 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.
11. The date specified by MIC in written notice to you that coverage ended due to fraud or intentional misrepresentation of a material fact. If coverage ends due to fraud or intentional misrepresentation of a material fact, coverage will be retroactively terminated at MIC's discretion to the original date of coverage or the date on which the fraudulent act took place. After two years, coverage can only be retroactively terminated for fraud. Fraud includes but is not limited to:
 - a. Knowingly providing MIC with false material information such as information related to your eligibility or another person's eligibility for coverage or status as a 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.

No misstatements made in your application for coverage under this plan, except fraudulent misstatements, shall be used to void the Contract or deny a claim for benefits received after the expiration of the two year period beginning on the date you have been covered under this plan for two years.

Upon the death of the subscriber or if the subscriber and/or member terminates this Policy due to eligibility for Medicare, dissolution of marriage or for a child that is no longer eligible as a dependent as specified in this Policy or for any other reason, the remaining members may choose to continue coverage under this MIC plan.

EE. Complaints

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

You may call Customer Service at one of the telephone numbers listed inside the front cover or by writing to the address below in *Internal review*, 1.a. You also may contact the Commissioner of Commerce, Minnesota Department of Commerce, at (651) 296-2488 or 1-800-657-3602.

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

- Claim
- Inpatient
- Network
- Provider

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

Medical Necessity Review: Means MIC's evaluation of the necessity, appropriateness, and efficacy of the use of health care services, procedures, and facilities, for the purpose of determining the medical necessity of the service or admission.

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

You may appoint an authorized representative to make a complaint on your behalf. You may be required to sign an authorization which will allow MIC to release confidential information to your authorized representative and allow them to act on your behalf during the complaint process.

Upon request, MIC will assist you with completion and submission of your written complaint. MIC will also

complete a complaint form on your behalf and mail it to you for your signature upon request.

At any time during the complaint process, you have a right to submit any information or testimony that you want MIC to consider and to review any information that MIC relied on in making its decision.

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.

Internal 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. Complaints that do not involve a medical necessity review by MIC:
 - a. For an oral complaint, if MIC does not communicate a decision within 10 calendar 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 CP595
PO Box 9310
Minneapolis, MN 55440-9310

MIC will provide written notice of its internal review decision to you and your attending provider within 30 calendar days from receipt of your complaint or request.

- b. For a written complaint, MIC will provide written notice of its internal review decision to you within 30 days from initial receipt of your complaint.

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.

- c. If MIC's internal review decision upholds the initial decision made by MIC, you have a right to submit a request for external review.
- 2. Complaints that involve a medical necessity review by MIC:
 - a. Your complaint must be made within one year following MIC's initial decision and may be made orally or in writing.
 - b. MIC will provide written notice of its internal review decision to you and your attending provider within 30 calendar days from receipt of your complaint.
 - c. When an initial decision by MIC not to grant a prior authorization request is made before or during an ongoing service requiring MIC's authorization, and your attending *provider* believes that MIC's decision warrants an expedited appeal, you or your attending *provider* will have the opportunity to request an expedited review by telephone. Alternatively, if MIC concludes that a delay could seriously jeopardize your life, health, or ability to regain maximum function, MIC will process your *claim* as an expedited review. In such cases, MIC will notify you and your attending *provider* by telephone of its decision no later than 72 hours after receiving the request.
 - d. If MIC's internal review decision upholds the initial decision made by MIC, you may have a right to submit a written request for external review as described in this section.

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

External review

NOTE: Information concerning how to request external review if MIC denies your request for an exception to the MIC Drug List is found in the ***Prescription Drugs*** section of this Policy. Information concerning how to request external review for other decisions by MIC is described below.

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:

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.

Minnesota Department of Commerce
85 7th Place East, Suite 280
St. Paul, MN 55101-2198

You must submit your written request for external review within six months from the date of MIC's decision. A filing fee of \$25 must accompany your written request, unless waived by the Commissioner. An independent review organization contracted with the State Commissioner of Administration will review your request. You may submit additional information that you want the review organization to consider. You will be notified of the review organization's decision within 45 days. The Department of Commerce will refund the filing fee if the review organization completely reverses MIC's decision. 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.

Under most circumstances, you must complete the internal review, described above, before you proceed to external review. You may proceed to external review without completing the internal review if MIC agrees that you may do so, or if MIC fails to substantially comply with the complaint and review process described in this section, including meeting any required deadlines. For complaints that involve a medical necessity review, you may request an expedited external review at the same time you request an expedited internal review. You may also request an expedited external review if MIC's decision involves a medical condition for which the standard external review time would seriously jeopardize your life, health, or ability to regain maximum function, or if MIC's decision concerns an admission, availability of care, continued stay, or health care service for which you received emergency services and you have not been discharged from a facility. If an expedited review is requested and approved, a decision will be provided within 72 hours.

If MIC's decision involves a treatment that MIC considers investigative, the review organization will

base its decision on all documents submitted by you and MIC, your provider's recommendation, consulting reports from health care professionals, your benefits under this Policy of Coverage, federal Food and Drug Administration approval, and medical or scientific evidence or evidence-based standards.

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

Civil action

No civil action for benefits may be brought more than three years after the time a claim for benefits is required to have been submitted under this Policy.

FF. 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 the subscriber.

See *Definitions*. These words have specific meanings:

- Benefits
- Claim
- 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 (see *Introduction*). When this happens, you will receive a new policy or amendment approved and signed by an executive officer of MIC. 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.

Reinstatement

If any renewal premium is not paid within the time granted the subscriber for payment, a subsequent acceptance of premium by MIC shall reinstate the Policy. In all other respects the subscriber and MIC will have the same rights under the Policy as they had immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with a reinstatement.

GG. Definitions

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

Term	Definition
Approved clinical trial	<p>A phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening condition, is not designed exclusively to test toxicity or disease pathophysiology, and is described in any of the following subparagraphs:</p> <ol style="list-style-type: none"> 1. The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration. 2. The study or investigation is a drug trial that is exempt from having such an investigational new drug application. 3. The study or investigation is approved or funded by one of the following: (i) the National Institutes of Health (NIH), the Centers for Disease Control and Prevention, the Agency for Health Care Research and Quality, the Centers for Medicare and Medicaid Services, or cooperating group or center of any of the entities described in this item; (ii) a cooperative group or center of the United States Department of Defense or the United States Department of Veterans Affairs; (iii) a qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants; or (iv) the United States Departments of Veterans Affairs, Defense, or Energy if the trial has been reviewed or approved through a system of peer review determined by the secretary to: (a) be comparable to the system of peer review of studies and investigations used by the NIH, and (b) provide an unbiased scientific review by qualified individuals who have no interest in the outcome of the review.
Benefits	<p>The health services or supplies (described in this Policy and any subsequent amendments) approved by MIC as eligible for coverage.</p>

Term	Definition
Biologics	Any of a wide range of products designed to replicate natural substances in the body, including, but not limited to, products produced using biotechnology. Biologics include, but are not limited to, vaccines, blood and blood components or products, cellular and gene therapy products, tissue and tissue products, allergenics, recombinant therapeutic proteins, monoclonal antibodies, cytokines, growth factors, immunomodulators, and additional biological products regulated by the U.S. Food and Drug Administration and related agencies.
Claim	An invoice, bill or itemized statement for benefits provided to you.

Term	Definition
Within each definition, you may note bold words. These words also are defined in this section.	
Coinsurance	<p data-bbox="618 342 1451 474">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 data-bbox="618 510 1451 569">For in-network benefits, the coinsurance amount typically is based on the lesser of the:</p> <ol data-bbox="618 604 1451 737" style="list-style-type: none">1. Charge billed by the provider (i.e., retail); or2. Negotiated amount that the provider has agreed to accept as full payment for the benefit (i.e., wholesale). <p data-bbox="618 772 1451 999">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 data-bbox="618 1035 1451 1094">For out-of-network benefits, the coinsurance will be based on the lesser of the:</p> <ol data-bbox="618 1129 1451 1230" style="list-style-type: none">1. Charge billed by the provider (i.e., retail) or2. Non-network provider reimbursement amount. <p data-bbox="618 1266 1451 1398">For out-of-network benefits, in addition to any coinsurance and deductible amounts, you are responsible for any charges billed by the provider in excess of the non-network provider reimbursement amount.</p> <p data-bbox="618 1434 1451 1629">In addition, for the network pharmacies described in <i>Prescription Drugs</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 data-bbox="618 1665 1451 1726">The coinsurance may not exceed the charge billed by the provider for the benefit.</p>

Term	Definition
	Within each definition, you may note bold words. These words also are defined in this section.
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	<p>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.</p> <p>Amounts reimbursed or paid by a provider or manufacturer, including manufacturer coupons, point of service rebates, coupon cards, debit cards or other forms of reimbursement or payment on your behalf for a product or service, will not apply toward your deductible.</p>
Dependent	<p>Unless otherwise specified in this Policy:</p> <ol style="list-style-type: none"> 1. The subscriber's domestic partner or legally married spouse 2. A child of the subscriber, the subscriber's domestic partner or legally married spouse who is a: <ol style="list-style-type: none"> a. Natural or adopted child b. Child placed for adoption with the subscriber, the subscriber's domestic partner or legally married spouse c. Stepchild 3. A newborn grandchild who is financially dependent upon the subscriber or the subscriber's covered spouse, and who resides with that subscriber or the subscriber's covered spouse continuously from birth.

Term	Definition
	Within each definition, you may note bold words. These words also are defined in this section.
Designated facility	A designated facility means a network hospital that MIC has authorized to provide certain benefits to members , as described in this Policy.
Domestic Partner	An adult who: <ol style="list-style-type: none"> 1. Is in a committed and mutually exclusive relationship, jointly responsible for the subscriber's welfare and financial obligations; and 2. Resides with the subscriber in the same principal residence and intends to do so permanently; and 3. Is at least 18 years of age and unmarried; and 4. Is not a blood relative of the subscriber; and 5. Is mentally competent.
Emergency	A condition or symptom (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, would believe requires immediate treatment to: <ol style="list-style-type: none"> 1. Preserve your life; or 2. Prevent serious impairment to your bodily functions, organs, or parts; or 3. Prevent placing your physical or mental health (or, if you are pregnant, the health of your unborn child) in serious jeopardy.
Enrollment date	The date of the member's first day of coverage under this Policy.
Exchange	A governmental or non-profit entity established as an Exchange pursuant to the Affordable Care Act to make qualified health plans available to individuals and small employers.

Term	Definition
	Within each definition, you may note bold words. These words also are defined in this section.
Extended hours home care	Extended hours home care (skilled nursing services) is continuous and complex skilled nursing services greater than two consecutive hours per day provided in the member's home. The intent of extended hours home care is to assist the member with complex, direct, skilled nursing care, to develop caregiver competencies through training and education, and to optimize the member's health status and outcomes. The skilled nursing tasks must be required so frequently that the need is continuous. The duration of extended hours home care is temporary in nature and is not intended to be provided on a permanent ongoing basis.
Genetic testing	The analysis of human DNA, RNA, and chromosomes and those proteins and metabolites used to detect heritable or somatic disease-related genotypes or karyotypes for clinical purposes. A genetic test must be generally accepted in the scientific and medical communities as being specifically determinative for the presence, absence, or mutation of a gene or chromosome in order to qualify under this definition. Genetic test does not include a routine physical examination or a routine analysis, including a chemical analysis, of body fluids unless conducted specifically to determine the presence, absence, or mutation of a gene or chromosome.
Habilitative care	Health care services are considered habilitative when they are provided to help a person who has not learned or acquired a particular skill or function for daily living to learn, improve, or keep such skill or function, as long as measurable progress can be documented.
Hospital	A licensed facility that provides diagnostic, medical, therapeutic, rehabilitative and surgical services by, or under the direction of, a physician and with 24-hour R.N. nursing services. The hospital is not mainly a place for rest or custodial care , and is not a nursing home or similar facility.
Inpatient	An uninterrupted stay, following formal admission to a hospital , skilled nursing facility or licensed acute care facility. Inpatient services in a licensed residential treatment facility for treatment of emotionally disabled children will be covered as any other health condition.

Term	Definition
Within each definition, you may note bold words. These words also are defined in this section.	
Investigative	<p>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:</p> <ol style="list-style-type: none"> 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, III or IV trials; 2. Whether there are consensus opinions and recommendations reported in relevant scientific and medical literature, peer-reviewed journals or the reports of clinical trial committees and other technology assessment bodies; and 3. Whether there are consensus opinions of national and local health care providers in the applicable specialty or subspecialty that typically manages the condition as determined by a survey or poll of a representative sampling of these providers. <p>Notwithstanding the above, a drug being used for an indication or at a dosage that is an accepted off-label use for the treatment of cancer will not be considered by MIC to be investigative. MIC will determine if a use is an accepted off-label use based on published reports in authoritative peer-reviewed medical literature, clinical practice guidelines or parameters approved by national health professional boards or associations and entries in any authoritative compendia as identified by the Medicare program for use in the determination of a medically accepted indication of drugs and biologicals used off-label.</p>
Life-threatening condition	Any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.
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:

Term	Definition
	Within each definition, you may note bold words. These words also are defined in this section.
	<ol style="list-style-type: none"> 1. Be consistent with the medical standards and accepted practice parameters of the community as determined by health care providers in the same or similar general specialty as typically manages the condition, procedure or treatment at issue; and 2. Be an appropriate service, in terms of type, frequency, level, setting, and duration, to your diagnosis or condition; and 3. Help to restore or maintain your health; or 4. Prevent deterioration of your condition; or 5. Prevent the reasonably likely onset of a health problem or detect an incipient problem.
Member	A person who is enrolled under this Policy and on whose behalf the premium is being paid. In this Policy, the words you, your or yourself refer to the member.
Mental disorder	A physical or mental condition having an emotional or psychological origin, as defined in the current edition of the <i>Diagnostic and Statistical Manual of Mental Disorders (DSM)</i> .
Minnesota resident	A person who lives in Minnesota, and intends to reside in Minnesota, or has entered Minnesota with a job commitment or is seeking employment in Minnesota.
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 is available without charge.</p>
Non-network	A term used to describe a provider not under contract as a network provider .

Term	Definition
Non-network provider reimbursement amount	<p data-bbox="618 243 1377 306">Within each definition, you may note bold words. These words also are defined in this section.</p> <p data-bbox="618 342 1438 436">The amount that MIC will pay to a non-network provider for each benefit is based on one of the following, as determined by MIC:</p> <ul data-bbox="618 478 1455 919" style="list-style-type: none"> <li data-bbox="618 478 1406 636">a. A percentage of the amount Medicare would pay for the service in the location where the service is provided. MIC generally updates its data on the amount Medicare pays within 30 – 60 days after the Centers for Medicare and Medicaid Services updates its Medicare data; or <li data-bbox="618 657 1287 688">b. A percentage of the provider's billed charge; or <li data-bbox="618 709 1422 835">c. A nationwide provider reimbursement database that considers prevailing reimbursement rates and/or marketplace charges for similar services in the geographic area in which the service is provided; or <li data-bbox="618 856 1455 919">d. An amount agreed upon between MIC and the non-network provider. <p data-bbox="618 940 1466 1003">Contact Customer Service for more information concerning which services, including the applicable percentage if a Medicare-based</p> <p data-bbox="618 1024 1442 1087">For certain benefits, you must pay a portion of the non-network provider reimbursement amount as a coinsurance.</p> <p data-bbox="618 1108 1446 1434">In addition, if the amount billed by the non-network provider is greater than the non-network provider reimbursement amount, <i>the non-network provider will likely bill you for the difference</i>. This difference may be substantial, and it is in addition to any coinsurance or deductible amount you may be responsible for according to the terms described in this Policy. As a result, the amount you will be required to pay for services received from a non-network provider will likely be much higher than if you had received services from a network provider.</p>
Non-skilled care	<p data-bbox="618 1476 1446 1633">Care that does not require skilled nursing or rehabilitation staff to manage, observe, or evaluate your care. Any service that could be safely performed by a non-medical person (or yourself) without the supervision of a nurse is considered non-skilled care.</p>
Physician	<p data-bbox="618 1675 1455 1799">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.</p>

Term	Definition Within each definition, you may note bold words. These words also are defined in this section.
Placed for adoption	The assumption and retention of the legal obligation for total or partial support of the child in anticipation of adopting such child.
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.
Prescription drug	A drug approved by the FDA for the prescribed use and route of administration.

Term	Definition
<p>Within each definition, you may note bold words. These words also are defined in this section.</p>	
Preventive Health Services	<p>The following are considered preventive health services:</p> <ul style="list-style-type: none"> (1) evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force; (2) immunizations for routine use that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the members involved; (3) with respect to members who are infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; (4) with respect to members who are women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration (including Food and Drug Administration approved contraceptive methods, sterilization procedures, and related patient education and counseling). <p>Contact Customer Service for information regarding specific preventive health services and services that are rated “A” or “B”, and services that are included in guidelines supported by the Health Resources and Services Administration. For a list of preventive health services please click on this Preventive Services link.</p>
Professionally administered drugs.	<p>Professionally administered drugs must be, as determined by MIC, typically administered or directly supervised by a qualified provider or a licensed/certified health professional. MIC generally considers drugs that require intravenous infusion or injection, intrathecal infusion or injection, intramuscular injection, or intraocular injection, as well as drugs that, according to the manufacturer’s recommendations, must typically be administered by a health care provider, to be professionally administered drugs.</p>
Provider	<p>A health care professional or facility licensed, certified or otherwise qualified under state law to provide health services.</p>

Term	Definition
Within each definition, you may note bold words. These words also are defined in this section.	
Qualified individual	(1) An individual who is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening conditions, and (2) either (a) the referring health care professional is a network provider and has concluded that the individual's participation in the trial would be appropriate, or (b) the individual provides medical or scientific information establishing that their participation would be appropriate
Reasonable expectation of improvement	A reasonable expectation that the member's condition will improve over a predictable period of time according to generally accepted standards in the medical community.
Rehabilitative	Physical, occupational and speech therapy services are considered rehabilitative when they are provided to restore physical function or speech that has been impaired due to illness or injury.
Restorative	Surgery to rebuild or correct a physical defect that has a direct adverse effect on the physical health of a body part, and for which the restoration or correction is medically necessary .
Retail health clinic	Professional evaluation and medical management services provided to patients in a health care clinic located in a setting such as a retail store, grocery store or pharmacy. Services include treatment of common illnesses and certain preventive health care services.
Routine patient costs	All items and services that would be covered benefits if not provided in connection with a clinical trial. In connection with a clinical trial, routine patient costs do not include an investigative or experimental item, device, or service; items or services provided solely to satisfy data collection and analysis needs and not used in clinical management; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
Skilled care	A type of health care given when you need skilled nursing or rehabilitation staff to manage, observe, and evaluate your care. Nursing, physical therapy, occupational therapy, and speech therapy are considered skilled care. In addition to providing direct care, these professionals manage, observe, and evaluate your care. Any service that could be safely done by a non-medical person (or by yourself) without the supervision of a nurse is not considered skilled care.

Term	Definition
	Within each definition, you may note bold words. These words also are defined in this section.
Skilled nursing facility	A licensed bed or facility (including an extended care facility, hospital swing-bed and transitional care unit) that provides skilled nursing care, skilled transitional care, or other related health services including rehabilitative services.
Subscriber	The person to whom this Policy is issued.
Telemedicine	Telemedicine is the delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site. An originating site includes a health care facility at which a patient is located at the time the services are provided by means of telemedicine. Distant site means a site at which a licensed health care provider is located while providing health care services or consultations by means of telemedicine. A communication between a licensed health care provider and a patient that consists solely of an e-mail or facsimile transmission does not constitute telemedicine consultations or services.
Urgent care center	A health care facility distinguishable from an affiliated clinic or hospital whose primary purpose is to offer and provide immediate, short-term medical care for minor, immediate medical conditions on a regular or routine basis.
Virtual care	Professional evaluation and medical management services provided to patients, in locations such as their home or office, through e-mail, telephone, or webcam. Virtual care is used to address non-urgent medical symptoms for patients describing new or ongoing symptoms to which providers respond with substantive medical advice. Virtual care does not include telephone calls for reporting normal lab or test results or solely calling in a prescription to a pharmacy.

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