Medica Symphony® for HSA

Silver

Minnesota Policy of Coverage

MN- HSA10-PC-21-01

Medica Symphony® for HSA
Silver
$4,500 Per Member Deductible
$9,000 Per Family Deductible
Plan Code 2021-IFBSSHMG

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。

Nếu quý vị muốn trợ giúp dịch thông tin này miễn phí, hãy gọi vào số có trong tài liệu này hoặc ở mặt sau thẻ ID Medica của quý vị.

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، فاتصل على الرقم الوارد في هذه الوثيقة أو على ظهر بطاقة تعريف ميديكا الخاصة بك.

Если Вы хотите получить бесплатную помощь в переводе этой информации, позвоните по номеру телефона, указанному в данном документе и на обратной стороне Вашей индентификационной карты Medica.

ถ้าท่านต้องการความช่วยเหลือในการแปลข้อมูลนี้ฟรี, ให้โทหาเลขหมายที่มีอยู่ในเอกะสารนี้ หรือ อยู่ด้านหลังของบัต Medica ของท่าน.

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.

နမ့်အဘိုးတ်ကျိုးထံစၢးကလီနှ်နၤတ်ဂ့ၢ်တ်ကျိုးအံၤလၢအကလီနှ်, ကိးလီတဖိနီဉ်ဂ်ၢ်လၢအပဉ်ယာ်လၢလ်ာ်တီလ်ာ်မီအပူၤအံၤမ့တမ့်ဖဲနနှနီဉ်ခလော်အုဉ်သးခးက့အလိၢ်ခံတကပၤအဖိဒိဉ်နှဉ်တက့်.

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.

ይህን መረጃ ለመተርጎም ነጻ እርዳታ የሚፈልጉ ከሆነ በዝ ህ ሰነድ ዉስጥ ያለውን ቁጥር ወይም Medica መታወቅያ ካርድዎ በስተጀርባ ያለውን ይደውሉ።

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Díí t'áá jíík'e shá ata' hodoonih nínízingo éí ninaaltsoos Medica bee néího'dílzinígí bine'déé' námboo biká'ígíjjį' béésh bee hodíilnih.

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.

Helpful Resources

Medica Customer Service

Call Medica Customer Service at **1-888-592-8211** (TTY: **711**) if you have any questions. Health Plan Specialists are available 8 a.m. – 6 p.m. Central Monday – Friday (Closed 8 – 9 a.m. Thursdays). You can also send a secure message at **medica.com/ContactOnline**.

Nurse Line

Call **1-866-668-6548** (**TTY: 711**) to talk with a nurse for advice on where and when to get care, or how to provide care safely at home. Available 24/7. In a medical emergency, please call **911.**

Secure Member Site

You can view much of the information you may need by logging into your secure member site at **medicamember.com**. 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
- Access wellness tools and support
- 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 87.6% 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.



Senior Vice President and General Manager of Individual and Family Business



Senior Vice President and Secretary

Introduction

MIC offers Medica Symphony® for HSA. This Policy describes health services that are eligible for coverage and the procedures you must follow to obtain benefits.

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

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

Because many provisions are interrelated, you should read this Policy in its entirety. Reviewing just one or two sections may not give you a complete understanding of the coverage described. The most specific and appropriate section will apply for those benefits related to the treatment of a specific condition.

Members are subject to all terms and conditions of this Policy and health services must be medically necessary.

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

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

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 Symphony for HSA to be eligible for in-network benefits;
2. Identify yourself as a Medica Symphony for HSA member; and
3. Present your Medica Symphony for HSA identification card. Having and using a Medica Symphony for HSA identification card does not guarantee coverage.

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

You may contact Customer Service for estimates of the amount MIC has contracted to pay a particular network provider for a specific health care service and the amount you will pay as cost sharing for that service if received from that network provider. MIC will provide you with requested estimates within ten business days from the date MIC 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.

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 Symphony for HSA 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*

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

Member bill of rights

As a member of Medica Symphony for HSA, you have the right to:

1. Available and accessible services, including emergency services (defined in this Policy) 24 hours a day, seven days a week; and
2. Information about your health condition, appropriate or medically necessary treatment options and risks, regardless of cost or benefit coverage, so you can make an informed choice about your health care; and
3. Participate with providers in decision-making regarding your health care, including the right to refuse treatment recommended to you by MIC or any provider; and
4. Be treated with respect and recognition of your dignity and privacy, including privacy of your medical and financial records maintained by MIC or any network provider in accordance with existing law; and
5. Contact MIC and Minnesota's Commissioner of Commerce to file a complaint about issues related to benefits (see *Complaints*). To file a complaint with the Minnesota Department of Commerce call 1-800-657-3602 and request insurance information. You may begin a legal proceeding if you have a problem with MIC or any provider; and
6. Receive information about MIC, its services, its practitioners and providers, and member rights and responsibilities; and
7. Appeal a decision regarding your health care coverage by calling Customer Service at one of the telephone numbers listed inside the front cover. See *Complaints* for more information on your appeal rights; and
8. Make recommendations regarding MIC's member rights and responsibilities statement.

Member responsibilities

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

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

a. How to recognize common health problems and what to do when they occur; and
b. When and where to seek appropriate help; and
c. How to prevent health problems from recurring; and

5. Practicing preventive health care by:
   a. Having the appropriate tests, exams and immunizations recommended for your gender and age as described in this Policy; and
   b. Engaging in healthy lifestyle choices (such as exercise, proper diet and rest).

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

B. How To Access Your Benefits

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

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

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

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

Benefits

MIC will cover health services and supplies as in-network benefits only if they are provided by network providers or received from a non-network provider when MIC authorizes that care because in-network care is not available within your service or network access area. If there is no network provider and no non-network provider available within your service or network access area, MIC may require you to see a provider that we have negotiated a reduced fee with if that provider is closer to your residence than a requested non-network provider. Prior authorization may be required from MIC for certain in-network benefits. This Policy fully defines your benefits and describes procedures you must follow to obtain in-network benefits.

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

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

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.

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 Symphony for HSA 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 and patient). MIC will also cover prostheses and physical complications, including lymphedemas, at all stages of mastectomy.

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

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

Benefits

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

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

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

Additionally, under certain circumstances MIC will authorize your obtaining services from a non-network provider within the United States at the in-network benefit level. Such authorizations are generally provided only in situations where the requested services are not available from network providers. MIC will authorize services received from non-network providers only if in-network care is not available in your service or network access area, and may require a referral from an in-network provider. If there is no network provider and no non-network provider available within your service or network access area, MIC may require you to see a provider that we have negotiated a reduced fee with if that provider is closer to your residence than a requested non-network provider.

Be aware that if you choose to use out-of-network benefits, you will likely have to pay much more than if you use in-network benefits. The charges billed by your non-network provider may exceed the non-network provider reimbursement amount leaving a balance for you to pay in addition to any applicable coinsurance and deductible amount. **Please see the example calculation below.**

Because obtaining care from non-network providers may result in significant out of pocket expenses, it is important that you do the following *before* receiving services from a non-network provider:

- Discuss the expected billed charges with your non-network provider; and
- Contact Customer Service to verify the estimated non-network provider reimbursement amount for those services, so you are better able to calculate your likely out of pocket expenses; and
- If you wish to request that MIC authorize the non-network provider's services be covered at the in-network benefit level, follow the procedure described under *Prior Authorization* in *How to Access Your Benefits*.

An Example of How to Calculate Your Out of Pocket Costs*
You choose to receive non-emergency inpatient care at a non-network hospital provider without an authorization from MIC providing for in-network benefits. The out-of-network benefits described in this Policy apply to the services you receive. For purposes of this example, you have previously satisfied your deductible. The non-network hospital provider bills $30,000 for your hospital stay. MIC's non-network provider reimbursement amount for those hospital services is $15,000. You must pay a portion of the non-network provider reimbursement amount, generally as a percentage coinsurance. In addition, the non-network provider will likely bill you for the amount by which the provider's charge exceeds the non-network provider reimbursement amount. If your coinsurance is 40%, you will be required to pay:

- 40% Coinsurance (40% of $15,000 = $6,000) and
- The billed charges that exceed the non-network provider reimbursement amount ($30,000 - $15,000 = $15,000)
- The total amount you will owe is $6,000 + $15,000 = $21,000.

***Note:** The numbers in this example are used only for purposes of illustrating how out-of-network benefits are calculated. The actual numbers will depend on the services received.

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

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

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

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

Claims

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

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

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 *Eligibility And Enrollment.*

5. *Prescription drugs and medical equipment*

Enrolling in MIC does not guarantee that a particular prescription drug or piece of medical equipment will continue to be covered, even if the drug or equipment is covered at the start of the calendar year.

6. *Continuity of care*

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.

7. *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 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. To determine whether a certain service or supply requires prior authorization, please call Customer Service at one of the telephone numbers listed inside the front cover.

Your attending provider, you or someone on your behalf may contact MIC to request prior authorization. Your network provider will contact MIC to request prior authorization for a service or supply. You must contact MIC to request prior authorization for services or supplies received from a non-network provider. If a network provider fails to 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 health conditions;
- Home health care services;
- Durable medical equipment;
- Outpatient surgical procedures;
- Certain genetic tests;
- Certain drugs, biologics and biosimilars;
- Inpatient care, including mental health and substance use disorders, skilled nursing facility services, long 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.

Certain biologics, biosimilars and professionally administered drugs may be subject to step therapy. In certain cases, it is possible to get an exception to step therapy requirements, please see Exceptions to Step Therapy in *Prescription Drugs* or *Prescription Specialty Drugs*.

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.

This is not an all-inclusive list of all services and supplies that may require prior authorization.

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

- Name and telephone number of the provider who is making the request;
- Name, telephone number, address and type of specialty of the provider to whom you are being referred, if applicable;
- Services being requested and the date those services are to be rendered (if scheduled);
- Specific information related to your condition (for example, 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 5 business days of the date your request was received electronically (and within six business days if received through nonelectronic means), provided all information reasonably necessary to make a decision has been given to MIC.

MIC will respond within a time period not exceeding 48 hours (including at least one business day) 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 *Complaints*).

C. *How Providers Are Paid By MIC*

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

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

Network providers

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

1. A fee-for-service method, such as per service or percentage of charges;
2. A per episode arrangement, such as an amount per day, per stay, per case or per period of illness; or
3. A risk-sharing/value-based arrangement.

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 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 episode, 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 billed charge. The amount paid to the network provider, less any applicable coinsurance or deductible, is considered to be payment in full.

MIC also has risk-sharing/value-based contract arrangements with a number of providers. These contracts include various quality and efficiency measures designed to encourage high quality and efficient total care for members. Such arrangements may involve claims withhold and gain-sharing or risk sharing arrangements between MIC and such providers. Amounts paid or returned under these arrangements are not considered when determining the amounts you must pay for health services under this Policy.

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 based on the non-network provider reimbursement amount.

When an emergency service from a non-network provider is covered under this Policy, the non-network provider is paid the in-network benefit level.

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.

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.

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.)

You are responsible for paying the charges incurred when you miss or cancel an appointment.

Please see the applicable benefit section(s) of this Policy for specific information about your in-network and out-of-network benefits and coverage levels.

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

Coinsurance and deductibles

For in-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.)

   Silver - 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.

   Please note that amounts reimbursed or paid by a provider or manufacturer, including manufacturer coupons, 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*, 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.)*

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

   If you use out-of-network benefits, you may incur costs in addition to your coinsurance and deductible amount. If the amount that your non-network provider bills you is more than the non-network provider reimbursement amount, *you are responsible for paying the difference*. In addition, the difference will not be applied toward satisfaction of the deductible (described in more detail later in this section). See *Important member information about out-of-network benefits* in *How To Access Your Benefits*.

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

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

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

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

In-Network Out-of-pocket maximum

The out-of-pocket maximum is an accumulation of the applicable in-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 in-network out-of-pocket maximum for benefits received during a calendar year (see the Out-of-Pocket Expenses table in this section). Any amount or charge *not* covered, including charges for services not eligible for coverage, is *not* applicable toward the out-of-pocket maximum.

Please note that amounts reimbursed or paid by a provider or manufacturer, including manufacturer coupons, 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 in-network out-of-pocket maximum has been met (as described in the *Out-of-Pocket Expenses* table in this section), all other covered benefits received during the rest of the calendar year will be covered at 100%, except for any charge not covered by MIC.

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.

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.

Out-of-Pocket Expenses

	In-network benefits	Out-of-network benefits
For covered services from non-network providers, in addition to any applicable copayment, 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 and out-of-pocket maximum.		
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.	
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.**	
Per member	$4,500	Silver $7,100
Per family	$9,000	$14,200
Out-of-pocket maximum	**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.**	

	In-network benefits	Out-of-network benefits
For covered services from non-network providers, in addition to any applicable copayment, 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 and out-of-pocket maximum.		
Per member	The out-of-pocket maximum is the deductible.	Out-of-pocket maximum does not apply.
Per family	The out-of-pocket maximum is the deductible.	Out-of-pocket maximum does not apply.
Lifetime maximum amount payable per member	Unlimited	Unlimited

E. *Professional Services*

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

See *Definitions.* These words have specific meanings: benefits, coinsurance, deductible, emergency, genetic testing, hospital, inpatient, member, network, non-network, non-network provider reimbursement amount, physician, prenatal care, preventive health services, provider, retail health clinic, telemedicine, urgent care center, virtual care.

Prior authorization. Prior authorization from MIC may be required *before* you receive services or supplies. Prior authorization from MIC is ***also*** required before you receive certain biologics, biosimilars and professionally administered drugs. Certain biologics, biosimilars and professionally administered drugs may be subject to step therapy. In certain cases, it is possible to get an exception to step therapy requirements, please see Exceptions to Step Therapy in *Prescription Drugs* ***or*** *Prescription Specialty Drugs.* 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.

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

The most specific and appropriate section of this Policy will apply for professional services related to the treatment of a specific condition. For example, benefits for transplant services are described in *Organ And Bone Marrow Transplant Services And Other Complex Health Conditions.*

For some services, there may be a facility charge resulting in coinsurance (see *Hospital Services*) in addition to the professional services coinsurance. Also, more than one coinsurance may be required if you receive more than one service, or see more than one provider per visit.

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, Prescription Specialty 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	**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. 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. Some services received during an office visit may be covered under another benefit in this Policy. The most specific and appropriate benefit in this Policy will apply for each service received during an office visit. Call Customer Service at one of the telephone numbers listed inside the front cover to determine in advance whether a specific procedure is a benefit and the applicable coverage level for each service that you receive.	Nothing	40% coinsurance
2. Convenience care		

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.**		
a. Retail health clinic	Nothing	For emergency services from non-network providers, refer to *Emergency Services From Non-Network Providers*. 40% coinsurance for non-emergency services received from non-network providers.
b. Virtual care	Nothing	No coverage
a. Telemedicine	Nothing	40% coinsurance
b. Urgent care center visits	Nothing	For emergency services from non-network providers, refer to *Emergency Services From Non-Network Providers*. 40% coinsurance for non-emergency services received from non-network providers
c. Maternity care		
a. Prenatal care services that are considered preventive health services as defined in this Policy	Nothing The deductible does not apply.	Nothing The deductible does not apply.
b. Prenatal care services that are not considered preventive health services as defined in this Policy received from a physician during an office visit, an outpatient hospital visit or an inpatient stay	Nothing	40% coinsurance

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.**		
c. Services received for labor and delivery	Nothing	40% coinsurance
d. Postpartum office visit	Nothing	40% coinsurance
e.Home health care visit following delivery **Please note:** One home health visit is covered if it occurs within four 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 four days, please refer to *Home Health Care* for benefits.	Nothing	40% coinsurance
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.		
a. Child health supervision services, 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.	40% coinsurance Except you pay nothing for these services for members to age 6 and the deductible does not apply.

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.**		
b. Adult immunizations	Nothing The deductible does not apply.	40% coinsurance Except you pay nothing for these services for members to age 18 and the deductible does not apply.
c. Early disease detection services including physicals	Nothing The deductible does not apply.	40% 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.	40% coinsurance
e. Women's preventive health services including mammograms (including digital breast tomosynthesis), 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.	40% coinsurance

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.**

f. Other preventive health services, including tobacco cessation counseling	Nothing The deductible does not apply.	40% coinsurance
6. Allergy shots	Nothing	40% coinsurance
7. Refractive eye exams For members 19 years of age and older coverage is limited to one visit per calendar year for in-network and out-of-network benefits combined. **Please note:** This visit limit includes any visits that you pay for in order to satisfy any part of your deductible.	Nothing Except you pay nothing for these services for members under age 19 and the deductible does not apply	40% coinsurance
8. Chiropractic services to diagnose and to treat (by manual manipulation or certain therapies) conditions related to the muscles, skeleton and nerves of the body	Nothing	40% coinsurance
9. Genetic counseling, whether pre- or post-test, and whether occurring in an office, clinic or telephonically **Please note**: Genetic counseling for BRCA testing, if appropriate, is covered as a woman's preventive health service.	Nothing	40% coinsurance
10. Professional sign language interpreter services in a physician's office (Call Customer Service to arrange such services.)	Nothing	40% coinsurance

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.**		
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	Nothing	40% coinsurance
12. Anesthesia services received from a provider during an office visit or an outpatient hospital or ambulatory surgical center visit	Nothing	40% coinsurance
13. Services received from a physician during an emergency room visit	Nothing	For emergency services from non-network providers, see *Emergency Services From Non-Network Providers*. 40% coinsurance for non-emergency services provided in a non-network hospital emergency room.
14. Services received from a physician during an inpatient stay	Nothing	40% coinsurance
15. Anesthesia services received from a provider during an inpatient stay	Nothing	40% coinsurance
16. Outpatient lab and pathology	Nothing	40% coinsurance

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.**		
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.	Nothing	40% coinsurance
18. Outpatient x-rays and other imaging services	Nothing	40% coinsurance
19. Other outpatient hospital or ambulatory surgical center services received from a physician	Nothing	40% coinsurance
20. Treatment to lighten or remove the coloration of a port wine stain	Nothing	40% 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 *Maternity care*.	Nothing	40% coinsurance

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.**

22.	Neuropsychological evaluations/cognitive testing, limited to services necessary for the diagnosis or treatment of a medical illness or injury	Nothing	40% coinsurance
23.	Vision therapy and orthoptic and/or pleoptic training, to establish a home program, for the treatment of strabismus and other disorders of binocular eye movements **Please note:** The visit and exam limits include visits that you pay for in order to satisfy any part of your deductible.	Nothing Coverage is limited to a combined in-network and out-of-network total of five training visits and two follow-up eye exams per calendar year.	40% coinsurance Coverage is limited to a combined in-network and out-of-network total of five training visits and two follow-up eye exams per calendar year.
24.	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) 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. **Please note:** This limit includes eyewear that you pay for in order to satisfy any part of your deductible.	Nothing	40% coinsurance

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.**		
25. 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.
26. Medically necessary treatment recommended by your licensed health care professional for diagnosed pediatric acute-onset neuropsychiatric syndrome (PANS) and pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and include but are not limited to antibiotics, medication and behavioral therapies to manage neuropsychiatric symptoms, plasma exchange, and immunoglobulin	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.

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."

Coverage for specialty prescription drugs (drugs used to treat complex conditions and which may require special handling) is described in the next section, *Prescription Specialty Drugs*.

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

Important: MIC does not provide coverage for prescription drugs and other pharmacy services provided by out-of-network pharmacies.

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 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 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.

Generic drugs are your lower copayment or coinsurance options. Consider a generic covered drug if you and your provider decide such a drug is appropriate for your treatment. Generic drugs may be identified in the Drug List as Tier 1.

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 2.

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 3.

If you have questions about MIC's Drug List or whether a specific drug is covered (and/or whether the drug is 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 **medicamember.com**.

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.** Any exception that MIC grants will improve the coverage by only one benefit level. However, no member cost sharing will apply for exceptions applicable to preventive health services.

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** 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.

Exceptions to Step Therapy

In certain cases it is possible to get an exception to step therapy requirements. To obtain more information about the step therapy exception process, please go to **medica.com/StepTherapy** or call Customer Service at one of the telephone numbers listed at the front of this certificate. MIC will respond to a request for an exception to step therapy requirements within five days of receipt of a complete request. If you have a condition that may seriously jeopardize your life, health or ability to regain maximum function, MIC will respond within 72 hours of receipt of a complete request. If we do not approve your request for an exception to step therapy requirements, you have the right to appeal MIC's decision. MIC will respond to a request for such an appeal within five days of receipt of a complete request. If you have a condition that may seriously jeopardize your life, health or ability to regain maximum function, MIC will respond within 72 hours of receipt of a complete request. See *Complaints* for more information on your appeal rights. If MIC's decision on appeal upholds the initial denial of your request for an exception to step therapy requirements, you have a right to request an external review as described in *Complaints.*

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.

Generic requirement

Certain covered preferred brand and non-preferred brand drugs include a chemically equivalent generic drug on the Drug List. If you still choose to use a preferred brand or non-preferred brand prescription drug, MIC will pay the amount that MIC would have paid had you received the generic drug. You will pay, in addition to the applicable deductible or coinsurance described in the table, any remaining charges due to the pharmacy in excess of MIC's payment to the pharmacy. **These charges are not applied to your deductible or out-of-pocket maximum.**

If your health care provider requests that a preferred brand or non-preferred brand drug be dispensed as written and there is a chemically equivalent generic drug on the Drug List, the drug will be covered at the non-preferred brand benefit level.

Please note that receiving preferred brand or non-preferred brand drugs when an equivalent generic drug is on the Drug List may result in significantly more out-of-pocket costs.

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 received at a network pharmacy; and
2. Prescription drugs for family planning services or the treatment of sexually transmitted diseases when prescribed by or received from either a network or a non-network provider; and
3. Diabetic equipment and supplies, including blood glucose meters 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.

See *Prescription Specialty Drugs* for coverage of specialty prescription drugs.

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. Non-sedating antihistamines and non-sedating antihistamine/decongestant combinations.
8. Proton pump inhibitors, except for members twelve (12) years of age and younger, and those members who have a feeding tube.
9. Drugs prescribed by a provider who is not acting within his/her scope of licensure.

10. Homeopathic medicine.
11. Infertility drugs.
12. Specialty prescription drugs, except as described in *Prescription Specialty Drugs*.
13. Prescription drugs, including diabetic equipment and supplies and preventive drugs and other supplies, received at a non-network pharmacy.
14. 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.
15. Bulk powders, chemicals and products used in prescription drug compounding.
16. Products that are duplicative to, or are in the same class and category as, products on MIC's Drug List.
17. 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

	In-network benefits after deductible	***Out-of-network benefits after deductible**
1. Prescription drugs received at a retail pharmacy, other than those described below or in *Prescription Specialty Drugs*		
Generic (Tier 1): Nothing; or	No coverage	
Preferred brand (Tier 2): Nothing;or	No coverage	
Non-preferred brand (Tier 3): Nothing	No coverage	

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

Your Benefits and the Amounts You Pay		
	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.**

2. Orally-administered cancer treatment medications, other than those in *Specialty Prescription Drugs*

Generic (Tier 1): Nothing; or	No coverage
Preferred brand (Tier 2): Nothing; or	No coverage
Non-preferred brand (Tier 3): Nothing	No coverage

3. Prescription insulin drugs

$25 per prescription unit The deductible does not apply.	No coverage

4. Diabetic equipment and supplies, including blood glucose meters

Generic (Tier 1): Nothing; or	No coverage
Preferred brand (Tier 2): Nothing;or	No coverage
Non-preferred brand (Tier 3): Nothing	No coverage

5. 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 **medicamember.com** or call Customer Service.

Nothing The deductible does not apply.	No coverage

G. Prescription Specialty Drugs

This section describes coverage for specialty prescription drugs received from a designated specialty pharmacy. Specialty medications are high-technology, high cost, oral or injectable drugs used for the treatment of certain diseases that require complex therapies. Many specialty medications require special handling and in most cases are prescribed by a specialist.

Specialty prescription drugs are covered if they are:

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

A current list of designated specialty pharmacies is available on **medicamember.com.** You can also call Customer Service at one of the telephone numbers listed inside the front cover.

The table below describes your copayment or coinsurance for the specialty prescription drug. An additional copayment or coinsurance will apply for a provider's services if you require that they administer a self-administered drug. For these purposes, "self-administered drugs" are drugs that do not meet the definition of "professionally administered drugs."

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

Important: MIC does not provide coverage for prescription drugs and other pharmacy services provided by out-of-network pharmacies.

MIC's Specialty Drug List

MIC's specialty drug list (Specialty Drug List) is comprised of drugs that meet the medical needs of our members and have been selected based on their safety, effectiveness, uniqueness and cost. They have been approved by the Food and Drug Administration (FDA). A team of physicians and pharmacists meets regularly to review and update the Specialty Drug List.

You and 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 Specialty Drug List that affect medications you are receiving.

Preferred specialty prescription drugs are your lowest copayment or coinsurance option. For your lowest share of the cost, consider a preferred specialty prescription drug if you and your physician decide it is appropriate for your treatment. Preferred specialty drugs may be identified in the Specialty Drug List as Tier 4.

Non-preferred specialty prescription drugs have a higher copayment or coinsurance than preferred specialty prescription drugs. There is no copayment or coinsurance difference between a generic specialty prescription drug and a brand name specialty prescription drug within the non-preferred specialty prescription drug category. Consider a non-preferred specialty prescription drug if you and your physician decide it is appropriate for your treatment. Non-preferred specialty drugs may be identified in the Specialty Drug List as Tier 5.

If you have questions about MIC's Specialty Drug List or whether a specific specialty prescription drug is covered (and/or the benefit level at which the drug may be covered), or if you would like to request a copy of the Specialty Drug List, at no charge, call Customer Service at one of the telephone numbers listed inside the front cover. It is also available on **medicamember.com**.

Prescription unit

One prescription unit from a designated specialty pharmacy is a 31-consecutive-day supply.

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 Specialty Drug List. Copayment or coinsurance amounts will apply to each prescription unit dispensed.

Special requirements

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

Prior authorization

Certain specialty prescription drugs require prior authorization (approval in advance) from MIC in order to be covered. These medications are shown on the Specialty Drug List with the abbreviation "PA." The Specialty Drug List is available to providers, including designated specialty 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 specialty prescription drug (typically a preferred drug) before moving to certain other preferred or non-preferred drugs. The medications subject to Step Therapy are shown on the Specialty Drug List with the abbreviation "ST." You must meet applicable step therapy requirements before MIC will cover these preferred or non-preferred drugs.

Quantity limits (QL)

Certain covered specialty prescription drugs have limits on the maximum quantity allowed per prescription over a specific period of time. These specialty medications are shown on the Specialty 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 MIC-designated specialty pharmacy in order to be covered.

Preferred requirement for specialty prescription drugs

Certain covered non-preferred specialty drugs include a chemically equivalent preferred specialty drug on the Specialty Drug List. If you still choose to use a non-preferred specialty prescription drug, MIC will pay the amount that MIC would have paid had you received the preferred specialty drug. You will pay, in addition to the applicable deductible or coinsurance described in the table, any remaining charges due to the pharmacy in excess of MIC's payment to the pharmacy. **These charges are not applied to your deductible or out-of-pocket maximum.**

If your health care provider requests that a non-preferred specialty drug be dispensed as written and there is a chemically equivalent preferred specialty drug on the Specialty Drug List, the drug will be covered at the preferred benefit level.

Please note that receiving non-preferred specialty drugs when an equivalent preferred specialty drug is on the Specialty Drug List may result in significantly more out-of-pocket costs.

Exceptions to the Specialty Drug List

In certain cases, it is possible to get an exception that will cover a specialty medication that is generally not covered. **Please note that exceptions will only be allowed when specific clinical criteria are satisfied.** Any exception that MIC grants will improve the coverage by only one benefit level.

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

- Certifies to MIC in writing that he/she has considered all equivalent drugs on the Specialty Drug List and has determined that the drug prescribed will best treat your condition (unless the drug was removed from MIC's Specialty Drug List for safety reasons); or

- Indicates to MIC that drugs on the Specialty 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 Specialty Drug List for safety reasons.

If you have a 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 Specialty 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 Specialty 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.

Exceptions to Step Therapy

In certain cases it is possible to get an exception to step therapy requirements. To obtain more information about the step therapy exception process, please go to **medica.com/StepTherapy** or call Customer Service at one of the telephone numbers listed at the front of this certificate. MIC will respond to a request for an exception to step therapy requirements within five days of receipt of a complete request. If you have a condition that may seriously jeopardize your life, health or ability to regain maximum function, MIC will respond within 72 hours of receipt of a complete request. If we do not approve your request for an exception to step therapy requirements, you have the right to appeal MIC's decision. MIC will respond to a request for such an appeal within five days of receipt of a complete request. If you have a condition that may seriously jeopardize your life, health or ability to regain maximum function, MIC will respond within 72 hours of receipt of a complete request. See *Complaints* for more information on your appeal rights. If MIC's decision on appeal upholds the initial denial of your request for an exception to step therapy requirements, you have a right to request an external review as described in *Complaints.*

Covered

For benefits and the amounts you pay, see the table at the end of this section.

Not covered

The following are not covered:

1. Any amount above what MIC would have paid when you fail to identify yourself to the designated specialty pharmacy as a member. (MIC will notify you before enforcement of this provision.)
2. Replacement of a specialty prescription drug due to loss, damage or theft.
3. Specialty prescription drugs prescribed by a provider who is not acting within their scope of licensure.
4. Prescription drugs and OTC drugs, except as described in *Prescription Drugs*.
5. Specialty prescription drugs received from a pharmacy that is not a designated specialty pharmacy.
6. Weight loss medications.
7. Specialty drugs not listed on MIC's Specialty Drug List, unless covered through the exception process described in this Policy.
8. Infertility drugs.

9. 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 Specialty Drug List.

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

Your Benefits and the Amounts You Pay	
In-network benefits	**You pay (after deductible)**
1. Specialty prescription drugs received from a designated specialty pharmacy	**Preferred specialty prescription drugs (Tier 4):** Nothing; or **Non-preferred specialty prescription drugs (Tier 5):** Nothing
2. Orally-administered cancer treatment medications received from a designated specialty pharmacy	**Preferred specialty prescription drugs (Tier 4):** Nothing; or **Non-preferred specialty prescription drugs (Tier 5):** Nothing

H. *Hospital Services*

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

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

Prior authorization. Prior authorization from MIC may be required *before* you receive certain services or supplies, even if a provider has directed or recommended that you receive the services or supplies. Prior authorization from MIC is ***also*** required before you receive certain biologics, biosimilars and professionally administered drugs. Certain biologics, biosimilars and professionally administered drugs may be subject to step therapy. In certain cases, it is possible to get an exception to step therapy requirements, please see Exceptions to Step Therapy in *Prescription Drugs* ***or*** *Prescription Specialty Drugs.* 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.

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

More than one coinsurance may be required if you receive more than one service, or see more than one provider per visit.

Each member's hospital admission is separate from the admission of any other member. That means a separate deductible or coinsurance will be applied to both you and your newborn for inpatient services related to labor and delivery.

MIC covers up to 120 hours of services provided by a private duty nurse or personal care assistant who has provided home care services to a ventilator-dependent patient for the purpose of assuring adequate training of the hospital staff to communicate with that patient.

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.

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 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* and *Prescription Specialty 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.

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

Your Benefits and the Amount You Pay

Benefits	In-network benefits after deductible	* Out-of-network benefits after deductible
*** For out-of-network benefits, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.**		
1. Outpatient services:		
a. Services provided in a hospital emergency room	Nothing	Covered as an in-network benefit
b. Outpatient lab and pathology	Nothing	40% coinsurance
c. Outpatient x-rays and other imaging services	Nothing	40% coinsurance

Your Benefits and the Amount 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.**		
d. Maternity labor and delivery services	Nothing	40% coinsurance
e. Prenatal care services that are considered preventive health services as defined in this Policy	Nothing The deductible does not apply.	Nothing The deductible does not apply.
f. Prenatal care services that are not considered preventive health services as defined in this Policy	Nothing	40% coinsurance
g. 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	Nothing	40% coinsurance
h. Other outpatient services	Nothing	40% coinsurance
i. Other outpatient hospital and ambulatory surgical center services received from a physician	Nothing	40% coinsurance
j. Anesthesia services received from a provider during an office visit or an outpatient hospital or ambulatory surgical center visit	Nothing	40% coinsurance

Your Benefits and the Amount 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.**		
k. 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	Nothing	40% coinsurance
3. Inpatient services, including semi-private room and board in a hospital and services received from a physician during an inpatient stay:		
a. Inpatient services other than for maternity care	Nothing	40% coinsurance
b. Inpatient services for maternity care:		
i. For inpatient services related to prenatal care services that do not result in a delivery	Nothing	40% coinsurance
ii. For all other inpatient maternity labor and delivery services	Nothing	40% coinsurance

Your Benefits and the Amount 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.**		
iii. Anesthesia services received from a provider during an inpatient stay	Nothing	40% coinsurance

I. *Ambulance Services*

This section describes coverage for ambulance transportation and related services received for covered medical and medical-related dental services (as described in this Policy).

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

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

Covered

For benefits and the amounts you pay, see the table in this section. For non-emergency licensed ambulance services described in 2. in the table in this section:

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

Not covered

These services, supplies and associated expenses are not covered:

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

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

Your Benefits and the Amounts You Pay		
Benefits	**In-network benefits after deductible**	*** Out-of-network benefits after deductible**
*** For out-of-network benefits, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.**		
1. Ambulance services or ambulance transportation to the nearest hospital for an emergency	Nothing	See *Emergency Services From Non-Network Providers*.
2. Non-emergency licensed ambulance service that is arranged through an attending physician, as follows:		
a. Transportation from hospital to hospital when:	Nothing	40% coinsurance
i. Care for your condition is not available at the hospital where you were first admitted; or		
ii. Required by MIC		
b. Transportation from hospital to skilled nursing facility	Nothing	40% coinsurance

J. *Home Health Care*

This section describes coverage for home health care.

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

Prior authorization. Prior authorization from MIC may be required before you receive services or supplies, even if a provider has directed or recommended that you receive the services or supplies. Prior authorization from MIC is ***also*** required before you receive certain biologics, biosimilars and professionally administered drugs. Certain biologics, biosimilars and professionally administered drugs may be subject to step therapy. In certain cases, it is possible to get an exception to step therapy requirements, please see Exceptions to Step Therapy in *Prescription Drugs* ***or*** *Prescription Specialty Drugs.* 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.

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

Covered home health aide services must be ordered by a physician and related to the active and specific treatment of the covered member. Services and care must be provided by a home health aide that is supervised by a skilled service provider in accordance with Medicare guidelines.

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

- Leaving your home is not 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 or 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.

- *Benefits* apply to covered home health care services received from a network home health care agency. Benefits covered under 1., 2. and 4. in the table in this section are limited to a combined annual benefit maximum each calendar year. However, you may be eligible for additional hours of private duty nursing care per week under 1. in the table in this section if you have MIC coverage and are also enrolled in the Medical Assistance program. This additional care may include up to 120 hours of communication and interpretation services provided by a private duty nurse to a ventilator-dependent person during the time that person is in a licensed hospital.
- **Important:** *Out-of-network benefits* are not provided for home health care services. Home health care services are covered only if ordered or prescribed by a physician and received from a network home health care agency.

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 or occupational therapy provided in your home when you are not homebound.
7. Speech therapy provided in your home when you are not homebound.
8. Services primarily educational in nature.
9. Vocational and job rehabilitation.
10. Recreational therapy.
11. Self-care and self-help training (non-medical).
12. Health clubs.
13. Disposable supplies and appliances, except as described in this Policy.
14. Home infusion therapy provided by a non-network provider.
15. Voice training.
16. Outpatient rehabilitation and habilitative care services when no medical diagnosis is present.
17. 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*, *Prescription Specialty 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	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. Skilled nursing care when you are homebound, provided by or supervised by a registered nurse	Nothing For high-risk prenatal care services, the deductible does not apply. Coverage is limited to an in-network maximum of 180 visits per calendar year for numbers 1., 2. and 4. in this section combined. **Please note:** This visit limit includes any visits that you pay for in order to satisfy any part of your deductible.	No coverage
2. Skilled physical therapy, skilled occupational therapy or speech therapy when you are homebound	Nothing Coverage is limited to an in-network maximum of 180 visits per calendar year for numbers 1., 2. and 4. in this section combined. **Please note:** This visit limit includes any visits that you pay for in order to satisfy any part of your deductible.	No coverage
3. Home infusion therapy	Nothing For high-risk prenatal care services, the deductible does not apply.	No coverage

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.**		
4. Services received in your home from a physician	Nothing Coverage is limited to an in-network maximum of 180 visits per calendar year for numbers 1., 2. and 4. in this section combined. **Please note:** This visit limit includes any visits that you pay for in order to satisfy any part of your deductible.	No coverage

K. *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.

See *Definitions.* These words have specific meanings: benefits, coinsurance, deductible, habilitative care, network, non-network, non-network provider reimbursement amount, physician, rehabilitative.

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.

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. Out-of-network benefits covered under numbers 1, 2 and 3 in the table in this section are limited to a combined annual benefit maximum each calendar year. **There is not an out-of-pocket maximum that applies to these charges.** In addition to the deductible and coinsurance described for out-of-network benefits, you are responsible for any charges in excess of the non-network provider reimbursement amount. Please see *Important member information about out-of-network benefits* in *How To Access Your Benefits* for more information.

Not covered

These services, supplies and associated expenses are not covered:

1. Services primarily educational in nature.
2. Vocational and job rehabilitation.
3. Recreational therapy.
4. Self-care and self-help training (non-medical).

5. Health clubs.
6. Voice training.
7. Outpatient rehabilitation and habilitative care services when no medical diagnosis is present.
8. Group physical, speech and occupational therapy.

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

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	* Out-of-network benefits after deductible
*** 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. Physical therapy services received outside of your home		
a. Habilitative services	Nothing	40% coinsurance Coverage for physical, occupational and speech habilitative therapy is limited to an out-of-network combined maximum of 20 visits per calendar year. **Please note**: This visit limit includes any visits that you pay for in order to satisfy any part of your deductible.
b. Rehabilitative services	Nothing	40% coinsurance Coverage for physical, occupational and speech rehabilitative therapy is limited to an out-of-network combined maximum of 20 visits per calendar year. **Please note**: This visit limit includes any visits that you pay for in order to satisfy any part of your deductible.

Your Benefits and the Amounts You Pay		
Benefits	**In-network benefits after deductible**	*** Out-of-network benefits after deductible**
*** For out-of-network benefits, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.**		
2. Speech therapy services received outside of your home		
a. Habilitative services	Nothing	40% coinsurance Coverage for physical occupational and speech habilitative therapy is limited to an out-of-network combined maximum of 20 visits per calendar year. **Please note**: This visit limit includes any visits that you pay for in order to satisfy any part of your deductible.
b. Rehabilitative services	Nothing	40% coinsurance Coverage for physical, occupational and speech rehabilitative therapy is limited to an out-of-network combined maximum of 20 visits per calendar year. **Please note**: This visit limit includes any visits that you pay for in order to satisfy any part of your deductible.
3. Occupational therapy services received outside of your home		

a. Habilitative services	Nothing	40% coinsurance Coverage for physical, occupational and speech habilitative therapy is limited to an out-of-network combined maximum of 20 visits per calendar year. **Please note**: This visit limit includes any visits that you pay for in order to satisfy any part of your deductible.
b. Rehabilitative services	Nothing	40% coinsurance Coverage for physical, occupational and speech rehabilitative therapy is limited to an out-of-network combined maximum of 20 visits per calendar year. **Please note**: This visit limit includes any visits that you pay for in order to satisfy any part of your deductible.

L. *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*.

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

Prior authorization. Prior authorization from MIC may be required *before* you receive services or supplies. To determine if MIC requires prior authorization for a particular service or treatment, please call your plan's designated mental health and substance use disorder provider at the number on the back of your MIC ID card. See *How To Access Your Benefits* for more information about the prior authorization process.

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 and partial programs, which may include multiple services/modalities and lodging, 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 autism spectrum disorders.
   g. Services, care or treatment described as benefits in this Policy and 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.

e. Services, care or treatment ordered by a court on the basis of a behavioral health care evaluation performed by a physician or licensed psychologist and that includes an individual treatment plan.

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.

Covered

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

- For *in-network benefits*:

1. Your plan's designated mental health and substance use disorder provider will coordinate your network mental health services. If you require hospitalization, your plan's designated mental health and substance use disorder provider will refer you to one of its hospital providers. **Please note**: The hospital network for medical services and mental health and substance use disorder services may not be the same. Call your plan's designated mental health and substance use disorder provider at the number on the back of your MIC ID card.

2. **Emergency mental health services are covered as in-network benefits.** After receiving emergency mental health inpatient services please notify your plan's designated mental health and substance use disorder provider at the number on the back of your MIC ID card 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 provided that the health care professional or facility is licensed, certified or otherwise qualified under state law to provide the mental health services and practice independently:

a. Psychiatrist

b. Psychologist

c. Registered nurse certified as a clinical specialist or as a nurse practitioner in psychiatric and mental health nursing

d. Mental health clinic.

e. Mental health residential treatment center

f. Independent clinical social worker

g. Marriage and family therapist

h. Hospital that provides mental health services

2. Emergency mental health services are eligible for coverage under in-network benefits.

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

Not covered

These services, supplies and associated expenses are not covered:

1. Services for mental disorders not listed in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders.*
2. Services, 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. Telephonic psychotherapy treatment services, unless such services are provided in accordance with MIC's telemedicine policies and procedures.
5. 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.*
6. Services, including room and board charges, provided by health care professionals or facilities that are not appropriately licensed, certified or otherwise qualified under state law to provide mental health services. This includes, but is not limited to, services provided by mental health providers who are not authorized under state law to practice independently, and services received from a halfway house, housing with support, a Rule 36 facility, therapeutic group home, boarding school or ranch.
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.
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*, *Prescription Specialty 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	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. Outpatient services		
a. Evaluations, diagnostic and treatment services.	Nothing	40% coinsurance
b. Intensive outpatient programs	Nothing	40% coinsurance
2. Inpatient services		
a. Semi-private room and board	Nothing	40% coinsurance
b. Hospital or facility-based professional services	Nothing	40% coinsurance
c. Attending psychiatrist services	Nothing	40% coinsurance
d. Partial program	Nothing	40% coinsurance

M. *Substance Abuse*

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

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

Prior authorization. Prior authorization from MIC may be required *before* you receive services or supplies. To determine if MIC requires prior authorization for a particular service or treatment, please call your plan's designated mental health and substance use disorder provider at the number on the back of your MIC ID card. See *How To Access Your Benefits* for more information about the prior authorization process.

For purposes of this section:

1. Outpatient services include:
   a. Diagnostic evaluations.
   b. Outpatient treatment.
   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 and partial programs, which may include multiple services/modalities and lodging, delivered in an outpatient setting.
   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.
2. Inpatient services include:
   a. Semi-private room and board.
   b. Attending physician services.
   c. Hospital or facility-based professional services.
   d. Partial program. This may be in a freestanding facility or hospital based. Active treatment is provided through specialized programming with medical/psychological intervention and supervision during program hours. Partial program means a treatment program of 20 hours or more per week and may include lodging.
   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.

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.

Covered

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

- For *in-network benefits*:
  1. Your plan's designated mental health and substance use disorder provider will coordinate your network substance use disorder health services. If you require hospitalization, your plan's designated mental health and substance use disorder provider will refer you to one of its hospital providers. **Please note**: The hospital network for medical services and mental health and substance use disorder services may not be the same. Call your plan's designated mental health and substance use disorder provider at the number on the back of your MIC ID card.
  2. **Emergency substance use disorder services are covered as in-network benefits.** After receiving emergency substance use disorder inpatient services please notify your plan's designated mental health and substance use disorder provider at the number on the back of your MIC ID card as soon as reasonably possible.
  3. 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 provided that the health care professional or facility is licensed, certified or otherwise qualified under state law to provide the substance abuse services and practice independently.
     a. Psychiatrist
     b. Psychologist
     c. Registered nurse certified as a clinical specialist or as a nurse practitioner in psychiatric and mental health nursing
     d. Chemical dependency clinic
     e. Chemical dependency residential treatment center
     f. Hospital that provides substance abuse services
     g. Independent clinical social worker
     h. Marriage and family therapist
  2. Emergency substance abuse services are eligible for coverage under in-network benefits.

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

Not covered

These services, supplies and associated expenses are not covered:

1. Services for substance abuse disorders not listed in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders*.
2. Services, 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, including room and board charges, provided by health care professionals or facilities that are not appropriately licensed, certified or otherwise qualified under state law to provide mental health or substance abuse services. This includes, but is not limited to, services provided by mental health or substance abuse providers who are not authorized under state law to practice independently, and services received from a halfway house, therapeutic group home, boarding school or ranch.
6. 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.
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. 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*, *Prescription Specialty 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	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. Outpatient services		
a. Evaluations, diagnostic and treatment services	Nothing	40% coinsurance
b. Intensive outpatient programs	Nothing	40% coinsurance
2. Medication-assisted treatment **Please note:** When the prescription drug component of this treatment is received at a pharmacy, your *Prescription Drug* benefit will be applied.	Nothing	40% coinsurance
3. Inpatient services:		
a. Semi-private room and board	Nothing	40% coinsurance
b. Hospital or facility-based professional services	Nothing	40% coinsurance
c. Attending physician services	Nothing	40% coinsurance
d. Partial program	Nothing	40% coinsurance
4. Residential treatment services	Nothing	40% coinsurance

N. *Durable Medical Equipment And Prosthetics*

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

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

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

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. The list of eligible durable medical equipment and certain related supplies is periodically reviewed and modified by MIC.

To request a list of MIC's eligible durable medical equipment and certain related supplies, call Customer Service at one of the telephone numbers listed inside the front cover.

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

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

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. A standard model is defined durable medical equipment that meets the minimum specifications prescribed for your needs.

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

Not covered

These services, supplies and associated expenses 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.

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

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	* Out-of-network benefits after deductible
*** For out-of-network benefits, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.**		
1. Durable medical equipment and certain related supplies	Nothing	40% coinsurance
2. Repair, replacement or revision of durable medical equipment made necessary by normal wear and use	Nothing	40% coinsurance
3. Prosthetics:		

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.**		
a. Initial purchase of external prosthetic devices that replace a limb or an external body part, limited to: i. Artificial arms, legs, feet and hands; ii. Artificial eyes, ears and noses; iii. Breast prostheses.	Nothing	40% coinsurance
b. Scalp hair prosthesis due to alopecia areata Coverage is limited to one prosthesis per calendar year for in-network and out-of-network combined. **Please note:** The benefit maximum includes amounts you pay for scalp hair prosthesis in order to satisfy any part of your deductible.	Nothing	40% coinsurance
c. Repair, replacement or revision of artificial arms, legs, feet, hands, eyes, ears, noses and breast prostheses made necessary by normal wear and use	Nothing	40% coinsurance
4. Hearing aids for members 18 years of age and younger for hearing loss that is not correctable by other covered procedures **Please note:** Cochlear implants are covered as a surgical service under *Professional Services* or *Hospital.*	Nothing Limited to one hearing aid per ear every three years.	40% coinsurance Limited to one hearing aid per ear every three years.

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.**		
5. Insulin pumps and their related supplies	Nothing	40% coinsurance

O. *Miscellaneous Medical Services And Supplies*

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

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

Prior authorization. Prior authorization from MIC may be required *before* you receive services or supplies, 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.

Covered

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

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

Not covered

Other disposable supplies and appliances, except as described in this section, *Durable Medical Equipment and Prosthetics*, and *Prescription Drugs*.

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

Your Benefits and the Amounts You Pay		
Benefits	**In-network benefits after deductible**	*** Out-of-network benefits after deductible**
*** For out-of-network benefits, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.**		
1. Injectable pharmaceutical treatments for hemophilia and bleeding disorders	Nothing	40% coinsurance
2. Dietary medical treatment of phenylketonuria (PKU)	Nothing	40% coinsurance
3. Amino acid-based elemental oral formulas for the following diagnoses: a. cystic fibrosis; b. amino acid, organic acid, and fatty acid metabolic and malabsorption disorders; c. IgE mediated allergies to food proteins; d. food protein-induced enterocolitis syndrome; e. eosinophilic esophagitis; f. eosinophilic gastroenteritis; and g. eosinophilic colitis. Coverage for the diagnoses in 3.c.-3.g. above is limited to members five years of age and younger.	Nothing	40% coinsurance
4. Total parenteral nutrition	Nothing	40% coinsurance
5. Eligible ostomy supplies	Nothing	40% coinsurance

P. *Organ And Bone Marrow Transplants And Other Complex Health Conditions*

This section describes coverage for certain organ and bone marrow transplant services and services for other complex health conditions. Not all network hospitals are in-network for organ and bone marrow transplants and other complex health 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 complex health 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.

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.

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.

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): kidney, lung, heart, heart/lung, pancreas, pancreas/kidney, intestinal, 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.

More than one coinsurance may be required if you receive more than one service, or see more than one provider per visit.

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

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

  Other Complex Health Conditions: Defined services from the designated specialty complex care provider are covered when:

  1. You have received an undifferentiated diagnosis or diagnosis of a complex condition;
  2. You have been referred to the designated facility by your network provider;
  3. The designated facility has agreed to provide to you complex care health services; and
  4. You or your network referring provider have received an authorization number from Medica.

  Complex care health services are services provided for the exclusive purpose of treating a complex health condition that involves one or more of the following elements: (i) is life threatening; (ii) may cause serious disability or other severe consequences, including risk of morbidity or mortality; (iii) affects multiple organ systems; (iv) the required treatments are technically challenging and carry a risk of serious complications;(v) is medically complex or rare; or (vi) previous treatments have failed or there is no known diagnosis for the condition. A condition may meet one or more of the above criteria but still not require complex care health services. Whether treatment of a condition requires the provision of complex care health services will be determined by your network provider and the designated facility, in consultation with Medica.

  Important: An approved referral is required before you receive complex care health services. Please see Referrals to non-network providers in Prior Authorization and Referrals for more information about referral requirements and the process for receiving an authorized referral.

  Services covered under this section must be provided under the direction of a specialty complex care provider and received at a designated facility. Coverage under this section is provided for complex care medical services and that are:

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

Benefits for complex health conditions under this section apply to complex care health services provided at the designated facility by a specialty complex care provider.

Not covered

These services, supplies and associated expenses are not covered:

1. Organ and bone marrow transplant services except as described in this section.
2. Supplies and services related to transplants that would not be authorized by MIC under the medical criteria referenced in this section.
3. Chemotherapy, radiation therapy, drugs or any therapy used to damage the bone marrow and related to transplants that would not be authorized by MIC under the medical criteria referenced in this section.
4. Living donor transplants that would not be authorized by MIC under the medical criteria referenced in this section.
5. Islet cell transplants except for autologous islet cell transplants associated with pancreatectomy.
6. Services required to meet the patient selection criteria for the authorized 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 and Prescription Specialty Drugs or otherwise described as a specific benefit in this Policy.
11. Services provided by a non-network provider or non-designated facility.

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

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	* Out-of-network benefits after deductible
*** For out-of-network benefits, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.**		
1. Office visits	Nothing	No coverage

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.**		
2. Outpatient services		
a. Professional services		
i. Surgical services (as defined in the *Physicians' Current Procedural Terminology* code book) received from a physician during an office visit or an outpatient hospital visit	Nothing	No coverage
ii. Anesthesia services received from a provider during an office visit or an outpatient hospital or ambulatory surgical center visit	Nothing	No coverage
iii. Outpatient lab and pathology	Nothing	No coverage
iv. Outpatient x-rays and other imaging services	Nothing	No coverage
v. Other outpatient hospital services received from a physician	Nothing	No coverage
b. Hospital and ambulatory surgical center services		
i. Outpatient lab and pathology	Nothing	No coverage
ii. Outpatient x-rays and other imaging services	Nothing	No coverage

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.**		
iii. Other outpatient hospital services	Nothing	No coverage
3. Inpatient services	Nothing	No coverage
4. Services received from a physician during an inpatient stay	Nothing	No coverage
5. Anesthesia services received from a provider during an inpatient stay	Nothing	No coverage

Q. *Professionally Administered Drugs*

This section describes coverage for professionally administered drugs.

> **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.

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 is required before you receive certain biologics, biosimilars and professionally administered drugs. Certain biologics, biosimilars and professionally administered drugs may be subject to step therapy. In certain cases, it is possible to get an exception to step therapy requirements, please see Exceptions to Step Therapy in *Prescription Drugs* or *Prescription Specialty Drugs*. 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.

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

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.

R. *Reconstructive And Restorative Surgery*

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

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

Prior authorization. Prior authorization from MIC may be required before you receive services or supplies, 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.

Covered

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

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

More than one coinsurance may be required if you receive more than one service, or see more than one provider per visit.

Not covered

These services, supplies and associated expenses are not covered:

1. Revision of blemishes on skin surfaces and scars (including scar excisions) primarily for cosmetic purposes, unless otherwise covered in *Professional Services*.
2. Repair of a pierced body part and surgical repair of bald spots or loss of hair.
3. Repairs to teeth, including any other dental procedures or treatment, whether the dental treatment is needed because of a primary dental problem or as a manifestation of a medical treatment or condition.
4. Services and procedures primarily for cosmetic purposes.
5. Surgical correction of male breast enlargement primarily for cosmetic purposes.

6. Hair transplants.
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* and *Prescription Specialty Drugs,* or otherwise described as a specific benefit in this Policy.

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

Your Benefits and the Amounts You Pay

Benefits	**In-network benefits after deductible**	*** Out-of-network benefits after deductible**
*** For out-of-network benefits, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.**		
1. Office visits	Nothing	40% coinsurance
2. Outpatient services		
a. Professional services		
i. Surgical services (as defined in the *Physicians' Current Procedural Terminology* code book) received from a physician during an office visit or an outpatient hospital or ambulatory surgical center visit	Nothing	40% coinsurance
ii. Anesthesia services received from a provider during an office visit or an outpatient hospital or ambulatory surgical center visit	Nothing	40% coinsurance
iii. Outpatient lab and pathology	Nothing	40% coinsurance
iv. Outpatient x-rays and other imaging services	Nothing	40% coinsurance

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.**		
v. Other outpatient hospital or ambulatory surgical center services received from a physician	Nothing	40% coinsurance
b. Hospital and ambulatory surgical center services		
i. Outpatient lab and pathology	Nothing	40% coinsurance
ii. Outpatient x-rays and other imaging services	Nothing	40% coinsurance
iii. Other outpatient hospital and ambulatory surgical center services	Nothing	40% coinsurance
3. Inpatient services	Nothing	40% coinsurance
4. Services received from a physician during an inpatient stay	Nothing	40% coinsurance
5. Anesthesia services received from a provider during an inpatient stay	Nothing	40% coinsurance

S. *Skilled Nursing Facility Services*

This section describes coverage for use of skilled nursing facility services. Care must be provided under the direction of a physician. Skilled nursing facility services are eligible for coverage only if they qualify as reimbursable under Medicare.

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

Prior authorization. Prior authorization from MIC may be required *before* you receive services or supplies, 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.

Covered

For benefits and the amounts you pay, see the table in this section. Benefits covered under numbers 1 and 3 in the table in this Section are limited to a combined maximum of 120 days per calendar year.

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

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

Not covered

These services, supplies and associated expenses are not covered:

1. Custodial care and other non-skilled services.
2. Self-care or self-help training (non-medical).
3. Services primarily educational in nature.
4. Vocational and job rehabilitation.
5. Recreational therapy.

6. Health clubs.
7. Voice training.
8. Outpatient rehabilitation and habilitative care services when no medical diagnosis is present.
9. Group physical, speech and occupational therapy.

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

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	* Out-of-network benefits after deductible
*** 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. Daily skilled nursing care or daily skilled rehabilitation and habilitative services, including room and board Benefits are limited to 120 days per calendar year for in-network and out-of-network combined. **Please note**: This day limit includes any days that you pay for in order to satisfy any part of your deductible.	Nothing 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.	40% coinsurance 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.
2. Skilled physical therapy, skilled occupational therapy or speech therapy when room and board is not eligible to be covered	Nothing	40% coinsurance
3. Services received from a physician during an inpatient stay in a skilled nursing facility Benefits are limited to services received during 120 days of inpatient stay per calendar year for in-network and out-of-network combined. **Please note**: This day limit includes any days that you pay for in order to satisfy any part of your deductible.	Nothing	40% coinsurance

T. *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 network hospice program.

See *Definitions.* These words have specific meanings: benefits, coinsurance, deductible, member, network, physician, skilled nursing facility.

Covered

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

Hospice services are comprehensive palliative medical care and supportive social, emotional and spiritual services. These services are provided to terminally ill persons and their families, primarily in the patients' homes. A hospice interdisciplinary team, composed of professionals and volunteers, coordinates an individualized plan of care for each patient and family. The goal of hospice care is to make patients as comfortable as possible to enable them to live their final days to the fullest in the comfort of their own homes and with loved ones.

A hospice program means a hospice program that has entered into a separate contract with MIC to provide hospice services to members. The specific services you receive may vary depending upon which program you select.

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

- *In-network benefits apply to* hospice services arranged through a physician and received from a network 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 network hospice program.

To be eligible for the hospice benefits described in this section, you must:

1. Be a terminally ill patient; and
2. Have chosen a palliative treatment focus (i.e., one that emphasizes comfort and supportive services rather than treatment attempting to cure the disease or condition).

You will be considered terminally ill if there is a written medical prognosis by your physician that your life expectancy is six months or less if the terminal illness runs its normal course. This certification must be made not later than two days after the hospice care is initiated.

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

You may withdraw from the hospice program at any time upon written notice to the hospice program. You must follow the hospice program's requirements to withdraw from 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, including room and board charges or fees.
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-network hospice program.

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

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	Out-of-network benefits
1. Hospice services	Nothing	No coverage
2. Respite care **Please note:** Respite care is limited to not more than five consecutive days at a time.	Nothing	No coverage

U. *Temporomandibular Joint (TMJ) Disorder*

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

This section also describes benefits for professional, hospital and ambulatory surgical center services. TMJ disorder is covered the same as any other joint disorder under this Policy.

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

Prior authorization. Prior authorization from MIC may be required *before* you receive services or supplies, 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.

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

More than one coinsurance may be required if you receive more than one service, or see more than one provider per visit.

Not covered

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

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

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

Your Expenses 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. Office visits	Nothing	40% coinsurance
2. Outpatient services		
a. Professional services		
i. Surgical services (as defined in the *Physicians' Current Procedural Terminology* code book) received from a physician or dentist during an office visit or an outpatient hospital or ambulatory surgical center visit	Nothing	40% coinsurance
ii. Anesthesia services received from a provider during an office visit or an outpatient hospital or ambulatory surgical center visit	Nothing	40% coinsurance
iii. Outpatient lab and pathology	Nothing	40% coinsurance
iv. Outpatient x-rays and other imaging services	Nothing	40% coinsurance
v. Other outpatient hospital and ambulatory surgical center services received from a physician or dentist	Nothing	40% coinsurance

Your Expenses 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.**		
b. Hospital and ambulatory surgical center services		
i. Outpatient lab and pathology	Nothing	40% coinsurance
ii. Outpatient x-rays and other imaging services	Nothing	40% coinsurance
iii. Other outpatient hospital and ambulatory surgical center services	Nothing	40% coinsurance
4. Physical therapy received outside of your home	Nothing	40% coinsurance
5. Inpatient services	Nothing	40% coinsurance
6. Services received from a physician or dentist during an inpatient stay	Nothing	40% coinsurance
7. Anesthesia services received from a provider during an inpatient stay	Nothing	40% coinsurance
8. TMJ splints and adjustments if your primary diagnosis is joint disorder	Nothing	40% coinsurance

V. *Medical-Related Dental Services*

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

This section does not describe coverage for comprehensive dental procedures. Comprehensive dental procedures are services rendered by a dentist to treat teeth, their supporting soft tissue and bony structure or the alignment or occlusion of the teeth. These services are not covered under any section of this Policy.

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

Prior authorization. Prior authorization from MIC may be required *before* you receive services or supplies, 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.

Covered

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

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

Not covered

These services, supplies and associated expenses are not covered:

1. Dental services to treat an injury from biting or chewing.
2. Osteotomies and other procedures associated with the fitting of dentures or dental implants.
3. Dental implants (tooth replacement) 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	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. Charges for medical facilities and general anesthesia services that are: a. Recommended by a network physician; and b. Received during a dental procedure; and c. Provided to a member who: i. Is a child under age five (prior authorization is *not* required); or ii. Is severely disabled; or iii. Has a medical condition and requires hospitalization or general anesthesia for dental care treatment.	Nothing	40% coinsurance
2. For a dependent child, orthodontia related to cleft lip and palate	Nothing	40% coinsurance

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.**		
Please note. For a dependent child, benefits for oral surgery treatment for cleft lip and palate are covered in *Professional Services* and *Hospital Services*.		
3. Oral surgery for: 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.	Nothing	40% coinsurance
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: 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	Nothing	No coverage

Please note: 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.

W. *Emergency Services From Non-Network Providers*

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

See *Definitions*. These words have specific meanings: benefits, claim, coinsurance, deductible, emergency, hospital, inpatient, member, network, non-network, physician, provider

Covered

For benefits and the amounts you pay, see the table in this section. To be eligible for coverage, services must be due to an emergency, 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 the health services that you require do not meet the definition of emergency, you should refer to the remainder of this Policy for a description of your out-of-network benefits.

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

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

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

Not covered

These services, supplies and associated expenses are not covered:

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

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

Your Benefits and the Amounts You Pay	
Benefits	**In-network benefits after deductible**
1. Emergency services that are: a. Administered under the direction of a physician; *and* b. Otherwise eligible for coverage in this Policy.	Nothing
2. Ambulance service or ambulance transportation to the nearest hospital for an emergency	Nothing

X. *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. MIC will authorize referrals for services from non-network providers only if in-network care is not available in your service or network access area. The referral must be from an in-network provider. If there is no network provider and no non-network provider available within your service or network access area, MIC may require you to see a provider that we have negotiated a reduced fee with if that provider is closer to your residence than a requested non-network provider.

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

A standing referral is a referral issued by a network provider and authorized by MIC for conditions that require ongoing services from a specialist provider. You may apply for a standing referral to a non-network provider. If you would like to do so, contact MIC for more information. Standing referrals will only be covered for the period of time appropriate to your medical condition. A standing referral may be granted if MIC determines a standing referral is appropriate.

If appropriate, you must receive a standing referral for the following: a chronic health condition; a life threatening mental or physical illness; pregnancy beyond the first trimester; a degenerative disease or disability; or any other condition or disease of sufficient seriousness and complexity to require treatment by a specialist provider. Please note, standing referrals to non-network providers will only be authorized when the care you need is not available from network providers.

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

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

What you must do

1. Request a referral or standing referral from a *network provider* to receive *medically necessary* services from a *non-network provider*. The referral will be in writing and will:
   a. Indicate the time period during which services must be received; and
   b. Specify the service(s) to be provided; and
   c. Direct you to the *non-network provider* selected by your *network provider*.
2. Seek prior authorization from MIC by calling one of the telephone numbers listed inside the front cover. MIC does not guarantee coverage of services that are received before you obtain prior authorization from MIC.

3. If prior authorization has been obtained from MIC, pay the same amount you would have paid if the services had been received from a network provider.
4. Pay any charges not authorized for coverage by MIC.

What MIC will do

1. May require that you see another network provider selected by MIC before a determination by MIC that a referral to a non-network provider is medically necessary.
2. May require that you obtain a referral or standing referral (as described in this section) from a network provider to a non-network provider practicing in the same or similar specialty.
3. Provide coverage for health services that are:
   a. Otherwise eligible for coverage under this Policy;
   b. Recommended by a network physician; and
   c. Determined by MIC that care is not available from a network provider. If there is no network provider and no non-network provider available within your service or network access area, MIC may require you to see a provider that we have negotiated a reduced fee with if that provider is closer to your residence than a requested non-network provider.
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.

Y. *Harmful Use Of Medical Services*

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

See *Definitions.* These words have specific meanings: benefits, emergency, hospital, network, physician, prescription drug, provider.

When this section applies

After MIC notifies you that this section applies, you have 30 days to choose one network physician, hospital and pharmacy to be your coordinating health care providers.

If you do not choose your coordinating health care providers within 30 days, MIC will choose for you. Your in-network benefits are then restricted to services provided by or arranged through your coordinating health care providers.

Failure to receive services from or through your coordinating health care providers will result in a denial of coverage.

You must obtain a referral from your coordinating health care provider if your condition requires care or treatment from a provider other than your coordinating health care provider.

MIC will send you specific information about:

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

Z. *Exclusions*

See *Definitions*. These words have specific meanings: claim, coinsurance, 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.

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. 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 their 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. Services or supplies not directly related to care.
8. Autopsies, except as stated in *General Provisions*.
9. Enteral feedings, unless they are the sole source of nutrition; however, enteral feedings of standard infant formulas, standard baby food and regular grocery products used in blenderized formulas are excluded regardless of whether they are the sole source of nutrition.
10. Nutritional and electrolyte substances except as specifically described in Miscellaneous Medical Services And Supplies.
11. Physical, occupational or speech therapy when there is no reasonable expectation of improvement.
12. Reversal of voluntary sterilization.
13. Personal comfort or convenience items or services.
14. Custodial care, unskilled nursing or unskilled rehabilitation services.
15. Respite or rest care except as otherwise covered in *Hospice Services*.

16. Travel, transportation or living expenses. Certain travel or living expenses may be partially reimbursed when approved by MIC and related to services that have been authorized by MIC as described in *Organ And Bone Marrow Transplants And Other Complex Health Conditions*.
17. Household equipment, fixtures, home modifications and vehicle modifications.
18. Massage therapy, provided in any setting, even when it is part of a comprehensive treatment plan.
19. 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).
20. Services by persons who are family members or who share your legal residence.
21. Claims for benefits to the extent such claims have been paid under workers' compensation, employer liability or any similar law, auto insurance, or any other coverage or plan that is required to pay before this plan pays. In other words, MIC will not make duplicate payment on claims that have been paid previously by another payer.
22. Unless requested by MIC, charges for duplicating and obtaining medical records from non-network providers and non-network dentists.
23. Occlusal adjustment or occlusal equilibration.
24. Dental implants (tooth replacement) except dental implants related to cleft lip and palate for a dependent child as described in your Policy.
25. Dental prostheses.
26. Orthodontic treatment, except as described in *Medical-Related Dental Services.*
27. Treatment for bruxism.
28. 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).
29. Exams, other evaluations or other services received solely for the purpose of employment, insurance or licensure.
30. Exams, other evaluations or other services received solely for the purpose of judicial or administrative proceedings or research, except emergency examination of a child ordered by judicial authorities.
31. Non-medical self-care or self-help training.
32. Educational classes, programs or seminars, including but not limited to childbirth classes, except as described in *Professional Services*.
33. Coverage for costs associated with translation of medical records and claims to English.
34. Treatment for superficial veins, also referred to as telangiectasia, threat, reticular or spider veins.
35. Services not received from or under the direction of a physician, except as described in this Policy.
36. Preventive dental services.
37. Elective, induced abortions, except as *medically necessary* to protect the life of the mother.

38. Therapeutic acupuncture, dry needling or services billed by an acupuncturist.
39. Services for or related to vision therapy and orthoptic and/or pleoptic training, except as described in *Professional Services*.
40. 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.
41. Sensory Integration including Auditory Integration Training.
42. Orthognathic surgery for cosmetic purposes.
43. Surgery for morbid obesity.
44. 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.
45. Services for private-duty nursing, except as stated in *Home Health Care.*
46. Services for gender reassignment surgery, sex hormones related to surgery, related preparation and follow-up treatment, and care and counseling, unless medically necessary and prior authorization is obtained from MIC before you receive services.
47. Medical and hospital services that are directly related to a non-covered service will not be paid. If a particular type of service is denied, the bundle of services that accompanies that service, services that would not have been provided but for the provision of the non-covered service, are not covered. MIC does cover emergency services that are received to treat complications of a non-covered service.
48. Services which are not within the scope of licensure or certification of the provider.
49. Charges for services by a non-network provider in excess of the non-network provider reimbursement amount.
50. Non-emergency transportation.
51. Non-emergency services received outside the United States.
52. Services solely for or related to the treatment of snoring.
53. Out-of-network virtual care.
54. Any form, mixture or preparation of cannabis for medical or therapeutic use and any device or supplies related to its administration.
55. Animals and any service or treatment related to animals.
56. 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* and *Prescription Specialty Drugs* or otherwise described as a specific benefit in this Policy.

57. Procedures, tests or other services that are exclusively provided to monitor the effectiveness of non-covered fertilization procedures.
58. Physician, hospital and ambulatory surgical center services for the treatment of infertility.
59. Services for intrauterine insemination (IUI).
60. Collection, retrieval, purchase, freezing and/or storage of sperm or eggs.
61. Services related to adoption.
62. Drugs, supplies, biologics and biosimilars that have not been approved by the U.S. Food and Drug Administration (FDA).
63. Medical devices that have not been approved by the U.S. Food and Drug Administration (FDA), other than those granted a humanitarian device exemption.
64. New to market biologics, biosimilars and professionally administered drugs. Biologics, biosimilars 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.
65. Professionally administered drugs that do not meet both of the following requirements: (a) administered in conjunction with a covered benefit and (b) administered by a physician acting within the scope of the provider's license.

AA. *How To Submit A Claim*

This section describes the process for submitting a claim.

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

Claims for benefits from network providers

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

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

It is your responsibility to alert MIC regarding any discounts, coupons, rebates, or financial arrangements between you and a provider or manufacturer for health care items or services, prescribed drugs and/or devices. Discounts, coupons, rebates, or similar reimbursement provided to you by providers or manufacturers will not satisfy your out-of-pocket cost sharing responsibilities. Such amounts will not accumulate toward your deductible and out-of-pocket maximum. Call Customer Service at one of the telephone numbers listed at the front of this Policy.

Claims for benefits from non-network providers

Claim forms can be found at **medicamember.com** or you may request 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.

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

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

Mail to: Medica Insurance Company Claims
PO Box 981647
El Paso, TX 79998-1647

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.

Claims for emergency services provided outside the United States

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

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

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

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

Time limits

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

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

BB. *Coordination Of Benefits*

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

See *Definitions*. These words have specific meanings: benefits, claim, deductible, dependent, emergency, hospital, medically necessary, member, non-network, non-network provider reimbursement amount, provider, subscriber.

1. Applicability

a. This coordination of benefits (COB) provision applies to this plan when a member 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.*

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.* You should submit claims incurred as a result of a work-related sickness or injury to the employer for workers' compensation coverage, before submitting them to Medica.

vii. *No-fault automobile insurance.* You should submit claims incurred as a result of an automobile accident or injury to the responsible automobile insurance carrier, before submitting them to Medica.

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 60% 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.

CC.*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.

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

1. MIC has a right of subrogation against any third party, individual, corporation, insurer or other entity or person who may be legally responsible for payment of medical expenses related to your illness or injury. MIC's right of subrogation shall be governed according to this section. MIC's right to recover its subrogation interest applies only after you have received a full recovery for your illness or injury from another source of compensation for your illness or injury.
2. MIC's subrogation interest is the reasonable cash value of any benefits received by you.
3. MIC's right to recover its subrogation interest may be subject to an obligation by MIC to pay 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.
   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. Subject to the full recovery requirement set forth in paragraph 1. above, MIC may collect its subrogation interest from the proceeds of any settlement or judgment that includes or otherwise relates to payment of medical expenses recovered by you, your legal representative or the legal representative(s) of your estate or next-of-kin.

DD. *Eligibility And Enrollment*

This section describes who can enroll and how to enroll.

See *Definitions*. These words have specific meanings: dependent, member, mental disorder, physician, placed for adoption, premium, subscriber.

Who can enroll

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

Subscriber eligibility

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

1. be a Minnesota resident; and
2. 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
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. An illness that does not cause a child to be incapable of self-sustaining employment will not be considered a physical disability. 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.

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 Marketplace. 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 Marketplace. 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 individuals under the age of 21, coverage for new dependents may be added after the subscriber's coverage begins as described in *Open enrollmen*t and *Special enrollment above.* Newborn infants are eligible for benefits from the moment of birth, including coverage for illness, injury, congenital malformation, or premature birth, including birth defects, as specifically described in this Policy. Please note 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. In order for MIC to determine and communicate any additional premium owed for the newborn or newly adopted dependent, please notify MIC upon birth of the newborn or adoption or placement of adoption and 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 will withhold payment of any health benefits for the newborn or newly adopted dependent until the applicable premium has been paid. For that reason, it's very important that you request to MIC that the newborn or newly adopted dependent be added to the coverage. 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.

EE. *Ending Coverage*

This section describes when coverage ends under this Policy.

See *Definitions*. These words have specific meanings: claim, dependent, member, premium, subscriber.

When coverage ends

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

1. The date MIC notifies you that MIC will cease doing business. Coverage will end on the last day of a month. (To cease doing business means to discontinue issuing new individual health plans and to refuse to renew all of MIC's existing individual health plans.)
2. The end of the month for which the subscriber last paid the premium due.
3. The end of the month following the date the subscriber requests that coverage end. Written request for termination of the subscriber's 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.
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.

Time Limits on the Effect of Misstatements

No misstatements made in your application for coverage under this plan, except fraudulent misstatements, shall be used to void this Policy 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, the remaining members may choose to continue coverage under this MIC plan.

FF. *Complaints*

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

See *Definitions*. These words have specific meanings: claim, inpatient, network, provider.

You may call Customer Service at one of the telephone numbers listed inside the front cover or by writing to the address below in *Internal review*, 1.a. You also may contact the Commissioner of Commerce, Minnesota Department of Commerce, at (651) 539-1600 or 1-800-657-3602.

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.

    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 15 days from receipt of your complaint. If MIC cannot provide its determination within 15 days, MIC may take an additional 4 days and will notify you of the extension and the reason relating to it.

    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.

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*** and ***Prescription Specialty Drugs*** sections 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:

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 action at law or in equity shall be brought to recover on this Policy prior to the expiration of

60 days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

GG. *General Provisions*

This section describes the general provisions of this Policy.

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

Examination of a member

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.

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.

HH. *Definitions*

In this Policy (and in any amendments), some words have specific meanings. Within each definition, you may note bold words. These words also are defined in this section.

Approved clinical trial. 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:

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. The health services or supplies (described in this Policy and any subsequent amendments) approved by MIC as eligible for coverage.

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.

Biosimilar. A biosimilar is a biological product that is highly similar to and has no clinically meaningful differences from an existing FDA-approved reference product.

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

Coinsurance. The percentage amount you must pay to the **provider** for **benefits** received.

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

1. Charge billed by the **provider** (i.e., retail); or

2. Negotiated amount that the **provider** has agreed to accept as full payment for the **benefit** (i.e., wholesale).

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

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

1. Charge billed by the **provider** (i.e., retail) or

2. **Non-network provider reimbursement amount**.

For out-of-**network benefits**, in addition to any **coinsurance** and **deductible** amounts, you are responsible for any charges billed by the **provider** in excess of **the non-network provider reimbursement amount**.

In addition, for the **network** pharmacies described in *Prescription Drugs* and *Prescription Specialty Drugs*, the calculation of **coinsurance** amounts as described above do not include possible reductions for any volume purchase discounts or price adjustments that MIC may later receive related to certain **prescription drugs** and pharmacy services.

The **coinsurance** may not exceed the charge billed by the **provider** for the **benefit**.

Cosmetic. Services and procedures that improve physical appearance but do not correct or improve a physiological function, and that are not **medically necessary**, unless the service or procedure meets the definition of **reconstructive**.

Custodial care. Services to assist in activities of daily living that do not seek to cure, are performed regularly as a part of a routine or schedule, and, due to the physical stability of the condition, do not need to be provided or directed by a skilled medical professional. These services include help in walking, getting in or out of bed, bathing, dressing, feeding, using the toilet, preparation of special diets and supervision of medication that can usually be self-administered.

Deductible. The fixed dollar amount you must pay for eligible services or supplies before **claims** for health services or supplies received from **network** or **non-network providers** are reimbursable as in-**network** or out-of-**network benefits** under this Policy.

Please note that amounts reimbursed or paid by a provider or manufacturer, including manufacturer coupons, 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.

Dependent. Unless otherwise specified in this Policy:

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:

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.

In addition, a child under legal guardianship of the **subscriber,** the **subscriber's domestic partner** or **subscriber's** legally married spouse will be considered a **dependent**. However, MIC may request that the **subscriber** provide satisfactory proof of guardianship. See *Extending a child's eligibility* in *Eligibility And Enrollment* for details regarding **dependent** limiting ages.

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

Domestic partner. An adult who:

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:

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.

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.

Health Insurance Marketplace. A governmental or non-profit entity established as an Exchange, also referred to in this Policy as the "Marketplace," pursuant to the Affordable Care Act to make qualified health plans available to individuals and small employers.

Home health aide services. Part time or intermittent services to help you with activities of daily living.

Hospital. A licensed facility that provides diagnostic, medical, therapeutic, rehabilitative and surgical services by, or under the direction of, a **physician** and with 24-hour R.N. nursing services. The **hospital** is not mainly a place for rest or **custodial care**, and is not a nursing home or similar facility.

Inpatient. An uninterrupted stay, following formal admission to a **hospital**, **skilled nursing facility** or licensed acute care facility. **Inpatient** services in a licensed residential treatment facility for treatment of emotionally disabled children will be covered as any other health condition.

Investigative. As determined by MIC, a drug, device, diagnostic or screening procedure, or medical treatment or procedure is **investigative** if reliable evidence does not permit conclusions concerning its safety, effectiveness or effect on health outcomes. MIC will make its determination based upon an examination of the following reliable evidence, none of which shall be determinative in and of itself:

1. Whether there is final approval from the appropriate government regulatory agency, if required, including whether the drug or device has received final approval to be marketed for its proposed use by the United States Food and Drug Administration (FDA), or whether the treatment is the subject of ongoing Phase I, II, 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**.

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.

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:

1. Be consistent with the medical standards and accepted practice parameters of the community as determined by health care **providers** in the same or similar general specialty as typically manages the condition, procedure or treatment at issue; and

2. Be an appropriate service, in terms of type, frequency, level, setting and duration, to your diagnosis or condition; and

3. Help to restore or maintain your health; or

4. Prevent deterioration of your condition; or

5. Prevent the reasonably likely onset of a health problem or detect an incipient problem.

Member. A person who is enrolled under this Policy and on whose behalf the premium is being paid. In this Policy, the words you, your or yourself refer to the member.

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

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

The MIC **network provider** directory is available without charge.

Network access area. Used to define areas where there are MIC contracted providers outside the service area for a specific product.

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

Non-network provider reimbursement amount. The amount that MIC will pay to a **non-network provider** for each benefit is based on one of the following, as determined by MIC:

a. A percentage of the amount Medicare would pay for the service in the location where the service is provided. MIC generally updates its data on the amount Medicare pays within 30 – 60 days after the Centers for Medicare and Medicaid Services updates its Medicare data; or

b. A percentage of the **provider's** billed charge; or

c. A nationwide provider reimbursement database that considers prevailing reimbursement rates and/or marketplace charges for similar services in the geographic area in which the service is provided; or

d. An amount agreed upon between MIC and the **non-network provider**.

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

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

In addition, if the amount billed by the **non-network provider** is greater than the **non-network provider reimbursement amount,** *the **non-network provider** will likely bill you for the difference.* This difference may be substantial, and it is in addition to any **coinsurance** or **deductible** amount you may be responsible for according to the terms described in this Policy. As a result, the amount you will be required to pay for services received from a **non-network provider** will likely be much higher than if you had received services from a **network provider**.

In the case of an emergency service, the payment for the emergency benefit is calculated on the non-network provider reimbursement amount. The non-network, provider reimbursement amount is at least the greatest of the following three for that same service, consistent with our emergency standard reimbursement policy:

a. The median negotiated amount with network providers;

b. The amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services; and

c. The amount that would be paid under Medicare (Part A or Part B of title XVIII of the Social Security Act).

The non-network provider reimbursement amount 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. Charges in excess of the non-network, provider reimbursement amount do not accumulate to your deductible or out-of-pocket maximum.

Non-skilled care. 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.

Physician. A Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Optometry (O.D.) or Doctor of Chiropractic (D.C.) practicing within the scope of his or her licensure.

Placed for adoption. The assumption and retention of the legal obligation for total or partial support of the child in anticipation of adopting such child.

(Eligibility for a child **placed for adoption** with the **subscriber** ends if the placement is interrupted before legal adoption is finalized and the child is removed from placement.)

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

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

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

Prescription insulin drugs. Prescription drugs that contain insulin and are used to treat diabetes.

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

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

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

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.

Professionally administered drugs. 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.

Provider. A health care professional or facility licensed, certified or otherwise qualified under state law to provide health services.

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.

Reconstructive. Surgery to rebuild or correct a:

1. Body part when such surgery is incidental to or following surgery resulting from injury, sickness or disease of the involved body part; or

2. Congenital disease or anomaly which has resulted in a functional defect as determined by your **physician**.

In the case of mastectomy, surgery to reconstruct the breast on which the mastectomy was performed and surgery and reconstruction of the other breast to produce a symmetrical appearance shall be considered **reconstructive**.

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.

Rescission. The cancellation or discontinuance of coverage under a health plan that has a retroactive effect. Coverage will only be rescinded for fraud or intentional misrepresentation of material fact.

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.

Service area. The geographic area where this health insurance plan accepts members.

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 and occupational 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.

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.

Step Therapy. Process that involves trying an alternative covered drug first before moving to another covered drug for treatment of the same medical condition.

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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