Nebraska

Policy of Coverage

for Individuals and Families

Medica Insure[SM]

NE-Insure-PC-22-01

Bronze HSA Plan

Bronze H Plan Limited

Plan Identifier 2022-IFBIBHNE, 2022-IFBIBHNEL

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: Member Services, Route CP595, Minnetonka, MN 55305** or to 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. MEDICA 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.

ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປຂໍ້ມູນນີ້ຟຣີ, ໃຫ້ໂທຫາເລກໝາຍທີ່ມີຢູ່ໃນເອກະສານນີ້ ຫຼື ຢູ່ດ້ານຫຼັງຂອງບັດ Medica ຂອງທ່ານ.

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

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

နမ့်ဆဲဉီးတ၊်ကွိးထံစ၊းကလီနှ်နၤတ၊်ဂ့၊်တ၊်ကွိုးဆံၤလ၊းအကလီနှ်, ကိးလီတဲစိနှိဉ်ဂ်၊်လ၊းအပဉ်ယှာ်လ၊းလာ်တီလာ်မီအပူၤဆံၤမ့တမ့်ဖဲနနှနိုင်လော်အုဉ်သးဒးကှအလိၢ်ခံတကပၤအဖိခိဉ်နှဉ်တက့ာ်.

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

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

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

COMIFB-0119-M

Helpful Resources

Medica Member Services

Call the Medica Member Services phone number on the back of your Medica ID card (TTY **711**) if you have any questions. Health Plan Specialists are available 8 a.m. – 6 p.m. CT Monday – Friday (Closed 8 – 9 a.m. Thursdays). You can also send a secure message at **Medica.com/Contact**.

Marketplace Contact Center

Call **1-800-318-2596 (TTY 1-855-889-4325)** if you purchased your coverage through the Health Insurance Marketplace, referred to in this Policy as the "Marketplace," and you need assistance with your financial help (tax credits) or need to make changes to the demographic information on this Policy. Or visit **healthcare.gov/Contact-Us**.

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 signing in to your secure member site at **Medica.com/SignIn**. 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

Important Notice: This plan is an Exclusive Provider Organization (EPO) plan. EPO plans cover health care services only when provided by a doctor or facility who participates in the network. If you receive services from a non-network doctor or other health care provider, you will have to pay all of the costs for the services, except that emergency services must be covered regardless of whether they are delivered by a participating provider.

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Table Of Contents

Terms and Conditions

Term of this Policy

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

All coverage under this Policy begins and ends at 12:01 a.m. Central Time on the date the coverage becomes effective.

Entire agreement

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

1. This Policy of Coverage, the Benefit Chart section of this Policy of Coverage, any amendments; and
2. Your application for coverage.

Guaranteed renewal

This Policy will not be canceled or non-renewed merely because your health deteriorates. Renewal is subject to Medica's right to terminate this Policy due to your non-payment of premium or for fraud or intentional misrepresentation of a material fact, or as otherwise described in *Ending Coverage*. Medica has the right to change the premium as allowed under Nebraska law.

Nondiscrimination policy

Medica's policy is to treat all persons alike, without distinction 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 Member Services at the number on the back of your Medica ID card.

Assignment

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

Acceptance of coverage

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

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

Amendment

This Policy or the Benefit Chart section of this Policy may be amended as described in this Policy. When this happens, you will receive a new policy or amendment approved and signed by an executive officer of Medica. No other person or entity has authority to make any changes or amendments to this Policy. All amendments must be in writing.

Discretionary authority

Medica 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.

Certain terms are specifically defined in this Policy and Medica will interpret and construe the terms and conditions consistent with those definitions. It is important that you read and understand the defined terms.

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 Medica and network providers are contractual relationships between independent contractors. Network providers are not agents or employees of Medica. 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.

Notice

Except as otherwise provided in this Policy, written notice given by Medica to the subscriber will be deemed notice to all individuals covered under this Policy in the event of termination or nonrenewal of this Policy for any reason.

Cancellation

Your coverage may be canceled only under certain conditions. See *Ending Coverage* for additional information.

Reinstatement

If any renewal premium is not paid within the time granted the subscriber for payment, a subsequent acceptance of premium by Medica shall reinstate this Policy. In all other respects the subscriber and Medica will have the same rights under this 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.

Examination of a member

To settle a dispute concerning provision or payment of benefits under this Policy, Medica may require that you be examined or an autopsy of the member's body be performed. The examination or autopsy will be at Medica's expense.

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 Member Services at the number on the back of your Medica ID card.

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 Member Services at the number on the back of your Medica ID card to request these materials.

Legal actions

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

Payment of Claims

Except as set forth in this provision, all benefits are payable as described in this Policy. Any accrued benefits unpaid at the subscriber's or a covered dependent's death, at Medica's option, be paid to the beneficiary or to the estate, or for hospital, surgical nursing, or medical services, directly to the hospital or other person rendering such services.

Any payment made by us in good faith under the provision shall fully discharge Medica's obligation to the extent of the payment.

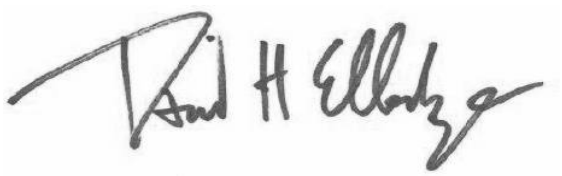
The right to change of beneficiary is reserved to the subscriber and the consent of the beneficiary or beneficiaries is not required to surrender or assign this Policy, to make any change of beneficiary or beneficiaries, or to make any other changes in this Policy that the subscriber is permitted to make.

Policy

This Policy is a legal contract between the subscriber and Medica and describes the benefits covered under this Policy.

IN WITNESS WHEREOF, Medica's Senior Vice President and General Manager of Individual and Family Business and Senior Vice President and Secretary hereby sign your contract.

Senior Vice President and General Manager of Individual and Family Business



Senior Vice President and Secretary

I. Introduction

A. About this Policy

This Medica Policy describes health services that are eligible for coverage and the procedures you must follow to obtain benefits. Because many provisions are interrelated, you should read this Policy in its entirety. The most specific and appropriate section will apply for those benefits related to the treatment of a specific condition.

For subscribers purchasing coverage through the Marketplace, the Marketplace will determine whether the subscriber is qualified to purchase coverage through the Marketplace and will notify Medica. Members are subject to all terms and conditions of this Policy.

Medica 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.

Benefits apply when you receive health services from network providers. Such services must be prescribed by and received from a network provider, unless otherwise indicated in this Policy. Benefits also apply to coverage for emergency services from non-network providers, including when you are traveling out of the service or network access area. Non-emergency care outside of your service or network access area is generally not covered. Follow-up care or scheduled care following an emergency must be received from a network provider to be covered as a benefit.

If a network provider refers you to a non-network provider, you must call Medica to determine if the services to be performed by the non-network provider are covered as benefits. Such referrals must be prior approved by Medica to be eligible for coverage as benefits. Medica approves referrals to non-network providers only if care is not available from network providers.

In this Policy, the words *you*, *your* and *yourself* refer to the member. The term *subscriber* refers to the person who is applying for or is issued this Policy.

B. Eligibility

To be eligible to enroll for coverage under this Policy, you must be a *subscriber* or *dependent* and meet the eligibility requirements stated below.

Subscriber eligibility

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

1. be a Nebraska resident; and
2. if you are enrolling in a Catastrophic Plan, be under the age of 30 at the start of the policy year or qualify for a hardship exemption, as determined by the Marketplace; and
3. complete an application form; and

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

Child only eligibility

Individuals under the age of 21 are eligible to enroll as a subscriber without an adult under this 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 spouse or domestic partner* must:

1. be a Nebraska resident; and
2. if enrolling in a Catastrophic Plan, be under the age of 30 or qualify for a hardship exemption, as determined by the Marketplace, when added as a dependent; and
3. not have failed to pay premium which you were obligated to pay for individual/family coverage with Medica or its affiliates for any period of coverage in the 12 months prior to the requested coverage effective date for you under this Policy.

To be eligible to enroll for coverage, a dependent child must be under the age of 26 (see *Extending a child's eligibility* below).

Extending a child's eligibility

A dependent child is no longer eligible for coverage under this Policy when he or she reaches the dependent limiting age of 26. However:

1. The child's eligibility continues if the child is incapable of self-sustaining employment by reason of intellectual 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 child, you must provide Medica 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, Medica may require annual proof of disability and dependency, or
2. A dependent child is eligible for continuing coverage under this Policy to the age of 30 if he or she is (a) unmarried, (b) a Nebraska resident, and (c) does not receive coverage under another health benefit plan. The child must have been covered as a dependent child under this Policy at the age of 26 in order to continue coverage under this provision.

C. Enrollment

Open enrollment and effective date of coverage

For subscribers and dependents, the period of time identified each year by Medica or by the Marketplace, as applicable, 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 the Marketplace for coverage offered through the Marketplace, or to Medica for coverage offered directly through Medica.

If you enroll for coverage during the open enrollment period, your coverage will be effective on January 1 of the following year. Services received before the effective date of this Policy are not covered.

Medica 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. For coverage obtained through the Marketplace, eligibility for special enrollment will be as determined by the Marketplace and confirmed by Medica. If coverage was not obtained through the Marketplace, eligibility for special enrollment will be determined by Medica. Medica requires documentation to be submitted to Medica 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.

Services received before the effective date of this Policy are not covered.

Please note, if coverage was obtained through the Marketplace, contact the Marketplace to notify them of the life event and to exercise your right for a special enrollment.

Medica 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, whether you enrolled through the Marketplace or not:

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 the Marketplace, you must contact the Marketplace to enroll the dependent and determine what types of plan changes can be made due to this special enrollment. 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 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 or date of placement for adoption, respectively or the first of the month following plan selection if allowed by Medica or the Marketplace 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 the Marketplace 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 Medica or the Marketplace, as applicable.

3. For subscribers currently enrolled through the Marketplace, 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 first day of the month following plan selection.

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 first day of the month following plan selection.

5. The subscriber or 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 Medica or the Marketplace, as applicable.

6. The subscriber demonstrates to Medica or the Marketplace, as applicable, 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 Medica or the Marketplace, as applicable.

7. The subscriber demonstrates to Medica or the Marketplace, as applicable, that enrollment or non-enrollment in a health plan was unintentional, inadvertent or erroneous and the result of the error, misrepresentation or inaction of the Marketplace or the United States Department of Health and Human Services, a non-Marketplace entity providing enrollment assistance or conducting enrollment activities, or Medica. Coverage is effective on the date established by Medica or the Marketplace, as applicable.

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 Medica or the Marketplace, as applicable.

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 first day of the month following plan selection. 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 the Marketplace during annual open enrollment or a special enrollment, and is determined by the Marketplace 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 Medica or the Marketplace, as applicable.

11. You or your dependent was enrolled in COBRA continuation coverage, or similar state program, for which an employer was paying all or part of the premiums, or for which a government entity was providing subsidies, and the employer completely ceases its contributions or the government subsidies completely cease. Coverage is effective on the first day of the month following plan selection.

Following are special enrollment opportunities available only if you enrolled through the Marketplace. Coverage is effective on the date established by the Marketplace. Contact the Marketplace for information about the limitations of each special enrollment opportunity.

1. For an Indian enrolling through the Marketplace, or the dependent of an Indian that is enrolled or is enrolling through the Marketplace on the same application as the Indian, on a monthly basis as determined by the Marketplace.

2. For subscribers enrolled through the Marketplace the subscriber or dependent enrolled in the same qualified health plan is determined to be newly eligible for an advance premium tax credit or has a change in eligibility for cost-sharing reductions.

3. A qualified individual, or his or her dependent, who is enrolled in an eligible employer-sponsored plan and is determined newly eligible for advance payments of the premium tax credit.

4. For subscribers and dependents enrolling through the Marketplace, in the event of gaining status as a citizen, national, or lawfully present individual, or being released from incarceration, as determined by the Marketplace.

5. For subscribers and dependents enrolling through the Marketplace, the subscriber demonstrates to the Marketplace and the Marketplace determines that exceptional circumstances apply.

6. The subscriber or dependent enrolled through the Marketplace adequately demonstrates to the Marketplace that a material error related to plan benefits, service area, or premium influenced the individual's decision to purchase a plan through the Marketplace.

7. For a consumer who resolves a data matching issue following the end of an inconsistency period or has an annual household income under 100 percent of the Federal Poverty Level and did not enroll in coverage while waiting for HHS to verify that he or she meets the citizenship, national, or immigration status.

If you enrolled directly with Medica, and you or your dependent experienced a decrease in income and had minimum essential coverage for one or more days in the previous sixty days before the date of financial change, you may be eligible for a special enrollment period through the Marketplace if you are eligible for advance premium tax credits.

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 enrollment* and *Special enrollment* above. Please note with regard to births and adoptions: Medica does not automatically know of a birth or adoption or whether the subscriber would like coverage for the newborn or newly adopted dependent. You must, therefore, request that the newborn or newly adopted dependent be added. If additional premium is required, Medica is entitled to all premiums due from 31 days following the time of the child's birth, adoption or placement for adoption until the time the covered subscriber notifies Medica of the birth or adoption.

Notification

Unless a longer period is provided in this Policy, the subscriber must notify Medica in writing within 31 days of the effective date of any changes to home address or name, or other facts identifying you or your dependents.

D. Premiums

Your premiums must be prepaid by the subscriber from the date coverage starts. If a subscriber or dependent has enrolled through a special enrollment period retroactively, your premiums must be paid by the date established by Medica.

If you are receiving an advance premium tax credit, you will need to pay your share of the first month's premium by the date established by Medica.

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.

Medica 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. Medica 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.

E. Grace period

The grace period for the subscriber's payment of premiums will be 31 days from the date a premium payment 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 *Ending Coverage*.

If you are receiving an advance premium tax credit, the grace period for the subscriber's payment of premiums will be 3 months from the date a premium payment is due.

- If you pay your full share of the premium at any time during this grace period, which includes any additional missed premium payments during the grace period, this Policy shall not be terminated.
- If your share of the full premium is not paid by the end of the grace period, coverage will end as stated in Ending Coverage. Medica will pay benefits only for the first month of the grace period.
- For example, if you fail to make the premium payment for March, April and May, Medica will pay benefits only for services you receive in March, unless you pay your full share of all the premiums for March, April and May by the end of May. Be aware that benefits will not be paid after the first month of the 3 month grace period.

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 Medica has provided coverage during the grace period, then that person may not be allowed to enroll in any other Medica (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 Medica 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 Medica policy consistent under Medica's process.

F. 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 this Policy maintains the actuarial value for the designated metal levels as defined in federal law. If we make a material modification to a term of this Policy that was also referenced on the most recent Summary of Benefits and Coverage (SBC) for this Policy, we will give you at least a 60 day advance notice prior to the effective date of the material modification. 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.

G. Benefits

What you must do to receive benefits

Each time you receive health services, you must:

1. Confirm with Medica that your provider is a network provider with your Medica plan to be eligible for benefits;
2. Identify yourself as a Medica member; and
3. Present your Medica identification card. Having and using a Medica identification card does not guarantee coverage.

If your provider asks for your health care identification card and you do not identify yourself as a Medica 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 Medica 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 Member Services at the number on the back of your Medica ID card.

Benefits

To see which providers are in your plan's network, check the online search tool on **Medica.com/SignIn** or call Member Services at the number on the back of your Medica ID card.

Medica will cover health services and supplies as described in this Policy for benefits only if they are provided by network providers or received from a non-network provider when Medica 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, Medica 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 also be required from Medica for certain benefits even if a provider has directed or recommended that you receive the services or supplies. This Policy fully defines your benefits and describes procedures you must follow to obtain benefits.

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

Medica will cover routine patient costs in connection with a qualified individual's participation in an approved clinical trial at the applicable benefit level. Routine patient

costs are items and services that would be covered benefits even when not provided 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.

Non-network providers

Emergency services received from non-network providers are covered benefits. To be eligible for coverage from non-network providers, services must be due to an emergency, as defined in Definitions.

Additionally, under certain circumstances Medica will authorize your obtaining services from a non-network provider within the United States. Such authorizations are generally provided only in situations where the requested services are not available from network providers. Medica 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, Medica 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.

Medica will also cover services from non-network providers when they perform radiology, anesthesiology, pathology and laboratory services, without your consent and knowledge, in a network provider setting.

In the following situations you are not responsible for any amounts above the network cost-sharing amount for such service calculated in accordance with the Federal No Surprises Act of 2020, and any implementing rules:

1. While obtaining emergency services at certain non-network emergency facilities or from certain non-network providers, as set forth in the definitions and terms and conditions of the Federal No Surprises Act of 2020, and any implementing rules;
2. While obtaining certain non-emergency services performed by certain non-network providers at certain network facilities (including, but not limited to, a hospital, a hospital outpatient department, a critical access hospital, or an ambulatory surgical center), as set forth in the definitions and under the terms and conditions of the Federal No Surprises Act of 2020, and any implementing rules, unless you have consented in a manner consistent with the Federal No Surprises Act of 2020; or
3. While obtaining air ambulance services from certain non-network providers, as set forth in the definitions and under the terms and conditions of the Federal No Surprises Act of 2020, and any implementing rules.

If you have questions about bills you receive from a non-network provider that provided services under the circumstances described above, please call Member Services at the number on the back of your Medica ID card. If you receive a bill that is larger than the applicable copayment, coinsurance, or deductible, you may submit the bill for processing to:

Member Services

Route CP595

PO Box 9310

Minneapolis, MN 55440-9310

When you access care from non-network providers, you will be responsible for filing claims in order to be reimbursed for covered benefits. For information on submitting claims, refer to *Submitting a claim*.

Exclusions

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

H. Providers

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

You must verify that your provider is a network provider each time you receive health services.

Network providers

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

1. A fee-for-service method, such as per service or percentage of charges;
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 Medica 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 copayment, coinsurance or deductible, is considered to be payment in full.

Medica 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 Medica 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 non-emergency service from a non-network provider is covered, the non-network provider is paid a fee for each covered service that is provided.

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, except to the extent the No Surprises Act of 2020 applies. Charges in excess of the non-network provider reimbursement amount do not accumulate to your deductible or out-of-pocket maximum.**

I. Submitting a claim

Claims for benefits from network providers

If you receive a bill for any benefit from a network provider, you may submit the claim following the procedures described below, under *Claims for benefits from non-network providers*, or call Member Services at the number on the back of your Medica ID card.

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 Medica member within 180 days of the date of service, you may be responsible for paying the cost of the service you received.

Claims for benefits from non-network providers

When you receive services from non-network providers, you will be responsible for filing claims in order to be reimbursed for covered benefits.

Claim forms can be found in the Document Center at **Medica.com/SignIn** or you may request claim forms by calling Member Services at the number on the back of your Medica ID card. If the claim forms are not sent to you within 15 days, you may submit an itemized statement without the claim form to Medica. You should retain copies of all claim forms and correspondence for your records.

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

You must submit the claim in English along with a Medica claim form to Medica no later than 365 days after receiving benefits except in the absence of legal capacity. Your Medica member number must be on the claim.

Mail to the address identified on the back of your identification card.

Medica will notify you of authorization of the claim within 30 days of receipt of the claim, or send written notice of the denial of the claim within 15 days of the determination.

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

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

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

Medica 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 Medica, 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 Medica has made a coverage determination regarding your claim.

J. Referrals and 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

Certain health services are covered only upon referral. All referrals to non-network providers and certain types of network providers require prior authorization by Medica. Prior authorization from Medica is required before you receive certain services or supplies even if a provider has directed or recommended that you receive the services or supplies in order to determine whether a particular service or supply is medically necessary and a benefit. Medica 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 Member Services at the number on the back of your Medica ID card.

Your attending provider, you or someone on your behalf may contact Medica to request prior authorization. Your network provider will contact Medica to request prior authorization for a service or supply. You must contact Medica 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 Medica include:

1. Reconstructive or restorative surgery procedures;
2. Treatment of a diagnosed temporomandibular joint (TMJ) disorder or craniomandibular disorder;
3. Solid organ and bone marrow transplant services – this prior authorization must be obtained before the transplant workup is initiated;
4. Treatment at a designated facility for complex health conditions;
5. Home health care services;
6. Durable medical equipment;
7. Outpatient surgical procedures;
8. Certain genetic tests;
9. Certain drugs, biologics and biosimilars;
10. Inpatient care, including mental health and substance use disorders, skilled nursing facility services, long-term acute care hospital (LTACH) and acute inpatient rehabilitation (AIR);
11. Certain outpatient mental health and substance use disorder services;
12. Certain imaging services;
13. Certain professionally administered drugs;
14. Non-emergency licensed air ambulance transportation; and
15. 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. To obtain more information about the step therapy exception process call Member Services at the number on the back of your Medica ID card.

Pregnancy/maternity care services received from a network provider do not require prior authorization or a referral and will be covered.

Please note: 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:

1. Name and telephone number of the provider who is making the request;
2. Name, telephone number, address and type of specialty of the provider to whom you are being referred, if applicable;

3. Services being requested and the date those services are to be rendered (if scheduled);
4. Specific information related to your condition (for example, medical records or a letter of medical necessity from your provider);
5. Other applicable member information (i.e., Medica member number).

Medica will review your request for prior authorization and provide a response to you and your attending provider within 15 calendar days after the date your request was received, provided all information reasonably necessary to make a decision has been given to Medica.

Medica will respond within a time period not exceeding 72 hours from the time of the initial request if 1) your attending provider believes that an expedited review is warranted, or 2) Medica 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 Medica does not approve the request for prior authorization, you have the right to appeal Medica's decision as described in *Complaints*.

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

Referrals to non-network providers

It is to your advantage to seek Medica's authorization for referrals to non-network providers *before* you receive services. Medica can then tell you what your benefits will be for the services you may receive. Medica 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, Medica 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.

If you want to apply for a standing referral to a non-network provider, contact Medica for more information. A standing referral is a referral issued by a network provider and authorized by Medica for conditions that require ongoing services from a specialist provider.

Standing referrals will only be covered for the period of time appropriate to your medical condition. A standing referral may be granted if Medica determines a standing referral clinically appropriate.

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 Medica by calling the number on the back of your Medica ID card. Medica does not guarantee coverage of services that are received before you obtain prior authorization from Medica.
3. If prior authorization has been obtained from Medica, 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 Medica.

What Medica will do

1. May require that you see another network provider selected by Medica before a determination by Medica that a referral to a non-network provider is medically necessary.
2. May require that you obtain a referral or standing referral 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 Medica 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, Medica 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 15 calendar days of receipt of your request provided that all information reasonably necessary to make a decision has been given to Medica. However, Medica 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) Medica 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.

K. Continuity of care

To request continuity of care or if you have questions about how this may apply to you, call Member Services at the number on the back of your Medica ID card.

If you are currently in an active course of treatment with a treating provider, you have a right to continuity of care. If the contract between Medica and your treating provider terminates without cause, you may be eligible to continue care with that provider. 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, Medica will authorize continuity of care as described above for the following conditions:

1. An ongoing course of treatment for a life-threatening condition;
2. An ongoing course of treatment for a serious acute condition, such as chemotherapy;
3. Scheduled non-elective surgery, including postoperative care;
4. Pregnant and undergoing a course of treatment for pregnancy. Health services may continue to be provided through the postpartum period; or
5. 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.

Continuity of care, as described above, will continue until the active course of treatment is complete, or 90 days, whichever is shorter. Authorization to continue to receive services from your current primary care provider, specialist or hospital may extend to the remainder of your life if a physician certifies that your life expectancy is 180 days or less.

Medica 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 Medica authorizes your request to continue care with your current provider, Medica 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 benefits. If your request is denied, Medica will explain the criteria used to make its decision. You may appeal this decision.

If your provider agrees to comply with Medica's prior authorization requirements, provides Medica with all necessary medical information related to your care, and accepts as payment in full the lesser of Medica'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 deductible and coinsurance or copay described in the Benefit Chart section of this Policy.

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

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

L. Harmful use of medical services

If it is determined that you are receiving certain prescription drugs in a quantity or manner that may harm your health, benefits for these medications will be restricted to medications

that are both prescribed by one specific network physician and dispensed by one specific network pharmacy. Failure to receive these medications in this manner will result in a denial of coverage. Medica will notify you regarding the specific physician and pharmacy assigned for you.

If you have questions about how this provision applies to you, including the specific physician or pharmacy assigned for you, you may call Member Services at the number on the back of your Medica ID card. Additionally, you have the right to appeal Medica's decision concerning the application of this section or the particular physician or pharmacy assigned for you. See *Complaints* for more information on your appeal rights.

M. Medica's Right to Subrogation and Reimbursement

This section describes Medica's right of subrogation and reimbursement. Medica's rights are subject to Nebraska 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 Nebraska and federal law on Medica's subrogation rights, contact an attorney.

1. Medica has a right of subrogation against any third party, individual, corporation, insurer (except as provided in Neb. Rev. Stat. § 44-3, 159) or other entity or person who may be legally responsible for payment of medical expenses related to your illness or injury. Medica's right of subrogation shall be governed according to this section. Medica'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. Medica's subrogation interest is the reasonable cash value of any benefits received by you.

3. Medica's right to recover its subrogation interest may be subject to an obligation by Medica to pay a pro rata share of your disbursements, attorney fees and costs and other expenses incurred in obtaining the recovery from another source unless Medica is separately represented by an attorney. If Medica is represented by an attorney, an agreement regarding allocation of the disbursements, fees and costs may be reached.

4. By accepting coverage under the contract, you agree:

    a. That if Medica 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 Medica for the benefits paid in accordance with Nebraska law.

    b. To cooperate with Medica or its designee to help protect Medica's legal rights under this subrogation and reimbursement provision and to provide all information Medica may reasonably request to determine its rights under this provision.

    c. To provide prompt written notice to Medica when you make a claim against a party for injuries.

d. To provide prompt written notice of Medica's subrogation rights to any party against whom you assert a claim for injuries.

e. To do nothing to decrease or limit Medica's rights under this provision, either before or after receiving benefits, or under the contract.

f. Medica may take action to preserve its legal rights. This includes bringing suit in your name.

g. Medica may collect its subrogation interest from the proceeds of any settlement or judgment recovered by you, your legal representative or the legal representative(s) of your estate or next-of-kin.

h. To hold in trust the proceeds of any settlement or judgment for Medica's benefit under this provision.

i. You will cooperate with Medica in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:

    i. Signing and/or delivering such documents as Medica or its agents reasonably request to secure the subrogation and reimbursement claim.

    ii. Responding to requests for information about any accident or injuries, and providing all information Medica may reasonably request to determine its rights under this subrogation and reimbursement provision.

    iii. Making court appearances.

    iv. Obtaining Medica's consent or its agents' consent before releasing any party from liability or payment of medical expenses.

    v. Complying with the terms of this section.

II. Out-of-Pocket Expenses

You are responsible for paying the cost of a service that is not medically necessary or is not a covered 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.

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

Please see the Benefit Chart section of this Policy for specific information about your benefits and coverage levels. To verify coverage before receiving a particular service or supply, call Member Services at the number on the back of your Medica ID card.

A. Cost sharing: copayments, coinsurance and deductibles

For benefits, you must pay the following:

1. Any applicable copayment, coinsurance and deductible as described in the Benefit Chart section of this Policy.

   You must pay an annual deductible. The time period used to determine how much of your deductible you have satisfied is a 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 exceeds the non-network provider reimbursement amount for certain services from certain non-network providers. **If the amount billed by certain non-network providers 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 copayment, coinsurance or deductible amount you may be responsible for according to the terms described in this Policy.**

   To inquire about the non-network provider reimbursement amount for a particular procedure, call Member Services at the number on the back of your Medica ID card. 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.

   Member Services 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.

Cost sharing reductions

Cost-sharing is a combination of coinsurance, copayments and your deductible.

If the Marketplace determines you are eligible for a cost-sharing reduction, you will be offered one of three silver cost-sharing variations based on your household income. This will lower your cost-sharing for benefits. If you move between different cost-sharing variations because of a redetermination of your eligibility for a specific cost-sharing variation, the time period does not start again when you move to a new cost-sharing variation, including a standard silver plan. Because different variations may have different deductibles, if you move to a plan with a higher deductible because of a change in your income, you will have to meet the new higher deductible, but the amounts you paid already will be counted toward the new higher deductible. You might also move to a plan with a lower deductible based on a change in income, if you have already satisfied the high deductible, it will count toward your new deductible and out-of-pocket maximums, but you will not receive a rebate of the excess you have paid over your new deductible.

In the event a cost-sharing variation plan is no longer available through the Marketplace as outlined in the *Ending Coverage* section, and you move to the standard cost-sharing version of that same plan, the time period for determining your cost-sharing does not start again for that calendar year.

For example, if you satisfy a $500 deductible and pay $100 in co-payments in one plan variation, then move to a different plan variation with a $750 deductible as a result of a change in eligibility, the $500 would apply towards the new deductible and you would need to satisfy the remaining $250 of the new deductible.

American Indians and Alaska Natives

If the Marketplace determines you are eligible for a zero cost-sharing variation, you will be offered a zero cost-sharing variation of the plan you have chosen. This will eliminate your cost-sharing for benefits. An individual that the Marketplace determines is an American Indian or Alaska Native will have no cost sharing required on benefits received from Indian Health Services, an Indian Tribe, Tribal Organization, or Urban Indian Organization (each as defined in 25 U.S.C. 1603), or through a referral under contract health services, as contract health services are defined and provided pursuant to 42 C.F. R. Subpart C and any other guidance issued pursuant to that section. If you intend this Policy to qualify as an HSA-compliant high deductible health plan allowing you to contribute to an HSA, you should carefully consider whether to accept a cost-sharing reduction for services from these providers. The cost-sharing reduction will disqualify this Policy from being an HSA-compliant high deductible health plan.

B. Out-of-pocket maximum

The out-of-pocket maximum is an accumulation of the:

- copayments
- coinsurance, and
- deductible

paid for benefits received during a calendar year. Unless otherwise specified, you will *not* be required to pay more than the out-of-pocket maximum for benefits received during a calendar year. 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 out-of-pocket maximum has been met, all other covered benefits received during the rest of the calendar year will be covered at 100%, except for any charge not covered by Medica. The out-of-pocket maximum is described in the Out-of-Pocket Expenses table in the Benefit Chart section of this Policy.

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

III. Covered Benefits

Prior authorization (approval in advance) is required before you receive certain services listed below. To determine if Medica requires prior authorization for a particular service or treatment, please call Medica Member Services at the number on the back of your Medica ID card. Please see *Prior authorization* in *Referrals and Prior Authorization* for more information about prior authorization requirements and processes.

A. Ambulance

Medica covers ambulance services as described in the Benefit Chart section of this Policy.

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 the Benefit Chart section of this Policy).

B. Anesthesia

Medica covers anesthesia services as described in the Benefit Chart section of this Policy.

Not covered:

Anesthesia services provided by a non-network provider.

C. Chiropractic or Osteopathic Manipulation

Medica covers chiropractic or osteopathic services to treat conditions related to muscles, skeleton and nerves of the body. This includes spinal manipulations or other manipulative therapies.

Not covered:

1. Chiropractic or osteopathic services provided by a non-network provider.
2. Massage therapy which is performed in conjunction with other treatment by a chiropractor as part of a prescribed treatment plan that is billed separately.

D. Diabetes Management and Supplies

Medica covers:

- diabetes self-management training and education, including medical nutrition therapy, received from a provider in a program consistent with national educational standards (as established by the American Diabetes Association) and patient management home visits when medically necessary;
- diabetic equipment and supplies, including blood glucose meters when received from a network pharmacy;

- insulin pumps and their related supplies when received from a network durable medical equipment provider; and
- routine foot care if part of treatment for diabetes.

Not covered:

Diabetes management and supplies received from or provided by a non-network provider.

E. Diagnostic Imaging

Medica covers diagnostic imaging services such x-rays and other imaging services when:

- ordered by a provider, and
- provided in a clinic or outpatient hospital facility.

Not covered:

Diagnostic imaging services provided by a non-network provider.

F. Durable Medical Equipment, Prosthetics and Miscellaneous Medical Supplies

Medica covers only a limited selection of durable medical equipment and certain related supplies, and hearing aids that meet the criteria established by Medica. 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 Medica. To request a list of Medica's eligible durable medical equipment and certain related supplies, call Member Services at the number on the back of your Medica ID card.

Medica determines if durable medical equipment will be purchased or rented. Medica'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 Member Services at the number on the back of your Medica ID card.

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 Medica, but the model you select is not Medica'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 Drugs* section of this Policy.

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 the Benefit Chart section of this Policy when prescribed by a network provider.

To request a list of network durable medical equipment providers, call Member Services at the number on the back of your Medica ID card.

Not covered:

1. Durable medical equipment and supplies, prosthetics, appliances and hearing aids provided by a non-network provider.
2. Durable medical equipment and supplies, prosthetics, appliances and hearing aids not on the Medica eligible list.
3. Charges in excess of the Medica standard model of durable medical equipment, prosthetics or hearing aids.
4. Repair, replacement or revision of properly functioning durable medical equipment, prosthetics and hearing aids, including, but not limited to, due to loss, damage or theft.
5. Duplicate durable medical equipment, prosthetics and hearing aids, including repair, replacement or revision of duplicate items.
6. Disposable supplies and appliances, except as described in this Policy.

G. Emergency Room

Medica covers emergency room services, as described in the Benefit Chart section of this Policy, where a prudent layperson would believe that a condition or symptom requires immediate treatment to:

1. Preserve your life; or
2. Prevent serious impairment to your bodily functions, organs or parts; or
3. Prevent placing your physical or mental health in serious jeopardy.

Emergency services from non-network providers will be covered benefits. To be eligible for coverage from non-network providers, services must be due to an emergency, as defined in *Definitions*.

You must notify Medica of emergency inpatient services as soon as reasonably possible after receiving inpatient services. Call Member Services at the number on the back of your Medica ID card.

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

If the health services that you require do not meet the definition of emergency, you should refer to the most specific section of this Policy for a description of your benefits.

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

For information on submitting claims for emergency services received in a foreign country, refer to *Submitting a claim*.

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.

H. Genetic Counseling and Testing

Medica covers genetic counseling, whether pre-test or post-test, and whether occurring in an office, clinic or telephonically. Medica also covers genetic testing when the test will directly affect treatment decisions or frequency of screening for a disease, or when results of the test will affect reproductive choices. Please see the Benefit Chart section of this Policy for more information.

Not covered:

1. Genetic counseling and testing services provided by a non-network provider.
2. Genetic testing when performed in the absence of symptoms or high risk factors for a heritable disease.
3. Genetic testing when knowledge of genetic status will not affect treatment decisions, frequency of screening for the disease or reproductive choices.
4. Genetic testing that has been performed in response to direct to consumer marketing and not under the direction of your physician.

I. Home Health Care

Medica 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 respiratory care and 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 respiratory therapist or 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 in the Benefit Chart section of this Policy apply to covered home health care services received from a network home health care agency. Please see the Benefit Chart for more information.

Not covered:

1. Home health care provided by a non-network provider.
2. Extended hours home care.
3. Companion, homemaker and personal care services.
4. Services provided by a member of your family.
5. Custodial care and other non-skilled services.
6. Physical, occupational or speech therapy provided in your home for convenience.
7. Skilled nursing care or skilled physical or occupational therapy provided in your home when you are not homebound.
8. Speech therapy provided in your home when you are not homebound.
9. Services primarily educational in nature.
10. Vocational and job rehabilitation.
11. Recreational therapy.
12. Self-care and self-help training (non-medical).
13. Health clubs.
14. Disposable supplies and appliances, except as described in this Policy.
15. Physical, occupational or speech therapy services when there is no reasonable expectation of improvement.
16. Voice training.
17. Outpatient rehabilitation services when no medical diagnosis is present.
18. 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.

J. Hospice

Medica covers hospice services including respite care. Care must be ordered, provided or arranged under the direction of a physician and received from a hospice program.

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.

Medica contracts with hospice programs 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.

Medical social services are services provided by the hospice's medical social worker and are directly related to the hospice patient's medical condition.

Bereavement counseling is provided to a covered family member, within six months of the patient's death.

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:

1. Hospice services provided by a non-network provider.
2. Respite care for more than five consecutive days at a time.

3. Home health care and skilled nursing facility services when services are not consistent with the hospice program's plan of care.
4. Services not included in the hospice program's plan of care, including room and board charges or fees.
5. Services not provided by the hospice program.
6. Hospice daycare, except when recommended and provided by the hospice program.
7. Any services provided by a family member or friend, or individuals who are residents in your home.
8. Financial or legal counseling services, except when recommended and provided by the hospice program.
9. Housekeeping or meal services in your home, except when recommended and provided by the hospice program.
10. Bereavement counseling, except when recommended and provided by the hospice program.

K. Hospital

Medica covers physician directed hospital and ambulatory surgical center services as described in the Benefit Chart section of this Policy. More than one copayment or coinsurance may be required if you receive more than one service, or see more than one provider per visit.

Important: The most specific and appropriate section of this Policy will apply for benefits related to the treatment of a specific condition.

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 this Policy ends during your inpatient stay, Medica will not cover the portion of your inpatient stay or other services received after this Policy terminates.

Not covered:

1. Services received from a non-network hospital or non-network ambulatory surgical center.
2. 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*.
3. Admission to another hospital is not covered when care for your condition is available at the network hospital where you were first admitted.

L. Infertility Services

Medica's coverage is limited to the diagnosis of infertility as described in the Benefit Chart section of this Policy. Coverage includes benefits for professional, hospital and ambulatory surgical services. All services, supplies and associated expenses for the treatment of infertility are not covered.

Not covered:

1. Services received for the diagnosis of infertility provided by a non-network provider.
2. Procedures, tests or other services that are exclusively provided to monitor the effectiveness of non-covered fertilization procedures.
3. Physician, hospital and ambulatory surgical center services for the treatment of infertility.
4. Infertility drugs.
5. 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.
6. Services related to surrogate pregnancy for a person not covered as a member under this Policy.
7. Services related to adoption.
8. Collection, retrieval, purchase, freezing and/or storage of sperm or eggs.
9. Services for intrauterine insemination (IUI).

M. Lab and Pathology

Medica covers services provided in a clinic or outpatient hospital facility as described in the Benefit Chart section of this Policy. Inpatient lab and pathology services are covered at the *Hospital or Skilled Nursing Facility* benefit level as described in the Benefit Chart section of this Policy.

Please note: Lab and pathology for preventive health care services are covered at the *Preventive Health Care* benefit level as described in the Benefit Chart section of this Policy.

Not covered:

Lab and pathology services provided by a non-network provider.

N. Maternity

Medica covers medical services for prenatal care, labor and delivery, postpartum care and related complications as described in the Benefit Chart section of this Policy.

Under the **Newborns' and Mothers' Health Protection Act of 1996** Medica 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, Medica may not require a provider to obtain prior authorization from Medica for a length of stay of 48 hours or less (or 96 hours, as applicable).

More than one copayment or coinsurance may be required if you receive more than one service or see more than one provider per visit. Medica encourages you to enroll your newborn dependent under this Policy within 31 days from the date of birth, date of placement for adoption or date of adoption.

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

Not all services that are received during your pregnancy are considered prenatal care. Some of the services that are not considered prenatal care include (but are not limited to) treatment of the following:

1. Conditions that existed prior to (and independently of) the pregnancy, such as diabetes or lupus, even if the pregnancy has caused those conditions to require more frequent care or monitoring.
2. Conditions that have arisen concurrently with the pregnancy but are not directly related to care of the pregnancy, such as back and neck pain or skin rash.
3. Miscarriage and ectopic pregnancy.

Services that are not considered prenatal care may be eligible for coverage under the most specific and appropriate section of this Policy. Please refer to the Benefit Chart section of this Policy for coverage information.

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 this Policy ends during your inpatient stay, Medica will not cover the portion of your inpatient stay or other services received after this Policy terminates.

Not covered:

1. Maternity care provided by a non-network provider.
2. Health care professional services for maternity labor delivery in the home.
3. Services from a doula.
4. Childbirth and other educational classes.

O. Medical Related Dental

Medica covers certain dental services received from a physician or dentist as described in the Benefit Chart section of this Policy.

Medica covers the evaluation(s) to determine whether you have temporomandibular joint (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. TMJ disorder is covered the same as any other joint disorder as described in the Benefit Chart section of this Policy.

Not covered:

1. Medical-related dental services provided by a non-network provider.
2. General dentistry including, but not limited to, diagnostic and preventive services, restorative services, endodontic services, periodontal services, indirect fabrications, dentures and bridges, and orthodontic services.
3. Dental services to treat an injury from biting or chewing.
4. Treatment for bruxism.
5. Tooth extractions.
6. Osteotomies and other procedures associated with the fitting of dentures or dental implants.
7. Dental prostheses.
8. Occlusal adjustment or occlusal equilibrium.
9. Dental implants (tooth replacement).
10. Orthognathic surgery for cosmetic purposes.
11. Diagnostic casts, diagnostic study models and bite adjustments unless related to the treatment of TMJ disorder and craniomandibular disorder.
12. 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.

P. Mental Health

Medica covers services to diagnose and treat mental disorders listed in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* as described in the Benefit Chart section of this Policy.

Mental health benefits

Medica requires prior authorization (approval in advance) before you receive certain mental health services or treatment. To determine if Medica 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 Medica ID card. Please see *Referrals*

and Prior Authorization in the *Introduction* for more information about prior authorization requirements and processes.

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 Medica ID card.**

Emergency mental health services are covered 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 Medica ID card as soon as reasonably possible.

Outpatient mental health services include:

1. Diagnostic evaluations and psychological testing.
2. Psychotherapy and psychiatric services.
3. 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).
4. Relationship and family therapy if there is a clinical diagnosis.
5. Treatment of serious or persistent disorders.
6. Diagnostic evaluation for attention deficit hyperactivity disorder (ADHD) or autism spectrum disorders.
7. Treatment of pathological gambling.

Inpatient services include:

1. Room and board.
2. Attending psychiatric services.
3. Hospital or facility-based professional services.
4. 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.
5. Residential treatment services. Residential treatment services must be provided in a program or facility that is licensed, accredited or certified to provide such services by the appropriate state agency, or accredited by CARF International or JCAHO.

   These services include:

   a. A residential treatment program serving children and adolescents with severe emotional disturbance; or

   b. 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.

Not covered:

1. Mental health services provided by a non-network provider.
2. Services for mental disorders not listed in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders.*
3. Services, care or treatment that is not medically necessary.
4. Relationship and family therapy in the absence of a clinical diagnosis.
5. Telephonic psychotherapy treatment services, unless such services are provided in accordance with Medica's telemedicine policies and procedures.
6. 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*.
7. 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 at a halfway house, therapeutic group home, boarding school or ranch.
8. Services to assist in activities of daily living that do not seek to cure and are performed regularly as a part of a routine or schedule.
9. 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.
10. 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.

Q. 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.

Medica covers office visits as described in the Benefit Chart section of this Policy.

Important: The most specific and appropriate section of this Policy will apply for benefits related to the treatment of a specific condition. For some services, there may be a facility charge resulting in copayment or coinsurance in addition to the provider services copayment or coinsurance. More than one copayment or coinsurance may also be required if you receive more than one service, or see more than one provider per visit. Call Member Services at the number on the back of your Medica ID card to determine in advance whether a specific procedure is a benefit and the applicable coverage level for each service that you receive.

Not covered:

1. Office visit services provided by a non-network provider.
2. 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.

R. Organ and Bone Marrow Transplants and Other Complex Health Conditions

Medica covers certain organ and bone marrow transplant services and services for other complex health conditions. Not all network hospitals are designated facilities 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. 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.

Organ and Bone Marrow Transplants: Medica uses specific medical criteria to determine benefits for organ and bone marrow transplant services. Because medical technology is constantly changing, Medica 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 Medica's medical criteria.

Coverage is provided for the following human organ transplants, if appropriate, under Medica's medical criteria and not otherwise excluded from coverage:

- 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.

Benefits apply to transplant services provided by a network provider and received at a designated facility for transplant services. Medica 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.

Medica 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 Medica provides). Based on the type of transplant you receive, Medica 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:

1. Services provided by a non-network provider or non-designated facility.
2. Organ and bone marrow transplant services, except as described in this section.
3. Supplies and services related to transplants that would not be authorized by Medica under the medical criteria referenced in this section.
4. Chemotherapy, radiation therapy, drugs or any therapy used to damage the bone marrow and related to transplants that would not be authorized by Medica under the medical criteria referenced in this section.
5. Living donor transplants that would not be authorized by Medica under the medical criteria referenced in this section.
6. Islet cell transplants except for autologous islet cell transplants associated with pancreatectomy.
7. 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.
8. Mechanical, artificial or non-human organ implants or transplants and related services that would not be authorized by Medica under the medical criteria referenced in this section.
9. Services that are investigative.
10. Private collection and storage of umbilical cord blood for directed use.
11. 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.

S. Prescription Drugs

Prescription drugs and supplies are covered if they are:

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

The Benefit Chart section of this Policy 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. 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.*

While diabetic equipment and supplies, including blood glucose meters, are covered under the diabetic equipment and supplies benefit in this section, coverage for insulin pumps and related supplies is described under *Durable Medical Equipment, Prosthetics and Miscellaneous Medical Supplies*.

Medica's Drug List

Medica'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 Medica 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 Medica's 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 Medica identifies as a generic product. Medica 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 Medica 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 Medica identifies as a brand name product. Medica 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 Medica 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 Medica'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 Member Services at the number on the back of your Medica ID card. It is also available on **Medica.com/SignIn.**

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 Medica'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).

Medica 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/SignIn** or call Member Services.

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 Medica 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 *Referrals and Prior Authorization* 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 Member Services 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 Medica'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 Medica will cover these preferred brand or non-preferred brand drugs.

Quantity limits (QL)

Certain covered drugs have limits on the maximum quantity allowed per prescription over a specific time period. The medications subject to quantity limits are shown on Medica's 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 Medica's Drug List. If you still choose to use a preferred brand or non-preferred brand prescription drug, Medica will pay the amount that Medica would have paid had you received the generic drug. You will pay, in addition to the applicable deductible, copayment or coinsurance described in the table, any remaining charges due to the pharmacy in excess of Medica'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.

Exceptions to the Drug List

In certain cases, it is possible to get an exception to the coverage rules described under *Medica's Drug List* above. **Please note that exceptions will only be allowed when specific clinical criteria are satisfied.** Any exception that Medica grants will improve the coverage by only one benefit level. However, no member cost sharing will apply for exceptions applicable to preventive health services.

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 Medica's Drug List, an expedited review may be requested. Medica 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), Medica will make a determination and provide notification within 72 hours of receiving the request.

If Medica denies your request for an exception, you, your provider or other designee may request an independent review of Medica's decision by an external review organization. To make a request, you may call Member Services at the number on the back of your Medica ID card or contact Medica by writing to Member Services, 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 Medica's Drug List exception process or for more information regarding the expedited review process, call Member Services at the number on the back of your Medica ID card.

Not covered:

1. Prescription drugs, including diabetic equipment and supplies and preventive drugs and other supplies, received at a non-network pharmacy.
2. Any amount above what Medica would have paid when you fail to identify yourself to the pharmacy as a member. (Medica will notify you before enforcement of this provision.)
3. 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.
4. Replacement of a drug due to loss, damage or theft.
5. Appetite suppressants.
6. Weight loss medications.
7. Sexual dysfunction medications.
8. Non-sedating antihistamines and non-sedating antihistamine/decongestant combinations.
9. Proton pump inhibitors, except for members twelve (12) years of age and younger, and those members who have a feeding tube.
10. Drugs prescribed by a provider who is not acting within his/her scope of licensure.
11. Homeopathic medicine.
12. Infertility drugs.
13. Specialty prescription drugs, except as described in *Prescription Specialty Drugs*.
14. Drugs and supplies not listed on Medica'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 Medica'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 Medica's Drug List.

T. Prescription Specialty Drugs

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 Medica's drug list (unless identified as not covered), and
- Received from a designated specialty pharmacy.

A current list of designated specialty pharmacies is available on **Medica.com/SignIn**. You can also call Member Services at the number on the back of your Medica ID card.

The Benefit Chart section of this Policy 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."

Medica's Specialty Drug Program

Medica's 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 Drug List. Specialty prescription drugs are displayed on Medica's Drug List as Tier 4. The Benefit Chart section of this Policy describes your copayment or coinsurance for the specialty prescription drug.

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 Medica's Drug List that affect medications you are receiving.

If you have questions about Medica's 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 Medica's Drug List, at no charge, call Member Services at the number on the back of your Medica ID card. It is also available on **Medica.com/SignIn**.

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 Medica's medication request guidelines. This includes quantity limits that are indicated on Medica's 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 Medica in order to be covered. These medications are shown on Medica's Drug List with the abbreviation "PA." Medica's Drug List is available to providers, including designated specialty pharmacies. Please see *Prior authorization* in *Referrals and Prior Authorization* 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 Member Services 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 Medica's authorization criteria.

Step therapy (ST)

Step therapy is a process that involves trying an alternative covered prescription drug before moving to the requested drug. The medications subject to Step Therapy are shown on Medica's Drug List with the abbreviation "ST." You must meet applicable step therapy requirements before Medica will cover the requested drug.

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 Medica's Drug List with the abbreviation "QL." Some quantity limits are based on the manufacturer's packaging, FDA labeling or clinical guidelines.

Exceptions to Medica's 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 specialty drug exception that Medica grants will be covered at Tier 4.

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 Medica's Drug List, an expedited review may be requested. Medica 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), Medica will make a determination and provide notification within 72 hours of receiving the request.

If Medica denies your request for an exception, you, your provider or other designee may request an independent review of Medica's decision by an external review organization. To make a request, you may call Member Services at the number on the back of your Medica ID card or contact Medica by writing to Member Services, 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 Medica's Drug List exception process or for more information regarding the expedited review process, call Member Services at the number on the back of your Medica ID card.

Not covered:

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

U. Preventive Health Care

Medica covers the following eligible preventive health services as described in the Benefit Chart section of this Policy:

1. Child health supervision services, including well-baby care.
2. Immunizations.
3. Early disease detection services including physicals.
4. Routine screening procedures for cancer. For example, screening for colorectal cancer may include a fecal occult blood test, a flexible sigmoidoscopy, a colonoscopy, a barium enema, or the most reliable, medically recognized screening test available.
5. Women's preventive health services including mammograms, screenings for cervical cancer, human papillomavirus (HPV) testing, counseling for sexually transmitted infections, counseling for immunodeficiency virus (HIV), BRCA genetic testing and related genetic counseling (when appropriate) and sterilization.
6. Other preventive health services.

Please see the definition of Preventive Health Services for more information.

Please note: If you receive preventive and non-preventive health services during the same visit, the non-preventive health services may be subject to a copayment, coinsurance or

deductible, as described in other applicable sections in the Benefit Chart section of this Policy. The most specific and appropriate benefit will apply for each service received during a visit.

Not covered:

Preventive health services provided by a non-network provider.

V. Professionally Administered Drugs

Medica 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.

Prior authorization (approval in advance) 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. To obtain more information about the step therapy exception process call Member Services at the number on the back of your Medica ID card.

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.

Not covered:

Professionally administered drugs provided by a non-network provider.

W. Reconstructive and Restorative Surgery (Including Mastectomy Reconstruction)

Medica covers medically necessary reconstructive and restorative surgery services. To be eligible, reconstructive and restorative surgery services must be medically necessary and not cosmetic.

Medica 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. Medica will also cover prostheses and physical complications, including lymphedemas, at all stages of mastectomy.

Not covered:

1. Reconstructive and restorative surgery services provided by a non-network provider.

2. Revision of blemishes on skin surfaces and scars (including scar excisions) primarily for cosmetic purposes, unless otherwise covered in this Policy.
3. Repair of a pierced body part and surgical repair of bald spots or loss of hair.
4. 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.
5. Services and procedures primarily for cosmetic purposes.
6. Surgical correction of male breast enlargement primarily for cosmetic purposes.
7. Hair transplants.
8. 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.
9. Orthognathic surgery for cosmetic purposes.

X. Rehabilitative and Habilitative Therapies

Medica covers the following rehabilitative and habilitative care provided on an outpatient basis:

- physical therapy,
- speech therapy,
- occupational therapy,
- chiropractic physiotherapy,
- osteopathic physiotherapy, and
- cardiac and pulmonary rehabilitation

as described in the Benefit Chart section of this Policy. A physician must direct your care. Coverage for services provided on an inpatient basis is as described under Hospital.

Not covered:

1. Rehabilitative and habilitative therapies provided by a non-network provider.
2. Services primarily educational in nature.
3. Vocational and job rehabilitation.
4. Recreational therapy.
5. Self-care and self-help training (non-medical).
6. Health clubs.

7. Physical, occupational or speech therapy services when there is no reasonable expectation of improvement.
8. Voice training.
9. Group physical, speech and occupational therapy.

Y. Skilled Nursing Facility

Medica covers skilled nursing facility services as described in the Benefit Chart section of this Policy. Care must be provided under the direction of a physician.

Not covered:

1. Services received from a non-network skilled nursing facility.
2. Custodial care and other non-skilled services.
3. Self-care or self-help training (non-medical).
4. Services primarily educational in nature.
5. Vocational and job rehabilitation.
6. Recreational therapy.
7. Health clubs.
8. Physical, occupational or speech therapy services when there is no reasonable expectation of improvement.
9. Voice training.
10. Outpatient rehabilitation services when no medical diagnosis is present.
11. Group physical, speech and occupational therapy.

Z. Substance Use Disorder

Medica covers the diagnosis and treatment of substance use disorders listed in the current edition of *Diagnostic and Statistical Manual of Mental Disorders*.

Substance use disorder benefits

Medica requires prior authorization (approval in advance) before you receive certain substance use disorder services or treatment. To determine if Medica 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 Medica ID card. Please see *Referrals and Prior Authorization* in the *Introduction* for more information about prior authorization requirements and processes.

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 Medica ID card.

Emergency substance use disorder services are covered 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 Medica ID card as soon as reasonably possible.

Outpatient substance use disorder services include:

1. Diagnostic evaluations.
2. Outpatient treatment.
3. 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).
4. Intensive outpatient programs, including day treatment and partial programs, which may include multiple services/modalities and lodging, delivered in an outpatient setting.

Inpatient substance use disorder services include:

1. Room and board.
2. Attending physician services.
3. Hospital or facility-based professional services.
4. 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.
5. 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**.**

Not covered:

1. Substance use disorder services provided by a non-network provider.
2. Services for substance use disorder disorders not listed in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders*.
3. Services, care or treatment that is not medically necessary.
4. Services to hold or confine a person under chemical influence when no medical services are required, regardless of where the services are received.
5. Telephonic substance use disorder treatment services, unless such services are provided in accordance with Medica's telemedicine policies and procedures.

6. Services, including room and board charges, provided by health care professionals or facilities that are not:

   - appropriately licensed,
   - certified, or
   - otherwise qualified under state law to provide substance use disorder services.

   This includes, but is not limited to:

   - services provided by mental health or substance use disorder providers who are not authorized under state law to practice independently, and
   - services received from a halfway house, therapeutic group home, boarding school or ranch.

7. Room and board charges associated with substance use disorder treatment services providing less than 30 hours a week per individual of chemical dependency services, including:

   - group and individual counseling,
   - client education, and
   - other services specific to chemical dependency rehabilitation.

8. Services to assist in activities of daily living that do not seek to cure and are performed regularly as a part of a routine or schedule.

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

AA. Temporomandibular Joint (TMJ) Disorder

See *Medical-Related Dental*.

BB. Urgent Care

Medica covers urgent care center visits as described in the Benefit Chart section of this Policy. Urgent care is a health care facility whose primary purpose is to offer and provide immediate, short-term medical care for minor medical conditions on a regular or routine basis.

CC. Vision

Medica covers vision services for members under age 19 including frames, lenses or contact lenses when prescribed solely for vision correction, and related fittings as described in the

Benefit Chart section of this Policy. Lenses include single vision, bifocal, trifocal or lenticular with choice of glass or plastic lenses.

Contact lenses may be medically necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Contact lenses may be determined to be medically necessary in the treatment of the following conditions:

- keratoconus;
- pathological myopia;
- aphakia;
- anisometropia;
- aniseikonia;
- aniridia;
- corneal disorders;
- post-traumatic disorders;
- irregular astigmatism;
- high ametropia; and
- bullous keratopathy.

Not Covered:

1. Vision services provided by a non-network provider.
2. The purchase, replacement or repair of eyeglasses, eyeglass frames or contact lenses when prescribed solely for vision correction, and their related fittings for members 19 years of age or older.
3. Refractive eye exams for members 19 years of age and older.
4. Refractive eye surgery.

DD. Exclusions

Medica will not provide coverage for any of the services, treatments, supplies or items described below even if it is recommended or prescribed by a physician or it is the only available treatment for your condition. **Important: The list below describes exclusions <u>in addition to</u> the services, supplies and associated expenses already listed as Not covered elsewhere 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. 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 specifically stated in this Policy.
4. A drug, device or medical treatment or procedure that is investigative.
5. Services or supplies not directly related to care.
6. Autopsies, except as stated in this Policy.
7. 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.
8. Nutritional and electrolyte substances except as specifically described in this Policy.
9. Physical, occupational or speech therapy when there is no reasonable expectation of improvement.
10. Reversal of voluntary sterilization.
11. Personal comfort or convenience items or services.
12. Custodial care, unskilled nursing or unskilled rehabilitation services.
13. Respite or rest care except as otherwise covered in this Policy under *Hospice*.
14. Travel, transportation or living expenses. Certain travel or living expenses may be partially reimbursed when approved by Medica and related to services that have been authorized by Medica as described in *Organ and Bone Marrow Transplants and Other Complex Health Conditions*.
15. Household equipment, fixtures, home modifications and vehicle modifications.
16. Services to treat nicotine addiction except as stated in this Policy under *Prescription Drugs*.
17. Massage therapy, provided in any setting, even when it is part of a comprehensive treatment plan.
18. Routine foot care, except for members with diabetes, blindness, peripheral vascular disease, peripheral neuropathies and significant neurological conditions such as Parkinson's disease, Alzheimer's disease, multiple sclerosis and amyotrophic lateral sclerosis (ALS).
19. Services by persons who are family members or who share your legal residence.
20. Services for which coverage is available under workers' compensation, employer liability or any similar law.
21. Unless requested by Medica, charges for duplicating and obtaining medical records from non-network providers and non-network dentists.
22. Services prohibited by law or regulation.
23. 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).

24. Exams, other evaluations or other services received solely for the purpose of employment, insurance or licensure.
25. Exams, other evaluations or other services received solely for the purpose of judicial or administrative proceedings or research, except (1) emergency examination of a child ordered by judicial authorities or (2) services that are otherwise a covered benefit under the plan and medically necessary.
26. Non-medical self-care or self-help training.
27. Educational classes, programs or seminars, including but not limited to childbirth classes, except as described in this Policy.
28. Nutritional counseling, except as described in this Policy.
29. Coverage for costs associated with translation of medical records and claims to English.
30. Treatment for superficial veins, also referred to as telangiectasia, threat, reticular or spider veins.
31. Services not received from or under the direction of a physician, except as described in this Policy.
32. Elective, induced abortions, except as medically necessary to protect the life of the mother.
33. Therapeutic acupuncture, dry needling or services billed by an acupuncturist.
34. Services for or related to vision therapy and orthoptic and/or pleoptic training, except as described in this Policy.
35. 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.
36. Sensory Integration including Auditory Integration Training.
37. Orthognathic surgery for cosmetic purposes.
38. Surgery for morbid obesity (also known as bariatric surgery).
39. Charges that are eligible, paid or payable under any medical payment, personal injury protection, automobile or other coverage that is payable without regard to fault, including charges that are applied toward any deductible, copayment or coinsurance requirement of such coverage.
40. Services for private duty nursing.
41. 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 Medica before you receive services.
42. 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. Medica does cover emergency services that are received to treat complications of a non-covered service.

43. Services which are not within the scope of licensure or certification of the provider.
44. Non-emergency transportation, except as described in this Policy.
45. Non-emergency services received outside the United States.
46. Services solely for or related to the treatment of snoring.
47. Services provided to treat injuries or illness as a result of committing a felony or attempting to commit a felony.
48. Interpreter services.
49. Charges for interest, mailing and delivery.
50. 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.
51. Any form, mixture or preparation of cannabis for medical or therapeutic use and any device or supplies related to its administration.
52. Non medical services (including but not limited to legal services, social rehabilitation, educational services except as described in this Policy, vocational rehabilitation, job placement services, animals and any service or treatment related to animals).
53. Assisted reproductive technology services, including but not limited to: in vitro fertilization (IVF); gamete intrafallopian transfer (GIFT); zygote intrafallopian transfer (ZIFT); 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.
54. Services for intrauterine insemination (IUI).
55. Collection, retrieval, purchase, freezing and/or storage of sperm or eggs.
56. Services related to adoption.
57. Drugs, supplies, biologics and biosimilars that have not been approved by the U.S. Food and Drug Administration (FDA).
58. Medical devices that have not been approved by the U.S. Food and Drug Administration (FDA), other than those granted a humanitarian device exemption.
59. 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 Medica.
60. 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.

IV. Coordination of This Contract's Benefits With Other Benefits

This provision applies unless prohibited by Nebraska law.

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one plan. Plan is defined below.

The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payment from all plans does not exceed 100% of the total allowable expense.

A. Definitions

A. A plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(1) Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

(2) Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage other than the medical benefits coverage in automobile "no fault" and traditional "fault" type contracts; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

B. This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether this plan is a primary plan or secondary plan when the person has health care coverage under more than one plan. When this plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits do not exceed 100% of the total allowable expense.

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

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

(1) The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.

(2) If a person is covered by 2 or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.

(3) If a person is covered by 2 or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.

(4) If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.

(5) The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. Closed panel plan is a plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

B. Order of benefit determination rules

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

A. The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other plan.

B. (1) Except as provided in Paragraph (2), a plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both plans state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

C. A plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that other plan.

D. Each plan determines its order of benefits using the first of the following rules that apply:

(1) **Non-dependent or Dependent.** The plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the primary plan and the plan that covers the person as a dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, policyholder, subscriber or retiree is the secondary plan and the other plan is the primary plan.

(2) **Dependent Child Covered Under More Than One Plan**. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one plan the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

- The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
- If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree;

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

- The plan covering the custodial parent;
- The plan covering the spouse of the custodial parent;
- The plan covering the non-custodial parent; and then
- The plan covering the spouse of the non-custodial parent.

(c) For a dependent child covered under more than one plan of individuals who are the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(d) For a dependent child who has coverage under either or both parents' plans and also has coverage as a dependent under a spouse's plan, the rule in paragraph (7) (longer/shorter) applies.

(3) **Active Employee or Retired or Laid-off Employee.** The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The plan covering that same person as a retired or laid-off employee is the secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) **COBRA or State Continuation Coverage.** If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) **Workers' Compensation.** Coverage under any workers' compensation act or similar law applies first. You should submit claims for expenses incurred as a result of an on-duty injury to the employer, before submitting them to Medica.

(6) **No-fault Automobile Insurance.** Coverage under the No-Fault Automobile Insurance Act or similar law applies first.

(7) **Longer or Shorter Length of Coverage.** The plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the primary plan and the plan that covered the person the shorter period of time is the secondary plan.

(8) If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

C. Effect on the benefits of this plan

A. When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a plan year are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage. Also, where the primary plan is medical payments from motor vehicle insurance policy, the secondary plan shall credit payments from the motor vehicle insurance policy to deductibles, copayments and coinsurance after discounts under the health plan.

B. If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

D. Right to receive and release needed information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. Medica may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. Medica need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give Medica any facts it needs to apply those rules and determine benefits payable.

E. Facility of payment

A payment made under another plan may include an amount that should have been paid under this plan. If it does, Medica may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. Medica 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 the reasonable cash value of the benefits provided in the form of services.

F. Right of recovery

If the amount of the payments made by Medica is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

G. 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 Medica. 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.

V. Complaints

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

You may call Member Services at the number on the back of your Medica ID card or by writing to the address below in *Internal review*, 1.a. You also may contact the Nebraska Department of Insurance at P.O. Box 82089, Lincoln, NE 68501-2089, tel. 877-564-7323, doi.nebraska.gov.

Complaint: Means any grievance against Medica, 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 Medica's evaluation of the necessity, appropriateness, health care setting 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 Medica 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 Medica to release confidential information to your authorized representative and allow them to act on your behalf during the complaint process.

Upon request, Medica will assist you with completion and submission of your written complaint. Medica 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 Medica to consider and to review any information that Medica relied on in making its decision.

In addition to directing complaints to Member Services as described in this section, you may direct complaints at any time to the Director of Insurance at the telephone number listed at the beginning of this section.

Internal review

You may direct any question or complaint to Member Services by calling the number on the back of your Medica ID card or by writing to the address listed below.

1. Complaints that do not involve a medical necessity review by Medica:

    a. For an oral complaint, if you determine that Medica's decision is partially or wholly adverse to you, Medica will provide you with a complaint form to submit your complaint in writing. Mail the completed form to:

        Member Services

        Route CP595

PO Box 9310

Minneapolis, MN 55440-9310

b. Your written complaint will be considered an internal review. You must submit your written complaint within one year after receiving a denial from Medica. Your internal review will be conducted by a qualified individual associated with Medica who was not involved in making the initial decision. You have the right to submit written material for your internal review, but you do not have the right to attend the review. For a written complaint, Medica will provide written notice of its internal review decision to you within 15 working days from initial receipt of your complaint. If Medica cannot make a decision within 15 working days, you will be notified of the reason, and Medica may take up to an additional 15 working days to issue a written decision.

2. Complaints that involve a medical necessity review by Medica:

   a. Your complaint must be made within 180 days following Medica's initial decision and may be made orally or in writing.

   b. Medica will provide written notice of its internal review decision to you and your attending provider, when applicable, within 15 working days from receipt of your complaint.

   c. When an initial decision by Medica does not grant a prior authorization request made before or during an ongoing service, and your attending provider believes that Medica's decision warrants an expedited review you or your attending provider will have the opportunity to request an expedited review by telephone. Alternatively, if Medica concludes that a delay could seriously jeopardize your life, health or ability to regain maximum function, or could subject you to severe pain that cannot be adequately managed without the care or treatment you are requesting, Medica will process your claim as an expedited review. In such cases, Medica will notify you and your attending provider by telephone of its decision no later than 72 hours after receiving the request.

   d. If Medica's internal review decision upholds the initial decision made by Medica, you have a right to submit a written request for external review as described in this section.

   e. If your complaint involves Medica's decision to reduce or terminate an ongoing course of treatment that Medica previously approved, the treatment will be covered pending the outcome of the review process.

External review

If you consider Medica's decision upon completion of your internal review to be partially or wholly adverse to you, you may submit a written request for external review of Medica's decision if your case involves medical necessity, investigative/experimental procedures or a rescission of a policy determination. There is no cost to you for the external review except for any applicable state filing fees. This process is coordinated by the Nebraska Department of Insurance. You may submit your written request through Nebraska Department of Insurance portal at: **ecmp.nebraska.gov/DOI-ER/**. This online application replaces the need to complete forms and submit them to the Nebraska Department of Insurance by mail or fax. Printable versions of external review forms are also available on the Nebraska Department of Insurance's website at **doi.nebraska.gov/** or they

can be mailed to you upon request by calling the Nebraska Department of Insurance at 1-877-564-7323 (toll-free in Nebraska) or 402-471-0888.

You must submit your written request for external review within four months from the date you receive Medica's decision. 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 from receipt of your request. The external review decision will be binding. Contact the Nebraska Department of Insurance 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 Medica agrees that you may do so, or if Medica fails to substantially comply with the complaint and review process described in this section, including meeting any required deadlines. You may request an expedited external review at the same time you request an expedited internal review if (a) you have a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed; or (b) for investigative/experimental procedures, your physician certifies in writing that treatment would be less effective if not promptly initiated. You may also request an expedited external review after completing the internal review if (a) Medica's decision involves a medical condition for which the standard external review time would seriously jeopardize your life, health or would jeopardize your ability to regain maximum function; (b) for investigative/experimental procedures, your physician certifies in writing that treatment would be less effective if not promptly initiated; or (c) Medica'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.

Civil action

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

VI. Ending Coverage

This section describes when coverage ends under this Policy.

When coverage ends

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

1. The date Medica notifies you that Medica will cease doing business or discontinue a particular product. 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 Medica's existing individual health plans.)
2. The end of the month for which the subscriber last paid the premium due, except as specifically described in item 3 below concerning subscribers receiving an advance premium tax credit.
3. If the subscriber is receiving an advance premium tax credit, the end of the first month for which the subscriber failed to pay the subscriber's share of all premiums due during the grace period. For example, if you fail to pay your share of the premium in March you have until the end of May (a 3 month grace period) to pay your premiums due during the grace period in full. If you do not pay all premiums for March, April and May, your coverage will be terminated as of the end of March.
4. For coverage purchased outside the Marketplace, 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 Medica at least 31 days before the date of termination. However, the effective date of such termination must be the end of the month, except as provided in item 5 below. Any refund of premium shall be mailed to the subscriber upon receipt of this notice by Medica.
5. If the subscriber enrolled through the Marketplace, the date on which the subscriber requests termination if the subscriber has given the Marketplace at least 14 days' notice before a requested termination date. If the subscriber has not provided the Marketplace with at least 14 days' notice of a requested termination, termination will be effective 14 days after notice is received by the Marketplace. Any refund of premium shall be mailed to the subscriber upon receipt of the termination instructions by Medica.
6. 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.
7. 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 Medica was provided written notification of your address change. However, Medica may approve other arrangements.
8. 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 Medica within 90 days after removal from active military duty.
9. When the subscriber is enrolled under this Policy, coverage for dependents will end the date the subscriber's coverage ends.

10. 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.

11. For a spouse, the end of the month following the date of divorce.

12. 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.

13. The date specified by Medica 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 Medica'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 or claims retroactively denied for fraudulent misstatements made in the application for coverage. Fraud includes but is not limited to:

    a. Knowingly providing Medica with false material information such as information related to your eligibility or another person's eligibility 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.

14. If you are enrolled in a Catastrophic Plan, the end of the policy year in which the subscriber covered under the plan is more than 30 years of age, or your hardship exemption issued by the Marketplace expires.

15. For coverage purchased through the Marketplace, on the date established by the Marketplace when the Marketplace makes a determination that you are no longer eligible for coverage under this Policy.

16. For coverage purchased through the Marketplace, on the date your plan is no longer certified or offered through the Marketplace.

17. The date immediately preceding the effective date of new coverage selected by a member during an applicable open or special enrollment period.

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 Medica plan.

VII. 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.

Acute inpatient rehabilitation (AIR). An intensive form of medical rehabilitation in which patients receive three or more hours per day of core therapies (physical therapy, occupational therapy and speech therapy) overseen by a physician specialized in rehabilitation with around the clock nursing care.

Advance premium tax credit (APTC). The advance premium assistance credit available under Internal Revenue Code section 36B, as determined by the Marketplace, for individuals who meet certain income requirements, as determined by the Marketplace.

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 meets the criteria described in subparagraphs 1 – 3 below:

1. The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial; and
2. The subject or purpose of the clinical trial must be the evaluation of an item or service that meets the definition of a Benefit and is not otherwise excluded under this Policy; and
3. The clinical trial must be described in one of the following subparagraphs:
    a. The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration.
    b. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
    c. 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 Medica 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.

The **coinsurance** amount is typically 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, Medica 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 Medica **member.**

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 Medica 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.**

Copayment. The fixed dollar amount you must pay to the **provider** for **benefits** received.

When you receive eligible health services from a **network provider** and a **copayment** applies, you pay the lesser of the charge billed by the **provider** for the **benefit** (i.e., retail) or your **copayment**. Medica pays any remaining amount according to the written agreement between Medica and the **provider**. The **copayment** may not exceed the retail 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 providers are reimbursable as **benefits** under this Policy.

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 spouse
2. A child of the **subscriber,** the **subscriber's domestic partner** or spouse who is a:
    a. Natural or adopted child
    b. Child **placed for adoption** with the **subscriber,** the **subscriber's domestic partner** or spouse
    c. Stepchild
3. An unmarried grandchild who is dependent upon and resides continuously from birth with the **subscriber, subscriber's domestic partner** or the **subscriber's** spouse.
4. A child under legal guardianship of the **subscriber,** the **subscriber's** domestic partner or **subscriber's** spouse. However, Medica 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 Medica 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 or emergency medical condition. A medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including, but not limited to, severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the person afflicted with such condition in serious jeopardy or, in the case of a behavioral condition, placing the health of such persons or others in serious jeopardy, (b) serious impairment to such person's bodily functions, (c) serious impairment of any bodily organ or part of such person, or (d) serious disfigurement of such person.

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 four 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 that help a person who has not learned or acquired a particular skill or function for daily living to learn, improve or keep such skills and functioning for daily living, as long as measurable progress can be documented. These services may include physical and occupational therapy, speech-language pathology and other services in a variety of inpatient and/or outpatient settings.

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.

HSA-compliant high deductible health plan. A plan that complies with the requirements of Internal Revenue Code section 223 that allows an individual to contribute to a health savings account.

Indian. Indians as defined in section 4 of the Indian Health Care Improvement Act.

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 Medica, 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. Medica will make its determination based upon an examination of the following reliable evidence, none of which shall be determinative in and of itself:

1. Whether there is final approval from the appropriate government regulatory agency, if required, including whether the drug or device has received final approval to be marketed for its proposed use by the United States Food and Drug Administration (FDA), or whether the treatment is the subject of ongoing Phase I, II or III trials;
2. Whether there are consensus opinions and recommendations reported in relevant scientific and medical literature, peer-reviewed journals or the reports of clinical trial committees and other technology assessment bodies; and
3. Whether there are consensus opinions of national and local health care **providers** in the applicable specialty or subspecialty that typically manages the condition as determined by a survey or poll of a representative sampling of these **providers**.

Notwithstanding the above, a drug being used for an indication or at a dosage that is an accepted off-label use for the treatment of cancer and HIV/AIDS will not be considered by Medica to be

investigative. Medica 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.

Long-term acute care hospitals (LTACHs). Facilities that specialize in the treatment of patients with serious medical conditions that require care on an ongoing basis but no longer require intensive care or extensive diagnostic procedures. These patients are typically discharged from the intensive care units and require more care than they can receive in a rehabilitation center, skilled nursing facility, or at home.

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).

Nebraska resident. A person who lives in Nebraska, and intends to reside in Nebraska, or has entered Nebraska with a job commitment or is seeking employment in Nebraska.

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 Medica or has made other arrangements with Medica to provide **benefits** to you. The participation status of **providers** will change from time to time.

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

Network access area. Used to define areas where there are Medica 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 Medica will pay to a **non-network provider** for each benefit is based on one of the following, as determined by Medica:

1. A percentage of the amount Medicare would pay for the service in the location where the service is provided. Medica 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

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

3. 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

4. An amount agreed upon between Medica and the **non-network provider; or**

5. An amount required by the No Surprises Act of 2020, when applicable.

Contact Member Services 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 **copayment, deductible or 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 **copayment, coinsurance** or **deductible** amount you may be responsible for according to the terms described in this Policy, except to the extent the No Surprises Act of 2020 applies. 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**.

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.

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 Member Services 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.

Primary care provider. A **provider** who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice, or general medicine or a provider providing services at a **retail health clinic.**

Professionally administered drugs. Professionally administered drugs must be, as determined by Medica, typically administered or directly supervised by a qualified provider or a licensed/certified health professional. Medica 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 health plan. A health plan that meets the requirements of federal law and is certified by the Marketplace as meeting the requirements.

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.

Respiratory care. Services related to active medical or surgical treatment which requires the skill of a registered nurse or respiratory therapist. These services include, but are not limited to: airway maintenance, chest physiotherapy, delivery of medications, oxygen therapy, obtaining laboratory samples and pulmonary function testing.

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.

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, or in the patient's home or wherever the patient is located. 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 of common illnesses, as determined by Medica, 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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American Indians and Alaska Natives

An individual that the Marketplace determines is an American Indian or Alaska Native will have no cost sharing required on benefits received from Indian Health Services, an Indian Tribe, Tribal Organization, or Urban Indian Organization (each as defined in 25 U.S.C. 1603), or through a referral under contract health services, as contract health services are defined and provided pursuant to 42 C.F. R. Subpart C and any other guidance issued pursuant to that section. If you visit one of these providers and have no cost-sharing, this Policy is no longer HSA-compatible.

Your Out-Of-Pocket Expenses

The most specific and appropriate section of this Policy will apply for benefits related to the treatment of a specific condition.

Copayments, coinsurances, deductibles and out-of-pocket maximums 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 copayments, coinsurances, deductibles and out-of-pocket maximums on a yearly basis in order to meet the requirements for this Policy to stay at the same metal level (Platinum, Gold, Silver or Bronze).

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

Important Information:

About Your Deductible

- After you reach your deductible, you pay coinsurance until your out-of-pocket maximum has been met.
- The following do not accumulate toward your deductible:
  - Coinsurance
  - Any charges in excess of the non-network provider reimbursement amount
  - 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
  - Health care this Policy does not cover
- Certain benefits in this Policy have limits. These limits might include visit limits, day limits, or hour limits. These limits are noted in the Benefit Chart section of this Policy and apply whether or not you have met your deductible.

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About Your Out-of-Pocket Maximum

- The following accumulate toward your out-of-pocket maximum:
  - Deductible and coinsurance
- The following do not accumulate toward your out-of-pocket maximum:
  - Any charges in excess of the non-network provider reimbursement amount
  - 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
  - Health care this Policy does not cover
  - Charges you pay in addition to your deductible or coinsurance when you choose to use a preferred brand or non-preferred brand prescription drug when a chemically equivalent generic drug is available

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Please note: Services from non-network providers are not covered, except emergency services and services authorized by Medica. For certain covered services from certain non-network providers, in addition to any applicable 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.		
	Network Providers	
	Tier 1 – Preferred	**Tier 2 – Standard**
Deductible (*The amount you pay for certain eligible services each year before this Policy starts to pay.)* **Note:** On a family plan, members have an individual, as well as a shared family deductible.	**Individual plan:** $6,800	
	Family plan: Per member: $6,800 Shared family**:** $13,600	
Out-of-pocket maximum *(The most you pay in a year for eligible services covered by this Policy.)* N**ote:** On a family plan, members have an individual, as well as a shared family out-of-pocket maximum.	**Individual plan:** $7,050	
	Family plan: Per member: $7,050 Shared family: $14,100	
Lifetime maximum *(The maximum amount this Policy will pay for eligible services during your lifetime.)*	**Individual and family plan:** Per member: Unlimited	

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Please note: Services from non-network providers are not covered, except emergency services and services authorized by Medica. For certain covered services from certain non-network providers, in addition to any applicable 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.		
	Network Providers	
	Tier 1 – Preferred	**Tier 2 – Standard**
A. *Ambulance*		
1. Ambulance services or ambulance transportation to the nearest hospital for an emergency	20% coinsurance	
2. Non-emergency licensed ambulance service that is arranged through an attending physician, as follows:		
a. Transportation from hospital to hospital when:		
i. Care for your condition is not available at the hospital where you were first admitted; or	20% coinsurance	
ii. Required by Medica	20% coinsurance	
b. Transportation from hospital to skilled nursing facility	20% coinsurance	
B. *Anesthesia*		
1. Anesthesia services received from a provider during a covered office visit or an outpatient hospital or ambulatory surgical center visit	20% coinsurance	

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	Network Providers	
	Tier 1 – Preferred	**Tier 2 – Standard**
2. Anesthesia services received from a provider during a covered inpatient stay	20% coinsurance	
C. *Chiropractic or Osteopathic Manipulation*		
1. Chiropractic or osteopathic services to treat (by spinal manipulations or other manipulative therapies) conditions related to the muscles, skeleton and nerves of the body Coverage is limited to 20 visits per calendar year. For other therapies, see *Rehabilitative and Habilitative Therapies.*	20% coinsurance	
D. *Diabetes Management and Supplies*		
1. Diabetes self-management training and education, including medical nutrition therapy, received from a provider in a program consistent with national educational standards (as established by the American Diabetes Association), and patient management home visits when medically necessary	20% coinsurance	

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	Network Providers	
	Tier 1 – Preferred	**Tier 2 – Standard**
2. Diabetic equipment and supplies, including blood glucose meters received from a pharmacy	See *Prescription Drugs*	
3. Insulin pumps and their related supplies received from a durable medical equipment provider	See *Durable Medical Equipment, Prosthetics and Miscellaneous Medical Supplies*	
E. *Diagnostic Imaging*		
1. Outpatient MRI, CT and PET CT scans in an office or hospital	20% coinsurance	
2. Professional services for an outpatient MRI, CT or PET CT scan in an office or hospital	20% coinsurance	
3. Outpatient x-rays and other imaging services in an office or hospital	20% coinsurance	
F. *Durable Medical Equipment, Prosthetics and Miscellaneous Medical Supplies*		
1. Durable medical equipment and certain related supplies	20% coinsurance	

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	Network Providers	
	Tier 1 – Preferred	**Tier 2 – Standard**
2. Repair, replacement or revision of durable medical equipment made necessary by normal wear and use	20% coinsurance	
3. Prosthetics:		
a. Initial purchase of external prosthetic devices that replace a limb or an external body part, limited to:	20% coinsurance	
i. Artificial arms, legs, feet, and hands;		
ii. Artificial eyes, ears and noses;		
iii. Breast prostheses		
b. Repair, replacement or revision of artificial arms, legs, feet, hands, eyes, ears, noses and breast prostheses made necessary by normal wear and use	20% coinsurance	
4. Ear level or bone conduction hearing aids intended to improve the sense of hearing for a member 18 years of age and younger with a hearing impairment, including all parts,	20% coinsurance	

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	Network Providers	
	Tier 1 – Preferred	**Tier 2 – Standard**
replacement parts, parts for repair, tubing and ear molds The ear level or bone conduction hearing aids must be purchased from a licensed audiologist with the medical clearance from an otolaryngologist. Costs related to dispensing these aids include evaluation, fitting, programming, probe microphone measurements, repairs, adjustments, servicing and maintenance, ear molds and ear mold impressions and auditory rehabilitation and training. It also includes replacement of a hearing aid and associated services within three months of the dispensing date if the hearing aid gain and output fail to meet the prescribed targets or the hearing aid is unable to be repaired or adjusted. Coverage for all of the services is limited to a maximum of $3,000 every 48 months. **Please note:** Cochlear implants are covered as a surgical service under *Office Visits* or *Hospital.*		

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	Network Providers	
	Tier 1 – Preferred	**Tier 2 – Standard**
5. Injectable pharmaceutical treatments for hemophilia and bleeding disorders	20% coinsurance	
6. Dietary medical treatment of phenylketonuria (PKU)	20% coinsurance	
7. Amino acid-based elemental oral formulas for the following diagnoses:		
a. cystic fibrosis	20% coinsurance	
b. amino acid, organic acid, and fatty acid metabolic and malabsorption disorders	20% coinsurance	
c. IgE mediated allergies to food proteins Coverage is limited to members five years of age and younger.	20% coinsurance	
d. food protein-induced enterocolitis syndrome Coverage is limited to members five years of age and younger.	20% coinsurance	
e. eosinophilic esophagitis	20% coinsurance	

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	Network Providers	
	Tier 1 – Preferred	**Tier 2 – Standard**
Coverage is limited to members five years of age and younger.		
f. eosinophilic gastroenteritis Coverage is limited to members five years of age and younger.	20% coinsurance	
g. eosinophilic colitis Coverage is limited to members five years of age and younger.	20% coinsurance	
8. Total parenteral nutrition	20% coinsurance	
9. Eligible ostomy supplies	20% coinsurance	
10. Insulin pumps and their related supplies	20% coinsurance	
G. *Emergency Room*		
Please note: Some services received during an emergency room 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 emergency room visit.		
1. Hospital emergency room	20% coinsurance	

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	Network Providers	
	Tier 1 – Preferred	**Tier 2 – Standard**
2. Services received from a physician during a hospital emergency room visit	20% coinsurance	
H. *Genetic Counseling and Testing*		
1. 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.	20% coinsurance	
2. Genetic testing services received in an office or outpatient hospital setting **Please note**: BRCA testing, if appropriate, is covered as a women's preventive health service.	20% coinsurance	
I. *Home Health Care*		
1. Skilled nursing care when you are homebound Coverage is limited to four hours per day and to 60 visits per calendar year for numbers 1., 2., 3., 4. and 6. in this section combined.	20% coinsurance	

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	Network Providers	
	Tier 1 – Preferred	**Tier 2 – Standard**
2. Skilled physical therapy, skilled occupational therapy or speech therapy when you are homebound Coverage is limited to 60 visits per calendar year for numbers 1., 2., 3., 4. and 6. in this section combined.	20% coinsurance	
3. Home health aide services when you are homebound Coverage is limited to 60 visits per calendar year for numbers 1., 2., 3., 4. and 6. in this section combined.	20% coinsurance	
4. Respiratory care when you are homebound Coverage is limited to 60 visits per calendar year for numbers 1., 2., 3., 4. and 6. in this section combined.	20% coinsurance	
5. Home infusion therapy	20% coinsurance	
6. Services received in your home from a physician Coverage is limited to 60 visits per calendar year for numbers 1., 2., 3., 4. and 6. in this section combined.	20% coinsurance	

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	Network Providers	
	Tier 1 – Preferred	**Tier 2 – Standard**
J. *Hospice*		
1. Hospice care	20% coinsurance	
2. Respite care Coverage is limited to five consecutive days at a time.	20% coinsurance	
K. *Hospital*		
1. Outpatient hospital or ambulatory surgical center services		
a. Surgical services (as defined in the Physicians' Current Procedural Terminology code book) received from a physician	20% coinsurance	
b. Other outpatient hospital and ambulatory surgical center services received from a physician	20% coinsurance	
c. Outpatient facility services, including services provided in a hospital observation room	20% coinsurance	
2. Inpatient hospital services		

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	Network Providers	
	Tier 1 – Preferred	**Tier 2 – Standard**
a. Inpatient services, other than maternity care, including room and board in a hospital	20% coinsurance	
b. Inpatient services received from a physician during an inpatient stay	20% coinsurance	
L. *Infertility Services*		
1. Services to diagnose infertility	Covered at the corresponding benefit level, depending on type of services provided. For example, office visits are covered at the office visit benefit level and surgical services are covered at the surgical services benefit level.	
M. *Lab and Pathology*		
1. Lab and pathology services received in an office or outpatient hospital	20% coinsurance	
N. *Maternity*		
Note: Items 1 and 2 describes coverage for prenatal services only. Coverage of labor and delivery services is as described elsewhere in this section.		

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	Network Providers	
	Tier 1 – Preferred	**Tier 2 – Standard**
1. Prenatal care services that are considered preventive health services as defined in this Policy	See *Preventive Health Care*	
2. Prenatal care services that are not considered preventive health services as defined in this Policy		
a. Hospital and ambulatory surgical center services for prenatal care in an inpatient setting	20% coinsurance	
b. Hospital and ambulatory surgical center services for prenatal care in an outpatient setting	20% coinsurance	
c. Professional services for prenatal care in an inpatient or outpatient setting	20% coinsurance	
d. Home health care		
i. Skilled nursing care when you are homebound due to a high risk pregnancy	See *Home Health Care*	
ii. Home infusion therapy	See *Home Health Care*	
3. Labor and delivery services		

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	Network Providers	
	Tier 1 – Preferred	**Tier 2 – Standard**
Please note: Maternity labor and delivery services are considered inpatient services regardless of the length of hospital stay.		
a. Hospital services, including room and board charges	20% coinsurance	
b. Professional services while at a hospital	20% coinsurance	
4. Postnatal care, including a home health care visit following delivery **Please note:** One home health visit is covered if it occurs within four days of discharge. If services are received after four days, please refer to *Home Health Care* for benefits.	20% coinsurance	
O. *Medical-Related Dental*		
1. Oral surgery to treat medical conditions, such as cleft lip or palate, oral neoplasms, non-dental cysts, fracture of the jaws or trauma of the mouth and jaws	See *Office Visits* and *Hospital*	
2. Charges for medical facilities and general anesthesia services that are:	See *Anesthesia* and *Hospital*	

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	Network Providers	
	Tier 1 – Preferred	**Tier 2 – Standard**
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 eight; or		
ii. Is severely disabled; or		
iii. Has a condition and requires hospitalization or general anesthesia for dental care treatment		
3. Accident-related dental services to treat an injury to sound, natural teeth and to repair (not replace) sound, natural teeth. The following conditions apply: Coverage is limited to services received within 12 months of the date of the injury. **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	20% coinsurance	

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	Network Providers	
	Tier 1 – Preferred	**Tier 2 – Standard**
teeth, the tooth must have a life expectancy of one year.		
4. Treatment of temporomandibular joint (TMJ) disorder and craniomandibular disorder	Covered at the corresponding benefit level, depending on type of services provided. For example, office visits are covered at the office visit benefit level and surgical services are covered at the surgical services benefit level.	
P. *Mental Health*		
1. Office visits, including evaluations, diagnostic and treatment services	20% coinsurance	
2. Intensive outpatient programs	20% coinsurance	
3. Inpatient services, including residential treatment services		
a. Room and board	20% coinsurance	
b. Hospital or facility-based professional services	20% coinsurance	
c. Attending psychiatrist services	20% coinsurance	
d. Partial program	20% coinsurance	

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	Network Providers	
	Tier 1 – Preferred	**Tier 2 – Standard**
Q. *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 Member Services at the number on the back of your Medica ID card to determine in advance whether a specific procedure is a benefit and the applicable coverage level for each service that you receive.		
1. Office visit services that are not considered preventive health services as defined in this Policy	20% coinsurance	
2. Urgent care center visits	20% coinsurance	
3. Convenience care		
a. Retail health clinic	20% coinsurance	

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	Network Providers	
	Tier 1 – Preferred	**Tier 2 – Standard**
b. Virtual care	Nothing	
4. Telemedicine	20% coinsurance	
5. Allergy Shots	20% coinsurance	
6. Neuropsychological evaluations/cognitive testing, limited to services necessary for the diagnosis or treatment of a medical illness or injury	20% coinsurance	
7. Surgical Services (as defined in the Physicians' Current Procedural Terminology code book) received from a physician	20% coinsurance	
R. *Organ and Bone Marrow Transplants and Other Complex Health Conditions*		
1. Organ and bone marrow transplant services and other complex health conditions	Covered at the corresponding benefit level, depending on type of services provided. For example, office visits are covered at the office visit benefit level and surgical services are covered at the surgical services benefit level.	

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	Network Providers	
	Tier 1 – Preferred	**Tier 2 – Standard**
S.*Prescription Drugs*		
1. Prescription drugs received at a retail pharmacy, other than those described below or in *Prescription Specialty Drugs*	**Generic (Tier 1):** 20% coinsurance **Preferred brand (Tier 2):** 20% coinsurance **Non-preferred brand (Tier 3):** 20% coinsurance	
2. Orally-administered cancer treatment medications, other than those described in *Prescription Specialty Drugs*	**Generic (Tier 1):** 20% coinsurance **Preferred brand (Tier 2):** 20% coinsurance **Non-preferred brand (Tier 3):** 20% coinsurance	
3. Prescription insulin drugs	$25 per prescription unit The deductible does not apply.	
4. Diabetic equipment and supplies, including blood glucose meters **Please note:** Coverage for insulin pumps and their related supplies is described under *Durable Medical Equipment, Prosthetics and Miscellaneous Medical Supplies.*	**Generic (Tier 1):** 20% coinsurance **Preferred brand (Tier 2):** 20% coinsurance **Non-preferred brand (Tier 3):** 20% coinsurance	
5. All FDA-approved drugs (including women's contraceptives) 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	Nothing The deductible does not apply.	

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	Network Providers	
	Tier 1 – Preferred	**Tier 2 – Standard**
limited. For a current list, go to **Medica.com/SignIn** or call Member Services.		
T. *Prescription Specialty Drugs*		
1. Specialty prescription drugs displayed as Tier 4 with a 'SP' indicator on Medica's Drug List received from a designated specialty pharmacy other than those described below	**Specialty prescription drugs (Tier 4)**: 30% coinsurance	
2. Specialty prescription drugs displayed as Tier 4 without a 'SP' indicator on Medica's Drug List filled at a network retail pharmacy	**Specialty prescription drugs (Tier 4):** 30% coinsurance	
3. Orally-administered cancer treatment medications received from a designated specialty pharmacy	**Specialty prescription drugs (Tier 4):** 20% coinsurance	
U. *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 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.		

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	Network Providers	
	Tier 1 – Preferred	**Tier 2 – Standard**
1. Child health supervision services, including well-baby care	Nothing The deductible does not apply.	
2. Immunizations	Nothing The deductible does not apply.	
3. Early disease detection services, including physicals	Nothing The deductible does not apply.	
4. Routine screening procedures for cancer	Nothing The deductible does not apply.	
5. Women's preventive health services including mammograms, BRCA genetic testing and related genetic counseling (when appropriate), screenings for cervical cancer, human papillomavirus (HPV) testing, counseling for sexually transmitted infections, counseling for immunodeficiency virus (HIV), and sterilization	Nothing The deductible does not apply.	
6. All FDA-approved drugs (including women's contraceptives) and other supplies and services that are considered preventive health services	See *Prescription Drugs*	

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	Network Providers	
	Tier 1 – Preferred	**Tier 2 – Standard**
7. Other preventive health services	Nothing The deductible does not apply.	
V. *Professionally Administered Drugs*		
1. Professionally administered drugs that are required to be administered at a designated facility	**If administered at a designated facility:** Covered at the corresponding 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 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 benefit level. **If not administered at a designated facility:** No coverage	
2. Professionally administered drugs that are not required to be administered at a designated facility	Covered at the corresponding 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	

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	Network Providers	
	Tier 1 – Preferred	**Tier 2 – Standard**
	the professionally administered drug is covered at the office visit 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 benefit level.	
W. *Reconstructive and Restorative Surgery (Including Mastectomy Reconstruction)*		
1. Reconstructive and restorative surgery	Covered at the corresponding benefit level, depending on type of services provided. For example, office visits are covered at the office visit benefit level and surgical services are covered at the surgical services benefit level.	
X. *Rehabilitative and Habilitative Therapies*		
1. Outpatient physical, occupational or speech therapy services, or chiropractic or osteopathic physiotherapy Coverage is limited to 45 rehabilitative and 45 habilitative visits per calendar year.	20% coinsurance	
2. Outpatient cardiac rehabilitation	20% coinsurance	

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	Network Providers	
	Tier 1 – Preferred	**Tier 2 – Standard**
Coverage is limited to 18 visits per event.		
3. Outpatient pulmonary rehabilitation Coverage is limited to 18 visits per calendar year.	20% coinsurance	
Y. *Skilled Nursing Facility*		
1. Daily skilled nursing care or daily skilled rehabilitation services in a skilled nursing facility, acute inpatient rehabilitation facility or long-term acute care hospital, including room and board Benefits are limited to services received during 60 days of inpatient stay per calendar year.	20% coinsurance	
2. Skilled physical therapy, skilled occupational therapy or speech therapy when room and board is not eligible to be covered	20% coinsurance	
3. Services received from a physician during an inpatient stay in a skilled nursing facility, acute inpatient rehabilitation facility or long-term acute care hospital	20% coinsurance	

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	Network Providers	
	Tier 1 – Preferred	**Tier 2 – Standard**
Benefits are limited to services received during 60 days of inpatient stay per calendar year.		
Z.*Substance Use Disorder*		
1. Office visits, including evaluations, diagnostic and treatment services	20% coinsurance	
2. Intensive outpatient programs	20% coinsurance	
3. 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.	20% coinsurance	
4. Inpatient services, including residential treatment services		
a. Room and board	20% coinsurance	
b. Hospital or facility-based professional services	20% coinsurance	
c. Attending physician services	20% coinsurance	
d. Partial program	20% coinsurance	

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	Network Providers	
	Tier 1 – Preferred	**Tier 2 – Standard**
AA. *Treatment of Temporomandibular Joint (TMJ) Disorder*		
1. Treatment of temporomandibular joint (TMJ) disorder and craniomandibular disorder	See *Medical-Related Dental*	
BB. *Urgent Care*		
1. Urgent care center visits	See *Office Visits*	
CC. *Vision*		
1. Refractive eye exams Coverage is limited to one visit per calendar year for members 18 years and younger (coverage continues through the end of the month in which the member turns 19).	20% coinsurance	
2. 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 Coverage is limited to five training visits and two follow-up eye exams per calendar year.	20% coinsurance	

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	Network Providers	
	Tier 1 – Preferred	**Tier 2 – Standard**
3. 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.	20% coinsurance	