Medica Solo[SM]

Gold

Minnesota Policy of Coverage

Medica Solo[SM]
Gold
$1,000 Per Member Deductible
$2,000 Per Family Deductible
Plan Code 2023-IFBSGMA

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 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.

MN-Copay 11-PC-23-01

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.

နမ့်အဲၣ်ဒိးတၢ်ကွိးထံစၢ်ၤကလီနၤ့နၤတၢ်ဂ့ၢ်တၢ်ကွိၤအံၤလၢအကလီန့ၣ်,ကိးလီတဲစိနီၣ်ဂံၢ်လၢအပၣ်ယှာ်လၢလံာ်တီလံာ်မီအပူၤအံၤမ့တမ့ၢ်ဖဲနနီၣ်ငခလေံာ်အှၣ်သးခးက့အလိၢ်ခံတကပၤအဖီခိၣ်န့ၣ်တက့ၢ်.

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

ይህን መረጃ ለመተርጎም ነጻ እርዳታ የሚፈልጉ ከሆነ በዚ ህ ሰነድ ውስጥ ያለውን ቁጥር ወይም Medica መታወቂያ ካርድዎ በስተጀርባ ያለውን ይደውሉ።

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’ígíįjį’ béésh bee hodíilnih.

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

Helpful Resources

Medica Member Services

Call Medica Member Services at **1 (888) 592-8211** (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**.

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 M**edica.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 prescription drugs and how they're covered by your plan
- Look up providers and pharmacies in your network
- Access wellness tools and support
- Pay your premium

Table Of Contents

MEDICA INSURANCE COMPANY (MEDICA)
INDIVIDUAL POLICY
(Policy)

Notice: This disclosure is required by Minnesota law. This Policy is expected to return on average 87.2% of your premium dollar for health care coverage.

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

Important Consumer Information

Guarantee Renewal

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

Policy

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

Senior Vice President, Markets

Senior Vice President and Secretary

Introduction

Medica offers Medica Solo℠. This Policy describes health services that are eligible for coverage and the procedures you must follow to obtain benefits.

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

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

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

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

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.

Some terms used have specific meanings. In this Policy, the words *you*, *your* and *yourself* refer to the member. See *Definitions* for more terms with specific meanings.

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

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

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

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 one of the telephone numbers listed inside the front cover.

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

If you need alternative formats, such as large print or an audio format, please call Member Services at one of the telephone numbers listed inside the front cover to request these materials.

Term of this Policy

All coverage under this Policy begins and ends at 12:01 a.m. Central Time.

Premiums

Your premiums must be prepaid by the subscriber from the date coverage starts.

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

Medica does not accept premium payment directly or indirectly from any third party including, but not limited to, any 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 provider directly or indirectly.

Grace Period

The grace period for the subscriber's payment of premiums will be 31 days from the date a premium is due. If you pay the premium at any time during this grace period, this Policy shall not be terminated. If premium is not paid by the end of the grace period, coverage will end as stated in the *Ending Coverage* section.

If the person obligated to pay premiums under this Policy has not paid the past due premiums by the end of the grace period, and 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.

Changes to this Policy

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

Entire Agreement

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

1. This Policy and any amendments.
2. The Medica Solo Application form.

Acceptance of coverage

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

The subscriber understands and agrees that any omissions or incorrect statements knowingly made by you in connection with your enrollment under this Policy may invalidate your coverage.

Nondiscrimination policy

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 one of the telephone numbers listed inside the front cover.

A. *Member Rights And Responsibilities*

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

Member bill of rights

As a member of Medica Solo, you have the right to:

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

Member responsibilities

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

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

a. How to recognize common health problems and what to do when they occur; and

b. When and where to seek appropriate help; and

c. How to prevent health problems from recurring; and

5. Practicing preventive health care by:

a. Having the appropriate tests, exams and immunizations recommended for your gender and age as described in this Policy; and

b. Engaging in healthy lifestyle choices (such as exercise, proper diet and rest).

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

B. How To Access Your Benefits

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

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

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

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

Benefits

Medica will cover health services and supplies as in-network benefits only if they are provided by network providers or received from a non-network provider when Medica authorizes that care because in-network care is not available within your service area or network access area. If there is no network provider and no non-network provider available within your service area 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 be required from Medica for certain in-network benefits. This Policy fully defines your benefits and describes procedures you must follow to obtain in-network benefits.

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

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

Referrals

Certain health services are covered only upon referral; read this Policy carefully for referral requirements. All referrals to non-network providers and certain types of network providers

must be prior authorized by Medica to be eligible for coverage at your highest level of benefits.

Emergency services

Emergency services from non-network providers will be covered as in-network benefits. This Policy explains the covered health services associated with emergency care.

Providers

Enrolling in Medica Solo 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 in-network benefits. You must verify that your provider is a network provider each time you receive health services.

Exclusions

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

Post-mastectomy coverage

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 if the mastectomy was medically necessary (as determined by the attending physician and patient). Medica will also cover prostheses and physical complications, including lymphedemas, at all stages of mastectomy.

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

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

Benefits

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

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

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

Under certain circumstances Medica will authorize your obtaining services from a non-network provider within the United States at the in-network benefit level. Such authorizations are generally provided only in situations where the requested services are not available from network providers. Medica will authorize services received from non-network providers only if in-network care is not available in your service area 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 area 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.

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

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

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

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

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

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

Surprise billing protections

Generally, as described above, you will pay much more for your health care if you receive services from a non-network provider than when you receive services from a network provider.

In the following situations benefits for care accessed from non-network providers in the United States will be eligible for coverage as in-network benefits. The non-network provider is prohibited by law from billing you for any amounts above the in-network cost-sharing amount for such services:

1. Benefits for out-of-network emergency services at emergency facilities, except for certain post-stabilization services that you have consented to;
2. Benefits for non-emergency services performed by most non-network health care professionals at network health care facilities, unless you have consented to those out-of-network services; or
3. Benefits for air ambulance services from non-network air ambulance providers.

If you think you've been balance billed inappropriately, or you didn't consent to these out-of-network services, please see **cms.gov/NoSurprises/Consumers** for more information about your rights under these protections.

For purposes of this *Surprise billing protections* section, the following definitions apply:

Emergency facility. The emergency department of a hospital or an independent freestanding emergency department.

Network health care facility. A hospital, hospital outpatient department, critical access hospital, or an ambulatory surgical center.

Medica and a non-network provider who has provided benefits that are subject to the *Surprise billing protections* listed above may later reach agreement on a different non-network provider reimbursement amount through negotiation or independent dispute resolution. Any change in the non-network provider reimbursement amount as a result of a later agreement, that results in additional amounts paid or returned under these agreements, are not considered when determining the amounts you must pay for health services under this Policy.

Please see the public notice at the end of this Policy of your additional rights and protections against surprise medical bills ("Your Rights and Protections Against Surprise Medical Bills").

Additionally, you are not responsible, pursuant to Minnesota Statute 62Q.556, for any amounts above what you would be required to pay for in-network benefits, unless you provide advance written consent, if your network provider sent your lab work to a non-network laboratory for testing.

If you have questions about bills you receive from a non-network provider that provided services under the circumstances described under Minnesota Statute 62Q.556, please call Member Services at one of the telephone numbers listed at the front of this Policy. 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

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

Exclusions

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

Claims

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

Post-mastectomy coverage

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.

3. *Cancellation*

Your coverage may be canceled only under certain conditions. This Policy describes all reasons for cancellation of coverage. See *Ending Coverage* for additional information.

4. *Coverage for a newborn or newly adopted child*

Medica does not automatically know of a birth or whether the covered subscriber would like coverage for the newborn or newly adopted dependent. Call Member Services at one of the telephone numbers listed inside the front cover for more information.

The covered subscriber's dependent newborn infant or newly adopted child is covered under this Policy from the moment of birth, adoption or placement for adoption if the following two conditions are met.

1. You notify Medica in writing of the birth of the newborn infant or adoption or placement for adoption and request that the newborn infant or newly adopted dependent be added to this Policy.
2. You provide additional premium for the newborn infant's birth, adoption, or placement for adoption. Medica requires additional premium to add the newborn infant or newly adopted dependent to your current Policy. Medica is entitled to all premiums due from the

time of the newborn infant's birth, adoption or placement for adoption until the time the covered subscriber notifies Medica of the birth or adoption.

Medica will withhold payment of any benefits for the newborn infant or newly adopted dependent until the applicable premium has been paid. For that reason, it's very important that you request to Medica that the newborn infant or newly adopted dependent be added to your Policy.

Medica may reduce payment by the amount of premium that is past due for any health benefits for the child until any premium you owe is paid. For more information, see *Eligibility And Enrollment.*

5. *Prescription drugs and medical equipment*

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

6. *Continuity of care*

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

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 in-network benefits. If your request is denied, Medica will explain the criteria used to make its decision. You may appeal this decision, as described in *Complaints*.

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

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

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

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

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

1. An ongoing course of treatment for a life-threatening physical or mental condition;
2. An ongoing course of treatment for a serious acute condition, such as chemotherapy;
3. 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;
5. An ongoing course of treatment for a health condition for which a treating physician or provider attests that discontinuing care by that physician or provider would worsen the condition or interfere with anticipated outcomes;
6. Undergoing a course of institutional or inpatient care from the provider or facility, when continuity of care is required under the Federal Consolidated Appropriations Act of 2020 and its implementing regulations;
7. A physical or mental disability defined as an inability to engage in one or more major life activities, provided that the disability has lasted or can be expected to last for at least one year, or can be expected to result in death; or
8. A disabling or chronic condition that is in an acute phase.

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

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

If your provider agrees to comply with 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 in-network deductible and coinsurance or copayment described in this Policy. If your provider does not agree to these terms, in addition to the deductible and coinsurance described in this Policy for in-network benefits, you will be responsible for any charges in excess of the non-network provider reimbursement amount, except as described in *Your Rights and Protections Against Surprise Medical Bills* at the end of this Policy.

If Medica's contract with your hospital ends

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

Continuity of care at a hospital applies only if your provider agrees to comply with 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. This does not apply when Medica terminates a provider's contract for cause.

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

1. An ongoing course of treatment for a life-threatening physical or mental condition;
2. An ongoing course of treatment for a serious acute condition, such as chemotherapy;
3. 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;

5. An ongoing course of treatment for a health condition for which a treating physician or provider attests that discontinuing care by that physician or provider would worsen the condition or interfere with anticipated outcomes;
6. Undergoing a course of institutional or inpatient care from the provider or facility, when continuity of care is required under the Federal Consolidated Appropriations Act of 2020 and its implementing regulations;
7. A physical or mental disability defined as an inability to engage in one or more major life activities, provided that the disability has lasted or can be expected to last for at least one year, or can be expected to result in death; or
8. A disabling or chronic condition that is in an acute phase.

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

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

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

1. If you are receiving culturally appropriate services and Medica does not have a network provider who has special expertise in the delivery of those culturally appropriate services within Medica's time and distance requirements; or
2. If you do not speak English and Medica does not have a network provider who can communicate with you, either directly or through an interpreter, within Medica's time and distance requirements.

Continuity of care for (1) or (2) applies only 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.

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 in-network benefits. If your request is denied, Medica will explain the criteria used to make its decision. You may appeal this decision, as described in *Complaints*.

7. *Prior authorization*

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

Prior authorization from Medica may be required before you receive certain services or supplies in order to determine whether a particular service or supply is medically necessary and a benefit. This applies even when the services are provided by a network provider or provided as the result of referral or direction by a network provider. 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 one of the telephone numbers listed inside the front cover.

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:

- Reconstructive or restorative surgery procedures;
- Treatment of a diagnosed temporomandibular joint (TMJ) disorder or craniomandibular disorder;
- Solid organ and bone marrow transplant services – this prior authorization must be obtained before the transplant workup is initiated;
- Treatment at a designated facility for complex health conditions;
- Home health care services;
- Durable medical equipment;
- Outpatient surgical procedures;
- Certain genetic tests;
- Certain prescription drugs, biologics and biosimilars;
- Inpatient care, including mental health and substance use disorders, skilled nursing facility services, long-term acute care hospital (LTACH) and acute inpatient rehabilitation (AIR);
- Certain outpatient mental health and substance use disorder services;
- Certain imaging services;
- Certain professionally administered prescription drugs;
- Non-emergency licensed air ambulance transportation; and
- In-network benefits for services from non-network providers, with the exception of emergency services.

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

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

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

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

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

Medica will review your request for prior authorization and provide a response to you and your attending provider within 5 business days of the date your request was received electronically (and within six business days if received through nonelectronic means), provided all information reasonably necessary to make a decision has been given to Medica.

Medica will respond within a time period not exceeding 48 hours (including at least one business day) from the time of the initial request if 1) your attending provider believes that an expedited review is warranted, or 2) 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 your request for prior authorization, you have the right to appeal Medica's decision as described in *Complaints*. If you are a new Medica member and have a prior authorization for services from your former health plan, Medica will accept that prior authorization for at least the first 60 days of coverage under this plan. In order to obtain coverage for this 60-day period, you or your provider must send Medica documentation of the previous prior authorization. For coverage to continue after the 60-day period, you, someone on your behalf or your attending provider should submit a request for prior authorization to Medica prior to the end of this 60-day period.

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*).

C. How Providers Are Paid By Medica

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

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

Network providers

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

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

The methods by which specific network providers are paid may change from time to time. Methods also vary by network provider. The primary method of payment is fee-for-service. Fee-for-service payment means that 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 service from a non-network provider is covered, the non-network provider is paid a fee for each covered service that is provided based on the non-network provider reimbursement amount.

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

Payment of claims

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

D. Your Out-Of-Pocket Expenses

This section describes the expenses that are your responsibility to pay. These expenses are commonly called out-of-pocket expenses.

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

You are responsible for paying the cost of a service that is not medically necessary or a benefit even if the following occurs:

1. A provider performs, prescribes or recommends the service; or
2. The service is the only treatment available; or
3. You request and receive the service even though your provider does not recommend it.

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

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

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

Copayments, coinsurance and deductibles

For in-network benefits, you must pay the following:

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

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

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

   Please note that amounts reimbursed or paid by a provider or manufacturer, including manufacturer coupons, rebates, coupon cards, debit cards or other forms of reimbursement or payment on your behalf for a product or service, will not apply toward your deductible.
2. Any charge that is not covered under this Policy.

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

1. Any applicable coinsurance and deductible as described in this Policy. *You must pay an annual deductible. (See the Out-of-Pocket Expenses table in this section.)*
2. Any charge that exceeds the non-network provider reimbursement amount. ***This means you are required to pay the difference between what Medica pays to the provider and what the provider bills. As a result, you may have substantial out-of-pocket expense when you use a non-network provider.***

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

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

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

   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.

In-network out-of-pocket maximum

The out-of-pocket maximum is described in the Out-of-Pocket Expenses table in this section.

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.

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.

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

Out-of-Pocket Expenses

	In-network benefits	*Out-of-network benefits
***For covered services from non-network providers, in addition to any applicable copayment, deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible and out-of-pocket maximum.**		
Copayment or coinsurance	**Copayments 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 copayments and coinsurance on a yearly basis in order to meet the requirements for the Policy to stay at the same metal level (Platinum, Gold, Silver or Bronze).** **You will receive a notice of change 30 days in advance.** See specific benefit for applicable copayment or coinsurance.	
Deductible	**Deductible may be subject to a "cost of living" increase on a yearly basis. This "cost of living" increase is tied to the Consumer Price Index (CPI) and may be up to, but no greater than, the CPI.** **There may also be adjustments made to the deductible on a yearly basis in order to meet the requirements for the Policy to stay at the same metal level (Platinum, Gold, Silver or Bronze).** **You will receive a notice of change 30 days in advance.**	
Per member	$1,000	$5,200
Per family	$2,000	$10,400

	In-network benefits	*Out-of-network benefits
***For covered services from non-network providers, in addition to any applicable copayment, deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible and out-of-pocket maximum.**		
Out-of-pocket maximum	**Out-of-pocket maximum may be subject to a "cost of living" increase on a yearly basis. This "cost of living" increase is tied to the Consumer Price Index (CPI) and may be up to, but no greater than, the CPI.** **There may also be adjustments made to the out-of-pocket maximum on a yearly basis in order to meet the requirements for the Policy to stay at the same metal level (Platinum, Gold, Silver or Bronze).** **You will receive a notice of change 30 days in advance.**	
Per member	$8,500	Out-of-pocket maximum does not apply.
Per family	$17,000	Out-of-pocket maximum does not apply.
Lifetime maximum amount payable per member	Unlimited	Unlimited

E. Professional Services

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

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

Prior authorization. ***Prior authorization from Medica may be required*** **before** ***you receive services or supplies.*** Prior authorization from Medica is also required before you receive certain biologics, biosimilars and professionally administered prescription drugs. Certain biologics, biosimilars and professionally administered prescription drugs may be subject to step therapy. In certain cases, it is possible to get an exception to step therapy requirements, please see *Exceptions to Step Therapy* in *Prescription Drugs* or *Prescription Specialty Drugs*. For a list of the specific services and supplies that require Medica's prior authorization, please call Member Services at one of the telephone numbers listed inside the front cover. See *How To Access Your Benefits* for more information about the prior authorization process.

Covered

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

- *In-network benefits* apply to:
  1. Professional services received from a network provider;
  2. Professional services for testing and treatment of a sexually transmitted disease and testing for AIDS and other HIV-related conditions received from a network provider or a non-network provider;
  3. Family planning services, for the voluntary planning of the conception and bearing of children, received from a network provider or a non-network provider. For the purpose of this benefit, family planning services does not include infertility treatment;
  4. When the circumstances described in *Surprise billing protections* apply for certain out-of-network professional services.
- *Out-of-network benefits* apply to professional services received from a non-network provider. **There is not an out-of-pocket maximum that applies to these charges.** In addition to the deductible and coinsurance, you will be responsible for any charges in excess of the non-network provider reimbursement amount, except as described in Your Rights and Protections Against Surprise Medical Bills at the end of this Policy. Please see *Important member information about out-of-network benefits* in *How To Access Your Benefits* for more information.

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

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

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

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

Not covered

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

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

Your Benefits and the Amounts You Pay

Benefits	**In-network benefits after deductible**	***Out-of-network benefits after deductible**
*** For certain covered services from certain non-network providers, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.**		
1. Office visits **Please not**e: 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 one of the telephone numbers listed inside the front cover to determine in advance whether a specific procedure is a benefit and the applicable coverage level for each service that you receive.	Primary care provider: $40 copayment The deductible does not apply. Specialty care provider: $70 copayment The deductible does not apply.	40% coinsurance

Your Benefits and the Amounts You Pay		
Benefits	**In-network benefits after deductible**	***Out-of-network benefits after deductible**
*** For certain covered services from certain non-network providers, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.**		
2. Convenience care		
a. Retail health clinic	$20 copayment. The deductible does not apply.	For emergency services from non-network providers, refer to *Emergency Services From Non-Network Providers*. 40% coinsurance for non-emergency services received from non-network providers.
b. Virtual care	$20 copayment. The deductible does not apply.	No coverage
3. Telehealth	Primary care provider: $40 copayment The deductible does not apply. Specialty care provider: $70 copayment The deductible does not apply.	40% coinsurance
4. Urgent care center visits	30% coinsurance	For emergency services from non-network providers, refer to *Emergency Services From Non-Network Providers*. 40% coinsurance for non-emergency services received from non-network providers

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	*Out-of-network benefits after deductible

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

5. Maternity care		
a. Prenatal care services that are considered preventive health services as defined in this Policy	Nothing The deductible does not apply.	Nothing The deductible does not apply.
b. Prenatal care services that are not considered preventive health services as defined in this Policy, received from a physician during an office visit, an outpatient hospital visit or an inpatient stay	30% coinsurance	40% coinsurance
c. Services received for labor and delivery	30% coinsurance	40% coinsurance
d. Postpartum office visits in the first 12 weeks following delivery:	30% coinsurance	40% coinsurance
i. A comprehensive postnatal visit with a provider not more than three weeks from the date of delivery;		
ii. Any postnatal visits recommended by a provider between three and 11 weeks from the date of delivery; and		
iii. A comprehensive postnatal visit with a provider 12 weeks from the date of delivery		

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	*Out-of-network benefits after deductible

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

e. Home health care visit following delivery **Please note:** One home health visit is covered if it occurs within four days of discharge. Services eligible for coverage include but are not limited to, parent education, assistance and training in breast and bottle feeding and conducting any necessary and appropriate clinical tests. If services are received after four days, please refer to *Home Health Care* for benefits.	30% coinsurance	40% coinsurance
6. Preventive health care **Please note:** If you receive preventive health services 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 elsewhere in this Policy. The most specific and appropriate benefit in this Policy will apply for each service received during a visit.		
a. Child health supervision services, including well-baby care, pediatric preventive services, appropriate immunizations up to age 18, developmental assessments, and appropriate laboratory services	Nothing The deductible does not apply.	40% coinsurance Except 1) you pay nothing for immunizations up to age 18 and the deductible does not apply and 2) you pay nothing for the remaining child health supervision services for members up to age 6 and the deductible does not apply.

Your Benefits and the Amounts You Pay		
Benefits	**In-network benefits after deductible**	***Out-of-network benefits after deductible**
*** For certain covered services from certain non-network providers, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.**		
b. Adult immunizations	Nothing The deductible does not apply.	40% coinsurance
c. Early disease detection services including physicals	Nothing The deductible does not apply.	40% coinsurance
d. Routine screening procedures for cancer including, but not limited to, screening for prostate cancer (including prostate-specific antigen for blood test and a digital rectal exam and without age limitation), ovarian cancer and colorectal cancer	Nothing The deductible does not apply.	40% coinsurance

Your Benefits and the Amounts You Pay		
Benefits	**In-network benefits after deductible**	***Out-of-network benefits after deductible**
*** For certain covered services from certain non-network providers, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.**		
e. Women's preventive health services including mammograms (including digital breast tomosynthesis), BRCA genetic testing and related genetic counseling (when appropriate), screenings for cervical cancer (including pap smears), human papillomavirus (HPV) testing, counseling for sexually transmitted infections, counseling for immunodeficiency virus (HIV) and sterilization **Please note:** Preventive mammogram screenings include, but are not limited to, coverage for women at risk for breast cancer. "At risk for breast cancer" means 1) having a family history with one or more first- or second-degree relatives with breast cancer; 2) testing positive for BRCA1 or BRCA2 mutations; 3) having heterogeneously dense breasts or extremely dense breasts based on the Breast Imaging Reporting and Data System established by the American College of Radiology; or 4) having a previous diagnosis of breast cancer.	Nothing The deductible does not apply.	40% coinsurance
f. Other preventive health services, including tobacco cessation counseling	Nothing The deductible does not apply.	40% coinsurance
7. Allergy shots	30% coinsurance	40% coinsurance

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	*Out-of-network benefits after deductible
*** For certain covered services from certain non-network providers, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.**		
8. Refractive eye exams For members 19 years of age and older coverage is limited to one visit per calendar year for in-network and out-of-network benefits combined. **Please note:** This visit limit includes any visits that you pay for in order to satisfy any part of your deductible.	$40 copayment The deductible does not apply. Except you pay nothing for these services for members under age 19 and the deductible does not apply.	40% coinsurance
9. Chiropractic services to diagnose and to treat (by manual manipulation or certain therapies) conditions related to the muscles, skeleton and nerves of the body	$40 copayment The deductible does not apply.	40% coinsurance
10. 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.	Primary care provider: $40 copayment The deductible does not apply. Specialty care provider: $70 copayment The deductible does not apply.	40% coinsurance
11. Professional sign language interpreter services in a physician's office (Call Member Services to arrange such services.)	$40 copayment The deductible does not apply.	40% coinsurance

Your Benefits and the Amounts You Pay		
Benefits	**In-network benefits after deductible**	***Out-of-network benefits after deductible**
*** For certain covered services from certain non-network providers, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.**		
12. Surgical services (as defined in the Physicians' Current Procedural Terminology code book) received from a physician during an office visit or an outpatient hospital or ambulatory surgical center visit	30% coinsurance	40% coinsurance
13. Anesthesia services received from a provider during an office visit or an outpatient hospital or ambulatory surgical center visit	30% coinsurance	40% coinsurance
14. Services received from a physician during an emergency room visit	30% coinsurance	For emergency services from non-network providers, see *Emergency Services From Non-Network Providers*. 40% coinsurance for non-emergency services provided in a non-network hospital emergency room.
15. Services received from a physician during an inpatient stay	30% coinsurance	40% coinsurance
16. Anesthesia services received from a provider during an inpatient stay	30% coinsurance	40% coinsurance
17. Outpatient lab and pathology **Please note:** CA-125 serum tumor marker testing when conducted as a surveillance test for ovarian cancer for at-risk women is covered at the corresponding benefit level, dependent on the type of services provided.	30% coinsurance	40% coinsurance

Your Benefits and the Amounts You Pay		
Benefits	**In-network benefits after deductible**	***Out-of-network benefits after deductible**
*** For certain covered services from certain non-network providers, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.**		
18. Genetic testing when test results will directly affect treatment decisions or frequency of screening for a disease, or when results of the test will affect reproductive choices. **Please note**: BRCA testing, if appropriate, is covered as a woman's preventive health service.	30% coinsurance	40% coinsurance
19. Outpatient x-rays and other imaging services	30% coinsurance	40% coinsurance
20. Other outpatient hospital or ambulatory surgical center services received from a physician	30% coinsurance	40% coinsurance
21. Elimination of port wine stain or treatment to lighten or remove the coloration of a port wine stain	30% coinsurance	40% coinsurance
22. Diabetes self-management training and education (for Type I, Type II and gestational), including medical nutrition therapy, received from a provider in a program consistent with national educational standards (as established by the American Diabetes Association)	30% coinsurance	40% coinsurance
23. Neuropsychological evaluations/cognitive testing, limited to services necessary for the diagnosis or treatment of a medical illness or injury	30% coinsurance	40% coinsurance

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	*Out-of-network benefits after deductible
*** For certain covered services from certain non-network providers, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.**		
24. Vision therapy and orthoptic and/or pleoptic training, to establish a home program, for the treatment of strabismus and other disorders of binocular eye movements **Please note:** The visit and exam limits include visits that you pay for in order to satisfy any part of your deductible.	30% coinsurance Coverage is limited to a combined in-network and out-of-network total of five training visits and two follow-up eye exams per calendar year.	40% coinsurance Coverage is limited to a combined in-network and out-of-network total of five training visits and two follow-up eye exams per calendar year.
25. Eyewear, including eyeglass lenses, frames or contact lenses received from an optical provider		
a. Members 18 years of age and younger (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. Lenses include single vision, bifocal, trifocal or lenticular with choice of glass or plastic lenses. Contact lenses are limited to coverage once every calendar year. Low vision aids which are hand-held lenses, spectacle mounted lenses or telescopic lens systems are limited to one device every calendar year. Please note: This limit includes eyewear that you pay for in order to satisfy any part of your deductible.	30% coinsurance	40% coinsurance

Your Benefits and the Amounts You Pay		
Benefits	**In-network benefits after deductible**	***Out-of-network benefits after deductible**
*** For certain covered services from certain non-network providers, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.**		
b. Members over age 18	Medica pays up to $125 every twenty-four months per member for in-network and out-of-network benefits combined. You are responsible for any costs in excess of $125. The deductible does not apply.	Medica pays up to $125 every twenty-four months per member for in-network and out-of-network benefits combined. You are responsible for any costs in excess of $125. The deductible does not apply.

Your Benefits and the Amounts You Pay		
Benefits	**In-network benefits after deductible**	***Out-of-network benefits after deductible**
*** For certain covered services from certain non-network providers, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.**		
26. 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 • bullous keratopathy	30% coinsurance	40% coinsurance

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	*Out-of-network benefits after deductible
*** For certain covered services from certain non-network providers, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.**		
27. Routine patient costs in connection with a qualified individual's participation in an approved clinical trial	Covered at the corresponding in-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit in-network benefit level and surgical services are covered at the surgical services in-network benefit level.	Covered at the corresponding out-of-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit out-of-network benefit level and surgical services are covered at the surgical services out-of-network benefit level.
28. Medically necessary treatment recommended by your provider for diagnosed pediatric acute-onset neuropsychiatric syndrome (PANS) and pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and include but are not limited to antibiotics, prescription drugs and behavioral therapies to manage neuropsychiatric symptoms, plasma exchange, and immunoglobulin	Covered at the corresponding in-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit in-network benefit level and surgical services are covered at the surgical services in-network benefit level.	Covered at the corresponding out-of-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit out-of-network benefit level and surgical services are covered at the surgical services out-of-network benefit level.
29. Surveillance tests for ovarian cancer for at-risk women		
a. Routine screening procedures for ovarian cancer	See *Preventive Health Care*	See *Preventive Health Care*

Your Benefits and the Amounts You Pay		
Benefits	**In-network benefits after deductible**	***Out-of-network benefits after deductible**
*** For certain covered services from certain non-network providers, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.**		
b. Diagnostic surveillance tests for ovarian cancer	Covered at the corresponding in-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit benefit level and diagnostic imaging is covered at the diagnostic imaging benefit level.	Covered at the corresponding out-of-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit out-of-network benefit level and diagnostic imaging is covered at the diagnostic imaging benefit level.

F. Prescription Drugs

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

Prescription drugs and supplies are covered if they are:

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

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

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

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

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

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

Medica's Prescription Drug List

Medica's prescription drug list (Drug List) is comprised of prescription drugs that meet the medical needs of our members and have proven safety and effectiveness. It includes both brand-name and generic prescription drugs. The prescription drugs on this list have been approved by the Food and Drug Administration (FDA). The Drug List identifies whether a prescription drug is classified by Medica as a preferred generic, generic, preferred brand or non-preferred brand prescription drug. A team of physicians and pharmacists meets regularly to review and update the Drug List. Your provider can use this list to select prescription drugs for your health care needs, while helping you maximize your prescription drug benefit. You will be notified in advance if there are any changes to the Drug List that affect prescription drugs 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 prescription drug: (1) that contains the same active ingredient as a brand name prescription drug and is chemically equivalent to a brand name prescription drug in strength, concentration, dosage form and route of administration; or (2) that Medica identifies as a preferred generic or generic product. Medica uses industry standard resources to determine a prescription 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.

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

Brand: A prescription drug: (1) that is manufactured and marketed under a trademark or name by a specific prescription drug manufacturer; or (2) that Medica identifies as a brand name product. Medica uses industry standard resources to determine a prescription 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 prescription drugs on the Drug List have a higher copayment or coinsurance. You may consider a preferred brand covered prescription drug to treat your condition if you and your provider decide it is appropriate. Covered preferred brand prescription drugs may be identified in the Drug List as Tier 3.

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

If you have questions about the Drug List or whether a specific prescription drug is covered (and/or whether the prescription drug is preferred generic, generic, preferred brand or non-preferred brand), or if you would like to request a copy of the Drug List at no charge, call Member Services at one of the telephone numbers listed inside the front cover. It is also available on **Medica.com/SignIn**.

Investigative

As determined by Medica, a prescription 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 prescription drug or device has received final approval to be marketed for its proposed use by the 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 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 prescription drug being used for an indication or at a dosage that is an accepted off-label use for the treatment of cancer will not be considered by 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 prescription drugs and biologicals used off-label.

Exceptions to the Drug List

In certain cases, it is possible to get an exception to the coverage rules described under *Medica's Prescription 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. 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 prescription drug not included on the 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 one of the telephone numbers listed inside the front cover 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 the Drug List exception process or for more information regarding the expedited review process, call Member Services at one of the telephone numbers listed inside the front cover.

Antipsychotic prescription drugs

Medica provides coverage for antipsychotic prescription drugs prescribed to treat emotional disturbance or mental illness that are not found on the Medica Drug List when the following criteria are met. Coverage will be issued on an annual basis if the prescribing provider:

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

For more information about getting an exception to coverage rules for antipsychotic prescription drugs that are not found on the Medica Drug List, see *Exceptions to the Drug List*.

You may continue to receive certain prescription drugs for diagnosed mental illness or emotional disturbance when Medica's Drug List changes or you change health plans for up to one year following the change, if you meet criteria for continuation.

Prescription unit

A prescription unit is the amount that will be dispensed unless it is limited by the prescription drug manufacturer's packaging, dosing instructions or Medica's prescription drug 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 prescription 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 prescription drugs there are special requirements that must be met in order to receive coverage. These include:

Prior authorization (PA)

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

Step therapy (ST)

Step therapy is a process that involves trying an alternative covered prescription drug first (typically a generic prescription drug) before moving to a preferred brand or non-preferred brand covered prescription drug for treatment of the same medical condition. The prescription drugs 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 prescription drugs.

Exceptions to Step Therapy

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

appeal upholds the initial denial of your request for an exception to step therapy requirements, you have a right to request an external review as described in *Complaints.*

Quantity limits (QL)

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

Pharmacy requirement

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

Generic requirement

Certain covered preferred brand and non-preferred brand prescription drugs include a chemically equivalent generic prescription drug on the 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 prescription drug. You will pay, in addition to the applicable deductible, or 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 prescription drug be dispensed as written and there is a chemically equivalent generic prescription drug on the Drug List, the prescription drug will be covered at the non-preferred brand benefit level.

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

Covered

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

Benefits

1. Covered prescription drugs received at a network pharmacy; and

2. Prescription drugs for family planning services or the treatment of sexually transmitted diseases when prescribed by or received from either a network or a non-network provider; and

3. Diabetic equipment and supplies, including blood glucose meters when received from a network pharmacy; and

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

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

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

Not covered

The following are not covered:

1. Any amount above what 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.)
2. Prescription drugs prescribed for investigative uses.
3. Over the counter (OTC) drugs that by federal or state law do not require a prescription drug order or refill and any prescription drug that is therapeutically equivalent to an OTC drug, except those that are considered preventive health services.
4. Replacement of a prescription drug due to loss, damage or theft.
5. Appetite suppressants.
6. Weight loss prescription drugs.
7. Sexual dysfunction prescription drugs.
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. Prescription drugs prescribed by a provider who is not acting within his/her scope of licensure.
11. Homeopathic medicine.
12. Infertility prescription drugs.
13. Specialty prescription drugs, except as described in *Prescription Specialty Drugs*.
14. Prescription drugs, including diabetic equipment and supplies and preventive prescription drugs and other supplies, received at a non-network pharmacy.

15. Prescription drugs and supplies not listed on the Drug List, unless covered through the exception process described in *Exceptions to the Drug List*. Such exclusions are in addition to prescription drugs or classes of prescription drugs excluded under other provisions of this Policy.
16. Bulk powders, chemicals and products used in prescription drug compounding.
17. Products that are duplicative to, or are in the same class and category as, products on the Drug List, unless covered through the exception process described under "Exceptions to the Drug List" in this section.
18. New to market prescription drugs: Products recently approved by the FDA and introduced into the market will not be covered until they are reviewed and considered for placement on the Drug List.

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

Your Benefits and the Amounts You Pay

In-network benefits after deductible	*Out-of-network benefits after deductible

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

1. Prescription drugs received at a retail pharmacy, other than those described below or in *Prescription Specialty Drugs*

Preferred generic (Tier 1): $10 copayment per prescription unit The deductible does not apply.	No coverage
Generic (Tier 2): $10 copayment per prescription unit The deductible does not apply.	No coverage
Preferred brand (Tier 3): 30% coinsurance	No coverage
Non-preferred brand (Tier 4): 50% coinsurance	No coverage

2. Orally-administered cancer treatment prescription drugs, other than those described below or in *Prescription Specialty Drugs*

Preferred generic (Tier 1): $10 copayment per prescription unit The deductible does not apply.	No coverage

Your Benefits and the Amounts You Pay		
	In-network benefits after deductible	***Out-of-network benefits after deductible**
*** For certain covered services from certain non-network providers, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.**		
	Generic (Tier 2): $10 copayment per prescription unit The deductible does not apply.	No coverage
	Preferred brand (Tier 3): $70 copayment per prescription unit The deductible does not apply.	No coverage
	Non-preferred brand (Tier 4): $70 copayment per prescription unit The deductible does not apply.	No coverage
3. Prescription insulin drugs		
	$25 copayment per prescription unit The deductible does not apply.	No coverage
4. Diabetic equipment and supplies, including blood glucose meters		
	Preferred generic (Tier 1): $10 copayment per prescription unit The deductible does not apply.	No coverage
	Generic (Tier 2): $10 copayment per prescription unit The deductible does not apply.	No coverage
	Preferred brand (Tier 3): 30% coinsurance	No coverage
	Non-preferred brand (Tier 4): 50% coinsurance	No coverage

Your Benefits and the Amounts You Pay	
In-network benefits after deductible	***Out-of-network benefits after deductible**

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

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

   Please note: The list of covered preventive prescription drugs and other services is specific and limited. For a current list, go to **Medica.com/SignIn** or call Member Services.

Nothing The deductible does not apply.	No coverage, except you pay nothing for immunizations for members up to age 18 and the deductible does not apply.

G. Prescription Specialty Drugs

This section describes coverage for specialty prescription drugs, typically received from a designated specialty pharmacy. Specialty prescription drugs are high-technology, high cost, oral or injectable prescription drugs used for the treatment of certain diseases that require complex therapies. Many specialty prescription drugs 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 the 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 one of the telephone numbers listed inside the front cover.

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

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

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

Medica's Specialty Prescription Drug Program

The Drug List is comprised of prescription drugs that meet the medical needs of our members and have been selected based on their safety, effectiveness, uniqueness and cost. These prescription drugs have been approved by the FDA. A team of physicians and pharmacists meets regularly to review and update the Drug List. Specialty prescription drugs are displayed on the Drug List as Tier 5. The Benefit Chart section of this Policy describes your copayment or coinsurance for the specialty prescription drug.

You and your provider can use this list to select prescription drugs for your health care needs, while helping you maximize your prescription drug benefit. You will be notified in advance if there are any changes to the Drug List that affect prescription drugs you are receiving.

If you have questions about the Drug List or whether a specific specialty prescription drug is covered (and/or the benefit level at which the prescription drug may be covered), or if you would like to request a copy of the Drug List, at no charge, call Member Services at one of the telephone numbers listed inside the front cover. 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 prescription drug manufacturer's packaging, dosing instructions or Medica's prescription drug request guidelines. This includes quantity limits that are indicated on the Drug List. Copayment or coinsurance amounts will apply to each prescription unit dispensed.

Special requirements

For some prescription drugs 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 prescription drugs are shown on the Drug List with the abbreviation "PA." The Drug List is available to providers, including designated specialty pharmacies. Please see *Prior authorization* in *How To Access Your Benefits* for more information about prior authorization requirements and processes. Your network provider who prescribes the prescription drug should initiate the prior authorization process. You must contact Member Services to request prior authorization for prescription drugs prescribed by a non-network provider. You will pay the entire cost of the prescription drug received if you do not meet Medica's prior authorization criteria.

Step therapy (ST)

Step therapy is a process that involves trying an alternative covered prescription drug before moving to the requested prescription drug. The prescription drugs 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 the requested prescription 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 prescription drugs are shown on the Drug List with the abbreviation "QL." Some quantity limits are based on the manufacturer's packaging, FDA labeling or clinical guidelines.

Pharmacy requirement

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

Investigative

As determined by Medica, a prescription 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 prescription drug or device has received final approval to be marketed for its proposed use by the 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 prescription drug being used for an indication or at a dosage that is an accepted off-label use for the treatment of cancer will not be considered by 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 prescription drugs and biologicals used off-label.

Exceptions to the Drug List

In certain cases, it is possible to get an exception that will cover a specialty prescription drug that is generally not covered. **Please note that exceptions will only be allowed when specific clinical criteria are satisfied.** Any specialty prescription drug exception that Medica grants will be covered at Tier 5.
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 prescription drug not included on the 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 one of the telephone numbers listed inside the front cover 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 the Drug List exception process or for more information regarding the expedited review process, call Member Services at one of the telephone numbers listed inside the front cover.

Antipsychotic prescription drugs

Medica provides coverage for antipsychotic prescription drugs prescribed to treat emotional disturbance or mental illness that are not found on the Medica Drug List when the following criteria are met. Coverage will be issued on an annual basis if the prescribing provider:

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

For more information about getting an exception to coverage rules for antipsychotic prescription drugs that are not found on the Medica Drug List, see *Exceptions to the Drug List*.

You may continue to receive certain prescription drugs for diagnosed mental illness or emotional disturbance when Medica's Drug List changes or you change health plans for up to one year following the change, if you meet criteria for continuation.

Exceptions to Step Therapy

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

Covered

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

Not covered

The following are not covered:

1. Any amount above what 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.)
2. Replacement of a specialty prescription drug due to loss, damage or theft.
3. Specialty prescription drugs prescribed by a provider who is not acting within their scope of licensure.
4. Prescription drugs prescribed for investigative uses.
5. Prescription drugs and OTC drugs, except as described in *Prescription Drugs*.
6. Specialty prescription drugs noted on the Drug List with a 'SP' indicator and are received from a pharmacy that is not a designated specialty pharmacy.
7. Weight loss prescription drugs.
8. Specialty prescription drugs not listed on the Drug List, unless covered through the exception process described in *Exceptions to the Drug List*.
9. Infertility prescription drugs.
10. New to market prescription drugs: Products recently approved by the FDA and introduced into the market will not be covered until they are reviewed and considered for placement on the Drug List.

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

Your Benefits and the Amounts You Pay

In-network benefits	You pay (after deductible)
*** For certain covered services from certain non-network providers, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.**	
1. Specialty prescription drugs displayed as Tier 5 with a 'SP' indicator on the Drug List received from a designated specialty pharmacy other than those described below	**Specialty prescription drugs (Tier 5):** 30% coinsurance
2. Specialty prescription drugs displayed as Tier 5 without a 'SP' indicator on the Drug List filled at a network retail pharmacy	**Specialty prescription drugs (Tier 5):** 30% coinsurance
3. Orally-administered cancer treatment prescription drugs received from a designated specialty pharmacy	**Specialty prescription drugs (Tier 5):** $70 copayment per prescription unit The deductible does not apply.

H. Hospital Services

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

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

Prior authorization. Prior authorization from Medica may be required before you receive certain services or supplies, even if a provider has directed or recommended that you receive the services or supplies. Prior authorization from Medica is also required before you receive certain biologics, biosimilars and professionally administered prescription drugs. Certain biologics, biosimilars and professionally administered prescription drugs may be subject to step therapy. In certain cases, it is possible to get an exception to step therapy requirements, please see *Exceptions to Step Therapy* in *Prescription Drugs* or *Prescription Specialty Drugs*. ***For a list of the specific services and supplies that require Medica's prior authorization, please call Member Services at one of the telephone numbers listed inside the front cover. See* How To Access Your Benefits *for more information about the prior authorization process.***

Newborns and Mother's Health Protection Act of 1996

Generally, 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).

Covered

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

- *In-network benefits* apply to:
  1. Hospital services received from a network hospital or ambulatory surgical center; and
  2. When the circumstances described in *Surprise billing protections* apply for certain out-of-network professional services.
- *Out-of-network benefits* apply to hospital services received from a non-network hospital or ambulatory surgical center. **There is not an out-of-pocket maximum that applies to these charges.** In addition to the deductible and coinsurance described for out-of-network benefits, you will be responsible for any charges in excess of the non-network provider reimbursement amount, except under the circumstances described in *Your Rights and Protections Against Surprise Medical Bills* at the end of this Policy. Please see *Important member information about out-of-network benefits* in *How To Access Your Benefits* for more information.

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

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

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

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

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

Not covered

1. Prescription drugs received at a hospital on an outpatient basis, except prescription drugs that meet the definition of "professionally administered prescription drugs" or prescription drugs received in an emergency room or a hospital observation room. Coverage for "professionally administered prescription drugs" is as described under *Professionally Administered Prescription Drugs*. Coverage for prescription drugs is as described in *Prescription Drugs* and *Prescription Specialty Drugs*.
2. Admission to another hospital is not covered when care for your condition is available at the network hospital where you were first admitted.

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

Your Benefits and the Amount You Pay

Benefits	In-network benefits after deductible	* Out-of-network benefits after deductible
*** For certain covered services from certain non-network providers, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.**		
1. Outpatient services:		
a. Services provided in a hospital emergency room	30% coinsurance	Covered as an in-network benefit
b. Outpatient lab and pathology	30% coinsurance	40% coinsurance
c. Outpatient x-rays and other imaging services	30% coinsurance	40% coinsurance
d. Maternity labor and delivery services	30% coinsurance	40% coinsurance

Your Benefits and the Amount You Pay		
Benefits	**In-network benefits after deductible**	*** Out-of-network benefits after deductible**
*** For certain covered services from certain non-network providers, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.**		
e. Prenatal care services that are considered preventive health services as defined in this Policy	Nothing The deductible does not apply.	Nothing The deductible does not apply.
f. Prenatal care services that are not considered preventive health services as defined in this Policy	30% coinsurance	40% coinsurance
g. Genetic testing when test results will directly affect treatment decisions or frequency of screening for a disease, or when results of the test will affect reproductive choices **Please note**: BRCA testing, if appropriate, is covered as a woman's preventive health service	30% coinsurance	40% coinsurance
h. Other outpatient services	30% coinsurance	40% coinsurance
i. Other outpatient hospital and ambulatory surgical center services received from a physician	30% coinsurance	40% coinsurance
j. Anesthesia services received from a provider during an office visit or an outpatient hospital or ambulatory surgical center visit	30% coinsurance	40% coinsurance

Your Benefits and the Amount You Pay		
Benefits	**In-network benefits after deductible**	*** Out-of-network benefits after deductible**
*** For certain covered services from certain non-network providers, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.**		
k. Routine patient costs in connection with a qualified individual's participation in an approved clinical trial	Covered at the corresponding in-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit in-network benefit level and surgical services are covered at the surgical services in-network benefit level.	Covered at the corresponding out-of-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit out-of-network benefit level and surgical services are covered at the surgical services out-of-network benefit level.
2. Services provided in a hospital observation room	30% coinsurance	40% coinsurance
3. Inpatient services, including semi-private room and board in a hospital and services received from a physician during an inpatient stay:		
a. Inpatient services other than for maternity care	30% coinsurance	40% coinsurance
b. Inpatient services for maternity care:		
i. For inpatient services related to prenatal care services that do not result in a delivery	30% coinsurance	40% coinsurance
ii. For all other inpatient maternity labor and delivery services	30% coinsurance	40% coinsurance
iii. Anesthesia services received from a provider during an inpatient stay	30% coinsurance	40% coinsurance

I. Ambulance Services

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

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

Prior authorization. Prior authorization from Medica may be required *before* you receive certain services or supplies, even if a provider has directed or recommended that you receive the services or supplies. For a list of the specific services and supplies that require Medica's prior authorization, please call Member Services at one of the telephone numbers listed inside the front cover. See *How To Access Your Benefits* for more information about the prior authorization process.

Covered

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

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

Not covered

These services, supplies and associated expenses are not covered:

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

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

Your Benefits and the Amounts You Pay		
Benefits	**In-network benefits after deductible**	*** Out-of-network benefits after deductible**
*** For certain covered services from certain non-network providers, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.**		
1. Ambulance services or ambulance transportation to the nearest hospital for an emergency	30% coinsurance	See *Emergency Services From Non-Network Providers*.
2. Non-emergency licensed ambulance service that is arranged through an attending physician, as follows:		
a. Transportation from hospital to hospital when:	30% coinsurance	40% coinsurance
i. Care for your condition is not available at the hospital where you were first admitted; or		
ii. Required by Medica		
b. Transportation from hospital to skilled nursing facility	30% coinsurance	40% coinsurance

J. Home Health Care

This section describes coverage for home health care.

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

Prior authorization. Prior authorization from Medica may be required before you receive services or supplies, even if a provider has directed or recommended that you receive the services or supplies. Prior authorization from Medica is also required before you receive certain biologics, biosimilars and professionally administered prescription drugs. Certain biologics, biosimilars and professionally administered prescription drugs may be subject to step therapy. In certain cases, it is possible to get an exception to step therapy requirements, please see *Exceptions to Step Therapy* in *Prescription Drugs* or *Prescription Specialty Drugs*. For a list of the specific services and supplies that require Medica's prior authorization, please call Member Services at one of the telephone numbers listed inside the front cover. See How To Access Your Benefits for more information about the prior authorization process.

Covered

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

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

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

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

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

Please note: Your place of residence is where you make your home. This may be your own dwelling, a relative's home, an apartment complex that provides assisted living services or some other type of institution. However, an institution will not be considered your home if it is a hospital or skilled nursing facility.

- *Benefits* apply to covered home health care services received from a network home health care agency. Benefits covered under 1., 2. and 4. in the table in this section are limited to a combined annual benefit maximum each calendar year. However, you may be eligible for additional hours of private duty nursing care per week under 1. in the table in this section if you have Medica coverage and are also enrolled in the Medical Assistance program. This additional care may include up to 120 hours of communication and interpretation services provided by a private duty nurse or personal care assistant to a ventilator-dependent person during the time that person is in a licensed hospital.

  Important: *Out-of-network benefits* are not provided for home health care services. Home health care services are covered only if ordered or prescribed by a physician and received from a network home health care agency.

Not covered

These services, supplies and associated expenses are not covered:

1. Extended hours home care.
2. Companion, homemaker and personal care services.
3. Services provided by a member of your family.
4. Custodial care and other nonskilled services.
5. Physical, speech or occupational therapy provided in your home for convenience.
6. Skilled nursing care or skilled physical or occupational therapy provided in your home when you are not homebound.
7. Speech therapy provided in your home when you are not homebound.
8. Services primarily educational in nature.
9. Vocational and job rehabilitation.
10. Recreational therapy.
11. Self-care or self-help training (non-medical), including, but not limited to, educational therapy, aerobic conditioning, therapeutic exercises, work hardening programs, etc., and all related material and products for these programs.
12. Health clubs.
13. Disposable supplies and appliances, except as described in *Miscellaneous Medical Services And Supplies* and in *Prescription Drugs*.
14. Home infusion therapy provided by a non-network provider.
15. Voice training.
16. Outpatient rehabilitation and habilitative care services when no medical diagnosis is present.
17. Prescription drugs provided or administered by a physician or other provider, except those prescription drugs that meet the definition of “professionally administered prescription drugs.” Coverage for “professionally administered prescription drugs” is as described under *Professionally Administered Prescription Drugs*. Coverage for prescription drugs is as described in *Prescription Drugs*, *Prescription Specialty Drugs* or otherwise described as a specific benefit elsewhere in this section.

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

Your Benefits and the Amounts You Pay		
Benefits	**In-network benefits after deductible**	*** Out-of-network benefits after deductible**
*** For certain covered services from certain non-network providers, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.**		
1. Skilled nursing care when you are homebound, provided by or supervised by a registered nurse	30% coinsurance Coverage is limited to an in-network maximum of 180 visits per calendar year for numbers 1., 2. and 4. in this section combined. A visit is considered up to two continuous hours. **Please note:** This visit limit includes any visits that you pay for in order to satisfy any part of your deductible.	No coverage
2. Skilled physical therapy, skilled occupational therapy or speech therapy when you are homebound	30% coinsurance Coverage is limited to an in-network maximum of 180 visits per calendar year for numbers 1., 2. and 4. in this section combined. **Please note:** This visit limit includes any visits that you pay for in order to satisfy any part of your deductible.	No coverage
3. Home infusion therapy	30% coinsurance	No coverage

Your Benefits and the Amounts You Pay		
Benefits	**In-network benefits after deductible**	*** Out-of-network benefits after deductible**
*** For certain covered services from certain non-network providers, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.**		
4. Services received in your home from a physician	Primary care provider: $40 copayment The deductible does not apply. Specialty care provider: $70 copayment The deductible does not apply. Coverage is limited to an in-network maximum of 180 visits per calendar year for numbers 1., 2. and 4. in this section combined. **Please note:** This visit limit includes any visits that you pay for in order to satisfy any part of your deductible.	No coverage

K. Sleep Studies

This section describes coverage for sleep studies.

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

Covered

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

- *In-network benefits* apply to sleep studies received from a network provider.
- *Out-of-network benefits* apply to sleep studies received from a non-network provider.

Not covered

These services, supplies and associated expenses are not covered:

1. Services received from a non-network provider.

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

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	* Out-of-network benefits after deductible
*** For certain covered services from certain non-network providers, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.**		
1. Sleep studies conducted in the home	$150 copayment The deductible does not apply.	40% coinsurance
2. Sleep studies conducted in a facility	30% coinsurance	40% coinsurance

L. Physical, Speech And Occupational Therapies

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

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

Prior authorization. Prior authorization from Medica may be required *before* you receive services or supplies, even if a provider has directed or recommended that you receive the services or supplies. For a list of the specific services and supplies that require Medica's prior authorization, please call Member Services at one of the telephone numbers listed inside the front cover. See *How To Access Your Benefits* for more information about the prior authorization process.

Covered

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

- *In-network benefits* apply to:
  1. Outpatient physical therapy, speech therapy and occupational therapy services arranged through a physician and received from a network physical therapist, a network occupational therapist, a network speech therapist or a network physician; and
  2. When the circumstances described in *Surprise billing protections* apply for certain out-of-network professional services.
- *Out-of-network benefits* apply to outpatient physical therapy, speech therapy and occupational therapy services arranged through a physician and received from a non-network physical therapist, a non-network occupational therapist, a non-network speech therapist or a non-network physician. Out-of-network benefits covered under numbers 1, 2 and 3 in the table in this section are limited to a combined annual benefit maximum each calendar year. **There is not an out-of-pocket maximum that applies to these charges.** In addition to the deductible and coinsurance described for out-of-network benefits, you are responsible for any charges in excess of the non-network provider reimbursement amount, except as described in *Your Rights and Protections Against Surprise Medical Bills* at the end of this Policy. Please see *Important member information about out-of-network benefits* in *How To Access Your Benefits* for more information.

Not covered

These services, supplies and associated expenses are not covered:

1. Services primarily educational in nature.
2. Vocational and job rehabilitation.
3. Recreational therapy.

4. Self-care or self-help training (non-medical), including, but not limited to, educational therapy, aerobic conditioning, therapeutic exercises, work hardening programs, etc., and all related material and products for these programs.
5. Health clubs.
6. Voice training.
7. Outpatient rehabilitation and habilitative care services when no medical diagnosis is present.
8. Group physical, speech and occupational therapy.

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

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	* Out-of-network benefits after deductible
*** For certain covered services from certain non-network providers, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.**		
1. Physical therapy services received outside of your home		
a. Habilitative services	30% coinsurance	40% coinsurance Coverage for physical, occupational and speech habilitative therapy is limited to an out-of-network combined maximum of 20 visits per calendar year. **Please note**: This visit limit does not apply to services for treatment of autism spectrum disorders. This visit limit includes any visits that you pay for in order to satisfy any part of your deductible.

Your Benefits and the Amounts You Pay		
Benefits	**In-network benefits after deductible**	*** Out-of-network benefits after deductible**
*** For certain covered services from certain non-network providers, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.**		
b. Rehabilitative services	30% coinsurance	40% coinsurance Coverage for physical, occupational and speech rehabilitative therapy is limited to an out-of-network combined maximum of 20 visits per calendar year. **Please note**: This visit limit does not apply to services for treatment of autism spectrum disorders. This visit limit includes any visits that you pay for in order to satisfy any part of your deductible.
2. Speech therapy services received outside of your home		
a. Habilitative services	30% coinsurance	40% coinsurance Coverage for physical occupational and speech habilitative therapy is limited to an out-of-network combined maximum of 20 visits per calendar year. **Please note**: This visit limit does not apply to services for treatment of autism spectrum disorders. This visit limit includes any visits that you pay for in order to satisfy any part of your deductible.

Your Benefits and the Amounts You Pay		
Benefits	**In-network benefits after deductible**	*** Out-of-network benefits after deductible**
*** For certain covered services from certain non-network providers, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.**		
b. Rehabilitative services	30% coinsurance	40% coinsurance Coverage for physical, occupational and speech rehabilitative therapy is limited to an out-of-network combined maximum of 20 visits per calendar year. **Please note**: This visit limit does not apply to services for treatment of autism spectrum disorders. This visit limit includes any visits that you pay for in order to satisfy any part of your deductible.
3. Occupational therapy services received outside of your home		
a. Habilitative services	30% coinsurance	40% coinsurance Coverage for physical, occupational and speech habilitative therapy is limited to an out-of-network combined maximum of 20 visits per calendar year. **Please note**: This visit limit does not apply to services for treatment of autism spectrum disorders. This visit limit includes any visits that you pay for in order to satisfy any part of your deductible.

Your Benefits and the Amounts You Pay		
Benefits	**In-network benefits after deductible**	*** Out-of-network benefits after deductible**
*** For certain covered services from certain non-network providers, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.**		
b. Rehabilitative services	30% coinsurance	40% coinsurance Coverage for physical, occupational and speech rehabilitative therapy is limited to an out-of-network combined maximum of 20 visits per calendar year. **Please note**: This visit limit does not apply to services for treatment of autism spectrum disorders. This visit limit includes any visits that you pay for in order to satisfy any part of your deductible.

M. Mental Health

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

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

Prior authorization. Prior authorization from Medica may be required *before* you receive services or supplies. 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. See *How To Access Your Benefits* for more information about the prior authorization process.

For purposes of this section:

1. Outpatient services include:
   a. Diagnostic evaluations and psychological testing.
   b. Psychotherapy and psychiatric services.
   c. Relationship and family therapy if there is a clinical diagnosis.
   d. Intensive outpatient programs, including day treatment and partial programs, which may include multiple services/modalities and lodging, delivered in an outpatient setting (up to 19 hours per week).
   e. Intensive behavioral and developmental therapy for the treatment of autism spectrum disorder when provided in accordance with an individualized treatment plan prescribed by the member's treating physician or mental health professional.
   f. Treatment of serious or persistent disorders.
   g. Diagnostic evaluation for attention deficit hyperactivity disorder (ADHD) or autism spectrum disorder (ASD).
   h. Services, care or treatment described as benefits in this Policy and ordered by a court on the basis of a behavioral health care evaluation performed by a physician or licensed psychologist and that includes an individual treatment plan.
   i. Treatment of pathological gambling.
2. Inpatient services include:
   a. Semi-private room and board.
   b. Attending psychiatric services.
   c. Hospital or facility-based professional services.
   d. Partial program. This may be in a freestanding facility or hospital based. Active treatment is provided through specialized programming with medical/psychological intervention and supervision during program hours. Partial program means a treatment program of 20 hours or more per week and may include lodging.
   e. Services, care or treatment ordered by a court on the basis of a behavioral health care evaluation performed by a physician or licensed psychologist and that includes an individual treatment plan.
   f. Residential treatment services. These services include either:

i. A residential treatment program serving children and adolescents with severe emotional disturbance, certified under Minnesota Rules parts 2960.0580 to 2960.0700; or

ii. A licensed or certified mental health treatment program providing intensive therapeutic services.

Covered

For benefits and the amounts you pay, see the table in this section. **Note:** Inpatient services in a licensed residential treatment facility for treatment of emotionally disabled children will be covered as any other health condition.

- For *in-network benefits*:
  1. Your plan's designated mental health and substance use disorder provider will coordinate your network mental health services. If you require hospitalization, your plan's designated mental health and substance use disorder provider will refer you to one of its hospital providers. **Please note**: The hospital network for medical services and mental health and substance use disorder services may not be the same. Call your plan's designated mental health and substance use disorder provider at the number on the back of your Medica ID card.
  2. **Emergency mental health services and other mental health services under the circumstances described in *Surprise billing protections* are covered as in-network benefits.** After receiving emergency mental health inpatient services please notify your plan's designated mental health and substance use disorder provider at the number on the back of your Medica ID card as soon as reasonably possible.

- For *out-of-network benefits*:
  1. Mental health services from a non-network provider listed below will be eligible for coverage under out-of-network benefits provided that the health care professional or facility is licensed, certified or otherwise qualified under state law to provide the mental health services and practice independently:
     a. Psychiatrist
     b. Psychologist
     c. Registered nurse certified as a clinical specialist or as a nurse practitioner in psychiatric and mental health nursing
     d. Mental health clinic.
     e. Mental health residential treatment center
     f. Independent clinical social worker
     g. Marriage and family therapist
     h. Hospital that provides mental health services
  2. Emergency mental health services are eligible for coverage under in-network benefits.

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

Not covered

These services, supplies and associated expenses are not covered:

1. Services for mental disorders not listed in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders.*
2. Services, care or treatment that is not medically necessary. Court-ordered mental health treatment in accordance with MN statute 62Q.535 is not subject to a separate medical necessity review.
3. Relationship and family therapy in the absence of a clinical diagnosis.
4. Starting July 1, 2023, unscheduled telephonic psychotherapy treatment services, unless such services are provided in accordance with Medica's policies and procedures.
5. Outside of an assessment, services as treatments for the primary diagnoses of learning disabilities.
6. Services, including room and board charges, provided by health care professionals or facilities that are not appropriately licensed, certified or otherwise qualified under state law to provide mental health services. This includes, but is not limited to, services provided by mental health providers who are not authorized under state law to practice independently, and services received from a halfway house, housing with support, a Rule 36 facility, therapeutic group home, boarding school or ranch.
7. Services to assist in activities of daily living that do not seek to cure and are performed regularly as a part of a routine or schedule.
8. Mental health residential treatment services that do not provide all of the following: room and board; group, family and individual counseling; client education; other services specific to mental health treatment; on-site medical/psychiatric assessment within 48 hours of admission, medical/psychiatric follow-up visits at least once per week; and nursing coverage.
9. Room and board for outpatient services.
10. Prescription drugs provided or administered by a physician or other provider, except those prescription drugs that meet the definition of "professionally administered prescription drugs." Coverage for "professionally administered prescription drugs" is as described under *Professionally Administered Prescription Drugs*. Coverage for prescription drugs is as described in *Prescription Drugs*, *Prescription Specialty Drugs* or otherwise described as a specific benefit elsewhere in this section.

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

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	* Out-of-network benefits after deductible
*** For certain covered services from certain non-network providers, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.**		
1. Outpatient services		
a. Evaluations, diagnostic and treatment services.	$40 copayment The deductible does not apply.	40% coinsurance
b. Intensive outpatient programs	$40 copayment The deductible does not apply.	40% coinsurance
c. Intensive behavioral and developmental therapy for the treatment of autism spectrum disorder when provided in accordance with an individualized treatment plan prescribed by the member's treating physician or mental health professional. Examples of such therapy include, but are not limited to, Early Intensive Developmental & Behavioral Intervention (EIDBI), Applied Behavioral Analysis (ABA), Intensive Early Intervention Behavior Therapy (IEIBT), Intensive Behavioral Intervention (IBI) and Lovaas therapy.	30% coinsurance	40% coinsurance
2. Inpatient services		
a. Semi-private room and board	30% coinsurance	40% coinsurance
b. Hospital or facility-based professional services	30% coinsurance	40% coinsurance
c. Attending psychiatrist services	30% coinsurance	40% coinsurance
d. Partial program	30% coinsurance	40% coinsurance

N. Substance Use Disorder

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

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

Prior authorization. Prior authorization from Medica may be required *before* you receive services or supplies. 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. See *How To Access Your Benefits* for more information about the prior authorization process.

For purposes of this section:

1. Outpatient services include:
   a. Diagnostic evaluations.
   b. Outpatient treatment.
   c. Medication-assisted treatment (the use of prescription drugs in conjunction with counseling and behavioral therapies to help maintain sobriety, prevent relapse, and reduce craving in order to sustain recovery).
   d. Intensive outpatient programs, including day treatment and partial programs, which may include multiple services/modalities and lodging, delivered in an outpatient setting.
   e. Services, care or treatment provided by the Minnesota Department of Corrections to a member while the member is committed to the Minnesota Department of Corrections' custody following a conviction for a first-degree driving while impaired offense if:
      i. A court of competent jurisdiction makes a preliminary determination based on a chemical use assessment conducted under Minnesota Statutes section 169A.70 that treatment may be appropriate and includes this determination as part of the sentencing order; and
      ii. The Department of Corrections makes a determination based on a chemical assessment conducted while the member is in the custody of the department that treatment is appropriate.

      Medica must receive a copy of the court's preliminary determination and supporting documents and the assessment by the Department of Corrections.

      Substance use disorder treatment provided by the Minnesota Department of Corrections that meets all of the above requirements is not subject to a separate medical necessity review by Medica.
2. Inpatient services include:
   a. Semi-private room and board.

b. Attending physician services.
c. Hospital or facility-based professional services.
d. Partial program. This may be in a freestanding facility or hospital based. Active treatment is provided through specialized programming with medical/psychological intervention and supervision during program hours. Partial program means a treatment program of 20 hours or more per week and may include lodging.
e. Services, care or treatment provided by the Minnesota Department of Corrections to a member while the member is committed to the Minnesota Department of Corrections' custody following a conviction for a first-degree driving while impaired offense if:

   i. A court of competent jurisdiction makes a preliminary determination based on a chemical use assessment conducted under Minnesota Statutes section 169A.70 that treatment may be appropriate and includes this determination as part of the sentencing order; and

   ii. The Department of Corrections makes a determination based on a chemical assessment conducted while the member is in the custody of the department that treatment is appropriate.

   Medica must receive a copy of the court's preliminary determination and supporting documents and the assessment by the Department of Corrections.

   Substance use disorder treatment provided by the Minnesota Department of Corrections that meets all of the above requirements is not subject to a separate medical necessity review by Medica.

f. Substance use disorder residential treatment services. These are services from a licensed chemical dependency rehabilitation program that provides intensive therapeutic services following detoxification.

Covered

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

- For *in-network benefits*:
  1. Your plan's designated mental health and substance use disorder provider will coordinate your network substance use disorder health services. If you require hospitalization, your plan's designated mental health and substance use disorder provider will refer you to one of its hospital providers. **Please note**: The hospital network for medical services and mental health and substance use disorder services may not be the same. Call your plan's designated mental health and substance use disorder provider at the number on the back of your Medica ID card.
  2. **Emergency substance use disorder services and other substance use disorder services under the circumstances described in *Surprise billing protections* are covered as in-network benefits.** After receiving emergency substance use disorder inpatient services please notify your plan's designated mental health and substance use disorder provider at the number on the back of your Medica ID card as soon as reasonably possible.
  3. In-network benefits will apply to services, care or treatment provided by the Minnesota Department of Corrections to a member while the member is committed to the Minnesota Department of Corrections' custody following a conviction for a first-degree driving while

impaired offense, provided the services, care or treatment meet the criteria outlined in this section.

- For *out-of-network benefits*:
  1. Substance use disorder services from a non-network provider listed below will be eligible for coverage under out-of-network benefits provided that the health care professional or facility is licensed, certified or otherwise qualified under state law to provide the substance use disorder services and practice independently.
     a. Psychiatrist
     b. Psychologist
     c. Registered nurse certified as a clinical specialist or as a nurse practitioner in psychiatric and mental health nursing
     d. Chemical dependency clinic
     e. Chemical dependency residential treatment center
     f. Hospital that provides substance use disorder services
     g. Independent clinical social worker
     h. Marriage and family therapist
  2. Emergency substance use disorder services are eligible for coverage under in-network benefits.

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

Not covered

These services, supplies and associated expenses are not covered:

1. Services for substance use disorders not listed in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders*.
2. Services, care or treatment that is not medically necessary.
3. Services to hold or confine a person under chemical influence when no medical services are required, regardless of where the services are received.
4. Starting July 1, 2023, unscheduled telephonic substance use disorder treatment services, unless such services are provided in accordance with Medica's policies and procedures.
5. Services, including room and board charges, provided by providers or facilities that are not appropriately licensed, certified or otherwise qualified under state law to provide mental health or 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.
6. Substance use disorder residential treatment services that do not provide all of the following: room and board; group, family and individual counseling; client education; other services specific to substance use disorder treatment; on-site medical/psychiatric assessment within 48 hours of admission, medical/psychiatric follow-up visits at least once per week; and 24-hour nursing coverage.

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

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

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	* Out-of-network benefits after deductible
*** For certain covered services from certain non-network providers, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.**		
1. Outpatient services		
a. Evaluations, diagnostic and treatment services	$40 copayment The deductible does not apply.	40% coinsurance
b. Intensive outpatient programs	$40 copayment The deductible does not apply.	40% coinsurance
2. Medication-assisted treatment **Please note:** When the prescription drug component of this treatment is received at a pharmacy, your *Prescription Drug* benefit will be applied.	$40 copayment The deductible does not apply.	40% coinsurance
3. Inpatient services:		
a. Semi-private room and board	30% coinsurance	40% coinsurance
b. Hospital or facility-based professional services	30% coinsurance	40% coinsurance
c. Attending physician services	30% coinsurance	40% coinsurance
d. Partial program	30% coinsurance	40% coinsurance
4. Residential treatment services	30% coinsurance	40% coinsurance

O. Durable Medical Equipment And Prosthetics

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

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

Prior authorization. Prior authorization from Medica may be required *before* you receive certain services or supplies, even if a provider has directed or recommended that you receive the services or supplies. For a list of the specific services and supplies that require Medica's prior authorization, please call Member Services at one of the telephone numbers listed inside the front cover. See *How To Access Your Benefit*s for more information about the prior authorization process.

Covered

For benefits and the amounts you pay, see the table in this section. Medica covers only a limited selection of durable medical equipment and certain supplies 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 supplies is periodically reviewed and modified by Medica.

To request a list of Medica's eligible durable medical equipment and certain supplies, call Member Services at one of the telephone numbers listed inside the front cover.

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 one of the telephone numbers listed inside the front cover.

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

If the durable medical equipment or prosthetic device 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 Drug* section of this Policy.

- *In-network benefits* apply to:
  1. Durable medical equipment and certain supplies and prosthetic services prescribed by a physician and received from a network durable medical equipment provider; and
  2. When the circumstances described in *Surprise billing protections* apply for certain out-of-network professional services.

  To request a list of network durable medical equipment providers, call Member Services at one of the telephone numbers listed inside the front cover.
- *Out-of-network benefits* apply to durable medical equipment and certain supplies and prosthetic services prescribed by a physician and received from a non-network provider. **There is not an out-of-pocket maximum that applies to these charges.** In addition to

the deductible and coinsurance described for out-of-network benefits, you are responsible for charges in excess of the non-network provider reimbursement amount, except as described in *Your Rights and Protections Against Surprise Medical Bills* at the end of this Policy. *Please see Important member information about out-of-network benefits* in *How To Access Your Benefits* for more information.

Not covered

These services, supplies and associated expenses are not covered:

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

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

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	* Out-of-network benefits after deductible
*** For certain covered services from certain non-network providers, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.**		
1. Durable medical equipment and certain supplies	30% coinsurance	40% coinsurance
2. Repair, replacement or revision of durable medical equipment made necessary by normal wear and use	30% coinsurance	40% coinsurance

Your Benefits and the Amounts You Pay		
Benefits	**In-network benefits after deductible**	*** Out-of-network benefits after deductible**
3. Prosthetics:		
a. Initial purchase of external prosthetic devices that replace a limb or an external body part, limited to: i. Artificial arms, legs, feet and hands; ii. Artificial eyes, ears and noses; iii. Breast prostheses.	30% coinsurance	40% coinsurance
b. Scalp hair prosthesis due to alopecia areata Coverage is limited to one prosthesis per calendar year for in-network and out-of-network combined. **Please note:** The benefit maximum includes amounts you pay for scalp hair prosthesis in order to satisfy any part of your deductible.	30% coinsurance	40% coinsurance
c. Repair, replacement or revision of artificial arms, legs, feet, hands, eyes, ears, noses and breast prostheses made necessary by normal wear and use	30% coinsurance	40% coinsurance
4. Insulin pumps and their related supplies	30% coinsurance	40% coinsurance

P. Hearing Aids And Services

This section describes coverage for hearing aids and services.

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

Prior authorization. Prior authorization from Medica may be required *before* you receive certain services or supplies, even if a provider has directed or recommended that you receive the services or supplies. For a list of the specific services and supplies that require Medica's prior authorization, please call Member Services at one of the telephone numbers listed inside the front cover. See *How To Access Your Benefit*s for more information about the prior authorization process.

Covered

For benefits and the amounts you pay, see the table in this section. Medica covers hearing exams. Medica also covers hearing aids for hearing loss that is not correctable by other covered procedures. Medica covers only a limited selection of hearing aids that meet the criteria established by Medica. Some items ordered by your provider, even if medically necessary, may not be covered. The list of hearing aids is periodically reviewed and modified by Medica. To request a list of Medica's hearing aids, call Member Services at the number on the back of your Medica ID card.

If the hearing aids are 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.

To request a list of hearing aid vendors, call Member Services at the number on the back of your Medica ID card.

Not covered

These services, supplies and associated expenses are not covered:

1. Hearing exams, hearing aids and related services provided by a non-network provider.
2. Hearing aids not on the Medica eligible list.
3. Charges in excess of the Medica standard model of hearing aids.
4. Repair, replacement or revision of properly functioning hearing aids, including, but not limited to, due to loss, damage or theft.
5. Duplicate hearing aids, including repair, replacement or revision of duplicate items.

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

Your Benefits and the Amounts You Pay		
Benefits	**In-network benefits after deductible**	*** Out-of-network benefits after deductible**
*** For certain covered services from certain non-network providers, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.**		
1. Routine hearing exams that are considered preventive health services as defined in this Policy	See *Preventive Health Care*	See *Preventive Health Care*
2. Routine hearing exams that are not considered preventive health services as defined in this Policy	Primary care provider: $40 copayment The deductible does not apply. Specialty care provider: $70 copayment The deductible does not apply.	40% coinsurance
3. Hearing aids for hearing loss that is not correctable by other covered procedures **Please note:** Cochlear implants are covered as a surgical service under *Professional Services* or *Hospital.*	30% coinsurance Limited to one hearing aid per ear every three years.	40% coinsurance Limited to one hearing aid per ear every three years.

Q. Miscellaneous Medical Services And Supplies

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

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

Prior authorization. Prior authorization from Medica may be required *before* you receive services or supplies, even if a provider has directed or recommended that you receive the services or supplies. For a list of the specific services and supplies that require Medica's prior authorization, please call Member Services at one of the telephone numbers listed inside the front cover. See *How To Access Your Benefits* for more information about the prior authorization process.

Covered

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

- *In-network benefits* apply to:
  1. Miscellaneous medical services and supplies received from a network provider; and
  2. When the circumstances described in *Surprise billing protections* apply for certain out-of-network professional services.
- *Out-of-network benefits* apply to miscellaneous medical services and supplies received from a non-network provider. **There is not an out-of-pocket maximum that applies to these charges**. In addition to the deductible and coinsurance described for out-of-network benefits, you are responsible for any charges in excess of the non-network provider reimbursement amount, except as described in *Your Rights and Protections Against Surprise Medical Bills* at the end of this Policy. Please see *Important member information about out-of-network benefits* in *How To Access Your Benefits* for more information.

Not covered

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

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

Your Benefits and the Amounts You Pay		
Benefits	**In-network benefits after deductible**	*** Out-of-network benefits after deductible**
*** For certain covered services from certain non-network providers, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.**		
1. Injectable pharmaceutical treatments for hemophilia and bleeding disorders	30% coinsurance	40% coinsurance
2. Dietary medical treatment of phenylketonuria (PKU)	30% coinsurance	40% coinsurance
3. Amino acid-based elemental oral formulas for the following diagnoses: a. cystic fibrosis; b. amino acid, organic acid, and fatty acid metabolic and malabsorption disorders; c. IgE mediated allergies to food proteins; d. food protein-induced enterocolitis syndrome; e. eosinophilic esophagitis; f. eosinophilic gastroenteritis; and g. eosinophilic colitis. Coverage for the diagnoses in 3.c.-3.g. above is limited to members five years of age and younger.	30% coinsurance	40% coinsurance
4. Total parenteral nutrition	30% coinsurance	40% coinsurance
5. Eligible ostomy supplies	30% coinsurance	40% coinsurance

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

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

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

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

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

Prior authorization. Prior authorization from Medica is required *before* you receive services or supplies, even if a provider has directed or recommended that you receive the services or supplies. For a list of the specific services and supplies that require Medica's prior authorization, please call Member Services at one of the telephone numbers listed inside the front cover. See *How To Access Your Benefits* for more information about the prior authorization process.

Covered

Organ and Bone Marrow Transplants: 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 (see *Not covered* below): kidney, lung, heart, heart/lung, pancreas, pancreas/kidney, intestinal, liver, allogeneic, autologous and syngeneic bone marrow. Bone marrow transplants include the transplant of stem cells from bone marrow, peripheral blood and umbilical cord blood.

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

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

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

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

  For in-network benefits, 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

These services, supplies and associated expenses are not covered:

1. Supplies and services related to transplants that would not be authorized by Medica under the medical criteria referenced in this section.
2. Living donor transplants that would not be authorized by Medica under the medical criteria referenced in this section.
3. Islet cell transplants except for autologous islet cell transplants associated with pancreatectomy.
4. 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.
5. 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.
6. Services that are investigative.
7. Private collection and storage of umbilical cord blood for directed use.
8. Prescription drugs provided or administered by a physician or other provider on an outpatient basis, except those prescription drugs that meet the definition of “professionally administered prescription drugs.” Coverage for “professionally administered prescription drugs” is as described under *Professionally Administered Prescription Drugs*. Coverage for prescription drugs is as described in *Prescription Drugs* and *Prescription Specialty Drugs*.
9. Services provided by a non-network provider or non-designated facility.

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

Your Benefits and the Amounts You Pay		
Benefits	**In-network benefits after deductible**	*** Out-of-network benefits after deductible**
*** For certain covered services from certain non-network providers, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.**		
1. Office visits	Primary care provider: $40 copayment The deductible does not apply. Specialty care provider: $70 copayment The deductible does not apply.	No coverage
2. Outpatient services		
a. Professional services		
i. Surgical services (as defined in the *Physicians' Current Procedural Terminology* code book) received from a physician during an office visit or an outpatient hospital visit	30% coinsurance	No coverage
ii. Anesthesia services received from a provider during an office visit or an outpatient hospital or ambulatory surgical center visit	30% coinsurance	No coverage
iii. Outpatient lab and pathology	30% coinsurance	No coverage
iv. Outpatient x-rays and other imaging services	30% coinsurance	No coverage

Your Benefits and the Amounts You Pay		
Benefits	**In-network benefits after deductible**	*** Out-of-network benefits after deductible**
*** For certain covered services from certain non-network providers, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.**		
v. Other outpatient hospital services received from a physician	30% coinsurance	No coverage
b. Hospital and ambulatory surgical center services		
i. Outpatient lab and pathology	30% coinsurance	No coverage
ii. Outpatient x-rays and other imaging services	30% coinsurance	No coverage
iii. Other outpatient hospital services	30% coinsurance	No coverage
3. Inpatient services	30% coinsurance	No coverage
4. Services received from a physician during an inpatient stay	30% coinsurance	No coverage
5. Anesthesia services received from a provider during an inpatient stay	30% coinsurance	No coverage

S. Professionally Administered Prescription Drugs

This section describes coverage for professionally administered prescription drugs.

See *Definitions*. These words have specific meanings: benefits, coinsurance, deductible, designated facility, hospital, medically necessary, member, network, non-network, non-network provider reimbursement amount, physician, professionally administered prescription drugs, provider.

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

If you require certain professionally administered prescription drugs, we may direct you to a designated facility with whom we have an arrangement to provide those certain professionally administered prescription 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 prescription drugs are directed to a designated facility and you or your provider choose not to obtain your professionally administered prescription drug from that designated facility, benefits are not available under this policy for that professionally administered prescription drug.

Prior authorization. Prior authorization from Medica is required before you receive certain biologics, biosimilars and professionally administered prescription drugs. Certain biologics, biosimilars and professionally administered prescription drugs may be subject to step therapy. In certain cases, it is possible to get an exception to step therapy requirements, please see *Exceptions to Step Therapy* in *Prescription Drugs* or *Prescription Specialty Drugs.* For a list of the specific services and supplies that require Medica's prior authorization, please call Member Services at one of the telephone numbers listed inside the front cover. See *How To Access Your Benefits* for more information about the prior authorization process.

Covered

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

- *In-network benefits* apply to:
  1. Professionally administered prescription drugs received from a network provider; and
  2. When the circumstances described in *Surprise billing protections* apply for certain out-of-network professional services.
- *Out-of-network benefits* apply to professionally administered prescription drugs received from a non-network provider. **There is not an out-of-pocket maximum that applies to these charges.** In addition to the deductible and coinsurance described for out-of-network benefits, you will be responsible for any charges in excess of the non-network provider reimbursement amount, except as described in *Your Rights and Protections Against Surprise Medical Bills* at the end of this Policy. Please see *Important member information about out-of-network benefits* in *How To Access Your Benefits* for more information.

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	*Out-of-network benefits after deductible
***For certain covered services from certain non-network providers, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.**		
1. Professionally administered prescription drugs that are required to be administered at a designated facility	**If administered at a designated facility:** Covered at the corresponding in-network benefit level, depending on whether it is administered during a home health care visit, office visit or outpatient hospital visit. For example, if the professionally administered prescription drug was administered during an office visit, then the professionally administered prescription drug is covered at the office visit in-network benefit level. If the professionally administered prescription drug was administered during a home health care visit, then the professionally administered prescription drug is covered at the home health care visit in-network benefit level. **If not administered at a designated facility:** No coverage	No coverage

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	*Out-of-network benefits after deductible
***For certain covered services from certain non-network providers, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.**		
2. Professionally administered prescription drugs that are not required to be administered at a designated facility	Covered at the corresponding in-network benefit level, depending on whether it is administered during a home health care visit, office visit or outpatient hospital visit. For example, if the professionally administered prescription drug was administered during an office visit, then the professionally administered prescription drug is covered at the office visit in-network benefit level. If the professionally administered prescription drug was administered during a home health care visit, then the professionally administered prescription drug is covered at the home health care visit in-network benefit level.	Covered at the corresponding out-of-network benefit level, depending on whether it is administered during a home health care visit, office visit or outpatient hospital visit. For example, if the professionally administered prescription drug was administered during an out-of-network office visit, then the professionally administered prescription drug is covered at the out-of-network office visit benefit level.

T. Reconstructive And Restorative Surgery

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

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

Prior authorization. Prior authorization from Medica may be required before you receive services or supplies, even if a provider has directed or recommended that you receive the services or supplies. For a list of the specific services and supplies that require Medica's prior authorization, please call Member Services at one of the telephone numbers listed inside the front cover. See *How To Access Your Benefits* for more information about the prior authorization process.

Covered

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

- *In-network benefits* apply to:
  1. Reconstructive and restorative surgery services received from a network provider; and
  2. When the circumstances described in *Surprise billing protections* apply for certain out-of-network professional services.
- *Out-of-network benefits* apply to reconstructive and restorative surgery services received from a non-network provider. **There is not an out-of-pocket maximum that applies to these charges.** In addition to the deductible and coinsurance described for out-of-network benefits, you will be responsible for any charges in excess of the non-network provider reimbursement amount, except as described in *Your Rights and Protections Against Surprise Medical Bills* at the end of this Policy. Please see *Important member information about out-of-network benefits* in *How To Access Your Benefits* for more information.

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

Not covered

These services, supplies and associated expenses are not covered:

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

4. Services and procedures primarily for cosmetic purposes. However, emergency treatment of complications from cosmetic surgery is covered as described in *Emergency Services From Non-Network Providers*.
5. Surgical correction of male breast enlargement primarily for cosmetic purposes.
6. Hair transplants.
7. Prescription drugs provided or administered by a physician or other provider on an outpatient basis, except those prescription drugs that meet the definition of "professionally administered prescription drugs." Coverage for "professionally administered prescription drugs" is as described under *Professionally Administered Prescription Drugs*. Coverage for prescription drugs is as described in *Prescription Drugs* and *Prescription Specialty Drugs*.

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

Your Benefits and the Amounts You Pay

Benefits	**In-network benefits after deductible**	*** Out-of-network benefits after deductible**
*** For certain covered services from certain non-network providers, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.**		
1. Office visits	Primary care provider: $40 copayment The deductible does not apply. Specialty care provider: $70 copayment The deductible does not apply.	40% coinsurance

Your Benefits and the Amounts You Pay		
Benefits	**In-network benefits after deductible**	*** Out-of-network benefits after deductible**
*** For certain covered services from certain non-network providers, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.**		
2. Outpatient services		
a. Professional services		
i. Surgical services (as defined in the *Physicians' Current Procedural Terminology* code book) received from a physician during an office visit or an outpatient hospital or ambulatory surgical center visit	30% coinsurance	40% coinsurance
ii. Anesthesia services received from a provider during an office visit or an outpatient hospital or ambulatory surgical center visit	30% coinsurance	40% coinsurance
iii. Outpatient lab and pathology	30% coinsurance	40% coinsurance
iv. Outpatient x-rays and other imaging services	30% coinsurance	40% coinsurance
v. Other outpatient hospital or ambulatory surgical center services received from a physician	30% coinsurance	40% coinsurance
b. Hospital and ambulatory surgical center services		
i. Outpatient lab and pathology	30% coinsurance	40% coinsurance

Your Benefits and the Amounts You Pay		
Benefits	**In-network benefits after deductible**	*** Out-of-network benefits after deductible**
*** For certain covered services from certain non-network providers, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.**		
ii. Outpatient x-rays and other imaging services	30% coinsurance	40% coinsurance
iii. Other outpatient hospital and ambulatory surgical center services	30% coinsurance	40% coinsurance
3. Inpatient services	30% coinsurance	40% coinsurance
4. Services received from a physician during an inpatient stay	30% coinsurance	40% coinsurance
5. Anesthesia services received from a provider during an inpatient stay	30% coinsurance	40% coinsurance

U. Skilled Nursing Facility Services

This section describes coverage for use of skilled nursing facility services. Care must be provided under the direction of a physician.

See *Definitions.* These words have specific meanings: acute inpatient rehabilitation (AIR), benefits, coinsurance, custodial care, deductible, hospital, inpatient, long-term acute care hospital (LTACH), network, non-network, non-network provider reimbursement amount, physician, skilled care, skilled nursing facility.

Prior authorization. Prior authorization from Medica may be required *before* you receive services or supplies, even if a provider has directed or recommended that you receive the services or supplies. For a list of the specific services and supplies that require Medica's prior authorization, please call Member Services at one of the telephone numbers listed inside the front cover. See *How To Access Your Benefits* for more information about the prior authorization process.

Covered

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

- *In-network benefits* apply to skilled nursing facility services arranged through a physician; and
  1. Received from a network skilled nursing facility; or
  2. Received from a non-network provider under the circumstances described in *Surprise billing protections*.
- *Out-of-network benefits* apply to skilled nursing facility services arranged through a physician and received from a non-network skilled nursing facility. **There is not an out-of-pocket maximum that applies to these charges.** In addition to the deductible and coinsurance described for out-of-network benefits, you will be responsible for any charges in excess of the non-network provider reimbursement amount, except as described in Y*our Rights and Protections Against Surprise Medical Bills* at the end of this Policy. Please see *Important member information about out-of-network benefits* in *How To Access Your Benefits* for more information.

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

Not covered

These services, supplies and associated expenses are not covered:

1. Custodial care and other non-skilled services.
2. Self-care or self-help training (non-medical), including, but not limited to, educational therapy, aerobic conditioning, therapeutic exercises, work hardening programs, etc., and all related material and products for these programs.

3. Services primarily educational in nature.
4. Vocational and job rehabilitation.
5. Recreational therapy.
6. Health clubs.
7. Voice training.
8. Outpatient rehabilitation and habilitative care services when no medical diagnosis is present.
9. Group physical, speech and occupational therapy.

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

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	* Out-of-network benefits after deductible
*** For certain covered services from certain non-network providers, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.**		
1. Daily skilled nursing care or daily skilled rehabilitation and habilitative services in a skilled nursing facility, acute inpatient rehabilitation (AIR) facility or long-term acute care hospital (LTACH), including room and board Benefits are limited to 120 days per calendar year for in-network and out-of-network combined. **Please note**: This day limit includes any days that you pay for in order to satisfy any part of your deductible.	30% coinsurance	40% coinsurance
2. Skilled physical therapy, skilled occupational therapy or speech therapy when room and board is not eligible to be covered	30% coinsurance	40% coinsurance

Your Benefits and the Amounts You Pay		
Benefits	**In-network benefits after deductible**	*** Out-of-network benefits after deductible**
*** For certain covered services from certain non-network providers, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.**		
3. Services received from a physician during an inpatient stay in a skilled nursing facility, acute inpatient rehabilitation (AIR) facility or long-term acute care hospital (LTACH) Benefits are limited to services received during 120 days of inpatient stay per calendar year for in-network and out-of-network combined. **Please note**: This day limit includes any days that you pay for in order to satisfy any part of your deductible.	30% coinsurance	40% coinsurance

V. Hospice Services

This section describes coverage for hospice services including respite care. Care must be ordered, provided or arranged under the direction of a physician and received from a network hospice program.

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

Covered

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

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

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

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

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

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

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

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

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

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

Not covered

These services, supplies and associated expenses are not covered:

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

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

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	Out-of-network benefits
*** For certain covered services from certain non-network providers, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.**		
1. Hospice services	30% coinsurance	No coverage
2. Respite care **Please note:** Respite care is limited to not more than five consecutive days at a time.	30% coinsurance	No coverage

W. Temporomandibular Joint (TMJ) Disorder

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

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

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

Prior authorization. Prior authorization from Medica may be required *before* you receive services or supplies, even if a provider has directed or recommended that you receive the services or supplies. For a list of the specific services and supplies that require Medica's prior authorization, please call Member Services at one of the telephone numbers listed inside the front cover. See How To Access Your Benefits for more information about the prior authorization process.

Covered

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

- *In-network benefits* apply to:
  1. TMJ services received from a network provider; and
  2. When the circumstances described in *Surprise billing protections* apply for certain out-of-network professional services.
- *Out-of-network benefits* apply to TMJ services received from a non-network provider**. There is not an out-of-pocket maximum that applies to these charges.** In addition to the deductible and coinsurance described for out-of-network benefits, you will be responsible for any charges in excess of the non-network provider reimbursement amount, except as described in Y*our Rights and Protections Against Surprise Medical Bills* at the end of this Policy. *Please see Important member information about out-of-network benefits* in *How To Access Your Benefits* for more information.

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

Not covered

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

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

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

Your Expenses and the Amounts You Pay		
Benefits	**In-network benefits after deductible**	*** Out-of-network benefits after deductible**
*** For certain covered services from certain non-network providers, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.**		
1. Office visits	Primary care provider: $40 copayment The deductible does not apply. Specialty care provider: $70 copayment The deductible does not apply.	40% coinsurance
2. Outpatient services		
a. Professional services		
i. Surgical services (as defined in the *Physicians' Current Procedural Terminology* code book) received from a physician or dentist during an office visit or an outpatient hospital or ambulatory surgical center visit	30% coinsurance	40% coinsurance
ii. Anesthesia services received from a provider during an office visit or an outpatient hospital or ambulatory surgical center visit	30% coinsurance	40% coinsurance
iii. Outpatient lab and pathology	30% coinsurance	40% coinsurance

Your Expenses and the Amounts You Pay		
Benefits	**In-network benefits after deductible**	*** Out-of-network benefits after deductible**
*** For certain covered services from certain non-network providers, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.**		
iv. Outpatient x-rays and other imaging services	30% coinsurance	40% coinsurance
v. Other outpatient hospital and ambulatory surgical center services received from a physician or dentist	30% coinsurance	40% coinsurance
b. Hospital and ambulatory surgical center services		
i. Outpatient lab and pathology	30% coinsurance	40% coinsurance
ii. Outpatient x-rays and other imaging services	30% coinsurance	40% coinsurance
iii. Other outpatient hospital and ambulatory surgical center services	30% coinsurance	40% coinsurance
4. Physical therapy received outside of your home	30% coinsurance	40% coinsurance
5. Inpatient services	30% coinsurance	40% coinsurance
6. Services received from a physician or dentist during an inpatient stay	30% coinsurance	40% coinsurance
7. Anesthesia services received from a provider during an inpatient stay	30% coinsurance	40% coinsurance
8. TMJ splints and adjustments if your primary diagnosis is joint disorder	30% coinsurance	40% coinsurance

X. Medical-Related Dental Services

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

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

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

Prior authorization. Prior authorization from Medica may be required *before* you receive services or supplies, even if a provider has directed or recommended that you receive the services or supplies. For a list of the specific services and supplies that require Medica's prior authorization, please call Member Services at one of the telephone numbers listed inside the front cover. See *How To Access Your Benefits* for more information about the prior authorization process.

Covered

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

- *In-network benefits* apply to:
  1. Medical-related dental services received from a network provider; and
  2. When the circumstances described in *Surprise billing protections* apply for certain out-of-network professional services.
- *Out-of-network benefits* apply to medical-related dental services received from a non-network provider. **There is not an out-of-pocket maximum that applies to these charges.** In addition to the deductible and coinsurance described for out-of-network benefits, you will be responsible for any charges in excess of the non-network provider reimbursement amount, except as described in Y*our Rights and Protections Against Surprise Medical Bills* at the end of this Policy. Please see *Important member information about out-of-network benefits* in *How To Access Your Benefits* for more information.

Note: For dependents up to the limiting age, Medica covers inpatient and outpatient expenses arising from medical and dental treatment of cleft lip and cleft palate, including orthodontic and oral surgery treatment. Benefits for dependents age 19 and older are limited to inpatient or outpatient expenses arising from medical and dental treatment that was scheduled or initiated prior to the dependent turning age 19. See Extending a child's eligibility in *Eligibility And Enrollment* for details regarding dependent limiting ages. If the dependent is enrolled in a dental plan and orthodontic services are eligible for coverage under the dental plan, the dental plan shall be primary.

Not covered

These services, supplies and associated expenses are not covered:

1. Dental services to treat an injury from biting or chewing.
2. Osteotomies and other procedures associated with the fitting of dentures or dental implants.
3. Dental implants (tooth replacement) except dental implants related to cleft lip and palate for a dependent child as described in this section.
4. Dental procedures or treatment when the dental treatment is needed because of a primary dental problem or as a manifestation of a medical treatment or condition.
5. Any orthodontia including that associated with orthognathic procedures or accident-related dental injuries, except as described in number 2 in the table in this section.
6. Tooth extractions, except as described in this section.
7. Any dental procedures or treatment related to periodontal disease.
8. Endodontic procedures and treatment, including root canal procedures and treatment.
9. Routine diagnostic and preventive dental services.

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

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	* Out-of-network benefits after deductible
*** For certain covered services from certain non-network providers, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.**		
1. Charges for medical facilities and general anesthesia services that are: a. Recommended by a network physician; and b. Received during a dental procedure; and c. Provided to a member who: i. Is a child under age five (prior authorization is *not* required); or ii. Is severely disabled; or	30% coinsurance	40% coinsurance

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	* Out-of-network benefits after deductible
*** For certain covered services from certain non-network providers, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.**		
iii. Has a medical condition and requires hospitalization or general anesthesia for dental care treatment.		
2. For a dependent child, orthodontia related to cleft lip and palate **Please note.** For a dependent child, benefits for oral surgery treatment for cleft lip and palate are covered in *Professional Services* and *Hospital Services*.	30% coinsurance	40% coinsurance
3. Oral surgery for: a. Partially or completely unerupted impacted teeth; or b. A tooth root without the extraction of the entire tooth (this does not include root canal therapy); or c. The gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth.	30% coinsurance	40% coinsurance
4. Accident-related dental services to treat an injury to sound, natural teeth and to repair (not replace) sound, natural teeth. The following conditions apply:	30% coinsurance	No coverage

a. Coverage is limited to services initiated within 6 months of the date of the injury and received within 24 months from the later of:

   i. The date you are first covered under the Policy; or

   ii. The date of the injury

Please note: A sound natural tooth means a tooth (including supporting structures) that is free from disease that would prevent continual function of the tooth for at least one year. In case of primary baby teeth, the tooth must have a life expectancy of one year.

Y. Gender Affirmation Care

This section describes coverage for medically necessary treatment for gender dysphoria, as defined in the Diagnostic and Statistical Manual of Mental Disorders. Treatment includes surgical and non-surgical services and mental health services.

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

Prior authorization. Prior authorization from Medica may be required *before* you receive services or supplies, even if a provider has directed or recommended that you receive the services or supplies. For a list of the specific services and supplies that require Medica's prior authorization, please call Member Services at one of the telephone numbers listed inside the front cover. See *How To Access Your Benefits* for more information about the prior authorization process.

Medically necessary surgical and non-surgical services for the treatment of gender dysphoria are not cosmetic.

Medical necessity review is based on Medica's policy, which references multiple resources, including but not limited to the World Professional Association for Transgender Health (WPATH) Standards of Care for the Health of Transsexual, Transgender and Gender Nonconforming People.

Please note: Coverage for prescription drugs that are medically necessary for the treatment of gender dysphoria is as described in *Prescription Drugs* and *Prescription Specialty Drugs*.

Covered

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

- *In-network benefits* apply to:
  1. Gender affirmation care received from a network provider; and
  2. When the circumstances described in *Surprise billing protections* apply for certain out-of-network professional services.
- *Out-of-network benefits* apply to gender affirmation care received from a non-network provider.

There is not an out-of-pocket maximum that applies to these charges. In addition to the deductible and coinsurance described for out-of-network benefits, you will be responsible for any charges in excess of the non-network provider reimbursement amount, except as described in Y*our Rights and Protections Against Surprise Medical Bills* at the end of this Policy. Please see *Important Member information about out-of-network benefits* in *How To Access Your Benefits* for more information.

Not covered

These services, supplies and associated expenses are not covered:

1. Services, care or treatment that are not medically necessary.
2. Services received from a non-network provider.

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

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible	* Out-of-network benefits after deductible
*** For certain covered services from certain non-network providers, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.**		
1. Gender affirmation care	Covered at the corresponding in-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit in-network benefit level and surgical services are covered at the surgical services in-network benefit level.	Covered at the corresponding out-of-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit out-of-network benefit level and surgical services are covered at the surgical services out-of-network benefit level.

Z. Emergency Services From Non-Network Providers

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

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

Covered

For benefits and the amounts you pay, see the table in this section. To be eligible for coverage, services must be due to an emergency, as defined in Definitions.

You must notify Medica of emergency inpatient services as soon as reasonably possible after receiving inpatient services. Call Member Services at one of the telephone numbers listed inside the front cover.

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

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

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

If you are confined in a non-network facility as a result of an emergency, you will be eligible for in-network benefits until you have validly consented to post-stabilization care from non-network providers. Please see *Surprise billing protections* and *Your Rights and Protections Against Surprise Medical Bills* at the end of this Policy.

If you receive scheduled or follow-up care after an emergency, you must visit a network provider to receive in-network benefits.

Not covered

These services, supplies and associated expenses are not covered:

1. Non-emergency care from non-network providers, except emergency services and services authorized by Medica.
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, except as described in Y*our Rights and Protections Against Surprise Medical Bills* at the end of this Policy.
3. Follow-up care or scheduled care from a non-network provider except as described in *How to Access Your Benefits*. Follow-up care or scheduled care under this exclusion does not include emergency services provided at certain out-of-network facilities, as those terms are defined and used under the Federal No Surprises Act of 2020.
4. Transfers and admissions to network hospitals solely at the convenience of the member.

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

Your Benefits and the Amounts You Pay

Benefits	In-network benefits after deductible
*** For certain covered services from certain non-network providers, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible.**	
1. Emergency services that are: a. Administered under the direction of a physician; *and* b. Otherwise eligible for coverage in this Policy.	30% coinsurance
2. Ambulance service or ambulance transportation to the nearest hospital for an emergency	30% coinsurance

AA. Referrals To Non-Network Providers

This section describes coverage for referrals from network providers to non-network providers. In-network benefits will apply to referrals from network providers to non-network providers as described in this section. It is to your advantage to seek 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 area 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 area 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.

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

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

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

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

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

What you must do

1. Request a referral or standing referral from a *network provider* to receive *medically necessary* services from a *non-network provider*. The referral will be in writing and will:
   a. Indicate the time period during which services must be received; and
   b. Specify the service(s) to be provided; and
   c. Direct you to the non-network provider selected by your network provider.
2. Seek prior authorization from Medica by calling one of the telephone numbers listed inside the front cover. 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 (as described in this section) from a network provider to a non-network provider practicing in the same or similar specialty.
3. Provide coverage for health services that are:
   a. Otherwise eligible for coverage under this Policy;
   b. Recommended by a network physician; and
   c. Determined by 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 area 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 ten business 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 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 seeking.

BB. Harmful Use Of Medical Services

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

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

When this section applies

If it is determined that you are receiving certain prescription drugs in a quantity or manner that may harm your health, benefits for these prescription drugs will be restricted to prescription drugs that are both prescribed by one specific network physician and dispensed by one specific network pharmacy. Failure to receive these prescription drugs 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.

CC. Exclusions

See *Definitions*. These words have specific meanings: claim, coinsurance, copayment, cosmetic, custodial care, emergency, genetic testing, investigative, medically necessary, member, non-network, physician, provider, reconstructive.

Medica will not provide coverage for any of the services, treatments, supplies or items described in this section even if it is recommended or prescribed by a provider or it is the only available treatment for your condition.

This section describes additional exclusions to the services, supplies and associated expenses already listed as ***Not covered*** in this Policy. These include:

1. Services that are not medically necessary. This includes but is not limited to services inconsistent with the medical standards and accepted practice parameters of the community and services inappropriate—in terms of type, frequency, level, setting and duration—to the diagnosis or condition.
2. Services or prescription drugs used to treat conditions that are cosmetic in nature, unless otherwise determined to be reconstructive. However, emergency treatment of complications from cosmetic surgery is covered as described in *Emergency Services From Non-Network Providers.*
3. Refractive eye surgery.
4. The purchase, replacement or repair of low vision aids, eyeglasses, eyeglass frames or contact lenses when prescribed solely for vision correction, and their related fittings, except as stated in *Professional Services.*
5. Hearing aids (including internal, external or implantable hearing aids or devices) and other devices to improve hearing, and their related fittings, except cochlear implants and their related fittings and except as stated in *Hearing Aids And Services*.
6. A prescription drug, device or medical treatment or procedure that is investigative.
7. Autopsies, except as stated in *General Provisions*.
8. 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.
9. Nutritional and electrolyte substances except as specifically described in *Miscellaneous Medical Services And Supplies*.
10. Physical, occupational or speech therapy when there is no reasonable expectation of improvement.
11. Reversal of voluntary sterilization.
12. Personal comfort or convenience items or services.
13. Custodial care, unskilled nursing or unskilled rehabilitation services.
14. Respite or rest care except as otherwise covered in this Policy under *Hospice Services*.
15. 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*.

16. Household equipment, fixtures, home modifications and vehicle modifications.
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. Claims for benefits to the extent such claims have been paid under workers' compensation, employer liability or any similar law, auto insurance, or any other coverage or plan that is required to pay before this plan pays. In other words, Medica will not make duplicate payment on claims that have been paid previously by another payer.
21. Unless requested by Medica, charges for duplicating and obtaining medical records from non-network providers and non-network dentists.
22. Occlusal adjustment or occlusal equilibration, except related to the surgical and non-surgical treatment of temporomandibular joint (TMJ) disorder.
23. Dental implants (tooth replacement) except dental implants related to cleft lip and palate for a dependent child as described in *Medical-Related Dental Services*.
24. Dental prostheses.
25. Orthodontic treatment, except as described in *Medical-Related Dental Services*.
26. Treatment for bruxism.
27. Services to treat injuries that occur while on military duty and received as a result of war, or any act of war (whether declared or undeclared). This exclusion does not apply if you are a civilian.
28. Exams, other evaluations or other services received solely for the purpose of employment, insurance or licensure.
29. Exams, other evaluations or other services received solely for the purpose of judicial or administrative proceedings or research, except emergency examination of a child ordered by judicial authorities.
30. Self-care or self-help training (non-medical), including, but not limited to, educational therapy, aerobic conditioning, therapeutic exercises, work hardening programs, etc., and all related material and products for these programs.
31. Educational classes, programs or seminars, including but not limited to childbirth classes, except as described in *Professional Services*.
32. Coverage for costs associated with translation of medical records and claims to English.
33. Treatment for superficial veins, also referred to as telangiectasia, threat, reticular or spider veins.
34. Preventive dental services.
35. Elective, induced abortions, except as medically necessary to protect the life of the mother.
36. Therapeutic acupuncture, dry needling or services billed by an acupuncturist.
37. Services for or related to vision therapy and orthoptic and/or pleoptic training, except as described in *Professional Services*.
38. Sensory Integration including Auditory Integration Training.

39. Orthognathic surgery for cosmetic purposes. However, emergency treatment of complications from cosmetic surgery is covered as described in *Emergency Services From Non-Network Providers*.
40. Surgery for morbid obesity (also known as bariatric surgery).
41. 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 member's body.
42. Services for private-duty nursing, except as stated in *Home Health Care*.
43. 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.
44. Services which are not within the scope of licensure or certification of the provider.
45. Charges for services by a non-network provider in excess of the non-network provider reimbursement amount.
46. Non-emergency transportation.
47. Non-emergency services received outside the United States.
48. Services solely for or related to the treatment of snoring.
49. Out-of-network virtual care.
50. Any form, mixture or preparation of cannabis for medical or therapeutic use and any device or supplies related to its administration.
51. Animals and any service or treatment related to animals.
52. Prescription drugs provided or administered by a physician or other provider on an outpatient basis, except those prescription drugs that meet the definition of "professionally administered prescription drugs." Coverage for "professionally administered prescription drugs" is as described under *Professionally Administered Prescription Drugs*. Coverage for prescription drugs is as described in *Prescription Drugs* and *Prescription Specialty Drug*s.
53. Procedures, tests or other services that are exclusively provided to monitor the effectiveness of non-covered fertilization procedures.
54. Physician, hospital and ambulatory surgical center services for the treatment of infertility.
55. Services for intrauterine insemination (IUI).
56. Collection, retrieval, purchase, freezing and/or storage of sperm or eggs.
57. Services related to adoption.
58. Prescription drugs, supplies, biologics and biosimilars that have not been approved by the FDA.
59. Medical devices that have not been approved by the FDA, other than those granted a humanitarian device exemption.
60. New to market biologics, biosimilars and professionally administered prescription drugs. Biologics, biosimilars and professionally administered prescription 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.

61. Professionally administered prescription drugs that do not meet both of the following requirements: (a) administered in conjunction with a covered benefit and (b) administered by a provider acting within the scope of the provider's license.
62. Conversion therapy, which is any practice by a mental health practitioner or mental health professional that seeks to change a person's sexual orientation or gender identity, including efforts to change behaviors or gender expressions or to eliminate or reduce sexual or romantic attractions or feelings toward people regardless of gender. Conversion therapy does not include counseling that provides assistance to a person undergoing gender affirmation care. It also does not include counseling that provides acceptance, support, and understanding of a person or facilitates a person's coping, social support, and identity exploration and development, including sexual-orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, as long as the counseling does not seek to change the person's sexual orientation or gender identity.

DD. How To Submit A Claim

This section describes the process for submitting a claim.

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

Claims for benefits from network providers

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

Network providers are required to submit claims within 180 days from when you receive a service. If your provider asks for your health care identification card and you do not identify yourself as a 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 prescription 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 one of the telephone numbers listed at the front of this Policy.

Claims for benefits from non-network providers

Claim forms can be found in the Document Center at **Medica.com/SignIn** or you may request claim forms by calling Member Services at one of the telephone numbers listed inside the front cover. You should retain copies of all claim forms and correspondence for your records.

Generally, 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. Your Medica member number must be on the claim.

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

Upon receipt of your claim for benefits from non-network providers, Medica will pay to you directly the non-network provider reimbursement amount. Medica will notify you of authorization or denial of the claim within 30 days of receipt of the claim.

If your claim does not contain all the information 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:

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

EE. Coordination Of Benefits

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

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

1. *Applicability*

a. This coordination of benefits (COB) provision applies to this plan when a member or the member's covered dependent has health care coverage under more than one plan. *Plan* and *this plan* are defined below.

b. If this coordination of benefits provision applies, the *Order of benefit determination rules* should be looked at first. Those rules determine whether the benefits of this plan are determined before or after those of another plan. Under the *Order of benefit determination rules*, the benefits of this plan:

i. Shall not be reduced when this plan determines its benefits before another plan; but

ii. May be reduced when another plan determines its benefits first. The above reduction is described in *Effect on the benefits of this plan.*

2. *Definitions that apply to this section*

a. Plan is any of these which provides benefits or services for, or because of, medical or dental care or treatment:

i. Group or non-group insurance or group-type coverage, whether insured or uninsured, or individual coverage. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

ii. Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

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

b. “This plan” is the part of this Policy that provides benefits for health care expenses.

c. *Primary plan/secondary plan.* The *Order of benefit determination rules* state whether this plan is a primary plan or secondary plan as to another plan covering the person.

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

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

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

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

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

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

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

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

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

3. *Order of benefit determination rules*

a. *General.* When there is a basis for a claim under this plan and another plan, this plan is a secondary plan which has its benefits determined after those of the other plan, unless:

   i. The other plan has rules coordinating its benefits with the rules of this plan; and

   ii. Both the other plan's rules and this plan's rules, in number 3b below, require that this plan's benefits be determined before those of the other plan.

b. *Rules.* This plan determines its order of benefits using the first of the following rules which applies:

   i. *Nondependent/dependent.* The benefits of the plan that covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the plan, which covers the person as a dependent.

   ii. *Dependent child/parents not separated or divorced.* Except as stated in 3.b.iii. below, when this plan and another plan cover the same child as a dependent of different persons, called *parents*:

      a. The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

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

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

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

a. First, the plan of the parent with custody of the child;

b. Then, the plan of the spouse of the parent with the custody of the child; and

c. Finally, the plan of the parent not having custody of the child.

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

iv. *Joint custody.* If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering follow the *Order of benefit determination rules* outlined in 3.b.ii.

v. *Active/inactive employee.* The benefits of a plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

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

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

viii. *Longer/shorter length of coverage***.** If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member or subscriber longer are determined before those of the plan which covered that person for the shorter term.

4. *Effect on the benefits of this plan*

a. *When this section applies***.** This number 4 applies when, in accordance with number 3 *Order of benefit determination rules*, this plan is a secondary plan as to one or more other plans. In that event, the benefits of this plan may be reduced under this section. Such other plan or plans are referred to as *the other plans* in b. immediately below.

b. *Reduction in this plan's benefits.* The benefits of this plan will be reduced when the sum of:

   i. The benefits that would be payable for the allowable expense under this plan in the absence of this COB provision; and

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

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

   When this plan is a secondary plan, this plan will pay the balance of any remaining expenses determined to be eligible under this Policy, according to the out-of-network benefits described in this Policy. Most out-of-network benefits are covered at 60% of the non-network provider reimbursement amount, after you pay the applicable deductible amount. In no event will this plan provide duplicate coverage.

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

5. *Right to receive and release needed information*

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

6. *Facility of payment*

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

7. *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 following:

a. The persons it has paid or for whom it has paid; or

b. Insurance companies; or

c. Other organizations.

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

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

8. *Coordination for Medicare-eligible individuals*

The benefits under this Policy are not intended to duplicate any benefits to which members are, or would be, eligible for under Medicare Part B. If we have covered a service under this Policy, any sums payable under Medicare Part B for that service must be paid to 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.

FF. Medica's Right To Subrogation And Reimbursement

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

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

1. Medica has a right of subrogation against any third party, individual, corporation, insurer or other entity or person who may be legally responsible for payment of medical expenses related to your illness or injury. 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 from any recovery a pro rata share of your disbursements, attorney fees and costs, and other expenses incurred in obtaining a recovery from another source unless Medica is separately represented by an attorney. If Medica is represented by an attorney, an agreement regarding allocation may be reached. If an agreement cannot be reached, the matter must be submitted to binding arbitration.
4. By accepting coverage under this Policy, you agree:
   a. That if 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 to Minnesota 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 do nothing to decrease or limit Medica's rights under this provision, either before or after receiving benefits, or under this Policy.
   e. Medica may take action to preserve its legal rights. This includes bringing suit in your name.
   f. Subject to the full recovery requirement set forth in paragraph 1. above, Medica may collect its subrogation interest from the proceeds of any settlement or judgment that includes or otherwise relates to payment of medical expenses recovered by you, your legal representative or the legal representative(s) of your estate or next-of-kin.

GG. Eligibility And Enrollment

This section describes who can enroll and how to enroll.

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

Who can enroll

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

Subscriber eligibility

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

1. be a Minnesota resident; and
2. complete an application form provided by Medica; and
3. be accepted by Medica for enrollment.

Child only eligibility

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

Dependent eligibility

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

1. be a Minnesota resident; and
2. for a dependent child, be under the age of 26 (see "Extending a child's eligibility" below); and
3. be accepted by Medica for enrollment.

Extending a child's eligibility

A dependent child is no longer eligible for coverage under this Policy at the end of the year in which he or she reaches the dependent limiting age of 26. The dependent child may be eligible for a special enrollment period at the end of the month in which the dependent child reaches the dependent limiting age of 26. See the section on *Special enrollment periods and effective date of coverage* for more information. However, the child's eligibility continues in the following situation:

- *Disabled dependent.* The child is incapable of self-sustaining employment by reason of developmental disability, mental illness, mental disorder or physical disability and is chiefly dependent upon the subscriber for support and maintenance. An illness that does not cause a child to be incapable of self-sustaining employment will not be considered a physical

disability. To continue coverage for a disabled dependent, you must provide 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. Your disabled dependent is covered under this Policy regardless of age.

Enrollment

Open enrollment and effective date of coverage

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

If you enroll for coverage during the open enrollment period, your coverage will be effective as determined based on the date you completed your plan selection. Services received before the effective date of this Policy are not covered.

Medica may ask you for information about your eligibility for coverage if, for example, we suspect fraud, or to determine if you qualify for our Medicare estimation program. By accepting coverage under this Policy, you agree to cooperate with our reasonable request for information.

Special enrollment periods and effective date of coverage

Special enrollment periods are provided to subscribers and dependents under certain circumstances. Unless otherwise stated, you shall have 60 days following the date of the qualifying event to exercise your right for a special enrollment period. If you or your dependent did not receive timely notice of a qualifying event that makes you or your dependent eligible for a special enrollment period, and you or your dependent were otherwise unaware that the qualifying event occurred, you will have 60 days following the date your knew, or reasonably should have known, about the qualifying event to select a plan.

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

Qualifying events through MNsure

MNsure offers additional special enrollment periods. Eligibility for those special enrollment periods will be as determined by MNsure. Contact MNsure to notify them of the qualifying event and to exercise your right for a special enrollment period, but please note that this Policy is not available for purchase through MNsure. Coverage is effective on the date established by MNsure. Contact MNsure for information about the limitations of each special enrollment period.

Qualifying events through MNsure or through Medica

Eligibility for a special enrollment period will be determined by Medica. Medica may ask you for information about your eligibility for the special enrollment period. By accepting coverage under this Policy, you agree to cooperate with our reasonable request for information.

Unless noted otherwise, if you enroll with Medica for any of the following qualifying events, your coverage will be effective on the first day of the month following the date you select your new plan.

The following are the qualifying events for special enrollment periods:

1. The subscriber gains a dependent through marriage, birth, adoption, placement for adoption, or child support order or other court order. For adding dependent children to this Policy, the notification period is not limited to 60 days for newborns or children newly adopted or newly placed for adoption, although you are encouraged to notify Medica within this time period. 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 MNsure. 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 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 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.
3. The subscriber or dependent enrolled in the same qualified health plan is determined to be newly ineligible for the advance premium tax credit or cost-sharing reductions.
4. A subscriber or dependent gains access to a new qualified health plan as a result of a permanent move. The subscriber 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 MNsure. Moving solely for medical treatment or vacation does not qualify a subscriber or dependent for this special enrollment period.
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 eligibility for Medicaid 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 qualifying event to exercise his or her right for a

special enrollment period. 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.

6. The subscriber demonstrates to Medica or MNsure, as applicable, that the health plan providing coverage to him or her substantially violated a material provision of its contract.
7. The subscriber demonstrates to Medica or MNsure, 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 or the United States Department of Health and Human Services, or a non-MNsure entity providing enrollment assistance or conducting enrollment activities.
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.
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. 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 subscriber or dependent applies for coverage on MNsure during annual open enrollment or a special enrollment, and is determined by MNsure as potentially eligible for Medicaid or CHIP, and is later determined ineligible for Medicaid or CHIP after open enrollment ended or more than 60 days after the qualifying event. It also applies if the subscriber 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.

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 effective date of coverage* and *Special enrollment* p*eriods and effective date of coverage* above. Newborn infants are eligible for benefits from the moment of birth, including coverage for illness, injury, congenital malformation, or premature birth, including birth defects, as specifically described in this Policy.

Please note with regard to births and adoptions: Medica does not automatically know of a birth or adoption or whether the subscriber would like the newborn infant or newly adopted dependent to be added to the Policy.

Newborn infants and newly adopted dependents are eligible for coverage under this Policy from the moment of birth, adoption, or newly placed for adoption if the following two conditions are met:

1. You notify Medica in writing of the birth of the newborn infant, adoption or child newly placed for adoption and request that the newborn infant or newly adopted dependent be added to this Policy.
2. You provide additional premium for the newborn infant's birth, adoption, or child newly placed for adoption. Medica requires additional premium to add the newborn infant or newly adopted dependent to your current Policy. Medica is entitled to all premiums due

from the time of the newborn infant's birth, adoption or child newly placed for adoption until the time the covered subscriber notifies Medica of the birth or adoption.

Medica will withhold payment of any health benefits for the newborn or newly adopted dependent until the applicable premium has been paid. For that reason, it's very important that you request to Medica that the newborn or newly adopted dependent be added to the coverage.

Medica may reduce payment by the amount of premium that is past due for any health benefits for the child until any premium you owe is paid.

Notification

As a member, it is your responsibility to notify Medica of any changes that might affect your coverage. You should report these changes to Medica immediately. These changes include, but are not limited to:

1. Eligibility for Medicare or Medicaid.
2. Coverage under other health insurance.
3. Loss of eligibility for coverage due to divorce or death of the subscriber.
4. You have moved.
5. The addition of newly acquired dependents
6. Changes in qualified dependent status.

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

HH. Ending Coverage

This section describes when coverage ends under this Policy.

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

When coverage ends

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

1. The date Medica notifies you that Medica will cease doing business. Coverage will end on the last day of a month. (To cease doing business means to discontinue issuing new individual health plans and to refuse to renew all of Medica's existing individual health plans.)
2. The end of the month for which the subscriber last paid the premium due.
3. The end of the month following the date the subscriber requests that coverage end. Written request for termination of the subscriber's and/or dependents' coverage must be received by Medica at least 31 days before the date of termination. However, the effective date of such termination must be the end of the month. Any refund of premium shall be mailed to the subscriber upon receipt of this notice by Medica.
4. If the subscriber terminates this Policy within the first ten days of receiving it, coverage shall terminate retroactive to the effective date of this Policy.
5. The end of the month following the date 31 days after we notify you that coverage will end because you do not reside in your plan's service area, provided the notification is made within one year following the date Medica was provided written notification of your address change. However, Medica may approve other arrangements.
6. The end of the month following the date you enter active military duty for more than 31 days. Upon completion of active military duty, your coverage will be reinstated if you notify Medica within 90 days after removal from active military duty.
7. When the subscriber is enrolled under this Policy, coverage for enrolled dependents will end the date the subscriber's coverage ends, unless as noted in *Continuation*.
8. The date of the death of the member. When the subscriber is enrolled under this Policy and in the event of the subscriber's death, coverage for the subscriber's enrolled dependents will terminate the end of the month in which the subscriber's death occurred. The enrolled dependents have continuation rights available as stated in *Continuation*.
9. For a spouse, the end of the month following the date of divorce, unless as noted in *Continuation*.
10. For an enrolled dependent child, the end of the year in which the child is no longer eligible as a dependent as specified in this Policy.
11. The date specified by Medica in written notice to you that coverage ended due to fraud or intentional misrepresentation of a material fact. Medica shall send the written notice to you 30 days in advance of Medica's rescission action. 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 for fraud. Fraud includes but is not limited to:

a. Knowingly providing Medica with false material information during the enrollment process such as information related to your eligibility or another person's eligibility for coverage or status as a dependent; or
b. Permitting the use of your member identification card by any unauthorized person; or
c. Using another person's member identification card; or
d. Submitting fraudulent claims; or
e. Engaging in any fraudulent activity related to your eligibility for coverage under this Policy.

Time Limits on the Effect of Misstatements

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

Continuation

In the following circumstances, Minnesota law requires that the subscriber and his or her dependents be allowed to maintain continuation coverage as follows:

1. For instances where the subscriber's spouse or dependent children lose coverage because of the subscriber's enrollment under Medicare, coverage may be continued until the earliest of:
    a. 36 months after continuation was elected;
    b. The date coverage is obtained under other health insurance coverage; or
    c. The date coverage would otherwise terminate under this Policy.
2. For instances where dependent children lose coverage as a result of loss of dependent eligibility, coverage may be continued until the earliest of:
    a. 36 months after continuation was elected;
    b. The date coverage is obtained under other health insurance coverage; or
    c. The date coverage would otherwise terminate under this Policy.
3. For instances of dissolution of marriage from the subscriber, coverage for the subscriber's spouse and dependent children may be continued until the earliest of:
    a. The date the former spouse becomes covered under other health insurance coverage; or
    b. The date coverage would otherwise terminate under this Policy.

In no event shall the amount of premium or fee contributions charged exceed 102 percent of the cost to the plan for such period of coverage for other similarly situated spouses and dependent children who are not the survivors of a deceased subscriber, without regard to whether such cost is paid by the employer or employee. Failure of the survivor to make premium payments within 90 days after notice of the requirement to pay the premiums shall be a basis for the termination of this Policy without written consent. In event of a termination by reason of the survivor's failure to make the required premium payment,

written notice of cancellation must be mailed to the survivor's last known address at least 30 days before the cancellation.

The member may also be eligible for a special enrollment period. If the subscriber was enrolled through MNsure, please contact MNsure for more information on special enrollment periods. See *Special enrollment periods and effective date of coverage* for more information.

II. 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).

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

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

Complaint: Means any grievance against 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 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 Commissioner of Commerce 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 one of the telephone numbers listed inside the front cover or by writing to the address listed below.

1. Complaints that do not involve a review by Medica of whether an item or service was medically necessary:

   a. For an oral complaint, if Medica does not communicate a decision within 10 calendar days from Medica's receipt of the complaint, or 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

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

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

   c. If Medica's internal review decision upholds the initial decision made by Medica, you have a right to submit a request for external review.

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

   a. Your complaint must be made within one year 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 within 15 days from receipt of your complaint. If Medica cannot provide its determination within 15 days, Medica may take an additional 4 days and will notify you of the extension and the reason relating to it.

   c. When an initial decision by 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 may have a right to submit a written request for external review as described in this section.

External review

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

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

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

You must submit your written request for external review within six months from the date of Medica's decision. A filing fee of $25 must accompany your written request, unless waived by the Commissioner. An independent review organization contracted with the State Commissioner of Administration will review your request. You may submit additional information that you want the review organization to consider. You will be notified of the review organization's decision within 45 days. The Department of Commerce will refund the filing fee if the review organization completely reverses Medica's decision. The external review decision will not be binding on you but will be binding on Medica. Medica may seek judicial review on grounds that the decision was arbitrary and capricious, involved an abuse of discretion or any other standard less favorable to the enrollee than a preponderance of the evidence. Contact the Commissioner of Commerce for more information about the external review process.

Under most circumstances, you must complete the internal review, described above, before you proceed to external review. You may proceed to external review without completing the internal review if 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. For complaints that involve a medical necessity review, you may request an expedited external review at the same time you request an expedited internal review. You may also request an expedited external review if Medica's decision involves a medical condition for which the standard external review time would seriously jeopardize your life, health or ability to regain maximum function, or if 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.

If Medica's decision involves a treatment that Medica considers investigative, the review organization will base its decision on all documents submitted by you and Medica, your provider's recommendation, consulting reports from health care professionals, your benefits under this Policy, federal FDA approval, and medical or scientific evidence or evidence-based standards.

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

Civil action

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

JJ. General Provisions

This section describes the general provisions of this Policy.

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

Examination of a member

During the pendency of a claim, for 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.

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.

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.

Notice

Except as otherwise provided in this Policy, written notice given by Medica will be deemed notice to all affected in the administration of this Policy in the event of termination or nonrenewal of this Policy.

However, notice of termination for nonpayment of premium shall be given by Medica to the subscriber.

Entire agreement

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

Amendment

This Policy may be amended in accordance with this Policy (see *Introduction*). When this happens, you will receive a new policy or amendment approved and signed by an executive officer of 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.

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 the Policy. In all other respects the subscriber and Medica will have the same rights under the Policy as they had immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with a reinstatement.

KK. 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.

Approved clinical trial. A phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other **life-threatening condition**, is not designed exclusively to test toxicity or disease pathophysiology, and is described in any of the following subparagraphs:

1. The study or investigation is conducted under an investigational new **prescription drug** application reviewed by the FDA.
2. The study or investigation is a **prescription drug** trial that is exempt from having such an investigational new **prescription drug** application.
3. The study or investigation is approved or funded by one of the following: (i) the National Institutes of Health (NIH), the Centers for Disease Control and Prevention, the Agency for Health Care Research and Quality, the Centers for Medicare and Medicaid Services or cooperating group or center of any of the entities described in this item; (ii) a cooperative group or center of the United States Department of Defense or the United States Department of Veterans Affairs; (iii) a qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants; or (iv) the United States Departments of Veterans Affairs, Defense, or Energy if the trial has been reviewed or approved through a system of peer review determined by the secretary to: (a) be comparable to the system of peer review of studies and investigations used by the NIH, and (b) provide an unbiased scientific review by **qualified individuals** who have no interest in the outcome of the review.

Benefits. The health services or supplies (described in this Policy and any subsequent amendments) approved by 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 FDA and related agencies.

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

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

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

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

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

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

When the wholesale amount is not known nor readily calculated at the time the **benefit** is provided, 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**.

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

1. Charge billed by the **provider** (i.e., retail) or
2. **Non-network provider reimbursement amount**.

For out-of-**network benefits**, in addition to any **coinsurance** and **deductible** amounts, you are responsible for any charges billed by the **provider** in excess of **the non-network provider reimbursement amount**, except as described in Your Rights and Protections Against Surprise Medical Bills at the end of this Policy.

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**.

For out-of-**network benefits**, in addition to any **coinsurance** and **deductible** amounts, you are responsible for any charges in excess of the **non-network provider reimbursement amount**, except as described in *Your Rights and Protections Against Surprise Medical Bills* at the end of this Policy.

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 **prescription drugs** that can usually be self-administered.

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

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

Dependent. Unless otherwise specified in this Policy:

1. The **subscriber's domestic partner** or legally married spouse
2. A child of the **subscriber,** the **subscriber's domestic partner** or legally married spouse who is a:
   a. Natural or adopted child
   b. Child **placed for adoption** with the **subscriber,** the **subscriber's domestic partner** or legally married spouse
   c. Stepchild
3. A newborn grandchild who is financially dependent upon the **subscriber** or the **subscriber's** covered spouse, and who resides with that **subscriber** or the **subscriber's** covered spouse continuously from birth.
4. A child under legal guardianship of the **subscriber,** the **subscriber's domestic partner** or **subscriber's** legally married 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. A condition or symptom (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, would believe requires immediate treatment to:

1. Preserve your life; or
2. Prevent serious impairment to your bodily functions, organs or parts; or
3. Prevent placing your physical or mental health (or, if you are pregnant, the health of your unborn child) in serious jeopardy.

Emergency facility. The **emergency** department of a **hospital** or an independent freestanding **emergency** department.

Enrollment date. The date of the **member's** first day of coverage under this Policy.

Extended hours home care. Extended hours home care (skilled nursing services) is continuous and complex skilled nursing services greater than two consecutive hours per day provided in the **member's** home. The intent of **extended hours home care** is to assist the **member** with complex, direct, skilled nursing care, to develop caregiver competencies through training and education, and to optimize the **member's** health status and outcomes. The skilled nursing tasks must be required so frequently that the need is continuous. The duration of

extended hours home care is temporary in nature and is not intended to be provided on a permanent ongoing basis.

Genetic testing. The analysis of human DNA, RNA, and chromosomes and those proteins and metabolites used to detect heritable or somatic disease-related genotypes or karyotypes for clinical purposes. A genetic test must be generally accepted in the scientific and medical communities as being specifically determinative for the presence, absence or mutation of a gene or chromosome in order to qualify under this definition. Genetic test does not include a routine physical examination or a routine analysis, including a chemical analysis, of body fluids unless conducted specifically to determine the presence, absence or mutation of a gene or chromosome.

Habilitative care. Health care services are considered habilitative when they are provided to help a person who has not learned or acquired a particular skill or function for daily living to learn, improve or keep such skill or function, as long as measurable progress can be documented.

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

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

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

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

Investigative. As determined by Medica, a **prescription 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 **prescription drug** or device has received final approval to be marketed for its proposed use by the 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 **prescription drug** being used for an indication or at a dosage that is an accepted off-label use for the treatment of cancer will not be considered by 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 **prescription drugs** and biologicals used off-label.

Life-threatening condition. Any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

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).

Mental health residential treatment services. Consistent with the member's diagnosis and presentation, and the level and intensity of care as indicated by external clinical guidelines, a licensed or certified residential mental health treatment program must provide the following:

1. A 24-hour per day, structured setting, inclusive of room and board; and
2. The program administers at least the following basic services:
    - A combination of group, family and individual counseling provided by a clinically or appropriately licensed mental health professional and or graduate level professional in process of obtaining licensure working under the oversight of licensed mental health practitioner;
    - On-site or virtual psychiatric assessment within 48 hours of admission;
    - Psychiatric follow-up visits at least once per week provided by a licensed psychiatric prescriber for mental health treatment, or psychiatric or medical follow-up visits as clinically indicated for substance use treatment;
    - Individual and or family therapy a minimum of once weekly provided by a licensed mental health professional for mental health treatment;

- Weekly client education (e.g. mindfulness, reflective journaling);
- Other services specific to mental health treatment and substance use treatment;
- Adequate nursing coverage for the specific level of care;
- A written, specific, and person-centered treatment plan with viable discharge planning to support ongoing recovery efforts.

Please note: Individual, family and group counseling/therapy that is provided must be based on evidence-based modalities with proven efficacy. Therapy provided using modalities with unproven efficacy must occur in addition to the evidence based practices.

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

Network. A term used to describe a **provider** (such as a **hospital**, **physician**, home health agency, **skilled nursing facility** or pharmacy) that has entered into a written agreement with 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.

Network health care facility. A **hospital**, **hospital** outpatient department, critical access **hospital**, or an ambulatory surgical center.

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 equal to the median of Medica's **network** contracted rates for the same or similar services in the geographic area in which the service is provided.

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**.

Except when the protections described in the *Surprise billing protections* apply, 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.

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**.

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 as described in *Surprise billing protections*. Charges in excess of the **non-network provider reimbursement amount** do not accumulate to your **deductible** or **out-of-pocket maximum**.

Non-skilled care. Care that does not require skilled nursing or rehabilitation staff to manage, observe or evaluate your care. Any service that could be safely performed by a non-medical person (or yourself) without the supervision of a nurse is considered **non-skilled care**.

Out-of-pocket maximum. The total of the **copayments**, **coinsurance**, and **deductible** paid for **benefits** received under this Policy during a calendar year. Unless otherwise specified, you will not be required to pay more than the **out-of-pocket maximum** for **benefits** received under this Policy 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**. 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.

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

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

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

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

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

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

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

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

1. evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force;
2. immunizations for routine use that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the **members** involved;
3. with respect to **members** who are infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;

4. with respect to **members** who are women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration (including FDA-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. For a list of **preventive health services** please visit **Medica.com/SignIn**.

Professionally administered prescription drugs. Professionally administered **prescription 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 **prescription drugs** that require intravenous infusion or injection, intrathecal infusion or injection, intramuscular injection or intraocular injection, as well as **prescription drugs** that, according to the manufacturer's recommendations, must typically be administered by a health care **provider**, to be **professionally administered prescription drugs**.

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

Qualified individual. (1) An individual who is eligible to participate in an **approved clinical trial** according to the trial protocol with respect to treatment of cancer or other **life-threatening conditions**, and (2) either (a) the referring health care professional is a **network provider** and has concluded that the individual's participation in the trial would be appropriate, or (b) the individual provides medical or scientific information establishing that their participation would be appropriate.

Reasonable expectation of improvement. A reasonable expectation that the **member's** condition will improve over a predictable period of time according to generally accepted standards in the medical community.

Reconstructive. Surgery to rebuild or correct a:

1. Body part when such surgery is incidental to or following surgery resulting from injury, sickness or disease of the involved body part; or
2. Congenital disease or anomaly which has resulted in a functional defect as determined by your **physician**.

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

Rehabilitative. Physical, occupational and speech therapy services are considered **rehabilitative** when they are provided to restore physical function or speech that has been impaired due to illness or injury.

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

Restorative. Surgery to rebuild or correct a physical defect that has a direct adverse effect on the physical health of a body part, and for which the restoration or correction is **medically necessary**.

Retail health clinic. Professional evaluation and medical management services provided to patients in a health care clinic located in a setting such as a retail store, grocery store or

pharmacy. Services include treatment of common illnesses and certain preventive health services.

Routine patient costs. All items and services that would be covered **benefits** if not provided in connection with a clinical trial. In connection with a clinical trial, **routine patient costs** do not include an **investigative** or experimental item, device or service; items or services provided solely to satisfy data collection and analysis needs and not used in clinical management; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

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

Skilled care. A type of health care given when you need skilled nursing or rehabilitation staff to manage, observe and evaluate your care. Nursing, physical therapy and occupational therapy are considered **skilled care**. In addition to providing direct care, these professionals manage, observe and evaluate your care. Any service that could be safely done by a non-medical person (or by yourself) without the supervision of a nurse is not considered **skilled care**.

Skilled nursing facility. A licensed bed or facility (including an extended care facility, **hospital** swing-bed and transitional care unit) that provides skilled nursing care, skilled transitional care or other related health services including **rehabilitativ**e services.

Special enrollment period. A time outside of the annual open enrollment period during which individuals and their qualified **dependents** are able to sign up for coverage. Individuals and/or qualified **dependents** are only eligible for a special enrollment period if they experience certain specified events. Please see *Enrollment*, for more information about **special enrollment periods**.

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

Store-and-forward technology. The asynchronous electronic transfer or transmission of a **member's** medical information or data from an originating site to a distant site for the purposes of diagnostic and therapeutic assistance in the care of a **member**.

Subscriber. The person to whom this Policy is issued.

Substance use disorder residential treatment services. Substance use disorder residential treatment services are services from a licensed chemical dependency rehabilitation program that provides intensive therapeutic services following detoxification.

1. A 24-hour per day, structured setting, inclusive of room and board; and
2. The program administers at least the following basic services:

    - A combination of group, family and individual counseling provided by a clinically or appropriately licensed mental health professional and or graduate level professional in process of obtaining licensure working under the oversight of licensed mental health professional.
    - Completion of a substance use disorder or chemical health assessment
    - Access to psychiatric services provided by a licensed psychiatric prescriber for mental health treatment as clinically indicated for substance use treatment
    - Individual and or family therapy a minimum of once weekly provided by a licensed mental health professional for substance use disorder or mental health treatment.

- Weekly client education (e.g. mindfulness, reflective journaling, sleep hygiene, anger management or safe sex practices.
- Other services specific to mental health treatment and or substance use treatment.
- Adequate nursing coverage for the specific level of care
- A written, specific, and person-centered treatment plan with viable discharge planning to support ongoing recovery efforts.

Please note: Individual, family and group counseling/therapy that is provided must be based on evidence-based modalities with proven efficacy. Therapy provided using modalities with unproven efficacy must occur in addition to the evidence-based practices.

Telehealth. Telehealth, sometimes referred to as telemedicine, is the delivery of health care services or consultations through the use of two-way interactive audio and visual communications to provide support or health care delivery and facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a **member's** health care. **Telehealth** includes the application of secure video conferencing, **store-and-forward technology**, and synchronous interactions between a **member** located at an originating site and a **provider** located at a distant site. An originating site includes a site at which a **member** is located at the time the services are provided by means of **telehealth**. Distant site means a site at which a **provider** is located while providing health care services or consultations by means of **telehealth**. A communication between a **provider** and a **member** that consists solely of an e-mail or facsimile transmission does not constitute **telehealth** consultations or services. **Telehealth** does not include communication between **providers** that consists solely of a telephone conversation, e-mail, or facsimile transmission. **Telehealth** does not include **telemonitoring services**.

Until July 1, 2023, **telehealth** includes audio-only communication between a **provider** and a **member** if the communication is a scheduled appointment and the standard of care for that particular service can be met through the use of audio-only communication. However, substance use disorder treatment services and mental health care services delivered through **telehealth** by means of audio-only communication may be covered without a scheduled appointment if the communication was initiated by the **member** while in an **emergency** or crisis situation and a scheduled appointment was not possible due to the need of an immediate response. This paragraph expires July 1, 2023.

Telemonitoring services. The remote monitoring of clinical data related to the **member's** vital signs or biometric data by a monitoring device or equipment that transmits the data electronically to a **provider** for analysis. Telemonitoring is intended to collect a **member's** health-related data for the purpose of assisting a **provider** in assessing and monitoring the **member's** medical condition or status.

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 by a **virtual care provider**. **Virtual care** is used to address non-emergent medical symptoms for **members** for a subset of non-emergent infections and illnesses 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 drug** to a pharmacy.

LL. Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by a non-network provider at a network hospital or network health care facility, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a physician or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Non-network" describes providers and facilities that haven't signed a contract with your health plan. Non-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at a network health care facility but are unexpectedly treated by a non-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from a non-network provider or emergency facility, the most the provider or emergency facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at a network hospital or network health care facility

When you get services from a network hospital or network health care facility, certain providers there may be non-network providers. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

Ending surprise air ambulance bills

Air ambulance transportation that is provided to you by non-network providers will be covered at in-network cost sharing rates. Non-network air ambulance providers can't balance bill you. They can only bill you for the usual cost-sharing amount set by your plan. In addition, in-network cost sharing for out-of-network services must be applied to your in-network deductible/out-of-pocket maximum.

External review

If you believe you have been wrongly billed, you may request an independent review of Medica's decision by an external review organization by contacting Minnesota Department of

Commerce at **(651) 539-1600 or 1 (800) 657-3602**. For more information about external review, see *Complaints*.

Visit **cms.gov/NoSurprises/Consumers** for more information about your rights under federal law.