MEDICA®

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MEDICA HEALTH PLANS EMPLOYEE BENEFIT PLAN HEALTH AND WELFARE BENEFITS PLAN DOCUMENT

Administered by Medica Self-Insured

MEDICA HEALTH PLANS

FAIRVIEW AND NORTH MEMORIAL VANTAGE WITH MEDICA 2750-20% HSA

BPL #28855

GROUP #10876

JANUARY 1, 2015

MEDICA CUSTOMER SERVICE

Minneapolis/St. Paul Metro Area:
1-855-569-7526

TTY Users: National Relay Center:
1-800-855-2880 then ask them to dial Medica at
1-855-569-7526

Find more information about your benefits by logging on to mymedica.com.

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[illegible] Medica

Yoo odeeyssi kun bilashitti afaan keetitti akka sii hiikamu feete lakkoofsa caaardiii meedikaa (Medica) gama dubaarra jiru kana bilbili.

Если вам нужна помощь в переводе этой информации, позвоните по номеру, указанному на обратной стороне вашей медецинской карточки плана Medica.

[illegible] Medica ។

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Dine k'ehji shich'i' hadoodzih ninizingo, beesh bee hane'e binumber naaltsoos bikaahigii bich'i' hodiilnih ei doodaii bee neehozin biniiye nanitinigii bine'dee bikaa doo aldo'.

Para sa tulong sa Tagalog, tawagan ang numerong kabilang sa dokumentong ito o sa likod ng iyong ID card.

若需要中文协助，请拨打本文件内或您会员卡背面的电话号码。

UNV1011

If you want free help translating this information, call the number on the back of your Medica identification card.

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Table of Contents

Introduction 4

What you must do to be eligible for benefits 4
If you need language interpretation 5
Medica's nondiscrimination policy 5
Health savings accounts 5

Plan Overview 6

General plan information 6
Funding 7
Method of calculating the amount of contribution 7
Benefits 7
Post-mastectomy coverage 8
HIPAA compliance 8

ERISA Information 10

Statement of ERISA rights 10

Before You Access Care 12

Provider network 12
Prior authorization 12
Standing referrals to non-network providers 13
Benefits 14
Claims 15
Travel program 15
Continuity of care 15

Benefits & Coverage 17

Deductibles, Out-of-Pocket Maximums, and Lifetime Maximum 17
Covered benefits and the amounts you pay 19
Ambulance 20
Anesthesia 20
Behavioral Health – Mental Health 21
Behavioral Health – Substance Abuse 23
Clinical Trials 25
Durable Medical Equipment, Prosthetics, and Medical Supplies 25
Emergency Room Care 28
Genetic Testing and Counseling 29
Home Health Care 30
Hospice Services 32
Hospital Services 33
Infertility Treatment 34
Lab and Pathology 35
Medical-Related Dental Services 36
Physical, Speech, and Occupational Therapies 39
Physician Services 41
Pregnancy – Maternity Care 45
Prescription Drugs 47
Prescription Specialty Drugs 50

Preventive Health Care....51
Reconstructive and Restorative Surgery....53
Skilled Nursing Facility....54
Temporomandibular Joint (TMJ) and Craniomandibular Disorder....55
Transplant Services....56
Weight Loss Surgery....58
X-Ray and Other Imaging....59

Covered Health Services....60

Ambulance services....60
Behavioral health – mental health....60
Behavioral health – substance abuse....61
Durable medical equipment, prosthetics, and medical supplies....62
Emergency room care....63
Home health care....63
Hospice services....63
Infertility treatment....64
Medical-related dental services....64
Newborn coverage....64
Pregnancy – maternity care....65
Newborns' and Mothers' Health Protection Act of 1996....66
Physician services....66
Post-mastectomy coverage....66
Prescription drugs....66
Prescription specialty drugs....68
Transplant services – organ and bone marrow....70
Weight loss surgery....71

Exclusions....72

Role of Medica....76

Network providers....76
Withhold arrangements....77
Non-network providers....77

Harmful Use of Medical Services....78

When this section applies....78

How to Submit a Claim....79

Claims for benefits from network providers....79
Claims for benefits from non-network providers....79
Claims for services provided outside the United States....79
Time limits....80

Coordination of Benefits....81

Applicability....81
Definitions that apply to this section....81
Order of benefit determination rules....82
Effect on the benefits of this plan....84
Right to receive and release needed information....84
Facility of payment....85
Right of recovery....85

Right of Recovery **86**
Subrogation 86
Reimbursement 87
Consequences 88
Eligibility and Enrollment **89**
Who can enroll 89
How to enroll 89
Initial enrollment and effective date of coverage 89
Open enrollment and effective date of coverage 90
Special enrollment and effective date of coverage 90
Qualified Medical Child Support Order (QMCSO) 93
Ending Coverage **95**
When your coverage ends 95
Continuation **97**
Your right to continue coverage under federal law 97
Other continuation coverage 102
Insurability 103
Complaints **104**
Claim denials 104
First level of review 104
External review 105
Your right to take legal action 105
Other complaints 105
General Provisions **106**
Definitions **108**
Signature **119**

Introduction

See **Definitions** at the end of this document for defined terms and phrases.

This plan is offered as named on the cover of this Plan Document. Medica Health Plans (sponsor) has established the Medica Health Plans Employee Benefit Plan (plan) through which medical benefits are provided to certain employees and their dependents. The plan is administered by Medica Health Plans (plan administrator). This plan was originally established January 1, 2002. This restatement of the plan is effective January 1, 2015 unless specifically stated otherwise.

The plan is an employee welfare benefit plan within the meaning of the Employee Retirement Income Security Act of 1974 (ERISA). **This document serves both as the written plan document and the summary plan description (SPD).** The plan is a self-insured medical plan generally intended to meet the requirements of Section 106 and Section 105(h) of the Internal Revenue Code of 1986 (Code).

When changes are made to the plan, the plan administrator will notify enrollees or covered persons as required by law and those individuals will receive a new plan or an amendment to this plan.

In this plan, the words you, your, and yourself refer to the covered person. The word sponsor refers to the organization through which you are eligible for coverage.

This plan defines benefits and describes the health services for which you have coverage and the procedures you must follow to obtain in-network coverage. Coverage is subject to all terms and conditions of the plan. As a condition of coverage under the plan, you must consent to the release and re-release of medical information necessary for the administration of this plan. The confidentiality of such information will be maintained in accordance with existing law.

Because many provisions are interrelated, you should read this plan 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.

What you must do to be eligible for benefits

Each time you receive health services, you must:

1. Identify yourself as a covered person under the plan; and
2. Present your plan identification card. However, possession and use of a plan identification card does not necessarily 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 covered person under the plan within 180 days of the date of service, you may be responsible for paying the cost of the service you received.

If you need language interpretation

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

If you have an impairment that requires alternative communication formats such as Braille or large print, please call Customer Service at one of the telephone numbers listed inside the front cover to request these materials.

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

Medica's nondiscrimination policy

Medica's policy is to treat all persons alike, without distinctions based on race, color, creed, religion, national origin, gender, marital status, status with regard to public assistance, disability, sexual orientation, age, genetic information, or any other classification protected by law.

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

Health savings accounts

This coverage is intended to comply with the requirements of the Internal Revenue Code section 223 for a federally qualified high deductible health plan. This coverage may qualify you to make a pre-tax contribution to a health savings account. You are responsible for the cost of all health services, other than preventive care, up to the deductible amount.

Plan Overview

The information contained in this section of the plan provides general information regarding the plan required to be disclosed by ERISA. It is important to remember that this section of the plan is only an overview. You also need to refer to the section that describes a particular plan requirement in detail.

Language interpretation services will be provided upon request, as needed in connection with the interpretation of this document. Please contact Customer Service to make such a request. **If this plan is translated into another language, this written English version governs all coverage decisions.**

General plan information

ERISA requires the plan administrator to disclose certain information about the plan and various entities with responsibilities under the plan.

Plan Name

Medica Health Plans Employee Benefit Plan

Sponsoring Employer (Sponsor), Address, and Telephone Number of Sponsor

Medica Health Plans
401 Carlson Parkway
PO Box 9310
Minneapolis, MN 55440-9310
(952) 992-3888

Plan Administrator, Business Address, and Business Telephone Number of Plan Administrator

Medica Health Plans
401 Carlson Parkway
PO Box 9310
Minneapolis, MN 55440-9310
(952) 992-3888

Agent for Service of Legal Process

Senior Vice President of Human Resources

Sponsor IRS Employer Identification Number (EIN)

41-1242261

Plan Year

January 1 through December 31

Plan Number

501

Type of Welfare Plan

Medical

Type of Administration

Self-insured

The sponsor has entered into a service agreement with Medica Self-Insured (Medica) under which Medica performs a variety of administrative services with respect to the medical benefits provided under the plan. The agreement is for administrative services only. Medica does not insure the provision of benefits under the plan; Medica is not a health insurer.

Name and Address of Claims Administrator

Medica Self-Insured
401 Carlson Parkway
Minnetonka, MN 55305

Funding

Benefits under the plan are paid from the general assets of sponsor. You may be responsible for a portion of the cost of the coverage provided under this plan. The portion of the cost of coverage for which the enrollee is responsible may be paid on a pre-tax basis through a cafeteria plan of sponsor if such a plan is made available by sponsor.

Method of calculating the amount of contribution

Actuarial analysis by an independent firm.

Benefits

Plan benefits are furnished in accordance with this plan, which is issued by the plan administrator. This plan provides an explanation of the benefits offered by the plan. If there is a conflict between any other document and the plan document, the plan document shall govern.

The benefits described in this plan document detail the medical benefits available under the plan. **Benefits & Coverage** describes the coinsurance and deductible amounts that impact how much the plan pays and how much you pay. The procedures to be followed in obtaining benefits or presenting claims for benefits under the plan and seeking remedies for redress of claims that are denied in whole or in part are described in this plan.

This plan covers medically necessary health services as described throughout the plan. Please pay particular attention to the benefits that have limitations. Some benefits require that certain

things be done first (i.e., prior authorization be obtained). Not following these requirements may impact whether benefits are paid under this plan. Additionally, you consent to the release and re-release of medical information necessary for the administration of this plan as a condition of coverage under this plan. Certain services are specifically excluded from coverage under this plan. The fact that a provider recommends or orders services does not always mean the services are covered or medically necessary. For additional details, see **Exclusions**. This plan coordinates the benefits it provides with other coverage and/or other sources of payment. For additional details, see **Right of Recovery**.

Post-mastectomy coverage

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

HIPAA compliance

This plan will be administered in a manner consistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and all implementing regulations. The HIPAA privacy standards address disclosure to a plan sponsor of protected health information (or PHI). The sponsor may use or disclose PHI received from the plan or from another party acting on behalf of the plan for certain limited purposes. These include health care operations purposes and health care payment purposes relating to the plan. However, with respect to such PHI, the sponsor agrees as follows:

1. The sponsor will not use or further disclose such PHI other than as permitted or required by this plan or as required by law (as defined in the HIPAA privacy standards).
2. The sponsor will ensure that any agents, including a subcontractor, to whom the sponsor provides PHI received from the plan or from another party acting on behalf of the plan, agree to the same restrictions and conditions that apply to the sponsor with respect to such PHI.
3. The sponsor will not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the sponsor, except under an authorization which meets the requirements of the HIPAA privacy standards.
4. The sponsor will report to the plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the sponsor becomes aware.
5. The sponsor will make available PHI in accordance with your right of access under the HIPAA privacy standards.
6. The sponsor will make available PHI for amendment and incorporate any amendments to PHI in accordance with the HIPAA privacy standards.

7. The sponsor will make available the information required to provide an accounting of certain disclosures of PHI in accordance with the HIPAA privacy standards.

8. The sponsor will make its internal practices, books, and records relating to the use and disclosure of PHI received from the plan or another party on behalf of the plan, available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the plan with the HIPAA privacy standards.

9. If feasible, the sponsor will return or destroy all PHI received from the plan, or another party acting on behalf of the plan, that the sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made. If such return or destruction is not feasible, the sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.

10. The sponsor will ensure that adequate separation between the plan and the sponsor is established as follows:

    a. Only the following persons under control of the sponsor may be given access to the PHI that is disclosed:

       Compensation & Benefits Specialist; Senior Benefits Analyst; Manager, HR Operations; Director, Human Resources and Human Resources Officer

    b. The access to and use of PHI by the persons described above is restricted to the plan administration functions that the sponsor performs for the plan.

    c. If any of the persons described above do not comply with the above provisions relating to HIPAA compliance, the sponsor will impose sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions may be imposed progressively (for example, an oral warning, a written warning, time off without pay, and termination), if appropriate. Sanctions, when imposed, will be commensurate with the severity of the violation.

11. The HIPAA security standards govern the security of electronic protected health information created, received, maintained or transmitted by the plan. The sponsor agrees as follows:

    a. The sponsor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains or transmits on behalf of the plan.

    b. The sponsor will ensure that the adequate separation required by the HIPAA privacy standard is supported by reasonable and appropriate security measures.

    c. The sponsor will ensure that any agent, including a subcontractor, to whom it provides electronic protected health information, agrees to implement reasonable and appropriate security measures to protect the information.

    d. The sponsor will report to the plan any security incident of which it becomes aware.

ERISA Information

Statement of ERISA rights

The Employee Retirement Income Security Act of 1974 (ERISA) guarantees certain rights and protection to participants of benefit plans and certain others. Federal law and regulations require that a “Statement of ERISA Rights” be included in this description of the plan for the sponsor. For purposes of this Statement of ERISA Rights only, the terms *you* and *your dependents* refer to enrollees and covered persons who have such rights and protections under ERISA.

You may examine, without charge, all plan documents, including any insurance contracts, collective bargaining agreements, annual reports, summary plan descriptions, and other documents filed with the Department of Labor. You may examine copies of these documents in the plan administrator’s office, or you may ask a supervisor where copies of the documents are available.

If you want a personal copy of plan documents or related material, you should send a written request to the plan administrator. You will be charged only a reasonable charge for the copies.

You are entitled to receive a summary of the plan’s annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

You or your dependents are entitled to continue coverage under the plan if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review this plan for information regarding COBRA continuation coverage rights.

You should be provided a certification of creditable coverage, free of charge, from the plan when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. To request a certification of creditable coverage, contact Customer Service at one of the telephone numbers listed inside the front cover. Upon receipt of your request, the certification of creditable coverage will be issued as soon as reasonably possible.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the benefit plan. These individuals, called *fiduciaries*, have an obligation to administer the plan prudently and to act in the interest of plan participants and beneficiaries. The named fiduciary for this plan is the plan administrator. No one, including your employer, union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from receiving benefits or exercising your rights under ERISA.

When you become eligible for payments from the plan, you should follow the appropriate steps for filing a claim. In case of claim denial, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the plan administrator review and reconsider the claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan to provide you the materials and pay you up to $110.00 per day until you receive your materials, unless the materials were not sent because of reasons beyond the control of the plan administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file a suit in a state or federal court, subject to any binding arbitration requirements contained in the plan. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay costs and legal fees. For example, if you are successful, the court may order the person you sued to pay those costs and fees. If you lose or if the court finds your suit to be frivolous, you may be ordered to pay these costs and fees.

If you have any questions about the plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Before You Access Care

This section provides information for you to consider before you access care.

Provider network

In-network benefits are available through your provider network. To see which providers are in your plan's network, check the online search tool on mymedica.com or contact Customer Service. Certain providers may be in other Medica networks, but not in your network.

While a particular provider may be in your provider directory at the time you enroll, it is not guaranteed that this provider will be available to provide you with health services or will remain a network provider.

If you access services from providers that are not in your network, out-of-network benefits will apply.

Prior authorization

Note: Prior authorization 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 plan applicable on the date you receive services.

Prior authorization from the plan may be required before you receive certain services or supplies to determine whether a particular service or supply is medically necessary and is a covered benefit. This applies even when the services are provided by a network provider or provided as the result of a referral or direction by a network provider. To determine whether a specific service or supply requires prior authorization, please call Customer Service at one of the telephone numbers listed inside the front cover or sign in at mymedica.com. Emergency services do not require prior authorization.

You, someone on your behalf, or your attending provider may contact Customer Service to request prior authorization. Your network provider will contact Customer Service to request prior authorization for a service or supply. You must contact Customer Service to request prior authorization for services or supplies received from a non-network provider. If a network provider fails to obtain prior authorization after you have consulted with them about services requiring prior authorization, you are not subject to a penalty for failure to obtain prior authorization.

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

- Reconstructive or restorative surgery;
- Certain drugs;
- Home health care;
- Medical supplies and durable medical equipment;
- Outpatient surgical procedures;

- Certain genetic tests; and
- Skilled nursing facility services.

Prior authorization is always required for:

- Organ and bone marrow transplant services; and
- In-network benefits for services from non-network providers, with the exception of emergency services.

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, a letter of medical necessity from your provider); and
- Other applicable covered person information (i.e., plan identification number).

Medica uses written procedures and criteria when reviewing your request for prior authorization. Medica will review your request and provide a response to you and your attending provider within 10 business days after the date your request was received, provided all information reasonably necessary to make a decision has been made available to Medica.

Both you and your provider will be informed of the decision as soon as the medical condition warrants, not to exceed 72 hours from the time of the initial request if your attending provider believes that an expedited review is warranted, or if it is concluded that a delay could seriously jeopardize your life, health, or ability to regain maximum function, or subject you 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**.

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**).

Standing referrals to non-network providers

A standing referral is a referral issued by a network provider for conditions that require ongoing services from a specialist provider. Standing referrals to non-network providers are available if the services you need are not reasonably available from a network provider. In this situation, in-network benefits will apply to the services described in the referral. You may apply for and, if

appropriate, receive a standing referral for: 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.

Standing referrals will only be provided for the period of time appropriate to your medical condition. Standing referrals will not be issued to accommodate personal preferences, family convenience, or other non-medical reasons.

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

Benefits

In general, eligible health services and supplies are covered as in-network benefits only if they're provided by network providers, provided by a non-network provider to whom you were specifically directed by a network provider, or if Medica authorizes them.

Under certain circumstances, Medica will authorize non-network provider services at the in-network benefit level. Such authorizations are generally provided only in situations where the requested services aren't available from network providers.

Be aware that if you use out-of-network benefits, you will likely have to pay much more than if you use in-network benefits. The charges billed by the non-network provider may exceed what Medica would pay them, leaving a balance for you to pay *in addition to* any applicable coinsurance and deductible amount. This additional amount you must pay to the provider will *not* be applied toward your out-of-pocket maximum amount. You will owe this amount regardless of whether you previously reached your out-of-pocket maximum. **Please see the example calculation below.**

It is important that you do the following before receiving services from a non-network provider:

- Discuss the expected billed charges with the non-network provider; and
- Contact Customer Service to verify the estimated amount Medica would pay for those services; and
- Calculate your likely out-of-pocket expenses.

An example of how to calculate your out-of-pocket costs*

Scenario:

You choose to receive non-emergency inpatient care at a non-network hospital without having been specifically directed there by a network provider or having an authorization from the plan. The out-of-network benefits apply to these services.

Assumptions:

1. You have previously satisfied your deductible.
2. The non-network hospital bills $30,000 for your hospital stay.

3. Medica's non-network provider reimbursement amount for those hospital services is $15,000.

    a. You must pay a portion of this amount, generally as a percentage coinsurance. In this scenario, we will use 40% coinsurance.

    b. In addition, the non-network provider will likely bill you for the amount that their charge exceeds what Medica reimburses them.

4. For this non-network hospital stay, you will be required to pay:

    - 40% coinsurance (40% of $15,000 = $6,000) and
    - The provider's 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.

    The $6,000 amount you pay as coinsurance *will* be applied to your out-of-pocket maximum.

    The $15,000 amount you pay for billed charges in excess of the non-network provider reimbursement amount *will not* be applied toward the out-of-pocket maximum.

You will owe the provider this $15,000 amount regardless of whether you have previously reached your out-of-pocket maximum.

***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.

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.

Travel program

The plan has made arrangements for you to receive medically necessary services at the in-network benefit level when you are traveling outside the service area and do not have access to a network provider. Travel program coverage is subject to all of the terms and conditions set forth in this plan. Call Customer Service at one of the telephone numbers listed inside the front cover to confirm that your provider is a travel program provider, and present your identification card at the time of service. This program is not available for all services (i.e., virtual care or chiropractic services) and may not be available in all areas.

Continuity of care

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

In certain situations, you have a right to continuity of care:

1. If your current provider is terminated without cause, you may be eligible to continue care with that provider at the in-network benefit level.
2. If you are new to Medica as a result of the sponsor changing its third party administrator and your current provider is not a network provider, you may be eligible to continue care with that provider at the in-network benefit level.

This applies only if your provider agrees to comply with the prior authorization requirements, provide all necessary medical information related to your care, and accept as payment in full the lesser of the network provider reimbursement or the provider's customary charge for the service. This does not apply when a provider's contract is terminated for cause.

Upon request, the plan will authorize continuity of care for up to 120 days as described in 1. and 2. above for the following conditions:

- an acute condition;
- a life-threatening mental or physical illness;
- pregnancy beyond the first trimester of pregnancy;
- a physical or mental disability defined as an inability to engage in one or more major life activities, provided that the disability has lasted or can be expected to last for at least one year, or can be expected to result in death; or
- a disabling or chronic condition that is in an acute phase.

Authorization to continue to receive services from your current provider may extend to the remainder of your life if a physician certifies that your life expectancy is 180 days or less.

Upon request, Medica will authorize continuity of care for up to 120 days as described in 1. and 2. above in the following situations:

- if you are receiving culturally appropriate services and a network provider who has special expertise in the delivery of those culturally appropriate services is not available; or
- if you do not speak English and a network provider who can communicate with you, either directly or through an interpreter, is not available.

The plan 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 the plan authorizes your request to continue care with your current provider, the plan 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, the plan will explain the criteria used to make its decision. You may appeal this decision.

Benefits & Coverage

This section describes the services eligible for coverage and the expenses that are your responsibility to pay.

More detail about the services, procedures, drugs, and supplies that are covered can be found in **Covered Health Services**.

DEDUCTIBLES, OUT-OF-POCKET MAXIMUMS, AND LIFETIME MAXIMUM

Deductibles

Your plan may require that you meet a deductible amount before your claims for services are covered. The table below will indicate whether or not your plan has a deductible and where it will apply.

Out-of-pocket maximum

Your out-of-pocket maximum is an accumulation of coinsurance and deductibles that you paid for benefits received during the calendar year. Unless otherwise specified, you won't be required to pay more than this amount.

Please note: Charges for services that aren't covered and charges a non-network provider bills you that are in excess of the non-network provider reimbursement amount will not apply toward your out-of-pocket maximum. You will owe these amounts even if you had already reached your out-of-pocket maximum with amounts paid for other services.

Lifetime maximum amount

This is the maximum amount the sponsor will pay for covered out-of-network services that you receive while you are covered under this plan or any and all other benefit plans, programs, or arrangements offered by the sponsor. Any lifetime maximum dollar limit referenced pertains only to those health care services and supplies that are not essential health benefits as defined in the Patient Protection and Affordable Care Act, including any amendments, regulations, rules, or other guidance issued with respect to the Act. Note, that if you reach a lifetime benefit maximum under one benefit package, option, plan, program, or arrangement offered by sponsor and either change packages, options, plans, programs, or arrangements offered by sponsor at open enrollment or under a special enrollment opportunity, the amounts paid for benefits under the first benefit package, option, plan, program, or arrangement will carry forward and count towards the applicable lifetime maximum benefit under the second benefit package, option, plan, program, or arrangement offered by sponsor. In other words, the lifetime maximum does not start anew.

Deductibles, Out-Of-Pocket Maximums, and Lifetime Maximum		
	Your cost if you visit an:	
	In-network provider	**Out-of-network provider**
Coinsurance	See specific benefit for applicable coinsurance.	
Deductible		
Per covered person	$2,750	$4,500
Per family	$5,500	$10,000
When covered persons in a family unit (an enrollee and his or her dependents) have together paid the applicable per family deductible for benefits received during a calendar year, then all covered persons of the family unit are considered to have satisfied the applicable per family deductible for that calendar year.		
Out-of-pocket maximum		
Per covered person	$5,500	$10,000
Per family	$11,000	$20,000
When covered persons in a family unit (an enrollee and his or her dependents) have together met the applicable per family out-of-pocket maximum for benefits received during the calendar year, then all covered persons of the family unit are considered to have met the applicable per family out-of-pocket maximum for that calendar year.		
Lifetime maximum amount payable per covered person	Unlimited	$1,000,000. Applies to all benefits you receive under this plan or that you have received under another benefit package, option, plan, program, or arrangement offered by sponsor prior to participation in this plan.

Covered benefits and the amounts you pay

Important information

- Prior authorization from the plan may be required before you receive some services or supplies, even if a provider has directed or recommended that you receive them. Call Customer Service at one of the telephone numbers listed inside the front cover for a complete list of services and supplies that require Medica's prior authorization. See **Before You Access Care** for more information about the prior authorization process.
- For out-of-network benefits, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. These charges will not be applied toward satisfaction of the deductible or the out-of-pocket maximum. Please see **Benefits** in **Before You Access Care** for more information and an example calculation of out-of-pocket costs associated with out-of-network benefits.
- Any day, visit, or service limitation in this section includes days, visits, or services that you pay for in order to satisfy any part of your applicable deductible.

AMBULANCE

See **Covered Health Services** for more information about ambulance services.

Ambulance		
	Your cost if you visit an:	
Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
1. Emergency ambulance services or emergency ambulance transportation	20% coinsurance	Covered as an in-network benefit.
2. Non-emergency licensed ambulance service – see eligibility criteria below	20% coinsurance	40% coinsurance

Non-emergency ambulance transportation, that's arranged through an attending physician, is eligible for in-network coverage when it is:

1. Provided by a network provider; or
2. Provided by a non-network provider to whom you have been specifically directed by a network provider.

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 above.

ANESTHESIA

Anesthesia services can be received from a provider during an office visit, an outpatient hospital visit, an ambulatory surgical center visit, or during an inpatient stay.

Anesthesia		
	Your cost if you visit an:	
Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
1. Anesthesia services received in a non-inpatient setting	20% coinsurance	40% coinsurance
2. Anesthesia services received during an inpatient stay	20% coinsurance	40% coinsurance

BEHAVIORAL HEALTH – MENTAL HEALTH

Prior authorization. For in-network and out-of-network mental health prior authorization benefit requirements, call the designated mental health/substance abuse provider for your network at 1-800-848-8327 or TTY users, please contact: National Relay Center at 1-800-855-2880, then ask them to dial the designated mental health/substance abuse provider at 1-866-567-0550.

See **Covered Health Services** for more information.

Behavioral Health – Mental Health		
	Your cost if you visit an:	
Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
1. Office visits, including evaluations, diagnostic, and treatment services	20% coinsurance	40% coinsurance
2. Intensive outpatient programs	20% coinsurance	40% coinsurance

Behavioral Health – Mental Health		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
3. Inpatient services (including residential treatment services) **Note:** These services include inpatient services in a licensed residential treatment facility for treatment of emotionally disabled children.		
a. Room and board	20% coinsurance	40% coinsurance
b. Hospital or facility-based professional services	20% coinsurance	40% coinsurance
c. Attending psychiatrist services	20% coinsurance	40% coinsurance
d. Partial program	20% coinsurance	40% coinsurance

Not covered:

1. Services for mental disorders not listed in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM).
2. Services, care, or treatment that is not medically necessary.
3. Relationship counseling.
4. Family counseling services in the absence of a clinical diagnosis.
5. Services for telephone psychotherapy.
6. Services beyond the initial evaluation to diagnose intellectual or learning disabilities, as those conditions are defined in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM).
7. Services, including room and board charges, provided by health care professionals or facilities that are not appropriately licensed, certified, or otherwise qualified under state law to provide mental health services. This includes, but is not limited to, services provided by mental health providers who are not authorized under state law to practice independently, and services received from a halfway house, housing with support, therapeutic group home, boarding school, or ranch.

8. Services to assist in activities of daily living that do not seek to cure and are performed regularly as a part of a routine or schedule.
9. Room and board charges associated with mental health residential treatment services providing less than 30 hours a week per individual of mental health services, or lacking an on-site medical/psychiatric assessment within 48 hours of admission, psychiatric follow-up visits at least once per week, and 24-hour nursing coverage.

BEHAVIORAL HEALTH – SUBSTANCE ABUSE

Prior authorization. For prior authorization requirements of in-network and out-of-network benefits, call the designated mental health/substance abuse provider for your network at 1-800-848-8327 or TTY users, please contact: National Relay Center at 1-800-855-2880, then ask them to dial the designated mental health/substance abuse provider at 1-866-567-0550.

See **Covered Health Services** for more information.

Behavioral Health – Substance Abuse		
	Your cost if you visit an:	
Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
1. Office visits, including evaluations, diagnostic, and treatment services	20% coinsurance	40% coinsurance
2. Intensive outpatient programs	20% coinsurance	40% coinsurance
3. Opiate replacement therapy	20% coinsurance	40% coinsurance
4. Inpatient services (including residential treatment services)		
a. Room and board	20% coinsurance	40% coinsurance
b. Hospital or facility-based professional services	20% coinsurance	40% coinsurance
c. Attending physician services	20% coinsurance	40% coinsurance

Not covered:

1. Services for substance abuse disorders not listed in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM).
2. Services, care, or treatment that is not medically necessary.
3. Services to hold or confine a person under chemical influence when no medical services are required, regardless of where the services are received.
4. Telephonic substance abuse treatment services.
5. Services, including room and board charges, provided by health care professionals or facilities that are not appropriately licensed, certified, or otherwise qualified under state law to provide substance abuse services. This includes, but is not limited to, services provided by mental health or substance abuse providers who are not authorized under state law to practice independently, and services received from a halfway house, therapeutic group home, boarding school, or ranch.
6. Room and board charges associated with substance abuse treatment services providing less than 30 hours (15 hours for children and adolescents) a week per individual of chemical dependency services, including group and individual counseling, client education, and other services specific to chemical dependency rehabilitation.
7. Services to assist in activities of daily living that do not seek to cure and are performed regularly as a part of a routine or schedule.

CLINICAL TRIALS

Approved clinical trials, as defined in **Definitions**, are covered.

Clinical Trials		
	Your cost if you visit an:	
Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
1. 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.

DURABLE MEDICAL EQUIPMENT, PROSTHETICS, AND MEDICAL SUPPLIES

See **Covered Health Services** for more information about durable medical equipment, prosthetics, and medical supplies.

Durable Medical Equipment, Prosthetics, and Medical Supplies		
	Your cost if you visit an:	
Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
1. Durable medical equipment and certain related supplies	20% coinsurance	40% coinsurance

Durable Medical Equipment, Prosthetics, and Medical Supplies		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
2. Prosthetics:	20% coinsurance	40% coinsurance
a. 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		
b. Scalp hair prostheses due to alopecia areata – limited to one prosthesis (i.e. wig) per covered person per calendar year		
c. Repair, replacement, or revision of prostheses made necessary by normal wear and use		
3. Hearing aids for covered persons 18 years of age and younger for hearing loss that is not correctable by other covered procedures	20% coinsurance. Coverage is limited to one hearing aid per ear every three years. Related services must be prescribed by a network provider.	40% coinsurance. Coverage is limited to one hearing aid per ear every three years.
4. Breast pumps	Nothing. The deductible does not apply.	40% coinsurance
5. Medical supplies:	20% coinsurance	40% coinsurance
a. Blood clotting factors		

Durable Medical Equipment, Prosthetics, and Medical Supplies		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
b. Dietary medical treatment of phenylketonuria (PKU) c. Total parenteral nutrition d. Amino acid-based elemental formulas for these diagnoses: i. Cystic fibrosis; ii. Amino acid, organic acid, and fatty acid metabolic and malabsorption disorders; iii. IgE mediated allergies to food proteins; iv. Food protein induced enterocolitis syndrome; v. Eosinophilic esophagitis; vi. Eosinophilic gastroenteritis; and		

Durable Medical Equipment, Prosthetics, and Medical Supplies		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
vii. Eosinophilic colitis Coverage for the diagnoses in iii.–vii. above is limited to covered persons five years of age and younger.		
6. Eligible ostomy supplies	20% coinsurance	40% coinsurance
7. Insulin pumps and other eligible diabetic equipment and supplies	20% coinsurance	40% coinsurance

Not covered:

1. Durable medical equipment, supplies, prosthetics, appliances, and hearing aids not on the plan eligible list.
2. Charges in excess of the plan standard model of durable medical equipment, prosthetics, or hearing aids.
3. Repair, replacement, or revision of durable medical equipment, prosthetics, and hearing aids, except when made necessary by normal wear and use.
4. Repair, replacement, or revision of durable medical equipment, prosthetics, and hearing aids, due to loss, damage, or theft.
5. Duplicate durable medical equipment, prosthetics, and hearing aids, including repair, replacement, or revision of duplicate items.
6. Other disposable supplies and appliances, except as described in **Benefits & Coverage** or **Covered Health Services**.

EMERGENCY ROOM CARE

Emergency services from non-network providers will be covered as in-network benefits. If you are confined in a non-network facility as a result of an emergency, you will be eligible for in-

network benefits until your attending physician agrees it is safe to transfer you to a network facility.

See **Covered Health Services** for more information about emergency room care.

Emergency Room Care			
		Your cost if you visit an:	
	Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
1.	Services provided in a hospital or facility-based emergency room	20% coinsurance	Covered as an in-network benefit.
2.	Services received from a physician during an emergency room visit	20% coinsurance	Covered as an in-network benefit.

GENETIC TESTING AND COUNSELING

Genetic Testing and Counseling			
		Your cost if you visit an:	
	Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
1.	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 received in an office or outpatient hospital **Please note:** BRCA testing, if appropriate, is covered as a women's preventive health service.	20% coinsurance	40% coinsurance

Genetic Testing and Counseling			
		Your cost if you visit an:	
	Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
2.	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 women's preventive health service.	20% coinsurance	40% coinsurance

HOME HEALTH CARE

Home health care is covered when directed by a physician, and received from a home health care agency that is authorized by the laws of the state in which treatment is received.

In-network benefits will apply to home health care services ordered or prescribed by a physician and:

1. Received from a network home health care agency; or
2. Received from a non-network home health care agency to whom you have been specifically directed by a network provider.

See **Covered Health Services** for more information.

Home Health Care			
		Your cost if you use an:	
	Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
1.	Home health care services including the following: a. Intermittent skilled care when you are homebound, provided by or supervised by a registered nurse b. Skilled physical, speech, or occupational therapy when you are homebound c. Home infusion therapy Benefits covered under a. and b. above are limited to a combined maximum of 120 visits per calendar year for in-network and 60 visits per calendar year for out-of-network benefits. If you have Medica coverage and are also enrolled in the Medical Assistance Program, you may be eligible for additional intermittent skilled care.	20% coinsurance	40% coinsurance
2.	Services received in your home from a physician	20% coinsurance	40% coinsurance

Not covered:

1. Companion, homemaker, and personal care services.
2. Services provided by a member of your family.
3. Custodial care and other non-skilled services.
4. Physical, speech, or occupational therapy provided in your home for convenience.

5. Services provided in your home when you are not homebound.
6. Services primarily educational in nature.
7. Vocational and job rehabilitation.
8. Recreational therapy.
9. Self-care and self-help training (non-medical).
10. Health clubs.
11. Disposable supplies and appliances, except as described in **Durable Medical Equipment, Prosthetics, and Medical Supplies** and **Prescription Drugs** in **Benefits & Coverage**.
12. Physical, speech, or occupational therapy services when there is no reasonable expectation that the covered person's condition will improve over a predictable period of time according to generally accepted standards in the medical community.
13. Voice training.
14. Home health aide services, except when rendered in conjunction with intermittent skilled care and related to the medical condition under treatment.

HOSPICE SERVICES

Hospice services and respite care are covered when ordered, provided, or arranged under the direction of a physician, and received from a hospice program.

See **Covered Health Services** for more information.

Hospice Services		
	Your cost if you use an:	
Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
1. Hospice services	20% coinsurance	40% coinsurance

Not covered:

1. Respite care for more than five consecutive days at a time.
2. Home health care and skilled nursing facility services when services are not consistent with the hospice program's plan of care.
3. Services not included in the hospice program's plan of care.
4. Services not provided by the hospice program.

5. Hospice daycare, except when recommended and provided by the hospice program.
6. Any services provided by a family member or friend, or individuals who are residents in your home.
7. Financial or legal counseling services, except when recommended and provided by the hospice program.
8. Housekeeping or meal services in your home, except when recommended and provided by the hospice program.
9. Bereavement counseling, except when recommended and provided by the hospice program.

HOSPITAL SERVICES

Hospital and ambulatory surgical center services are covered. A physician must direct your care.

Hospital Services		
	Your cost if you visit an:	
Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
1. Outpatient hospital or ambulatory surgical center services	20% coinsurance	40% coinsurance
2. Services provided in a hospital observation room	20% coinsurance	40% coinsurance
3. Inpatient services For associated professional services, see **Physician Services** in **Benefits & Coverage**.	20% coinsurance	40% coinsurance

Not covered:

1. Drugs received at a hospital on an outpatient basis, except drugs requiring intravenous infusion or injection, intramuscular injection, or intraocular injection, or drugs received in an emergency room or a hospital observation room. Coverage for

drugs is as described in **Prescription Drugs**, **Prescription Specialty Drugs** in **Benefits & Coverage**, or otherwise described as a specific benefit in this plan.

2. Transfers and admissions to network hospitals solely at the convenience of the covered person.

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

INFERTILITY TREATMENT

Coverage for infertility treatment is limited to a maximum of $5,000 per covered person per calendar year for in-network and out-of-network benefits combined.

In-network benefits apply to:

1. Infertility services received from a network provider; and
2. Infertility services provided by a non-network provider to whom you have been specifically directed by a network provider.

Out-of-network benefits apply to infertility services received from non-network providers, unless specifically described above as in-network benefits or as otherwise specifically authorized by Medica as in-network benefits.

See **Covered Health Services** for more information.

Infertility Treatment		
	Your cost if you visit an:	
Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
1. Office visits, including any services provided during such visits	20% coinsurance	40% coinsurance
2. Outpatient services received at a hospital	20% coinsurance	40% coinsurance
3. Inpatient services	20% coinsurance	40% coinsurance
4. Services received from a physician during an inpatient stay	20% coinsurance	40% coinsurance

Not covered:

1. Drugs provided or administered by a physician or other provider on an outpatient basis, except those requiring intravenous infusion or injection, intramuscular injection, or intraocular injection. Coverage for drugs is as described in **Prescription Drugs**, **Prescription Specialty Drugs**, or otherwise described as a specific benefit in **Benefits & Coverage**.
2. In vitro fertilization (IVF), gamete and zygote intrafallopian transfer (GIFT and ZIFT) procedures.
3. Services for a condition that a physician determines cannot be successfully treated.
4. Services related to surrogate pregnancy for a person not covered as a covered person under the plan.
5. Sperm banking.
6. Adoption.
7. Donor sperm.
8. Donor eggs.
9. Embryo and egg storage.

LAB AND PATHOLOGY

Lab and Pathology			
		Your cost if you visit an:	
	Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
1.	Lab and pathology services received in an office or other non-inpatient hospital setting	20% coinsurance	40% coinsurance
2.	Lab and pathology services received during an inpatient hospital setting	20% coinsurance	40% coinsurance

MEDICAL-RELATED DENTAL SERVICES

Medical-related dental services are covered. Services must be received from a physician or dentist.

In-network benefits apply to medical-related dental services:

1. Received from a network provider; or
2. Received from a non-network provider to whom you have been specifically directed by a network provider.

Medical-Related Dental Services		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
1. Charges for medical facilities and general anesthesia services that are: a. Recommended by a physician; b. Received during a dental procedure; and c. Provided to a covered person who is: i. a child under age five; ii. is severely disabled; or iii. has a condition and requires hospitalization or general anesthesia for dental care treatment	20% coinsurance	40% coinsurance
2. For a dependent child, orthodontia, dental implants, and oral surgery treatment related to cleft lip and palate	20% coinsurance	40% coinsurance

Medical-Related Dental Services		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
3. Accident-related dental services to treat an injury to and to repair (not replace) sound, natural teeth. The following conditions apply: a. Coverage is limited to services received within 24 months from the later of: i. The date you are first covered under the plan; or ii. The date of the injury b. A sound, natural tooth means a tooth (including supporting structures) that is free from disease that would prevent continual function of the tooth for at least one year. In the case of primary (baby) teeth, the tooth must have a life expectancy of one year.	20% coinsurance	40% coinsurance
4. Oral surgery for: a. Partially or completely unerupted impacted teeth;	20% coinsurance	40% coinsurance

Medical-Related Dental Services		
	Your cost if you visit an:	
Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
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		

Not covered:

1. Dental services to treat an injury from biting or chewing.
2. 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.
3. Osteotomies and other procedures associated with the fitting of dentures or dental implants.
4. Dental implants (tooth replacement), except as described in this section for the treatment of cleft lip and palate.
5. 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.
6. Any orthodontia, except as described in this section for the treatment of cleft lip and palate.
7. Tooth extractions, except as described in this section.
8. Any dental procedures or treatment related to periodontal disease.
9. Endodontic procedures and treatment, including root canal procedures and treatment, unless provided as accident-related dental services as described in this section.
10. Routine diagnostic and preventive dental services.

PHYSICAL, SPEECH, AND OCCUPATIONAL THERAPIES

Physical therapy, speech therapy, and occupational therapy services provided on an outpatient basis are covered. 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 under **Hospital Services** in **Benefits & Coverage**.

Physical, Speech, and Occupational Therapies		
	Your cost if you visit an:	
Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
1. Physical therapy services received outside of your home		
a. Habilitative services	20% coinsurance	40% coinsurance. Coverage for physical and occupational therapy is limited to a combined limit of 20 visits per calendar year.
b. Rehabilitative services	20% coinsurance	40% coinsurance. Coverage for physical and occupational therapy is limited to a combined limit of 20 visits per calendar year.
2. Speech therapy services received outside of your home		
a. Habilitative services	20% coinsurance	40% coinsurance. Coverage for speech therapy is limited to 20 visits per calendar year.
b. Rehabilitative services	20% coinsurance	40% coinsurance. Coverage for speech therapy is limited to 20 visits per calendar year.

Physical, Speech, and Occupational Therapies		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
3. Occupational therapy services received outside of your home		
a. Habilitative services	20% coinsurance	40% coinsurance. Coverage for physical and occupational therapy is limited to a combined limit of 20 visits per calendar year.
b. Rehabilitative services	20% coinsurance	40% coinsurance. Coverage for physical and occupational therapy is limited to a combined limit of 20 visits per calendar year.

Not covered:

1. Services primarily educational in nature.
2. Vocational and job rehabilitation.
3. Recreational therapy.
4. Self-care and self-help training (non-medical).
5. Health clubs.
6. Voice training.
7. Group physical, speech, and occupational therapy.
8. Physical, speech, or occupational therapy services (including but not limited to services for the correction of speech impediments or assistance in the development of verbal clarity) when there is no reasonable expectation that the covered person's condition will improve over a predictable period of time according to generally accepted standards in the medical community.
9. Massage therapy, provided in any setting, even when it is part of a comprehensive treatment plan.

PHYSICIAN SERVICES

Services described in this section must be received from or directed by a physician.

For some services, there may be a facility charge in addition to the physician services coinsurance.

See **Covered Health Services** for more information.

Physician Services			
		Your cost if you visit an:	
Benefits		**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
1.	Office visits **Please note:** Some services received during an office visit may be covered under another benefit in **Benefits & Coverage**. The most specific and appropriate benefit will apply for each service received during an office visit. For example, certain services may be considered surgical or imaging services; see below and **X-Ray and Other Imaging** for coverage of these services. In such instances, both an office visit coinsurance and outpatient surgical or imaging coinsurance apply.	20% coinsurance	40% coinsurance

Physician Services		
	Your cost if you visit an:	
Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
2. Urgent care center visits **Please note:** Some services received during an urgent care center visit may be covered under another benefit in **Benefits & Coverage**. The most specific and appropriate benefit will apply for each service received during an urgent care center visit. For example, certain services may be considered surgical or imaging services; see below and **X-Ray and Other Imaging** for coverage of these services. In such instances, both an urgent care center visit coinsurance and outpatient surgical coinsurance apply.	20% coinsurance	Covered as an in-network benefit.
3. Convenience care/retail health clinic visits	20% coinsurance	40% coinsurance
4. Virtual care	20% coinsurance	40% coinsurance

Physician Services			
		Your cost if you visit an:	
Benefits		In-network provider, after deductible:	Out-of-network provider, after deductible:
5.	Chiropractic services to diagnose and to treat (by manual manipulation or certain therapies) conditions related to the muscles, skeleton, and nerves of the body	20% coinsurance	40% coinsurance. Coverage is limited to a maximum of 15 visits per calendar year.
6.	Surgical services (as defined in the Physicians' Current Procedural Terminology code book):		
	a. Received from a physician during an office visit, an urgent care visit, or an outpatient hospital or ambulatory surgical center visit	20% coinsurance	40% coinsurance
	b. Received from a physician during an inpatient stay	20% coinsurance	40% coinsurance
7.	Non-surgical services received from a physician during an inpatient stay	20% coinsurance	40% coinsurance
8.	Other outpatient hospital or ambulatory surgical center services received from a physician	20% coinsurance	40% coinsurance
9.	Routine annual eye exams	Nothing. The deductible does not apply.	40% coinsurance
10.	Allergy shots	20% coinsurance	40% coinsurance

Physician Services		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
11. Diabetes self-management training and education, including medical nutrition therapy received from a provider in a program consistent with national educational standards (as established by the American Diabetes Association)	20% coinsurance	40% coinsurance
12. Acupuncture. Limited to 15 visits per calendar year for in-network and out-of-network benefits combined.	20% coinsurance	40% coinsurance
13. Neuropsychological evaluations/cognitive testing, limited to services necessary for the diagnosis or treatment of a medical illness or injury	20% coinsurance	40% coinsurance
14. Vision therapy and orthoptic and/or pleoptic training, to establish a home program, for the treatment of strabismus and other disorders of binocular eye movements. Coverage is limited to a combined in-network and out-of-network total of 5 training visits and 2 follow-up eye exams per calendar year.	20% coinsurance	40% coinsurance

Physician Services		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
15. Treatment to lighten or remove the coloration of a port wine stain	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.

Not covered:

Drugs provided or administered by a physician or other provider, except those requiring intravenous infusion or injection, intramuscular injection, or intraocular injection.

PREGNANCY – MATERNITY CARE

Pregnancy services are covered, and include medical services for prenatal care, labor and delivery, postnatal care, and any related complications.

In-network benefits apply to:

1. Maternity services received from a network provider;
2. Maternity services received from a non-network provider to whom you have been specifically directed by a network provider; or
3. Emergency services received from a network provider or a non-network provider. If you are confined in a non-network facility as a result of an emergency, you will be eligible for in-network benefits until your attending physician agrees it is safe to transfer you to a network facility.

See **Covered Health Services** for more information.

Pregnancy – Maternity Care			
		Your cost if you visit an:	
	Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
1.	Outpatient prenatal services	Nothing. The deductible does not apply.	0% coinsurance. The deductible does not apply.
2.	Inpatient hospital stay for labor and delivery services – mother	20% coinsurance	40% coinsurance
3.	Physician services received during an inpatient stay for labor and delivery – mother	20% coinsurance	40% coinsurance
4.	Inpatient hospital stay – newborn **Please note:** Newborn must be added as a dependent on your plan for this coverage to apply.	20% coinsurance	40% coinsurance
5.	Physician services received during an inpatient stay – newborn **Please note:** Newborn must be added as a dependent on your plan for this coverage to apply.	20% coinsurance	40% coinsurance
6.	Labor and delivery services at a free-standing birth center		
	a. Facility services for labor and delivery – mother	20% coinsurance	40% coinsurance
	b. Physician services received for labor and delivery – mother	20% coinsurance	40% coinsurance

Pregnancy – Maternity Care		
	Your cost if you visit an:	
Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
c. Physician services – newborn **Please note:** Newborn must be added as a dependent on your plan for this coverage to apply.	20% coinsurance	40% coinsurance
7. Postnatal services	20% coinsurance	40% coinsurance
8. Home health care visit following delivery	20% coinsurance	40% coinsurance

Not covered:

1. Health care professional services for home labor and delivery.
2. Services from a doula.
3. Childbirth and other educational classes.

PRESCRIPTION DRUGS

Prescription drugs and supplies received from a pharmacy or a designated mail order pharmacy are covered. The coverage in the table below is your coinsurance for prescription and over-the-counter (OTC) drugs. You may experience an additional charge if you require a provider to administer self-administered drugs.

For more information about your prescription drug coverage, see **Covered Health Services**.

In this section, the phrase "covered drugs" is meant to include those prescription drugs, OTC drugs, and supplies found on the Preferred Drug List (PDL) that are prescribed by an authorized provider, unless those drugs and supplies are identified as not covered. The phrase "professionally administered drugs" means drugs that require intravenous infusion or injection, intramuscular injection, or intraocular injection; the phrase "self-administered drugs" means all other drugs. Specialty prescription drugs are defined in **Prescription Specialty Drugs** in **Benefits & Coverage**.

Prescription unit

Supply for one prescription unit from a pharmacy: 31-consecutive-day supply (or, in the case of contraceptives, up to a one-cycle supply)

Supply for one prescription unit from a designated mail order pharmacy: 93-consecutive-day supply (or, in the case of contraceptives, up to a three-cycle supply)

This is how the unit will be dispensed unless it is limited by the drug manufacturer's packaging, dosing instructions, or Medica's medication request guidelines. This includes quantity limits that are indicated on the PDL. Coinsurance amounts will apply to each prescription unit dispensed.

Three prescription units may be dispensed for covered drugs prescribed to treat chronic conditions. Medica has specifically designated some network pharmacies to dispense multiple prescription units. For the list of these designated pharmacies, visit mymedica.com or call Customer Service.

Prescription Drugs		
Your cost if you visit an:		
In-network pharmacy, after deductible:	**Out-of-network pharmacy, after deductible:**	**Mail order pharmacy, after deductible:**
Pharmacy: 31-consecutive day supply, or in the case of contraceptives, up to a one-cycle supply **Mail order pharmacy:** 93-consecutive day supply, or in the case of contraceptives, up to a three-cycle supply		
1. Outpatient covered drugs other than those described below or in **Prescription Specialty Drugs** in **Benefits & Coverage**		
Tier 1: 20% coinsurance per prescription unit; or **Tier 2:** 20% coinsurance per prescription unit; or **Tier 3:** 40% coinsurance per prescription unit	40% coinsurance per prescription unit	**Tier 1:** 20% coinsurance per prescription unit; or **Tier 2:** 20% coinsurance per prescription unit; or **Tier 3:** 40% coinsurance per prescription unit
2. Infertility covered drugs. Limited to a maximum benefit of $3,000 per calendar year for all infertility covered drugs described in **Prescription Drugs** and **Prescription Specialty Drugs** in **Benefits & Coverage** combined.		
Tier 1: 20% coinsurance per prescription unit; or **Tier 2:** 20% coinsurance per prescription unit; or **Tier 3:** 40% coinsurance per prescription unit	40% coinsurance per prescription unit	**Tier 1:** 20% coinsurance per prescription unit; or **Tier 2:** 20% coinsurance per prescription unit; or **Tier 3:** 40% coinsurance per prescription unit

Prescription Drugs		
Your cost if you visit an:		
In-network pharmacy, after deductible:	**Out-of-network pharmacy, after deductible:**	**Mail order pharmacy, after deductible:**
Pharmacy: 31-consecutive day supply, or in the case of contraceptives, up to a one-cycle supply **Mail order pharmacy:** 93-consecutive day supply, or in the case of contraceptives, up to a three-cycle supply		
3. Diabetic equipment and supplies, including blood glucose meters		
Tier 1: 20% coinsurance per prescription unit; or **Tier 2:** 20% coinsurance per prescription unit; or **Tier 3:** 40% coinsurance per prescription unit	40% coinsurance per prescription unit	**Tier 1:** 20% coinsurance per prescription unit; or **Tier 2:** 20% coinsurance per prescription unit; or **Tier 3:** 40% coinsurance per prescription unit
4. Drugs and other supplies (including women's contraceptives), and tobacco cessation products that are considered preventive health services		
Tier 1: Nothing per prescription unit; or **Tier 2:** Nothing per prescription unit; or **Tier 3:** Nothing per prescription unit The deductible does not apply.	40% coinsurance per prescription unit	**Tier 1:** Nothing per prescription unit; or **Tier 2:** Nothing per prescription unit; or **Tier 3:** Nothing per prescription unit The deductible does not apply. **Please note:** Tobacco cessation products are not available through a mail order pharmacy.

Not covered:

1. Any amount above what the plan would have paid when you fail to identify yourself as a covered person to the pharmacy. (The plan will notify you before enforcement of this provision.)
2. Replacement of a drug due to loss, damage, or theft.
3. Appetite suppressants.
4. Tobacco cessation products or services dispensed through a mail order pharmacy.
5. Drugs prescribed by a provider who is not acting within his/her scope of licensure.

6. Erectile dysfunction medications.
7. Non-sedating antihistamines and non-sedating antihistamine/decongestant combinations.
8. Homeopathic medicine.
9. Specialty prescription drugs, except as described in **Prescription Specialty Drugs** in **Benefits & Coverage**.

PRESCRIPTION SPECIALTY DRUGS

Specialty prescription drugs received from a designated specialty pharmacy are covered.

Specialty prescription drugs include, but are not limited to, high technology prescription drug products for individuals with diseases that require complex therapies. Such specialty prescription drugs are identified on Medica's Specialty Preferred Drug List (SPDL).

In this section, the phrase "professionally administered drugs" means drugs requiring intravenous infusion or injection, intramuscular injection, or intraocular injection; the phrase "self-administered drugs" means all other drugs.

See **Covered Health Services** for additional important information about your specialty prescription drug coverage.

The table below describes your coinsurance for the specialty prescription drug. An additional coinsurance will apply for a provider's services if you require that they administer a self-administered drug.

Prescription unit

Supply for one prescription unit of a specialty prescription drug from a designated specialty pharmacy: 31-consecutive-day supply

This is how the unit will be dispensed unless it is limited by the drug manufacturer's packaging, dosing instructions, or Medica's medication request guidelines. This includes quantity limits that are indicated on the SPDL.

Prescription Specialty Drugs	
Benefits	**You pay, after deductible**
1. Specialty prescription drugs, other than those described below, received from a designated specialty pharmacy	**Tier 1 specialty prescription drugs:** 20% coinsurance up to a maximum of $200 per prescription unit; or **Tier 2 specialty prescription drugs:** 40% coinsurance per prescription unit

Prescription Specialty Drugs	
Benefits	**You pay, after deductible**
2. Specialty infertility prescription drugs received from a designated specialty pharmacy. Limited to a maximum benefit of $3,000 per calendar year for all infertility drugs described in **Prescription Drugs** and **Prescription Specialty Drugs** in **Benefits & Coverage** combined.	**Tier 1 specialty prescription drugs:** 20% coinsurance up to a maximum of $200 per prescription unit; or **Tier 2 specialty prescription drugs:** 40% coinsurance per prescription unit
3. Specialty growth hormone when prescribed by a physician for the treatment of a demonstrated growth hormone deficiency and received from a designated specialty pharmacy	**Tier 1 specialty prescription drugs:** 20% coinsurance up to a maximum of $200 per prescription unit; or **Tier 2 specialty prescription drugs:** 40% coinsurance per prescription unit

Not covered:

1. Any amount above what the plan would have paid when you fail to identify yourself to the designated specialty pharmacy as a covered person. (The plan will notify you before enforcement of this provision.)
2. Replacement of a specialty drug due to loss, damage, or theft.
3. Specialty prescription drugs prescribed by a provider who is not acting within their scope of licensure.
4. Prescription drugs, and OTC drugs, except as described in **Prescription Drugs** in **Benefits & Coverage**.
5. Specialty prescription drugs received from a pharmacy that is not a designated specialty pharmacy.

PREVENTIVE HEALTH CARE

Routine preventive services are as defined by state and federal law.

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

See **Covered Health Services** for more information.

Preventive Health Care			
		Your cost if you visit an:	
	Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
1.	Child health supervision services, including well-baby care	Nothing. The deductible does not apply.	0% coinsurance. The deductible does not apply.
2.	Immunizations	Nothing. The deductible does not apply.	40% coinsurance
3.	Early disease detection services including physicals	Nothing. The deductible does not apply.	40% coinsurance
4.	Routine screening procedures for cancer including, but not limited to, screening for ovarian cancer and prostate cancer	Nothing. The deductible does not apply.	40% coinsurance
5.	Women's preventive health services including mammograms, screenings for cervical cancer, human papillomavirus (HPV) testing, counseling for sexually transmitted infections, counseling for human immunodeficiency virus (HIV), BRCA genetic testing and related genetic counseling (when appropriate), and sterilization	Nothing. The deductible does not apply.	40% coinsurance
6.	Other preventive health services	Nothing. The deductible does not apply.	40% coinsurance

RECONSTRUCTIVE AND RESTORATIVE SURGERY

Professional, hospital, and ambulatory surgical center services for reconstructive and restorative surgery are covered. To be eligible, reconstructive and restorative surgery services must be medically necessary and not cosmetic.

Reconstructive and Restorative Surgery			
		Your cost if you visit an:	
	Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
1.	Reconstructive and restorative surgery	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.

Not covered:

1. Revision of blemishes on skin surfaces and scars (including scar excisions) primarily for cosmetic purposes, unless otherwise covered in **Physician Services** in **Benefits & Coverage**.
2. Repair of a pierced body part and surgical repair of bald spots or loss of hair.
3. Repairs to teeth, including any other dental procedures or treatment, whether the dental treatment is needed because of a primary dental problem or as a manifestation of a medical treatment or condition.
4. Services and procedures primarily for cosmetic purposes.
5. Surgical correction of male breast enlargement primarily for cosmetic purposes.
6. Hair transplants.
7. Drugs provided or administered by a physician or other provider on an outpatient basis, except those requiring intravenous infusion or injection, intramuscular injection, or intraocular injection. Coverage for drugs is as described in **Prescription Drugs**,

Prescription Specialty Drugs in **Benefits & Coverage**, or otherwise described as a specific benefit in this plan.

SKILLED NURSING FACILITY

Skilled nursing facility services are covered. Care must be provided under the direction of a physician.

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

Skilled nursing facility services are eligible for coverage only if you are admitted to a skilled nursing facility within 30 days after a hospital admission of at least three consecutive days for the same illness or condition.

Skilled Nursing Facility			
		Your cost if you visit an:	
	Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
1.	Daily skilled care or daily skilled rehabilitation services, including room and board, up to 120 days per person per calendar year for in-network and out-of-network services combined	20% coinsurance	40% coinsurance
2.	Skilled physical, speech, or occupational therapy when room and board is not eligible to be covered	20% coinsurance	40% coinsurance
3.	Services received from a physician during an inpatient stay in a skilled nursing facility	20% coinsurance	40% coinsurance

Not covered:

1. Custodial care and other non-skilled services.
2. Self-care or self-help training (non-medical).
3. Services primarily educational in nature.

4. Vocational and job rehabilitation.
5. Recreational therapy.
6. Health clubs.
7. Physical, speech, or occupational therapy services when there is no reasonable expectation that the covered person's condition will improve over a predictable period of time according to generally accepted standards in the medical community.
8. Voice training.
9. Group physical, speech, and occupational therapy.
10. Long-term care.

TEMPOROMANDIBULAR JOINT (TMJ) AND CRANIOMANDIBULAR DISORDER

Temporomandibular Joint (TMJ) and Craniomandibular Disorder		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
1. Treatment of temporomandibular joint (TMJ) disorder and craniomandibular disorder	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.

TRANSPLANT SERVICES

Prior authorization from the plan is required before you receive transplant services or supplies, even if a provider has directed or recommended that you receive services or supplies. See **Before You Access Care** for more information about the prior authorization process.

See **Covered Health Services** for more information.

Transplant Services			
		Your cost if you visit an:	
	Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
1.	Organ and bone marrow transplant services **Prior authorization is required for all transplant services.**	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.	No coverage
2.	Transportation and lodging reimbursement, as described below, is available for reasonable and necessary expenses. Reimbursement will be for you and a companion, when you receive approved transplant services at a designated facility, and you live more than 50 miles from that facility, and will include: a. Transportation for you and one companion (traveling on the same day(s)) to and/or from a designated facility for transplant services for pre-transplant, transplant, and post-transplant services. If you are a minor child, transportation expenses for two companions will be reimbursed.		Reimbursement of expenses for out-of-network services is not covered.

Transplant Services		
	Your cost if you visit an:	
Benefits	In-network provider, after deductible:	Out-of-network provider, after deductible:
b. Lodging for you (while not confined) and one companion. Reimbursement is available for a per diem amount of up to $50 for one person or up to $100 for two people. If you are a minor child, reimbursement for lodging expenses for two companions is available, up to a per diem amount of $100. There is a lifetime maximum of $10,000 per covered person for all transportation and lodging expenses incurred by you and your companion(s). Meals are not reimbursable under this benefit. The deductible does not apply to this reimbursement benefit. You are responsible for paying all amounts not reimbursed under this benefit. Such amounts do not count toward your out-of-pocket maximum or toward satisfaction of your deductible.		

Not covered:

1. Supplies and services related to transplants that would not be authorized by the plan under the medical criteria referenced in this section.
2. Chemotherapy, radiation therapy, drugs, or any therapy used to damage the bone marrow and related to transplants that would not be authorized by the plan under the medical criteria referenced in this section.
3. Living donor transplants that would not be authorized by the plan under the medical criteria referenced in this section.
4. Services required to meet the patient selection criteria for the authorized transplant procedure. This includes treatment of nicotine or caffeine addiction, services and related expenses for weight loss programs, nutritional supplements, appetite suppressants, and supplies of a similar nature not otherwise covered under this plan.
5. Mechanical, artificial, or non-human organ implants or transplants and related services that would not be authorized by the plan under the medical criteria referenced in this section.
6. Transplants and related services that are investigative.
7. Private collection and storage of umbilical cord blood for directed use.

8. Drugs provided or administered by a physician or other provider on an outpatient basis, except those requiring intravenous infusion or injection, intramuscular injection, or intraocular injection. Coverage for drugs is as described in **Prescription Drugs**, **Prescription Specialty Drugs**, or otherwise described as a specific benefit in **Benefits & Coverage** in this plan.

WEIGHT LOSS SURGERY

Coverage for surgery for morbid obesity is provided. Prior authorization from the plan is required before you receive services or supplies, even if a provider has directed or recommended that you receive the services or supplies.

Services must be provided under the direction of a designated network physician and received at a designated network facility. This section also describes benefits for professional, hospital, and ambulatory surgical center services.

See **Covered Health Services** for more information.

Weight Loss Surgery		
	Your cost if you visit an:	
Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
1. Weight loss surgery services	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.	No coverage

Not covered:

1. Surgery for morbid obesity when performed by a network physician that is not a designated physician or received at a network facility that is not a designated facility.
2. Surgery for morbid obesity when performed by a non-network physician or received at a non-network hospital.

3. Surgery for morbid obesity, except as described in this section.
4. Services and procedures primarily for cosmetic purposes.
5. Supplies and services for surgery for morbid obesity that would not be authorized by the plan.
6. Services required to meet the patient selection criteria for an authorized surgery for morbid obesity. This includes services and related expenses for weight loss programs, nutritional supplements, appetite suppressants, and supplies of a similar nature not otherwise covered under this plan.
7. Drugs provided or administered by a physician or other provider on an outpatient basis, except those requiring intravenous infusion or injection, intramuscular injection, or intraocular injection. Coverage for drugs is as described in **Prescription Drugs**, **Prescription Specialty Drugs**, or otherwise described as a specific benefit in **Benefits & Coverage** in this plan.

X-RAY AND OTHER IMAGING

X-Ray and Other Imaging			
		Your cost if you visit an:	
	Benefits	**In-network provider, after deductible:**	**Out-of-network provider, after deductible:**
1.	X-rays and other imaging services received in a non-inpatient setting	20% coinsurance	40% coinsurance
2.	MRI, CT, and PET CT scans	20% coinsurance	40% coinsurance
3.	X-rays and other imaging services received in an inpatient setting	20% coinsurance	40% coinsurance

Covered Health Services

This section describes services covered on this plan. The **Benefits & Coverage** section provides coverage specifics and what you would pay for each service.

Ambulance services

Ambulance services for an emergency are covered when provided by a licensed ambulance service. If you are taken to a non-network hospital, emergency health services at that hospital are covered.

Non-emergency ambulance transportation that's arranged through an attending physician is eligible for coverage when certain criteria are met. See **Benefits & Coverage.**

Behavioral health – mental health

In order to be covered, services must diagnose or treat mental disorders listed in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM).

Outpatient mental disorder services include:

- Diagnostic evaluations and psychological testing.
- Psychotherapy and psychiatric services.
- Intensive outpatient programs, including day treatment, meaning time limited comprehensive treatment plans, which may include multiple services and modalities, delivered in an outpatient setting (up to 19 hours per week).
- Treatment for a minor, including family therapy.
- Treatment of serious or persistent disorders.
- Diagnostic evaluation for attention deficit hyperactivity disorder (ADHD) or pervasive development disorders (PDD).
- Treatment of pathological gambling.

Inpatient mental disorder services include:

- Room and board.
- Attending psychiatric services.
- Hospital or facility-based professional services.
- 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.
- Residential treatment services. These services include either:
    - A residential treatment program serving children and adolescents with severe emotional disturbance, certified under law; or
    - A licensed or certified mental health treatment program providing intensive therapeutic services. In addition to room and board, at least 30 hours a week per individual of

mental health services must be provided, including group and individual counseling, client education, and other services specific to mental health treatment. Also, the program must provide an on-site medical/psychiatric assessment within 48 hours of admission, psychiatric follow-up visits at least once per week, and 24-hour nursing coverage.

The designated mental health/substance abuse provider will arrange your in-network mental health benefits. If you require hospitalization, the designated mental health/substance abuse provider will refer you to one of its hospital providers (please note that the designated mental health/substance abuse provider's hospital network differs from the your hospital network.)

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

Mental health services from a non-network provider listed below will be eligible for coverage under out-of-network benefits. These services must be obtained from a health care professional or facility that is licensed, certified, or otherwise qualified under state law to provide the mental health services, and practice independently:

- Psychiatrist
- Psychologist
- Registered nurse certified as a clinical specialist or as a nurse practitioner in psychiatric and mental health nursing
- Mental health clinic
- Mental health residential treatment center
- Independent clinical social worker
- Marriage and family therapist
- Hospital that provides mental health services

Behavioral health – substance abuse

In order to be covered, services must diagnose or treat substance abuse disorders listed in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM).

Outpatient substance abuse services include:

- Diagnostic evaluations.
- Outpatient treatment.
- Intensive outpatient programs, including day treatment and partial programs, which may include multiple services and modalities, delivered in an outpatient setting (up to 19 hours per week).
- Services, care, or treatment for a covered person that has been placed in the Minnesota Department of Corrections' custody following a conviction for a first-degree driving while impaired offense; to be eligible, such services, care, or treatment must be required and provided by the Minnesota Department of Corrections.

Inpatient substance abuse services include:

- Room and board.

- Attending physician services.
- Hospital or facility-based professional services.
- Services, care, or treatment for a covered person that has been placed in the Minnesota Department of Corrections' custody following a conviction for a first-degree driving while impaired offense; to be eligible, such services, care, or treatment must be required and provided by the Minnesota Department of Corrections.
- Residential treatment services. These are services from a licensed chemical dependency rehabilitation program that provides intensive therapeutic services following detoxification. In addition to room and board, at least 30 hours (15 hours for children and adolescents) per week per individual of chemical dependency services must be provided, including group and individual counseling, client education, and other services specific to chemical dependency rehabilitation.

The designated mental health/substance abuse provider arranges in-network substance abuse benefits. If you require hospitalization, the designated mental health/substance abuse provider will refer you to one of its hospital providers (please note that the designated mental health/substance abuse provider's hospital network differs from the your hospital network.)

In-network benefits will apply to services, care or treatment for a covered person that has been placed in the Minnesota Department of Corrections' custody following a conviction for a first-degree driving while impaired offense. To be eligible, such services, care, or treatment must be required and provided by the Minnesota Department of Corrections.

Emergency substance abuse services are eligible for coverage under in-network benefits.

Substance abuse services from a non-network provider listed below will be eligible for coverage under out-of-network benefits. These services must be obtained from a health care professional or facility that is licensed, certified, or otherwise qualified under state law to provide the substance abuse services, and practice independently:

- Psychiatrist
- Psychologist
- Registered nurse certified as a clinical specialist or as a nurse practitioner in psychiatric and mental health nursing
- Chemical dependency clinic
- Chemical dependency residential treatment center
- Independent clinical social worker
- Marriage and family therapist
- Hospital that provides substance abuse services

Durable medical equipment, prosthetics, and medical supplies

The plan covers only a limited selection of durable medical equipment, prosthetics, medical supplies, and hearing aids. The repair, replacement, or revision of durable medical equipment is covered if it is made necessary by normal wear and use. Hearing aids and certain medical supplies must meet specific criteria and some items ordered by your physician, even if they're

medically necessary, may not be covered. The plan determines if durable medical equipment will be purchased or rented.

The plan periodically reviews and modifies the list of eligible durable medical equipment and certain related supplies. To request the most up-to-date list, call Customer Service at one of the telephone numbers listed inside the front cover.

If the durable medical equipment, prosthetic device, or hearing aid is covered by the plan, but the model you choose is not the plan's standard model, you will be responsible for the cost difference.

In-network benefits apply when eligible equipment, services, and supplies are prescribed by a physician and received from a network provider. Hearing aids are covered as described in **Benefits & Coverage**, when prescribed by a network provider.

To request a list of durable medical equipment providers, call Customer Service at one of the telephone numbers listed inside the front cover.

Out-of-network benefits apply when eligible equipment, services and supplies are received from a non-network provider, unless specifically authorized by Medica as in-network benefits.

Emergency room care

Emergency services from non-network providers will be covered as in-network benefits. If you receive scheduled or follow-up care after an emergency, services must be received from a network provider in order for you to receive in-network benefits.

Home health care

Home health care must be directed by a physician and received from a home health care agency authorized by the laws of the state in which treatment is received.

The plan considers you homebound when leaving your home would directly and negatively affect your physical health. A dependent child may still be considered "confined to home" when attending school where life support specialized equipment and help are available.

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, a hospital or skilled nursing facility will not be considered your home.

Hospice services

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

Respite care is a form of hospice services that gives your uncompensated primary caregivers (i.e., family members or friends) rest or relief when necessary to maintain a terminally ill covered person at home.

Respite care is limited to not more than five consecutive days at a time.

A plan of care must be established and communicated by the hospice program staff to Medica. To be eligible for coverage, hospice services must be consistent with the hospice program's plan of care.

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

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

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

Covered persons 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.

Infertility treatment

The diagnosis and treatment of infertility in connection with the voluntary planning of conceiving a child is covered. Coverage includes benefits for professional, hospital, and ambulatory surgical center services. Infertility treatment must be received from or under the direction of a physician. See **Benefits & Coverage – Prescription Drugs** for coverage of infertility drugs.

Medical-related dental services

Medically necessary outpatient dental services are covered. Comprehensive dental procedures are not considered medical-related dental services and aren't covered under this plan. See **Benefits & Coverage** for specific services that are covered or excluded.

Newborn coverage

Your dependent newborn is covered from birth. The plan does not automatically know of a birth or whether you would like coverage for the newborn dependent. Call Customer Service at one

of the telephone numbers listed inside the front cover for more information. If additional premium is required, the plan is entitled to all premiums due from the time of the infant's birth until the time you notify the plan of the birth. The plan may reduce payment by the amount of premium that is past due for any health benefits for the newborn infant until any premium you owe is paid. For more information, see **Eligibility and Enrollment**.

Pregnancy – maternity care

Benefits for your pregnancy care include medical services for prenatal care, labor and delivery, postnatal care, and related complications.

Prenatal care

Prenatal services include:

- Office visits for prenatal care, including professional services, lab, pathology, x-rays, and imaging;
- Hospital and ambulatory surgical center services for prenatal care, including professional services received during an inpatient stay for prenatal care;
- Intermittent skilled care or home infusion therapy due to a high risk pregnancy; and
- Supplies for gestational diabetes.

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

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

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

Labor and delivery

Maternity labor and delivery services are considered inpatient services regardless of the length of hospital stay.

Postnatal care

Postnatal care includes routine follow-up care from your physician after delivery.

One home health care visit is covered if it occurs within 4 days of discharge. If services are received after 4 days, please refer to **Home Health Care** in **Benefits & Coverage** for benefits.

Newborns' and Mothers' 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 covered person 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 covered person'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).

For benefits and the amounts you pay, see **Benefits & Coverage**. Each covered person's admission is separate from the admission of any other covered person. A separate deductible and coinsurance will be applied to both you and your newborn child for inpatient services related to maternity labor and delivery. **Please note:** We encourage you to enroll your newborn dependent under the plan within 30 days from the date of birth, date of placement for adoption, or date of adoption. Please refer to **Eligibility and Enrollment** for additional information.

Physician services

In-network benefits apply to:

- Professional services received from a network provider;
- Professional services received from a non-network provider to whom you have been specifically directed by a network provider;
- Emergency services received from a network provider or a non-network provider.

Post-mastectomy coverage

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

Prescription drugs

Preferred Drug List (PDL)

Medica's PDL identifies whether a drug is classified by Medica as a Tier 1, Tier 2, or Tier 3 covered drug. In general, only drugs on Medica's PDL are eligible for coverage.

The PDL is grouped into the following tiers:

Tier 1 is your lowest coinsurance option. For the lowest out-of-pocket expense, you should consider a Tier 1 covered drug if you and your physician decide it is appropriate for your treatment.

Tier 2 is your higher coinsurance option. You may consider a Tier 2 covered drug to treat your condition if you and your physician decide it is appropriate.

Tier 3 is your highest coinsurance option. The covered drugs in Tier 3 are usually more costly.

If you have questions about Medica's PDL or whether a specific drug is covered (and/or the PDL tier in which the drug may be covered), or if you would like to request a copy of the PDL at no charge, call Customer Service at one of the telephone numbers listed inside the front cover. The PDL is also available when you sign in at mymedica.com.

Medica selects drugs for the PDL based on recommendations of an independent Pharmacy and Therapeutics (P&T) Committee that includes practicing physicians and pharmacists. Placement of a drug on the PDL, and the tier to which a drug is assigned, are based on the drug's safety, efficacy, uniqueness, and cost.

Exceptions to the PDL

Exceptions to the PDL can include antipsychotic drugs prescribed to treat emotional disturbance or mental illness, and certain drugs for diagnosed mental illness or emotional disturbance if removed from the PDL or you change health plans. Antipsychotic drug(s) prescribed to treat emotional disturbance or mental illness will be covered if the prescribing provider certifies in writing to Medica that the health care provider has considered all equivalent drugs in the health plan's PDL and has determined that the drug prescribed will best treat the patient's condition, unless the drug was removed from Medica's PDL for safety reasons. Medica will grant an exception to the PDL if the patient's health care provider indicates to us that any of the following apply: (a) the PDL drug causes an adverse reaction in the patient; (b) the PDL drug is contraindicated for the patient; or (c) the health care provider demonstrates to the health plan that the prescription drug must be dispensed as written to provide maximum medical benefit to the patient, unless the drug was removed from Medica's PDL for safety reasons. If you would like to request a copy of Medica's PDL exception process, call Customer Service at one of the telephone numbers listed inside the front cover.

Prior authorization

Certain covered drugs require prior authorization, as indicated on the PDL. The network provider who prescribes the drug initiates prior authorization. The PDL is made available to providers, including pharmacies, and the designated mail order pharmacies. You are responsible for paying the cost of drugs received if you do not meet the plan's authorization criteria.

Step therapy

The plan requires a step therapy process prior to coverage of certain drugs, as indicated on the PDL. Step therapy involves trying an alternative covered drug first (typically a Tier 1 drug) before moving to a Tier 2 or Tier 3 covered drug for treatment of the same medical condition.

Applicable step therapy requirements must be met before Medica will cover Tier 2 or Tier 3 covered drugs.

Quantity limits

Certain covered drugs are assigned quantity limits, as indicated on the PDL. These limits indicate the maximum quantity allowed per prescription over a specific time period. Some quantity limits are based on packaging, FDA labeling, or clinical guidelines.

Mail order pharmacy benefits

Mail order pharmacy benefits apply when covered drugs are received from a designated mail order pharmacy.

Diabetic equipment and supplies (excluding blood glucose meters) are available via mail order if received from a designated mail order pharmacy.

Preventive drugs and other services, as specifically defined in **Definitions**, are eligible for mail order coverage. **This group of drugs and supplies is specific and limited.** For the current list of such drugs and supplies, please refer to the Preventive Drug and Supply List within the PDL or call Customer Service. **Note: Tobacco cessation products are not available through mail order.**

Retail pharmacy benefits

Retail pharmacy benefits include, but are not limited to:

- Preventive drugs and other services, as specifically defined in **Definitions**. **This group of drugs and supplies is specific and limited.** For the current list of such drugs and supplies, please refer to the Preventive Drug and Supply List within the PDL or call Customer Service.
- Diabetic equipment and supplies, including blood glucose meters.
- Tobacco cessation products prescribed by a provider authorized to prescribe the product.
- Insulin pumps, as covered under **Durable Medical Equipment, Prosthetics, and Medical Supplies** in **Benefits & Coverage**.

See **Prescription Specialty Drugs** in **Benefits & Coverage** for growth hormone and other specialty prescription drug coverage information.

Prescription specialty drugs

Designated specialty pharmacies

A designated specialty pharmacy means a specialty pharmacy that has entered into a separate contract with Medica to provide specialty prescription drug services to covered persons. For the current list of designated specialty pharmacies, call Customer Service at one of the telephone numbers listed inside the front cover or sign in at mymedica.com. Note that certain specialty pharmacies may be in other Medica networks but not in your network.

Specialty Preferred Drug List (SPDL)

Medica has a tiered SPDL that identifies specialty prescription drugs that are covered, unless they are otherwise listed as not covered in this plan. The SPDL also identifies whether a drug is classified by Medica as a Tier 1 or Tier 2 specialty prescription drug. In general, only specialty prescription drugs on Medica's SPDL are eligible for benefits under this plan.

The applicable coinsurance amounts for coverage of drugs on the SPDL are set forth in the benefits table in **Prescription Specialty Drugs** in **Benefits & Coverage**.

If you have questions about Medica's SPDL or whether a specific specialty prescription drug is covered (and/or the SPDL tier in which the drug may be covered), or if you would like to request a copy of the SPDL at no charge, call Customer Service at one of the telephone numbers listed inside the front cover. The SPDL is also available by signing in at mymedica.com.

Medica selects specialty drugs for the SPDL based on recommendations of an independent Pharmacy and Therapeutics (P&T) Committee that includes practicing physicians and pharmacists. Placement of a specialty drug on the SPDL, and the tier to which a specialty drug is assigned, are based on the specialty drug's safety, efficacy, uniqueness, and cost.

Exceptions to the SPDL

Exceptions to the SPDL can include antipsychotic drugs prescribed to treat emotional disturbance or mental illness, and certain drugs for diagnosed mental illness or emotional disturbance if removed from the SPDL or you change health plans. Antipsychotic drug(s) prescribed to treat emotional disturbance or mental illness will be covered if the prescribing provider certifies in writing to Medica that the health care provider has considered all equivalent drugs in the health plan's SPDL and has determined that the drug prescribed will best treat the patient's condition, unless the drug was removed from Medica's SPDL for safety reasons. Medica will grant an exception to the SPDL if the patient's health care provider indicates to us that any of the following apply: (a) the SPDL drug causes an adverse reaction in the patient; (b) the SPDL drug is contraindicated for the patient; or (c) the health care provider demonstrates to the health plan that the prescription drug must be dispensed as written to provide maximum medical benefit to the patient, unless the drug was removed from Medica's SPDL for safety reasons. If you would like to request a copy of Medica's SPDL exception process, call Customer Service at one of the telephone numbers listed inside the front cover.

Prior authorization

Certain specialty prescription drugs require prior authorization from Medica. The network provider who prescribes the specialty drug initiates prior authorization. The SPDL is made available to providers, including designated specialty pharmacies. You are responsible for paying the cost of specialty prescription drugs you receive if you do not meet Medica's authorization criteria.

Step therapy

The plan requires step therapy prior to coverage of specific specialty prescription drugs as indicated on the SPDL. Step therapy involves trying an alternative covered specialty prescription drug (typically a Tier 1 specialty prescription drug) before moving to certain other

Tier 1 or Tier 2 specialty prescription drugs for treatment of the same medical condition. Applicable step therapy requirements must be met before the plan will cover certain Tier 1 or Tier 2 specialty prescription drugs.

Quantity limits

Certain specialty prescription drugs are assigned quantity limits as indicated on the SPDL. These limits indicate the maximum quantity allowed per prescription over a specific time period. Some quantity limits are based on packaging, FDA labeling, or clinical guidelines.

Transplant services – organ and bone marrow

Certain organ and bone marrow transplant services are covered if provided under the direction of a network physician and received at a designated transplant facility. These transplant and related services (including organ acquisition and procurement) must be medically necessary, appropriate for the diagnosis, without contraindications, and be non-investigative.

Benefits for each individual covered person will be determined based on their clinical circumstances according to medical criteria used by the plan administrator. Because medical technology is constantly changing, the plan reserves the right to review and update these medical criteria.

Coverage is provided for the following human organ transplants, if appropriate, and those that are not otherwise excluded from coverage:

- Cornea
- Kidney
- Lung
- Heart
- Heart/lung
- Pancreas
- Liver
- Allogeneic, autologous, and syngeneic bone marrow. Bone marrow transplants include the transplant of stem cells from bone marrow, peripheral blood, and umbilical cord blood.

The preceding is not a comprehensive list of eligible transplant services.

In-network benefits apply to transplant services provided by a network provider and received at a designated transplant facility. A designated transplant facility means a facility that has entered into a separate contract with Medica to provide certain transplant-related health services. You may be evaluated and listed as a potential transplant recipient at multiple designated transplant facilities.

For in-network benefits, the plan 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. Based on the type of transplant you receive, the plan will determine the specific time period medically necessary.

There is no coverage for out-of-network benefits.

Weight loss surgery

In-network benefits apply to surgery for morbid obesity provided by a designated network physician and received at a designated network facility. A designated physician or designated facility is a network physician or hospital that has been designated by Medica to provide surgery for morbid obesity. To request a list of designated physicians and facilities to provide surgery for morbid obesity, call Customer Service at one of the telephone numbers listed inside the front cover.

There is no coverage for out-of-network benefits.

Exclusions

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

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

1. Services that are not medically necessary. This includes but is not limited to services inconsistent with the medical standards and accepted practice parameters of the community and services inappropriate—in terms of type, frequency, level, setting, and duration—to the diagnosis or condition.
2. Services or drugs used to treat conditions that are cosmetic in nature, unless otherwise determined to be reconstructive.
3. Refractive eye surgery, including but not limited to LASIK surgery.
4. The purchase, replacement, or repair of eyeglasses, eyeglass frames, or contact lenses when prescribed solely for vision correction, and their related fittings.
5. Services provided by an audiologist when not under the direction of a physician.
6. Hearing aids (including internal, external, or implantable hearing aids or devices) and other devices to improve hearing, and their related fittings, except as described in **Durable Medical Equipment, Prosthetics, and Medical Supplies** in **Benefits & Coverage**.
7. A drug, device, or medical treatment or procedure that is investigative.
8. Genetic testing when performed in the absence of symptoms or high risk factors for a genetic disease; genetic testing when knowledge of genetic status will not affect treatment decisions, frequency of screening for the disease, or reproductive choices; genetic testing that has been performed in response to direct-to-consumer marketing and not under the direction of your physician.
9. Services or supplies not directly related to care.
10. Autopsies.
11. 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.
12. Nutritional and electrolyte substances, except as specifically described in **Durable Medical Equipment, Prosthetics, and Medical Supplies** in **Benefits & Coverage**.
13. Physical, occupational, or speech therapy or chiropractic services when there is no reasonable expectation that the condition will improve over a predictable period of time.
14. Reversal of voluntary sterilization.
15. Personal comfort or convenience items or services.

16. Custodial care, unskilled nursing, or unskilled rehabilitation services.
17. Respite or rest care, except as otherwise covered in **Hospice Services** in **Benefits & Coverage**.
18. Travel, transportation, or living expenses, except as described in **Transplant Services** in **Benefits & Coverage**.
19. Household equipment, fixtures, home modifications, and vehicle modifications.
20. Massage therapy, provided in any setting, even when it is part of a comprehensive treatment plan.
21. Routine foot care, except for covered persons 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.
22. Services by persons who are family members or who share your legal residence.
23. Services for which coverage is available under workers' compensation, employer liability, or any similar law.
24. Services received before coverage under the plan becomes effective.
25. Services received after coverage under the plan ends.
26. Unless requested by the plan, charges for duplicating and obtaining medical records from non-network providers and non-network dentists.
27. Photographs, except for the condition of multiple dysplastic syndrome.
28. Occlusal adjustment or occlusal equilibration.
29. Dental implants (tooth replacement), except as described in **Medical-Related Dental Services** in **Benefits & Coverage**.
30. Dental prostheses.
31. Any orthodontia, except as described in **Medical-Related Dental Services** in **Benefits & Coverage** for the treatment of cleft lip and palate.
32. Treatment for bruxism.
33. Services prohibited by law or regulation, or illegal under Minnesota law.
34. Services to treat injuries that occur while on military duty, and any services received as a result of war or any act of war (whether declared or undeclared).
35. Exams, other evaluations, or other services received solely for the purpose of employment, insurance, or licensure.
36. 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 unless otherwise covered under this plan.
37. Non-medical self-care or self-help training.

38. Educational classes, programs, or seminars, including but not limited to childbirth classes, except as described in **Physician Services** in **Benefits & Coverage**.
39. Coverage for costs associated with translation of medical records and claims to English.
40. Treatment for superficial veins, also referred to as spider veins or telangiectasia.
41. Services not received from or under the direction of a physician, except as described in this plan.
42. Orthognathic surgery for cosmetic purposes.
43. Services for sex transformation operations.
44. Sensory integration, including auditory integration training.
45. Services for or related to vision therapy and orthoptic and/or pleoptic training, except as described in **Physician Services** in **Benefits & Coverage**.
46. Services for or related to intensive behavior therapy treatment programs for the treatment of autism spectrum disorders. Examples of such services include, but are not limited to, Intensive Early Intervention Behavior Therapy Services (IEIBTS), Intensive Behavioral Intervention (IBI), and Lovaas therapy.
47. Health care professional services for home labor and delivery.
48. Any form, mixture or preparation of cannabis for medical or therapeutic use and any device or supplies related to its administration.
49. Services solely for or related to the treatment of snoring.
50. Interpreter services.
51. Services provided to treat injuries or illnesses that are the result of committing a felony or attempting to commit a felony.
52. Services for private duty nursing, except as described in **Home Health Care** in **Benefits & Coverage**. Examples of private duty nursing services include, but are not limited to, skilled or unskilled services provided by an independent nurse who is ordered by the covered person or the covered person's representative, and not under the direction of a physician.
53. Laboratory testing that has been performed in response to direct-to-consumer marketing and not under the direction of a physician.
54. Medical devices that are not approved by the U.S. Food and Drug Administration (FDA), other than those granted a humanitarian device exemption.
55. Health clubs.
56. Long-term care.
57. Expenses associated with participation in weight loss programs, including but not limited to membership fees and the purchase of food, dietary supplements, or publications.

58. Any charges for mailing, interest, and delivery, such as the cost for mailing medical records.

Role of Medica

The plan administrator has entered into a service agreement with Medica Self-Insured (Medica) under which Medica performs a variety of administrative services with respect to the medical benefits provided under the plan. Medica's responsibilities generally consist of initially determining the validity of claims pursuant to the terms of the plan and administering benefit payments under this plan. The service agreement between the plan administrator and Medica is for administrative services only. Medica does not insure the provision of benefits under the plan; Medica is not a health insurer. Medica is a third party retained by the plan administrator. Medica is not a COBRA administrator.

Throughout this document you will see references to Medica making a determination regarding benefits, such as prior authorizations, exceptions or approvals of certain services. In making these determinations Medica is acting on behalf of the plan administrator.

The relationships between Medica, the plan administrator, 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 covered person is that of health care provider and patient. The provider is solely responsible for health care provided to any covered person.

This section describes how providers are generally paid for health services. See **Definitions** at the end of this document for defined terms and phrases.

Network providers

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

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

The methods by which specific network providers are paid may change from time to time. Methods also vary by network provider. The primary method of payment under your plan is a combination of a fee-for-service method with a risk-sharing arrangement that involves the network sharing a portion of the financial risk for the provision of covered services to all covered persons in your plan.

Fee-for-service payment means that the network provider is paid a fee for each service provided. If the payment is per service, the network provider's payment is determined according to a set fee schedule. The amount the network provider receives is the lesser of the fee schedule or what the network provider would have otherwise billed. If the payment is percentage of charges, the network provider's payment is a set percentage of the provider's

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

In certain risk-sharing payment arrangements, the network provider is paid a specific amount for a particular unit of service, such as an amount per day, an amount per stay, an amount per episode, an amount per case, an amount per period of illness, an amount per covered person, or an amount per service with targeted outcome. If the amount paid is less than the cost of providing or arranging for a covered person's health services, the network provider may bear some of the shortfall. If the amount paid to the network provider is more than the cost of providing or arranging a covered person's health services, the network provider may keep some of the excess. In other *risk-sharing* arrangements, the network accepts a portion of the financial risk for the provision of covered services to all covered persons enrolled in a particular Medica product.

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

Withhold arrangements

For some network providers paid on a fee-for-service basis, some of the payment is set aside. This is sometimes referred to as a physician contingency reserve or holdback. The withhold amount generally will not exceed 15 percent of the fee schedule amount. In general, a portion of network hospitals' fee for service payments is not held back. However, when it is, the withhold amount will not usually exceed 10 percent of the fee schedule amount.

Network providers may earn the withhold amount based on the product's financial performance and/or meeting certain performance standards identified in the network provider's contract including, but not limited to, quality and utilization. Based on individual measures, the percentage of the withhold amount paid, if any, can vary among network providers.

Non-network providers

When a service from a non-network provider is covered, the non-network provider is paid a fee for each covered service that is provided. This payment may be less than the charges billed by the non-network provider. If this happens, you are responsible for paying the difference.

Harmful Use of Medical Services

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

When this section applies

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

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

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

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

Medica will send you specific information about:

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

How to Submit a Claim

This section describes the process for submitting a claim.

Claims for benefits from network providers

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

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

Claims for benefits from non-network providers

Claim forms are provided in your enrollment materials. You may request additional claim forms by calling Customer Service at one of the telephone numbers listed inside the front cover. If the claim forms are not sent to you within 15 days, you may submit an itemized statement without the claim form to Medica. You should retain copies of all claim forms and correspondence for your records.

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

Mail to: Medica
PO Box 30990
Salt Lake City, UT 84130

Upon receipt of your claim for benefits from non-network providers, the plan will generally pay to you directly the non-network provider reimbursement amount. The plan will only pay the provider of services if:

1. The non-network provider is one that the plan has determined can be paid directly; and
2. The non-network provider notifies the plan of your signature on file authorizing that payment be made directly to the provider.

Call Customer Service at one of the telephone numbers listed inside the front cover for a list of non-network providers that the plan will not pay directly.

Claims for services provided outside the United States

Claims for 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 proof of travel.
- Such other documentation as the plan may request.

For services rendered in a foreign country, the plan will pay you directly.

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

Time limits

The plan will reconcile a claim within 30 days following receipt of the claim. In the event that additional time is needed to rectify a claim, the plan shall notify you in writing within the initial 30-day period and shall indicate the circumstances requiring an extension of up to 15 days. If a claim does not contain all the information Medica needs to make a determination, Medica may request additional information from you. Upon receipt of the additional information, Medica will notify you of authorization or denial of the claim within 15 days. If you do not respond to Medica's request for information within 45 days, Medica may deny the claim.

In addition, if a claim is denied, in whole or in part, you may follow the procedure outlined in **Complaints**. All administrative procedures of the plan should be exhausted prior to initiating legal action. If you intend to initiate legal action regarding a claim for benefits due under the plan, you must do so within two years after the claim is submitted to the plan. However, you may not bring legal action after the expiration of that two-year period.

Coordination of Benefits

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

Applicability

1. This coordination of benefits (COB) provision applies to this plan when an employee or the employee's covered dependent has health care coverage under more than one plan. Plan and this plan are defined below.
2. If this coordination of benefits provision applies, **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 **Order of benefit determination rules**, the benefits of this plan:
   a. Shall not be reduced when this plan determines its benefits before another plan; but
   b. May be reduced when another plan determines its benefits first. The above reduction is described in **Effect on the benefits of this plan.**

Definitions that apply to this section

1. Plan is any of these which provides benefits or services for, or because of, medical or dental care or treatment:
   a. 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.
   b. 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 contract or other arrangement for coverage under a. or b. 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.
2. This plan is the part of the plan that provides benefits for health care expenses.
3. *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.

4. *Allowable expense* means a necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made. Allowable expense does not include the deductible for covered persons with a primary high deductible plan and who notify Medica of an intention to contribute to a health savings account.

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

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

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

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

5. 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.

Order of benefit determination rules

1. *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:
   a. The other plan has rules coordinating its benefits with the rules of this plan; and
   b. Both the other plan's rules and this plan's rules, in 2. below, require that this plan's benefits be determined before those of the other plan.
2. *Rules.* This plan determines its order of benefits using the first of the following rules which applies:
   a. *Nondependent/dependent.* The benefits of the plan that covers the person as an employee, covered person, or enrollee (that is, other than as a dependent) are determined before those of the plan, which covers the person as a dependent.

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

i. 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

ii. 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 2.b.i. 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.

c. *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:

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

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

iii. 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.

d. *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 2.b.

e. *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.

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

g. *No-fault automobile insurance*. Coverage under the No-Fault Automobile Insurance Act or similar law applies first.

h. *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, covered person, or enrollee longer are determined before those of the plan which covered that person for the shorter term.

Effect on the benefits of this plan

1. *When this section applies*. This section applies when, in accordance with **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 2. immediately below.

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

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

   b. 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 the plan, according to the out-of-network benefits described. Most out-of-network benefits are covered at 60 percent 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.

Right to receive and release needed information

Certain facts are needed to apply these COB rules. The plan has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. The plan need not tell, or get the consent of, any person to do this. Unless applicable 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 the plan any facts it needs to pay the claim.

Facility of payment

A payment made under another plan may include an amount, which should have been paid under this plan. If it does, the plan 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. The plan 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.

Right of recovery

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

1. The persons it has paid or for whom it has paid; or
2. Insurance companies; or
3. Other organizations.

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

Please note: See **Right of Recovery** for additional information.

Right of Recovery

This section describes this plan's right of recovery.

This plan has a right to subrogate and to reimbursement where a third party, individual, corporation, insurer, or other entity or person who may be legally responsible for payment of medical expenses related to a covered person's illness or injury. For purposes of this provision, covered person includes (1) any individual who at the time an eligible expense is incurred is covered under the plan and for which the plan is obligated to provide coverage, and (2) any individual who has had benefits paid by the plan. Covered person also includes any person acting on behalf of the covered person, including but not limited to the covered person's attorney and the covered person's estate.

With respect to these rights of recovery, the following rules apply:

1. **First dollar recovery.** This plan shall be reimbursed from any recovery before payment of any other existing claims or payments to any other persons, including but not limited to any claims for general damages, specific damages other than medical expenses, attorney fees, or costs incurred in obtaining the recovery. For purposes of this provision, recovery is not limited to a court award. It includes any award or determination by a third party, judgment, voluntary settlement, or any other payment or arrangement for payment for or on behalf of a covered person or a covered person's estate. This plan may collect the proceeds of any such recovery regardless of whether the covered person has been fully compensated.
2. **Value of interest.** The plan's recovery interest is the reasonable cash value of any benefits provided by the plan or for which the plan may be obligated to provide.

Subrogation

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand, or right. If a covered person receives a benefit payment from the plan for an injury caused by a third party, and the covered person later receives any payment for that same condition or injury from another person, organization, or insurance company, the plan has the right to recover any payments made by the plan to the covered person. This process of recovering earlier payments is called subrogation. In case of subrogation, covered persons may be asked to sign and deliver information or documents necessary for the plan to protect its right to recover benefit payments made. The covered person agrees to provide the plan all assistance necessary as a condition of participation in the plan, including cooperation and information submitted to as supplied by a workers' compensation, liability insurance carrier, and any medical benefits, no-fault insurance, or school insurance coverage that are paid or payable.

The plan shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type, for the reasonable value of services and benefits the plan provided to covered persons from any or all of the following:

- Third parties, including any person alleged to have caused a covered person to suffer injuries or damages.

- The covered person's employer.
- Any person or entity obligated to provide benefits or payments to covered persons, including benefits or payments for underinsured or uninsured motorist protection (these third parties and persons or entities are collectively referred to as third parties).

The covered person agrees as follows:

- To assign to the plan all rights of recovery against third parties, to the extent of the reasonable value of services and benefits the plan provided, plus reasonable costs of collection.
- To cooperate with the plan in protecting its legal rights to subrogation and reimbursement.
- That the plan's rights will be considered as the first priority claim against third parties, to be paid before any other of the covered person's claims are paid.
- That the covered person will do nothing to prejudice the plan's rights under this provision, either before or after the need for services or benefits under the plan.
- That the plan may, at its discretion, take necessary and appropriate action to preserve its rights under these subrogation provisions, including filing suit in the covered person's name.
- That regardless of whether or not a covered person has been fully compensated, the plan may collect from the proceeds of any full or partial recovery that a covered person or the legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, the reasonable value of services provided under the plan.
- To hold in trust for the plan's benefit under these subrogation provisions any proceeds of settlement or judgment.
- That the plan shall be entitled to recover reasonable attorney fees from the covered person incurred in collection proceeds held by the covered person.
- That the covered person will not accept any settlement that does not fully compensate or reimburse the plan without its written approval.
- To execute and deliver such documents (including a written confirmation of assignment, and consent to release medical records) and provide such help (including responding to requests for information about any accident or injuries and making court appearances) as the plan may reasonably request from the covered person.
- The plan will not pay fees, costs, or expenses the covered person incurs with any claim or lawsuit, without the plan's prior written consent.

Reimbursement

Where medical expenses for which the plan has provided coverage or for which the plan may have an obligation to provide coverage are involved, the plan has a right to reimbursement from the covered person for benefits paid by the plan. This includes the right to seek equitable or other relief from any party in control of recovery proceeds to which this provision applies. Moreover, any future benefits will serve to offset any payments that have already been made by the plan but which it was unable to recover.

Consequences

If a covered person does not comply with the obligations described in this provision, the plan has the right to seek recovery of the actual costs and fees expended in enforcing the plan's rights to subrogate and/or receive reimbursement under this provision from the covered person.

Eligibility and Enrollment

This section describes who can enroll and how to enroll.

Who can enroll

All qualified employees and dependents as defined in **Definitions** are eligible for coverage under this plan. In order for an eligible dependent to enroll in the plan, the qualified employee must also be enrolled.

How to enroll

Submit an application for coverage for the qualified employee and/or any dependents to the plan administrator:

1. During the initial enrollment period as described in this section under **Initial enrollment and effective date of coverage**; or
2. During the open enrollment period as described in this section under **Open enrollment and effective date of coverage**; or
3. During a special enrollment period as described in this section under **Special enrollment and effective date of coverage**.

Dependents will not be enrolled without the qualified employee also being enrolled. A child who is the subject of a QMCSO can be enrolled as described in this section under **Qualified Medical Child Support Order (QMCSO)** and under **Special enrollment and effective date of coverage.**

Initial enrollment and effective date of coverage

Qualified employees must submit an application for the qualified employee and/or any dependents to the plan administrator during the initial enrollment period, which will be communicated to the qualified employee by the plan administrator.

A covered person who is a child entitled to receive coverage through a QMCSO is not subject to any initial enrollment period restrictions, except as noted in this section.

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

For qualified employees and dependents who enroll during the initial enrollment period, coverage begins on the first day of the first calendar month following or coinciding with the date the employee first meets the definition of a qualified employee.

Open enrollment and effective date of coverage

Qualified employees must submit an application for the qualified employee and any dependents to the plan administrator during the open enrollment period, which will be communicated to the qualified employee by the plan administrator. Open enrollment period means the period of time occurring toward the end of the calendar year during which qualified employees and eligible dependents who are not covered under the plan may elect to begin coverage effective the first day of the upcoming calendar year.

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

For qualified employees and dependents who enroll during the open enrollment period, coverage begins on the first day of the calendar year for which the open enrollment period was held.

Special enrollment and effective date of coverage

Special enrollment periods are provided to qualified employees and dependents under certain circumstances. Qualified employees and dependents who are eligible to enroll during a special enrollment period may enroll in any medical benefit package or option available to similarly situated individuals who enroll when first eligible. **However, all other provisions of the plan, including but not limited to provisions setting a lifetime maximum on benefits, will apply to special enrollees.**

1. Loss of other coverage

    a. A special enrollment period will apply to a qualified employee and dependent if the individual was covered under Medicaid or a State Children's Health Insurance Plan (SCHIP) and lost that coverage as a result of loss of eligibility. The qualified employee or dependent must present evidence of the loss of coverage and request enrollment within 60 days after the date such coverage terminates.

       In the case of the qualified employee's loss of coverage, this special enrollment period applies to the qualified employee and all of his or her dependents. In the case of a dependent's loss of coverage, this special enrollment period applies to both the dependent who has lost coverage and the qualified employee.

    b. A special enrollment period will apply to a qualified employee and dependent if the qualified employee or dependent was covered under creditable coverage other than Medicaid or a State Children's Health Insurance Plan at the time the qualified employee or dependent was eligible to enroll under the plan, whether during initial enrollment, open enrollment, or special enrollment, and declined coverage for that reason.

       The qualified employee or dependent must present to the plan administrator either evidence of the loss of prior coverage due to loss of eligibility for that coverage or evidence that employer contributions toward the prior coverage have terminated, and

request enrollment in writing within 31 days of the date of the loss of coverage or the date the employer's contribution toward that coverage terminates.

For purposes of 1.b.:

i. Prior coverage does not include federal or state continuation coverage;

ii. Loss of eligibility includes:

- loss of eligibility as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment;
- cessation of dependent status;
- incurring a claim that causes the qualified employee or dependent to meet or exceed the lifetime maximum limit on all benefits;
- if the prior coverage was offered through an individual health maintenance organization (HMO), a loss of coverage because the qualified employee or dependent no longer resides or works in the HMO's service area;
- if the prior coverage was offered through a group HMO, a loss of coverage because the qualified employee or dependent no longer resides or works in the HMO's service area and no other coverage option is available; and
- the prior coverage no longer offers any benefits to the class of similarly situated individuals that includes the qualified employee or dependent.

iii. Loss of eligibility occurs regardless of whether the qualified employee or dependent is eligible for or elects applicable federal or state continuation coverage;

iv. Loss of eligibility does not include a loss due to failure of the qualified employee or dependent to pay premiums on a timely basis or termination of coverage for cause;

In the case of the qualified employee's loss of other coverage, the special enrollment period described above applies to the qualified employee and all of his or her dependents. In the case of a dependent's loss of other coverage, the special enrollment period described above applies only to the dependent that has lost coverage and the qualified employee; dependents will not be enrolled without the qualified employee also being enrolled.

c. A special enrollment period will apply to a qualified employee and dependent if the eligible employee or dependent was covered under benefits available under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, or any applicable state continuation laws at the time the qualified employee or dependent was eligible to enroll under the plan, whether during initial enrollment, open enrollment, or special enrollment and declined coverage for that reason.

The qualified employee or dependent must present to the plan administrator evidence that the qualified employee or dependent has exhausted such COBRA or

state continuation coverage and has not lost such coverage due to failure of the qualified employee or dependent to pay premiums on a timely basis or for cause, and request enrollment in writing within 31 days of the date of the exhaustion of coverage.

For purposes of 1.c.:

i. Exhaustion of COBRA or state continuation coverage includes:

- losing COBRA or state continuation coverage for any reason other than those set forth in ii. below;
- losing coverage as a result of the employer's failure to remit premiums on a timely basis; or
- losing coverage as a result of the qualified employee or dependent incurring a claim that meets or exceeds the lifetime maximum limit on all benefits and no other COBRA or state continuation coverage is available; or
- if the prior coverage was offered through a health maintenance organization (HMO), losing coverage because the qualified employee or dependent no longer resides or works in the HMO's service area and no other COBRA or state continuation coverage is available.

ii. Exhaustion of COBRA or state continuation coverage does not include a loss due to failure of the qualified employee or dependent to pay premiums on a timely basis or termination of coverage for cause;

iii. In the case of the qualified employee's exhaustion of COBRA or state continuation coverage, the special enrollment period described above applies to the qualified employee and all of his or her dependents. In the case of a dependent's exhaustion of COBRA or state continuation coverage, the special enrollment period described above applies only to the dependent who has lost coverage and the eligible employee; dependents will not be enrolled without the qualified employee also being enrolled.

2. The dependent is a new spouse of the enrollee or qualified employee, provided that the marriage is legal and enrollment is requested in writing within 31 days of the date of marriage and provided that the qualified employee also enrolls during this special enrollment period. Coverage is effective on the date of the marriage.

3. The dependent is a new dependent child of the enrollee or qualified employee, provided that enrollment is requested in writing within 31 days of the enrollee or qualified employee acquiring the dependent and provided that the qualified employee also enrolls during this special enrollment period. In the case of birth, coverage is effective on the date of birth; in the case of adoption, placement for adoption, or placement as a foster child, coverage is effective the date of adoption or placement. In all other cases, coverage is effective the date the enrollee acquires the dependent child.

4. The dependent is the spouse of the enrollee or qualified employee through whom the dependent child described in 3. above claims dependent status and:

   a. That spouse is eligible for coverage; and

   b. Is not already enrolled under the plan; and

   c. Enrollment is requested in writing within 31 days of the dependent child becoming a dependent; and

   d. The qualified employee also enrolls during this special enrollment period; and

   Coverage is effective on the date coverage for the dependent child is effective, as set forth in 3. above.

5. The dependents are eligible dependent children of the enrollee or qualified employee and enrollment is requested in writing within 31 days of a dependent, as described in 2. or 3. above, becoming eligible to enroll under the coverage provided the qualified employee also enrolls during this special enrollment period. Coverage is effective on the date coverage for the dependent is effective, as set forth in 2. or 3. above (as applicable).

6. When the employer is provided with notice of a QMCSO and a copy of the order, as described in this section, the employer will provide the eligible dependent child with a special enrollment period provided the qualified employee also enrolls during this special enrollment period. Coverage is effective the first day of the first calendar month following the date the written request for enrollment is received by the plan administrator. Any child who is a covered person pursuant to a QMCSO will be covered without application of waiting periods.

7. The dependent is a new domestic partner of the enrollee or qualified employee, provided the domestic partnership is registered and enrollment is requested in writing within 31 days of the date of registration, and the qualified employee also enrolls during the special enrollment period.

Qualified Medical Child Support Order (QMCSO)

The plan will provide coverage in accordance with a QMCSO pursuant to the applicable requirements under Section 609 of the Employee Retirement Income Security Act (ERISA) and Section 1908 of the Social Security Act. It is the plan administrator’s responsibility to determine whether a medical child support order is qualified.

Upon receipt of a medical child support order issued by an appropriate court or governmental agency, the plan administrator will follow its established procedures in determining whether the medical child support order is qualified. Covered persons may obtain a copy of the plan’s QMCSO procedures from the plan administrator, free of charge.

1. Where a QMCSO requires coverage be provided under the plan for a qualified employee’s dependent child who is not already a covered person, such child will be provided a special enrollment period. If the qualified employee whose dependent child is the subject of the QMCSO is not an enrollee at the time enrollment for the dependent child is requested, the

qualified employee may also enroll for coverage under the plan during the special enrollment period.

2. Where a QMCSO requires coverage be provided under the plan for a qualified employee's dependent child who is already a covered person, such child will continue to be provided coverage under the plan pursuant to the terms of the QMCSO.

Ending Coverage

This section describes when coverage ends under the plan. When this happens you may exercise your right to continue your coverage as described in **Continuation**.

When your coverage ends

Unless otherwise specified, coverage ends the earliest of the following:

1. The date on which this plan terminates. If the relationship between the plan administrator and Medica ends, coverage under the plan will not necessarily end. Only the sponsor determines when this plan terminates.
2. The end of the month for which the enrollee or covered person last paid any required contribution to the plan.
3. The end of the month in which the covered person is no longer eligible as determined by the plan administrator. See **Eligibility and Enrollment** for information on eligibility.
4. The end of the month in which the enrollee request that coverage end due to a change in status defined by the IRS. Contact Human Resources for a specific definition.
5. The effective date of a plan amendment terminating coverage for the class to which a covered person belongs.
6. The date the plan administrator approves the enrollee's or covered person's request to end his or her coverage.
7. The date specified by the plan administrator because a covered person permitted the use of his or her identification card by any unauthorized person or used another person's card or submitted fraudulent claims.
8. The date a covered person enters active military duty for more than 31 days. Upon completion of active military duty, contact the plan administrator to discuss reinstatement of coverage.
9. For a dependent domestic partner, the date in which the individual no longer meets the criteria to be a dependent domestic partner.
10. For a child who is entitled to coverage through a QMCSO, the earliest of the following:
    a. The end of the month in which a QMCSO ceases to be effective; or
    b. The end of the month in which the child has immediate and comparable coverage under another plan; or
    c. The end of the month in which the qualified employee who is ordered by the QMCSO to provide coverage is no longer eligible as determined by the plan administrator; or
    d. The date the sponsor terminates family or dependent coverage; or
    e. The date the plan is terminated by the sponsor; or

f. The end of the month for which the relevant premium or contribution toward the premium is last paid.

11. The date specified by the plan administrator in written notice to a covered person that coverage ended due to the plan administrator's determination that the covered person committed fraud in applying for this coverage or for any of its benefits. Fraud includes, but is not limited to, intentionally providing the plan administrator with false material information such as:

    a. Information related to an enrollee's eligibility or another person's eligibility for coverage or status as a dependent; or

    b. Information related to an enrollee's health status or that of any dependent; or

    c. Intentional misrepresentation of the employer-employee relationship.

    Coverage will be retroactively terminated at the plan administrator's discretion to the original date of coverage or the date on which the fraudulent act took place. No continuation privilege will be extended.

Continuation

This section describes continuation coverage provisions. When coverage ends, covered persons may be able to continue coverage under federal law. All aspects of continuation coverage administration are the responsibility of the plan administrator.

Additionally, when you lose group health coverage, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. You and your family may have coverage options through the Exchange, Medicaid, or other group health plan coverage options (such as a spouse's plan). For example, you may be eligible to buy an individual or family plan through the Exchange. By enrolling in coverage through the Exchange, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees. Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

The paragraph below describes the continuation coverage provisions. Federal continuation is described in **Your right to continue coverage under federal law**.

If your coverage ends, you should review your rights under federal law with the plan administrator.

Your right to continue coverage under federal law

Notwithstanding the provisions regarding termination of coverage described in **Ending Coverage**, you may be entitled to extended or continued coverage as follows:

COBRA continuation coverage

Continued coverage shall be provided as required under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended (as well as the Public Health Service Act (PHSA), as amended). The plan administrator shall, within the parameters of federal law, establish uniform policies pursuant to which such continuation coverage will be provided. See General COBRA information in this section.

USERRA continuation coverage

Continued coverage shall be provided as required under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended. The plan administrator shall, within the parameters of federal law, establish uniform policies pursuant to which such continuation coverage will be provided. See General USERRA information in this section.

General COBRA information

COBRA requires employers with 20 or more employees to offer employees and their families (spouse and/or dependent children) the opportunity to pay for a temporary extension of health coverage (called continuation coverage) at group rates in certain instances where health

coverage under employer sponsored group health plan(s) would otherwise end. This coverage is a group health plan for purposes of COBRA.

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

Qualified beneficiary

For purposes of this section, a qualified beneficiary is defined as:

1. A covered employee (a current or former employee who is actually covered under the plan and not just eligible for coverage);
2. A covered spouse of a covered employee; or
3. A dependent child of a covered employee. (A child placed for adoption with or born to an employee or former employee receiving COBRA continuation coverage is also a qualified beneficiary.)

Enrollee's loss

The enrollee has the right to elect continuation of coverage if there is a loss of coverage under the plan because of termination of the enrollee's employment (for any reason other than gross misconduct), or the enrollee becomes ineligible to participate under the terms of the plan due to a reduction in his or her hours of employment.

Enrollee's spouse's loss

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

1. Death of the enrollee;
2. A termination of the enrollee's employment (for any reason other than gross misconduct) or reduction in the enrollee's hours of employment with the employer;
3. Divorce or legal separation from the enrollee; or
4. The enrollee's entitlement to (actual coverage under) Medicare.

Enrollee's child's loss

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

1. Death of the enrollee if the enrollee is the parent through whom the child receives coverage;
2. The enrollee's termination of employment (for any reason other than gross misconduct) or reduction in the enrollee's hours of employment with the employer;
3. The enrollee's divorce or legal separation from the child's other parent;

4. The enrollee's entitlement to (actual coverage under) Medicare if the enrollee is the parent through whom the child receives coverage; or
5. The enrollee's child ceases to be a dependent child under the terms of the plan.

Responsibility to inform

Under the law, the enrollee and dependent have the responsibility to inform the plan administrator of a divorce, legal separation, or a child losing dependent status under the plan within 60 days of the date of the event, or the date on which coverage would be lost because of the event.

Also, an enrollee and dependent who have been determined to be disabled under the Social Security Act as of the time of the enrollee's termination of employment or reduction of hours or within 60 days of the start of the continuation period must notify the plan administrator of that determination within 60 days of the determination. If determined under the Social Security Act to no longer be disabled, he or she must notify the plan administrator within 30 days of the determination.

The enrollee's employer has the responsibility to notify the plan administrator of the enrollee's death, termination of employment or reduction in hours.

Bankruptcy

Rights similar to those described above may apply to retirees (and the spouses and dependents of those retirees) if the enrollee's employer commences a bankruptcy proceeding and these individuals lose coverage.

Election rights

When notified that one of these events has happened, the plan administrator will notify the enrollee and dependents of the right to choose continuation coverage.

Consistent with federal law, the enrollee and dependents have 60 days to elect continuation coverage, measured from the later of:

1. The date coverage would be lost because of one of the events described above, or
2. The date notice of election rights is received.

If continuation coverage is elected within this period, the coverage will be retroactive to the date coverage would otherwise have been lost.

The enrollee and the enrollee's covered spouse may elect continuation coverage on behalf of other covered dependents entitled to continuation coverage. However, each person entitled to continuation coverage has an independent right to elect continuation coverage. The enrollee's covered spouse or dependent child may elect continuation coverage even if the enrollee does not elect continuation coverage.

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

Type of coverage and cost

If the enrollee and the enrollee's dependents elect continuation coverage, the employer is required to provide coverage that, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or employees' dependents.

Under the law, a person electing continuation coverage may have to pay all or part of the premium for continuation coverage. The amount charged cannot exceed 102 percent of the cost of the coverage. The amount may be increased to 150 percent of the applicable premium for months after the 18th month of continuation coverage when the additional months are due to a disability under the Social Security Act.

There is a grace period of at least 30 days for the regularly scheduled premium.

Duration of COBRA coverage

Federal law requires that you be allowed to maintain continuation coverage for 36 months unless you lost coverage under the plan because of termination of employment or reduction in hours. In that case, the required continuation coverage period is 18 months. The 18 months may be extended if a second event (e.g., divorce, legal separation, or death) occurs during the initial 18-month period. It also may be extended to 29 months in the case of an employee or employee's covered dependent who is determined to be disabled under the Social Security Act at the time of the employee's termination of employment or reduction of hours, or within 60 days of the start of the 18-month continuation period.

If an employee or the employee's covered dependent is entitled to 29 months of continuation coverage due to his or her disability, the other family members' continuation period is also extended to 29 months. If the enrollee becomes entitled to (actually covered under) Medicare, the continuation period for the enrollee's dependents is 36 months measured from the date of the enrollee's Medicare entitlement even if that entitlement does not cause the enrollee to lose coverage.

Under no circumstances is the total continuation period greater than 36 months from the date of the original event that triggered the continuation coverage.

Federal law provides that continuation coverage may end earlier for any of the following reasons:

1. The enrollee's employer no longer provides group health coverage to any of its employees;
2. The premium for continuation coverage is not paid on time;
3. Coverage is obtained under another group health plan (as an employee or otherwise) that does not contain any exclusion or limitation with respect to any applicable pre-existing condition; or
4. The enrollee becomes entitled to (actually covered under) Medicare.

Continuation coverage may also end earlier for reasons which would allow regular coverage to be terminated, such as fraud.

Trade Act of 2002

Pursuant to the Trade Act of 2002, certain employees and former employees who are receiving trade adjustment assistance (TAA) may be eligible for a special second COBRA election. TAA is generally available to those employees who have lost their jobs or suffered reduction in hours because of import competition and shifts in production to other countries. If you are potentially eligible for these rights under the Trade Act, you will receive additional information regarding it at the time of your termination of employment or reduction in hours.

General USERRA information

USERRA requires employers to offer employees and their families (spouse and/or dependent children) the opportunity to pay for a temporary extension of health coverage (called continuation coverage) at group rates in certain instances where health coverage under employer sponsored group health plan(s) would otherwise end. This coverage is a group health plan for the purposes of USERRA.

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

Employee's loss

The employee has the right to elect continuation of coverage if there is a loss of coverage under the plan because of absence from employment due to service in the uniformed services, and the employee was covered under the plan at the time the absence began, and the employee, or an appropriate officer of the uniformed services, provided the employer with advance notice of the employee's absence from employment (if it was possible to do so).

Service in the uniformed services means the performance of duty on a voluntary or involuntary basis in the uniformed services under competent authority, including active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and the time necessary for a person to be absent from employment for an examination to determine the fitness of the person to perform any of these duties.

Uniformed services means the U.S. Armed Services, including the Coast Guard, the Army National Guard, and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty, and the commissioned corps of the Public Health Service.

Election rights

The employee or the employee's authorized representative may elect to continue the employee's coverage under the plan by making an election on a form provided by the plan administrator. The employee has 60 days to elect continuation coverage measured from the date coverage would be lost because of the event described above. If continuation coverage is elected within this period, the coverage will be retroactive to the date coverage would otherwise have been lost. The employee may elect continuation coverage on behalf of other covered dependents, however, there is no independent right of each covered dependent to elect. If the employee does not elect,

there is no USERRA continuation available for the spouse or dependent children. In addition, even if the employee does not elect USERRA continuation, the employee has the right to be reinstated under the plan upon reemployment, subject to the terms and conditions of the plan.

Type of coverage and cost

If the employee elects continuation coverage, the employer is required to provide coverage that, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees. The amount charged cannot exceed 102 percent of the cost of the coverage unless the employee's leave of absence is less than 31 days, in which case the employee is not required to pay more than the amount that they would have to pay as an active employee for that coverage. There is a grace period of at least 30 days for the regularly scheduled premium.

Duration of USERRA coverage

When an employee takes a leave for service in the uniformed services, coverage for the employee and dependents for which coverage is elected begins the day after the employee would lose coverage under the plan. Coverage continues for up to 24 months.

Federal law provides that continuation coverage may end earlier for any of the following reasons:

1. The employer no longer provides group health coverage to any of its employees;
2. The premium for continuation coverage is not paid on time;
3. The employee loses their rights under USERRA as a result of a dishonorable discharge or other undesirable conduct;
4. The employee fails to return to work following the completion of his or her service in the uniformed services; or
5. The employee returns to work and is reinstated under the plan as an active employee.

Continuation coverage may also end earlier for reasons which would allow regular coverage to be terminated, such as fraud.

COBRA and USERRA coverage are concurrent

If the employer is subject to both COBRA and USERRA, and you elect COBRA continuation coverage in addition to USERRA continuation coverage, these coverages run concurrently.

Other continuation coverage

Notwithstanding the provisions regarding termination of coverage described in **Ending Coverage**, you may be entitled to extended or continued coverage as follows:

Severance program

An enrollee who terminates employment and is entitled to severance under a severance plan offered by the sponsor may have a portion of the premium (for any available COBRA

continuation coverage) paid by the sponsor. This may include the cost of coverage for the enrollee's family. The severance plan or arrangement under which the enrollee receives payment determines benefits with respect to continuation coverage.

Retirees – early retirement

An employee of the sponsor who retires from employment with the sponsor through the early retirement option and who was an enrollee at the time he or she retired, shall remain eligible for coverage under this plan as a retiree. Dependents of the early retiree shall be eligible for coverage on the same basis as dependents of qualified employees. The sponsor may pay a portion of the premium for such coverage. Any available COBRA continuation coverage may run concurrently with early retiree coverage.

Leaves of absence

An enrollee on a leave of absence from employment with the sponsor and that is approved by the sponsor may be entitled to continuation coverage. The sponsor may pay a portion of the premium for such coverage. Eligibility, as it pertains to the availability of continuation coverage during a leave of absence, shall be determined by the sponsor, in accordance with its leave of absence policy. Any available COBRA continuation coverage may run concurrently with leave of absence coverage.

Domestic partner

If coverage for domestic partners is available under the plan, an enrolled dependent domestic partner and domestic partner's child who lose eligibility due to termination of the domestic partner relationship may be entitled to continuation coverage. If the domestic partner relationship terminates, an affidavit must be completed to terminate coverage under the plan. Eligibility, as it pertains to the availability of continuation coverage for domestic partners, shall be determined by the plan administrator, in accordance with its domestic partner coverage policy.

Insurability

A person does not have to demonstrate insurability to elect continuation coverage. At the end of the 18, 24, 29, or 36-month continuation period, as applicable, there is no opportunity to enroll in an individual conversion health plan.

Complaints

Claim denials

The plan will provide you with the following written information if a claim is denied (in whole or in part):

1. The reason(s) for the denial;
2. Reference to the provision(s) of the plan on which the denial is based;
3. A description of any additional material or information you must submit to complete processing of the claim and why such information is necessary; and
4. An explanation of the plan's claim review procedures.

Generally, the plan will notify you of denial within 30 calendar days after the plan receives proof of the claim.

First level of review

1. If you are dissatisfied with Medica's claim denial, you or an authorized representative may submit a written request for an appeal to Medica at the following address:

   Medica
   Customer Service
   PO Box 9310, Route 0501
   Minneapolis, MN 55440-9310

   You must request an appeal within 180 days from the date of the claim denial. The appeal request should state the reasons you believe the claim denial was improper and should be accompanied by any additional information, material, or comments you consider appropriate. You may also review any pertinent documents related to the claim.
2. The denied claim shall be reviewed by Medica and a decision made within 30 calendar days after receiving the written request for review. The decision of Medica shall be in writing and will include the specific reasons for the decision as well as specific references to the pertinent plan provisions on which the decision is based.
3. The denied claim will be reviewed and a decision made by Medica within 72 hours if your attending provider believes that Medica's decision warrants an expedited appeal or if Medica concludes that a delay could seriously jeopardize your life, health, or ability to regain maximum function, or subject you to severe pain that cannot be adequately managed without the care or treatment you are requesting. In such cases, you may have the right to request an external review while your appeal review is being conducted.

External review

If you are not satisfied with Medica's appeal decision, you or an authorized representative may submit to Medica a request for an external review by an independent review organization (IRO). This review will be coordinated by Medica. Your request must be submitted to Medica within 4 months following the date of Medica's appeal decision. You may submit additional information to be reviewed by the IRO. You will be notified of the IRO's decision within 45 days. If waiting the standard 45-day turnaround time might jeopardize your life, health, or ability to regain maximum function, or if this timeframe would subject you to severe pain that cannot be managed without the care or treatment you are requesting, you or your attending provider may request an expedited 72-hour external review. You may also request an expedited external review if your appeal concerns an admission, continued stay, or health care service for which you received emergency services and you have not been discharged from a facility. The IRO's decision is a final, binding decision. For more information or to submit a request for external review, contact Medica at the address listed above.

Your right to take legal action

If you are not satisfied with Medica's appeal decision, you may file a civil action suit under Section 502 (a) of the Employee Retirement Income Security Act of 1974 (ERISA). If you intend to initiate legal action regarding a claim for benefits due under the plan, you must do so within two years after the claim is submitted to the plan. You may not bring legal action after the expiration of that two-year period.

Other complaints

If you have a complaint or dispute with this plan regarding something other than a claim denial, you may contact the plan administrator in an attempt to resolve the complaint in an informal manner. You may also direct any question or complaint to Customer Service at one of the telephone numbers listed inside the front cover.

General Provisions

This section describes the general provisions of the plan.

Records

The sponsor, the plan administrator, Medica, and others to whom the sponsor has delegated duties and responsibilities under the plan shall keep accurate and detailed records of any matters pertaining to administration of the plan in compliance with applicable law.

Examination of a covered person

To settle a dispute concerning provision or payment of benefits under the plan, the plan administrator may require that you be examined or an autopsy of the covered person's body be performed. The examination or autopsy will be at the plan's expense.

Clerical error and misstatements

Should a clerical error be found or should any misstatement of relevant facts pertaining to coverage under the plan be found, and should such error or misstatement affect the existence or amount of coverage under the plan, the plan administrator reserves the right to investigate the matter and determine the existence or amount of coverage. For example, you will not be eligible for coverage beyond the scheduled termination of coverage because of a failure to record the termination. On the other hand, you will not be deprived of coverage under the plan because of a clerical error.

Plan amendment and termination

Any change or amendment to or termination of the plan, its benefits, or its terms and conditions, in whole or in part, whether prospective or retroactive, shall be made solely in a written amendment (in the case of a change or amendment) or in written resolution (in the case of termination) to the plan, approved by the Board of Directors (if a corporation), the general partner(s) (if a partnership), the proprietor (if a sole proprietorship) or similar governing body (in all other cases) of the sponsor or any of their designees to whom such Board of Directors, general partner(s), proprietor, or similar body has delegated in writing the foregoing authority. You will receive notice of any amendment to the plan in accordance with applicable law. No one has the authority to make any oral modification to the plan.

Applicable law

This plan is intended to be construed, and all rights and duties hereunder are to be governed, in accordance with the laws of the State of Minnesota, except to the extent such laws are preempted by the laws of the United States of America.

USERRA

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) imposes certain obligations on employers. This plan shall be administered in a manner consistent with USERRA.

Enrollee rights

The action of the sponsor in creating this plan shall not be construed to constitute and shall not be evidence of any contractual relationship between the sponsor and any enrollee, or as a right of any enrollee to continue in the employment of the sponsor, or as a limitation of the right of the sponsor to discharge any of its employees, with or without cause.

Family and Medical Leave Act of 1993 (FMLA)

The Family and Medical Leave Act of 1993 (FMLA) imposes certain obligations on employers with fifty (50) or more employees. This plan shall be administered in a manner consistent with the FMLA and the applicable employer's FMLA policy.

Reservation of discretion

The plan administrator and its delegate have the full discretionary power to interpret and apply the terms of the plan, and its components (including, without limitation, supplying omissions from, correcting deficiencies in, or resolving inconsistencies or ambiguities in the language of the plan and its underlying documents) as they relate to matters for which the named fiduciary has responsibility. All decisions of the plan administrator and its delegate as to the facts of the case, interpretation of any provisions of the plan, or its application to any case and any other interpretative matter, determination, or question under the plan will be final and binding on all affected parties.

Definitions

Words and phrases with specific meanings are defined in this section.

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

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

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

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. Full coinsurance payments may apply to scheduled appointments canceled less than 24 hours before the appointment time or to missed appointments.

For in-network benefits, the coinsurance amount 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, on behalf of the sponsor, 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 covered person of Medica.

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 will be responsible for any charges billed by the provider in excess of the non-network provider reimbursement amount.

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

Continuous creditable coverage. The maintenance of continuous and uninterrupted creditable coverage by a qualified employee or dependent. A qualified employee or dependent is considered to have maintained continuous creditable coverage if enrollment is requested under the plan within 63 days of termination of the previous creditable coverage.

Convenience care/retail health clinic. A health care clinic located in a setting such as a retail store, grocery store, or pharmacy, which provides treatment of common illnesses and certain preventive health care services.

Cosmetic. Services and procedures that improve physical appearance but do not correct or improve a physiological function, and that are not medically necessary, or as determined by the plan.

Covered person. A person who is enrolled under the plan.

Creditable coverage. Health coverage provided under one of the following plans:

1. A group health benefit plan, including a self-insured plan;
2. Health insurance coverage, whether through a group or individual contract;
3. Medicare;
4. Medicaid (other than coverage consisting solely of benefits under the program for distribution of pediatric vaccines);
5. A state health benefit risk pool;
6. A military health plan or other coverage provided under United States Code, title 10, chapter 55;
7. A medical care program of the Indian Health Service or of a tribal organization;
8. The Federal Employees Health Benefits Program or other similar coverage provided under federal law applicable to government organizations and employees;
9. A health benefit plan provided under Section 5(e) of the federal Peace Corps Act;
10. State Children's Health Insurance Program; or
11. A public health plan similar to any of the above plans established or maintained by a state, the U.S. government, a foreign country, or any political subdivision of a state, the U.S. government, or a foreign country.

Coverages of the following types, including any combination of the following types, are *not* creditable coverage:

1. Coverage only for accident, or disability income insurance, or any combination thereof;
2. Coverage issued as a supplement to liability insurance;
3. Liability insurance;
4. Workers' compensation insurance;
5. Automobile medical payment insurance;
6. Credit-only insurance;
7. Coverage for on-site medical clinics;
8. Limited scope dental or vision coverage;
9. Coverage for long-term care, nursing home care, home health care, community-based care, or any combination of these;
10. Coverage only for a specified disease or illness;
11. Hospital indemnity or other fixed indemnity insurance; or
12. Medicare supplemental health insurance, benefits supplemental to military health care, and similar supplemental coverage if such benefits are provided under a separate policy or contract of insurance.

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

Deductible. The fixed dollar amount you must pay for eligible services or supplies before claims for health services or supplies received from providers are reimbursable as benefits under this plan.

Dependent. Unless otherwise specified in the plan, the following are considered dependents:

1. The enrollee's spouse.
2. The enrollee's domestic partner.
3. The domestic partner's natural or adopted child up to the age of 26.
4. The following dependent children up to the dependent limiting age of 26:
    a. The enrollee's or enrollee's spouse's natural or adopted child;
    b. A child placed for adoption with the enrollee or enrollee's spouse;

c. A child for whom the enrollee or the enrollee's spouse has been appointed legal guardian; however, upon request by the plan, the enrollee must provide satisfactory proof of legal guardianship;

d. The enrollee's stepchild; and

e. A child placed as a foster child with the enrollee or the enrollee's spouse; and

f. The enrollee's or enrollee's spouse's unmarried grandchild who is dependent upon and resides with the enrollee or enrollee's spouse continuously from birth.

5. The enrollee's or enrollee's spouse's disabled child who is a dependent incapable of self-sustaining employment by reason of developmental disability, mental illness, mental disorder, or physical disability and is chiefly dependent upon the enrollee 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. This dependent may remain covered under the plan regardless of age and without application of health screening or waiting periods. To continue coverage for a disabled dependent, you must provide the plan with proof of such disability and dependency within 31 days of the child reaching the dependent limiting age set forth in 4. above. Beginning two years after the child reaches the dependent limiting age, the plan may require annual proof of disability and dependency.

6. The enrollee's or enrollee's spouse's disabled dependent who is incapable of self-sustaining employment by reason of developmental disability, mental illness, mental disorder, or physical disability and is chiefly dependent upon the enrollee or enrollee's spouse for support and maintenance. For coverage of a disabled dependent, you must provide the plan with proof of such disability and dependency at the time of the dependent's enrollment.

Designated facility. A network hospital that Medica has authorized to provide certain benefits to covered persons, as described in this plan.

Designated mental health/substance abuse provider. An organization, entity, or individual selected by the plan to provide or arrange for the mental health and substance abuse services covered under this plan.

Designated physician. A network physician that Medica has authorized to provide certain benefits to covered persons, as described in this plan.

Domestic partner. An adult who the plan administrator determines is in a qualified domestic partnership satisfying all of the following requirements:

1. The partners have had a single, committed relationship of mutual caring for at least twelve (12) months and intend to remain in the relationship indefinitely;
2. The partners share the same permanent residence and have done so for at least twelve (12) months;
3. The partners are not related by blood or a degree of closeness which would prohibit marriage under the law of the state in which they reside;

4. Neither partner is married as defined by federal or common law to another person, and neither is a member of another domestic partnership;
5. Each partner is mentally competent to consent or contract;
6. Both partners are at least 18 years of age; and
7. The partners are financially interdependent, jointly responsible for each other's basic living expenses and if asked, able to provide documents proving at least three of the following situations to demonstrate such financial interdependence:
   - Joint ownership of real property or a common leasehold interest in real property;
   - Common ownership of an automobile;
   - Joint bank or credit accounts;
   - A will which designates the other as primary beneficiary;
   - A beneficiary designation form for a retirement plan or life insurance policy signed and completed to the effect that one partner is a beneficiary of the other; or
8. Designation of one partner as holding power of attorney for healthcare decisions for the other.

The plan administrator shall require the enrollee to provide satisfactory documentation to the plan of the domestic partner relationship by completing the Medica Health Plans Domestic Partnership Declaration Form.

Special Tax Implications of Domestic Partner Benefits Coverage:

Imputed Income – In most cases an enrollee's contributions for domestic partner coverage must be after-tax because the domestic partner and his or her children generally do not qualify as the enrollee's dependents under the Internal Revenue Code (IRC). That means that the portion of the enrollee's health plan(s) premium which is for the domestic partner and the domestic partner's dependents will be deducted from the enrollee's pay after taxes are withheld. Medica Health Plans' contribution toward domestic partner coverage in most cases will be considered "imputed income," or taxable income to the enrollee. This can have tax implications, which the enrollee should discuss with his or her tax advisor.

Qualified Dependents Under Internal Revenue Code – In certain instances, a domestic partner or his or her child may qualify as the enrollee's dependent under the Internal Revenue Code. In this case, the premiums would be eligible for before-tax contribution and would not be subject to imputed income calculations. The enrollee should discuss this situation with his or her tax advisor, and if it applies to the enrollee, he or she should contact Medica HR—Benefits at MedHRBen@medica.com for additional information.

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.

Employee. Any person employed by the sponsor on or after the effective date of this plan, except that it shall not include a self-employed individual as described in Section 401(c) of the Code. All employees who are treated as employed by a single employer under Subsections (b), (c), or (m) of Section 414 of the Code are treated as employed by a single employer for purposes of this plan. Employee does not include any of the following:

1. Any employee included within a unit of employees covered under a collective bargaining unit unless such agreement expressly provides for coverage of the employee under this plan;
2. Any employee who is a nonresident alien and receives no earned income from the sponsor from sources within the United States; and
3. Any employee who is a leased employee as defined in Section 414(n)(2) of the Code.

Enrollee. A qualified employee who the plan administrator determines is enrolled under the plan.

Enrollment date. The date of the qualified employee's or dependent's first day of coverage under the plan.

Genetic testing. An analysis of human DNA, RNA, chromosomes, proteins, or metabolites, if the analysis detects genotypes, mutations, or chromosomal changes. Genetic testing includes pharmacogenetic testing. Genetic testing does not include an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition. For example, an HIV test, complete blood count, or cholesterol test is not a genetic test.

Habilitative. Health care services are considered habilitative when they are provided to improve an impairment in physical function or speech due to congenital or developmental conditions that have impeded normal speech and motor development.

HIPAA privacy standards. Standards for Privacy of Individually Identifiable Health Information issued pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended, and codified at 45 CFR Parts 160 and 164.

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.

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

1. Whether there is final approval from the appropriate government regulatory agency, if required, including whether the drug or device has received final approval to be marketed

for its proposed use by the United States Food and Drug Administration (FDA), or whether the treatment is the subject of ongoing Phase I, II, or III trials;

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

Notwithstanding the above, a drug being used for an indication or at a dosage that is an accepted off-label use for the treatment of cancer will not be considered by the plan to be investigative. The plan will determine if a use is an accepted off-label use based on published reports in authoritative peer-reviewed medical literature, clinical practice guidelines, or parameters approved by national health professional boards or associations, and entries in any authoritative compendia as identified by the Medicare program for use in the determination of a medically accepted indication of drugs and biologicals used off-label.

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

Medically necessary. Diagnostic testing and medical treatment, consistent with the diagnosis of and prescribed course of treatment for your condition, and preventive services. Medically necessary care must meet the following criteria:

1. Be consistent with the medical standards and accepted practice parameters of the community as determined by health care providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue; and
2. Be an appropriate service, in terms of type, frequency, level, setting, and duration, to your diagnosis or condition; and
3. Help to restore or maintain your health; or
4. Prevent deterioration of your condition; or
5. Prevent the reasonably likely onset of a health problem or detect an incipient problem.

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).

Network. A provider (such as a hospital, physician, home health agency, skilled nursing facility, or pharmacy) that has entered into a written agreement to provide benefits to covered persons in this plan and is identified in this plan's provider directory. The participation status of providers will change from time to time.

This plan's network provider directory will be furnished automatically, without charge. It may be obtained by signing in at mymedica.com or contacting Customer Service.

Non-network. A provider outside this plan's network.

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

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, on behalf of sponsor, and the non-network provider.

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

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

In addition, if the amount billed by the non-network provider is greater than the non-network provider reimbursement amount, the non-network provider will likely bill you for the difference. This difference may be substantial, and it is in addition to any coinsurance or deductible amount you may be responsible for according to the terms described in this plan. Furthermore, such difference will not be applied toward the out-of-pocket maximum described in **Benefits & Coverage**. Additionally, you will owe these amounts regardless of whether you previously reached your out-of-pocket maximum with amounts paid for other services. 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.

Out-of-pocket maximum. An accumulation of coinsurance and deductibles paid for benefits received during a calendar year. Unless otherwise specified, you will not be required to pay more than the applicable per covered person out-of-pocket maximum for benefits received during a calendar year.

After an applicable out-of-pocket maximum has been met, all other covered benefits received during the rest of the calendar year will be covered at 100 percent, except for any charge not covered by the plan, or charge in excess of the non-network provider reimbursement amount.

There are separate in-network and out-of-network out-of-pocket maximums for this plan. Once your out-of-pocket maximum for in-network and out-of-network is met, then other benefits in the same category are covered at 100 percent. For example, if your eligible out-of-pocket maximum for in-network benefits is met, all in-network benefits for the remainder of the calendar year are covered at 100 percent, but your out-of-network benefits will not be covered at 100 percent until that out-of-pocket maximum is met.

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

Pharmacogenetic testing. A type of genetic testing that attempts to use personal gene-based information to determine the proper drug and dosage for an individual. Pharmacogenetic testing seeks to determine how a drug is absorbed, metabolized, or cleared from the body of an individual based on their genetic makeup.

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 as a foster child. The acceptance of the placement in your home of a child who has been placed away from his or her parents or guardians in 24-hour substitute care and for whom a state agency has placement and care responsibility. Eligibility for a child placed as a foster child with the enrollee or enrollee's spouse ends when such placement is terminated.

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 enrollee ends if the placement is interrupted before legal adoption is finalized and the child is removed from placement.

Plan. The plan of health care coverage established by sponsor for its covered persons, as this plan currently exists or may be amended in the future.

Plan administration functions. Administration functions performed by sponsor on behalf of the plan (such as quality assurance, claims processing, auditing, and other similar functions). Plan administration functions do not include functions performed by sponsor in connection with any other benefit or benefit plan of sponsor.

Plan administrator. Medica Health Plans.

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.

Preventive health service. 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 covered person involved;

3. With respect to covered persons 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 covered persons who are women, such additional preventive care and screenings not described in 1. as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Contact Customer Service for information regarding specific preventive health services, 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 sign in at medica.com.

Protected health information or PHI. With some exceptions, information that: (i) identifies or could reasonably be used to identify you; and (ii) relates to your physical or mental health or condition, the provision of your health care, or your payment for health care.

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

Qualified employee. The plan administrator determines an employee's status as a qualified employee.

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.

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. Health care services are considered rehabilitative when they are provided to restore physical function or speech that has been impaired due to illness or injury.

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

Retiree. An employee of sponsor who retires from employment with sponsor through the early retirement option and who was an enrollee at the time he/she retired through the early retirement option.

Routine foot care. Services that are routine foot care may require treatment by a professional and include but are not limited to any of the following:

1. Cutting, paring, or removing corns and calluses;
2. Nail trimming, clipping, or cutting; and
3. Debriding (removing toenails, dead skin, or underlying tissue).

Routine foot care may also include hygiene and preventive maintenance such as:

1. Cleaning and soaking the feet; and
2. Applying skin creams in order to maintain skin tone.

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

Skilled care. Nursing or rehabilitation services requiring the skills of technical or professional medical personnel to develop, provide, and evaluate your care and assess your changing condition. Long-term dependence on respiratory support equipment and/or the fact that services are received from technical or professional medical personnel do not by themselves define the need for skilled care.

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

Sponsor. Medica Health Plans.

Travel program. A national program in which you can receive the in-network benefit level for most services when traveling outside the service area if your provider is a travel program provider. See **Before You Access Care** for more information about the travel program.

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 through e-mail, telephone, or webcam. Virtual care includes interactive audiovisual telehealth services. Virtual care is used to address non-urgent medical symptoms for patients describing new or ongoing symptoms to which providers respond with substantive medical advice. Virtual care does not include telephone calls for reporting normal lab or test results, or solely calling in a prescription to a pharmacy.

Signature

IN WITNESS WHEREOF, the SVP HRLF of the sponsor has executed the foregoing plan on behalf of sponsor on this 18th day of February, 2015.

By: Deb Knutson
(please print)

(signature on file)
(signature)

Its: SVP HRLF