MEDICA®

MEDICA CHOICE PASSPORT ND

CERTIFICATE OF COVERAGE

PRIDE, INC.

MEDICA CHOICE PASSPORT ND 2800-0% HSA + RX COPAYS

BPL #65719

DOC #50678

Discrimination is Against the Law

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

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

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

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

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

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

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

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

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

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

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

إذا كنت تريد مساعدة مجانية في ترجمة هذه المعلومات، فاتصل على الرقم الوارد في هذه الوثيقة أو على ظهر بطاقة تعريف ميديكا الخاصة بك.

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

ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປຂໍ້ມູນນີ້ຟຣີ, ໃຫ້ໂທຫາເລກໝາຍທີ່ມີຢູ່ໃນເອກະສານນີ້ ຫຼື ຢູ່ດ້ານຫຼັງຂອງບັດ Medica ຂອງທ່ານ.

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

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

[illegible]

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

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

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

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

COMIFB-0119-M

MEDICA CUSTOMER SERVICE

The specific customer service phone number for your plan is found on the back of your ID card.

General Customer Service:

1-800-952-3455

TTY Users: National Relay Center: 711 then ask them to dial Medica at 1-800-952-3455

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

Welcome!

We're glad you're a Medica member. Health insurance can be complicated. The information found in the pages of this Certificate of Coverage can help you better understand your coverage and how it works.

You may need to reference multiple sections to get a complete picture of your coverage and what you will pay when you receive care. If you have more than one service during a visit, you may pay a separate copayment or coinsurance for each service. The most specific section of this certificate will apply. Use the **Where to Find It** section to learn about related benefits when you access common services.

Some terms used have specific meanings.

In this certificate, the words "you," "your" and "yourself" refer to you, the member. The word "employer" refers to the organization through which you are eligible for coverage. See the **Definitions** section at the end of this document for more terms with specific meanings.

Where to Find It

Note: This is a quick guide to some common benefits. For a complete understanding of your coverage, be sure to read any other related sections in this certificate.

Do you need…	***Read section(s):***
Immediate medical attention? • Ambulance • Emergency room • Urgent care	Ambulance Emergency Room Care Physician and Professional Services
Quick access to care? • Convenience care • Retail health clinic • Virtual care • Telemedicine	Physician and Professional Services Telemedicine Health Services
To visit a provider or clinic? • Chiropractic care • Office visit	Physician and Professional Services
Preventive care? • Immunizations • Physicals • Women's preventive services	Preventive Health Care
Prescription drugs or supplies? • Diabetic equipment and supplies • Outpatient medications • Preventive medications and products • Specialty medications	Prescription Drugs Prescription Specialty Drugs
A medical test? *Examples: blood work, ultrasounds* • Genetic testing and counseling • Lab and pathology services • X-rays, imaging, MRI, CT and PET CT scans	Genetic Testing and Counseling Lab and Pathology X-Rays and Other Imaging

Do you need…	***Read section(s):***
Outpatient surgery? • Anesthesia services • Outpatient/ambulatory surgical center services (facility charge) • Physician services (doctor charge)	Anesthesia Hospital Services Physician and Professional Services
Services provided during a hospital stay? • Anesthesia services • Hospital services (facility charge) • Physician services (doctor charge)	Anesthesia Hospital Services Physician and Professional Services
Mental health or behavioral health services? • Inpatient services • Office visit	Behavioral Health – Mental Health
Substance abuse services? • Inpatient services • Office visit	Behavioral Health – Substance Abuse
Pregnancy care services? • Breast pumps • Inpatient services • Postnatal services • Prenatal services	Durable Medical Equipment, Prosthetics and Medical Supplies Pregnancy – Maternity Care
Medical supplies or equipment? *Examples: crutches, CPAP, wheelchair, oxygen* • Insulin pumps and related supplies • Durable medical equipment and medical supplies • Hearing aids • Prosthetics	Durable Medical Equipment, Prosthetics and Medical Supplies
Medical-related dental care? • Accident-related dental services • Oral surgery • Treatment of temporomandibular joint (TMJ) and craniomandibular disorder	Medical-Related Dental Services Temporomandibular Joint (TMJ) and Craniomandibular Disorder

Do you need…	***Read section(s):***
Help recovering? *Example: Help received after a hospital stay, injury or surgery* • Home health care services • Physical, speech and occupational therapies • Skilled nursing facility services	 Home Health Care Physical, Speech and Occupational Therapies Skilled Nursing Facility

Table of Contents

Introduction

This certificate explains the benefits covered under the Contract between Medica and the employer. To see the Contract between Medica and the employer, contact the employer. This certificate is provided to you by, or on behalf of, your employer. This certificate is not a legal contract between you and Medica.

How you accept coverage

When you accept the health care coverage described in this certificate, you, on behalf of yourself and any dependents enrolled under the Contract:

1. Authorize the use of your Social Security number for purpose of identification unless otherwise prohibited by state law; and
2. Agree that the information you supplied Medica for purposes of enrollment is accurate and complete.

In addition, you understand and agree that if you intentionally omit or incorrectly state any material facts in connection with your enrollment under the Contract, Medica may retroactively cancel your coverage.

Members are subject to all terms and conditions of the Contract and health services must meet the definition of "medically necessary" (see **Definitions**).

Medica may arrange for others to administer services on its behalf, including arrangement of access to a provider network, claims processing and medical necessity reviews. To ensure that your benefits are managed appropriately, please work with these persons or vendors when needed as they conduct their work for Medica.

The employer is responsible for paying premiums to Medica and notifying you of any changes to this certificate (as required by applicable law).

If you need language interpretation

Language interpretation services are available to help you understand your benefits under this certificate. To request these services, call Customer Service at one of the telephone numbers listed at the front of this certificate.

If you need alternative formats, such as Braille or large print, call Customer Service at one of the telephone numbers listed at the front of this certificate to request these materials.

If this certificate is translated into another language or an alternative 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 at the front of this certificate.

Your Rights and Responsibilities

Member bill of rights

As a member, you have the right to:

1. Available and accessible services, including emergency services (defined in this certificate) 24 hours a day, seven days a week; and
2. Information about your health condition, appropriate or medically necessary treatment options and risks, regardless of cost or benefit coverage, so you can make an informed choice about your health care; and
3. Participate with providers in decision making regarding your health care, including the right to refuse treatment recommended to you by Medica or any provider; and
4. Be treated with respect and recognition of your dignity and privacy, including privacy of your medical and financial records maintained by Medica or any network provider in accordance with existing law; and
5. Contact Medica Customer Service and the North Dakota Commissioner of Insurance to file a complaint or an appeal about issues related to benefits (see **How Do I File a Complaint**). You may begin a legal proceeding if you have a problem with Medica or any provider. To file a complaint with the North Dakota Department of Insurance, call 1-800-247-0560 and request health insurance information; and
6. Receive information about Medica, its services, its practitioners and providers and member rights and responsibilities; and
7. Appeal a decision regarding your health care coverage by calling Customer Service at one of the telephone numbers listed at the front of this certificate. See **How Do I File a Complaint** for information on your appeal rights; and
8. Make recommendations regarding Medica's member rights and responsibilities statement.

Member responsibilities

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

1. Establishing a relationship with a network provider before becoming ill, as this allows for continuity of care; and
2. Providing the necessary information to health care professionals or Medica needed to determine the appropriate care. This objective is best obtained when you share:
    a. Information about lifestyle practices; and
    b. Personal health history; and

3. Understanding your health problems and agreeing to, and following, the plans and instructions for care given by those providing health care; and
4. Practicing self-care by knowing:
    a. How to recognize common health problems and what to do when they occur; and
    b. When and where to seek appropriate help; and
    c. How to prevent health problems from recurring; and
5. Practicing preventive health care by:
    a. Having the appropriate tests, exams and immunizations recommended for your gender and age as described in this certificate; and
    b. Engaging in healthy lifestyle choices (such as exercise, proper diet and rest).

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

Before You Access Care

This section provides information for you to consider before you access care. More information about when and where to get care can be found at medica.com/membertips.

What you must do to receive benefits

Each time you receive health services, you must:

1. For your highest level of coverage, confirm that your provider is in your plan's network; and
2. Present your Medica identification (ID) card. Having and using a Medica ID card does not guarantee coverage.

If your provider asks for your ID card information and you do not provide it within 180 days of when you received services, you may be responsible for paying the full cost of those services. (Network providers must submit claims within 180 days from when you receive a service.)

Provider network

In-network benefits are available through your plan's 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.

Additional network administrative support is provided by one or more organizations under contract with Medica.

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, your out-of-network benefits will apply. For more information about out-of-network care, see the tip sheet at medica.com/membertips.

Prior authorization

You may need prior authorization (approval in advance) from Medica before you receive certain services or supplies. When reviewing your request for prior authorization, Medica uses written procedures and criteria to determine whether a particular service or supply is medically necessary and is a covered benefit. To verify whether a specific service or supply requires prior authorization, please call Customer Service at one of the telephone numbers listed at the front of this certificate.

Emergency services do not require prior authorization.

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

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

If a network provider fails to request prior authorization after you have consulted with them about services requiring prior authorization, you will not be penalized for this failure.

You must contact Customer Service to request prior authorization for services or supplies received from a non-network provider.

We recommend that you confirm with us that all services and supplies requiring prior authorization, including those received from a network provider, have been prior authorized by Medica. You may contact Customer Service for this confirmation.

Prior authorization is required for the following services and supplies, as described below and in the sections of this certificate that discuss the applicable benefit:

- Solid organ and blood and marrow transplant services – this prior authorization must be obtained before the transplant workup is initiated;
- In-network benefits for services from non-network providers, with the exception of emergency services;
- Certain reconstructive or restorative surgery procedures;
- Weight loss surgery;
- Certain drugs and biologics;
- Certain home health care services;
- Certain medical supplies and durable medical equipment;
- Certain outpatient surgical procedures;
- Certain genetic tests;
- Certain imaging services;
- Non-emergency licensed air ambulance transportation; and
- Skilled nursing facility services.

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

This is not a complete 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 making the request;
- Name, telephone number, address and, if applicable, the type of specialty of the provider to whom you are being referred;
- Services being requested and the date those services are to be provided (if scheduled);

- Specific information related to your condition (for example, a letter of medical necessity from your provider); and
- Other applicable member information (i.e., Medica member number).

Medica will review your request for prior authorization and respond to you and your attending provider within a reasonable period of time appropriate to your medical circumstances. Medica will generally respond within 15 calendar days of the date your request was received, provided all information reasonably necessary to make a decision has been given to Medica.

However, Medica will respond within a time period not exceeding 72 hours from the time of the initial request if:

- 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
- you could be subject to severe pain that cannot be adequately managed without the care or treatment you are requesting.

If we do not have the information necessary to make a decision, Medica may request additional information. Upon the receipt of the additional information, Medica will notify you, your authorized representative or your attending physician of their determination as described above. If Medica does not receive the information within 45 days, Medica may deny the claim.

Under certain circumstances, Medica may conduct concurrent reviews to verify whether services are still medically necessary. If we conclude that services are no longer medically necessary, Medica will advise both you and your attending provider in writing of our decision. If we do not approve continuing coverage, you or your attending provider may appeal our initial decision (see **How Do I File a Complaint**).

If Medica fails to respond within the required timeframe, benefits will be covered as otherwise described in this certificate.

Referrals to non-network providers

To receive in-network benefits for services received from a non-network provider, you will need to follow the steps described below. If you receive services from a non-network provider without following these steps, your out-of-network benefits will apply. For more information, see the tip sheet at medica.com/membertips.

Referrals will not be authorized to meet personal preferences, family convenience or other non-medical reasons. Referrals also will not be approved for care that has already been provided.

What you must do:

1. Request a referral or standing referral* from a network provider to receive medically necessary services from a non-network provider. The referral will be in writing and will:
    a. Indicate the time period for when services must be received; and

b. Specify the service(s) to be provided; and

c. Direct you to the non-network provider selected by your network provider.

2. Ask your network provider to request prior authorization from Medica. Medica does not guarantee coverage for services that are received before you receive prior authorization.

3. If Medica approves the prior authorization request, your in-network benefit will apply.

4. Pay any amounts that were not approved for coverage by Medica.

*A standing referral is a referral issued by a network provider and authorized by Medica for conditions that require ongoing services from a specialist. Standing referrals will only be authorized for the period of time appropriate to your medical condition. To request a standing referral, contact Customer Service. If Medica denies your request for a standing referral, you have the right to appeal this decision as described in **How Do I File a Complaint**.

Medica:

1. May require that you see another network provider that Medica selects before determining that a referral to a non-network provider is medically necessary.

2. May require that you obtain a referral or standing referral (as described in this section) from a network provider to a non-network provider practicing in the same or similar specialty.

3. Will provide coverage for health services that are:

   a. Otherwise eligible for coverage under this certificate; and

   b. Recommended by a network physician.

4. Will notify you that your coverage is either approved or denied within 15 calendar days of receiving your request, provided all information reasonably necessary to make a decision has been made available.

5. Will review your request for prior authorization and respond to you and your attending provider within a reasonable period of time appropriate to your medical circumstances. Medica will generally respond within ten business days of receiving your request, provided that all information reasonably necessary to make a decision has been given to Medica. However, Medica will respond within a time period not exceeding 72 hours from the time of the initial request if: 1) your attending provider believes that an expedited review is warranted, or 2) Medica concludes that a delay could seriously jeopardize your life, health or ability to regain maximum function, or 3) you could be subject to severe pain that cannot be adequately managed without the care or treatment you are seeking.

Visiting non-network providers and why you pay more

In general, eligible health services and supplies are only covered as in-network benefits if they're provided by network providers or if Medica approves them.

If the care you need is not available from a network provider, Medica may authorize non-network provider services at the in-network benefit level.

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 amounts billed by the non-network provider may be more than what Medica would pay, leaving a balance for you to pay in addition to any coinsurance and deductible amount you owe. This additional amount you must pay the provider will not be counted toward your out-of-pocket maximum amount. You will owe this amount whether or not 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 with the non-network provider what the bill is expected to be; and
- Contact Customer Service to verify the estimated amount Medica would pay for those services; and
- Calculate your likely share of the costs; and
- To request that Medica authorize coverage of the non-network provider's services at the in-network benefit level, follow the prior authorization process described above.

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

Example:

You choose to receive inpatient care (not an emergency) at a non-network hospital without an authorization from Medica. Your out-of-network benefits apply to these services.

Assumptions:

1. You have previously fulfilled 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 a percentage coinsurance. In this example, we will use 40% coinsurance.
    b. In addition, the non-network provider will likely bill you for the difference between what they charge and the amount that Medica pays them.

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 amount that exceeds the non-network provider reimbursement amount ($30,000 - $15,000 = $15,000)

Therefore, 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 amounts in excess of the non-network provider reimbursement amount **will not** be applied toward your out-of-pocket maximum. You will owe the provider this $15,000 amount whether or not 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 you receive. For more information about out-of-network care, see the tip sheet at medica.com/membertips.

When do I need to submit a claim

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

Continuity of care

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

1. If Medica terminates its contract with your current provider without cause, you may be eligible to continue care with that provider at the in-network benefit level.
2. If you are a new Medica member as a result of your employer changing health plans 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 Medica's prior authorization requirements. This includes providing Medica with all necessary medical information related to your care, and accepting as payment in full the lesser of Medica's network provider reimbursement or the provider's customary charge for the service. This does not apply when Medica terminates a provider's contract for cause. If Medica terminates your current provider's contract for cause, we will inform you of the change and how your care will be transferred to another network provider.

Upon request, Medica 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. Health services may continue to be provided through the completion of postpartum care;
- a physical or mental disability defined as an inability to engage in one or more major life activities, provided 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 Medica does not have a network provider who has special expertise in the delivery of those culturally appropriate services; 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.

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

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 at the front of this certificate.

What's Covered and How Much Will I Pay

This section describes the services eligible for coverage and any expenses that you will need to pay.

Important information about your benefits

- Before you receive certain services or supplies, you will need to get prior authorization from Medica. To find out when you need to do this, see **What to keep in mind** after each benefit section or call Customer Service at one of the telephone numbers listed at the front of this certificate. Also refer to **Before You Access Care** for more information about the prior authorization process.
- When you use out-of-network benefits, in addition to the deductible and coinsurance, you will likely need to pay your provider any billed amount above what Medica pays the provider (the non-network provider reimbursement amount). **These charges are not applied to your deductible or out-of-pocket maximum.** Please see **Visiting non-network providers and why you pay more** in **Before You Access Care** for more information and an example showing out-of-pocket costs associated with out-of-network benefits.
- Certain benefits in this certificate have limits. These limits might include day limits, visit limits or dollar limits. These limits are noted in this certificate and apply whether or not you have met your deductible.

Key concepts

Deductibles

Your plan may require that you pay a certain dollar amount before your insurance starts to pay. This amount is called a deductible.

The table below shows whether your plan has a deductible, how much it is and whether you have separate deductibles for each family member or a combined deductible for everyone. Each benefit table in this certificate shows whether the deductible applies to a particular service.

Deductibles are determined by the Contract between Medica and the employer. If the deductibles increase when Medica and the employer renew the Contract, you may have additional out-of-pocket expenses as a result.

For more information about deductibles and other common cost-sharing terms, see the tip sheet at medica.com/membertips.

Out-of-pocket maximum

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

Please note: The following amounts do not apply toward your out-of-pocket maximum:

- **Charges for services that aren't covered; and**
- **Charges a non-network provider bills you that are more than the non-network provider reimbursement amount; and**
- **Charges you pay in addition to your deductible or coinsurance when you choose to use a preferred brand or non-preferred brand prescription drug when a chemically equivalent generic drug is available.**

You will owe these amounts even if you have already reached your out-of-pocket maximum.

DEDUCTIBLES, OUT-OF-POCKET MAXIMUMS AND LIFETIME MAXIMUM

Deductibles, Out-Of-Pocket Maximums and Lifetime Maximum		
	Your cost if you visit a:	
	Network provider:	**Non-network provider:**
Coinsurance	See specific benefit for applicable coinsurance.	
Deductible		
Per member	$2,800	$4,250
Per family	$5,600	$8,500
The deductible is the amount you must pay for eligible services each Contract year before the plan will begin to pay claims. If you have family members on the plan, you will each have to meet your own individual deductible before receiving benefits, unless the family deductible is met. Once the family deductible has been met, the plan will pay benefits for all covered family members.		
Out-of-pocket maximum		
Per member	$6,750	$10,250
Per family	$13,500	$20,500
This plan has both a per member out-of-pocket maximum **and** a per family out-of-pocket maximum. The per member out-of-pocket maximum applies individually to each family member until the family out-of-pocket maximum is met. Coinsurance and deductibles paid by each covered family member for covered benefits for the Contract year count toward the individual's annual per member out-of-pocket maximum **and** toward the annual per family out-of-pocket maximum.		
Lifetime maximum amount Medica will pay per member	Unlimited	Unlimited

AMBULANCE

Ambulance		
	Your cost if you visit a:	
Benefits	Network provider:	Non-network provider:
1. Emergency ambulance services or emergency ambulance transportation	Nothing after deductible	Covered as an in-network benefit.
2. Non-emergency licensed ambulance service that is arranged through an attending physician, as follows: a. Transportation from hospital to hospital when: i. Care for your condition is not available at the hospital where you were first admitted; or ii. Required by Medica b. Transportation from hospital to skilled nursing facility	Nothing after deductible	20% coinsurance after deductible

What's covered

When you use out-of-network benefits, in addition to the deductible and coinsurance, you will likely need to pay your provider any billed amount above what Medica pays the provider (the non-network provider reimbursement amount). **These charges are not applied to your deductible or out-of-pocket maximum.** Please see **Visiting non-network providers and why you pay more** in **Before You Access Care** for more information and an example showing out-of-pocket costs associated with out-of-network benefits.

The following notice concerning air ambulance services is provided as required by the North Dakota Insurance Department:

For non-network air ambulance service providers licensed by the North Dakota Department of Health, the reimbursement rate is equal to the average of Medica's reimbursement rates for the same service for in-network air ambulance providers licensed by the North Dakota Department of Health.

What to keep in mind

Ambulance services for an emergency are covered when provided by a licensed ambulance service. If you are taken to a non-network hospital, only emergency health services at that hospital are covered as described in **Emergency Room Care**.

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

Prior authorization (approval in advance) is required before you receive non-emergency licensed air ambulance transportation.

What's 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			
		Your cost if you visit a:	
	Benefits	**Network provider:**	**Non-network provider:**
1.	Anesthesia services received during an office visit	Nothing after deductible	20% coinsurance after deductible
2.	Anesthesia services received during an outpatient hospital or ambulatory surgical center visit	Nothing after deductible	20% coinsurance after deductible
3.	Anesthesia services received during an inpatient stay	Nothing after deductible	20% coinsurance after deductible

What to keep in mind

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.

When you use out-of-network benefits, in addition to the deductible and coinsurance, you will likely need to pay your provider any billed amount above what Medica pays the provider (the non-network provider reimbursement amount). **These charges are not applied to your deductible or out-of-pocket maximum.** Please see **Visiting non-network providers and why you pay more** in **Before You Access Care** for more information and an example showing out-of-pocket costs associated with out-of-network benefits.

BEHAVIORAL HEALTH – MENTAL HEALTH

Behavioral Health – Mental Health			
		Your cost if you visit a:	
	Benefits	Network provider:	Non-network provider:
1.	Office visits, including evaluations, diagnostic and treatment services	Nothing after deductible	20% coinsurance after deductible
2.	Intensive outpatient programs	Nothing after deductible	20% coinsurance after deductible
3.	Applied Behavioral Analysis (ABA) for the treatment of autism spectrum disorders for children when provided in accordance with an individualized treatment plan prescribed by the member's treating physician or mental health professional	Nothing after deductible	20% coinsurance after deductible
4.	Inpatient services (including residential treatment services)		
	a. Room and board	Nothing after deductible	20% coinsurance after deductible
	b. Hospital or facility-based professional services	Nothing after deductible	20% coinsurance after deductible
	c. Attending psychiatrist services	Nothing after deductible	20% coinsurance after deductible
	d. Partial program	Nothing after deductible	20% coinsurance after deductible

What's covered

Outpatient mental health services include:

1. Diagnostic evaluations and psychological testing, including that for attention deficit hyperactivity disorder (ADHD) or pervasive development disorders (PDD).

2. Psychotherapy and psychiatric services.
3. Mental health 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 3 hours per day).
4. Relationship and family therapy if there is a clinical diagnosis.
5. Treatment of serious or persistent disorders.
6. Treatment of pathological gambling.

Inpatient mental health services include:

1. Room and board.
2. Attending psychiatric services.
3. Hospital or facility-based professional services.
4. Partial program. "Partial program" means a continuous hospital-based treatment program of at least 3 hours, but not more than 12 hours, per 24-hour period and includes the medically necessary treatment services provided by licensed professionals under the supervision of a licensed physician or residential treatment in a program approved by Medica.
5. Mental health residential treatment services. These services include either:
    - A residential treatment program serving children and adolescents with severe emotional disturbance, licensed under North Dakota Century Code Title 25-03.2-03; or
    - A licensed or certified mental health treatment program providing intensive therapeutic services. In addition to room and board, each individual must receive at least 30 hours of mental health services a week, 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.

When you use out-of-network benefits, in addition to the deductible and coinsurance, you will likely need to pay your provider any billed amount above what Medica pays the provider (the non-network provider reimbursement amount). **These charges are not applied to your deductible or out-of-pocket maximum.** Please see **Visiting non-network providers and why you pay more** in **Before You Access Care** for more information and an example showing out-of-pocket costs associated with out-of-network benefits.

What to keep in mind

Medica requires prior authorization (approval in advance) before you receive certain mental health services or treatment. To determine if Medica requires prior authorization for a particular service or treatment, please call your plan's designated mental health and substance abuse provider at 1-800-848-8327 or TTY users, please contact: National Relay Center 711, then ask

them to dial Medica Behavioral Health at 1-866-567-0550. Please see **Prior authorization** in **Before You Access Care** for more information about prior authorization requirements and processes.

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)*.

If you have more than one service or modality on the same day, you may pay a separate copayment or coinsurance for each service.

Your plan's designated mental health and substance abuse provider will coordinate your in-network mental health services. If you require hospitalization, your plan's designated mental health and substance abuse provider will refer you to one of its hospital providers. **Please note:** The hospital network for medical services and mental health and substance abuse services is not the same.

Emergency mental health services do not require prior authorization and 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

What's 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 and family therapy in the absence of a clinical diagnosis.
4. Services for telephone psychotherapy, however services that are provided in accordance with Medica's telemedicine policies and procedures may be eligible for coverage under **Telemedicine Health Services** in this certificate.
5. Services beyond the initial evaluation to diagnose intellectual or learning disabilities.
6. Services, including room and board charges, provided by health care professionals or facilities that are not appropriately licensed, certified or otherwise qualified under state law to provide mental health services. This includes, but is not limited to, services provided by

mental health providers who are not authorized under state law to practice independently, and services received at a halfway house, housing with support, therapeutic group home, boarding school or ranch.

7. Room and board charges associated with mental health residential treatment services when less than 30 hours a week of mental health services are provided per individual, an on-site medical/psychiatric assessment is not provided within 48 hours of admission and the program has not provided psychiatric follow-up visits at least once per week, or 24-hour nursing coverage.

BEHAVIORAL HEALTH – SUBSTANCE ABUSE

Behavioral Health – Substance Abuse			
		Your cost if you visit a:	
	Benefits	**Network provider:**	**Non-network provider:**
1.	Office visits, including evaluations, diagnostic and treatment services	Nothing after deductible	20% coinsurance after deductible
2.	Intensive outpatient programs	Nothing after deductible	20% coinsurance after deductible
3.	Medication-assisted treatment **Note:** When the prescription drug component of this treatment is received at a pharmacy, your prescription drug benefit will be applied.	Nothing after deductible	20% coinsurance after deductible
4.	Inpatient services (including residential treatment services)		
	a. Room and board	Nothing after deductible	20% coinsurance after deductible
	b. Hospital or facility-based professional services	Nothing after deductible	20% coinsurance after deductible
	c. Attending physician services	Nothing after deductible	20% coinsurance after deductible
	d. Partial program	Nothing after deductible	20% coinsurance after deductible

What's covered

Outpatient substance abuse services include:

1. Diagnostic evaluations.
2. Outpatient treatment.

3. Medication-assisted treatment (the use of medications in conjunction with counseling and behavioral therapies to help maintain sobriety, prevent relapse and reduce craving in order to sustain recovery).
4. Substance abuse intensive outpatient programs, including day treatment and partial programs, which may include multiple services and modalities, delivered in an outpatient setting.

Inpatient substance abuse services include:

1. Room and board.
2. Attending physician services.
3. Hospital or facility-based professional services.
4. Partial program. "Partial program" means a continuous hospital-based treatment program of at least 3 hours, but not more than 12 hours, per 24-hour period and includes the medically necessary treatment services provided by licensed professionals under the supervision of a licensed physician or residential treatment in a program approved by Medica.
5. Substance abuse residential treatment services 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.

When you use out-of-network benefits, in addition to the deductible and coinsurance, you will likely need to pay your provider any billed amount above what Medica pays the provider (the non-network provider reimbursement amount). **These charges are not applied to your deductible or out-of-pocket maximum.** Please see **Visiting non-network providers and why you pay more** in **Before You Access Care** for more information and an example showing out-of-pocket costs associated with out-of-network benefits.

What to keep in mind

Medica requires prior authorization (approval in advance) before you receive certain substance abuse services or treatment. To determine if Medica requires prior authorization for a particular service or treatment, please call your plan's designated mental health and substance abuse provider at 1-800-848-8327 or TTY users, please contact: National Relay Center 711, then ask them to dial Medica Behavioral Health at 1-866-567-0550. Please see **Prior authorization** in **Before You Access Care** for more information about prior authorization requirements and processes.

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)*.

Your plan's designated mental health and substance abuse provider arranges in-network substance abuse benefits. If you require hospitalization, your plan's designated mental health and substance abuse provider will refer you to one of its hospital providers. **Please note:** The hospital network for medical services and mental health and substance abuse services is not the same.

Emergency substance abuse services do not require prior authorization and 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

What's 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, unless such services are provided in accordance with Medica's telemedicine policies and procedures.
5. Services, including room and board charges, provided by health care professionals or facilities that are not appropriately licensed, certified or otherwise qualified under state law to provide 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 at 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.

CLINICAL TRIALS

Clinical Trials			
		Your cost if you visit a:	
	Benefits	Network provider:	Non-network provider:
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.

What's covered

Routine patient costs that would be eligible for coverage under this certificate, if the services were provided outside of the clinical trial, will be covered.

What to keep in mind

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

When you use out-of-network benefits, in addition to the deductible and coinsurance, you will likely need to pay your provider any billed amount above what Medica pays the provider (the non-network provider reimbursement amount). **These charges are not applied to your deductible or out-of-pocket maximum.** Please see **Visiting non-network providers and why you pay more** in **Before You Access Care** for more information and an example showing out-of-pocket costs associated with out-of-network benefits.

What's not covered

The item, device or service that is considered investigative is not covered.

DURABLE MEDICAL EQUIPMENT, PROSTHETICS AND MEDICAL SUPPLIES

Durable Medical Equipment, Prosthetics and Medical Supplies			
		Your cost if you visit a:	
	Benefits	**Network provider:**	**Non-network provider:**
1.	Durable medical equipment and certain related supplies	Nothing after deductible	20% coinsurance after deductible
2.	Prosthetics: 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. Repair, replacement or revision of prostheses made necessary by normal wear and use	Nothing after deductible	20% coinsurance after deductible
3.	Hearing aids for members 18 years of age and younger for hearing loss due to functional congenital malformation of the ears that is not correctable by other covered procedures	Nothing after deductible Coverage is limited to one hearing aid per ear every three years.	20% coinsurance after deductible Coverage is limited to one hearing aid per ear every three years.
4.	Breast pumps	Nothing. The deductible does not apply.	20% coinsurance after deductible

Durable Medical Equipment, Prosthetics and Medical Supplies		
	Your cost if you visit a:	
Benefits	**Network provider:**	**Non-network provider:**
5. Medical supplies: a. Injectable pharmaceutical treatments for hemophilia and bleeding disorders b. Dietary medical treatment of phenylketonuria (PKU) and maple syrup urine disease 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;	Nothing after deductible	20% coinsurance after deductible

Durable Medical Equipment, Prosthetics and Medical Supplies			
	Benefits	Your cost if you visit a: Network provider:	Non-network provider:
	vi. Eosinophilic gastroenteritis; and vii. Eosinophilic colitis Coverage for the diagnoses in iii.–vii. above is limited to members five years of age and younger.		
6.	Eligible ostomy supplies	Nothing after deductible	20% coinsurance after deductible
7.	Insulin pumps and their related supplies	Nothing after deductible	20% coinsurance after deductible

What's covered

Medica covers only a limited selection of durable medical equipment, prosthetics and medical supplies. 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 durable medical equipment, prosthetics and medical supplies must meet specific criteria, and some items ordered by your physician, even if they're medically necessary, may not be covered. Medica determines if durable medical equipment will be purchased or rented.

When you use out-of-network benefits, in addition to the deductible and coinsurance, you will likely need to pay your provider any billed amount above what Medica pays the provider (the non-network provider reimbursement amount). **These charges are not applied to your deductible or out-of-pocket maximum.** Please see **Visiting non-network providers and why you pay more** in **Before You Access Care** for more information and an example showing out-of-pocket costs associated with out-of-network benefits.

What to keep in mind

Medica 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 at the front of this certificate.

Medica requires prior authorization (approval in advance) before you receive certain durable medical equipment, prosthetics and/or medical supplies. To determine if Medica requires prior

authorization for a particular piece of equipment, prosthetic or supply, please contact Medica Customer Service at one of the numbers listed at the front of this certificate, by logging into mymedica.com or at the number or address listed on the back of your ID card. Please see **Prior authorization** in **Before You Access Care** for more information about prior authorization requirements and processes.

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

If the durable medical equipment, prosthetic device or hearing aid is covered by Medica, but the model you choose is not Medica's standard model, you will be responsible for the cost difference. A standard model is defined durable medical equipment that meets the minimum specifications prescribed for your needs.

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

In-network benefits apply when eligible equipment, services and supplies are prescribed by a physician and received from a network provider. Hearing aids, when prescribed by a network provider, are covered as described in the table above.

To request a list of durable medical equipment providers and/or hearing aid vendors, call Customer Service at one of the telephone numbers listed at the front of this certificate.

Out-of-network benefits apply when eligible equipment, services and supplies are prescribed by a physician and received from a non-network provider.

What's not covered

1. Durable medical equipment, supplies, prosthetics, appliances and hearing aids not on the Medica eligible list.
2. Charges in excess of the Medica standard model of durable medical equipment, prosthetics or hearing aids.
3. Repair, replacement or revision of properly functioning durable medical equipment, prosthetics and hearing aids, including, but not limited to, due to loss, damage or theft.
4. Duplicate durable medical equipment, prosthetics and hearing aids, including repair, replacement or revision of duplicate items.
5. Low-protein modified food products or medical food to the extent these items are available under a department of health program.
6. Other disposable supplies and appliances, except as described in this section and **Prescription Drugs**.

EMERGENCY ROOM CARE

Emergency Room Care			
		Your cost if you visit a:	
	Benefits	**Network provider:**	**Non-network provider:**
1.	Services provided in a hospital or facility-based emergency room	Nothing after deductible	Covered as an in-network benefit.
2.	Other services received during an emergency room visit (for example x-rays, lab, physician)	Nothing after deductible	Covered as an in-network benefit.

What's covered

Emergency services provided in an emergency room of a hospital, whether network or non-network, from non-network providers will be covered as in-network benefits. In the event you receive such services, you will pay the in-network cost-share associated with the services provided. If you receive any other bill from an emergency room provider, please call Customer Service at one of the telephone numbers listed at the front of this certificate.

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

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

GENETIC TESTING AND COUNSELING

Genetic Testing and Counseling			
		Your cost if you visit a:	
	Benefits	**Network provider:**	**Non-network provider:**
1.	Genetic testing received in an office or outpatient hospital when test results will directly affect treatment decisions or frequency of screening for a disease, or when results of the test will affect reproductive choices **Please note:** BRCA testing, if appropriate, is covered as a women's preventive health service.	Nothing after deductible	20% coinsurance 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.	Nothing after deductible	20% coinsurance after deductible

What to keep in mind

Genetic testing is a complex and rapidly changing field. Many genetic tests require prior authorization (approval in advance) or have criteria that must be met for the test to be covered. To determine if Medica requires prior authorization for a particular genetic test, please call Medica Customer Service at one of the numbers listed at the front of this certificate. Please see **Prior authorization** in **Before You Access Care** for more information about prior authorization requirements and processes.

To better understand your coverage, please call Customer Service at one of the numbers listed at the front of this certificate. When you call, it's helpful to have the following information:

- The name of the test;
- The name of the lab performing the test;

- The name of the doctor ordering the test; and
- The reason you are going to have the test.

When you use out-of-network benefits, in addition to the deductible and coinsurance, you will likely need to pay your provider any billed amount above what Medica pays the provider (the non-network provider reimbursement amount). **These charges are not applied to your deductible or out-of-pocket maximum.** Please see **Visiting non-network providers and why you pay more** in **Before You Access Care** for more information and an example showing out-of-pocket costs associated with out-of-network benefits.

What's not covered

1. 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.
2. Laboratory testing (including genetic testing) that has been performed in response to direct-to-consumer marketing and not under the direction of a physician.

HOME HEALTH CARE

Home Health Care		
	Your cost if you visit a:	
Benefits	Network provider:	Non-network provider:
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 Contract year for in-network benefits and 60 visits per Contract year for out-of-network benefits.	Nothing after deductible	20% coinsurance after deductible
2. Services received in your home from a physician	Nothing after deductible	20% coinsurance after deductible

What's covered

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.

Medica will waive the requirement that you be homebound for a limited number of home visits for palliative care if you have a life-threatening, non-curable condition which has a prognosis of survival of two years or less. If you are eligible to receive palliative care in the home and you are not homebound, there is a maximum of 8 visits per Contract year. Additional palliative care visits are eligible under the home health services benefit if you are homebound and meet all other requirements as defined in this section.

When you use out-of-network benefits, in addition to the deductible and coinsurance, you will likely need to pay your provider any billed amount above what Medica pays the provider (the non-network provider reimbursement amount). **These charges are not applied to your deductible or out-of-pocket maximum.** Please see **Visiting non-network providers and why you pay more** in **Before You Access Care** for more information and an example showing out-of-pocket costs associated with out-of-network benefits.

What to keep in mind

Prior authorization (approval in advance) is required before you receive certain home health care services. Please see **Prior authorization** in **Before You Access Care** for more information about prior authorization requirements and processes.

Medica 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.

Each visit of 24 hours or any that lasts less than 24 hours, regardless of the length of the visit, equals one visit and will count toward the maximum number of visits for all services in this section.

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.

What's 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 club memberships.
11. Disposable supplies and appliances, except as described in **Durable Medical Equipment, Prosthetics and Medical Supplies** and **Prescription Drugs** in this section.
12. Physical, speech or occupational therapy services when there is no reasonable expectation that the member'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		
	Your cost if you visit a:	
Benefits	Network provider:	Non-network provider:
1. Hospice services	Nothing after deductible	20% coinsurance after deductible

What's covered

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

When you use out-of-network benefits, in addition to the deductible and coinsurance, you will likely need to pay your provider any billed amount above what Medica pays the provider (the non-network provider reimbursement amount). **These charges are not applied to your deductible or out-of-pocket maximum.** Please see **Visiting non-network providers and why you pay more** in **Before You Access Care** for more information and an example showing out-of-pocket costs associated with out-of-network benefits.

What to keep in mind

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

Medica contracts with hospice programs to provide hospice services to members. The specific services you receive may vary depending upon which program you select.

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

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

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.

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

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

What's not covered

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

HOSPITAL SERVICES

Hospital Services			
		Your cost if you visit a:	
	Benefits	Network provider:	Non-network provider:
1.	Outpatient hospital or ambulatory surgical center services	Nothing after deductible	20% coinsurance after deductible
2.	Services provided in a hospital observation room	Nothing after deductible	20% coinsurance after deductible
3.	Inpatient services For associated physician services, see **Physician and Professional Services** in this section.	Nothing after deductible	20% coinsurance after deductible

What's covered

Hospital and ambulatory surgical center services are covered.

When you use out-of-network benefits, in addition to the deductible and coinsurance, you will likely need to pay your provider any billed amount above what Medica pays the provider (the non-network provider reimbursement amount). **These charges are not applied to your deductible or out-of-pocket maximum.** Please see **Visiting non-network providers and why you pay more** in **Before You Access Care** for more information and an example showing out-of-pocket costs associated with out-of-network benefits.

What to keep in mind

Prior authorization (approval in advance) is required before you receive certain biologics and professionally administered drugs. Please see **Prior authorization** in **Before You Access Care** for more information about prior authorization requirements and processes.

A physician must direct your care.

If you remain in the hospital overnight, you may be admitted as an inpatient or kept for observation. You can check with your physician to ask which applies to you. The most appropriate benefit will apply, which will impact how much you pay.

For most hospital visits, other charges also will apply. These might include charges for physician services, anesthesia and others.

What's not covered

1. Drugs received at a hospital on an outpatient basis, except drugs that meet the definition of "professionally administered drugs" or drugs received in an emergency room or a hospital observation room. Coverage for drugs is as described in **Prescription Drugs**, **Prescription Specialty Drugs** or otherwise described as a specific benefit elsewhere in this section.
2. Transfers and admissions to network hospitals solely at the convenience of the member.
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

Infertility Treatment			
		Your cost if you visit a:	
	Benefits	**Network provider:**	**Non-network provider:**
1.	Office visits, including any services provided during such visits	Nothing after deductible	20% coinsurance after deductible
2.	Outpatient services received at a hospital	Nothing after deductible	20% coinsurance after deductible
3.	Inpatient services	Nothing after deductible	20% coinsurance after deductible
4.	Services received from a physician during an inpatient stay	Nothing after deductible	20% coinsurance after deductible

What's covered

The diagnosis and treatment of infertility in connection with the voluntary planning of conceiving a child are 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 **Prescription Drugs** in this section for coverage of infertility drugs.

Infertility treatment services, when received from a network provider, are covered as in-network benefits.

When you use out-of-network benefits, in addition to the deductible and coinsurance, you will likely need to pay your provider any billed amount above what Medica pays the provider (the non-network provider reimbursement amount). **These charges are not applied to your deductible or out-of-pocket maximum.** Please see **Visiting non-network providers and why you pay more** in **Before You Access Care** for more information and an example showing out-of-pocket costs associated with out-of-network benefits.

What to keep in mind

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

Prior authorization (approval in advance) is required before you receive certain biologics and professionally administered drugs. To determine if Medica requires prior authorization for a particular service or treatment, please call Medica Customer Service at one of the numbers

listed at the front of this certificate. Please see **Prior authorization** in **Before You Access Care** for more information about prior authorization requirements and processes.

What's not covered

1. Drugs provided or administered by a physician or other provider on an outpatient basis, except drugs that meet the definition of "professionally administered drugs." Coverage for drugs is as described in **Prescription Drugs**, **Prescription Specialty Drugs** or otherwise described as a specific benefit elsewhere in this section.
2. Assisted reproductive technology services, including but not limited to: in vitro fertilization (IVF); gamete intrafallopian transfer (GIFT); zygote intrafallopian transfer (ZIFT); tubal embryo transfer; intracytoplasmic sperm injection (ICSI); ova or embryo acquisition, retrieval, donation, preservation and/or storage; and/or any conception that occurs outside the woman's body.
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 member under the Contract.
5. Sperm banking and/or storage.
6. Donor sperm.
7. Donor eggs.
8. Services related to adoption.

LAB AND PATHOLOGY

Lab and Pathology			
		Your cost if you visit a:	
	Benefits	**Network provider:**	**Non-network provider:**
1.	Lab and pathology services received during an office visit	Nothing after deductible	20% coinsurance after deductible
2.	Lab and pathology services received during an outpatient hospital or ambulatory surgical center visit	Nothing after deductible	20% coinsurance after deductible
3.	Lab and pathology services received in an inpatient setting	Nothing after deductible	20% coinsurance after deductible

What's covered

Lab and pathology services ordered or prescribed by a physician will be covered as in-network benefits if they are received from a network provider.

What to keep in mind

When you use out-of-network benefits, in addition to the deductible and coinsurance, you will likely need to pay your provider any billed amount above what Medica pays the provider (the non-network provider reimbursement amount). **These charges are not applied to your deductible or out-of-pocket maximum.** Please see **Visiting non-network providers and why you pay more** in **Before You Access Care** for more information and an example showing out-of-pocket costs associated with out-of-network benefits.

MEDICAL-RELATED DENTAL SERVICES

Medical-Related Dental Services			
		Your cost if you visit a:	
	Benefits	**Network provider:**	**Non-network provider:**
1.	Charges for medical facilities and general anesthesia services that are recommended by a physician and received during a dental procedure for a member who: a. Is a child under age nine; b. Is severely disabled; or c. Has a condition that requires hospitalization or general anesthesia for dental care treatment	Nothing after deductible	20% coinsurance after deductible
2.	For a dependent child, orthodontia, dental implants and oral surgery treatment related to cleft lip and palate	Nothing after deductible	20% coinsurance after deductible

Medical-Related Dental Services		
	Your cost if you visit a:	
Benefits	**Network provider:**	**Non-network provider:**
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 Contract; 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.	Nothing after deductible	20% coinsurance after deductible

Medical-Related Dental Services		
	Your cost if you visit a:	
Benefits	Network provider:	Non-network provider:
4. Oral surgery for: a. Partially or completely unerupted impacted teeth; b. A tooth root without the extraction of the entire tooth (this does not include root canal therapy); or c. The gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth	Nothing after deductible	20% coinsurance after deductible

What's covered

Medically necessary outpatient dental services are covered as described above. Services must be received from a physician or dentist.

When you use out-of-network benefits, in addition to the deductible and coinsurance, you will likely need to pay your provider any billed amount above what Medica pays the provider (the non-network provider reimbursement amount). **These charges are not applied to your deductible or out-of-pocket maximum.** Please see **Visiting non-network providers and why you pay more** in **Before You Access Care** for more information and an example showing out-of-pocket costs associated with out-of-network benefits.

What to keep in mind

Comprehensive dental procedures are not considered medical-related dental services and aren't covered under this Contract.

What's 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, Speech and Occupational Therapies		
	Your cost if you visit a:	
Benefits	**Network provider:**	**Non-network provider:**
1. Physical therapy services received outside of your home		
a. Habilitative services	Nothing after deductible	20% coinsurance after deductible Coverage for physical and occupational therapy is limited to a combined maximum of 20 visits per Contract year.
b. Rehabilitative services	Nothing after deductible	20% coinsurance after deductible Coverage for physical and occupational therapy is limited to a combined maximum of 20 visits per Contract year.
2. Speech therapy services received outside of your home		
a. Habilitative services	Nothing after deductible	20% coinsurance after deductible Coverage for speech therapy is limited to 20 visits per Contract year.
b. Rehabilitative services	Nothing after deductible	20% coinsurance after deductible Coverage for speech therapy is limited to 20 visits per Contract year.

Physical, Speech and Occupational Therapies			
		Your cost if you visit a:	
	Benefits	Network provider:	Non-network provider:
3.	Occupational therapy services received outside of your home		
	a. Habilitative services	Nothing after deductible	20% coinsurance after deductible Coverage for physical and occupational therapy is limited to a combined maximum of 20 visits per Contract year.
	b. Rehabilitative services	Nothing after deductible	20% coinsurance after deductible Coverage for physical and occupational therapy is limited to a combined maximum of 20 visits per Contract year.

What's covered

Physical therapy, speech therapy and occupational therapy services arranged through a physician and provided on an outpatient basis are covered.

When you use out-of-network benefits, in addition to the deductible and coinsurance, you will likely need to pay your provider any billed amount above what Medica pays the provider (the non-network provider reimbursement amount). **These charges are not applied to your deductible or out-of-pocket maximum.** Please see **Visiting non-network providers and why you pay more** in **Before You Access Care** for more information and an example showing out-of-pocket costs associated with out-of-network benefits.

What to keep in mind

A physician must direct your care in order for it to be eligible for coverage.

Coverage for services provided on an inpatient basis is described under **Hospital Services** in this section.

What's 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 club memberships.
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 your 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 AND PROFESSIONAL SERVICES

Physician and Professional Services			
		Your cost if you visit a:	
	Benefits	**Network provider:**	**Non-network provider:**
1.	Office visits **Please note:** Some services received during an office visit may be covered under another benefit in this section. 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 in **X-Rays and Other Imaging** for coverage of these services. In such instances, both an office visit coinsurance and an outpatient surgical or imaging coinsurance apply.	Nothing after deductible	20% coinsurance after deductible

Physician and Professional Services			
		Your cost if you visit a:	
	Benefits	Network provider:	Non-network provider:
2.	Urgent care center visits **Please note:** Some services received during an urgent care center visit may be covered under another benefit in this section. 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 in **X-Rays and Other Imaging** for coverage of these services. In such instances, both an urgent care center visit coinsurance and outpatient surgical coinsurance apply.	Nothing after deductible	Covered as an in-network benefit.
3.	Convenience care		
	a. Retail health clinic	Nothing after deductible	20% coinsurance after deductible
	b. Virtual care	Nothing after deductible	20% coinsurance after deductible
4.	Chiropractic services to diagnose and to treat (by manual manipulation or certain therapies) conditions related to the muscles, skeleton and nerves of the body	Nothing after deductible	20% coinsurance after deductible Coverage is limited to a maximum of 15 visits per Contract year.

Physician and Professional Services			
		Your cost if you visit a:	
	Benefits	Network provider:	Non-network provider:
5.	Surgical services (as defined in the Physicians' Current Procedural Terminology code book):		
	a. Received from a physician during an office visit	Nothing after deductible	20% coinsurance after deductible
	b. Received from a physician during an urgent care visit or an outpatient hospital or ambulatory surgical center visit	Nothing after deductible	20% coinsurance after deductible
	c. Received from a physician in an inpatient setting	Nothing after deductible	20% coinsurance after deductible
6.	Non-surgical services received from a physician in an inpatient setting	Nothing after deductible	20% coinsurance after deductible
7.	Non-surgical outpatient hospital or ambulatory surgical center services received from or directed by a physician	Nothing after deductible	20% coinsurance after deductible
8.	Routine annual eye exams, including refraction and glaucoma screening	Nothing. The deductible does not apply.	No coverage
9.	Allergy shots	Nothing after deductible	20% coinsurance after deductible

Physician and Professional Services			
		Your cost if you visit a:	
	Benefits	**Network provider:**	**Non-network provider:**
10.	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)	Nothing after deductible	20% coinsurance after deductible
11.	Acupuncture Limited to 15 visits per Contract year for in-network and out-of-network benefits combined.	Nothing after deductible	20% coinsurance after deductible
12.	Neuropsychological evaluations/cognitive testing, limited to services necessary for the diagnosis or treatment of a medical illness or injury	Nothing after deductible	20% coinsurance after deductible
13.	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 Contract year.	Nothing after deductible	20% coinsurance after deductible

What's covered

In-network benefits apply to:

1. Professional services received from a network provider; and
2. Emergency services received from network or non-network providers.

When you use out-of-network benefits, in addition to the deductible and coinsurance, you will likely need to pay your provider any billed amount above what Medica pays the provider (the non-network provider reimbursement amount). **These charges are not applied to your deductible or out-of-pocket maximum.** Please see **Visiting non-network providers and why you pay more** in **Before You Access Care** for more information and an example showing out-of-pocket costs associated with out-of-network benefits.

What to keep in mind

Prior authorization (approval in advance) is required before you receive certain outpatient surgical services and certain biologics and professionally administered drugs. To determine if Medica requires prior authorization for a particular service or treatment, please call Medica Customer Service at one of the numbers listed at the front of this certificate. Please see **Prior authorization** in **Before You Access Care** for more information about prior authorization requirements and processes.

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 copayment or coinsurance.

What's not covered

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

PREGNANCY – MATERNITY CARE

Pregnancy – Maternity Care			
		Your cost if you visit a:	
	Benefits	**Network provider:**	**Non-network provider:**
1.	Outpatient prenatal services	Nothing. The deductible does not apply.	20% coinsurance after deductible
2.	Inpatient stay for labor and delivery services – for the mother **Please note:** Maternity labor and delivery services are considered inpatient services regardless of the length of the hospital stay.	Nothing after deductible	20% coinsurance after deductible
3.	Physician services received during an inpatient stay for labor and delivery – for the mother	Nothing after deductible	20% coinsurance after deductible
4.	Inpatient stay – for your newborn	Nothing after deductible	20% coinsurance after deductible
5.	Physician services received during an inpatient stay – for your newborn	Nothing after deductible	20% coinsurance after deductible
6.	Labor and delivery services at a free-standing birth center		
	a. Facility services for labor and delivery – for the mother **Please note:** Maternity labor and delivery services are considered inpatient services regardless of the length of the hospital stay.	Nothing after deductible	20% coinsurance after deductible

Pregnancy – Maternity Care			
		Your cost if you visit a:	
	Benefits	Network provider:	Non-network provider:
	b. Physician services received for labor and delivery – for the mother	Nothing after deductible	20% coinsurance after deductible
	c. Physician services – for your newborn	Nothing after deductible	20% coinsurance after deductible
7.	Postnatal services	Nothing after deductible	20% coinsurance after deductible
8.	Home health care visit following delivery	Nothing after deductible	20% coinsurance after deductible

What's covered

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

When you use out-of-network benefits, in addition to the deductible and coinsurance, you will likely need to pay your provider any billed amount above what Medica pays the provider (the non-network provider reimbursement amount). **These charges are not applied to your deductible or out-of-pocket maximum.** Please see **Visiting non-network providers and why you pay more** in **Before You Access Care** for more information and an example showing out-of-pocket costs associated with out-of-network benefits.

What to keep in mind

Enrolling your baby

Medica does not automatically know of a birth or whether you would like coverage for your baby. To enroll your newborn as a dependent, see **Who's Eligible for Coverage and How Do They Enroll**. Once enrolled, your baby will be covered from birth. If adding your baby raises your premium, Medica is entitled to all premiums due from the time the baby is born. If any premium amount is past due, Medica may reduce payment by the amount you owe when paying for your baby's health services. For more information, see **Who's Eligible for Coverage and How Do They Enroll**.

Prenatal care

Covered prenatal services include:

1. Office visits for prenatal care, including professional services, lab, pathology, x-rays and imaging;

2. Hospital and ambulatory surgery center services for prenatal care, including professional services received during an inpatient stay for prenatal care;
3. Intermittent skilled care or home infusion therapy due to a high-risk pregnancy; and
4. Supplies for gestational diabetes.

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

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

Services that are not considered prenatal care may be eligible for coverage under the most specific and appropriate section of this certificate. Please refer to those sections for coverage information. The **Where to Find It** section can help direct you to the right place.

Labor and delivery

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

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

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 member to less than 48 hours following a vaginal delivery (or less than 96 hours following a cesarean section). However, federal law generally does not prohibit the mother or newborn child member's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, Medica may not require a provider to obtain prior authorization from Medica for a stay of 48 hours or less (or 96 hours, as applicable).

Postnatal care

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

Your plan covers one home health care visit if it occurs within 4 days of discharge. For services received after 4 days, please see **Home Health Care** in this section.

For more information about pregnancy care, see the tip sheet at medica.com/membertips.

What’s 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 **A prescription unit is:** **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			
	Your cost if you visit a:		
	Network pharmacy:	**Non-network pharmacy:**	**Mail order pharmacy:**
1. Prescription drugs received at a retail pharmacy, other than those described below or in **Prescription Specialty Drugs**			
	Generic: $5 after deductible per prescription unit; or **Preferred brand:** $30 after deductible per prescription unit; or **Non-preferred brand:** $55 after deductible per prescription unit	**Generic:** 20% coinsurance after deductible per prescription unit; or **Preferred brand:** 20% coinsurance after deductible per prescription unit; or **Non-preferred brand:** 20% coinsurance after deductible per prescription unit	**Generic:** $10 after deductible per prescription unit; or **Preferred brand:** $60 after deductible per prescription unit; or **Non-preferred brand:** $110 after deductible per prescription unit

Prescription Drugs **A prescription unit is:** **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		
Your cost if you visit a:		
Network pharmacy:	**Non-network pharmacy:**	**Mail order pharmacy:**
2. Infertility covered drugs. Limited to a maximum benefit of $3,000 per Contract year for all infertility covered drugs described in **Prescription Drugs** and **Prescription Specialty Drugs**, combined.		
Generic: $5 after deductible per prescription unit; or **Preferred brand:** $30 after deductible per prescription unit; or **Non-preferred brand:** $55 after deductible per prescription unit	**Generic:** 20% coinsurance after deductible per prescription unit; or **Preferred brand:** 20% coinsurance after deductible per prescription unit; or **Non-preferred brand:** 20% coinsurance after deductible per prescription unit	**Generic:** $10 after deductible per prescription unit; or **Preferred brand:** $60 after deductible per prescription unit; or **Non-preferred brand:** $110 after deductible per prescription unit
3. Diabetic equipment and supplies, including blood glucose meters		
Generic: $5 after deductible per prescription unit; or **Preferred brand:** $30 after deductible per prescription unit; or **Non-preferred brand:** $55 after deductible per prescription unit	**Generic:** 20% coinsurance after deductible per prescription unit; or **Preferred brand:** 20% coinsurance after deductible per prescription unit; or **Non-preferred brand:** 20% coinsurance after deductible per prescription unit	**Generic:** $10 after deductible per prescription unit; or **Preferred brand:** $60 after deductible per prescription unit; or **Non-preferred brand:** $110 after deductible per prescription unit

Prescription Drugs **A prescription unit is:** **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			
	Your cost if you visit a:		
	Network pharmacy:	**Non-network pharmacy:**	**Mail order pharmacy:**
4.	Drugs and other supplies (including women's contraceptives), and tobacco cessation products and services that are considered preventive health services		
	Generic: Nothing per prescription unit; or The deductible does not apply. **Preferred brand:** Nothing per prescription unit; or The deductible does not apply. **Non-preferred brand:** Covered as an in-network non-preferred brand benefit under 1. in this table.	**Generic:** Covered as an out-of-network generic benefit under 1. in this table; or **Preferred brand:** Covered as an out-of-network preferred brand benefit under 1. in this table; or **Non-preferred brand:** Covered as an out-of-network non-preferred brand benefit under 1. in this table.	**Generic:** Nothing per prescription unit; or The deductible does not apply. **Preferred brand:** Nothing per prescription unit; or The deductible does not apply. **Non-preferred brand:** Covered as a mail order non-preferred brand benefit under 1. in this table. **Please note:** Tobacco cessation products are not available through a mail order pharmacy.

Prescription Drugs **A prescription unit is:** **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			
	Your cost if you visit a:		
	Network pharmacy:	**Non-network pharmacy:**	**Mail order pharmacy:**
5.	Outpatient medications commonly used to promote and maintain healthy outcomes for certain medical conditions, including but not limited to prescription insulin drugs		
	Generic: Nothing per prescription unit; or The deductible does not apply. **Preferred brand:** Nothing per prescription unit; or The deductible does not apply. **Non-preferred brand:** Covered as an in-network non-preferred brand benefit under 1. in this table, except for prescription insulin drugs which are covered at a $25 copayment per prescription unit. The deductible does not apply to prescription insulin drugs.	**Generic:** Covered as an out-of-network generic benefit under 1. in this table; or **Preferred brand:** Covered as an out-of-network preferred brand benefit under 1. in this table; or **Non-preferred brand:** Covered as an out-of-network non-preferred brand benefit under 1. in this table.	**Generic:** Nothing per prescription unit; or The deductible does not apply. **Preferred brand:** Nothing per prescription unit; or The deductible does not apply. **Non-preferred brand:** Covered as a mail order non-preferred brand benefit under 1. in this table, except for prescription insulin drugs which are covered at a $50 copayment per prescription unit. The deductible does not apply to prescription insulin drugs.

Your cost if you visit a:	
Network pharmacy:	**Non-network pharmacy:**
6. Self-administered cancer treatment medications	
Generic: Nothing after deductible per prescription unit; or **Preferred brand:** Nothing after deductible per prescription unit; or **Non-preferred brand:** Nothing after deductible per prescription unit	**Generic:** Covered as an out-of-network generic benefit under 1. in this table; or **Preferred brand:** Covered as an out-of-network preferred brand benefit under 1. in this table; or **Non-preferred brand:** Covered as an out-of-network non-preferred brand benefit under 1. in this table.

What's covered

Prescription drugs and certain over-the-counter (OTC) drugs and supplies are covered if they are:

- Prescribed by an authorized provider;
- Included on Medica's drug list (unless identified as not covered); and
- Received from a pharmacy or a designated mail order pharmacy.

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

What is Medica's Drug List

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

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

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

Generic drugs are your lowest coinsurance option. For your lowest share of the cost, consider a generic covered drug if you and your provider decide it is appropriate for your treatment.

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

Preferred brand drugs have a higher coinsurance. You may consider a preferred brand covered drug to treat your condition if you and your provider decide it is appropriate.

Non-preferred brand drugs have the highest coinsurance. The covered non-preferred brand drugs are usually more costly.

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

What to keep in mind

What is a prescription unit

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

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

One prescription unit from a designated mail order pharmacy is a 93-consecutive-day supply (or, in the case of contraceptives, up to a three-cycle supply).

Three prescription units from a pharmacy 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.

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

- Prior authorization (PA)

  Certain drugs require prior authorization (approval in advance) from Medica in order to be covered. These medications are shown on the Drug List with the abbreviation "PA." The Drug List is available to providers, including pharmacies and the designated mail order pharmacies. Please see **Prior authorization** in **Before You Access Care** for more information about prior authorization requirements and processes. Your network provider

who prescribes the drug should initiate the prior authorization process. You must contact Customer Service to request prior authorization for drugs prescribed by a non-network provider. You will pay the entire cost of the drug received if you do not meet Medica's authorization criteria.

- Step therapy (ST)

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

- Quantity limits (QL)

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

Exceptions to the Drug List

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

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

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

Mail order pharmacy

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

To learn more about how to use mail order pharmacy, log in to mymedica.com.

Generic requirement

Certain covered preferred brand and non-preferred brand drugs include a chemically equivalent generic drug on the Drug List. If you still choose to use a preferred brand or non-preferred brand prescription drug, Medica will pay the amount that Medica would have paid had you

received the generic drug. You will pay, in addition to the applicable deductible or coinsurance described in the table, any remaining charges due to the pharmacy in excess of Medica's payment to the pharmacy. **These charges are not applied to your deductible or out-of-pocket maximum.**

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

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

Additional considerations

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

The list of covered Preventive Drugs and Other Services is specific and limited. For a current list go to mymedica.com and refer to the Preventive Drug and Supply category on the Drug List, or call Customer Service.

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

What's not covered

1. Drugs and supplies that are not on Medica's Drug List, unless covered through the exception process described in this certificate.
2. Any amount above what Medica would have paid when you fail to identify yourself as a member to the pharmacy. (Medica will notify you before enforcement of this provision.)
3. Drugs that have not been approved by the Food and Drug Administration (FDA).
4. Over-the-counter (OTC) drugs not listed on Medica's Drug List.
5. Replacement of a drug due to loss, damage or theft.
6. Sexual dysfunction medications in excess of Medica's quantity limits.
7. Tobacco cessation products or services dispensed through a mail order pharmacy.
8. Drugs prescribed by a provider who is not acting within his/her scope of licensure.
9. Homeopathic medicine.
10. Specialty prescription drugs, except as described in **Prescription Specialty Drugs**.
11. Bulk powders, chemicals and products used in prescription drug compounding.

12. Products that are duplicative to, or are in the same class and category as products on Medica's Drug List.
13. New-to-market drugs: Products recently approved by the FDA and introduced into the market will not be covered until they are reviewed and considered for placement on the Drug List.

PRESCRIPTION SPECIALTY DRUGS

Prescription Specialty Drugs		
Benefits		**You pay:**
1.	Specialty prescription drugs received from a designated specialty pharmacy	**Preferred specialty prescription drugs:** $30 after deductible per prescription unit; or **Non-preferred specialty prescription drugs:** $55 after deductible per prescription unit
2.	Specialty infertility prescription drugs received from a designated specialty pharmacy. Limited to a maximum benefit of $3,000 per Contract year for all infertility drugs described in **Prescription Drugs** and **Prescription Specialty Drugs** combined.	**Preferred specialty prescription drugs:** $30 after deductible per prescription unit; or **Non-preferred specialty prescription drugs:** $55 after deductible 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	**Preferred specialty prescription drugs:** $30 after deductible per prescription unit; or **Non-preferred specialty prescription drugs:** $55 after deductible per prescription unit
4.	Self-administered cancer treatment medications	**Preferred specialty prescription drugs:** Nothing after deductible per prescription unit; or **Non-preferred specialty prescription drugs:** Nothing after deductible per prescription unit

What's covered

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

Specialty prescription drugs are covered if they are:

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

What is Medica's Specialty Drug List

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

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

Preferred specialty prescription drugs are your lowest coinsurance option. For your lowest share of the cost, consider a preferred specialty prescription drug if you and your physician decide it is appropriate for your treatment.

Non-preferred specialty prescription drugs have a higher coinsurance than preferred specialty prescription drugs. Consider a non-preferred specialty prescription drug if you and your physician decide it is appropriate for your treatment.

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

What to keep in mind

These benefits apply when covered specialty prescription drugs are received from a designated specialty pharmacy. A current list of designated specialty pharmacies is available on mymedica.com. You can also call Customer Service at one of the telephone numbers listed at the front of this certificate. Note that certain specialty pharmacies may be in other Medica networks but not in your network.

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

What is a prescription unit

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

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

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

- Prior authorization (PA)

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

- Step therapy (ST)

  Step therapy is a process that involves trying an alternative covered specialty prescription drug (typically a preferred drug) before moving to certain other preferred or non-preferred drugs. The medications subject to step therapy are shown on the Specialty Drug List with the abbreviation "ST." You must meet applicable step therapy requirements before Medica will cover these preferred or non-preferred drugs.

- Quantity limits (QL)

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

Exceptions to the Specialty Drug List

In certain cases, it is possible to get an exception to the coverage rules described under What is Medica's Specialty Drug List above. **Please note that exceptions will only be allowed when specific clinical criteria are satisfied.** Any exception that Medica grants will improve the coverage by only one benefit level.

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

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

Preferred requirement for specialty prescription drugs

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

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

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

What's not covered

1. Specialty prescription drugs that are not on Medica's Specialty Drug List, unless covered through the exception process described in this certificate.
2. Any amount above what Medica would have paid when you fail to identify yourself as a member to the designated specialty pharmacy. (Medica will notify you before enforcement of this provision.)
3. Specialty drugs that have not been approved by the Food and Drug Administration (FDA).
4. Replacement of a specialty prescription drug due to loss, damage or theft.
5. Specialty prescription drugs prescribed by a provider who is not acting within his/her scope of licensure.
6. Prescription drugs and certain OTC drugs, except as described in **Prescription Drugs** in this certificate.
7. Specialty prescription drugs received from a pharmacy that is not a designated specialty pharmacy.
8. Growth hormone, except as specifically described in the benefit table above.
9. New-to-market drugs: Products recently approved by the FDA and introduced into the market will not be covered until they are reviewed and considered for placement on the Specialty Drug List.

PREVENTIVE HEALTH CARE

Preventive Health Care			
		Your cost if you visit a:	
	Benefits	**Network provider:**	**Non-network provider:**
1.	Child health supervision services, including well-baby care	Nothing. The deductible does not apply.	20% coinsurance after deductible
2.	Immunizations	Nothing. The deductible does not apply.	20% coinsurance after deductible
3.	Early disease detection services including physicals	Nothing. The deductible does not apply.	No coverage
4.	Routine screening procedures for cancer	Nothing. The deductible does not apply.	20% coinsurance after deductible
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.	20% coinsurance after deductible
6.	Other preventive health services	Nothing. The deductible does not apply.	20% coinsurance after deductible

What to keep in mind

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 this section. The most specific and appropriate benefit will apply for each service you receive during a visit. For example:

- Your plan covers routine mammograms as described above. However, if your doctor recommends additional tests, such as a breast ultrasound or MRI, your x-ray or other imaging benefits will apply. For most plans, that means you'll incur costs for those tests.

When you use out-of-network benefits, in addition to the deductible and coinsurance, you will likely need to pay your provider any billed amount above what Medica pays the provider (the non-network provider reimbursement amount). **These charges are not applied to your deductible or out-of-pocket maximum.** Please see **Visiting non-network providers and why you pay more** in **Before You Access Care** for more information and an example showing out-of-pocket costs associated with out-of-network benefits.

For more information about preventive care, see the tip sheet at medica.com/membertips.

RECONSTRUCTIVE AND RESTORATIVE SURGERY

Reconstructive and Restorative Surgery		
	Your cost if you visit a:	
Benefits	Network provider:	Non-network provider:
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.

What's covered

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.

When you use out-of-network benefits, in addition to the deductible and coinsurance, you will likely need to pay your provider any billed amount above what Medica pays the provider (the non-network provider reimbursement amount). **These charges are not applied to your deductible or out-of-pocket maximum.** Please see **Visiting non-network providers and why you pay more** in **Before You Access Care** for more information and an example showing out-of-pocket costs associated with out-of-network benefits.

What to keep in mind

Prior authorization (approval in advance) is required before you receive certain reconstructive and/or restorative surgery services. Please see **Prior authorization** in **Before You Access Care** for more information about prior authorization requirements and processes.

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

What's not covered

1. Revision of blemishes on skin surfaces and scars (including scar excisions) primarily for cosmetic purposes, unless otherwise covered in **Physician and Professional Services** in this section.
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 drugs that meet the definition of "professionally administered drugs." Coverage for drugs is as described in **Prescription Drugs**, **Prescription Specialty Drugs** or otherwise described as a specific benefit elsewhere in this section.

SKILLED NURSING FACILITY

Skilled Nursing Facility		
	Your cost if you visit a:	
Benefits	**Network provider:**	**Non-network provider:**
1. Daily skilled care or daily skilled rehabilitation services, including room and board, up to 120 days per member per Contract year for in-network and out-of-network services combined	Nothing after deductible	20% coinsurance after deductible
2. Skilled physical, speech or occupational therapy when room and board is not eligible to be covered	Nothing after deductible	20% coinsurance after deductible
3. Services received from a physician during an inpatient stay in a skilled nursing facility	Nothing after deductible	20% coinsurance after deductible

What's covered

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

When you use out-of-network benefits, in addition to the deductible and coinsurance, you will likely need to pay your provider any billed amount above what Medica pays the provider (the non-network provider reimbursement amount). **These charges are not applied to your deductible or out-of-pocket maximum.** Please see **Visiting non-network providers and why you pay more** in **Before You Access Care** for more information and an example showing out-of-pocket costs associated with out-of-network benefits.

What to keep in mind

Prior authorization (approval in advance) is required before you receive skilled nursing facility services. Please see **Prior authorization** in **Before You Access Care** for more information about prior authorization requirements and processes.

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.

What's 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 club memberships.
7. Physical, speech or occupational therapy services when there is no reasonable expectation that the member'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.
11. Charges to hold a bed during a skilled nursing facility absence, due to hospitalization or any other reason.

TELEMEDICINE HEALTH SERVICES

Telemedicine Health Services		
	Your cost if you visit a:	
Benefits	**Network provider:**	**Non-network provider:**
1. Health services delivered by means of telemedicine	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, inpatient services are covered at the inpatient services in-network benefit level and behavioral health services are covered at the corresponding behavioral health 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, inpatient services are covered at the inpatient services out-of-network benefit level and behavioral health services are covered at the corresponding behavioral health services out-of-network benefit level.

What to keep in mind

When you use out-of-network benefits, in addition to the deductible and coinsurance, you will likely need to pay your provider any billed amount above what Medica pays the provider (the non-network provider reimbursement amount). **These charges are not applied to your deductible or out-of-pocket maximum.** Please see **Visiting non-network providers and why you pay more** in **Before You Access Care** for more information and an example showing out-of-pocket costs associated with out-of-network benefits.

TEMPOROMANDIBULAR JOINT (TMJ) AND CRANIOMANDIBULAR DISORDER

Temporomandibular Joint (TMJ) and Craniomandibular Disorder			
		Your cost if you visit a:	
	Benefits	**Network provider:**	**Non-network provider:**
1.	Treatment of temporomandibular joint (TMJ) disorder and craniomandibular disorder **Note:** Dental coverage is not provided under this benefit.	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.

What to keep in mind

When you use out-of-network benefits, in addition to the deductible and coinsurance, you will likely need to pay your provider any billed amount above what Medica pays the provider (the non-network provider reimbursement amount). **These charges are not applied to your deductible or out-of-pocket maximum.** Please see **Visiting non-network providers and why you pay more** in **Before You Access Care** for more information and an example showing out-of-pocket costs associated with out-of-network benefits.

TRANSPLANT SERVICES

Transplant Services			
		Your cost if you visit a:	
	Benefits	Network provider:	Non-network provider:
1.	Solid organ and blood and marrow transplant services **Prior authorization is required for all transplant services; this prior authorization must be obtained before the transplant workup is initiated.**	Covered at the corresponding in-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit in-network benefit level and surgical services are covered at the surgical services in-network benefit level.	Covered at the corresponding out-of-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit out-of-network benefit level and surgical services are covered at the surgical services out-of-network benefit level.
2.	Transportation and lodging reimbursement, as described below, is available for expenses primarily for and essential to the receipt of transplant services. Reimbursement will be for you and a companion or companions whose presence with you is necessary and essential in order for you to receive transplant services, when you receive approved transplant services at a designated facility selected exclusively for medical reasons 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, provided that the presence of both companions is necessary for you to receive transplant services.		Reimbursement of expenses for out-of-network services is not covered.

Transplant Services		
	Your cost if you visit a:	
Benefits	Network provider:	Non-network provider:
b. Lodging that is not lavish or extravagant under the circumstances for you (while not confined) and one companion (whose presence is necessary in order for you to receive transplant services). If you are a minor child, reimbursement for lodging expenses for two companions is available (provided that the presence of both companions is necessary in order for you to receive transplant services). Reimbursement is available for a per diem amount of up to $50 per person or up to $100 for two people. There is a lifetime maximum of $10,000 per member for all transportation and lodging expenses incurred by you and your companion(s). Meals are not reimbursable under this 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.		

What's covered

Certain solid organ and blood and marrow transplant services are covered if provided under the direction of a 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.

When you use out-of-network benefits, in addition to the deductible and coinsurance, you will likely need to pay your provider any billed amount above what Medica pays the provider (the non-network provider reimbursement amount). **These charges are not applied to your deductible or out-of-pocket maximum.** Please see **Visiting non-network providers and why you pay more** in **Before You Access Care** for more information and an example showing out-of-pocket costs associated with out-of-network benefits.

What to keep in mind

Prior authorization (approval in advance) from Medica is required before you receive transplant services or supplies. This prior authorization must be obtained before the transplant workup is initiated. Please see **Prior authorization** in **Before You Access Care** for more information about prior authorization requirements and processes.

Benefits for each individual member will be determined based on their clinical circumstances according to medical criteria used by Medica. Because medical technology is constantly changing, Medica 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 list above 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. Contact Customer Service to be connected with a Medica case manager for your transplant care.

Medica requires that all pre-transplant, transplant and post-transplant services, from the time of the initial evaluation through no more than one year after the date of the transplant, be received at one designated facility. Based on the type of transplant you receive, Medica will determine the specific time period medically necessary.

Out-of-network benefits apply to solid organ and blood and marrow transplant services provided by or at either a non-network provider or a non-designated transplant facility.

What's not covered

1. Supplies and services related to transplants that would not be authorized by Medica under the medical criteria referenced in this section.
2. Chemotherapy, radiation therapy, drugs or any therapy used to damage the bone marrow and related to transplants that would not be authorized by Medica under the medical criteria referenced in this section.
3. Living donor transplants that would not be authorized by Medica 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 and supplies of a similar nature not otherwise covered under this certificate.

5. Mechanical, artificial or non-human organ implants or transplants and related services that would not be authorized by Medica under the medical criteria referenced in this section.
6. 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 drugs that meet the definition of “professionally administered drugs.” Coverage for drugs is as described in **Prescription Drugs**, **Prescription Specialty Drugs** or otherwise described as a specific benefit elsewhere in this section.

WEIGHT LOSS SURGERY

Weight Loss Surgery		
	Your cost if you visit a:	
Benefits	Network provider:	Non-network provider:
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.	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.

What's covered

Coverage for surgery for morbid obesity is provided. Prior authorization from Medica is required before you receive weight loss surgery services or supplies.

In-network services must be provided by a designated network physician and received at a designated network facility. This section also describes benefits for professional, hospital and ambulatory surgical center services.

When you use out-of-network benefits, in addition to the deductible and coinsurance, you will likely need to pay your provider any billed amount above what Medica pays the provider (the non-network provider reimbursement amount). **These charges are not applied to your deductible or out-of-pocket maximum.** Please see **Visiting non-network providers and why you pay more** in **Before You Access Care** for more information and an example showing out-of-pocket costs associated with out-of-network benefits.

What to keep in mind

Prior authorization (approval in advance) is required before you receive weight loss surgery services. Please see **Prior authorization** in **Before You Access Care** for more information about prior authorization requirements and processes.

In-network benefits apply to surgery for morbid obesity provided by a designated physician and received at a designated facility. A designated physician or designated facility is a 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 at the front of this certificate.

Out-of-network benefits apply to surgery for morbid obesity provided by or at either of the following:

1. A non-network provider, or
2. A network physician or facility that is not a designated physician or designated facility.

What's 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, except as described in this section.
3. Services and procedures primarily for cosmetic purposes.
4. Supplies and services for surgery for morbid obesity that would not be authorized by Medica.
5. 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 and supplies of a similar nature not otherwise covered under this certificate.
6. Drugs provided or administered by a physician or other provider on an outpatient basis, except drugs that meet the definition of "professionally administered drugs." Coverage for drugs is as described in **Prescription Drugs**, **Prescription Specialty Drugs** or otherwise described as a specific benefit elsewhere in this section.

X-RAYS AND OTHER IMAGING

X-Rays and Other Imaging			
		Your cost if you visit a:	
	Benefits	Network provider:	Non-network provider:
1.	X-rays and other imaging services received during an office visit	Nothing after deductible	20% coinsurance after deductible
2.	X-rays and other imaging services received during an outpatient hospital or ambulatory surgical center visit **Note:** For these services received during an emergency room visit, see **Emergency Room Care**.	Nothing after deductible	20% coinsurance after deductible
3.	X-rays and other imaging services received in an inpatient setting	Nothing after deductible	20% coinsurance after deductible
4.	MRI, CT and PET CT scans **Note:** Some types of scans may require prior authorization.	Nothing after deductible	20% coinsurance after deductible

What to keep in mind

Prior authorization (approval in advance) is required before you receive certain imaging services. To determine if Medica requires prior authorization for a particular service or treatment, please call Medica Customer Service at one of the numbers listed at the front of this certificate. Please see **Prior authorization** in **Before You Access Care** for more information about prior authorization requirements and processes.

When you use out-of-network benefits, in addition to the deductible and coinsurance, you will likely need to pay your provider any billed amount above what Medica pays the provider (the non-network provider reimbursement amount). **These charges are not applied to your deductible or out-of-pocket maximum.** Please see **Visiting non-network providers and why you pay more** in **Before You Access Care** for more information and an example showing out-of-pocket costs associated with out-of-network benefits.

What's Not Covered

Medica will not provide coverage for any of the services, treatments, supplies or items described in this section even if it is recommended or prescribed by a 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 **What's not covered** in this certificate. 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 cochlear implants and their related fittings and except as described in **Durable Medical Equipment, Prosthetics and Medical Supplies** in **What's Covered and How Much Will I Pay**.
7. A drug, device or medical treatment or procedure that is investigative.
8. Services or supplies not directly related to your care.
9. Autopsies.
10. 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.
11. Nutritional and electrolyte substances, except as specifically described in **Durable Medical Equipment, Prosthetics and Medical Supplies** in **What's Covered and How Much Will I Pay**.
12. 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.
13. Reversal of voluntary sterilization.
14. Personal comfort or convenience items or services.
15. Custodial care, unskilled nursing or unskilled rehabilitation services.

16. Respite or rest care, except as otherwise covered in **Hospice Services** in **What's Covered and How Much Will I Pay**.
17. Travel, transportation or living expenses, except as described in **Transplant Services** in **What's Covered and How Much Will I Pay**.
18. Household equipment, fixtures, home modifications and vehicle modifications.
19. Charges billed by a non-network provider that are not in compliance with generally accepted coding and reimbursement guidelines, including those of the American Medical Association (AMA), the Centers for Medicare and Medicaid Services (CMS) and the community.
20. Massage therapy provided in any setting, even when it is part of a comprehensive treatment plan.
21. Routine foot care, except for members with diabetes, blindness, peripheral vascular disease, peripheral neuropathies and significant neurological conditions such as Parkinson's disease, Alzheimer's disease, multiple sclerosis and amyotrophic lateral sclerosis (ALS).
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 Contract becomes effective.
25. Services received after coverage under the Contract ends.
26. Unless requested by Medica, charges for duplicating and obtaining medical records from non-network providers and non-network dentists.
27. Photographs, except for the conditions of dysplastic nevi and melanoma.
28. Occlusal adjustment or occlusal equilibration.
29. Dental implants (tooth replacement), except as described in **Medical-Related Dental Services** in **What's Covered and How Much Will I Pay**.
30. Dental prostheses.
31. Any orthodontia, except as described in **Medical-Related Dental Services** in **What's Covered and How Much Will I Pay** for the treatment of cleft lip and palate.
32. Treatment for bruxism.
33. Services prohibited by applicable law or regulation.
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.
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 and Professional Services** in **What's Covered and How Much Will I Pay**.
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 certificate.
42. Elective, induced abortions, except as medically necessary to protect the life of the mother.
43. Orthognathic surgery for cosmetic purposes.
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 and Professional Services** in **What's Covered and How Much Will I Pay**.
46. Health care professional services for home labor and delivery.
47. Assisted reproductive technology services, including but not limited to: in vitro fertilization (IVF); gamete intrafallopian transfer (GIFT); zygote intrafallopian transfer (ZIFT); tubal embryo transfer; intracytoplasmic sperm injection (ICSI); ova or embryo acquisition, retrieval, donation, preservation and/or storage; and/or any conception that occurs outside the woman's body.
48. Services related to surrogate pregnancy for a person not covered as a member under the Contract.
49. Sperm banking and/or storage.
50. Donor sperm.
51. Donor eggs.
52. Services related to adoption.
53. Services solely for or related to the treatment of snoring.
54. Interpreter services.
55. Services for private duty nursing. 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 member or the member's representative and not under the direction of a physician.

56. Laboratory testing (including genetic testing) that has been performed in response to direct-to-consumer marketing and not under the direction of a physician.
57. Medical devices that have not been approved by the U.S. Food and Drug Administration (FDA), other than those granted a humanitarian device exemption.
58. Drugs, supplies and biologics that have not been approved by the U.S. Food and Drug Administration (FDA).
59. New-to-market biologics and professionally administered drugs. Biologics and professionally administered drugs recently approved by the FDA (including approval for a new indication) will not be covered until they are reviewed and approved for coverage by Medica.
60. Health club memberships.
61. Long-term care.
62. Treatment to lighten or remove the coloration of a port wine stain.
63. Expenses associated with participation in weight loss programs, including but not limited to membership fees and the purchase of food, dietary supplements or publications.
64. Any charges for mailing, interest and delivery, such as the cost for mailing medical records.
65. Animals and any service or treatment related to animals.
66. Charges incurred if you fail to keep a scheduled visit.

What if I Have More Than One Insurance Plan

This section describes how benefits are coordinated when you are covered under more than one plan. **However, when your other plan is Medicare or TRICARE, Medica will coordinate benefits in accordance with the Medicare Secondary Payer or TRICARE provisions of Federal law.** If you have questions about how these rules apply to you or a covered family member, contact Customer Service at one of the numbers listed at the front of this certificate.

Coordination for Medicare-eligible individuals

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

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

When coordination of benefits applies

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

Definitions that apply to this section

1. Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
    a. Plan includes: Group and nongroup insurance contracts, closed panel plans or other forms of group or group type coverage (whether insured or uninsured or individual coverage); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

b. Plan does not include: Hospital indemnity coverage or other fixed indemnity coverage; accident-only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident-type coverage; benefits for nonmedical components of long-term care policies; Medicare supplement policies; Medicaid policies or coverage under other federal governmental plans, unless permitted by law.

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 treated as a separate plan.

2. This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan.

   A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

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, it determines its payment for benefits first before those of any other plan without considering any other plan's benefits.

   When this plan is a secondary plan, it determines its benefits after another plan and may reduce the benefits it pays so that all plan benefits do not exceed 100 percent of the total allowable expense.

4. *Allowable expense* means any health care expense, including coinsurance or copayments and without reduction for any applicable deductible, that is covered in full or in part by any of the plans covering the person. Allowable expense does not include the deductible for members with a primary high deductible plan and who notify Medica of an intention to contribute to a health savings account.

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

   a. 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 one of the plans provides coverage for private hospital room expenses.

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

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

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

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

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

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

Order of benefit determination rules

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

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

   a. Except as provided in ii. below, a plan that does not contain a COB provision that is consistent with this regulation is always primary unless the provisions of both plans state that the complying plan is primary.

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

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

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

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

   b. *Dependent child covered under more than one plan.* Unless there is a court decree stating otherwise, when a dependent child is covered by more than one plan the order of benefits is determined as follows:

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

         a) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or

         b) If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

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

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

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

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

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

            - The plan covering the custodial parent;

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

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

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

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

e. *Longer or shorter length of coverage*. The plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the primary plan and the plan that covered the person the shorter period of time is the secondary plan.

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

Effect on the benefits of this plan

1. When this plan is the secondary plan, the benefits of this plan will be reduced by the benefits that would be payable for the allowable expenses under the other plans, whether or not a claim is made. In no event will this plan pay benefits which, combined with the benefits of the other plans, total more than the allowable expenses under this plan. 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.
2. If a member is enrolled in two or more closed panel plans and if, for any reasons, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

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 Contract, according to the out-of-network benefits described in this certificate. Most out-of-network benefits are covered at 80 percent of the non-network provider reimbursement amount, after you pay the applicable deductible amount. In no event will this plan provide duplicate coverage.

Right to receive and release needed information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. Medica has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. Medica need not tell, or get the consent of, any person to do this. Unless applicable federal or state law prevents disclosure of the information without the consent of the patient or the patient's representative, each person claiming benefits under this plan must give Medica any facts it needs to apply those rules and determine benefits payable.

Facility of payment

A payment made under another plan may include an amount, which should have been paid under this plan. If it does, Medica may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this plan. Medica will not have to pay that amount again. The term *payment made* includes providing benefits in the form of services, in which case *payment made* means reasonable cash value of the benefits provided in the form of services.

Right of recovery

If the amount of the payments made by Medica is more than should have been paid under this COB provision, Medica 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 **Medica's Right to Subrogation and Reimbursement** for additional information.

Medica's Right to Subrogation and Reimbursement

Medica has a right to subrogation and reimbursement. References to "you" or "your" in this section shall include you, your estate and your heirs and beneficiaries, unless otherwise stated.

Subrogation applies when Medica has paid benefits on your behalf for a sickness or injury for which any third party is allegedly responsible. The right to subrogation means that Medica is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the benefits that Medica paid that are related to the sickness or injury for which any third party is considered responsible.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a sickness or injury for which you receive a settlement, judgment or other recovery from any third party, you must use those proceeds to fully return to Medica 100% of any benefits you received from Medica for that sickness or injury. The right of reimbursement shall apply to any benefits received at any time until the rights are extinguished, resolved or waived in writing.

The following persons and entities are considered third parties:

1. A person or entity alleged to have caused you to suffer a sickness, injury or damages or who is legally responsible for the sickness, injury or damages.
2. Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the sickness, injury or damages.
3. The plan sponsor in a workers' compensation case or other matter alleging liability.
4. Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
5. Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

1. You will cooperate with Medica in protecting our legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
    a. Notifying Medica promptly, in writing, of any potential legal claim(s) you may have against any third party for acts which caused benefits to be paid or become payable.
    b. Providing any relevant information requested by Medica.
    c. Signing and/or delivering such documents as Medica or its agents reasonably request to secure the subrogation and reimbursement claim.
    d. Responding to requests for information about any accident or injuries.
    e. Making court appearances.

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

g. Complying with the terms of this section.

Your failures to cooperate with Medica or abide by the terms of the Contract are each considered a breach of the terms of the Contract. As such, Medica has the right to take legal action against you for the value of benefits Medica has paid relating to any sickness or injury alleged to have been caused or caused by any third party to the extent not recovered by Medica due to you or your representative not cooperating with us or your failure to abide by the terms of the Contract.

2. Medica has a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, Medica's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.

3. Medica's subrogation and reimbursement rights apply to full and partial settlements, judgments or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. Medica is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from our recovery without the plan's express written consent.

4. Regardless of whether you have been fully compensated or made whole, Medica may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which Medica may collect include, but are not limited to, economic, non-economic and punitive damages.

5. Benefits paid by Medica may also be considered to be benefits advanced.

6. If you receive any payment from any party as a result of sickness or injury, and Medica alleges some or all of those funds are due and owed to Medica, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.

7. By participating in and accepting benefits from Medica, you agree that any amounts recovered by you from any third party shall constitute Medica assets (to the extent of the amount of Medica benefits provided on behalf of the member).

8. Medica's rights to recovery will not be reduced due to your own negligence or comparative fault.

9. Upon Medica's request, you will assign in writing to Medica all rights of recovery against third parties, to the extent of the benefits Medica has paid for the sickness or injury.
10. You may not accept any settlement that does not fully reimburse Medica, without its written approval.
11. In the case of your death, giving rise to any survival claim, the provisions of this section apply to your estate and the personal representative of your estate. In the case of your death Medica's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse Medica is not extinguished by a release of claims or settlement agreement of any kind unless Medica expressly agrees in writing.
12. No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs or next of kin, your beneficiaries or any other person or party, except as part of a wrongful death claim in the case of your death, shall be valid if it does not reimburse Medica for 100% of its interest unless Medica provides written consent to the allocation.
13. The provisions of this section apply to the parents, guardian or other representative of a dependent child who incurs a sickness or injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's sickness or injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
14. If any third party causes or is alleged to have caused you to suffer a sickness or injury while you are covered under the Contract, the provisions of this section continue to apply, even after you are no longer covered.
15. Medica's administrators or agents administering the terms and conditions of the Contract's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions.

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 applies

After Medica notifies you that this 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 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 Do I 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 at the front of this certificate.

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

Claims for benefits from non-network providers

Claim forms are provided at medica.com/memberforms. You may also request claim forms by calling Customer Service at one of the telephone numbers listed at the front of this certificate. 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 Medica member number must be on the claim.

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

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

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

Medica will notify you of authorization or denial of the claim within 15 days of receipt of the claim.

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

Claims for 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 Medica may request.

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

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

Time limits

If you have a complaint or disagree with a decision by Medica, you may follow the complaint procedure outlined in **How Do I File a Complaint** or you may initiate legal action at any point.

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

How Do I File a Complaint

This section describes what to do if you have a complaint or would like to appeal a decision made by Medica.

You may direct any questions or complaints to Customer Service by calling one of the telephone numbers listed at the front of this certificate or contact Medica by writing to the address listed below in **First level of review**. You also may direct complaints to the North Dakota Commissioner of Insurance at (701) 328-2440 or 1-800-247-0560, or for TTY members at 711.

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

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

Upon request, Medica will assist you with completion and submission of your written complaint. Medica will also complete a complaint form on your behalf and mail it to you for your signature upon request.

In addition to directing complaints to Customer Service as described in this section, you may direct complaints at any time to the North Dakota Department of Insurance at 1-800-247-0560.

First level of review

You may direct any question or complaint to Customer Service by calling one of the telephone numbers listed at the front of this certificate or by writing to the address listed below:

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

1. If your complaint is regarding an initial decision made by Medica, your complaint must be made within one year following Medica's initial decision.
2. Medica will provide written notice of its first level review decision to you and your attending provider, when applicable, within 30 calendar days from receipt of your complaint or request.
3. When an initial decision by Medica not to grant a prior authorization request is made before or during an ongoing service requiring Medica's authorization and your attending provider believes that Medica's decision warrants an expedited appeal, you or your attending provider will have the opportunity to request an expedited first level review by telephone. Alternatively, 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 seeking, Medica will process your claim as an expedited review. In such cases, Medica will notify you and your

attending provider by telephone of its decision no later than 72 hours after receiving the request.

4. If Medica's first level review decision upholds the initial decision by Medica, you may have a right to request a voluntary second level review or submit a written request for external review as described in this section.

Voluntary second level of review

If you are not satisfied with Medica's first level review decision, you may request a voluntary second level of review through a hearing, either in person or in writing.

1. Your request must be in writing. It must be provided to Medica within one year following the date of Medica's first level review decision and must be sent to the address listed above in **First level of review**.
2. Testimony, explanation or other information provided by you, Medica staff, providers and others is reviewed.
3. Medica will provide written notice of its decision to you within 45 calendar days after receipt of your written request for a voluntary second level review.

External review

For decisions that involve a medical necessity review, a determination that a treatment is experimental or investigative or a rescission of coverage, if you consider Medica's decision to be partially or wholly adverse to you, you may submit a written request for external review of Medica's decision. Your request must be submitted in writing within four (4) months following the date you receive Medica's review decision. You must include a $25 filing fee with your written request. You may submit additional information to the external review organization. An approved Independent Review Organization selected by the North Dakota Commissioner will conduct the external review. You will be notified of the external review organization's decision within 45 days from receipt of your request. However, (a) if waiting the standard 45-day turnaround time might jeopardize your health or your ability to regain maximum function, or (b) if you received emergency services and have not been discharged from the facility, you or your attending provider may request an expedited, 72-hour external review at the same time any internal appeal is being processed. The external review decision will be binding on you and Medica. Requests for independent external review may be submitted to the address listed above in **First level of review** or to the North Dakota Commissioner of Insurance at the following address:

North Dakota Commissioner of Insurance
600 E. Boulevard Avenue
Bismarck, ND 58505
1-800-247-0560

Information on external review is also available at mymedica.com.

Civil action

If you are dissatisfied with Medica's first or second level review decision, you have the right to file a civil action under Section 502(a) of the Employee Retirement Income Security Act (ERISA).

Who's Eligible for Coverage and How Do They Enroll

This section describes who can enroll and how to enroll.

Who can enroll

To be eligible to enroll for coverage you must meet the eligibility requirements of the Contract and be a subscriber or dependent as defined in this certificate.

How to enroll

You must submit an application for coverage for yourself and any dependents to the employer:

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**; or
4. At any other time for consideration as a late entrant as described in this section under **Late enrollment and effective date of coverage.**

Dependents will not be enrolled without the eligible 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 6. under **Special enrollment and effective date of coverage**.

Notification

You must notify the employer in writing within 30 days of the effective date of any changes to address or name, addition or deletion of dependents, a dependent child reaching the dependent limiting age or other facts identifying you or your dependents. A newborn child, newly adopted child and a child newly placed for adoption are covered under the Contract for 31 days from the date of birth, adoption or placement. You must enroll your newborn child, newly adopted child or child newly placed for adoption and pay all required premiums within the first 31 days in order to continue the child's coverage. Your newborn child, your newly adopted child, a child newly placed for adoption with the subscriber, a child newly placed as a foster child and any child who is a member pursuant to a QMCSO will be covered without application of health screening or waiting periods.

The employer must notify Medica within 30 days of your initial enrollment application, changes to your name or address or changes to enrollment, including if you or your dependents are no longer eligible for coverage.

Initial enrollment and effective date of coverage

Initial enrollment is a 30-day time period starting with the date an eligible employee and dependents are first eligible to enroll for coverage under the Contract. An eligible employee must enroll within this period for coverage to begin the date he or she was first eligible to enroll. For information on enrolling newborns or children newly adopted or newly placed for adoption, see **Special enrollment and effective date of coverage** and **Notification**. An eligible employee and dependents who do not enroll during the initial enrollment period may enroll for coverage during the next open enrollment period, any applicable special enrollment periods or as a late entrant (if applicable, as described below).

An eligible employee and dependents who do not enroll during the initial enrollment period, an open enrollment period or during any applicable special enrollment period, as described in this section, will be considered late entrants.

A member 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 specified in the Contract.

Open enrollment and effective date of coverage

A minimum 14-day period set by the employer and Medica each year during which eligible employees and dependents who are not covered under the Contract may elect coverage for the upcoming Contract year. An application must be submitted to the employer for yourself and any dependents.

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

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

Special enrollment and effective date of coverage

Special enrollment periods are provided to eligible employees and dependents under certain circumstances. The effective date of coverage depends upon the type of special enrollment. In all cases, your coverage begins at 12:01 a.m. on the effective date of your coverage.

1. Loss of other coverage

    a. A special enrollment period will apply to an eligible 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 eligible 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 eligible employee's loss of coverage, this special enrollment period applies to the eligible 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 eligible employee.

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

The eligible employee or dependent must present 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 30 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;
- for dependents, the eligible employee's enrollment for benefits under Medicare;
- if the prior coverage was offered through an individual health maintenance organization (HMO), a loss of coverage because the eligible 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 eligible 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 eligible employee or dependent.

iii. Loss of eligibility occurs regardless of whether the eligible 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 eligible employee or dependent to pay premiums on a timely basis, situations allowing for a rescission of coverage or voluntary termination of coverage.

In the case of the eligible employee's loss of other coverage, the special enrollment period described above applies to the eligible 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 eligible employee. In the case of the eligible employee's enrollment in Medicare, the special enrollment period described above applies to his or her dependents.

c. A special enrollment period will apply to an eligible 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 eligible employee or dependent was eligible to enroll under the Contract, whether during initial enrollment, open enrollment or special enrollment and declined coverage for that reason.

The eligible employee or dependent must present evidence that the eligible employee or dependent has exhausted such COBRA or state continuation coverage and has not lost such coverage due to failure of the eligible employee or dependent to pay premiums on a timely basis or for cause, and request enrollment in writing within 30 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;
- if the prior coverage was offered through a health maintenance organization (HMO), losing coverage because the eligible 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 eligible employee or dependent to pay premiums on a timely basis; termination of coverage for cause; or voluntary termination of coverage prior to exhaustion.

In the case of the eligible employee's exhaustion of COBRA or state continuation coverage, the special enrollment period described above applies to the eligible 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.

For the special enrollment events described in 1.a., 1.b. and 1.c. above, coverage is effective on the first day of the first calendar month following the date on which the request for enrollment is received by Medica.

2. The dependent is a new spouse of the subscriber or eligible employee, provided the marriage is legal and enrollment is requested in writing within 30 days of the date of

marriage and provided the eligible employee also enrolls during this special enrollment period. Coverage is effective on the first day of the following month.

3. The dependent is a new dependent child of the subscriber or eligible employee, provided enrollment is requested in writing within 31 days of the subscriber or eligible employee acquiring the dependent and provided the eligible 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 subscriber acquires the dependent child.
4. The dependent is the spouse of the subscriber or eligible 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 Contract; and
    c. Enrollment is requested in writing within 30 days of the dependent child becoming a dependent; and
    d. The eligible employee also enrolls during this special enrollment period.

    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 subscriber or eligible employee and enrollment is requested in writing within 30 days of a dependent, as described in 2. or 3. above, becoming eligible to enroll under the coverage provided the eligible 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 provides Medica with notice of a QMCSO and a copy of the order, as described in this section, Medica will provide the eligible dependent child with a special enrollment period provided the eligible employee also enrolls during this special enrollment period. Coverage is effective on the first day of the first calendar month following the date the completed request for enrollment is received by Medica.

Late enrollment and effective date of coverage

An eligible employee or an eligible employee and dependents who do not enroll for coverage offered through the employer during the initial or open enrollment period or any applicable special enrollment period will be considered late entrants.

Late entrants who have maintained continuous coverage may enroll and coverage will be effective the first day of the month following the date of Medica's approval of the request for enrollment. Continuous coverage will be determined to have been maintained if the late entrant requests enrollment within 63 days after prior qualifying coverage ends. Your coverage begins at 12:01 a.m. on the effective date of your coverage.

Individuals who have not maintained continuous coverage may not enroll as late entrants.

Medica may allow enrollment at other times agreed upon between Medica and the employer. Certain restrictions stated in the Contract may apply.

Qualified Medical Child Support Order (QMCSO)

Medica 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 employer'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 employer will follow its established procedures in determining whether the medical child support order is qualified. The employer will provide Medica with notice of a QMCSO and a copy of the order, along with an application for coverage, within the greater of 30 days after issuance of the order or the time in which the employer provides notice of its determination to the persons specified in the order.

- Where a QMCSO requires coverage be provided under the Contract for an eligible employee's dependent child who is not already a member, such child will be provided a special enrollment period. If the eligible employee whose dependent child is the subject of the QMCSO is not a subscriber at the time enrollment for the dependent child is requested, the eligible employee must also enroll for coverage under the Contract during the special enrollment period.
- Where a QMCSO requires coverage be provided under the Contract for an eligible employee's dependent child who is already a member, such child will continue to be provided coverage under the Contract pursuant to the terms of the QMCSO.

When Does My Coverage End and What Are My Options for Continuing Coverage

This section describes when coverage ends under the Contract. When this happens you may exercise your right to continue your coverage as is also described in this section.

When your coverage ends

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

1. The end of the month in which the Contract is terminated by the employer or Medica in accordance with the terms of the Contract. If coverage is terminated by Medica, Medica will notify each subscriber at least 30 days in advance of the termination.
2. The end of the month for which the subscriber last paid his or her contribution toward the premium.
3. The end of the month in which the subscriber retires or is pensioned, unless Medica and the employer have agreed to provide coverage for retirees under the Contract or a separate Medicare contract.
4. The end of the month in which the member is no longer eligible as determined by the employer. (See **Who's Eligible for Coverage and How Do They Enroll** for information on eligibility.)
5. The end of the month in which the subscriber requests that coverage end. You must notify the employer in advance to terminate coverage.
6. The date specified by Medica in written notice to you that coverage ended due to fraud. If coverage ends due to fraud, coverage may be retroactively terminated at Medica's discretion to the original date of coverage or the date on which the fraudulent act took place. Fraud includes but is not limited to:
    a. Intentionally providing Medica with false material information such as:
        i. Information related to your eligibility or another person's eligibility for coverage or status as a dependent; or
        ii. Information related to your health status or that of any dependent; or
    b. Intentional misrepresentation of the employer-employee relationship; or
    c. Permitting the use of your member identification card by any unauthorized person; or
    d. Using another person's member identification card; or
    e. Submitting fraudulent claims.

    Medica reserves its right to pursue other civil remedies in the event of fraud or intentional misrepresentation with regard to any aspect of coverage under the Contract.

7. The end of the month following the date you enter active military duty for more than 31 days. Upon completion of active military duty, contact the employer for reinstatement of coverage.
8. The date of the death of the member. In the event of the subscriber's death, coverage for the subscriber's dependents will terminate the end of the month in which the subscriber's death occurred.
9. For a spouse, the end of the month following the date of divorce or annulment of the marriage.
10. For a dependent child, the end of the month in which the child is no longer eligible as a dependent.
11. For a child who is entitled to coverage through a QMCSO, the end of the month in which the earliest of the following occurs:
    a. The QMCSO ceases to be effective; or
    b. The child is no longer a child as that term is used in ERISA; or
    c. The child has immediate and comparable coverage under another plan; or
    d. The employee who is ordered by the QMCSO to provide coverage is no longer eligible as determined by the employer; or
    e. The employer terminates family or dependent coverage; or
    f. The Contract is terminated by the employer or Medica; or
    g. The relevant premium or contribution toward the premium is last paid.

Continuing your coverage

This section describes continuation coverage provisions. When coverage ends, members may be able to continue coverage under state law, federal law or both. If you are eligible under both state and federal law, the more generous provisions will generally apply.

Please note: All aspects of continuation coverage administration are the responsibility of the employer. Address questions related to arranging for continuation of coverage to the employer. If you have questions about your benefits under continuation coverage, contact Customer Service at one of the numbers listed at the front of this certificate.

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 healthcare.gov.

State continuation is described in 1. and federal continuation is described in 2.

If your coverage ends, you should review your rights under both state law and federal law with the employer. If you are entitled to continuation rights under both, the continuation provisions run concurrently and the more favorable continuation provision will apply to your coverage.

1. Your right to continue coverage under state law

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

a. North Dakota state continuation coverage.

Continued coverage shall be provided as required under North Dakota law. North Dakota state continuation requirements apply to all group health plans that are subject to state regulation, regardless of the number of employees in the group. The employer shall, within the parameters of North Dakota law, establish uniform policies pursuant to which such continuation coverage will be provided.

b. Notice of rights.

North Dakota law requires that covered employees and their dependents (spouse and/or dependent children) be offered the opportunity to pay for a temporary extension of health coverage (called continuation coverage) at group rates in certain instances where health coverage under an employer sponsored group health plan(s) would otherwise end.

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

Subscriber's loss

The subscriber is entitled to continuation of coverage for him or herself and his or her dependents if there is a loss of coverage under the Contract because of the subscriber's termination of employment. Continuation coverage is only available to a subscriber who has been continuously covered under the Contract and any other group health plan which the Contract may have replaced, during the entire 3-month period preceding the termination of employment. Continuation coverage is not available for the subscriber if he or she is covered by Medicare or by any other group health plan under which he or she was not covered immediately prior to the termination of employment.

In this section, layoff from employment means a reduction in hours to the point where the subscriber is no longer eligible for coverage under the Contract.

Subscriber’s spouse's loss

The subscriber’s covered spouse is entitled to continuation coverage if coverage under the Contract is lost for either of the following reasons:

a. Termination of the subscriber’s employment (however, continuation coverage is not available for the subscriber’s covered spouse if he or she is covered by Medicare or by any other group health plan under which he or she was not covered immediately prior to the subscriber’s termination of employment); or

b. Upon entry of a decree of annulment of marriage or divorce from the subscriber, if the decree requires the subscriber to provide continued coverage for the spouse.

Subscriber’s child's loss

The subscriber’s dependent child is entitled to continuation coverage if coverage under the Contract is lost for either of the following reasons:

a. Termination of the subscriber’s employment (however, continuation coverage is not available for the subscriber’s dependent child if he or she is covered by Medicare or by any other group health plan under which he or she was not covered immediately prior to the subscriber’s termination of employment); or

b. Upon entry of a decree of annulment of marriage or divorce of the subscriber and the child’s other parent, if the decree requires the subscriber to provide continued coverage for the child.

Election rights

When the employer is notified that one of these events has happened, the subscriber and the subscriber’s dependents will be notified of the right to continuation coverage.

Consistent with North Dakota law, the subscriber has 10 days to elect continuation coverage, in writing, for termination of the subscriber’s employment measured from the later of:

a. The date of termination of employment; or

b. The date notice of election rights is given to the subscriber.

Continuation coverage may not be elected more than 31 days after the date of termination. If continuation coverage is elected within this period, the coverage will be retroactive to the date coverage would otherwise have been lost.

The subscriber may elect continuation coverage on behalf of his or her dependents entitled to continuation coverage. Under certain circumstances, the subscriber’s covered spouse or dependent child may elect continuation coverage even if the subscriber does not elect continuation coverage.

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

Type of coverage and cost

Under North Dakota law, a person continuing coverage may have to make a monthly payment of all or part of the premium for continuation coverage. The amount charged cannot exceed 100 percent of the cost of the coverage unless coverage under the Contract has been lost because of the entry of a decree of annulment from marriage or divorce, in which case the amount charged cannot exceed 102 percent of the cost of the coverage.

Duration

Under the circumstances described above and for a certain period of time, North Dakota law requires that the subscriber and his or her dependents be allowed to maintain continuation coverage as follows:

a. For instances where coverage is lost due to the subscriber's termination of employment, coverage may be continued until the earliest of:

   i. 39 weeks after the date of the termination of employment; or

   ii. The date you or the subscriber become covered under another group health plan or Medicare; or

   iii. The end of the month for which contributions were made if the subscriber fails to make timely payment of required contribution; or

   iv. The date coverage would otherwise terminate under the Contract.

b. For instances of annulment of marriage or divorce from the subscriber, coverage of the subscriber's spouse and dependent children may be continued until the earliest of:

   i. 36 months after continuation coverage began; or

   ii. The date the subscriber's former spouse becomes remarried; or

   iii. The date coverage would otherwise terminate under the Contract.

Extension of benefits for total disability of the subscriber

Coverage may be extended for a member who becomes totally disabled while enrolled under the Contract and who continues to be totally disabled on the date the Contract is discontinued. Upon continued payment of applicable premium charges, coverage may be continued until the earliest of: (1) 12 months after the date the Contract is discontinued; or (2) the date the member is no longer totally disabled.

2. Your right to continue coverage under federal law

Notwithstanding the provisions regarding termination of coverage described in this section, 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 employer shall, within the parameters of federal law, establish uniform policies pursuant to which such continuation coverage will be provided.

General COBRA information

COBRA requires employers with 20 or more employees to offer subscribers 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:

a. A covered employee (a current or former employee who is actually covered under a group health plan and not just eligible for coverage);

b. A covered spouse of a covered employee; or

c. 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.)

Subscriber’s loss

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

Subscriber’s spouse's loss

The subscriber’s covered spouse has the right to choose continuation coverage if he or she loses coverage under the Contract for any of the following reasons:

a. Death of the subscriber;

b. A termination of the subscriber's employment (for any reason other than gross misconduct) or reduction in the subscriber's hours of employment with the employer;

c. Divorce or legal separation from the subscriber; or

d. The subscriber's entitlement to (actual coverage under) Medicare.

Subscriber's child's loss

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

a. Death of the subscriber if the subscriber is the parent through whom the child receives coverage;

b. The subscriber's termination of employment (for any reason other than gross misconduct) or reduction in the subscriber's hours of employment with the employer;

c. The subscriber's divorce or legal separation from the child's other parent;

d. The subscriber's entitlement to (actual coverage under) Medicare if the subscriber is the parent through whom the child receives coverage; or

e. The subscriber's child ceases to be a dependent child under the terms of the Contract.

Responsibility to inform

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

Also, a subscriber and dependent who have been determined to be disabled under the Social Security Act as of the time of the subscriber's termination of employment or reduction of hours or within 60 days of the start of the continuation period must notify the employer 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 employer within 30 days of the determination.

Bankruptcy

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

Election rights

When notified that one of these events has happened, the employer will notify the subscriber and covered dependents of the right to choose continuation coverage.

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

a. The date coverage would be lost because of one of the events described above; or

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

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

Type of coverage and cost

If the subscriber and the subscriber'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 Contract to similarly situated employees or employees' dependents.

Under federal 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 Contract 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 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 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 subscriber becomes entitled to (actually covered under) Medicare, the continuation period for the subscriber's dependents is 36 months measured from the date of the subscriber's Medicare entitlement, even if that entitlement does not cause the subscriber 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:

a. The subscriber's employer no longer provides group health coverage to any of its employees;

b. The premium for continuation coverage is not paid on time;

c. 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

d. The subscriber 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.

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 employer shall, within the parameters of federal law, establish uniform policies pursuant to which such continuation coverage will be provided.

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 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 Contract because of absence from employment due to service in the uniformed services, and the employee was covered under the Contract 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 Contract by making an election on a form provided by the employer. 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 Contract upon reemployment, subject to the terms and conditions of the Contract.

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 Contract 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 whom coverage is elected begins the day after the employee would lose coverage under the Contract. Coverage continues for up to 24 months.

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

a. The employer no longer provides group health coverage to any of its employees;

b. The premium for continuation coverage is not paid on time;

c. The employee loses their rights under USERRA as a result of a dishonorable discharge or other undesirable conduct;

d. The employee fails to return to work following the completion of his or her service in the uniformed services; or

e. The employee returns to work and is reinstated under the Contract 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 both COBRA and USERRA apply and you elect COBRA continuation coverage in addition to USERRA continuation coverage, these coverages run concurrently.

How Providers are Paid

Network providers

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

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

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 copayment, 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 member or an amount per service with targeted outcome. If the amount paid is less than the cost of providing or arranging for a member's health services, the network provider may bear some of the shortfall. If the amount paid to the network provider is more than the cost of providing or arranging a member's health services, the network provider may keep some of the excess. In other risk-sharing arrangements, the network accepts a portion of the financial risk for the provision of covered services to all members enrolled in a particular Medica product.

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

Withhold arrangements

For some network providers paid on a fee-for-service basis, some of the payment is held back. 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 5 percent of the fee schedule amount.

Network providers may earn the withhold amount based on Medica's financial performance as determined by Medica's Board of Directors and/or 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.

Additional Terms of Your Coverage

This section describes the general provisions of the Contract.

This plan

Your plan is offered through Medica Insurance Company (Medica).

NORTH DAKOTA LAW REGULATES THIS CERTIFICATE.

The benefits of the Contract providing your coverage are governed primarily by the law of a state other than Florida.

Examination of a member

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

Clerical error

You will not be deprived of coverage under the Contract because of a clerical error. However, you will not be eligible for coverage beyond the scheduled termination of your coverage because of a failure to record the termination.

Relationship between parties

The relationships between Medica, the employer and network providers are contractual relationships between independent contractors. Network providers are not agents or employees of Medica. The relationship between a provider and any member is that of health care provider and patient. The provider is solely responsible for health care provided to any member.

Assignment

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

Notice

Except as otherwise provided in this certificate, written notice given by Medica to an authorized representative of the employer will be deemed notice to all affected in the administration of the Contract in the event of termination or nonrenewal of the Contract.

However, notice of termination for nonpayment of premium shall be given by Medica to an authorized representative of the employer and to each subscriber.

Entire agreement

This certificate, the master group contract and its appendices and any amendments, the group application and the member enrollment forms are the entire Contract between the employer and Medica and replace all other agreements as of the effective date of the Contract.

Amendment

This certificate may be amended in accordance with the Contract. When this happens, you will receive a new certificate or an amendment approved and signed by an executive officer of Medica. No other person or entity has authority to make any changes or amendments to this certificate. All amendments must be in writing.

Medical Loss Ratio (MLR) standards under the federal Public Health Service Act

Federal law establishes standards concerning the percentage of premium revenue that insurers pay out for claims expenses and health care quality improvement activities. If the amount an insurer pays out for such expenses and activities is less than the applicable MLR standard, the insurer is required to provide a premium rebate. MLR calculations are based on aggregate market data rather than on a group by group basis. In the event Medica is required to pay rebates pursuant to federal law, Medica will pay such rebates to your employer, unless prohibited by federal law.

Health Savings Accounts (HSA)

This coverage is designed 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 your deductible amount.

For more information about health savings accounts, see the tip sheet at medica.com/membertips.

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 meets the criteria described in subparagraphs 1.-3. below:

1. The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial; and
2. The subject or purpose of the clinical trial must be the evaluation of an item or service that meets the definition of a benefit and is not otherwise excluded under this certificate; and
3. The clinical trial must be described in one of the following subparagraphs:
    a. The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration.
    b. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
    c. The study or investigation is approved or funded by one of the following: (i) the National Institutes of Health (NIH), the Centers for Disease Control and Prevention, the Agency for Health Care Research and Quality, the Centers for Medicare and Medicaid Services or cooperating group or center of any of the entities described in this item; (ii) a cooperative group or center of the United States Department of Defense or the United States Department of Veterans Affairs; (iii) a qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants; or (iv) the United States Departments of Veterans Affairs, Defense or Energy if the trial has been reviewed or approved through a system of peer review determined by the secretary to: (a) be comparable to the system of peer review of studies and investigations used by the NIH, and (b) provide an unbiased scientific review by qualified individuals who have no interest in the outcome of the review.

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

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

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

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

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

1. Charge billed by the provider (i.e., retail); or
2. Negotiated amount that the provider has agreed to accept as full payment for the benefit (i.e., wholesale).

When the wholesale amount is not known nor readily calculated at the time the benefit is provided, Medica uses an amount to approximate the wholesale amount.

For services from some network providers, however, the coinsurance is based on the provider's retail charge. The provider's retail charge is the amount that the provider would charge to any patient, whether or not that patient is a Medica member.

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

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

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

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

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

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

Continuous coverage. The maintenance of continuous and uninterrupted qualifying coverage by an eligible employee or dependent. An eligible employee or dependent is considered to have maintained continuous coverage if enrollment is requested under the Contract within 63 days of termination of the previous qualifying coverage.

Contract. An agreement between Medica and the employer. The agreement outlines coverage details and responsibilities for Medica, the employer and the employer's employees.

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

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

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

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

1. The subscriber's spouse. For these purposes, spouse is defined as any individual who is legally married under the laws of the jurisdiction (foreign or domestic) in which the marriage occurred.
2. The following dependent children up to the dependent limiting age of 26:
    a. The subscriber's natural or adopted child;
    b. A child placed for adoption with the subscriber;
    c. A child for whom the subscriber or the subscriber's spouse has been appointed legal guardian; however, upon request by Medica, the subscriber must provide satisfactory proof of dependency;
    d. The subscriber's unmarried stepchild;
    e. A child placed as a foster child with the subscriber or the subscriber's spouse; and
    f. The unmarried grandchild of the subscriber or the subscriber's covered spouse if (1) the parent of the grandchild is: unmarried, covered under this certificate and dependent on the subscriber and/or the subscriber's spouse; and (2) the grandchild is dependent upon the parent described in (1) above.

    For residents of a state other than North Dakota, the dependent limiting age may be higher if required by applicable state law.
3. The subscriber's or subscriber's spouse's unmarried disabled child, including a disabled dependent of an unmarried 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 subscriber for support and maintenance. An illness will not be considered a physical disability. This dependent may remain covered under the Contract regardless of age and without application of health screening or waiting periods. To continue coverage for a disabled dependent, you must provide Medica with proof of such disability and dependency within 31 days of the child reaching the dependent limiting age set forth in 2. above. Beginning two years after the child reaches the dependent limiting age, Medica may require annual proof of disability and dependency.

NOTE: The grandchild coverage referenced above, as stated in the definition of dependent, includes coverage for dependents of dependents, when required by North Dakota law.

Designated facility. A network hospital that Medica has authorized to provide certain benefits to members, as described in this certificate.

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

Designated physician. A network physician that Medica has authorized to provide certain benefits to members, as described in this certificate.

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.

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 help a person who has not learned or acquired a particular skill or function for daily living to learn, improve or keep such skill or function, as long as measurable progress can be documented.

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

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

Investigative. As determined by Medica, a drug, device, diagnostic or screening procedure or medical treatment or procedure is investigative if reliable evidence does not permit conclusions concerning its safety, effectiveness or effect on health outcomes. Investigative services may also be referred to as investigational, unproven or experimental. Medica will make its

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

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

Notwithstanding the above, a drug being used for an indication or at a dosage that is an accepted off-label use for the treatment of cancer will not be considered by Medica to be investigative. Medica will determine if a use is an accepted off-label use based on published reports in authoritative peer-reviewed medical literature, clinical practice guidelines or parameters approved by national health professional boards or associations and entries in the following drug compendia: *The American Hospital Formulary Service Drug Information* and the *United States Pharmacopeia Dispensing Information*.

Late entrant. An eligible employee or dependent who requests enrollment under the Contract other than during:

1. The initial enrollment period set by the employer; or
2. The open enrollment period set by the employer; or
3. A special enrollment period as described in **Who's Eligible for Coverage and How Do They Enroll**.

In addition, a member who is a child entitled to receive coverage through a QMCSO is not subject to any initial or open enrollment period restrictions.

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.

Medical necessity review. Medica's evaluation of the necessity, appropriateness and efficacy of the use of health care services, procedures and facilities for the purpose of determining the medical necessity of the service or admission.

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

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

2. Be an appropriate service, in terms of type, frequency, level, setting and duration, to your diagnosis or condition; and
3. Help to restore or maintain your health; or
4. Prevent deterioration of your condition; or
5. Prevent the reasonably likely onset of a health problem or detect an incipient problem.

Member. A person who is enrolled under the Contract.

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 with Medica or has made other arrangements with Medica to provide benefits to members of your plan. The network is identified online in your plan's provider directory. The participation status of providers will change from time to time.

The network provider directory will be furnished automatically without charge, and it may be obtained by signing in at mymedica.com or by contacting Customer Service.

Non-network. A provider not under contract as a network provider.

Non-network provider reimbursement amount. The amount that Medica will pay to a non-network provider, other than non-network air ambulance providers licensed by the North Dakota Department of Health, for each out-of-network benefit is based on one of the following, as determined by Medica:

1. A percentage of the amount Medicare would pay for the service in the location where the service is provided. Medica generally updates its data on the amount Medicare pays within 30-60 days after the Centers for Medicare and Medicaid Services updates its Medicare data; or
2. A percentage of the provider's billed charge; or
3. A nationwide provider reimbursement database that considers prevailing reimbursement rates and/or marketplace charges for similar services in the geographic area in which the service is provided; or
4. An amount agreed upon between Medica and the non-network provider.

The reimbursement rate applicable to a benefit provided by a non-network air ambulance provider licensed by the North Dakota Department of Health is equal to the average of the reimbursement rates for the same service that Medica applies to in-network air ambulance providers licensed by the North Dakota Department of Health.

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 certificate. Furthermore, such difference will not be applied toward the out-of-pocket maximum described in **What's Covered and How Much Will I Pay**. 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 Contract year. Unless otherwise specified, you will not be required to pay more than the applicable per member out-of-pocket maximum for benefits received during a Contract year.

The time period used to calculate whether you have met the out-of-pocket maximum (calendar year or Contract year) is determined by the Contract between Medica and the employer. If this time period changes when Medica and the employer renew the Contract, you will receive a new certificate of coverage that will specify the newly applicable time period and may have additional out-of-pocket expenses associated with this change.

After an applicable out-of-pocket maximum has been met, all other covered benefits received during the rest of the Contract year will be covered at 100 percent, except for any charge not covered by Medica, charge in excess of the non-network provider reimbursement amount or charge you pay in addition to your deductible or coinsurance when you choose to use a preferred brand or non-preferred brand prescription drug when a chemically equivalent generic drug is available.

Note that out-of-pocket maximum amounts are determined by the Contract between Medica and the employer and may increase when Medica and the employer renew the Contract. If this occurs, the new out-of-pocket maximum will apply for the rest of the current Contract year, whether or not you had met the previously applicable out-of-pocket maximum. This means that it is possible that your out-of-pocket maximum will increase mid-year when your employer's Contract with Medica is renewed and that you may have additional out-of-pocket expenses as a result.

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

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 subscriber or subscriber'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 subscriber ends if the placement is interrupted before legal adoption is finalized and the child is removed from placement.)

Premium. The monthly payment required to be paid by the employer on behalf of or for you.

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

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

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

Preventive health 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 member involved;
3. With respect to members who are infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
4. With respect to members who are women, such additional preventive care and screenings not described in 1. as provided for in comprehensive guidelines supported by the Health Resources and Services Administration (including Food and Drug Administration approved contraceptive methods, sterilization procedures and related patient education and counseling).

Contact Customer Service for information regarding specific preventive health services or visit the Health & Human Services website at HHS.gov/healthcare and search for "preventive services" to learn more about what's covered.

Professionally administered drugs. Drugs that require intravenous infusion or injection, intrathecal infusion or injection, intramuscular injection or intraocular injection, as well as drugs

that, according to the manufacturer's recommendations, must typically be administered by a health care provider.

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

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

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

1. A health benefit plan or a group health benefit plan as defined under North Dakota law;
2. Medicare;
3. Medicaid;
4. A state health benefit risk pool, including the North Dakota Comprehensive Health Association (CHAND);
5. State Children's Health Insurance Program (SCHIP);
6. 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;
7. TRICARE or other similar coverage provided under federal law applicable to the armed forces;
8. The Federal Employees Health Benefits Plan or other similar coverage provided under federal law applicable to government organizations and employees;
9. A medical care program of the Indian Health Service or of a tribal organization;
10. A health benefit plan under the Peace Corps Act.

Coverage of the following types, including any combination of the following types, are not qualifying coverage:

1. Coverage only for disability or income protection insurance;
2. Automobile medical payment coverage;
3. Liability insurance or coverage issued as a supplement to liability insurance;
4. Coverage for a specified disease or illness or to provide payments on a per diem, fixed indemnity or non-expense-incurred basis, if offered as independent, non-coordinated coverage;
5. Credit accident and health insurance as defined under North Dakota law;
6. Coverage designed solely to provide dental or vision care;

7. Accident only coverage;
8. Long-term care coverage as defined under North Dakota law;
9. Medicare supplemental health insurance as defined under North Dakota law;
10. Workers' compensation insurance; or
11. Coverage for on-site medical clinics operated by an employer for the benefit of the employer's employees and their dependents, in connection with which the employer does not transfer risk.

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.

Surgery that is cosmetic is not 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.

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

Residential treatment. A 24-hour-a-day program under the clinical supervision of a mental health professional, in a community residential setting other than an acute care hospital, for the active treatment of persons with mental illness.

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

Retail health clinic. Professional evaluation and medical management services provided to patients in a health care clinic located in a setting such as a retail store, grocery store or pharmacy. Services include treatment of common illnesses and certain preventive health care services.

Routine 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. Skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:

1. Care must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient; and
2. Care is ordered by a physician; and
3. Care is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair; and
4. Care requires clinical training in order to be delivered safely and effectively.

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

Subscriber. The person:

1. On whose behalf premium is paid; and
2. Whose employment is the basis for membership, according to the Contract; and
3. Who is enrolled under the Contract.

The definition of subscriber may also include a child for whom an employee is required to provide health coverage through a QMCSO. The child is considered a subscriber only if the:

1. Employer has determined and notified Medica that the support order is effective and meets all criteria of a QMCSO, as that term is used in the Employee Retirement Income Security Act (ERISA); and
2. Relevant employee is eligible to enroll for coverage according to the terms of the Contract.

When the subscriber is a child who is eligible for coverage as a result of a QMCSO, the child's certain rights and obligations pertaining to other subscribers are modified according to the terms of the Contract.

Telemedicine. Telemedicine is the delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site. An

originating site includes a health care facility at which a patient is located at the time the services are provided by means of telemedicine. A distant site means a site at which a licensed health care provider is located while providing health care services or consultations by means of telemedicine. A communication between a licensed health care provider and a patient that consists solely of an email or facsimile transmission does not constitute telemedicine consultations or services.

Total disability. Disability due to injury, sickness or pregnancy that requires regular care and attendance of a physician, and in the opinion of the physician:

1. Renders the employee unable to perform the duties of his or her regular business or occupation during the first two years of the disability; and
2. Renders the employee unable to perform the duties of any business or occupation for which he or she is reasonably fitted after the first two years of the disability.

Urgent care center. A health care facility distinguishable from an affiliated clinic or hospital whose primary purpose is to offer and provide immediate, short-term medical care for minor, immediate medical conditions on a regular or routine basis.

Virtual care. Professional evaluation and medical management services provided to patients, in locations such as their home or office, through email, telephone or webcam. Virtual care is used to address non-urgent medical symptoms for members 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.

Waiting period. In accordance with applicable state and federal laws, the period of time that must pass before an otherwise eligible employee and/or dependent is eligible to become covered under the Contract (as determined by the employer's eligibility requirements). However, if an eligible employee or dependent enrolls as a late entrant or through a special enrollment period as set forth in **Who's Eligible for Coverage and How Do They Enroll**, any period before such late or special enrollment is not a waiting period. Periods of employment in an employment classification that is not eligible for coverage under the Contract do not constitute a waiting period.