MEDICA®

MEDICA CHOICE PASSPORT

PLAN DOCUMENT

Administered by Medica Self-Insured

FREDRIKSON & BYRON, P.A.

MEDICA CHOICE PASSPORT

0%-25

BPL #94666

GROUP #55697, 98584

JANUARY 1, 2021

(AMENDED)

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.

နမ့ၢ်အဲၣ်ဒိးတၢ်ကျိးထံဝဲၤကလီနၤလၢတၢ်ဂ့ၢ်တၢ်ကျိၤအံၤလၢအကလီနူၣ်,ကိးလီတဲစိနီၣ်ဂံၢ်လၢအပၣ်ယှၣ်လၢလံာ်တီလံာ်မီအပူၤအံၤမ့တမ့ၢ်ဖဲနနူၣ်ငံၤလၢလံာ်အုၣ်သးစးက့အလိၢ်ခံတကပၤအဖီခိၣ်န့ၣ်တက့ၢ်.

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

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

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

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

Minneapolis/St. Paul Metro Area:
(952) 945-8000
Outside the Metro Area: 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 covered person under the plan. Health insurance can be complicated. The information found in the pages of this plan 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 plan 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 plan, the words "you," "your" and "yourself" refer to you, the covered person. 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 plan.

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
Outpatient surgery? • Anesthesia services • Outpatient/ambulatory surgical center services (facility charge)	Anesthesia Hospital Services

Do you need…	***Read section(s):***
• Physician services (doctor charge)	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

The following amendment has been incorporated into this Plan Document:

- 21FredriksonMaternity, effective 1/1/21

Introduction

Fredrikson & Byron, P.A. (sponsor) has established the Fredrikson & Byron, P.A. Medical Health Care Plan (plan) through which medical benefits are provided to certain employees and their dependents. The plan is administered by Fredrikson & Byron, P.A. (plan administrator). This plan was originally established January 1, 1982. This restatement of the plan is effective January 1, 2021, unless specifically stated otherwise.

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

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

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

How you accept coverage

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

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 the plan 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 plan, the plan administrator may retroactively cancel your coverage.

Covered persons are subject to all terms and conditions of the plan 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 sponsor or its designee is responsible for notifying you of any changes to this plan (as required by applicable law).

If you need language interpretation

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

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 plan to request these materials.

If this plan 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, gender identity, marital status, status with regard to public assistance, disability, sexual orientation, age, genetic information or any other classification protected by law.

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

Plan Overview

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

General plan information

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

Plan Name

Fredrikson & Byron, P.A. Medical Health Care Copay Plan

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

Fredrikson & Byron, P.A.
200 South Sixth Street
Suite 4000
Minneapolis, MN 55402-1425
(612) 492-7000

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

Fredrikson & Byron, P.A.
200 South Sixth Street
Suite 4000
Minneapolis, MN 55402-1425
(612) 492-7000

Agent for Service of Legal Process

Manager of Benefits

Sponsor IRS Employer Identification Number (EIN)

41-0971937

Plan Year

January 1 through December 31

This is also your record keeping year.

Plan Number

501

Type of Welfare Plan

Medical

Type of Administration

Self-insured

The sponsor has entered into a service agreement with Medica Self-Insured (Medica) under which Medica performs a variety of administrative services with respect to the medical benefits provided under the plan. Medica may, from time to time at its sole discretion, contract with other parties, related or unrelated, to arrange for provision of other administrative services including, but not limited to, arrangement of access to a provider network, claims processing services and complaint resolution assistance. The agreement is for administrative services only. Medica does not insure the provision of benefits under the plan; Medica is not a health insurer. The plan offers Medica Choice Passport.

Name and Address of Claims Administrator

Medica Self-Insured
401 Carlson Parkway
Minnetonka, MN 55305

Funding

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

Method of calculating the amount of contribution

The premium equivalent is determined based upon expected claims and projected costs.

Benefits

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

The benefits described in this plan document detail the medical benefits available under the plan. **What's Covered and How Much Will I Pay** describes the copayment, coinsurance and deductible amounts that impact how much the plan pays and how much you pay. The procedures to be followed in obtaining benefits or presenting claims for benefits under the plan and seeking remedies for redress of claims that are denied in whole or in part are described in this plan.

This plan covers medically necessary health services as described throughout the plan. Please pay particular attention to the benefits that have limitations. Some benefits require that certain things be done first (i.e., prior authorization be obtained). Not following these requirements may impact whether benefits are paid under this plan. Additionally, you consent to the release and re-release of medical information necessary for the administration of this plan as a condition of coverage under this plan. Certain services are specifically excluded from coverage under this plan. The fact that a provider recommends or orders services does not always mean the services are covered or medically necessary. For additional details, see **What's Not Covered**. This plan coordinates the benefits it provides with other coverage and/or other sources of payment. For additional details, see **Right to Subrogation and Reimbursement**.

HIPAA compliance

This plan will be administered in a manner consistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and all implementing regulations. The HIPAA privacy standards address disclosure to a plan sponsor of protected health information (or PHI). With some exceptions, protected health information or PHI is information that: (i) identifies or could reasonably be used to identify you and (ii) relates to your physical or mental health or condition, the provision of your health care or your payment for health care. The sponsor may use or disclose PHI received from the plan or from another party acting on behalf of the plan for certain limited purposes. These include health care operations purposes and health care payment purposes relating to the plan. However, with respect to such PHI, the sponsor agrees as follows:

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

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

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

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

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

       Manager of Benefits; Benefits Assistant; Chief Human Resource Officer; Controller; General Ledger Accountant; and Members of Benefits Committee

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

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

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

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

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

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

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

ERISA Information

Statement of ERISA rights

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

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

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

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

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

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

When you become eligible for payments from the plan, you should follow the appropriate steps for filing a claim. If the claim is denied or ignored, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to obtain copies of documents relating to the decision without charge. You have the right to have the plan administrator review and reconsider the claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan to provide you the materials and pay you up to $110.00 per day until you receive your materials, unless the materials were not sent because of reasons beyond the control of the plan administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file a suit in a state or federal

court, subject to any binding arbitration requirements contained in the plan. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay costs and legal fees. For example, if you are successful, the court may order the person you sued to pay those costs and fees. If you lose or if the court finds your suit to be frivolous, you may be ordered to pay these costs and fees.

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

Before You Access Care

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

It is your responsibility to alert Medica regarding any discounts, coupons, rebates or financial arrangements between you and a provider or manufacturer for health care items or services, prescribed drugs and/or devices. Discounts, coupons, rebates or similar reimbursement provided to you by providers or manufacturers will not satisfy your out-of-pocket cost-sharing responsibilities. Such amounts will not accumulate toward your deductible and out-of-pocket maximum. You can contact Medica by calling the telephone number on your Medica ID card.

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.

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

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 plan.

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 plan.

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 plan 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, biologics and biosimilars;
- 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 covered person information (i.e., Medica identification 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 10 business 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 an urgent care notification is incomplete, the plan will notify you or your provider as soon as possible, but no later than 24 hours following receipt of the incomplete notification. We may orally notify you or your provider that the notification is incomplete, unless you or your provider requests written notice. The notice will describe the information necessary to complete the notification and shall specify a reasonable time, no less than 48 hours, within which the claim must be completed. The plan shall decide the notification as soon as possible but not later than 48 hours after the earlier of (a) receipt of the specified information, or (b) the end of the period of time provided to submit the specified information.

In the case of an incorrectly filed notification, you will be notified as soon as possible but no later than 5 days following receipt by the plan of the incorrectly filed notification.

If you or your provider request to extend a service, involving urgent care, that requires notification and if the request is made at least 24 hours prior to the end of the initially approved period of time or number of treatments, the request shall be decided within no more than 24 hours after receipt of the request. Any other request to extend care shall be decided in the otherwise applicable timeframes for pre-service, urgent care, or post-service claims.

A decision by the plan to reduce or terminate an initially approved course of treatment is an adverse benefit decision that may be appealed by the claimant under the claims procedures, set forth in How Do I File a Complaint. Notification of a decision by the plan to reduce or terminate an initially approved course of treatment shall be provided sufficiently in advance of the reduction or termination to allow you to appeal the adverse decision and receive a decision on review under the claim procedures prior to the reduction or termination.

If we do not approve your request for prior authorization, you have the right to appeal Medica's decision as described in **How Do I File a Complaint**.

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**).

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 plan; and
   b. Recommended by a network physician.
4. 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 the plan 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 the plan 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 physician care (not an emergency) at a non-network provider 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 provider bills $5,000.
3. The plan's non-network provider reimbursement amount for those non-network provider services is $3,000.
    a. You must pay a portion of this amount, generally a percentage coinsurance. In this example, we will use 20% coinsurance.
    b. In addition, the non-network provider will likely bill you for the difference between what they charge and the amount that the plan pays them.

For these non-network physician services, you will be required to pay:

20% coinsurance (20% of $5,000 = $1,000), and

The provider's billed amount that exceeds the non-network provider reimbursement amount ($5,000 - $3,000 = $2,000)

Therefore, the total amount you will owe is $1,000 + $2,000 = $3,000.

The $1,000 amount you pay as coinsurance **will** be applied to your out-of-pocket maximum.

The $2,000 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 $2,000 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.

Non-network provider services – Additional information

Generally, as described above in **Visiting non-network providers and why you pay more**, you will pay much more for your health care if you receive services from a non-network provider than when you receive services from a network provider. However, in the following situations,

applicable law provides that you may not be responsible for any amounts above what you would be required to pay for in-network benefits, unless you provided advance written consent:

1. While you obtained care at an in-network hospital or ambulatory surgical center you also received eligible health care services from a non-network provider (a) without your knowledge; (b) due to the unavailability of a network provider within the facility; or (c) due to the need for unforeseen services arising at the time the services are being rendered; or
2. Your network provider sent your lab work to a non-network laboratory for testing.

If you have questions about bills you receive from a non-network provider that provided services under the circumstances described above, please call Customer Service at one of the telephone numbers listed at the front of this plan. If you receive a bill that is larger than the applicable in-network copayment, coinsurance or deductible, you may submit the bill for processing to:

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

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 new to Medica as a result of the sponsor changing third party administrators 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, advanced practice registered nurse, or physician assistant 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 plan.

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 plan. Also refer to **Before You Access Care** for more information about the prior authorization process.
- The plan provides coverage for mental health and substance abuse services in the same way it provides coverage for other health issues. The Mental Health Parity and Addiction Equity Act, as well as applicable law, requires the plan that offers mental health and substance abuse benefits, to provide coverage of those benefits in a way that is comparable to coverage for general medical and surgical care. Cost-sharing requirements and limitations on mental health and substance abuse benefits (such as copayments, visit limits and preauthorization requirements) must generally be comparable to, and no more restrictive than those for medical and surgical benefits.
- 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 the plan 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 plan have limits. These limits might include day limits, visit limits or dollar limits. These limits are noted in this plan 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 plan starts to pay. This amount is called a deductible. Please note that amounts reimbursed or paid by a provider or manufacturer, including manufacturer coupons, rebates, coupon cards, debit cards or other forms of reimbursement or payment on your behalf for a product or service, will not apply toward your deductible.

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 plan shows whether the deductible applies to a particular service.

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 copayments, coinsurance and deductibles that you paid for benefits received during the calendar year. Unless otherwise noted, you won't have to pay more than this amount. Amounts reimbursed or paid by a provider or manufacturer, including manufacturer coupons, rebates, coupon cards, debit cards or other forms of reimbursement or payment on your behalf for a product or service, will not apply toward your out-of-pocket maximum.

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.**

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:**
Copayment or coinsurance	See specific benefit for applicable copayment or coinsurance.	
Deductible	A deductible does not apply to in-network benefits.	
Per covered person		$200
Per family		$600
The deductible is the amount you must pay for eligible services each calendar 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.		
Please note that amounts reimbursed or paid by a provider or manufacturer, including manufacturer coupons, rebates, coupon cards, debit cards or other forms of reimbursement or payment on your behalf for a product or service, will not apply toward your deductible.		
Out-of-pocket maximum		
Per covered person	$3,000	$9,000
Per family	$6,000	No out-of-pocket maximum
This plan has both a per covered person out-of-pocket maximum **and** a per family out-of-pocket maximum. The per covered person out-of-pocket maximum applies individually to each family member until the family out-of-pocket maximum is met. Coinsurance, copayments and deductibles paid by each covered family member for covered benefits for the calendar year count toward the individual's annual per covered person out-of-pocket maximum **and** toward the annual per family out-of-pocket maximum.		
Please note that amounts reimbursed or paid by a provider or manufacturer, including manufacturer coupons, rebates, coupon cards, debit cards or other forms of reimbursement or payment on your behalf for a product or service, will not apply toward your out-of-pocket maximum.		

Deductibles, Out-Of-Pocket Maximums and Lifetime Maximum		
	Your cost if you visit a:	
	Network provider:	Non-network provider:
Lifetime maximum amount the plan will pay per covered person	Unlimited	Unlimited

AMBULANCE

Ambulance			
		Your cost if you visit a:	
	Benefits	Network provider:	Non-network provider:
1.	Emergency ambulance services or emergency ambulance transportation	20% coinsurance	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	20% coinsurance	Covered as an in-network benefit.

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 the plan 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

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	20% coinsurance after deductible
2.	Anesthesia services received during an outpatient hospital or ambulatory surgical center visit	Nothing	20% coinsurance after deductible
3.	Anesthesia services received during an inpatient stay	Nothing	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 the plan 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 **Please note:** Some services received during a mental health office visit may be covered under another benefit in this section. The most specific and appropriate benefit will apply for each service received during a mental health office visit.	$25/visit	20% coinsurance after deductible
2.	Intensive outpatient programs	$25/day	20% coinsurance after deductible
3.	Inpatient services (including residential treatment services) **Please note:** Inpatient services in a licensed residential treatment facility for treatment of emotionally disabled children will be covered as any other health condition.		
	a. Room and board	$700/visit	$700/visit. The deductible does not apply.
	b. Hospital or facility-based professional services	Nothing	20% coinsurance after deductible
	c. Attending psychiatrist services	Nothing	20% coinsurance after deductible
	d. Partial program	$700/visit	$700/visit. The deductible does not apply.

What's covered

Outpatient mental health services include:

1. Diagnostic evaluations and psychological testing, including that for attention deficit hyperactivity disorder (ADHD) or autism spectrum disorders.
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 or 19 hours per week).
4. Relationship and family therapy, including individual, group and multifamily 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. This may be in a freestanding facility or hospital-based. Active treatment is provided through specialized programming with medical/psychological intervention and supervision during program hours. Partial program means a treatment program of a minimum of 4 hours per day or 20 hours per week of care and may include lodging.
5. Mental health residential treatment services. These services include either:
    - A residential treatment program serving children and adolescents with severe emotional disturbance, certified under law; or
    - A licensed or certified mental health treatment program providing intensive therapeutic services. In addition to room and board, 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 the plan 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 offers a 24/7 behavioral health crisis line for covered persons at no additional cost. If you are experiencing a mental health crisis, you may call 1-800-848-8327 to speak with a behavioral health specialist.

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
- Licensed professional clinical counselor

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, including individual, group and multifamily 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 plan.
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. Services to assist in activities of daily living that do not seek to cure and are performed regularly as a part of a routine or schedule.
8. Room and board charges associated with mental health residential treatment services 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 **Please note:** Some services received during a substance abuse office visit may be covered under another benefit in this section. The most specific and appropriate benefit will apply for each service received during a substance abuse office visit.	$25/visit	20% coinsurance after deductible
2.	Intensive outpatient programs	$25/day	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.	$25/visit	20% coinsurance after deductible
4.	Inpatient services (including residential treatment services)		
	a. Room and board	$700/visit	$700/visit. The deductible does not apply.
	b. Hospital or facility-based professional services	Nothing	20% coinsurance after deductible
	c. Attending physician services	Nothing	20% coinsurance after deductible
	d. Partial program	$700/visit	$700/visit. The deductible does not apply.

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 (3 or more hours per day, up to 19 hours per week).
5. Services, care or treatment for a covered person that has been placed in any applicable Department of Corrections' custody following a conviction for a first-degree driving while impaired offense; to be eligible, such services, care or treatment must be required and provided by any applicable Department of Corrections.

Inpatient substance abuse services include:

1. Room and board.
2. Attending physician services.
3. Hospital or facility-based professional services.
4. Services, care or treatment for a covered person that has been placed in any applicable Department of Corrections' custody following a conviction for a first-degree driving while impaired offense; to be eligible, such services, care or treatment must be required and provided by any applicable Department of Corrections.
5. Partial program. This may be in a freestanding facility or hospital-based. Active treatment is provided through specialized programming with medical/psychological intervention and supervision during program hours. Partial program means a treatment program of a minimum of 4 hours per day or 20 hours per week of care and may include lodging.
6. 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 the plan 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 offers a 24/7 behavioral health crisis line for covered persons at no additional cost. If you are experiencing a substance use crisis, you may call 1-800-848-8327 to speak with a behavioral health specialist.

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.

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

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

CLINICAL TRIALS

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 plan, 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 the plan 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	20% coinsurance	20% coinsurance after deductible
2. Prosthetics: a. Initial purchase of external prosthetic devices that replace a limb or an external body part, limited to: i. Artificial arms, legs, feet and hands; ii. Artificial eyes, ears and noses; iii. Breast prostheses b. Scalp hair prosthesis due to alopecia areata Limited to one prosthesis (i.e. wig) per covered person per calendar year. c. Repair, replacement or revision of prostheses made necessary by normal wear and use	20% coinsurance	20% coinsurance after deductible

Durable Medical Equipment, Prosthetics and Medical Supplies			
		Your cost if you visit a:	
	Benefits	Network provider:	Non-network provider:
3.	Hearing aids for covered persons 18 years of age and younger for hearing loss that is not correctable by other covered procedures **Please note:** Cochlear implants are covered as a surgical service under **Physician and Professional Services**.	20% coinsurance 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	20% coinsurance after deductible
5.	Medical supplies: a. Injectable pharmaceutical treatments for hemophilia and bleeding disorders b. Dietary medical treatment of phenylketonuria (PKU) c. Total parenteral nutrition d. Amino acid-based elemental formulas for these diagnoses: i. Cystic fibrosis; ii. Amino acid, organic acid and fatty acid metabolic and malabsorption disorders; iii. IgE mediated allergies to food proteins;	20% coinsurance	20% coinsurance after deductible

Durable Medical Equipment, Prosthetics and Medical Supplies			
		Your cost if you visit a:	
	Benefits	Network provider:	Non-network provider:
	iv. Food protein induced enterocolitis syndrome; v. Eosinophilic esophagitis; vi. Eosinophilic gastroenteritis; and vii. Eosinophilic colitis Coverage for the diagnoses in iii.–vii. above is limited to covered persons five years of age and younger.		
6.	Eligible ostomy supplies	20% coinsurance	40% coinsurance after deductible
7.	Insulin pumps and their related supplies	20% coinsurance	40% 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 the plan 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 plan. 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 plan, 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 the plan, 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 plan.

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 plan.

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. 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	$200/visit	Covered as an in-network benefit.
2.	Other services received during an emergency room visit (for example x-rays, lab, physician)	Nothing	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 plan.

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	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.	$25/visit	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 plan. 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 plan. 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 the plan 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 calendar year for in-network benefits and 60 visits per calendar year for out-of-network benefits, unless the care is medically necessary and not considered custodial care. If you have Medica coverage and are also enrolled in the Medical Assistance Program, you may be eligible for additional intermittent skilled care.	Nothing	20% coinsurance after deductible
2. Services received in your home from a physician	Nothing	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 calendar 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 the plan 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. Prior authorization is also required before you receive certain biologics, biosimilars and professionally administered drugs. 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 covered person's condition will improve over a predictable period of time according to generally accepted standards in the medical community.

13. Voice training.

14. Home health aide services, except when rendered in conjunction with intermittent skilled care and related to the medical condition under treatment.

HOSPICE SERVICES

Hospice Services		
	Your cost if you visit a:	
Benefits	Network provider:	Non-network provider:
1. Hospice services	Nothing	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 the plan 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 covered persons. The specific services you receive may vary depending upon which program you select.

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

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

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

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

1. Be a terminally ill patient; and

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

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

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

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

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	$300/visit	20% coinsurance after deductible
2.	Services provided in a hospital observation room	$300/visit	20% coinsurance after deductible
3.	Inpatient services For associated physician services, see **Physician and Professional Services** in this section.	$700/visit	$700/visit. The deductible does not apply.

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

INFERTILITY TREATMENT AND ASSISTED REPRODUCTIVE TECHNOLOGY

Infertility Treatment and Assisted Reproductive Technology			
		Your cost if you visit a:	
	Benefits	Network provider:	Non-network provider:
1.	Office visits, including any services provided during such visits	Nothing	20% coinsurance after deductible
2.	Outpatient services received at a hospital	Nothing	20% coinsurance after deductible
3.	Inpatient services	Nothing	20% coinsurance after deductible
4.	Services received from a physician during an inpatient stay	Nothing	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. Certain assisted reproductive technology services, including in vitro fertilization, are covered, whether performed or undertaken as a treatment for infertility or for any other clinical reason. 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 and assisted reproductive technology 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 the plan 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 $15,000 per covered person per calendar year for in-network and out-of-network benefits combined. The infertility treatment limit of $15,000 is separate from the infertility drug limit of $3,000 per calendar year.

Prior authorization (approval in advance) is required before you receive certain biologics, biosimilars 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 plan. 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. Services for a condition that a physician determines cannot be successfully treated.
3. Services related to surrogate pregnancy for a person not covered as a covered person under the plan.
4. Sperm banking and/or storage.
5. Donor sperm.
6. Donor eggs.
7. 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	20% coinsurance after deductible
2.	Lab and pathology services received during an outpatient hospital or ambulatory surgical center visit	Nothing	20% coinsurance after deductible
3.	Lab and pathology services received in an inpatient setting	Nothing	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 the plan 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 covered person who: a. Is a child under age five; or b. Is severely disabled; or c. Has a condition that requires hospitalization or general anesthesia for dental care treatment.	$300/visit	20% coinsurance after deductible
2. For a dependent child, orthodontia, dental implants and oral surgery treatment related to cleft lip and palate	Nothing	20% coinsurance after deductible
3. Accident-related dental services to treat an injury to and to repair (not replace) sound, natural teeth. The following conditions apply: a. Coverage is limited to services received within 24 months from the later of: i. The date you are first covered under the plan; or ii. The date of the injury	Nothing	20% coinsurance after deductible

Medical-Related Dental Services		
	Your cost if you visit a:	
Benefits	Network provider:	Non-network provider:
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.		
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	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 the plan 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 plan.

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	$25/visit	20% coinsurance after deductible Coverage for physical and occupational therapy is limited to a combined maximum of 20 visits per calendar year.
b. Rehabilitative services	$25/visit	20% coinsurance after deductible Coverage for physical and occupational therapy is limited to a combined maximum of 20 visits per calendar year.
2. Speech therapy services received outside of your home		
a. Habilitative services	$25/visit	20% coinsurance after deductible Coverage for speech therapy is limited to 20 visits per calendar year.
b. Rehabilitative services	$25/visit	20% coinsurance after deductible Coverage for speech therapy is limited to 20 visits per calendar 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	$25/visit	20% coinsurance after deductible Coverage for physical and occupational therapy is limited to a combined maximum of 20 visits per calendar year.
	b. Rehabilitative services	$25/visit	20% coinsurance after deductible Coverage for physical and occupational therapy is limited to a combined maximum of 20 visits per calendar 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 the plan 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:** This benefit does not include services received from locations using "hospital-based outpatient billing" practices. The most specific and appropriate benefit in this plan will apply for each service received at that type of provider. If you are unsure if your provider uses these billing practices, please contact them. **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 copayment or coinsurance and an outpatient surgical or imaging copayment or coinsurance apply.	$25/visit	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:** This benefit does not include services received from locations using "hospital-based outpatient billing" practices. The most specific and appropriate benefit in this plan will apply for each service received at that type of provider. If you are unsure if your provider uses these billing practices, please contact them. **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 copayment or coinsurance and outpatient surgical copayment or coinsurance apply.	$25/visit	Covered as an in-network benefit.
3.	Convenience care		
	a. Retail health clinic	$10/visit	20% coinsurance after deductible
	b. Virtual care	$10/visit	20% coinsurance after deductible

Physician and Professional Services			
		Your cost if you visit a:	
	Benefits	Network provider:	Non-network provider:
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	$25/visit	20% coinsurance after deductible Coverage is limited to a maximum of 15 visits per calendar year.
5.	Surgical services (as defined in the Physicians' Current Procedural Terminology code book):		
	a. Received from a physician during an office visit	Nothing	20% coinsurance after deductible
	b. Received from a physician during an urgent care visit or an outpatient hospital or ambulatory surgical center visit	Nothing	20% coinsurance after deductible
	c. Received from a physician in an inpatient setting	Nothing	20% coinsurance after deductible
6.	Non-surgical services received from a physician in an inpatient setting	Nothing	20% coinsurance after deductible
7.	Non-surgical outpatient hospital or ambulatory surgical center services received from or directed by a physician	Nothing	20% coinsurance after deductible
8.	Routine eye exams	Nothing	20% coinsurance after deductible
9.	Allergy shots	Nothing	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	20% coinsurance after deductible
11.	Acupuncture Limited to 15 visits per calendar year for in-network and out-of-network benefits combined.	$25/visit	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	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 calendar year.	$25/visit	20% coinsurance after deductible

Physician and Professional Services		
	Your cost if you visit a:	
Benefits	Network provider:	Non-network provider:
14. Treatment to lighten or remove the coloration of a port wine stain	Covered at the corresponding in-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit in-network benefit level and surgical services are covered at the surgical services in-network benefit level.	Covered at the corresponding out-of-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit out-of-network benefit level and surgical services are covered at the surgical services out-of-network benefit level.

What's covered

In-network benefits apply to:

1. Professional services received from a network provider;
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 the plan 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, biosimilars 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 plan. 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.	Prenatal care services that are considered preventive health services	Nothing	20% coinsurance after deductible
2.	Prenatal care services that are not considered preventive health 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.
3.	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.	$700/visit	$700/visit. The deductible does not apply.
4.	Physician services received during an inpatient stay for labor and delivery – for the mother	Nothing	20% coinsurance after deductible

Pregnancy – Maternity Care			
		Your cost if you visit a:	
	Benefits	**Network provider:**	**Non-network provider:**
5.	Inpatient stay – for your newborn **Please note:** This coverage is separate from the coverage in items 3. and 4. above and applies to newborn dependents.	$700/visit	$700/visit. The deductible does not apply.
6.	Physician services received during an inpatient stay – for your newborn **Please note:** This coverage is separate from the coverage in items 3. and 4. above and applies to newborn dependents.	Nothing	20% coinsurance after deductible
7.	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.	$700/visit	$700/visit. The deductible does not apply.
	b. Physician services received for labor and delivery – for the mother	Nothing	20% coinsurance after deductible

Pregnancy – Maternity Care			
		Your cost if you visit a:	
	Benefits	Network provider:	Non-network provider:
	c. Physician services – for your newborn **Please note:** This coverage is separate from the coverage in item 7.b. above and applies to newborn dependents.	Nothing	20% coinsurance after deductible
8.	Postnatal services	Nothing	20% coinsurance after deductible
9.	Home health care visit following delivery	Nothing	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 the plan 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**.

Please note: We encourage you to enroll your newborn in your plan within 30 days of the date of birth, date of placement for adoption or date of adoption. 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 plan. 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 covered person's hospital admission is separate from the admission of any other covered person. That means a separate deductible and copayment or coinsurance will be applied to both you and your newborn for inpatient services related to labor and delivery.

Newborns' and Mothers' Health Protection Act of 1996

Generally, Medica may not restrict benefits for any hospital stay in connection with childbirth for the mother or newborn child covered person to less than 48 hours following a vaginal delivery (or less than 96 hours following a cesarean section). However, federal law generally does not prohibit the mother or newborn child covered person's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, Medica may not require a provider to obtain prior authorization from Medica for a 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. Services eligible for coverage include, but are not limited to, parent education, assistance and training in breast and bottle feeding and conducting any necessary and appropriate clinical tests.

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: $10 per prescription unit; or **Preferred brand:** $50 per prescription unit; or **Non-preferred brand:** $65 per prescription unit	**Generic:** $65 or 40% coinsurance after deductible (whichever is greater) per prescription unit; or **Preferred brand:** $65 or 40% coinsurance after deductible (whichever is greater) per prescription unit; or **Non-preferred brand:** $65 or 40% coinsurance after deductible (whichever is greater) per prescription unit	**Generic:** $20 per prescription unit; or **Preferred brand:** $100 per prescription unit; or **Non-preferred brand:** $130 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 calendar year for all infertility covered drugs described in **Prescription Drugs** and **Prescription Specialty Drugs**, combined.		
Generic: $10 per prescription unit; or **Preferred brand:** $50 per prescription unit; or **Non-preferred brand:** $65 per prescription unit	**Generic:** $65 or 40% coinsurance after deductible (whichever is greater) per prescription unit; or **Preferred brand:** $65 or 40% coinsurance after deductible (whichever is greater) per prescription unit; or **Non-preferred brand:** $65 or 40% coinsurance after deductible (whichever is greater) per prescription unit	**Generic:** $20 per prescription unit; or **Preferred brand:** $100 per prescription unit; or **Non-preferred brand:** $130 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:**
3. Diabetic equipment and supplies, including blood glucose meters		
Generic: 20% coinsurance per prescription unit; or **Preferred brand:** 20% coinsurance per prescription unit; or **Non-preferred brand:** 40% coinsurance per prescription unit	**Generic:** 40% coinsurance after deductible per prescription unit; or **Preferred brand:** 40% coinsurance after deductible per prescription unit; or **Non-preferred brand:** 40% coinsurance after deductible per prescription unit	**Generic:** 20% coinsurance per prescription unit; or **Preferred brand:** 20% coinsurance per prescription unit; or **Non-preferred brand:** 40% coinsurance per prescription unit
4. FDA-approved drugs (including certain women's contraceptives), tobacco cessation products and other supplies and services that are considered preventive health services		
Generic: Nothing per prescription unit; or **Preferred brand:** Nothing per prescription unit; or **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 **Preferred brand:** Nothing per prescription unit; or **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:**
Your cost if you visit a:		
Network pharmacy:	**Non-network pharmacy:**	
5. Orally-administered cancer treatment medications		
Generic: $10 per prescription unit; or **Preferred brand:** $25 per prescription unit; or **Non-preferred brand:** $25 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 covered persons 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 copayment or 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 copayment or 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 copayment or 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 plan. 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. Copayment or coinsurance amounts will apply to each prescription unit dispensed.

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

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.
- 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 covered person 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 plan.

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.

Additional considerations

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

Coverage for tobacco cessation includes all FDA-approved tobacco cessation products that are considered preventive health services. This coverage includes up to a 180-day supply per calendar year of tobacco cessation medication.

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 plan.
2. Any amount above what the plan would have paid when you fail to identify yourself as a covered person 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:** 20% coinsurance up to a maximum of $350 per prescription unit; or **Non-preferred specialty prescription drugs:** 40% coinsurance per prescription unit
2.	Specialty infertility prescription drugs received from a designated specialty pharmacy Limited to a maximum benefit of $3,000 per calendar year for all infertility covered drugs described in **Prescription Drugs** and **Prescription Specialty Drugs** combined	**Preferred specialty prescription drugs:** 20% coinsurance up to a maximum of $350 per prescription unit; or **Non-preferred specialty prescription drugs:** 40% coinsurance per prescription unit
3.	Specialty growth hormone when prescribed by a physician for the treatment of a demonstrated growth hormone deficiency and received from a designated specialty pharmacy	**Preferred specialty prescription drugs:** 20% coinsurance up to a maximum of $350 per prescription unit; or **Non-preferred specialty prescription drugs:** 40% coinsurance per prescription unit
4.	Orally-administered cancer treatment medications received from a designated specialty pharmacy	**Preferred specialty prescription drugs:** $25 per prescription unit; or **Non-preferred specialty prescription drugs:** $25 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 covered persons 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 copayment or coinsurance option. For your lowest share of the cost, consider a preferred specialty prescription drug if you and your physician decide it is appropriate for your treatment.

Non-preferred specialty prescription drugs have a higher copayment or 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 plan. 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 plan. Note that certain specialty pharmacies may be in other Medica networks but not in your network.

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

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. Copayment or 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.
- 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 plan.

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 plan.
2. Any amount above what the plan would have paid when you fail to identify yourself as a covered person 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 plan.
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, pediatric preventive services, appropriate immunizations up to age 18, developmental assessments, and appropriate laboratory services	Nothing	20% coinsurance after deductible
2.	Adult immunizations	Nothing	20% coinsurance after deductible
3.	Early disease detection services including physicals	Nothing	20% coinsurance after deductible
4.	Routine screening procedures for cancer including, but not limited to, screening for prostate cancer (including prostate-specific antigen blood test and a digital rectal exam and without age limitation), ovarian cancer and colorectal cancer	Nothing	20% coinsurance after deductible

Preventive Health Care			
		Your cost if you visit a:	
	Benefits	**Network provider:**	**Non-network provider:**
5.	Women's preventive health services including mammograms (including digital breast tomosynthesis), screenings for cervical cancer (including pap smears), 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	20% coinsurance after deductible
6.	Tobacco use counseling and intervention	Nothing	20% coinsurance after deductible
7.	Obesity-related chronic disease prevention, including digitally delivered counseling for covered persons 18 years of age and older that are at-risk for obesity related chronic disease using Medica's designated prevention program. Contact Medica Customer Service to access Medica's designated prevention program.	Nothing	No coverage

Preventive Health Care			
		Your cost if you visit a:	
	Benefits	Network provider:	Non-network provider:
8.	Diabetes management services for covered persons who have been diagnosed with diabetes and meet the criteria of Medica's designated diabetes management service. Diabetes management services include digitally delivered coaching and devices for tracking and monitoring progress. Contact Medica Customer Service to access Medica's designated diabetes management service	Nothing	No coverage
9.	Other preventive health services	Nothing	20% coinsurance after deductible
10.	Preventive abdominal aortic aneurysm tests	Nothing	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 copayment, 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 the plan 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.

Eligible surgical procedures and non-surgical services for gender reassignment are covered. Prior authorization is required for surgical services. For more information on gender reassignment services, go to: https://www.medica.com/-/media/documents/provider/utilization-management-policies/iii_sur_20-um-policy.pdf?la=en or contact Customer Service at one of the telephone numbers listed at the front of this plan.

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 the plan 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, the plan will cover all stages of reconstruction of the breast on which the mastectomy was performed and surgery and reconstruction of the other breast to produce a symmetrical appearance if the mastectomy was medically necessary (as determined by the attending physician and patient). The plan 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	Nothing	20% coinsurance after deductible
2.	Skilled physical, speech or occupational therapy when room and board is not eligible to be covered	Nothing	20% coinsurance after deductible
3.	Services received from a physician during an inpatient stay in a skilled nursing facility	Nothing	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 the plan 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 covered person's condition will improve over a predictable period of time according to generally accepted standards in the medical community.
8. Voice training.
9. Group physical, speech and occupational therapy.
10. Long-term care.
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 the plan 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.	Surgical and non-surgical treatment of temporomandibular joint (TMJ) disorder and craniomandibular disorder	Covered at the corresponding in-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit in-network benefit level and surgical services are covered at the surgical services in-network benefit level.	Covered at the corresponding out-of-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit out-of-network benefit level and surgical services are covered at the surgical services out-of-network benefit level.

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 the plan 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 covered person 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.		

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 the plan 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 covered person 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:

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

The 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 plan.

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.	No coverage

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.

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.

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

There is no coverage for out-of-network weight loss surgery services.

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 when performed by a non-network physician or received at a non-network hospital.
3. Surgery for morbid obesity, except as described in this section.
4. Services and procedures primarily for cosmetic purposes.
5. Supplies and services for surgery for morbid obesity that would not be authorized by Medica.
6. Services required to meet the patient selection criteria for an authorized surgery for morbid obesity. This includes services and related expenses for weight loss programs, nutritional supplements and supplies of a similar nature not otherwise covered under this plan.
7. Drugs provided or administered by a physician or other provider on an outpatient basis, except 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	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	20% coinsurance after deductible
3.	X-rays and other imaging services received in an inpatient setting	Nothing	20% coinsurance after deductible
4.	MRI, CT and PET CT scans **Note:** Some types of scans may require prior authorization.	Nothing	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 plan. 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 the plan 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 plan will not provide coverage for any of the services, treatments, supplies or items described in this section even if it is recommended or prescribed by a physician or it is the only available treatment for your condition.

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

1. Services that are not medically necessary. This includes but is not limited to services inconsistent with the medical standards and accepted practice parameters of the community and services inappropriate—in terms of type, frequency, level, setting and duration—to the diagnosis or condition.
2. Services or drugs used to treat conditions that are cosmetic in nature, unless otherwise determined to be reconstructive.
3. Refractive eye surgery, including but not limited to LASIK surgery.
4. The purchase, replacement or repair of eyeglasses, eyeglass frames or contact lenses when prescribed solely for vision correction and their related fittings.
5. Services provided by an audiologist when not under the direction of a physician.
6. Hearing aids (including internal, external or implantable hearing aids or devices) and other devices to improve hearing and their related fittings, except 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 covered persons with diabetes, blindness, peripheral vascular disease, peripheral neuropathies and significant neurological conditions such as Parkinson's disease, Alzheimer's disease, multiple sclerosis and amyotrophic lateral sclerosis (ALS).
22. Services by persons who are family members or who share your legal residence.
23. Claims for benefits to the extent such claims have been paid under workers' compensation, employer liability or any similar law, auto insurance or any other coverage or plan that is required to pay before this plan pays. In other words, the plan will not make a duplicate payment on claims that have been paid previously by another payer.
24. Services received before coverage under the plan becomes effective.
25. Services received after coverage under the plan ends.
26. Unless requested by Medica, charges for duplicating and obtaining medical records from non-network providers and non-network dentists.
27. Occlusal adjustment or occlusal equilibration.
28. Dental implants (tooth replacement), except as described in **Medical-Related Dental Services** in **What's Covered and How Much Will I Pay**.
29. Dental prostheses.
30. 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.
31. Treatment for bruxism.
32. Services prohibited by applicable law or regulation.
33. 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).
34. Exams, other evaluations or other services received solely for the purpose of employment, insurance or licensure.

35. 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.
36. Non-medical self-care or self-help training.
37. 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**.
38. Coverage for costs associated with translation of medical records and claims to English.
39. Treatment for superficial veins, also referred to as telangiectasia, thread, reticular or spider veins.
40. Services not received from or under the direction of a physician, except as described in this plan.
41. Orthognathic surgery for cosmetic purposes.
42. Sensory integration, including auditory integration training.
43. 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**.
44. Services for or related to intensive behavior therapy treatment programs for the treatment of autism spectrum disorders. Examples of such services include, but are not limited to, Early Intensive Developmental and Behavioral Intervention (EIDBI), Applied Behavioral Analysis (ABA), Intensive Early Intervention Behavior Therapy (IEIBT), Intensive Behavioral Intervention (IBI) and Lovaas therapy.
45. Health care professional services for home labor and delivery.
46. Services related to surrogate pregnancy for a person not covered as a covered person under the plan.
47. Sperm banking and/or storage.
48. Donor sperm.
49. Donor eggs.
50. Services related to adoption.
51. Any form, mixture or preparation of cannabis for medical or therapeutic use and any device or supplies related to its administration.
52. Services solely for or related to the treatment of snoring.
53. Interpreter services.
54. Services provided to treat injuries or illnesses that are the result of committing a felony or attempting to commit a felony.

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 covered person or the covered person'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, biologics and biosimilars that have not been approved by the U.S. Food and Drug Administration (FDA).
59. New-to-market biologics, biosimilars and professionally administered drugs. Biologics, biosimilars and professionally administered drugs recently approved by the FDA (including approval for a new indication) will not be covered until they are reviewed and approved for coverage by Medica.
60. Health club memberships.
61. Long-term care.
62. Expenses associated with participation in weight loss programs, including but not limited to membership fees and the purchase of food, dietary supplements or publications.
63. Any charges for mailing, interest and delivery, such as the cost for mailing medical records.
64. Animals and any service or treatment related to animals.
65. 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 plan.

Coordination for Medicare-eligible individuals

The benefits under this plan are not intended to duplicate any benefits to which covered persons are eligible for under Medicare. If we have covered a service under this plan, any sums payable under Medicare for that service must be paid to the plan. 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 law. We will not reduce the benefits due any covered person where federal law requires that we determine our benefits for that covered person 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. If this coordination of benefits provision applies, **Order of benefit determination rules** should be looked at first. Those rules determine whether the benefits of this plan are determined before or after those of another plan. Under **Order of benefit determination rules**, the benefits of this plan:
    a. Shall not be reduced when this plan determines its benefits before another plan; but
    b. May be reduced when another plan determines its benefits first. The above reduction is described in **Effect on the benefits of this plan**.

Definitions that apply to this section

1. A “*plan*” is any of these which provides benefits or services for, or because of, medical or dental care or treatment:
    a. Group insurance or group-type coverage, whether insured or uninsured, or individual coverage. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
    b. Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical

Assistance Programs, of the United States Social Security Act, as amended from time to time).

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

2. "*This plan*" is the part of the plan that provides benefits for health care expenses.

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

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

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

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

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

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

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

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

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

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

Order of benefit determination rules

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

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

   b. Both the other plan's rules and this plan's rules, in 2. below, require that this plan's benefits be determined before those of the other plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Effect on the benefits of this plan

1. *When this section applies*. This section applies when, in accordance with **Order of benefit determination rules**, this plan is a secondary plan as to one or more other plans. In that event, the *benefits* of this plan may be reduced under this section. Such other plan or plans are referred to as *the other plans* in 2. immediately below.

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

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

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

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

   When this plan is a secondary plan, this plan will pay the balance of any remaining expenses determined to be eligible under the plan, according to the out-of-network

benefits described in this plan. 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.

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

Right to receive and release needed information

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

Facility of payment

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

Right of recovery

If the amount of the payments made by the plan is more than 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 **Right to Subrogation and Reimbursement** for additional information.

Right to Subrogation and Reimbursement

The plan has a right to subrogate and to reimbursement. References to "you" or "your" in this **Right to Subrogation and Reimbursement** section shall include you, your estate and your heirs and beneficiaries unless otherwise stated.

Subrogation applies when the plan 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 the plan 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 the plan 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 the plan 100% of any benefits you received from the plan 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 against whom you may have any claim for professional malpractice arising out of or connected to a sickness or injury you allege or could have alleged were the responsibility of any third party.
6. 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 the plan in protecting our legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
    a. Notifying the plan 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 the plan.
    c. Signing and/or delivering such documents as the plan 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 the plan's consent or the plan's agents' consent before releasing any party from liability or payment of medical expenses.

g. Complying with the terms of this section.

Your failure to cooperate with the plan or abide by the terms of this plan are each considered a breach of the terms of this plan. As such, the plan has the right to take legal action against you for the value of benefits the plan 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 the plan due to you or your representative not cooperating with us or your failure to abide by the terms of this plan. If the plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the plan has the right to recover those fees and costs from you. You will also be required to pay interest as provided by law on any amounts you hold which should have been returned to the plan.

2. The plan has first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, the plan'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. The plan'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. The plan 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. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.

4. Regardless of whether you have been fully compensated or made whole, the plan 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 the plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the plan's subrogation and reimbursement rights.

5. Benefits paid by the plan 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 the plan alleges some or all of those funds are due and owed to the plan, 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 the plan, you agree that (i) any amounts recovered by you from any third party shall constitute plan assets (to the extent of the amount of plan benefits provided on behalf of the covered person), and (ii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the plan to enforce its reimbursement rights.

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

9. Upon the plan's request, you will assign in writing to the plan all rights of recovery against third parties, to the extent of the benefits the plan has paid for the sickness or injury.

10. The plan may, at its option, take necessary and appropriate action to preserve the plan's rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits you receive for the sickness or injury out of any settlement, judgment or other recovery from any third party considered responsible; and filing suit in your name or your estate's name, which does not obligate the plan in any way to pay you part of any recovery the plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund benefits as required under the terms of the plan is governed by a six-year statute of limitations.

11. You may not accept any settlement that does not fully reimburse the plan, without its written approval.

12. The plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

13. In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs, next of kin or beneficiaries. In the case of your death the plan'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 the plan is not extinguished by a release of claims or settlement agreement of any kind unless the plan expressly agrees in writing.

14. 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, shall be valid if it does not reimburse the plan for 100% of its interest unless the plan provides written consent to the allocation.

15. 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.

16. If any third party causes or is alleged to have caused you to suffer a sickness or injury while you are covered under this plan, the provisions of this section continue to apply, even after you are no longer covered.

17. The plan and all administrators or their agents administering the terms and conditions of the plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the plan.

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 plan.

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

Claims for benefits from non-network providers

Claim forms are provided 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 plan. 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 identification 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, the plan will generally pay to you directly the non-network provider reimbursement amount. The plan will only pay the provider of services if:

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

Medica will notify you of authorization or denial of the claim within 30 days of receipt of the claim.

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

Claims for 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, the plan will pay you directly.

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

Time limits

You may not bring legal action more than two years after Medica has made a coverage determination regarding your claim.

How Do I File a Complaint

Claim denials

Pre-Service Claims. Refer to *Prior authorization*.

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

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

Generally, the plan will notify you of denial within 30 calendar days after the plan receives proof of the claim. Despite the specified timeframes, nothing prevents you from voluntarily agreeing to extend the timeframes.

If a post-service claim is incomplete, the plan may deny the claim or may take an extension of time, as described in this paragraph. In addition, if the plan is not able to decide a post-service claim within the applicable timeframes, due to other matters beyond its control, one 15-day extension of the applicable timeframe is permitted, you will be notified in writing prior to the expiration of the initial timeframe applicable to the claim. The extension notice shall include a description of the matters beyond the plan's control that justify the extension and the date by which a decision is expected. No extension is permitted for urgent care claims.

First level of review

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

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

   You must request an appeal within 180 days from the date of the claim denial. The appeal request should state the reasons you believe the claim denial was improper and should be accompanied by any additional information, material or comments you consider appropriate. You may also review any pertinent documents related to the claim.

2. The denied claim shall be reviewed by Medica and a decision made within 30 calendar days after receiving the written request for review. The decision of Medica shall be in writing and will include the specific reasons for the decision as well as specific references to the pertinent plan provisions on which the decision is based.

3. The denied claim will be reviewed and a decision made by Medica within 72 hours if your attending provider believes that Medica's decision warrants an expedited appeal or if Medica concludes that a delay could seriously jeopardize your life, health or ability to regain maximum function, or subject you to severe pain that cannot be adequately managed without the care or treatment you are requesting. In such cases, you may have the right to request an external review while your appeal review is being conducted.

External review

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

Civil action

If you are not satisfied with Medica's first level or external review decision, you may file a civil action suit under Section 502 (a) of the Employee Retirement Income Security Act of 1974 (ERISA). You must exhaust your first level of appeal review before you have the right to bring a civil action under ERISA. No civil action for benefits may be brought more than two years after the time a claim for benefits is required to have been submitted under this plan.

Other complaints

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

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 plan and be an enrollee or dependent as defined in this plan.

How to enroll

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

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

Dependents will not be enrolled without the qualified employee also being enrolled. A child who is the subject of a QMCSO can be enrolled as described in this section under **Qualified Medical Child Support Order (QMCSO)** and 6. under **Special enrollment and effective date of coverage**.

Initial enrollment and effective date of coverage

Initial enrollment is a time period starting with the date a qualified employee and dependents are first eligible to enroll for coverage under the plan. A qualified employee must enroll within this period for coverage to begin the date he or she was first eligible to enroll. (The time period does not apply to newborns or children newly adopted or newly placed for adoption; see **Special enrollment and effective date of coverage**.) A qualified employee and dependents who do not enroll during the initial enrollment period may enroll for coverage during the next open enrollment period or any applicable special enrollment periods.

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

For qualified employees and dependents who enroll during the initial enrollment period, coverage begins on the date on which the employee first meets the definition of a qualified employee.

Your coverage begins at 12:01 a.m. on the effective date specified in the plan.

Open enrollment and effective date of coverage

A period communicated by the plan administrator each year during which qualified employees and dependents who are not covered under the plan may elect coverage for the upcoming calendar year. An application must be submitted to the plan administrator for yourself and any dependents.

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

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

Special enrollment and effective date of coverage

Special enrollment periods are provided to qualified employees and dependents under certain circumstances. 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 a qualified employee and dependent if the individual was covered under Medicaid or a State Children's Health Insurance Plan (SCHIP) and lost that coverage as a result of loss of eligibility. The qualified employee or dependent must present evidence of the loss of coverage and request enrollment within 60 days after the date such coverage terminates.

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

    b. A special enrollment period will apply to a qualified employee and dependent if the qualified employee or dependent was covered under a group health plan or health insurance coverage with benefits consisting of medical care at the time the qualified employee or dependent was eligible to enroll under the plan, whether during initial enrollment, open enrollment, or special enrollment and declined coverage for that reason.

        The qualified employee or dependent must present 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;
- if the prior coverage was offered through an individual health maintenance organization (HMO), a loss of coverage because the qualified employee or dependent no longer resides or works in the HMO's service area;
- if the prior coverage was offered through a group HMO, a loss of coverage because the qualified employee or dependent no longer resides or works in the HMO's service area and no other coverage option is available; and
- the prior coverage no longer offers any benefits to the class of similarly situated individuals that includes the qualified employee or dependent.

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

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

In the case of the qualified employee's loss of other coverage, the special enrollment period described above applies to the qualified employee and all of his or her dependents. In the case of a dependent's loss of other coverage, the special enrollment period described above applies only to the dependent that has lost coverage and the qualified employee.

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

The qualified employee or dependent must present evidence that the qualified employee or dependent has exhausted such COBRA or state continuation coverage and has not lost such coverage due to failure of the qualified employee or dependent to pay premiums on a timely basis or for cause, and request enrollment in writing within 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;
- losing coverage as a result of the qualified employee or dependent incurring a claim that meets or exceeds the lifetime maximum limit on all benefits and no other COBRA or state continuation coverage is available; or
- if the prior coverage was offered through a health maintenance organization (HMO), losing coverage because the qualified employee or dependent no longer resides or works in the HMO's service area and no other COBRA or state continuation coverage is available.

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

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

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 the plan administrator.

2. The dependent is a new spouse of the enrollee or qualified employee, provided the marriage is legal and enrollment is requested in writing within 30 days of the date of marriage and provided the qualified employee also enrolls during this special enrollment period. Coverage is effective on the date of the marriage.

3. The dependent is a new dependent child of the enrollee or qualified employee, provided enrollment is requested in writing within 30 days of the enrollee or qualified employee acquiring the dependent and provided the qualified employee also enrolls during this special enrollment period. In the case of birth, coverage is effective on the date of birth; in the case of adoption, placement for adoption or placement as a foster child, coverage is effective the date of adoption or placement. In all other cases, coverage is effective the date the enrollee acquires the dependent child.

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

   a. That spouse is eligible for coverage; and

   b. Is not already enrolled under the plan; and

c. Enrollment is requested in writing within 30 days of the dependent child becoming a dependent; and

d. The qualified 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 enrollee or qualified 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 qualified employee also enrolls during this special enrollment period. Coverage is effective on the date coverage for the dependent is effective, as set forth in 2. or 3. above (as applicable).

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

7. The dependent is a new domestic partner of the enrollee or qualified employee, provided the domestic partnership is registered and enrollment is requested in writing within 30 days of the date of registration, and the qualified employee also enrolls during the special enrollment period.

8. When the qualified employee or dependent becomes eligible for group health plan premium assistance provided by Medicaid or a State Children's Health Insurance Plan, the qualified employee must request enrollment within 60 days after the date the employee or dependent is determined to be eligible for premium assistance.

   In the case of the qualified employee becoming eligible for premium assistance, this special enrollment period applies to the qualified employee and all of his or her dependents. In the case of a dependent becoming eligible for premium assistance, this special enrollment period applies to both that dependent and the qualified employee. Coverage is effective the day after the date the prior coverage ended.

Qualified Medical Child Support Order (QMCSO)

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

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

- Where a QMCSO requires coverage be provided under the plan for a qualified employee's dependent child who is not already a covered person, such child will be provided a special enrollment period. If the qualified employee whose dependent child is the subject of the QMCSO is not an enrollee at the time enrollment for the dependent child is requested, the qualified employee may also enroll for coverage under the plan during the special enrollment period.
- Where a QMCSO requires coverage be provided under the plan for a qualified employee's dependent child who is already a covered person, such child will continue to be provided coverage under the plan pursuant to the terms of the QMCSO.

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

This section describes when coverage ends under the plan. 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 plan, coverage ends the earliest of the following:

1. The date on which this plan terminates. If the relationship between the plan administrator and Medica ends, coverage under the plan will not necessarily end. Only the sponsor determines when this plan terminates.
2. The effective date of a plan amendment terminating coverage for the class to which a covered person belongs.
3. The end of the month for which the enrollee or covered person last paid his or her contribution toward the premium.
4. The end of the month in which the covered person is no longer eligible as determined by the plan administrator. (See **Who's Eligible for Coverage and How Do They Enroll** for information on eligibility.)
5. The date the plan administrator approves the enrollee's or covered person's request to end his or her coverage.
6. The date specified by the plan administrator in written notice to you that coverage ended due to fraud. If coverage ends due to fraud, coverage may be retroactively terminated at the plan administrator's discretion to the original date of coverage or the date on which the fraudulent act took place. Fraud includes but is not limited to:
    a. Intentionally providing the plan administrator 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 Medica identification card by any unauthorized person; or
    d. Using another person's Medica identification card; or
    e. Submitting fraudulent claims.
7. The date you enter active military duty for more than 31 days. Upon completion of active military duty, contact the plan administrator to discuss reinstatement of coverage.
8. For a dependent domestic partner, the date in which the individual no longer meets the criteria to be a dependent domestic partner.

9. For a child who is entitled to coverage through a QMCSO, the earliest in which the following occurs:

   a. The end of the month in which a QMCSO ceases to be effective; or

   b. The child is no longer a child as that term is used in ERISA; or

   c. The end of the month in which the child has immediate and comparable coverage under another plan; or

   d. The end of the month in which the qualified employee who is ordered by the QMCSO to provide coverage is no longer eligible as determined by the plan administrator; or

   e. The date the sponsor terminates family or dependent coverage; or

   f. The date the plan is terminated by the sponsor; or

   g. The end of the month in which the relevant premium or contribution toward the premium is last paid.

Continuing your coverage

This section describes continuation coverage provisions. When coverage ends, covered persons may be able to continue coverage under federal law.

Please note: All aspects of continuation coverage administration are the responsibility of the plan administrator.

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

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

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

1. 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 under COBRA and/or USERRA as follows:

COBRA continuation coverage

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

General COBRA information

COBRA requires employers with 20 or more employees to offer enrollees 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.)

Enrollee's loss

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

Enrollee's spouse's loss

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

a. Death of the enrollee;

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

c. Divorce or legal separation from the enrollee; or

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

Enrollee's child's loss

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

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

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

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

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

e. The enrollee's child ceases to be a dependent child under the terms of the plan.

Responsibility to inform

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

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

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

Disability Extension

With respect to disability determinations, coverage for a Disability may be extended. A **Disability Extension** is applicable when the qualifying event is the **employee's** termination of employment or reduction of hours, and the extension applies to all qualified beneficiaries. If you or your dependent who is a qualified beneficiary is determined by the Social Security Administration to be disabled at any time during the first 60 days of continuation, then the continuation period for all qualified beneficiaries is extended to 29 months from the date coverage terminated.

For the 29-month continuation coverage period to apply, a qualified beneficiary must notify the Plan Administrator of the Social Security Administration disability within 60 days after the latest of: 1) the date of the Social Security disability determination; 2) the date of the qualifying event (the **employee's** termination of employment or reduction of hours); 3) the

date on which the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event; and 4) the date on which the qualified beneficiary is informed, either through the certificate of coverage or the initial COBRA notice, of both the responsibility to provide the notice of disability determination and the plan's procedures for providing such notice to the administrator.

The qualified beneficiary must notify the Plan Administrator of the Social Security disability determination before the end of the 18-month period following the qualifying event (the **employee's** termination of employment or reduction of hours.)

If during the 29-month extension period there is a "final determination" that a qualified beneficiary is no longer disabled, the qualified beneficiary must notify the Plan Administrator within 30 days after the date of this determination. This extension coverage ends for all qualified beneficiaries on the extension as of 1) the first day of the month that is more than 30 days after a final determination by the Social Security Administration that the formerly disabled qualified beneficiary is no longer disabled; or 2) the end of the coverage period that applies without regard to the disability extension.

You Must Give Notice of Some Qualifying Events

You and your dependents must notify the employer of any of the following events within 60 days of the occurrence of the event:

- Divorce or legal separation.
- A dependent child no longer meets the plan's eligibility requirements.

You must deliver or mail this notice to the plan administrator's Manager of Benefits. The notice must be in writing, must describe the qualifying event and the date it occurred, must identify the name(s) and address(es) of those persons entitled to COBRA continuation coverage, and must include appropriate documentation to support the qualifying event. For example, in the case of divorce or legal separation, you must provide a copy of divorce decree or order of legal separation. In the case of a dependent child losing eligibility for coverage, you must provide a copy of the child's birth certificate and other documentation confirming that the child is not enrolled as a full-time student.

If you or your dependents fail to provide this notice during this 60-day notice period, any dependent who loses coverage will NOT be offered the option to elect continuation coverage. Furthermore, if you or your dependents fail to provide this notice, and if any claims are mistakenly paid for expenses incurred after the date coverage was to terminate, then you and your dependents will be required to reimburse the plan for any claims paid.

When you notify the employer that a divorce or legal separation or a loss of dependent status will cause a loss of coverage, then the employer will notify the affected family members(s) of the right to elect continuation coverage. If you notify the employer of a qualifying event or disability determination (as described above) and the employer determines that there is no extension available, the employer will provide an explanation as to why you or your dependents are not entitled to elect continuation coverage.

Bankruptcy

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

Election rights

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

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

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 enrollee and the enrollee'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 enrollee's covered spouse or dependent child may elect continuation coverage even if the enrollee does not elect continuation coverage.

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

Type of coverage and cost

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

Under 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 plan because of termination of employment or reduction in hours. In that case, the required continuation coverage period is 18 months. The 18 months may be extended if a second event (e.g., divorce, legal separation or death) occurs during the initial 18-month period. It also may be extended to 29 months in the case of an employee or employee's 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 enrollee becomes entitled to (actually covered under) Medicare, the continuation period for the enrollee's dependents is 36 months measured from the date of the enrollee's Medicare entitlement even if that entitlement does not cause the enrollee to lose coverage.

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

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

a. The enrollee'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 enrollee becomes entitled to (actually covered under) Medicare.

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

Trade Act of 2002

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

USERRA continuation coverage

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

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

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

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

Election rights

The employee or the employee's authorized representative may elect to continue the employee's coverage under the plan by making an election on a form provided by the plan administrator. The employee has 60 days to elect continuation coverage measured from the date coverage would be lost because of the event described above. If continuation coverage is elected within this period, the coverage will be retroactive to the date coverage would otherwise have been lost. The employee may elect continuation coverage on behalf of other covered dependents; however, there is no independent right of each covered dependent to elect. If the employee does not elect, there is no USERRA continuation available for the spouse or dependent children. In addition, even if the employee does not elect USERRA continuation, the employee has the right to be reinstated under the plan upon reemployment, subject to the terms and conditions of the plan.

Type of coverage and cost

If the employee elects continuation coverage, the employer is required to provide coverage that, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees. The amount charged cannot exceed 102 percent of the cost of the coverage unless the employee's leave of absence is less than 31 days, in which case the employee is not required to pay more than the amount that they would have

to pay as an active employee for that coverage. There is a grace period of at least 30 days for the regularly scheduled premium.

Duration of USERRA coverage

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

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

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 plan as an active employee.

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

COBRA and USERRA coverage are concurrent

If both COBRA and USERRA apply and you elect COBRA continuation coverage in addition to USERRA continuation coverage, these coverages run concurrently.

2. Other continuation coverage

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

Domestic partner

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

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

The methods by which specific network providers are paid may change from time to time. Methods also vary by network provider. The primary method of payment under your plan is a fee-for-service.

Under fee-for-service and per episode arrangement, the network provider is paid a fee for each service or episode of care provided. These payments are determined according to a set fee schedule. The amount the network provider receives is the lesser of the fee schedule or what the network provider would have otherwise billed. If the payment is percentage of charges, the network provider's payment is a set percentage of the provider's billed charge. The amount paid to the network provider, less any applicable copayment, coinsurance or deductible is considered to be payment in full.

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

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, in addition to any applicable copayment, coinsurance, or deductible amounts.

Additional Terms of Your Coverage

This section describes the general provisions of the plan.

Applicable law

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

Examination of a covered person

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

Clerical error and misstatements

You will not be deprived of coverage under the plan because of a clerical error or misstatement by the plan or plan administrator. However, you will not be eligible for coverage beyond the scheduled termination of your coverage because of a failure to record the termination. If there is a clerical error or any misstatement of relevant facts pertaining to coverage under the plan, the plan administrator reserves the right to investigate the matter and determine the existence or amount of coverage.

Plan amendment and termination

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

Enrollee rights

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

Family and Medical Leave Act of 1993 (FMLA)

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

Relationship between parties

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

Discretionary authority

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

Definitions

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

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

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

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

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

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

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

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

For in-network benefits, the coinsurance amount 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 covered person.

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.

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

When you receive eligible health services from a network provider and a copayment applies, you pay the lesser of the charge billed by the provider for the benefit (i.e., retail) or your copayment. Any remaining amount is paid according to the written agreement with the provider. The copayment may not exceed the retail charge billed by the provider for the benefit.

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

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.

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

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 non-network providers are reimbursable as out-of-network benefits under this plan.

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

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

1. The enrollee's spouse.
2. Legally married same gender spouse to whom the employee is married under state or national law that recognizes same gender marriages.
3. Individual joined to the employee through a civil union in a jurisdiction that recognizes civil unions.
4. The enrollee's domestic partner.
5. The following dependent children up to the dependent limiting age of 26:
    a. The enrollee's or enrollee's spouse's natural or adopted child;
    b. A child placed for adoption with the enrollee or enrollee's spouse;
    c. A child for whom the enrollee or the enrollee's spouse has been appointed legal guardian; however, upon request by the plan, the enrollee must provide satisfactory proof of legal guardianship;
    d. The enrollee's stepchild;
    e. A child placed as a foster child with the enrollee or the enrollee's spouse;
    f. The enrollee's or enrollee's spouse's unmarried grandchild who is dependent upon and resides with the enrollee or enrollee's spouse continuously from birth; and
    g. A child of the enrollee's domestic partner, as long as the domestic partner is also covered as a dependent.
6. The enrollee's or enrollee's spouse's disabled child who is a dependent incapable of self-sustaining employment by reason of developmental disability, mental illness, mental disorder or physical disability and is chiefly dependent upon the enrollee for support and maintenance. An illness that does not cause a child to be incapable of self-sustaining employment will not be considered a physical disability. A disabled child may remain covered under the plan regardless of age and without application of health screening or waiting periods. To continue coverage for a disabled child, you must provide the plan with proof of such disability and dependency within 31 days of the child reaching the dependent limiting age set forth in 3. above. Beginning two years after the child reaches the dependent limiting age, the plan may require annual proof of disability and dependency.
7. The enrollee's or enrollee's spouse's disabled dependent, over the limiting age, who is incapable of self-sustaining employment by reason of developmental disability, mental illness, mental disorder or physical disability and is chiefly dependent upon the enrollee or enrollee's spouse for support and maintenance. For coverage of a disabled dependent, you must provide the plan with proof of such disability at the time of the dependent's

enrollment. You must also provide the plan with proof of dependency at the time of enrollment.

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

Designated mental health 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 plan.

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

Domestic partner. An adult who the sponsor determines:

1. Is in a committed and mutually exclusive relationship, jointly responsible for the enrollee's welfare and financial obligations; and
2. Resides with the enrollee in the same principal residence and intends to do so permanently; and
3. Is at least 18 years of age and unmarried; and
4. Is not a blood relative of the enrollee; and
5. Is mentally competent.

Emergency. A condition or symptom (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, would believe requires immediate treatment to:

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

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

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

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

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.

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 any authoritative compendia as identified by the Medicare program for use in the determination of a medically accepted indication of drugs and biologicals used off-label.

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

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

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

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

Network. A provider (such as a hospital, physician, home health agency, skilled nursing facility or pharmacy) that has entered into a written agreement with Medica or has made other arrangements with Medica to provide benefits to you. 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 the plan will pay to a non-network provider for each benefit is based on one of the following, as determined by Medica:

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

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

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

In addition, if the amount billed by the non-network provider is greater than the non-network provider reimbursement amount, the non-network provider will likely bill you for the difference. This difference may be substantial, and it is in addition to any coinsurance or deductible amount you may be responsible for according to the terms described in this plan. Furthermore, such difference will not be applied toward the out-of-pocket maximum described in **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 copayments, coinsurance and deductibles paid for benefits received during a calendar year. Unless otherwise specified, you will not be required to pay more than the applicable per covered person out-of-pocket maximum for benefits received during a calendar year.

Amounts reimbursed or paid by a provider or manufacturer, including manufacturer coupons, rebates, coupon cards, debit cards or other forms of reimbursement or payment on your behalf for a product or service, will not apply toward your out-of-pocket maximum.

The time period used to calculate whether you have met the out-of-pocket maximum (calendar year or plan year) is determined by the plan between Medica and the sponsor. If this time period changes when Medica and the sponsor renew the plan, you will receive a new plan document 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 calendar year will be covered at 100 percent, except for any charge not covered by the plan, or charge in excess of the non-network provider reimbursement amount.

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

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

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

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

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

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

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

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

Plan administrator. Fredrikson & Byron, P.A.

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 covered person involved;
3. With respect to covered persons who are infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
4. With respect to covered persons who are women, such additional preventive care and screenings not described in 1. as provided for in comprehensive guidelines supported by the Health Resources and Services Administration (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 employee. An employee of sponsor who is scheduled to work on a regular basis at least thirty (30) hours per week. The sponsor may choose to administer eligibility through use of the federal look-back measurement period, and as a result a qualified employee will also include an employee throughout the applicable stability period, who is determined to have worked an average of at least thirty (30) hours per week based on the sponsor's look-back measurement period, which determination is made in accordance with federal law. The plan administrator determines an employee's status as a qualified employee.

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

Reconstructive. Surgery to rebuild or correct a:

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

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

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.

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.

Sponsor. Fredrikson & Byron, P.A.

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.

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 covered persons 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. The period of time that must pass before an otherwise qualified employee and/or dependent is eligible to become covered under the plan (as determined by the sponsor's eligibility requirements). However, if a qualified employee or dependent enrolls through either an open enrollment period or a special enrollment period as set forth in **Who's Eligible for Coverage and How Do They Enroll**, any period before such open or special enrollment is not a waiting period. Periods of employment in an employment classification that is not eligible for coverage under the plan do not constitute a waiting period.

Signature

IN WITNESS WHEREOF, the Benefits Manager of the sponsor has executed the foregoing plan on behalf of sponsor on this 24th day of November, 2020.

By: Shelley Carter
(please print)

(signature on file)
(signature)

Its: Benefits Manager