MEDICA CHOICE PASSPORT MN

CERTIFICATE OF COVERAGE

MEDICA CHOICE PASSPORT MN 1000-20-20%

BPL #61929

DOC #89748

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English: ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-952-3455 (TTY: 711) for Medica, call 1-877-317-2410 (TTY: 711) for Dean Health Plan/Prevea360 Health Plan, or speak to your provider.

Spanish: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia de idiomas. También están disponibles de forma gratuita asistencia y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-952-3455 (TTY: 711) para Medica, llame al 1-877-317-2410 (TTY: 711) para Dean Health Plan/Prevea360 Health Plan o hable con su proveedor de atención médica.

Vietnamese/Việt: LƯU Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-952-3455 (TTY: 711) đối với Medica, gọi theo số 1-877-317-2410 (TTY: 711) đối với Dean Health Plan/Prevea360 Health Plan hoặc trao đổi với nhà cung cấp dịch vụ của quý vị.

Chinese Traditional: 注意：如果您說中文，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-800-952-3455 (TTY: 711) 聯絡 Medica，致電 1-877-317-2410 (TTY: 711) 聯絡 Dean Health Plan/Prevea360 Health Plan，或與您的提供者討論。

Hmong/Lus Hmoob: LUS CEEV: Yog hais tias koj hais Lus Hmoob ces muaj kev pab txhais lus pub dawb rau koj. Muaj khoom siv thiab muaj kev saib xyuas pab uas tsim nyog los npaj kom muaj cov ntaub ntawv uas siv tau dawb. Hu rau 1-800-952-3455 (TTY: 711) rau Medica, hu rau 1-877-317-2410 (TTY: 711) rau Dean Health Plan/Prevea360 Health Plan, los sis tham rau koj tus kws kuaj mob.

German/Deutsch: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-800-952-3455 (TTY: 711) für Medica bzw. 1-877-317-2410 (TTY: 711) für Dean Health Plan/Prevea360 Health Plan oder sprechen Sie mit Ihrem Gesundheitsdienstleister.

Cushitic-Oromo: XIYYEEFFANNOO: Ingiliffaa dubbattu taanaan, tajaajilli deggersa afaan bilisaa ni jira. Tajaajilli deggersa bu'ura dhiheessii odeeffannoo kaffaltii tokko malee ni jira. Lakkoofsa bilbilaa 1-800-952-3455 (TTY: 711) Tajaajila Fayyaaf, lakkoofsa Medica 1-877-317-2410 (TTY: 711), Dean Health Plan/Prevea360 Health Plan, ykn dhiheessaa keessan dubbisaa.

Arabic/العربية

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-800-952-3455 (الهاتف النصي: 711) للتواصل مع Medica، اتصل على الرقم 1-877-317-2410 (الهاتف النصي: 711) بشأن خطة الرعاية الصحية Dean Health Plan/Prevea360 Health Plan

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Korean/한국어: 주의: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. Medica 의 경우 1-800-952-3455(TTY: 711)번으로, Dean Health Plan/Prevea360 Health Plan 의 경우 1-877-317-2410(TTY: 711)번으로 전화하시거나, 서비스 제공업체에 문의하십시오.

Russian/Русский: Если вы говорите по-русски, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-952-3455 (TTY: 711) относительно Medica, позвоните по телефону 1-877-317-2410 (TTY: 711) относительно Dean Health Plan/Prevea360 Health Plan или обратитесь к своему поставщику услуг.

Laos/ ລາວ: ຂໍ້ຄວນເອົາໃຈໃສ່: ຖ້າທ່ານເວົ້າພາສາລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ນອກຈາກນີ້ ຈະມີເຄື່ອງຊ່ວຍເສີມ ແລະ ບໍລິການແບບທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້ໂດຍບໍ່ເສຍຄ່າ. ໂທຫາເບີ 1-800-952-3455 (TTY: 711) ສໍາລັບ Medica, ໂທ 1-877-317-2410 (TTY: 711) ສໍາລັບ Dean Health Plan/Prevea360 Health Plan ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

French/ Français: ATTENTION : si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-952-3455 (TTY : 711) pour Medica, appelez le 1-877-317-2410 (TTY : 711) pour le régime de santé Dean Health Plan/Prevea360, ou parlez à votre prestataire de santé.

Serbo-Croatian: PAŽNJA: Ako govorite srpski, dostupne su vam besplatne usluge tumača. Odgovarajuća dodatna pomagala i usluge za pružanje informacija u pristupačnim formatima su takođe dostupne besplatno. Za Medica zdravstveno osiguranje pozovite 1-800-952-3455 (TTY: 711), za Dean/Prevea360 zdravstveno osiguranje pozovite 1-877-317-2410 (TTY: 711) ili razgovarajte sa svojim pružaocem usluga.

Tagalog: PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-952-3455 (TTY: 711) para sa Medica, tumawag sa 1-877-317-2410 (TTY: 711) para sa Dean Health Plan/Prevea360 Health Plan, o makipag-usap sa iyong tagapagbigay ng serbisyo.

Karen/ထၢနှာ်လီၤဖဲအံၤ: ဟ်သူဉ်ဟ်သး– နမ့်ကတိၤကညီကျိာ်နှဉ် တၢ်အိဉ်ဒီး ကျိာ်တၢ်ဆိဉ်ထွဲမၤစၢၤလၢတလၢ်ဘူဉ်လၢ်စုၤလၢနဂီၢ်လီၤ. တၢ်အိဉ်ဒီး ပှၤနှၢ်ခါကွၢ်ဂီၤတဆူဉ်တက္ပၢၤအဂီၢ် ပီးလီဒီးတၢ်တိစၢၤမၤစၢၤလၢအကြားအဘဉ် လၢကဟ့ဉ်တၢ်ဂ့ၢ်တၢ်ကျိၤ လၢတၢ်မၤနှ်အီၤသ့တဖဉ် လၢတလၢ်ဘူဉ်လၢ်စုၤ လၢနဂီၢ်လီၤ. ကိး 1-800-952-3455 (TTY: 711) လၢ Medica အဂီၢ်, ကိး 1-877-317-2410 (TTY: 711) လၢ Dean Health Plan/Prevea360 Health Plan အဂီၢ်, မ့တမ့ၢ် ကတိၤတၢ်ဒီး နပှၤလၢဟ့ဉ်နၤတၢ်ကွၢ်ထွဲတက့ၢ်.

Amharic/ አማርኛ:- ማሳሰቢያ፦ አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎት በነፃ ይቀርብልዎታል። መረጃን በተደራሽ ቅርጸት ለማቅረብ ተገቢ የሆኑ ተጨማሪ እገዛዎች እና አገልግሎቶች እንዲሁ በነፃ ይገኛሉ። ለMedica በ1-800-952-3455 (TTY: 711) ይደውሉ፣ ለDean የጤና እቅድ/Prevea360 የጤና እቅድ በ1-877-317-2410 (TTY: 711) ይደውሉ ወይም ለእርስዎን አቅራቢ የሆነውን ያነጋግሩ።

MEDICA MEMBER SERVICES

The specific Member Services telephone number for your plan is found on the back of your Medica ID card.

General Member Services:

Minneapolis/St. Paul Metro Area: **952-945-8000** TTY: **711**

Outside the Metro Area: **1-800-952-3455**

Find more information about your benefits by signing in to your secure member site at **Medica.com/SignIn**.

Welcome!

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

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

Some terms used have specific meanings.

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

Where to Find It

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

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

Do you need…	***Read section(s):***
Outpatient surgery? • Anesthesia services • Outpatient/ambulatory surgical center services (facility charge) • Physician services (doctor charge)	Anesthesia Hospital Services Physician and Professional Services
Services provided during a hospital stay? • Anesthesia services • Hospital services (facility charge) • Physician services (doctor charge)	Anesthesia Hospital Services Physician and Professional Services
Behavioral health services – mental health or substance use services? • Inpatient services • Office visit	Behavioral Health – Mental Health and Substance Use
Pregnancy care services? • Breast pumps • Inpatient services • Postnatal services • Prenatal services	Durable Medical Equipment, Orthotics, 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, Orthotics, 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	Home Health Care
• Physical, speech and occupational therapies	Rehabilitative and Habilitative Therapies
• Skilled nursing facility services	Skilled Nursing Facility

Table of Contents

Introduction

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

How you accept coverage

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

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

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

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

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

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

If you need language interpretation

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

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

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

Medica’s nondiscrimination policy

Medica’s policy is to treat all persons alike, without distinctions based on race, color, creed, religion, national origin, sex, pregnancy, gender, gender identity, marital status, status with

regard to public assistance, disability, sexual orientation, age, genetic information or any other classification protected by law.

For more information, see the non-discrimination notice at the beginning of this certificate. If you have questions, call Member Services at one of the telephone numbers listed at the front of this certificate.

Your Rights and Responsibilities

Member bill of rights

As a member, you have the right to:

1. Available and accessible services, including emergency services (defined in this certificate) 24 hours a day, seven days a week; and
2. Information about your health condition, appropriate or medically necessary treatment options and risks, regardless of cost or benefit coverage, so you can make an informed choice about your health care; and
3. Participate with providers in decision making regarding your health care, including the right to refuse treatment recommended to you by Medica or any provider; and
4. Be treated with respect and recognition of your dignity and privacy, including privacy of your medical and financial records maintained by Medica or any network provider in accordance with existing law; and
5. Contact Medica Member Services and Minnesota's Commissioner of Commerce to file a complaint about issues related to benefits (see **How Do I File a Complaint**). You may begin a legal proceeding if you have a problem with Medica or any provider. To file a complaint with the Minnesota Department of Commerce, call **651-539-1600** and request insurance information; and
6. Receive information about Medica, its services, its providers and member rights and responsibilities; and
7. Appeal a decision regarding your health care coverage by calling Member Services at one of the telephone numbers listed at the front of this certificate. See **How Do I File a Complaint** for information on your appeal rights; and
8. Make recommendations regarding Medica's member rights and responsibilities statement.

Member responsibilities

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

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

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

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

Before You Access Care

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

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 Medica 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. Drug manufacturer coupons will count toward your coinsurance, copay, deductible and/or 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 at **Medica.com/SignIn** or contact Member Services. Certain providers may be in other Medica networks, but not in your network.

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

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/SignIn**.

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 Member Services at one of the telephone numbers listed at the front of this certificate.

Medica does not require prior authorization for the following:

- Emergency services;
- Access to obstetrical or gynecological care from a provider who specializes in obstetrics or gynecology (although some specific services may require prior authorization);
- Pregnancy/maternity care services (covered at the appropriate in-network or out-of-network benefit levels);
- Outpatient mental health treatment or outpatient substance use disorder treatment, except for treatment that is a medication;
- Antineoplastic cancer treatment that is consistent with guidelines of the National Comprehensive Cancer Network, except for treatment that is a medication;
- Preventive health services, as defined in **Definitions**;
- Pediatric hospice services provided by a licensed hospice provider; and
- Treatment delivered through a neonatal abstinence program operated by pediatric pain or palliative care subspecialists.

This is not a complete list of all services and supplies that do not require prior authorization. In addition, while there is no prior authorization requirement for these services, you may still have to obtain a prior authorization to go out of network in order to obtain these services from non-network providers. For more information, see the section below on **Prior authorization to receive in-network benefits from non-network providers**.

You, someone on your behalf or your attending provider may contact Member Services 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, someone on your behalf or your attending provider must contact Member Services to request prior authorization to receive in-network benefits 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 Member Services for this confirmation.

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

- Solid organ and blood and marrow transplant services - this prior authorization must be obtained before the transplant workup is initiated;
- In-network benefits for services from non-network providers, with the exception of emergency services;
- In-network benefits for services from non-network providers for a rare disease or condition, as defined in the **Rare Diseases** section;
- Certain reconstructive or restorative surgery procedures;
- 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;
- Skilled nursing facility services; and
- Surgical gender reassignment/affirmation services.

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 you are requesting to see;
- Services being requested and the date those services are to be provided (if scheduled);
- Specific information related to your condition (for example, a letter of medical necessity from your provider); and
- Other applicable member information (i.e., Medica member number).

Medica will review your request for prior authorization and respond to you and your attending provider within a reasonable period of time appropriate to your medical circumstances. Medica will respond within 5 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 48 hours (including at least one business day) or 72 hours, whichever is shorter, from the time of the initial request if:

- Your attending provider believes that an expedited review is warranted; or
- If it is concluded that a delay could seriously jeopardize your life, health or ability to regain maximum function; or

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

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

Medica will not retroactively deny or limit coverage for services that:

- Did not require prior authorization, unless the service was obtained through fraud or misinformation.
- The member has already received, solely on the basis of lack of prior authorization if the service would have been covered had the prior authorization been obtained.

For chronic health conditions, prior authorization does not expire, unless the standard of treatment for that health condition changes. For purposes of this section, a chronic health condition is a condition that is expected to last one year or more and either:

1. Requires ongoing medical attention to effectively manage the condition or prevent an adverse health event; or
2. Limits one or more activities of daily living.

If you are a new Medica member and have a prior authorization for services from your former health plan, Medica will accept that prior authorization for at least the first 60 days of coverage under this plan. In order to obtain coverage for this 60-day period, you or your provider must send Medica documentation of the previous prior authorization. For coverage to continue after the 60-day period, you, someone on your behalf or your attending provider should submit a request for prior authorization to Medica prior to the end of this 60-day period.

Under certain circumstances, Medica may 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**).

Prior authorization to receive in-network benefits from non-network providers

To receive in-network benefits for services received from a non-network provider, you, someone on your behalf or your attending provider must request prior authorization from Medica by following 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/SignIn**.

Requests, including standing requests*, to receive in-network benefits from a non-network provider will not be authorized to meet personal preferences, family convenience or other non-medical reasons. Requests also will not be approved for care that has already been provided.

What you must do:

1. You, someone on your behalf or your attending provider must request prior authorization from Medica to receive medically necessary in-network benefits from a non-network

provider. Medica does not guarantee coverage for services that are received before you receive prior authorization.

2. Include the following information in the prior authorization request:
   a. The time period for when services must be received;
   b. The services to be provided; and
   c. The name of the non-network provider.
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 request is a request to receive ongoing services from a specialist. Standing requests will only be authorized for the period of time appropriate to your medical condition. If Medica denies your request, 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 request to see a non-network provider is medically necessary.
2. Will provide coverage for health services that are:
   a. Otherwise eligible for coverage under this certificate; and
   b. Recommended by a network physician.
3. Will review the 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 5 business days of receiving the 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 48 hours (including at least one business day) or 72 hours, whichever is shorter, from the time of the initial request if: 1) your attending provider believes that an expedited review is warranted, or 2) Medica concludes that a delay could seriously jeopardize your life, health or ability to regain maximum function, or 3) you could be subject to severe pain that cannot be adequately managed without the care or treatment you are seeking

Visiting non-network providers and why you pay more

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

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

Be aware that if you use out-of-network benefits, you will likely have to pay much more than if you use in-network benefits. The amounts billed by the non-network provider may be more than what Medica would pay, leaving a balance for you to pay in addition to any

coinsurance and deductible amount you owe. This additional amount you must pay the provider will not be counted toward your out-of-pocket maximum amount. You will owe this amount whether or not you previously reached your out-of-pocket maximum. **Please see the example calculation below.**

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

- Discuss with the non-network provider what the bill is expected to be; and
- Contact Member Services to verify the estimated amount Medica would pay for those services; and
- Calculate your likely share of the costs; and
- To request that Medica authorize coverage of the non-network provider's services at the in-network benefit level, follow the prior authorization process described above.

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

Example:

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

Assumptions:

1. You have previously fulfilled your deductible.
2. The non-network hospital bills $30,000 for your hospital stay.
3. Medica's non-network provider reimbursement amount for those hospital services is $15,000.
    a. You must pay a portion of this amount, generally a percentage coinsurance. In this example, we will use 40% coinsurance.
    b. In addition, the non-network provider will likely bill you for the difference between what they charge and the amount that Medica pays them.

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

    40% coinsurance (40% of $15,000 = $6,000), and

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

    Therefore, the total amount you will owe is $6,000 + $15,000 = $21,000.

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

The $15,000 amount you pay for billed amounts in excess of the non-network provider reimbursement amount **will not** be applied toward your out-of-pocket maximum. You will owe the provider this $15,000 amount whether or not you have previously reached your out-of-pocket maximum.

***Note:** The numbers in this example are used only for purposes of illustrating how out-of-network benefits are calculated. The actual numbers will depend on the services you receive. For more information about out-of-network care, see the tip sheet at **Medica.com/SignIn**.

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.

Surprise Billing Protections

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.

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

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

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

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

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

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

If you have questions about bills you receive from a non-network provider that provided services under the circumstances described under Minnesota Statute 62Q.556, please call Member Services at the telephone number on the back of your Medica ID card. If you receive a bill that

is larger than the applicable copayment, coinsurance or deductible, you may submit the bill for processing to:

Member Services
Route CP0501
P.O. Box 9310
Minneapolis, MN 55440-9310

Continuity of care

Continuity of care is the process by which Medica authorizes a member, for a limited period of time, to continue accessing covered services with a treating provider who is not in Medica's network while still receiving in-network benefits. To request continuity of care, or if you have questions about whether you may be eligible, call Member Services at the telephone number on the back of your Medica ID card.

Continuity of care is available if you are in an active course of treatment with a treating provider, and:

1. The contract between Medica and the treating provider terminates without cause; or
2. You are a new Medica member because your employer terminated its health plan and your current treating provider is not a network provider.

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

1. An ongoing course of treatment for an acute condition;
2. A life-threatening mental or physical illness;
3. Undergoing a course of institutional or inpatient care from the provider or facility;
4. Scheduled non-elective surgery, including postoperative care;
5. Pregnant and undergoing a course of treatment for pregnancy. Health services may continue to be provided through the completion of postpartum care;
6. 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;
7. A disabling or chronic condition that is in an acute phase; and
8. An ongoing course of treatment for a chronic condition.

If approved, continuity of care will continue until the active course of treatment is complete, or 120 days, whichever is shorter.

Authorization to continue to receive services from your current 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:

1. If you are receiving culturally appropriate services and Medica does not have a network provider who has special expertise in the delivery of those culturally appropriate services; or
2. 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 treating provider to review your continuity of care request and will consider each continuity of care request on a case-by-case basis. If Medica authorizes your request to continue care with your current treating provider, Medica will explain how continuity of care will be provided. After the time period for which continuity of care is approved, 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.

Continuity of care applies only if your treating provider agrees to comply with Medica's prior authorization requirements, provides Medica with all necessary medical information related to your care and accepts as payment in full the lesser of Medica's network provider reimbursement or the provider's customary charge for the service.

Continuity of care is not available for treating providers that are terminated for cause. If Medica terminates your current treating provider's contract for cause, Medica will inform you of the change and how your care will be transferred to another network provider.

Under continuity of care, coverage will not be provided for services or treatments that are not otherwise covered under this Contract.

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 Member Services at one of the telephone numbers listed at the front of this certificate. Also refer to **Before You Access Care** for more information about the prior authorization process.
- Medica provides coverage for mental health and substance use disorder services in the same way it provides coverage for other health issues. The Mental Health Parity and Addiction Equity Act, as well as applicable state law, requires Medica, an insurer that offers mental health and substance use disorder benefits, to provide coverage of those benefits in a way that is comparable to coverage for general medical and surgical care. Cost-sharing requirements and limitations on mental health and substance use disorder benefits (such as copayments, visit limits and preauthorization requirements) must generally be comparable to, and no more restrictive than those for medical and surgical benefits.
- When you use out-of-network benefits, in addition to the deductible and coinsurance, you will likely need to pay your provider any billed amount above what Medica pays the provider (the non-network provider reimbursement amount). **These charges are not applied to your deductible or out-of-pocket maximum.** Please see **Visiting non-network providers and why you pay more** in **Before You Access Care** for more information and an example showing out-of-pocket costs associated with out-of-network benefits.
- Certain benefits in this certificate have limits. These limits might include day limits, visit limits or dollar limits. These limits are noted in this certificate and apply whether or not you have met your deductible.

Key concepts

Deductibles

Your plan may require that you pay a certain dollar amount before your insurance starts to pay. This amount is called a deductible. Drug manufacturer coupons will count toward your coinsurance, copay, deductible and/or out-of-pocket maximum.

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

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

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

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 Contract year. Unless otherwise noted, you won't have to pay more than this amount. Drug manufacturer coupons will count toward your coinsurance, copay, deductible and/or 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; and**
- **Charges you pay in addition to your deductible, copayment or coinsurance when you choose to use a preferred brand or non-preferred brand prescription drug when a chemically equivalent generic drug is available.**

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

DEDUCTIBLES, OUT-OF-POCKET MAXIMUMS AND LIFETIME MAXIMUM

Deductibles, Out-Of-Pocket Maximums and Lifetime Maximum		
	Your cost if you visit a:	
	Network provider:	**Non-network provider:**
Copayment or coinsurance	See specific benefit for applicable copayment or coinsurance.	
Deductible		
Per member	$1,000	$1,600
Per family	$2,500	$4,000
The deductible is the amount you must pay for eligible services each Contract year before the plan will begin to pay claims. If you have family members on the plan, you will each have to meet your own individual deductible before receiving benefits, unless the family deductible is met. Once the family deductible has been met, the plan will pay benefits for all covered family members.		
Drug manufacturer coupons will count toward your coinsurance, copay, deductible and/or out-of-pocket maximum.		
Out-of-pocket maximum		
Per member	$5,500	$11,000
Per family	$11,000	No out-of-pocket maximum
This plan has both a per member out-of-pocket maximum and a per family out-of-pocket maximum. The per member out-of-pocket maximum applies individually to each family member until the family out-of-pocket maximum is met. Coinsurance, copayments and deductibles paid by each covered family member for covered benefits for the Contract year count toward the individual's annual per member out-of-pocket maximum and toward the annual per family out-of-pocket maximum.		
Drug manufacturer coupons will count toward your coinsurance, copay, deductible and/or 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 Medica will pay per member	Unlimited	Unlimited

AMBULANCE

Ambulance		
	Your cost if you visit a:	
Benefits	**Network provider:**	**Non-network provider:**
1. Emergency ambulance services or emergency ambulance transportation	20% coinsurance after deductible	Covered as an in-network benefit.
2. Non-emergency licensed ambulance service that is arranged through an attending physician, as follows: a. Transportation from hospital to hospital when: i. Care for your condition is not available at the hospital where you were first admitted; or ii. Required by Medica b. Transportation from hospital, long term acute hospital (LTACH) or an acute inpatient rehab (AIR) to skilled nursing facility	20% coinsurance after deductible	40% coinsurance after deductible

Ambulance			
		Your cost if you visit a:	
	Benefits	Network provider:	Non-network provider:
3.	Licensed ambulance transportation arranged through an attending health care provider when the mother or newborn requires transfer to a different medical facility **Please note:** This coverage applies to the mother, dependent newborn and dependent newborn siblings who are covered under the plan.	Nothing. The deductible does not apply.	40% coinsurance after deductible

What's covered

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

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. As described in **Surprise Billing Protections**, when you obtain air ambulance services from certain nonparticipating providers of air ambulance services your in-network benefit will apply and any copayment, deductible and coinsurance will apply to your in-network deductible and out-of-pocket maximum.

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	20% coinsurance after deductible	40% coinsurance after deductible
2.	Anesthesia services received during an outpatient hospital or ambulatory surgical center visit	20% coinsurance after deductible	40% coinsurance after deductible
3.	Anesthesia services received during an inpatient stay	20% coinsurance after deductible	40% coinsurance after deductible

What to keep in mind

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

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

BEHAVIORAL HEALTH – MENTAL HEALTH AND SUBSTANCE USE

Behavioral Health – Mental Health and Substance Use			
		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 or substance use 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 or substance use office visit.	$20/visit. The deductible does not apply.	40% coinsurance after deductible
2.	Intensive outpatient programs	20% coinsurance after deductible	40% coinsurance after deductible
3.	Intensive behavioral and developmental therapy for the treatment of autism spectrum disorder, including applied behavioral analysis. Examples of such therapy include, but are not limited to, Early Intensive Developmental & Behavioral Intervention (EIDBI), Intensive Early Intervention Behavior Therapy (IEIBT), Intensive Behavioral Intervention (IBI) and Lovaas therapy.	20% coinsurance after deductible	40% coinsurance after deductible
4.	Partial hospitalization/day treatment/high intensity outpatient program	20% coinsurance after deductible	40% coinsurance after deductible

Behavioral Health – Mental Health and Substance Use			
		Your cost if you visit a:	
	Benefits	Network provider:	Non-network provider:
5.	Inpatient services (including mental health residential treatment services and substance use disorder 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	20% coinsurance after deductible	40% coinsurance after deductible
	b. Hospital or facility-based professional services	20% coinsurance after deductible	40% coinsurance after deductible
	c. Attending psychiatrist and physician services	20% coinsurance after deductible	40% coinsurance after deductible
6.	Medication-assisted treatment **Please note:** When the prescription drug component of this treatment is received at a pharmacy, your prescription drug benefit will be applied.	20% coinsurance after deductible	40% coinsurance after deductible

What's covered

Outpatient services include:

1. Diagnostic evaluations, assessment and treatment planning.
2. Treatment and procedures.
3. Medication management, including medication-assisted treatment.

4. Nutritional counseling.
5. Nutritional classes billed under HCPCS code S9452.
6. Intensive outpatient programs.
    a. For mental health services, the program may be freestanding or hospital-based and includes a prearranged weekly schedule of core services (e.g., individual counseling, group therapy, family psychoeducation, medication management and case management) that are provided over several sessions during the course of a week.
    b. For substance use-related and addictive disorders services, the program provides structured programming for adults and adolescents, consisting primarily of counseling and education about addiction related and mental health problems.
7. Intensive behavioral and developmental therapy for the treatment of autism spectrum disorder, including applied behavioral analysis.
8. Partial hospitalization/day treatment/high intensity outpatient program. This may be in a freestanding facility or hospital-based. Active treatment includes a prearranged weekly schedule of core services provided through specialized programming with medical/psychological intervention and supervision during program hours (e.g., individual counseling, group therapy, family psychoeducation, medication management and case management). The level of care is typically short-term intensive treatment that aims to reduce symptom disruption to the extent that intensive treatment is no longer required.
9. Individual, family and group therapy, if there is a clinical diagnosis.
10. Treatment of serious or persistent disorders.
11. Services, care or treatment described as benefits in this certificate and ordered by a court of competent jurisdiction to be provided by a network provider or another provider as required by law. The court order must be based on a behavioral care evaluation performed by a licensed psychiatrist or a doctoral level licensed psychologist. This evaluation must include a diagnosis and an individual treatment plan for care in the most appropriate, least restrictive environment. Medica is entitled to receive a copy of the court order and the behavioral care evaluation. This court-ordered coverage is not subject to a separate medical necessity determination. The evaluation performed by a network provider is also a covered service.
12. Treatment of pathological gambling.
13. Services, care or treatment provided by the Minnesota Department of Corrections to a member while the member is committed to the Department of Corrections' custody following a conviction for a first-degree driving while impaired offense if:
    a. A court of competent jurisdiction makes a preliminary determination based on a chemical use assessment conducted under Minnesota Statutes section 169A.70 that treatment may be appropriate and includes this determination as part of the sentencing order; and

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

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

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

Inpatient services include:

1. Room and board.
2. Attending psychiatric and physician services.
3. Hospital or facility-based professional services, including psychiatric residential treatment facility services.
4. Services, care or treatment described as benefits in this certificate and ordered by a court of competent jurisdiction to be provided by a network provider or another provider as required by law. The court order must be based on a behavioral care evaluation performed by a licensed psychiatrist or a doctoral level licensed psychologist. This evaluation must include a diagnosis and an individual treatment plan for care in the most appropriate, least restrictive environment. Medica is entitled to receive a copy of the court order and the behavioral care evaluation. This court-ordered coverage is not subject to a separate medical necessity determination. The evaluation performed by a network provider is also a covered service.
5. Mental health residential treatment services. These services include either:
    a. A residential treatment program serving children and adolescents with severe emotional disturbance, certified under Minnesota Rules parts 2960.0580 to 2960.0700; or
    b. A licensed or certified mental health treatment program providing intensive therapeutic services.
6. Substance use disorder residential treatment services are services from a licensed substance use disorder rehabilitation program that provides intensive therapeutic services following detoxification.
7. Services, care or treatment provided by the Minnesota Department of Corrections to a member while the member is committed to the Department of Corrections' custody following a conviction for a first-degree driving while impaired offense if:
    a. A court of competent jurisdiction makes a preliminary determination based on a chemical use assessment conducted under Minnesota Statutes section 169A.70 that treatment may be appropriate and includes this determination as part of the sentencing order; and

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

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

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

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

What to keep in mind

Medica offers a 24/7 behavioral health crisis line for members at no additional cost. If you are experiencing a mental health or 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 mental health or substance use services or treatment. For inpatient admissions, notification by the facility must be provided as soon as reasonably possible after admission. To determine if Medica requires prior authorization for a particular service or treatment, please call your plan's designated mental health and substance use disorder provider at the telephone number on the back of your Medica ID card. 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 health conditions or substance use conditions listed in the current edition of the *International Classification of Diseases (ICD)* or 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.

If you require inpatient or outpatient care and would like help selecting an in-network provider, call your plan’s designated mental health and substance use disorder provider at the telephone number on the back of your Medica ID card. **Please note:** The hospital network for medical services and mental health and substance use services is not the same.

Emergency mental health and substance use services do not require prior authorization and are eligible for coverage under in-network benefits.

Mental health and substance use 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 and substance use 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
- Substance use disorder clinic
- Substance use disorder residential treatment center
- Independent clinical social worker
- Marriage and family therapist
- Hospital that provides mental health and substance use services
- Licensed professional clinical counselor

What's not covered

1. Services performed in connection with conditions not classified in the current edition of the *International Classification of Diseases (ICD)* or the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* of the American Psychiatric Association.
2. Individual, family and group therapy, in the absence of a clinical diagnosis.
3. Services that are paid under state or federal law for purely educational purposes.
4. Services educational in nature, except as specifically described in this section and in the **Physician and Professional Services**, **Pregnancy – Maternity Care** and **Preventive Health Services** sections.
5. Services, including room and board charges, provided by provider or facilities that are not appropriately licensed, certified or otherwise qualified under state law to provide mental health and substance use services or which provide a primary treatment modality that is experimental or investigational as determined by Medica.
6. 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.
7. Mental health residential treatment services that do not provide all of the following: room and board; group, family and individual counseling; client education; other services specific to mental health treatment; on-site medical/psychiatric assessment within 48 hours of admission; medical/psychiatric follow-up visits at least once per week; and nursing coverage.
8. Substance use disorder residential treatment services that do not provide all of the following: room and board; group, family and individual counseling; client education; other services specific to substance use disorder treatment; on-site medical/psychiatric assessment within 48 hours of admission; medical/psychiatric follow-up visits at least once per week; and nursing coverage.

9. Services to hold or confine a person under chemical influence when no medical services are required, regardless of where the services are received.

CERTAIN CANCER-RELATED TESTING

Certain Cancer-Related Testing			
		Your cost if you visit a:	
	Benefits	**Network provider:**	**Non-network provider:**
1.	Prostate cancer screening, including prostate-specific antigen blood tests and digital rectal examination, for all men	See **Preventive Health Care**.	See **Preventive Health Care**.
2.	Diagnostic surveillance tests for ovarian cancer	Covered at the corresponding in-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit in-network benefit level and diagnostic imaging is covered at the in-network diagnostic imaging benefit level.	Covered at the corresponding out-of-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit out-of-network benefit level and diagnostic imaging is covered at the out-of-network diagnostic imaging benefit level.

What's covered

Medica covers diagnostic surveillance tests for ovarian cancer for women who are at-risk of ovarian cancer. Diagnostic surveillance testing for ovarian cancer means annual screening using: (1) CA-125 serum tumor marker testing; (2) transvaginal ultrasound; (3) pelvic examination; or (4) other proven ovarian cancer screening tests currently being evaluated by the FDA or the National Cancer Institute. At-risk for ovarian cancer means: (1) have a family history (a) with one or more first- or second-degree relatives with ovarian cancer; (b) of clusters of women relatives with breast cancer; or (c) of nonpolyposis colorectal cancer; or (2) testing positive for BRCA1 or BRCA2 mutations. **Please note:** Some pelvic examinations may be covered as preventive health services.

What to keep in mind

When you use out-of-network benefits, in addition to the deductible and coinsurance, you will likely need to pay your provider any billed amount above what Medica pays the provider (the non-network provider reimbursement amount). **These charges are not applied to your**

deductible or out-of-pocket maximum. Please see **Visiting non-network providers and why you pay more** in **Before You Access Care** for more information and an example showing out-of-pocket costs associated with out-of-network benefits.

CLINICAL TRIALS

Clinical Trials			
		Your cost if you visit a:	
	Benefits	**Network provider:**	**Non-network provider:**
1.	Routine patient costs in connection with a qualified individual's participation in an approved clinical trial	Covered at the corresponding in-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit in-network benefit level and surgical services are covered at the surgical services in-network benefit level.	Covered at the corresponding out-of-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit out-of-network benefit level and surgical services are covered at the surgical services out-of-network benefit level.

What's covered

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

What to keep in mind

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

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

What's not covered

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

DURABLE MEDICAL EQUIPMENT, ORTHOTICS, PROSTHETICS AND MEDICAL SUPPLIES

Durable Medical Equipment, Orthotics, Prosthetics and Medical Supplies			
		Your cost if you visit a:	
	Benefits	**Network provider:**	**Non-network provider:**
1.	Durable medical equipment and certain supplies	20% coinsurance after deductible	40% coinsurance after deductible
2.	Orthotic and prosthetic devices, supplies and services, including their repair and replacement	20% coinsurance after deductible	40% coinsurance after deductible
3.	Scalp hair prosthesis for hair loss due to a health condition, including alopecia areata or treatment for cancer, including all equipment and accessories necessary for regular use, when prescribed by a provider, unless there is a clinical basis for limitation. Coverage is limited to $1,000 per Contract year. If the cost for scalp hair prosthesis is less than $1,000, coverage will also be provided for any equipment or accessories necessary for regular use, when prescribed by a provider, up to a total combined dollar limit of $1,000 per Contract year.	20% coinsurance after deductible	40% coinsurance after deductible

Durable Medical Equipment, Orthotics, Prosthetics and Medical Supplies			
		Your cost if you visit a:	
	Benefits	**Network provider:**	**Non-network provider:**
4.	Hearing aids 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 after deductible Coverage is limited to one hearing aid per ear every three years.	40% coinsurance after deductible Coverage is limited to one hearing aid per ear every three years.
5.	Breast pumps	Nothing. The deductible does not apply.	40% coinsurance after deductible
6.	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 when medically necessary. Conditions for which it is medically necessary include, but are not limited to: i. Cystic fibrosis;	20% coinsurance after deductible	40% coinsurance after deductible

Durable Medical Equipment, Orthotics, Prosthetics and Medical Supplies			
	Benefits	Your cost if you visit a: Network provider:	Non-network provider:
	ii. Amino acid, organic acid and fatty acid metabolic and malabsorption disorders; iii. IgE mediated allergies to food proteins; iv. Food protein induced enterocolitis syndrome; v. Eosinophilic esophagitis; vi. Eosinophilic gastroenteritis; vii. Eosinophilic colitis; and viii. Mast cell activation syndrome		
7.	Eligible ostomy supplies	20% coinsurance after deductible	40% coinsurance after deductible
8.	Insulin pumps and their related supplies	20% coinsurance. The deductible does not apply.	40% coinsurance after deductible
9.	Eligible intermittent urinary catheters and insertion supplies	20% coinsurance after deductible	40% coinsurance after deductible

What's covered

Medica covers only a limited selection of durable medical equipment, orthotics, prosthetics and medical supplies. Medica covers orthotic and prosthetic devices or device systems, supplies, accessories, and services that are customized to the member's needs. Needs of the member

include performing physical activities such as, but not limited to running, biking and swimming, as well as devices for showering and bathing.

The repair, replacement or revision of durable medical equipment, orthotics and prosthetics is covered if it is made necessary by normal wear and use. Replacement of a prosthetic or custom orthotic device or the replacement of any part of the device is covered if an ordering health care provider determines it is necessary because: (1) of a change in the physiological condition of the member; (2) of an irreparable change in the condition of the device or in a part of a device, or (3) the condition of the device, or the part of the device, requires repairs and the cost of the repairs would be more than 60 percent of the cost of a replacement device or of the part being replaced.

Hearing aids and certain durable medical equipment, orthotics, 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.

Medica covers intermittent catheters with insertion supplies if intermittent catheterization is recommended by a member's health care provider. Medica covers 180 intermittent catheters with insertion supplies per month unless a lesser amount is prescribed by the member's health care provider.

Member cost-sharing for medical supplies necessary to effectively and appropriately treat or administer a drug prescribed to treat diabetes, asthma, or allergies requiring the use of epinephrine auto-injectors and received at an in-network pharmacy, through a designated mail order pharmacy, or from an in-network DME provider will be limited to $50 per month in total. The deductible does not apply.

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

What to keep in mind

Medica periodically reviews and modifies the list of eligible durable medical equipment and certain supplies. To request the most up-to-date list, call Member Services at one of the telephone numbers listed at the front of this certificate.

Medica requires prior authorization (approval in advance) before you receive certain durable medical equipment, orthotics, prosthetics and/or medical supplies. To determine if Medica requires prior authorization for a particular piece of equipment, orthotic, prosthetic or supply, please contact Member Services at one of the telephone numbers listed at the front of this certificate, by signing in at **Medica.com/SignIn** or at the telephone number or address listed on the back of your Medica 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, orthotics, prosthetics and medical supplies.

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

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

In-network benefits apply when eligible equipment, services and supplies are prescribed by a physician and received from a network provider. In-network benefits apply when eligible orthotics and prosthetics are prescribed by a physician or licensed health care prescriber 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 Member Services at one of the telephone numbers listed at the front of this certificate.

Out-of-network benefits apply when eligible equipment, services and supplies are prescribed by a physician and received from a non-network provider. Out-of-network benefits apply when eligible orthotics and prosthetics are prescribed by a physician or licensed health care prescriber and received from a non-network provider.

What's not covered

1. Durable medical equipment, supplies, orthotics, prosthetics, appliances and hearing aids not on the Medica eligible list.
2. Charges in excess of the Medica standard model of durable medical equipment, orthotics, prosthetics or hearing aids.
3. Repair, replacement or revision of properly functioning durable medical equipment, orthotics, prosthetics and hearing aids, including, but not limited to, due to loss, damage or theft.
4. Duplicate durable medical equipment, orthotics, 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**.
6. Hearing aids that are available over-the-counter.

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	20% coinsurance after deductible	Covered as an in-network benefit.
2.	Other services received during an emergency room visit (for example x-rays, lab, physician)	20% coinsurance after deductible	Covered as an in-network benefit.

What's covered

Emergency services provided in an emergency room of a hospital, whether network or non-network, from non-network providers will be covered as in-network benefits. Cost-sharing requirements that apply to emergency services received out-of-network are the same as the cost-sharing requirements that apply to services received in-network and count toward the in-network deductible. All coverage and charges for emergency services comply with the "No Surprises Act." Please see **Surprise Billing Protections** for more information if you receive any other bill from an emergency room provider.

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

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

GENDER AFFIRMATION CARE

Gender Affirmation Care			
		Your cost if you visit a:	
	Benefits	Network provider:	Non-network provider:
1.	Medically necessary gender affirming health care services for gender dysphoria, as defined in the *Diagnostic and Statistical Manual of Mental Disorders (DSM).* Treatment includes surgical and non-surgical services and mental health services. Medical necessity review is based on Medica's policy, which references multiple resources, including but not limited to the *World Professional Association for Transgender Health (WPATH) Standards of Care for the Health of Transsexual, Transgender and Gender Nonconforming People*. **Please note:** Coverage for drugs that are medically necessary for the treatment of gender dysphoria is as described in **Prescription Drugs** and **Prescription Specialty Drugs** in this section.	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

Medically necessary services for the treatment of gender dysphoria are covered. These services will be covered as in-network benefits if they are received from a network provider.

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

What to keep in mind

Medica requires prior authorization (approval in advance) before you receive any services related to surgical gender reassignment/affirmation. To determine if Medica requires prior authorization for a particular service or treatment, please contact Member Services at one of the telephone numbers listed at the front of this certificate, by signing in at **Medica.com/SignIn** or at the telephone number or address listed on the back of your Medica ID card. Please see **Prior authorization** in **Before You Access Care** for more information about prior authorization requirements and processes.

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

What's not covered

Services, care or treatment that are not medically necessary.

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. The deductible does not apply.	40% 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.	$20/visit. The deductible does not apply.	40% coinsurance after deductible
3. Rapid whole genome sequencing for members who: are age 21 or younger; have a complex or acute illness of unknown etiology; and are receiving inpatient hospital services in an intensive care unit or neonatal or high acuity pediatric care unit	Covered at the corresponding in-network benefit level, depending on type of services provided. For example, inpatient services are covered at the inpatient services in-network benefit level and lab services are covered at the in-network lab services benefit level.	Covered at the corresponding out-of-network benefit level, depending on type of services provided. For example, inpatient services are covered at the inpatient services out-of-network benefit level and lab services are covered at the out-of-network lab services benefit level.

Genetic Testing and Counseling		
	Your cost if you visit a:	
Benefits	Network provider:	Non-network provider:
4. Biomarker testing for the purpose of diagnosing, treating, managing, or monitoring illness or disease if the test provides clinical utility	Nothing. The deductible does not apply.	40% 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 Member Services at one of the telephone numbers listed at the front of this certificate. Please see **Prior authorization** in **Before You Access Care** for more information about prior authorization requirements and processes.

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

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

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

What's not covered

1. Genetic testing when performed in the absence of symptoms or high risk factors for a genetic disease; genetic testing when knowledge of genetic status will not affect treatment decisions, frequency of screening for the disease or reproductive choices; genetic testing that has been performed in response to direct-to-consumer marketing and not under the direction of your physician.
2. Laboratory testing (including genetic testing) that has been performed in response to direct-to-consumer marketing and not under the direction of a physician.

HOME HEALTH CARE

Home Health Care		
	Your cost if you visit a:	
Benefits	Network provider:	Non-network provider:
1. Home health care services including the following: a. Intermittent skilled nursing 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 Intermittent skilled nursing care consists of visits of up to two consecutive hours of care per date of service. Benefits covered under a. and b. above are limited to a combined maximum of 120 visits per Contract year for in-network benefits and 60 visits per Contract year for out-of-network benefits. **Please note:** This visit limit does not apply to services for treatment of mental health and/or substance use conditions. If you are also enrolled in the Medical Assistance Program, you may be eligible for additional skilled nursing care through the Medical Assistance Program. However, in no event will the total number of home health visits covered by Medica exceed the number of visits set forth above.	20% coinsurance after deductible	40% coinsurance after deductible
2. Services received in your home from a physician, physician's assistant or advanced practice registered nurse	20% coinsurance after deductible	40% coinsurance after deductible

What's covered

Home health care is covered when ordered by a physician, physician's assistant or advanced practice registered nurse and received from a home health care agency that is authorized by the laws of the state in which treatment is received.

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

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

What to keep in mind

Prior authorization (approval in advance) is required before you receive certain home health care services. Prior authorization is also required before you receive certain biologics, biosimilars and professionally administered drugs. Certain biologics, biosimilars and professionally administered drugs may be subject to step therapy requirements. In certain cases, it is possible to get an exception to step therapy requirements; please see Exceptions to Step Therapy in **Prescription Drugs** or **Prescription Specialty Drugs**. 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.

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.

If you are a ventilator-dependent patient with communication needs and you require home care nursing services in your home, Medica will cover up to 120 hours of interpreter services/communication training provided by a home care nurse during the time you are hospitalized in order to assure adequate training of the hospital staff to communicate with you.

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 educational in nature, except as specifically described in the **Behavioral Health – Mental Health and Substance Use, Physician and Professional Services, Pregnancy – Maternity Care** and **Preventive Health Services** sections.
7. Vocational and job rehabilitation.
8. Recreational therapy.
9. Self-care or self-help training (non-medical), including, but not limited to, educational therapy, aerobic conditioning, therapeutic exercises, work hardening programs, etc., and all related material and products for these programs.
10. Health club memberships.
11. Disposable supplies and appliances, except as described in **Durable Medical Equipment, Orthotics, Prosthetics and Medical Supplies** and **Prescription Drugs** in this section.
12. Voice training.
13. Home health aide services, except when rendered in conjunction with intermittent skilled nursing care and related to the medical condition under treatment.
14. Extended hours home care, except as described in this section for members who have Medica coverage and are also enrolled in the Medical Assistance Program.

HOSPICE SERVICES

Hospice Services		
	Your cost if you visit a:	
Benefits	Network provider:	Non-network provider:
1. Hospice services	Nothing. The deductible does not apply.	40% coinsurance after deductible

What's covered

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

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

What to keep in mind

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

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

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

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

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

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

1. Be a terminally ill patient; and

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

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

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

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

What's not covered

1. Respite care for more than five consecutive days.
2. Home health care and skilled nursing facility services when services are not consistent with the hospice program's plan of care.
3. Services not provided by the hospice program.
4. Hospice daycare, except when recommended and provided by the hospice program.
5. Any services provided by a family member or friend, or individuals who are residents in your home.
6. Financial or legal counseling services, except when recommended and provided by the hospice program.
7. Housekeeping or meal services in your home, except when recommended and provided by the hospice program.
8. 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	20% coinsurance after deductible	40% coinsurance after deductible
2.	Services provided in a hospital observation room	20% coinsurance after deductible	40% coinsurance after deductible
3.	Inpatient services For associated physician services, see **Physician and Professional Services** in this section.	20% coinsurance after deductible	40% coinsurance after deductible
4.	Inpatient services provided through a home hospitalization program, where available, as specifically described in this **Hospital Services** section For associated physician services, see the benefits described for physician services received in an inpatient setting under **Physician and Professional Services** in this section.	20% coinsurance after deductible	No coverage
5.	Inpatient and outpatient treatment of cleft lip and cleft palate for a dependent child	Covered at the corresponding in-network benefit level, depending on type of services provided.	Covered at the corresponding out-of-network benefit level, depending on type of services provided.

What's covered

Hospital and ambulatory surgical center services are covered. They will be covered as in-network benefits if they are:

1. Received from a network hospital or ambulatory surgical center; or
2. Emergency services received from a network provider or a non-network provider will be covered as in-network benefits. If you are admitted to a non-network hospital from an emergency department of a hospital, you will be eligible for in-network benefits until you have validly consented to post-stabilization care from non-network providers. Please see **Surprise Billing Protections** and **Your Rights and Protections Against Surprise Medical Bills** for more information.

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

Where available, certain network hospitals are designated facilities for the provision of inpatient services in a member's home through a home hospitalization program. Members who are accepted into a home hospitalization program by a designated facility have the option to receive inpatient services in the hospital or at their home through the home hospitalization program. Services covered through each such home hospitalization program are as defined by the designated facility and Medica. In order to be covered, such services must be provided under the direction of a physician and received through a designated facility. **Please note:** Not all network hospitals are designated facilities for covered home hospitalization programs. If you have a question concerning whether a particular hospital is such a designated facility, call Member Services at one of the telephone numbers listed at the front of this certificate.

What to keep in mind

Prior authorization (approval in advance) is required before you receive certain biologics, biosimilars and professionally administered drugs. Certain biologics, biosimilars and professionally administered drugs may be subject to step therapy requirements. In certain cases, it is possible to get an exception to step therapy requirements; please see Exceptions to Step Therapy in **Prescription Drugs** or **Prescription Specialty Drugs**. 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** and **Prescription Specialty Drugs** or otherwise described as a specific benefit elsewhere in this section.
2. Transfers and admissions to network hospitals solely at the convenience of the member.
3. Admission to another hospital is not covered when care for your condition is available at the network hospital where you were first admitted.

INFERTILITY DIAGNOSIS

Infertility Diagnosis			
		Your cost if you visit a:	
	Benefits	**Network provider:**	**Non-network provider:**
1.	Office visits, including any services provided during such visits	20% coinsurance after deductible	Covered as an in-network benefit.
2.	Outpatient services received at a hospital	20% coinsurance after deductible	Covered as an in-network benefit.

What's covered

The diagnosis of infertility is covered. Coverage includes benefits for professional, hospital and ambulatory surgical center services. Services for the diagnosis of infertility must be received from or under the direction of a physician. All services, supplies, drugs and associated expenses for fertility treatment are not covered.

The diagnosis of infertility will be covered at the in-network benefit level whether provided by a network or non-network provider.

What to keep in mind

To determine if Medica requires prior authorization for a particular service, please call Member Services at one of the telephone numbers listed at the front of this certificate. Please see **Prior authorization** in **Before You Access Care** for more information about prior authorization requirements and processes.

What's not covered

1. Physician, hospital and ambulatory surgical center services for fertility treatment.
2. Fertility treatment drugs.
3. Assisted reproductive technology services, including but not limited to: in vitro fertilization (IVF); gamete intrafallopian transfer (GIFT); zygote intrafallopian transfer (ZIFT); tubal embryo transfer; intracytoplasmic sperm injection (ICSI); ova or embryo acquisition, retrieval, donation, preservation and/or storage; and/or any conception that occurs outside the woman's body.
4. Services for or related to donation, preservation and/or storage of sperm, ova, embryos, stem cells and any other human tissue.
5. Services for intrauterine insemination (IUI).

6. Services for a condition that a physician determines cannot be successfully treated.
7. Services related to surrogate pregnancy for a person not covered as a member under the Contract.
8. Sperm banking and/or storage.
9. Donor sperm.
10. Donor eggs.
11. 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. The deductible does not apply.	40% coinsurance after deductible
2.	Lab and pathology services received during an outpatient hospital or ambulatory surgical center visit	Nothing. The deductible does not apply.	40% coinsurance after deductible
3.	Lab and pathology services received in an inpatient setting	Nothing. The deductible does not apply.	40% coinsurance after deductible
4.	CA-125 serum tumor marker testing when conducted as a surveillance test for ovarian cancer for at-risk women	Nothing. The deductible does not apply.	40% 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:

1. Received from a network provider; or
2. Received from a non-network provider under the circumstances described in **Surprise Billing Protections**.

What to keep in mind

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

MEDICAL-RELATED DENTAL SERVICES

Medical-Related Dental Services			
		Your cost if you visit a:	
	Benefits	**Network provider:**	**Non-network provider:**
1.	Charges for medical facilities and general anesthesia services that are recommended by a physician and received during a dental procedure for a member who: a. Is a child under age five; b. Is severely disabled; or c. Has a condition that requires hospitalization or general anesthesia for dental care treatment.	20% coinsurance after deductible	40% coinsurance after deductible
2.	For a dependent child, orthodontia, dental implants and oral surgery treatment related to cleft lip and palate. If orthodontic services are eligible for coverage under a dental insurance plan, the dental plan is primary and this plan is secondary.	20% coinsurance after deductible	40% coinsurance after deductible

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

Medical-Related Dental Services		
	Your cost if you visit a:	
Benefits	Network provider:	Non-network provider:
4. Oral surgery for: a. Partially or completely unerupted impacted teeth; b. A tooth root without the extraction of the entire tooth (this does not include root canal therapy); or c. The gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth	20% coinsurance after deductible	Covered as an in-network benefit.

What's covered

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

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

What to keep in mind

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

What's not covered

1. Dental services to treat an injury from biting or chewing.
2. Diagnostic casts, diagnostic study models and bite adjustments, unless related to the treatment of temporomandibular joint (TMJ) disorder and craniomandibular disorder or cleft lip and palate.

3. Osteotomies and other procedures associated with the fitting of dentures or dental implants.
4. Dental implants (tooth replacement), except as described in this section for the treatment of cleft lip and palate.
5. Dental services, including, but not limited to, preventive, major, minor and restorative services, except as described in this section and the **Reconstructive and Restorative Surgery** and **Temporomandibular Joint (TMJ) and Craniomandibular Disorder** sections.
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.

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 certificate 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.	$20/visit. The deductible does not apply.	40% 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 certificate 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.	$20/visit. The deductible does not apply.	Covered as an in-network benefit.
3.	Convenience care		
	a. Retail health clinic	$5/visit. The deductible does not apply.	40% coinsurance after deductible
	b. Virtual care	$5/visit. The deductible does not apply.	40% 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 **Please note:** Some services received during a visit may be covered under another benefit in this section. The most specific and appropriate benefit will apply for each service received during a visit. For example, certain services may be considered imaging services; see below and in **X-Rays and Other Imaging** for coverage of these services. In such instances, both a chiropractic services copayment or coinsurance and an imaging copayment or coinsurance apply.	$20/visit. The deductible does not apply.	40% coinsurance after deductible Coverage is limited to a maximum of 15 visits per Contract year.
5.	Surgical services (as defined in the Physicians' Current Procedural Terminology code book):		
	a. Received from a physician during an office visit	20% coinsurance after deductible	40% coinsurance after deductible
	b. Received from a physician during an urgent care visit or an outpatient hospital or ambulatory surgical center visit	20% coinsurance after deductible	40% coinsurance after deductible

Physician and Professional Services			
		Your cost if you visit a:	
	Benefits	Network provider:	Non-network provider:
	c. Received from a physician in an inpatient setting	20% coinsurance after deductible	40% coinsurance after deductible
6.	Non-surgical services received from a physician in an inpatient setting	20% coinsurance after deductible	40% coinsurance after deductible
7.	Non-surgical outpatient hospital or ambulatory surgical center services received from or directed by a physician	20% coinsurance after deductible	40% coinsurance after deductible
8.	Routine eye exams	Nothing. The deductible does not apply.	40% coinsurance after deductible
9.	Allergy shots	Nothing. The deductible does not apply.	40% coinsurance after deductible
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)	$20/visit. The deductible does not apply.	40% coinsurance after deductible
11.	Acupuncture Limited to 15 visits per Contract year for in-network and out-of-network benefits combined.	$20/visit. The deductible does not apply.	40% coinsurance after deductible
12.	Neuropsychological evaluations/cognitive testing, limited to services necessary for the diagnosis or treatment of a medical illness or injury	$20/visit. The deductible does not apply.	40% coinsurance after deductible

Physician and Professional Services			
		Your cost if you visit a:	
	Benefits	**Network provider:**	**Non-network provider:**
13.	Vision therapy and orthoptic and/or pleoptic training, to establish a home program, for the treatment of strabismus and other disorders of binocular eye movements Coverage is limited to a combined in-network and out-of-network total of 5 training visits and 2 follow-up eye exams per Contract year.	$20/visit. The deductible does not apply.	40% coinsurance after deductible
14.	Elimination or maximum feasible treatment of port wine stains	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.

Physician and Professional Services			
		Your cost if you visit a:	
	Benefits	Network provider:	Non-network provider:
15.	Treatment for diagnosed Lyme disease	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.
16.	Medically necessary treatment recommended by your licensed health care professional for diagnosed pediatric acute-onset neuropsychiatric syndrome (PANS) and pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS), including but not limited to antibiotics, medication and behavioral therapies to manage neuropsychiatric symptoms, plasma exchange and immunoglobulin	Covered at the corresponding in-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit in-network benefit level and surgical services are covered at the surgical services in-network benefit level.	Covered at the corresponding out-of-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit out-of-network benefit level and surgical services are covered at the surgical services out-of-network benefit level.
17.	The treatment of cleft lip and cleft palate for a dependent child	Covered at the corresponding in-network benefit level, depending on type of services provided.	Covered at the corresponding out-of-network benefit level, depending on type of services provided.

What's covered

In-network benefits apply to:

1. Professional services received from a network provider;
2. Professional services for testing and treatment of a sexually transmitted disease, and testing for AIDS and other HIV-related conditions received from a network provider or a non-network provider;
3. Medical treatment or services provided by a licensed pharmacist with the scope of their license, including the following services.
    a. Collect specimens, interpret results, notify the patient of results, and refer the patient to other health care providers for follow-up care;
    b. Initiate, modify, or discontinue drug therapy only pursuant to a protocol or collaborative practice agreement;
        - Protocol and collaborative practice agreement shall have the same meaning as set forth under the state pharmacy act;
    c. Initiate, order, and administer FDA-approved or authorized influenza and COVID-19 or SARS-CoV-2 vaccines to eligible individuals three years of age and older and all other FDA-approved vaccines to eligible individuals six years of age and older; and
    d. Prescribing and administering drugs to prevent the acquisition of HIV provided the pharmacist has met all the conditions under state law to undertake such actions.
4. Family planning services, for the voluntary planning of the conception and bearing of children, received from a network provider or a non-network provider. Family planning services do not include fertility treatment services;
5. Emergency services received from network or non-network providers; and
6. When the circumstances described in **Surprise Billing Protections** apply for certain out-of-network professional and physician services.

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

What to keep in mind

Prior authorization (approval in advance) is required before you receive certain outpatient surgical services and certain biologics, biosimilars and professionally administered drugs. Certain biologics, biosimilars and professionally administered drugs may be subject to step therapy requirements. In certain cases, it is possible to get an exception to step therapy

requirements; please see Exceptions to Step Therapy in **Prescription Drugs** or **Prescription Specialty Drugs**.

To determine if Medica requires prior authorization for a particular service or treatment, please call Member Services at one of the telephone numbers listed at the front of this certificate. Please see **Prior authorization** in **Before You Access Care** for more information about prior authorization requirements and processes.

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

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

What's not covered

1. Drugs provided or administered by a physician or other provider, except drugs that meet the definition of "professionally administered drugs." Coverage for drugs is as described in **Prescription Drugs** and **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. The deductible does not apply.	0% coinsurance. The deductible does not apply.
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.	20% coinsurance after deductible	40% coinsurance after deductible
4.	Physician services received during an inpatient stay for labor and delivery – for the mother	20% coinsurance after deductible	40% coinsurance after deductible
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.	20% coinsurance after deductible	40% coinsurance after deductible

Pregnancy – Maternity Care		
	Your cost if you visit a:	
Benefits	Network provider:	Non-network provider:
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.	20% coinsurance after deductible	40% 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.	20% coinsurance after deductible	40% coinsurance after deductible
b. Physician services received for labor and delivery – for the mother	20% coinsurance after deductible	40% coinsurance after deductible
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.	20% coinsurance after deductible	40% coinsurance after deductible
8. Postnatal services	Nothing. The deductible does not apply.	40% coinsurance after deductible
9. Home health care visit following delivery	Nothing. The deductible does not apply.	40% coinsurance after deductible

Pregnancy – Maternity Care		
	Your cost if you visit a:	
Benefits	**Network provider:**	**Non-network provider:**
10. Abortions and abortion-related 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 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.

What's covered

Pregnancy services are covered and include medical services for prenatal care, labor and delivery, postnatal care and any related complications. These services will be covered as in-network benefits if they are:

1. Received from a network provider; or
2. Emergency services received from a network provider or a non-network provider will be covered as in-network benefits. If you are admitted to a non-network hospital from an emergency department of a hospital, you will be eligible for in-network benefits until you have validly consented to post-stabilization care from non-network providers. Please see **Surprise Billing Protections** and **Your Rights and Protections Against Surprise Medical Bills** for more information.

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

What to keep in mind

<u>Enrolling your baby</u>

Newborn infants are eligible for benefits from the moment of birth, including coverage for illness, injury, congenital malformation or premature birth, including birth defects, as specifically described in this certificate. 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. In order for Medica to determine and communicate any additional premium owed for the newborn or newly adopted dependent, please notify Medica upon birth of the newborn, adoption, or placement of adoption and request that the newborn or newly adopted dependent be added. If adding your baby raises your premium, Medica is entitled to all premiums due from the time the baby is born. For that reason, it's very important that you request that the newborn or newly adopted dependent be added to the coverage. If any premium amount is past due, Medica may reduce payment by the amount you owe when paying for your baby's health services. For more information, see **Who's Eligible for Coverage and How Do They Enroll**.

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 nursing care or home infusion therapy due to a high-risk pregnancy; and
4. Supplies for gestational diabetes.

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

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

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

Labor and delivery

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

Each member's hospital admission is separate from the admission of any other member. That means a separate deductible and 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

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

Postnatal care

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

Medica also covers the following postnatal care in the first 12 weeks following delivery:

1. A comprehensive postnatal visit with a provider not more than three weeks from the date of delivery;
2. Any postnatal visits recommended by a provider between three and 11 weeks from the date of delivery; and
3. A comprehensive postnatal visit with a provider 12 weeks from the date of delivery.

A comprehensive postnatal visit includes a full assessment of the mother's and infant's physical, social and psychological well-being, including but not limited to: mood and emotional well-being; infant care and feeding; sexuality, contraception and birth spacing; sleep and fatigue; physical recovery from birth; chronic disease management; and health maintenance.

Your plan covers ambulance transportation between medical facilities for you and your newborn. For services, please see **Ambulance** in this section.

For more information about pregnancy care, see the tip sheet at **Medica.com/SignIn**.

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.
4. Fertility treatment.

PRESCRIPTION DRUGS

Prescription Drugs **A prescription unit is:** **Pharmacy:** 31-consecutive day supply, or in the case of prescription contraceptives, up to a 12-month supply **Mail order pharmacy:** 93-consecutive day supply, or in the case of prescription contraceptives, up to a 12-month 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:** $15 per prescription unit; or **Preferred brand:** $35 per prescription unit; or **Non-preferred brand:** $50 per prescription unit The deductible does not apply.	**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:** $30 per prescription unit; or **Preferred brand:** $70 per prescription unit; or **Non-preferred brand:** $100 per prescription unit The deductible does not apply.
2. Diabetic equipment and supplies, including blood glucose meters	**Generic:** 20% coinsurance. The deductible does not apply; or **Preferred brand:** 20% coinsurance. The deductible does not apply; or **Non-preferred brand:** 40% coinsurance. The deductible does not apply.	**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. The deductible does not apply; or **Preferred brand:** 20% coinsurance. The deductible does not apply; or **Non-preferred brand:** 40% coinsurance. The deductible does not apply.

Prescription Drugs **A prescription unit is:** **Pharmacy:** 31-consecutive day supply, or in the case of prescription contraceptives, up to a 12-month supply **Mail order pharmacy:** 93-consecutive day supply, or in the case of prescription contraceptives, up to a 12-month supply			
	Your cost if you visit a:		
	Network pharmacy:	**Non-network pharmacy:**	**Mail order pharmacy:**
3.	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 The deductible does not apply. **Preferred brand:** Nothing per prescription unit; or The deductible does not apply. **Non-preferred brand:** Covered as an in-network non-preferred brand benefit under 1. in this table.	**Generic:** Covered as an out-of-network generic benefit under 1. in this table; or **Preferred brand:** Covered as an out-of-network preferred brand benefit under 1. in this table; or **Non-preferred brand:** Covered as an out-of-network non-preferred brand benefit under 1. in this table.	**Generic:** Nothing per prescription unit; or The deductible does not apply. **Preferred brand:** Nothing per prescription unit; or The deductible does not apply. **Non-preferred brand:** Covered as a mail order non-preferred brand benefit under 1. in this table. **Please note:** Tobacco cessation products are not available through a mail order pharmacy.
4.	Prescription insulin drugs		
	$25 per prescription unit The deductible does not apply.	Covered as an out-of-network benefit under 1. in this table.	$50 per prescription unit The deductible does not apply.

Your cost if you visit a:	
Network pharmacy:	**Non-network pharmacy:**
5. Orally-administered cancer treatment medications	
Generic: $15 per prescription unit; or **Preferred brand:** $20 per prescription unit; or **Non-preferred brand:** $20 per prescription unit The deductible does not apply. **Please note**: Orally-administered anticancer medication does not require a higher copayment, deductible or coinsurance amount than intravenously administered or injected cancer medication.	**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**.

Member cost-sharing for drugs prescribed to treat diabetes, asthma, or allergies requiring the use of epinephrine auto-injectors and received at an in-network pharmacy or through a designated mail order pharmacy will be limited to $25 per prescription unit. The deductible does not apply.

Member cost-sharing for medical supplies necessary to effectively and appropriately treat or administer a drug prescribed to treat diabetes, asthma, or allergies requiring the use of epinephrine auto-injectors and received at an in-network pharmacy, through a designated mail order pharmacy, or from an in-network DME provider will be limited to $50 per month in total. The deductible does not apply.

What is Medica's Drug List

Medica's Drug List (Drug List) is comprised of drugs that meet the medical needs of our members and have proven safety and effectiveness. It includes both brand-name and generic drugs. The drugs on this list have been approved by the Food and Drug Administration (FDA). The Drug List identifies whether a drug is classified by Medica as a generic, preferred brand or non-preferred brand drug. A team of physicians and pharmacists meets regularly to review and

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

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

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

Generic drugs are your lowest 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 Member Services at one of the telephone numbers listed at the front of this certificate. It is also available on **Medica.com/SignIn**.

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 prescription contraceptives, one prescription unit is as prescribed by the prescribing provider and up to a 12-month supply).

One prescription unit from a designated mail order pharmacy is a 93-consecutive-day supply (or, in the case of prescription contraceptives, one prescription unit is as prescribed by the prescribing provider and up to a 12-month 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 **Medica.com/SignIn** or call Member Services.

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 Member Services to request prior authorization for drugs prescribed by a non-network provider. You will pay the entire cost of the drug received if you do not meet Medica's authorization criteria.

  Prior authorization will not be required for any covered prescription drugs if prescribed for preexposure prophylaxis ("PReP") and postexposure prophylaxis ("PeP") when used for the prevention or treatment of HIV.

- Step therapy (ST)

  Step therapy is a process that involves trying an alternative covered drug first (typically a generic drug) before moving to a preferred brand or non-preferred brand covered drug for treatment of the same medical condition. The medications subject to step therapy are shown on the Drug List with the abbreviation "ST." You must meet applicable step therapy requirements before Medica will cover these preferred brand or non-preferred brand drugs. When the treatment of stage four advanced metastatic cancer or associated conditions is covered, Medica will not limit or exclude from coverage an FDA-approved drug by mandating that a member with stage four advanced metastatic cancer or associated conditions follow a step therapy protocol if the use of the approved drug is consistent with:

  - An FDA-approved indication; and
  - A clinical practice guideline published by the National Comprehensive Care Network.

Step therapy will not be required for any covered prescription drugs if prescribed for preexposure prophylaxis ("PReP") and postexposure prophylaxis ("PeP") when used for the prevention or treatment of HIV.

- Quantity limits (QL)

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

Exceptions to the Drug List

In certain cases, it is possible to get an exception to the coverage rules described under What is Medica's Drug List above. **Please note that exceptions will only be allowed when specific clinical criteria are satisfied.** Any exception that Medica grants will improve the coverage by only one benefit level. However, no member cost-sharing will apply for exceptions applicable to preventive health services. Additionally, exceptions for contraceptives will be granted if the prescribing provider certifies to Medica in writing that the contraceptive prescribed is medically necessary for you.

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 Member Services at one of the telephone numbers listed at the front of this certificate.

Changes to the Drug List

You will be notified at least sixty (60) days in advance if there are any negative changes to the Drug List that affect covered prescription drugs you are receiving. If there is a change to the Drug List that increases your cost to obtain the covered prescription drug, you will continue to receive the drug at the same cost before the change for the remainder of the Contract year unless any of the following conditions stated below apply.

- The drug that has been deemed unsafe by the United States Food and Drug Administration (FDA).
- The drug that has been withdrawn from the market by the FDA or the manufacturer.
- Independent research, clinical guidelines, or evidence-based standards have been issued with drug-specific warnings or recommended changes regarding the drug's use for reasons related to previously unknown and imminent patient harm.
- The Drug List has been changed to include a generic or multisource brand name drug rated as therapeutically equivalent according to the FDA Orange Book, a biologic drug rated as interchangeable according to the FDA Purple Book, or a biosimilar at the same or lower cost as the drug impacted by the change.

Antipsychotic Prescription Drugs

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

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

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

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

Exceptions to Step Therapy

In certain cases, it is possible to get an exception to step therapy requirements. To obtain more information about the step therapy exception process, please go to **Medica.com/SignIn** or call Member Services at one of the telephone numbers listed at the front of this certificate.

Medica will respond to a request for an exception to step therapy requirements within five days of receipt of a complete request. If you have a condition that may seriously jeopardize your life, health or ability to regain maximum function, Medica will respond within 72 hours of receipt of a complete request.

If we do not approve your request for an exception to step therapy requirements, you have the right to appeal Medica's decision. Medica will respond to a request for such an appeal within five days of receipt of a complete request. If you have a condition that may seriously jeopardize your life, health or ability to regain maximum function, Medica will respond within 72 hours of receipt of a complete request. See **How Do I File a Complaint** for more information on your appeal rights.

If Medica's decision on appeal upholds the initial denial of your request for an exception to step therapy requirements, you have a right to request an external review as described in **How Do I File a Complaint**.

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, sign in at **Medica.com/SignIn**.

Generic requirement

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

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

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

Investigative

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

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

Notwithstanding the above, a drug being used for an indication or at a dosage that is an accepted off-label use for the treatment of cancer 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.

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 of tobacco cessation medication within a 365-day period.

The list of covered Preventive Drugs and Other Services is specific and limited. For a current list, sign in at **Medica.com/SignIn** and refer to the Preventive Drug and Supply category on the Drug List or call Member Services.

These pharmacy benefits include covered drugs for family planning services or the treatment of sexually transmitted diseases when they are prescribed by either a network or a non-network provider. Family planning services do not include fertility treatment services.

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, Orthotics, Prosthetics and Medical Supplies**.

Your cost-sharing for a prescription insulin drug that is used to treat diabetes will not exceed Medica's net price for that drug. The net price is Medica's cost for the drug, including any rebates or discounts received by or accrued directly or indirectly to Medica from a drug manufacturer or pharmacy benefit manager.

This section includes coverage for medications used in the treatment of autism spectrum disorder.

What's not covered

1. Drugs and supplies that are not on Medica's Drug List, unless covered through the exception process described in Exceptions to the Drug List in this section, or unless the requirements described in Antipsychotic Prescription Drugs in this section are satisfied.
2. Drugs that have not been approved by the Food and Drug Administration (FDA).
3. Over-the-counter (OTC) drugs not listed on Medica's Drug List.
4. Replacement of a drug due to loss, damage or theft.
5. Appetite suppressants.
6. Weight loss medications.
7. Sexual dysfunction medications.
8. Non-sedating antihistamines and non-sedating antihistamine/decongestant combinations.
9. Proton pump inhibitors, except for members 12 years of age and younger, and those members who have a feeding tube.

10. Tobacco cessation products or services dispensed through a mail order pharmacy.
11. Drugs prescribed by a provider who is not acting within his/her scope of licensure.
12. Homeopathic medicine.
13. Fertility treatment drugs.
14. Bulk powders, chemicals and products used in prescription drug compounding.
15. Products that are duplicative to, or are in the same class and category as products on Medica's Drug List, unless covered through the exception process described under Exceptions to the Drug List in this section.
16. 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 $75 per prescription unit; or **Non-preferred specialty prescription drugs:** 40% coinsurance per prescription unit The deductible does not apply.
2.	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 $75 per prescription unit; or **Non-preferred specialty prescription drugs:** 40% coinsurance per prescription unit The deductible does not apply.
3.	Orally-administered cancer treatment medications received from a designated specialty pharmacy	**Preferred specialty prescription drugs:** $20 per prescription unit; or **Non-preferred specialty prescription drugs:** $20 per prescription unit The deductible does not apply.

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 Drug List (unless identified as not covered); and
- Received from a designated specialty pharmacy.

Member cost-sharing for specialty drugs prescribed to treat diabetes, asthma, or allergies requiring the use of epinephrine auto-injectors will be limited to $25 per prescription unit. The deductible does not apply.

What is Medica's Specialty Drug Program

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

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.

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 Program, 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 Drug List at no charge, call Member Services at one of the telephone numbers listed at the front of this certificate. It is also available on **Medica.com/SignIn**.

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 **Medica.com/SignIn**. You can also call Member Services at one of the telephone numbers listed at the front of this certificate. Note that certain specialty pharmacies may be in other Medica networks but not in your network.

The table above describes your 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 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 Drug List with the abbreviation "PA." The 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 Member Services 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.

  Prior authorization will not be required for any covered prescription drugs if prescribed for preexposure prophylaxis ("PReP") and postexposure prophylaxis ("PeP") when used for the prevention or treatment of HIV.

- Step therapy (ST)

  Step therapy is a process that involves trying an alternative covered specialty prescription drug (typically a preferred drug) before moving to certain other preferred or non-preferred drugs. The medications subject to step therapy are shown on the Drug List with the abbreviation "ST." You must meet applicable step therapy requirements before Medica will cover these preferred or non-preferred drugs. When the treatment of stage four advanced metastatic cancer or associated conditions is covered, Medica will not limit or exclude from coverage an FDA-approved drug by mandating that a member with stage four advanced metastatic cancer or associated conditions follow a step therapy protocol if the use of the approved drug is consistent with:

  - An FDA-approved indication; and
  - A clinical practice guideline published by the National Comprehensive Care Network.

Step therapy will not be required for any covered prescription drugs if prescribed for preexposure prophylaxis ("PReP") and postexposure prophylaxis ("PeP") when used for the prevention or treatment of HIV.

- 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 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 Program

In certain cases, it is possible to get an exception to the coverage rules described under What is Medica's Specialty Drug Program 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 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 Member Services at one of the telephone numbers listed at the front of this certificate.

Changes to the Drug List

You will be notified at least sixty (60) days in advance if there are any negative changes to the Drug List that affect covered prescription drugs you are receiving. If there is a change to the Drug List that increases your cost to obtain the covered prescription drug, you will continue to receive the drug at the same cost before the change for the remainder of the Contract year unless any of the following conditions stated below apply.

- The drug that has been deemed unsafe by the United States Food and Drug Administration (FDA).
- The drug that has been withdrawn from the market by the FDA or the manufacturer.
- Independent research, clinical guidelines, or evidence-based standards have been issued with drug-specific warnings or recommended changes regarding the drug's use for reasons related to previously unknown and imminent patient harm.
- The Drug List has been changed to include a generic or multisource brand name drug rated as therapeutically equivalent according to the FDA Orange Book, a biologic drug rated as interchangeable according to the FDA Purple Book, or a biosimilar at the same or lower cost as the drug impacted by the change.

Antipsychotic Prescription Drugs

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

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

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

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

Exceptions to Step Therapy

In certain cases, it is possible to get an exception to step therapy requirements. To obtain more information about the step therapy exception process, please go to **Medica.com/SignIn** or call Member Services at one of the telephone numbers listed at the front of this certificate.

Medica will respond to a request for an exception to step therapy requirements within five days of receipt of a complete request. If you have a condition that may seriously jeopardize your life, health or ability to regain maximum function, Medica will respond within 72 hours of receipt of a complete request.

If we do not approve your request for an exception to step therapy requirements, you have the right to appeal Medica's decision. Medica will respond to a request for such an appeal within five days of receipt of a complete request. If you have a condition that may seriously jeopardize your life, health or ability to regain maximum function, Medica will respond within 72 hours of receipt of a complete request. See **How Do I File a Complaint** for more information on your appeal rights.

If Medica's decision on appeal upholds the initial denial of your request for an exception to step therapy requirements, you have a right to request an external review as described in **How Do I File a Complaint**.

Preferred requirement for specialty prescription drugs

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

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

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

Investigative

Drugs prescribed for investigative uses are not covered. As determined by Medica, a drug, device, diagnostic or screening procedure, or medical treatment or procedure is investigative if reliable evidence does not permit conclusions concerning its safety, effectiveness or effect on health

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

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

Notwithstanding the above, a drug being used for an indication or at a dosage that is an accepted off-label use for the treatment of cancer 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.

What's not covered

1. Specialty prescription drugs that are not on Medica's Drug List, unless covered through the exception process described in Exceptions to the Specialty Drug Program in this section or unless the requirements described in Antipsychotic Prescription Drugs in this section are satisfied.
2. Specialty drugs that have not been approved by the Food and Drug Administration (FDA).
3. Appetite suppressants.
4. Weight loss medications.
5. Replacement of a specialty prescription drug due to loss, damage or theft.
6. Specialty prescription drugs prescribed by a provider who is not acting within his/her scope of licensure.
7. Specialty prescription drugs received from a pharmacy that is not a designated specialty pharmacy.
8. Fertility treatment drugs.
9. Growth hormone, except as specifically described in the benefit table above.
10. 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.

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. The deductible does not apply.	0% coinsurance. The deductible does not apply.
2.	Adult immunizations	Nothing. The deductible does not apply.	40% coinsurance after deductible
3.	Early disease detection services including physicals Coverage is limited to one preventive physical exam per calendar year, unless additional visits are necessary to obtain all covered preventive health care.	Nothing. The deductible does not apply.	40% coinsurance after deductible
4.	Routine screening procedures for cancer including, but not limited to, screening for prostate cancer and colorectal cancer. See **Certain Cancer-Related Testing** for more information about surveillance testing for ovarian cancer for at-risk women and screening for prostate cancer for men.	Nothing. The deductible does not apply.	40% 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. The deductible does not apply.	40% coinsurance after deductible
Please note: Preventive mammogram screenings include coverage for women at average risk for breast cancer. Women may require additional imaging (e.g., magnetic resonance imaging (MRI), ultrasound, mammography) or diagnostic services and testing (including pathology evaluation) to complete the screening process or to address findings on the initial screening mammography. If such services or testing are indicated, they are included in this benefit.		
6. Obesity-related chronic disease prevention services, including digitally delivered counseling for members 18 years of age and older who are at risk for obesity-related chronic disease using Medica's designated prevention program Contact Member Services to access Medica's designated prevention program.	Nothing. The deductible does not apply.	No coverage
7. Tobacco use counseling and intervention	Nothing. The deductible does not apply.	40% coinsurance after deductible

Preventive Health Care			
		Your cost if you visit a:	
	Benefits	Network provider:	Non-network provider:
8.	All pre-exposure prophylaxis and post-exposure prophylaxis when used for the prevention or treatment of human immunodeficiency virus	Nothing. The deductible does not apply.	40% coinsurance after deductible
9.	Other preventive health services	Nothing. The deductible does not apply.	40% 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, laboratory and diagnostic imaging may be subject to other plan benefits if determined not to be part of a preventive visit. See **Lab and Pathology** and **X-Rays and Other Imaging** for more information. When you have symptoms or a history of an illness or injury, laboratory and diagnostic services relating to that illness or injury are no longer considered preventive health services.

You may be responsible for paying out-of-pocket costs for any services Medica does not deem preventive health services.

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

For more information about preventive care, see the tip sheet at **Medica.com/SignIn**.

RARE DISEASES

Rare Diseases		
	Your cost if you visit a:	
Benefits	**Network provider:**	**Non-network provider:**
1. Services from a licensed health care provider related to the diagnosis, monitoring and treatment of a rare disease or condition	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 inpatient services are covered at the inpatient services in-network benefit level.	Covered as an in-network benefit if the service is provided in the state of Minnesota. If the service is provided outside the state of Minnesota, the in-network copayment and coinsurance will apply after deductible. You will also likely need to pay your provider any billed amount above what Medica is required to pay the provider in accordance with Minnesota Statute Section 62Q.451, subd. 5.

What's covered

Medically necessary services from a licensed health care provider related to the diagnosis, monitoring and treatment of a rare disease or condition will be covered as described in the benefit table above.

Definition of Rare Disease or Condition

A "rare disease or condition" means any disease or condition:

1. That affects fewer than 200,000 persons in the United States and is chronic, serious, life-altering or life-threatening;
2. That affects more than 200,000 persons in the United States and a drug for treatment has been designated as a drug for a rare disease or condition pursuant to United States Code, title 21, section 360bb;
3. That is labeled as a rare disease or condition on the Genetic and Rare Diseases Information Center list created by the National Institutes of Health; or

4. For which a member:

    a. Has received two or more clinical consultations from a primary care provider or specialty provider that are specific to the presenting complaint;

    b. Has documentation in the member's medical record of a developmental delay through standardized assessment, developmental regression, failure to thrive or progressive multisystemic involvement; and

    c. Had laboratory or clinical testing that failed to provide a definitive diagnosis or resulted in conflicting diagnoses.

A rare disease or condition does not include an infectious disease that has widely available and known protocols for diagnosis and treatment and that is commonly treated in a primary care setting, even if it affects fewer than 200,000 persons in the United States.

Services Provided Outside the State of Minnesota by a Non-network Provider

When you receive services outside the state of Minnesota from a non-network provider, in addition to the copayment, coinsurance and deductible, you will likely need to pay your provider any billed amount above what Medica is required to pay the provider in accordance with Minnesota Statute Section 62Q.451, subd. 5. **These charges are not applied to your deductible or out-of-pocket maximum.**

Transition of Care to a Network Provider

If you meet the requirements in item 4. of the definition of rare disease or condition above but subsequently receive a definitive diagnosis that does not meet the definition of rare disease or condition in item 1., 2. or 3. of the definition, you must notify Medica of that information immediately. Covered services provided by a non-network provider related to the diagnosis will be covered as described in the benefit table for up to 60 additional days, during which you may transfer your care to an in-network provider. After this 60-day period, subsequent services provided by a non-network provider are no longer covered under this section of this certificate.

What to keep in mind

You must obtain prior authorization (approval in advance) from Medica that your disease or condition is a rare disease or condition as defined above before you can receive coverage under this section of the certificate. You may also need to obtain prior authorization for coverage of certain services or supplies. Please see **Prior authorization** in **Before You Access Care** for more information about prior authorization requirements and processes.

You must receive specialty prescription drugs as described in **Prescription Specialty Drugs**.

What's not covered

1. Medication, procedures or treatment, or laboratory or clinical testing, that is not covered under this Contract.
2. Medications received from a retail pharmacy. Coverage for medications received from a retail pharmacy is as described in **Prescription Drugs**.

3. Prescription specialty drugs. Coverage for prescription specialty drugs is as described in **Prescription Specialty Drugs**.

4. A drug, device or medical treatment or procedure that is investigative.

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. This includes the inpatient and outpatient treatment of cleft lip and cleft palate for a dependent child.	Covered at the corresponding in-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit in-network benefit level and surgical services are covered at the surgical services in-network benefit level.	Covered at the corresponding out-of-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit out-of-network benefit level and surgical services are covered at the surgical services out-of-network benefit level.

What's covered

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

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

What to keep in mind

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

After a mastectomy, and subject to applicable member cost-sharing, Medica will cover the following in a manner determined in consultation with the attending physician and member: 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 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. Dental services, including, but not limited to, preventive, major, minor and restorative services, except as described in this section and the **Medical-Related Dental Services** and **Temporomandibular Joint (TMJ) and Craniomandibular Disorder** sections.
4. Services and procedures primarily for cosmetic purposes. However, emergency treatment of complications from cosmetic surgery is covered as described in the **Emergency Room Care** section of this certificate.
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** and **Prescription Specialty Drugs**.

REHABILITATIVE AND HABILITATIVE THERAPIES

Rehabilitative and Habilitative 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	$20/visit. The deductible does not apply.	40% coinsurance after deductible Coverage for physical and occupational therapy is limited to a combined maximum of 20 visits per Contract year. **Please note:** This visit limit does not apply to services for treatment of mental health and/or substance use conditions.
b. Rehabilitative services	$20/visit. The deductible does not apply.	40% coinsurance after deductible Coverage for physical and occupational therapy is limited to a combined maximum of 20 visits per Contract year. **Please note**: This visit limit does not apply to services for treatment of mental health and/or substance use conditions.

Rehabilitative and Habilitative Therapies		
	Your cost if you visit a:	
Benefits	**Network provider:**	**Non-network provider:**
2. Speech therapy services received outside of your home		
a. Habilitative services	$20/visit. The deductible does not apply.	40% coinsurance after deductible Coverage for speech therapy is limited to 20 visits per Contract year. **Please note**: This visit limit does not apply to services for treatment of mental health and/or substance use conditions.
b. Rehabilitative services	$20/visit. The deductible does not apply.	40% coinsurance after deductible Coverage for speech therapy is limited to 20 visits per Contract year. **Please note**: This visit limit does not apply to services for treatment of mental health and/or substance use conditions.
3. Occupational therapy services received outside of your home		
a. Habilitative services	$20/visit. The deductible does not apply.	40% coinsurance after deductible Coverage for physical and occupational therapy is limited to a combined maximum of 20 visits per Contract year. **Please note**: This visit limit does not apply to services for treatment of mental health and/or substance use conditions.

Rehabilitative and Habilitative Therapies		
	Your cost if you visit a:	
Benefits	**Network provider:**	**Non-network provider:**
b. Rehabilitative services	$20/visit. The deductible does not apply.	40% coinsurance after deductible Coverage for physical and occupational therapy is limited to a combined maximum of 20 visits per Contract year. **Please note**: This visit limit does not apply to services for treatment of mental health and/or substance use conditions.

What's covered

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

Therapy services described in this section include coverage for the treatment of autism spectrum disorder.

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

What to keep in mind

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

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

What's not covered

1. Services educational in nature, except as specifically described in the **Behavioral Health – Mental Health and Substance Use, Physician and Professional Services**, **Pregnancy – Maternity Care** and **Preventive Health Services** sections.
2. Vocational and job rehabilitation.

3. Recreational therapy.
4. Self-care or self-help training (non-medical), including, but not limited to, educational therapy, aerobic conditioning, therapeutic exercises, work hardening programs, etc., and all related material and products for these programs.
5. Health club memberships.
6. Voice training.
7. Group physical, speech and occupational therapy.
8. Massage therapy, provided in any setting, even when it is part of a comprehensive treatment plan.

SKILLED NURSING FACILITY

Skilled Nursing Facility			
		Your cost if you visit a:	
	Benefits	Network provider:	Non-network provider:
1.	Daily skilled care or daily skilled rehabilitation services, including room and board, up to 120 days per member per Contract year for in-network and out-of-network services combined **Please note**: This day limit does not apply to services for treatment of mental health and/or substance use conditions	20% coinsurance after deductible	40% coinsurance after deductible
2.	Skilled physical, speech or occupational therapy when room and board is not eligible to be covered	20% coinsurance after deductible	40% coinsurance after deductible
3.	Services received from a physician during an inpatient stay in a skilled nursing facility	20% coinsurance after deductible	40% coinsurance after deductible

What's covered

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

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

What to keep in mind

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

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

What's not covered

1. Custodial care and other non-skilled services.
2. Self-care or self-help training (non-medical), including, but not limited to, educational therapy, aerobic conditioning, therapeutic exercises, work hardening programs, etc., and all related material and products for these programs.
3. Services educational in nature, except as specifically described in the **Behavioral Health – Mental Health and Substance Use**, **Physician and Professional Services**, **Pregnancy – Maternity Care** and **Preventive Health Services** sections.
4. Vocational and job rehabilitation.
5. Recreational therapy.
6. Health club memberships.
7. Voice training.
8. Group physical, speech and occupational therapy.
9. Long-term care. Long-term care includes custodial and non-skilled care, which may be provided in a variety of settings, including but not limited to, assisted living facilities, memory care facilities and retirement homes.
10. Charges to hold a bed during a skilled nursing facility absence due to hospitalization or any other reason.

SLEEP STUDIES

Sleep Studies		
	Your cost if you visit a:	
Benefits	**Network provider:**	**Non-network provider:**
1. Sleep studies:		
a. Conducted at home; and	$100/study. The deductible does not apply.	40% coinsurance after deductible
b. Professional services received for sleep studies conducted at home.	Nothing. The deductible does not apply.	40% coinsurance after deductible
Please note: This benefit includes two separate services. You may have a cost for each service.		
2. Sleep studies:		
a. Conducted at a facility; and	20% coinsurance after deductible	40% coinsurance after deductible
b. Professional services received for sleep studies conducted at a facility.	20% coinsurance after deductible	40% coinsurance after deductible
Please note: This benefit includes two separate services. You may have a cost for each service.		

What to keep in mind

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

TELEHEALTH SERVICES

Telehealth Services		
	Your cost if you visit a:	
Benefits	Network provider:	Non-network provider:
1. Health services delivered by means of telehealth	Covered at the corresponding in-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit in-network benefit level, inpatient services are covered at the inpatient services in-network benefit level and behavioral health services are covered at the corresponding behavioral health services in-network benefit level.	Covered at the corresponding out-of-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit out-of-network benefit level, inpatient services are covered at the inpatient services out-of-network benefit level and behavioral health services are covered at the corresponding behavioral health services out-of-network benefit level.

What to keep in mind

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

While telemonitoring services are not part of the telehealth benefit, telemonitoring is a covered service when:

1. The telemonitoring service is medically appropriate based on your medical condition or status;
2. You are cognitively and physically capable of operating the monitoring device or equipment, or you have a caregiver who is willing and able to assist with the monitoring device or equipment; and
3. You reside in a setting that is suitable for telemonitoring and not in a setting that has health care staff on site.

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's covered

Medica covers the surgical and non-surgical treatment of a diagnosed temporomandibular joint (TMJ) disorder. Services must be received from (or under the direction of) physicians or dentists. Coverage for treatment of TMJ disorder includes coverage for the treatment of craniomandibular disorder. TMJ disorder is covered the same as any other joint disorder as described in this certificate.

What to keep in mind

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

TRANSPLANT SERVICES

Transplant Services			
		Your cost if you visit a:	
	Benefits	**Network provider:**	**Non-network provider:**
1.	Solid organ and blood and marrow transplant services **Prior authorization is required for all transplant services; this prior authorization must be obtained before the transplant workup is initiated.**	Covered at the corresponding in-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit in-network benefit level and surgical services are covered at the surgical services in-network benefit level.	No coverage
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. Airfare is reimbursable only if the travel distance from your home to the designated transplant facility is 200 miles or more.		Reimbursement of transportation and lodging expenses for out-of-network transplant services is not provided.

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

What's covered

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

What to keep in mind

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

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

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

- 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 Member Services 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.

There is no coverage for out-of-network transplant services.

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. Living donor transplants that would not be authorized by Medica under the medical criteria referenced in this section.
3. Services required to meet the patient selection criteria for the authorized transplant procedure. This includes services and related expenses for weight loss programs, nutritional supplements, appetite suppressants and supplies of a similar nature not otherwise covered under this certificate.
4. 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.
5. Transplants and related services that are investigative.
6. Private collection and storage of umbilical cord blood for directed use.

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** and **Prescription Specialty Drugs**.

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	20% coinsurance after deductible	40% coinsurance after deductible
2.	X-rays and other imaging services received during an outpatient hospital or ambulatory surgical center visit **Please note:** For these services received during an emergency room visit, see **Emergency Room Care** in this section.	20% coinsurance after deductible	40% coinsurance after deductible
3.	X-rays and other imaging services received in an inpatient setting	20% coinsurance after deductible	40% coinsurance after deductible
4.	MRI, CT and PET CT scans **Please note:** Some types of scans may require prior authorization.	20% coinsurance after deductible	40% 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 Member Services at one of the telephone numbers listed at the front of this certificate. Please see **Prior authorization** in **Before You Access Care** for more information about prior authorization requirements and processes.

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

What's Not Covered

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

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

1. Services that are not medically necessary. This includes but is not limited to services inconsistent with the medical standards and accepted practice parameters of the community and services inappropriate—in terms of type, frequency, level, setting and duration—to the diagnosis or condition.
2. Services or drugs used to treat conditions that are cosmetic in nature, unless otherwise determined to be reconstructive. However, emergency treatment of complications from cosmetic surgery is covered as described in the **Emergency Room Care** section of this certificate.
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. Hearing aids that are available over-the-counter.
6. A drug, device or medical treatment or procedure that is investigative.
7. Services or supplies not directly related to your care.
8. Autopsies, except as described under **Examination of a member** in the **Additional Terms of Your Coverage** section.
9. 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.
10. Nutritional and electrolyte substances, except as specifically described in **Durable Medical Equipment, Orthotics, Prosthetics and Medical Supplies** in **What's Covered and How Much Will I Pay**.
11. Chiropractic services when there is no reasonable expectation that the condition will improve over a predictable period of time.
12. Reversal of voluntary sterilization.
13. Personal comfort or convenience items or services.
14. Custodial care, unskilled nursing or unskilled rehabilitation services.

15. Respite or rest care, except as otherwise covered in **Hospice Services** in **What's Covered and How Much Will I Pay**.
16. Travel, transportation or living expenses, except as described in **Transplant Services** in **What's Covered and How Much Will I Pay**. For information about ambulance services, see **Ambulance** in **What's Covered and How Much Will I Pay**.
17. Household equipment, fixtures, home modifications and vehicle modifications.
18. Charges billed that are not in compliance with generally accepted coding, billing and reimbursement guidelines, including those of the American Medical Association (AMA), the Centers for Medicare and Medicaid Services (CMS) and the community.
19. Massage therapy, provided in any setting, even when it is part of a comprehensive treatment plan.
20. Routine foot care, except as medically necessary for members who are at risk for developing foot disorders secondary to systemic disease or another medical condition. Such care must be performed by a licensed provider acting within the scope of their license to be eligible for coverage.
21. Services by persons who are family members or who share your legal residence.
22. Claims for benefits to the extent such claims have been paid under workers' compensation, employer liability or any similar law, auto insurance or any other coverage or plan that is required to pay before this plan pays. In other words, Medica will not make duplicate payment on claims that have been paid previously by another payer.
23. Services received before coverage under the Contract becomes effective.
24. Services received after coverage under the Contract ends.
25. Unless requested by Medica, charges for duplicating and obtaining medical records from non-network providers and non-network dentists.
26. Occlusal adjustment or occlusal equilibration. This exclusion does not apply to the surgical and non-surgical treatment of temporomandibular joint (TMJ) disorder.
27. Dental implants (tooth replacement), except as described in **Medical-Related Dental Services** in **What's Covered and How Much Will I Pay**.
28. Dental prostheses, except as covered in the **Medical-Related Dental Services** and the **Reconstructive and Restorative Surgery** sections.
29. 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.
30. Treatment for bruxism.
31. Services prohibited by applicable law or regulation in the jurisdiction in which they are received. If you have questions regarding how this exclusion applies to your benefits, please call Member Services at one of the telephone numbers listed at the front of this certificate.

32. 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). This exclusion does not apply if you are a civilian.
33. Exams, other evaluations or other services received solely for the purpose of employment, insurance or licensure.
34. 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.
35. Self-care or self-help training (non-medical), including, but not limited to, educational therapy, aerobic conditioning, therapeutic exercises, work hardening programs, etc., and all related material and products for these programs.
36. Educational classes, programs or seminars, including but not limited to childbirth classes. However, diabetes self-management training and education is covered as described in **Physician and Professional Services** in **What's Covered and How Much Will I Pay** and a home health care visit following delivery is covered as described in **Pregnancy – Maternity Care** in **What's Covered and How Much Will I Pay**.
37. Services primarily educational in nature, except as specifically set forth in this certificate.
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. Orthognathic surgery for cosmetic purposes. However, emergency treatment of complications from cosmetic surgery is covered as described in the **Emergency Room Care** section of this certificate.
41. 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**.
42. Health care professional services for home labor and delivery.
43. Bariatric surgery, including initial procedures, surgical revisions and subsequent procedures.
44. Services for fertility treatment.
45. Fertility treatment drugs.
46. Assisted reproductive technology services, including but not limited to: in vitro fertilization (IVF); gamete intrafallopian transfer (GIFT); zygote intrafallopian transfer (ZIFT); tubal embryo transfer; intracytoplasmic sperm injection (ICSI); ova or embryo acquisition, retrieval, donation, preservation and/or storage; and/or any conception that occurs outside the woman's body.
47. Services for or related to donation, preservation and/or storage of sperm, ova, embryos, stem cells and any other human tissue.

48. Services for intrauterine insemination (IUI).
49. Services related to surrogate pregnancy for a person not covered as a member under the Contract.
50. Sperm banking and/or storage.
51. Donor sperm.
52. Donor eggs.
53. Services related to adoption.
54. Any form, mixture or preparation of cannabis for medical or therapeutic use and any device or supplies related to its administration.
55. Appetite suppressants.
56. Weight loss medications.
57. Services solely for the treatment of snoring.
58. Interpreter services, except as described for ventilator-dependent patients in **Home Health Care** in **What's Covered and How Much Will I Pay**.
59. Services for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.
60. Extended hours home care, except as described in **Home Health Care** in **What's Covered and How Much Will I Pay** for members who have Medica coverage and are also enrolled in the Medical Assistance Program.
61. Services for private duty nursing. Examples of private duty nursing services include, but are not limited to, skilled or unskilled services provided by an independent nurse who is ordered by the member or the member's representative and not under the direction of a physician.
62. Laboratory testing (including genetic testing) that has been performed in response to direct-to-consumer marketing and not under the direction of a physician.
63. Medical devices that have not been approved by the U.S. Food and Drug Administration (FDA), other than those granted a humanitarian device exemption.
64. Drugs, supplies, biologics and biosimilars that have not been approved by the U.S. Food and Drug Administration (FDA).
65. 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.
66. Health club memberships.

67. Long-term care. Long-term care includes custodial and non-skilled care, which may be provided in a variety of settings, including but not limited to, assisted living facilities, memory care facilities and retirement homes.

68. Expenses associated with participation in weight loss programs, including but not limited to membership fees and the purchase of food, dietary supplements or publications.

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

70. Animals and any service or treatment related to animals.

71. Charges incurred if you fail to keep a scheduled visit.

72. Conversion therapy, which is any practice by a mental health practitioner or mental health professional that seeks to change a person's sexual orientation or gender identity, including efforts to change behaviors or gender expressions or to eliminate or reduce sexual or romantic attractions or feelings toward people regardless of gender. Conversion therapy does not include counseling that provides assistance to a person undergoing gender transition. It also does not include counseling that provides acceptance, support and understanding of a person or facilitates a person's coping, social support and identity exploration and development, including sexual-orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, as long as the counseling does not seek to change the person's sexual orientation or gender identity.

73. Computer software, whether downloaded, on a server or personal computer, web-based or as a mobile application ("App"), including any subscription fees related to the implementation, administration, monitoring or usage of such Apps.

74. Sales tax.

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 Member Services at one of the telephone numbers listed at the front of this certificate.

Coordination for Medicare-eligible individuals

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

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

When coordination of benefits applies

1. This coordination of benefits (COB) provision applies to this plan when an employee or the employee's covered dependent has health care coverage under more than one plan. “Plan” and “this plan” are defined below.
2. 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 Contract 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 members 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 member does not comply with the plan provisions, the amount of such reduction will not be considered an allowable expense. Examples of such provisions are those related to second surgical opinions and preferred provider arrangements.

5. "*Claim determination period*" means a Contract 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, member or subscriber (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*. You should submit claims incurred as a result of a work-related sickness or injury to the employer for workers' compensation coverage, before submitting them to Medica.

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

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, member or subscriber 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.

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

Facility of payment

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

Right of recovery

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

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

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

Please note: See **Medica's Right to Subrogation and Reimbursement** for additional information.

Medica's Right to Subrogation and Reimbursement

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

1. Medica has a right of subrogation against any third party, individual, corporation, insurer or other entity or person who may be legally responsible for payment of medical expenses related to your illness or injury. Medica's right of subrogation shall be governed according to this section and state and federal law. Medica's right to recover its subrogation interest applies only after you have received a full recovery from another source of compensation for your illness or injury. In this regard, full recovery does not include benefits paid by Medica or another health benefit plan to you or for your benefit. Subject to the full recovery requirement, Medica may collect its subrogation interest from the proceeds of any payment of medical expenses recovered by you, your legal representative or the legal representative(s) of your estate or next-of-kin.
2. Medica may take action to preserve its legal rights to subrogation. This includes bringing suit in your name.
3. Medica's subrogation interest is the reasonable cash value of any benefits received by you.
4. Medica's right to recover its subrogation interest may be subject to an obligation by Medica to pay from any recovery a pro rata share of your disbursements, attorney fees and costs and other expenses incurred in obtaining a recovery from another source unless Medica is separately represented by an attorney. If Medica is represented by an attorney, an agreement regarding allocation may be reached. If an agreement cannot be reached, the matter must be submitted to binding arbitration.
5. By accepting coverage under the Contract, you agree:
    a. To provide prompt written notice to Medica when you make a claim against a party for injuries.
    b. That if Medica pays benefits for medical expenses you incur as a result of any act by a third party for which the third party is or may be legally responsible and you later obtain full recovery, you are obligated to reimburse Medica for the benefits paid in accordance to Minnesota law.

Harmful Use of Medical Services

If Medica determines that you are receiving health services or prescription drugs in a quantity or manner that may harm your health, Medica may restrict your benefits to services provided by or arranged through one specific network physician, one specific network pharmacy and, in certain situations, one specific network hospital (your “coordinating health care providers”). Medica will choose your coordinating health care providers or determine if you may choose your own coordinating health care providers. Your benefits are restricted to services provided by or arranged through your coordinating health care providers. If you are subject to this section, Medica may deny claims for health services or prescription drugs you receive from a non-coordinating health care provider if such services and prescription drugs are harmful to your health.

If you have questions about how this provision applies to you, including the specific physician, pharmacy or hospital assigned for you, call Member Services at one of the telephone numbers listed at the front of this certificate. Additionally, you have the right to appeal Medica’s decision concerning the application of this section. See **How Do I File a Complaint** for more information on your appeal rights.

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 Member Services at one of the telephone numbers listed at the front of this certificate.

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

Claims for benefits from non-network providers

Claim forms are provided in the Document Center at **Medica.com/SignIn**. You may also request claim forms by calling Member Services at one of the telephone numbers listed at the front of this certificate. You should retain copies of all claim forms and correspondence for your records.

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

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

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

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

Medica will notify you of authorization or denial of the claim within 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, Medica will pay you directly.

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

Time limits

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

How Do I File a Complaint

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

You may call Member Services at one of the telephone numbers listed at the front of this certificate or by writing to the address below in **First level of review**.

You may also contact the Commissioner of Commerce, Minnesota Department of Commerce, at **651-539-1600** or **1-800-657-3602**. You may submit a complaint with the Minnesota Department of Commerce through their online portal at https://mn.gov/commerce/consumer/file-a-complaint/ or by emailing the complaint to consumer.protection@state.mn.us.

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

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

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

At any time during the complaint process, you have a right to submit any information or testimony that you want Medica to consider and to review any information that Medica relied on in making its decision.

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

First level of review

You may direct any question or complaint to Member Services by calling one of the telephone numbers listed at the front of this certificate or by writing to the address listed below.

1. Complaints that do not involve a medical necessity review by Medica:
    a. For an oral complaint, if Medica does not communicate a decision within 10 calendar days from Medica's receipt of the complaint or if you determine that Medica's decision is partially or wholly adverse to you, Medica will provide you with a complaint form to submit your complaint in writing. Mail the completed form to:

        Medica Member Services
        Route 0501
        P.O. Box 9310
        Minneapolis, MN 55440-9310

Medica will provide written notice of its first level of review decision to you within 30 days from the initial receipt of your complaint.

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

c. If Medica's first level of review decision upholds the initial decision made by Medica, you have a right to request a second level review. The second level of review, as described below, must be exhausted before you have the right to submit a request for external review.

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

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

b. Medica shall conduct a review of the documentation by a physician who did not make the adverse determination. Medica will provide written notice of its first level of review decision to you and your attending provider within 15 days from receipt of your complaint. If Medica cannot provide its determination within 15 days, Medica may take an additional 4 days and will notify you of the extension and the reason relating to it.

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

d. If Medica's first level of review decision upholds the initial decision made by Medica, you have a right to request a second level of review or submit a written request for external review as described in this section. The second level of review is optional and you may submit a request for external review without exhausting the second level of review.

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

Second level of review

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

1. Your request can be oral or in writing. It must be provided to Medica within one year following the date of Medica's first level review decision. If your request is in writing, it must be sent to the address listed above in **First level of review**.
2. Regardless of the method chosen for review (hearing or a written reconsideration), testimony, explanation or other information provided by you, Medica staff, providers and others is reviewed. The person who recommends resolution of the second level review decision will not be the same person who made the first level review decision.
3. Medica will provide written notice of its second level of review decision to you within:
    a. 30 calendar days from receipt of written notice of your appeal for required second level of review regardless of the method chosen for review (hearing or a written reconsideration); or
    b. 45 calendar days from receipt of written notice of your appeal for optional second level of review (if reviewed by hearing) or 30 calendar days from receipt of written notice of your appeal for optional second level of review (if reviewed by written reconsideration).
4. If your request involves Medica's decision to reduce or terminate an ongoing course of treatment that Medica previously approved, the treatment will be covered pending the outcome of this second level review process.

For some complaints, the second level of review must be exhausted before you have the right to submit a request for external review. For other complaints, this second level of review is optional before you may submit a request for external review. Generally, a second level of review is optional if the complaint requires a medical necessity review. Medica will inform you in writing whether the second level of review is optional or required.

External review

If you consider Medica's decision to be partially or wholly adverse to you, you may submit a written request for external review of Medica's decision to the Commissioner of Commerce. You may use the External Review Appeal Form for your request. This form can be found at **https://mn.gov/commerce-stat/pdfs/external-review-appeal.pdf**. Either email the request to **consumer.protection@state.mn.us** or mail it to:

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

You must submit your written request for external review within six months from the date of Medica's decision. An independent review organization contracted with the State Commissioner of Administration will review your request. You may submit additional information that you want the review organization to consider. You will be notified of the review organization's decision within 45 days. The external review decision will not be binding on you but will be binding on Medica. Medica may seek judicial review on grounds that the decision

was arbitrary and capricious or involved an abuse of discretion. Contact the Commissioner of Commerce for more information about the external review process.

Under most circumstances, you must complete all required levels of review, described above, before you proceed to external review. You may proceed to external review without completing the required levels of review if Medica agrees that you may do so, or if Medica fails to substantially comply with the complaint and review process described in this section, including meeting any required deadlines. For complaints that involve a medical necessity review, you may request an expedited external review at the same time you request an expedited first level of review. You may also request an expedited external review if Medica's decision involves a medical condition for which the standard external review time would seriously jeopardize your life, health or ability to regain maximum function or if Medica's decision concerns an admission, availability of care, continued stay or health care service for which you received emergency services and you have not been discharged from a facility. If an expedited review is requested and approved, a decision will be provided within 72 hours.

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

Complaints regarding fraudulent marketing practices or agent misrepresentation cannot be submitted for external review. If you have a complaint regarding fraudulent marketing practices or agent misrepresentation, you may contact the Commissioner of Commerce at the Minnesota Department of Commerce.

Civil action

If you are dissatisfied with Medica's first or second level review decision or the external review decision, you have the right to file a civil action under Section 502(a) of the Employee Retirement Income Security Act (ERISA). No civil action for benefits may be brought more than three years after the time a claim for benefits is required to have been submitted under this certificate.

Who's Eligible for Coverage and How Do They Enroll

This section describes who can enroll and how to enroll.

Who can enroll

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

If you are a new employee of the employer and you meet all applicable eligibility requirements, you may have an enrollment right as described below in the initial or special enrollment sections.

How to enroll

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

1. During the initial enrollment period as described in this section under **Initial enrollment and effective date of coverage**; or
2. During the open enrollment period as described in this section under **Open enrollment and effective date of coverage**; or
3. During a special enrollment period as described in this section under **Special enrollment and effective date of coverage**; or
4. At any other time for consideration as a late entrant as described in this section under **Late enrollment and effective date of coverage**.

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

Notification

You must notify the employer in writing within 30 days of the effective date of any changes to your address or name, addition or deletion of dependents, a dependent child or eligible grandchild reaching the dependent limiting age or other facts identifying you or your dependents. (For dependent children, including eligible grandchildren, the notification period is not limited to 30 days for newborns or children newly adopted or newly placed for adoption; however, we encourage you to enroll your new dependent under the Contract within 30 days from the date of birth, date of placement for adoption or date of adoption.) Your newborn child, your newly adopted child, a child newly placed for adoption with the subscriber, a child newly placed as a foster child, a newly eligible grandchild and any child who is a member pursuant to a QMCSO will be covered without application of health screening or waiting periods.

The employer must notify Medica, as set forth in the Contract, of your initial enrollment application, changes to your name or address or changes to enrollment, including if you or your dependents are no longer eligible for coverage.

Initial enrollment and effective date of coverage

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

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

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

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

Open enrollment and effective date of coverage

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

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

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

Special enrollment and effective date of coverage

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

1. Loss of other coverage

    a. A special enrollment period will apply to an eligible employee and dependent if the individual was covered under Medicaid or a State Children's Health Insurance Plan (SCHIP) and lost that coverage as a result of loss of eligibility. The eligible employee

or dependent must present evidence of the loss of coverage and request enrollment within 60 days after the date such coverage terminates.

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

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

The eligible employee or dependent must present either evidence of the loss of prior coverage due to loss of eligibility for that coverage or evidence that employer contributions toward the prior coverage have terminated and request enrollment in writing within 30 days of the date of the loss of coverage or the date the employer's contribution toward that coverage terminates.

For purposes of 1.b.:

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

ii. Loss of eligibility includes:

- loss of eligibility as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment;
- cessation of dependent status;
- for dependents, the eligible employee's enrollment for benefits under Medicare;
- if the prior coverage was offered through an individual health maintenance organization (HMO), a loss of coverage because the eligible employee or dependent no longer resides or works in the HMO's service area;
- if the prior coverage was offered through a group HMO, a loss of coverage because the eligible employee or dependent no longer resides or works in the HMO's service area and no other coverage option is available; and
- the prior coverage no longer offers any benefits to the class of similarly situated individuals that includes the eligible employee or dependent.

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

iv. Loss of eligibility does not include a loss due to failure of the eligible employee or dependent to pay premiums on a timely basis, situations allowing for a rescission of coverage or voluntary termination of coverage.

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

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

The eligible employee or dependent must present evidence that the eligible employee or dependent has exhausted such COBRA or state continuation coverage and has not lost such coverage due to failure of the eligible employee or dependent to pay premiums on a timely basis or for cause, and request enrollment in writing within 30 days of the date of the exhaustion of coverage.

For purposes of 1.c.:

i. Exhaustion of COBRA or state continuation coverage includes:

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

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

In the case of the eligible employee's exhaustion of COBRA or state continuation coverage, the special enrollment period described above applies to the eligible employee and all of his or her dependents. In the case of a dependent's exhaustion of COBRA or state continuation coverage, the special enrollment period described above applies only to the dependent who has lost coverage and the eligible employee.

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

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

3. The dependent is a new dependent child of the subscriber or eligible employee, provided enrollment is requested in writing within 30 days of the subscriber or eligible employee acquiring the dependent (for dependent children, the notification period is not limited to 30 days for newborns or children newly adopted or newly placed for adoption) and provided the eligible employee also enrolls during this special enrollment period. In the case of birth, coverage is effective on the date of birth; in the case of adoption, placement for adoption or placement as a foster child, coverage is effective the date of adoption or placement. In all other cases, coverage is effective the date the subscriber acquires the dependent child.

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

   a. That spouse is eligible for coverage; and

   b. Is not already enrolled under the Contract; and

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

   d. The eligible employee also enrolls during this special enrollment period.

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

5. The dependents are eligible dependent children of the subscriber or eligible employee and enrollment is requested in writing within 30 days of a dependent, as described in 2. or 3. above, becoming eligible to enroll under the coverage provided the eligible employee also enrolls during this special enrollment period. Coverage is effective on the date coverage for the dependent is effective, as set forth in 2. or 3. above (as applicable).

6. When the employer provides Medica with notice of a QMCSO and a copy of the order, as described in this section, Medica will provide the eligible dependent child with a special enrollment period provided the eligible employee also enrolls during this special enrollment period. Coverage is effective on the first day of the first calendar month following the date the completed request for enrollment is received by Medica.

7. When the eligible employee or dependent becomes eligible for group health plan premium assistance provided by Medicaid or a State Children’s Health Insurance Plan, the eligible 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 eligible employee becoming eligible for premium assistance, this special enrollment period applies to the eligible 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 eligible employee. Coverage is effective on the first day of the first calendar month following the date on which the request for enrollment is received by Medica.

Late enrollment and effective date of coverage

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

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

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

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

Qualified Medical Child Support Order (QMCSO)

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

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

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

- Where a QMCSO requires coverage be provided under the Contract for an eligible employee's dependent child who is already a member, such child will continue to be provided coverage under the Contract pursuant to the terms of the QMCSO.

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

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

When your coverage ends

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

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

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

Time limits on the effect of misstatements

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

7. The end of the month following the date you enter active military duty for more than 31 days. Upon completion of active military duty, contact the employer for reinstatement of coverage.
8. The date of the death of the member. In the event of the subscriber's death, coverage for the subscriber's dependents will terminate the end of the month in which the subscriber's death occurred. Dependents' continuation rights are as stated at the end of this section.
9. For a spouse, the end of the month following the date of divorce, unless the continuation rights described in this certificate are exercised.
10. For a dependent child, the end of the month in which the child is no longer eligible as a dependent, unless the continuation rights described in this certificate are exercised. Medica will provide written notice to a subscriber who has dependent child coverage that coverage ends when the child reaches the age of 26. This notice will be sent 60 days before the child reaches the age of 26.
11. For a child who is entitled to coverage through a QMCSO, the end of the month in which the earliest of the following occurs:
    a. The QMCSO ceases to be effective; or
    b. The child is no longer a child as that term is used in ERISA; or
    c. The child has immediate and comparable coverage under another plan; or
    d. The employee who is ordered by the QMCSO to provide coverage is no longer eligible as determined by the employer; or
    e. The employer terminates family or dependent coverage; or
    f. The Contract is terminated by the employer or Medica; or
    g. The relevant premium or contribution toward the premium is last paid.

Continuing your coverage

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

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

You may have other options available to you when you lose group health coverage. You and your family may have coverage options through the Marketplace, Medicaid or other group health plan coverage options (such as a spouse's plan). Some of these options may cost less than continuation coverage. For example, you may be eligible to buy an individual or family plan through the Marketplace. By enrolling in coverage through the Marketplace, 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. You can learn more about many of these options at **Healthcare.gov.**

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

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

1. Your right to continue coverage under state law

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

a. Minnesota state continuation coverage.

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

b. Notice of rights.

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

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

Subscriber's loss

The subscriber has the right to continuation of coverage for him or herself and his or her dependents if there is a loss of coverage under the Contract because of the subscriber's voluntary or involuntary termination of employment (for any reason other than gross misconduct) or layoff from employment.

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

Subscriber’s spouse's loss

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

a. Death of the subscriber;

b. A termination of the subscriber’s employment (for any reason other than gross misconduct) or layoff from employment;

c. Dissolution of marriage from the subscriber;

d. The subscriber’s enrollment for benefits under Medicare.

Subscriber’s child's loss

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

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

b. Termination of the subscriber’s employment (for any reason other than gross misconduct) or layoff from employment;

c. The subscriber’s dissolution of marriage from the child's other parent;

d. The subscriber’s enrollment for benefits under Medicare if the subscriber is the parent through whom the child receives coverage;

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

Election rights

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

Consistent with Minnesota law, the subscriber and dependents have 60 days to elect continuation coverage for reasons of termination of the subscriber’s employment or the subscriber’s layoff from employment measured from the later of:

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

b. The date notice of election rights is received.

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

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

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

Type of coverage and cost

If continuation coverage is elected, the subscriber's employer is required to provide coverage that, as of the time coverage is being provided, is identical to the coverage provided under the Contract to similarly situated employees or employees' dependents.

Under Minnesota law, a person continuing coverage may have to make a monthly payment to the employer of all or part of the premium for continuation coverage. The amount charged cannot exceed 102 percent of the cost of the coverage.

Surviving dependents of a deceased subscriber have 90 days after notice of the requirement to pay continuation premiums to make the first payment.

Duration

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

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

   i. 18 months after the date of the termination of or layoff from employment;

   ii. The date the subscriber becomes covered 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

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

b. For instances where the subscriber's spouse or dependent children lose coverage because of the subscriber's enrollment under Medicare, coverage may be continued until the earliest of:

   i. 36 months after continuation was elected;

   ii. The date coverage is obtained under another group health plan; or

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

c. For instances where dependent children lose coverage as a result of loss of dependent eligibility, coverage may be continued until the earliest of:

   i. 36 months after continuation was elected;

   ii. The date coverage is obtained under another group health plan; or

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

d. For instances of dissolution of marriage from the subscriber, coverage of the subscriber's spouse and dependent children may be continued until the earliest of:

   i. The date the former spouse becomes covered under another group health plan; or

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

   If dissolution of marriage occurs during the period of time when the subscriber's spouse is continuing coverage due to the subscriber's termination of or layoff from employment, coverage of the subscriber's spouse may be continued until the earlier of:

   i. The date the former spouse becomes covered under another group health plan; or

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

e. Upon the death of the subscriber, the coverage of a subscriber's spouse or dependent children may be continued until the earlier of:

   i. The date the surviving spouse and dependent children become covered under another group health plan; or

   ii. The date coverage would have terminated under the Contract had the subscriber lived.

Extension of benefits for total disability of the subscriber

Coverage may be extended for a subscriber and his or her dependents in instances where the subscriber is absent from work due to total disability, as defined in **Definitions**. If the subscriber is required to pay all or part of the premium for the extension of coverage, payment shall be made to the employer. The amount charged cannot exceed 100 percent of the cost of the coverage.

2. Your right to continue coverage under federal law

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

General COBRA information

COBRA generally requires employers with 20 or more employees to offer subscribers and their families (spouse and/or dependent children) the opportunity to pay for a temporary extension of health coverage (called continuation coverage) at group rates in certain instances where health coverage under employer sponsored group health plan(s) would otherwise end.

This 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 covered dependent child of a covered employee. (A child placed for adoption with or born to an employee or former employee receiving COBRA continuation coverage is also a qualified beneficiary.)

Subscriber's loss

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

Subscriber's spouse's loss

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

a. Death of the subscriber;

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

c. Divorce or legal separation from the subscriber; or

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

Subscriber's child's loss

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

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

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

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

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

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

Responsibility to inform

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

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

Bankruptcy

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

Election rights

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

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

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

b. The date notice of election rights is received.

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

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

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

Type of coverage and cost

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

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

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

Duration of COBRA coverage

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

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

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

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

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

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

c. Coverage is obtained under another group health plan (as an employee or otherwise) that does not contain any exclusion or limitation with respect to any applicable pre-existing condition; or

d. The subscriber becomes entitled to (actually covered under) Medicare.

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

USERRA continuation coverage

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

General USERRA information

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

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

Employee's loss

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

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

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

Election rights

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

Type of coverage and cost

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

Duration of USERRA coverage

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

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

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

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

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

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

e. The employee returns to work and is reinstated under the Contract as an active employee.

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

COBRA and USERRA coverage are concurrent

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

How Providers are Paid

Network providers

Network providers are paid using various types of contractual arrangements, which are intended to promote the delivery of health care in a cost efficient and effective manner. These arrangements are not intended to affect your access to health care. These payment methods may include: 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 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 members. Such arrangements may involve claims withhold and gain-sharing or risk-sharing arrangements between Medica and such providers. Amounts paid or returned under these arrangements are not considered when determining the amounts you must pay for health services under this certificate.

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 Contract.

This plan

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

MINNESOTA LAW REGULATES THIS CERTIFICATE.

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

Examination of a member

During the pendency of a claim for benefits under the Contract, Medica may require that you be examined or an autopsy of the member's body be performed. The examination or autopsy will be at Medica's expense.

Clerical error

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

Relationship between parties

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

Assignment

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

Notice

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

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

Entire agreement

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

Amendment

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

Discretionary authority

Medica has discretion to interpret and construe all of the terms and conditions of the Contract and make determinations regarding benefits and coverage under the Contract; provided, however, that this provision shall not be construed to specify a standard of review upon which a court may review a claim denial or any other decision made by Medica with respect to a member.

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

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

Definitions

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

Abortion. Any medical treatment intended to induce the termination of a pregnancy with a purpose other than producing a live birth.

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 certificate and any subsequent amendments) approved by Medica as eligible for coverage.

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

Biomarker. A characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacologic responses to a specific therapeutic intervention, including but not limited to known gene-drug interactions for medications being considered for use or already being administered. Biomarkers include but are not limited to gene mutations, characteristics of genes, or protein expression.

Biomarker testing. The analysis of an individual's tissue, blood or other biospecimen for the presence of a biomarker. Biomarker testing includes but is not limited to single-analyst tests; multiplex panel tests; protein expression; and whole exome, whole genome and whole transcriptome sequencing.

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.

Clinical utility. Information that is used to formulate a treatment or monitoring strategy that informs a patient's outcome and impacts the clinical decision. The most appropriate test may include information that is actionable and some information that cannot be immediately used to formulate a clinical decision. For biomarker testing, clinical utility may be demonstrated by medical and scientific evidence, as outlined in Minnesota statute.

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

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

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

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

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

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

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

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

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

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

Complaint. Any grievance against Medica, submitted by you or another person on your behalf, that is not the subject of litigation. Complaints may involve, but are not limited to, the scope of coverage for health care services; retrospective denials or limitations of payment for services; eligibility issues; denials, cancellations or non-renewals of coverage; surprise billing;

administrative operations; and the quality, timeliness and appropriateness of health care services rendered. If the complaint is from an applicant, the complaint must relate to the application. If the complaint is from a former member, the complaint must relate to services received during the time the individual was a member.

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

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

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.

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

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

Drug manufacturer coupons will count toward your coinsurance, copay, deductible and/or out-of-pocket maximum.

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

1. The subscriber's spouse. For these purposes, spouse is defined as any individual who is legally married under the laws of the jurisdiction (foreign or domestic) in which the marriage occurred.
2. The following dependent children up to the dependent limiting age of 26:
    a. The subscriber's or subscriber's spouse's natural or adopted child;

b. A child placed for adoption with the subscriber or subscriber's spouse;

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

d. The subscriber's stepchild;

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

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

For residents of a state other than Minnesota, the dependent limiting age may be higher if required by applicable state law.

3. The subscriber's or subscriber'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 subscriber for support and maintenance. A disabled child may remain covered under the Contract regardless of age and without application of health screening or waiting periods. To continue coverage for a disabled child, you must provide Medica with proof of such disability and dependency within 31 days of the child reaching the dependent limiting age set forth in 2. above. Beginning two years after the child reaches the dependent limiting age, Medica may require annual proof of disability and dependency.

4. The subscriber's or subscriber'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 subscriber or subscriber's spouse for support and maintenance. For coverage of a disabled dependent, you must provide Medica with proof of such disability at the time of the dependent's enrollment. You must also provide Medica with proof of dependency at the time of enrollment.

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

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

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

1. Preserve your life; or

2. Prevent serious impairment to your bodily functions, organs or parts; or

3. Prevent placing your physical or mental health (or, if you are pregnant, the health of your unborn child) in serious jeopardy.

When determining if a situation is an emergency, Medica will consider the presenting symptoms, including, but not limited to, severe pain, to ensure that the decision to reimburse the emergency care is not made solely on the basis of the actual diagnosis.

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

Extended hours home care. The provision of skilled nursing services for greater than two consecutive hours per day provided in the member's home.

Fertility treatment. Treatment or procedure intended to assist conception, undergone as the result of infertility or for any other reason.

Gender affirming health care services. All medical, surgical, counseling or referral services, including telehealth services, that an individual may receive to support and affirm that individual's gender identity or gender expression and that are legal under the laws of the State of Minnesota.

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.

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

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

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

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

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

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

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

Member. A person who is enrolled under the Contract.

Mental health condition (also sometimes referred to as "mental disorder" or "mental illness"). Includes all conditions covered under the plan, except for substance use conditions, that fall under any of the diagnostic categories listed in the mental, behavioral and

neurodevelopmental disorders chapter (or equivalent chapter) of the most current edition of the *International Classification of Diseases (ICD)* or that are listed in the most current version of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*. This definition shall be used to determine "mental health" benefits as set forth in this certificate.

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

1. A 24-hour-per-day, structured setting, inclusive of room and board; and
2. The program administers at least the following basic services:
    - A combination of group, family and individual counseling provided by a clinically or appropriately licensed mental health professional and/or graduate level professional in the process of obtaining licensure working under the oversight of a licensed mental health practitioner;
    - On-site or virtual psychiatric assessment within 48 hours of admission;
    - Psychiatric follow-up visits at least once per week provided by a licensed psychiatric prescriber for mental health treatment;
    - Individual and/or family therapy a minimum of once weekly provided by a licensed mental health professional for mental health treatment;
    - Weekly client education (e.g., mindfulness, reflective journaling);
    - Other services specific to mental health treatment;
    - Adequate nursing coverage for the specific level of care; and
    - A written, specific and person-centered treatment plan with viable discharge planning to support ongoing recovery efforts.

Network. A provider (such as a hospital, physician, home health agency, skilled nursing facility or pharmacy) that has entered into a written agreement with Medica or has made other arrangements with Medica to provide benefits to members of your plan. The network is identified online in your plan's provider directory. The participation status of providers will change from time to time.

The network provider directory will be furnished automatically, without charge and it may be obtained by signing in at **Medica.com/SignIn** or by contacting Member Services.

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

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

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

1. A percentage of the amount Medicare would pay for the service in the location where the service is provided. Medica generally updates its data on the amount Medicare pays

within 30-60 days after the Centers for Medicare and Medicaid Services updates its Medicare data; or

2. A percentage of the provider's billed charge; or
3. A nationwide provider reimbursement database that considers prevailing reimbursement rates and/or marketplace charges for similar services in the geographic area in which the service is provided; or
4. An amount agreed upon between Medica and the non-network provider; or
5. An amount equal to the median of Medica's network contracted rates for the same or similar services in the geographic area in which the service is provided.

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

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

Except in the circumstances subject to the protections described in the **Surprise Billing Protections**, if the amount billed by the non-network provider is greater than the non-network provider reimbursement amount, the non-network provider will likely bill you for the difference. This difference may be substantial, and it is in addition to any copayment, coinsurance or deductible amount you may be responsible for according to the terms described in this certificate. Furthermore, such difference will not be applied toward the out-of-pocket maximum described in **What's Covered and How Much Will I Pay**. Additionally, you will owe these amounts regardless of whether you previously reached your out-of-pocket maximum with amounts paid for other services. As a result, the amount you will be required to pay for services received from a non-network provider will likely be much higher than if you had received services from a network provider.

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

Drug manufacturer coupons will count toward your coinsurance, copay, deductible and/or out-of-pocket maximum.

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

After an applicable out-of-pocket maximum has been met, all other covered benefits received during the rest of the Contract year will be covered at 100 percent, except for any charge not covered by Medica or charge in excess of the non-network provider reimbursement amount or charge you pay in addition to your deductible, copayment or coinsurance when you choose to

use a preferred brand or non-preferred brand prescription drug when a chemically equivalent generic drug is available.

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

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

Pharmacist. Any individual who has a pharmacy degree and is licensed as a pharmacist under state law and is acting within the scope of the pharmacy practice laws.

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

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

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

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

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

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

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

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

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

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

1. Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF);
2. Immunizations for routine use that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) with respect to the member involved (an ACIP recommendation is considered in effect after it has been adopted by the Director of the CDC, and a recommendation is considered to be for routine use if it is listed on the CDC's Immunization Schedules);
3. With respect to members who are infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA);
4. With respect to members who are women, such additional preventive care and screenings not described in 1. as provided for in comprehensive guidelines supported by the HRSA (including Food and Drug Administration approved contraceptive methods, sterilization procedures and related patient education and counseling)

The USPSTF, ACIP and HRSA issue new and updated recommendations and guidelines. New or updated recommendations and guidelines from the USPSTF, ACIP and HRSA are covered as preventive health services starting on the first day of the Contract year that begins one year after the final recommendations and guidelines are issued.

Contact Member Services 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, including a physician assistant, or facility licensed, certified or otherwise qualified under state law to provide health services.

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

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

1. A health plan in which a health carrier has issued a policy, contract or certificate for the coverage of medical and hospital benefits, including blanket accident and sickness insurance other than accident only coverage;

2. Part A or Part B of Medicare;
3. A medical assistance medical care plan as defined under Minnesota law;
4. A general assistance medical care plan as defined under Minnesota law;
5. Minnesota Comprehensive Health Association (MCHA);
6. A self-insured health plan;
7. The MinnesotaCare program as defined under Minnesota law;
8. The public employee insurance plan as defined under Minnesota law;
9. The Minnesota employees insurance plan as defined under Minnesota law;
10. TRICARE or other similar coverage provided under federal law applicable to the armed forces;
11. Coverage provided by a health care network cooperative or by a health provider cooperative;
12. The Federal Employees Health Benefits Plan or other similar coverage provided under federal law applicable to government organizations and employees;
13. A medical care program of the Indian Health Service or of a tribal organization;
14. A health benefit plan under the Peace Corps Act;
15. State Children's Health Insurance Program (SCHIP); or
16. A public health plan similar to any of the above plans established or maintained by a state, the U.S. government, a foreign country or any political subdivision of a state, the U.S. government or a foreign country.

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

1. Coverage only for disability or income protection insurance;
2. Automobile medical payment coverage;
3. Liability insurance or coverage issued as a supplement to liability insurance;
4. Coverage for a specified disease or illness or to provide payments on a per diem, fixed indemnity or non-expense-incurred basis, if offered as independent, non-coordinated coverage;
5. Credit accident and health insurance as defined under Minnesota law;
6. Coverage designed solely to provide dental or vision care;
7. Accident only coverage;
8. Long-term care coverage as defined under Minnesota law;
9. Medicare supplemental health insurance as defined under Minnesota law;
10. Workers' compensation insurance; or

11. Coverage for on-site medical clinics operated by an employer for the benefit of the employer's employees and their dependents, in connection with which the employer does not transfer risk.

Rapid whole genome sequencing. An investigation of the entire human genome, including coding and noncoding regions and mitochondrial deoxyribonucleic acid, to identify disease causing genetic changes that returns the final results in 14 days. It includes patient-only whole genome sequencing and duo and trio whole genome sequencing of the patient and the patient's biological parent or parents.

Reconstructive. Surgery to rebuild or correct a:

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

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

Surgery that is cosmetic is not reconstructive.

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

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

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.

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

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

Subscriber. The person:

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

Substance use condition (also sometimes referred to as "substance use disorder"). Includes all conditions covered under the plan that fall under any of the diagnostic categories listed as a mental or behavioral disorder due to psychoactive substance use (or equivalent category) in the mental, behavioral and neurodevelopmental disorders chapter (or equivalent chapter) of the most current version of the *International Classification of Diseases (ICD)* or that are listed as a Substance-Related and Addictive Disorder (or equivalent category) in the most current version of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*. This definition shall be used to determine "substance use" benefits as set forth in this certificate.

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

1. A 24-hour-per-day, structured setting, inclusive of room and board; and
2. The program administers at least the following basic services:
    - A combination of group, family and individual counseling provided by a clinically or appropriately licensed mental health professional and/or graduate level professional in the process of obtaining licensure working under the oversight of a licensed mental health professional;
    - Completion of a substance use disorder or chemical health assessment;
    - Access to psychiatric services provided by a licensed psychiatric prescriber for mental health treatment as clinically indicated for substance use disorder treatment;
    - Individual and/or family therapy a minimum of once weekly provided by a licensed mental health professional for substance use disorder or mental health treatment;
    - Weekly client education (e.g., mindfulness, reflective journaling, sleep hygiene, anger management or safe sex practices);
    - Other services specific to mental health treatment and/or substance use disorder treatment;
    - Adequate nursing coverage for the specific level of care; and
    - A written, specific and person-centered treatment plan with viable discharge planning to support ongoing recovery efforts.

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

Until July 1, 2027, telehealth includes audio-only communication between a health care provider and a patient if the communication is a scheduled appointment and the standard of care for that particular service can be met through the use of audio-only communications. However, substance use disorder treatment services and mental health care services delivered through telehealth by means of audio-only communication may be covered without a scheduled appointment if the communication was initiated by the patient while in an emergency or crisis

situation and a scheduled appointment was not possible due to the need of an immediate response.

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

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

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

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

Virtual care. Professional evaluation and medical management services provided to patients, in locations such as their home or office, through email, telephone or webcam. Virtual care is used to address non-emergent medical symptoms for members describing new or ongoing symptoms to which providers respond with substantive medical advice. Virtual care does not include telephone calls for reporting normal lab or test results or solely calling in a prescription to a pharmacy.

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

Your Rights and Protections Against Surprise Medical Bills

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

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

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

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

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

Balance billing is prohibited when you receive:

Emergency services

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

Certain services at a network hospital or network health care facility

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

Ending Surprise Air Ambulance Bills

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

External Review

If you believe you have been wrongly billed, you may request an independent review of Medica's decision by an external review organization by contacting Minnesota Department of Commerce at **651-539-1600** or **1-800-657-3602**. For more information about external review, see **How Do I File a Complaint**.

Visit **Cms.gov/nosurprises/consumers** for more information about your rights under federal law.