Medica Solo℠

Minnesota Policy of Coverage

MN-SOLO-PC07-100-01

Medica Solo provides benefits for prenatal care services. Medica Solo does not cover maternity care services which include maternity labor and delivery services, and post partum care services.

Medica Solo $9,300
Non-qualified Plan
Plan Code SYF

MEDICA
CUSTOMER SERVICE

- Minneapolis/St. Paul
  Metro Area:
  (952) 992-1805 or

- Outside the Metro Area:
  1-866-894-8051

- TTY Minneapolis/St. Paul
  Metro Area:
  (952) 992-3650 or

- TTY Outside the Metro Area:
  1-800-234-8819

Table Of Contents

MIC Customer Service iii

Table of Contents iv

Disclosure required by Minnesota law ix

Introduction x
To be eligible for benefits x
Definitions x
Language interpretation xi
Term of this Policy xi
Premiums xi
Grace Period xi
Changes to this Policy xi
Entire Agreement xii
Acceptance of coverage xii
Nondiscrimination policy xii

A. Member Rights And Responsibilities 1
Subscriber bill of rights 1
Subscriber responsibilities 1

B. How To Access Your Benefits 3
Important subscriber information about in-network benefits 3
Important subscriber information about out-of-network benefits 4
Cancellation 5
Prescription drugs and medical equipment 6
Continuity of Care 6
Prior authorization 8
Pre-existing condition limitations 9

C. How Providers Are Paid By MIC 11
Network providers 11
Non-network providers 12

D. Your Out-Of-Pocket Expenses 13
Expenses you must pay 13
Out-of-pocket maximum 14
Lifetime maximum amount 15
Lifetime maximum amount 15
Out-of-pocket expenses 16

E. Professional Services 17
Covered 17
Not covered 18

Office visits 18
Convenient/urgent care center visits 18
Maternity care 18
Preventive health care 19
Routine screening procedures for cancer 20
Allergy shots 20
Refractive eye exams 20
Chiropractic services 20
Professional sign language interpreter services 20
Surgical services 20
Services received from a physician during an emergency room visit 21
Services received from a physician during an inpatient stay 21
Outpatient lab, pathology and x-rays 21
Other outpatient hospital or ambulatory surgical center services 21
Treatment to lighten or remove the coloration of a port wine stain 21
Diabetes self-management training and education 21
NeuropSYFhological evaluations/cognitive testing 22
Vision therapy 22
Eyewear 22

F. Prescription Drugs And Pharmacy Services 23
Prior authorization 25
Covered 25
Prescription unit 26
Not covered 27
Outpatient prescription drugs 28
Emergency prescription drugs 28
Diabetic supplies and equipment 28

G. Specialty Prescription Drug Program 29

H. Hospital Services 34
Covered 34
Not covered 34
Outpatient services 35
Services provided in a hospital observation room 35
Inpatient services 36

I. Ambulance Services 37
Covered 37
Not covered 37
Ambulance services or ambulance transportation 38
Non-emergency licensed ambulance service 38

J. Home Health Care 39
Covered 39
Not covered 40
Intermittent skilled care 41
Skilled physical or speech or occupational therapy 41
Home infusion therapy 41

Services received in your home from a physician ... 41

K. **Outpatient Rehabilitation ... 42**
Covered ... 42
Not covered ... 42
Physical therapy received outside of your home ... 43
Occupational therapy received outside of your home ... 43
Speech therapy received outside of your home ... 43

L. **Mental Health ... 44**
Covered ... 45
Not covered ... 47
Outpatient services ... 48
Inpatient services ... 48

M. **Substance Abuse ... 49**
Covered ... 50
Not covered ... 52
Outpatient services ... 53
Inpatient services ... 53

N. **Durable Medical Equipment And Prosthetics ... 54**
Covered ... 54
Not covered ... 55
Durable medical equipment and certain related supplies ... 55
Repair, replacement or revision of durable medical equipment ... 55
Prosthetics ... 55
Hearing aids ... 56
Eligible ostomy supplies ... 56

O. **Miscellaneous Medical Services And Supplies ... 57**
Covered ... 57
Not covered ... 57
Blood clotting factors ... 58
Dietary medical treatment of PKU ... 58
Total parenteral nutrition ... 58

P. **Organ And Bone Marrow Transplant Services ... 59**
Covered ... 59
Not covered ... 60
Office visits ... 61
Outpatient services ... 61
Inpatient services ... 61
Services received from a physician during an inpatient stay ... 61

Q. **Surgery For Weight Loss ... 63**
Not covered ... 63
Office visits ... 64
Outpatient services ... 64
Inpatient services ... 64

Services received from a physician 64

R. Reconstructive And Restorative Surgery 65
Covered 65
Not covered 66
Office visits 66
Outpatient services 66
Inpatient services 67
Services received from a physician during an inpatient stay 67

S. Skilled Nursing Facility Services 68
Covered 68
Not covered 68
Daily skilled care or daily skilled rehabilitation services 69
Skilled physical or occupational therapy 69
Services received from a physician during an inpatient stay in a skilled nursing facility 70

T. Hospice Services 71
Covered 71
Not covered 72
Hospice services 73

U. Temporomandibular Joint (TMJ) Disorder 74
Covered 74
Not covered 75
Initial office visit for evaluation 75
Office visits 75
Outpatient services 75
Physical therapy received outside of your home 76
Inpatient services 76
Services received from a physician or dentist during an impatient stay 76
TMJ splints and adjustment 76

V. Medical-Related Dental Services 77
Covered 77
Not covered 78
Charges for medical facility and general anesthesia services 78

W. Emergency Services From Non-Network Providers 80
Covered 80
Not covered 80
Emergency services 81
Ambulance service or ambulance transportation 81

X. Referrals To Non-Network Providers 82
What you must do 82
What MIC will do 82

Y. Harmful Use Of Medical Services 84
When this section applies 84

Z. Exclusions **85**

AA. How To Submit A Claim **90**
Claims for benefits from network providers 90
Claims for benefits from non-network providers 90
Claims for emergency services provided outside the U.S 91
Time limits 91

BB. Coordination Of Benefits **92**
Applicability 92
Definitions that apply to this section 92
Order of benefit determination rules 94
Effect on the benefits of this plan 95
Right to receive and release needed information 96
Facility of payment 96
Right of recovery 97

CC. Right Of Recovery **98**

DD. Eligibility And Enrollment **100**
Who can enroll 100
Notification 100
The date your coverage begins 100

EE. Ending Coverage **101**
When coverage ends 101

FF. Complaints **103**
First level of review 103
Second level of review 104
External review 105

GG. General Provisions **106**

HH. Definitions **108**

MEDICA INSURANCE COMPANY (“MIC”)
INDIVIDUAL POLICY
(“Policy”)

Notice: This disclosure is required by Minnesota law. This Policy is expected to return on average 79.5% of your premium dollar for health care coverage.

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

Important Consumer Information

Cancellation Within First Ten Days

The subscriber may cancel this Policy by delivering or mailing a written notice or sending a telegram to:

Medica Insurance Company
401 Carlson Parkway
Attn: Route CP320
Minnetonka, MN 55305-5387

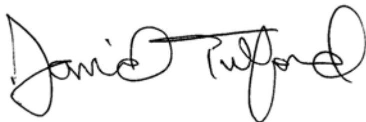
This Policy must be returned before midnight the tenth day after the date you receive this Policy. Notice given by mail and return of this Policy are effective when postmarked, properly addressed, and postage prepaid. MIC shall return all premiums within ten days after it receives notice of cancellation and the returned Policy. However, the subscriber must then pay any claims incurred prior to such cancellation.

Guarantee Renewal

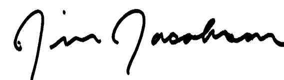
MIC guarantees to renew this Policy as long as the premium is paid on or before the due date or within the grace period. Renewal is subject to MIC’s right to terminate your Policy due to non-payment of premium or for fraud or misrepresentation, or as otherwise described in *Ending Coverage*. MIC has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

Policy

This Policy is a legal contract between the subscriber and Medica Insurance Company (“MIC”) and describes the benefits covered under this Policy. This policy is issued on a subscriber only basis. There is no coverage for spouses, or other dependents, under this policy.



President



Senior Vice President and Assistant Secretary

Introduction

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

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

In this Policy, the words *you*, *your* and *yourself* refer to the member.

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

MIC may arrange for various persons or entities to provide administrative services on its behalf, including claims processing and utilization management services. To ensure efficient administration of your benefits, you must cooperate with them in the performance of their responsibilities.

See Definitions. These words have specific meanings:

- Benefit
- Claim
- Medically necessary
- Member
- Network
- Premium
- Provider

To be eligible for in-network benefits

Each time you receive health services, you must:

1. Confirm with MIC that your provider is a network provider with Medica Solo to be eligible for in-network benefits;
2. Identify yourself as a Medica Solo member; and
3. Present your Medica Solo identification card. (If you do not show your Medica Solo identification card, providers have no way of knowing that you are a Medica Solo member and you may receive a bill for health services or be required to pay at the time you receive health services.) However, possession and use of a Medica Solo identification card does not necessarily guarantee coverage.

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

Definitions

Many words in this Policy have specific meanings. These words are identified in each section and defined in *Definitions* (at the end of this Policy).

Language interpretation

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

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

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

Term of this Policy

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

Premiums

Your premiums must be prepaid at the address set forth below:

Medica Insurance Company
NW7105 P.O. Box 1450
Minneapolis, MN 55485-7105

Grace Period

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

Changes to this Policy

MIC may change this Policy at Policy renewal, or at any time when required by federal or state regulatory agencies. When this happens, you will receive a new Policy or amendment.

MIC may change the benefits, as described above, or MIC may change the premium with 30 days written notice.

Entire Agreement

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

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

Acceptance of coverage

By accepting the health care coverage described in this Policy the subscriber authorizes the use of a social security number for purpose of identification and declares that the information supplied by the subscriber to MIC for purposes of enrollment is accurate and complete.

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

Nondiscrimination policy

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

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

A. *Member Rights And Responsibilities*

Member bill of rights

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

1. Available and accessible services, including emergency services (defined in this Policy) 24 hours a day, seven days a week;
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;
3. Participate with providers in decision-making regarding your health care, including the right to refuse treatment recommended to you by MIC or any provider;
4. Be treated with respect and recognition of your dignity and privacy; including privacy of your medical and financial records maintained by MIC or any network provider in accordance with existing law;
5. Contact MIC and Minnesota's Commissioner of Commerce to file a complaint about issues related to benefits (see Complaints). You may begin a legal proceeding if you have a problem with MIC or any provider;
6. Receive information about MIC, its services, its practitioners and providers, and members' rights and responsibilities.
7. Appeal a decision regarding your health care coverage by calling Customer Service at one of the telephone numbers listed inside the front cover. See *Complaints* for more information on your appeal rights; and
8. Make recommendations regarding MIC's members' rights and responsibilities statement.

See *Definitions*. These words have specific meanings:

- Benefits
- Emergency
- Medically necessary
- Member
- Network
- Provider

To file a complaint with the Minnesota Department of Commerce call (651) 296-2488 or 1-800-657-3602 and request insurance information.

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:

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

1. Establishing a relationship with a network provider before becoming ill, as this allows for continuity of care;
2. Providing the necessary information to health care professionals or MIC needed to determine the appropriate care. This objective is best obtained when you share:
   a. Information about lifestyle practices; and
   b. Personal and family health history;
3. Understanding your health problems and agreeing to, and following, the plans and instructions for care given by those providing health care;
4. Practicing self-care by knowing:
   a. How to recognize common health problems and what to do when they occur;
   b. When and where to seek appropriate help; and
   c. How to prevent health problems from recurring;
5. Practicing preventive health care by:
   a. Having the appropriate tests, exams and immunizations recommended for your gender and age as described in this Policy; and
   b. Engaging in healthy lifestyle choices (such as exercise, proper diet and rest).

B. How To Access Your Benefits

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

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

Benefits

MIC will cover health services and supplies as in-network benefits only if they are provided by network providers or are authorized by MIC. Prior authorization may be required from MIC for certain in-network benefits. This Policy fully defines your benefits and describes procedures you must follow to obtain in-network benefits.

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

Lifetime maximum amount

In-network and out-of-network benefits are subject to a combined lifetime maximum amount payable by MIC. See *Your Out-Of-Pocket Expenses* for a detailed explanation of the lifetime maximum amount.

Referrals

Certain health services are covered only upon referral; read this Policy carefully for referral requirements. All referrals to non-network providers and certain types of network providers must be prior authorized by MIC to be eligible for coverage at your highest level of benefits.

Emergency services

Emergency services from non-network providers will be covered as in-network benefits only if you follow required procedures. This Policy explains these procedures and the covered health services associated with emergency care.

See **Definitions**. These words have specific meanings:

- Benefits
- Claim
- Coinsurance
- Copayment
- Deductible
- Emergency
- Enrollment date
- Hospital
- Inpatient
- Medically necessary
- Member
- Network
- Non-network
- Non-network provider reimbursement amount
- Pre-existing condition
- Premium
- Prescription drug
- Provider
- Qualifying coverage
- Reconstructive
- Restorative
- Skilled nursing facility
- Subscriber

Providers

Enrolling in Medica Solo does not guarantee that a particular provider (in the MIC network provider directory) will remain a network provider or provide you with health services. When a provider no longer participates with MIC, you must choose to receive health services from network providers to continue to be eligible for in-network benefits.

You must verify that your provider is a network provider each time you receive health services.

Exclusions

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

Mental health and Substance abuse

MIC's designated mental health and substance abuse provider will arrange your mental health and substance abuse benefits. MIC's designated mental health and substance abuse provider uses a limited network of hospitals for the provision of mental health and substance abuse benefits.

Except for emergencies:

- All mental health and substance abuse services must be arranged by MIC's designated mental health and substance abuse provider; and
- A treatment plan, including any inpatient services must be prior authorized by MIC's designated mental health and substance abuse provider to be eligible for coverage.

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

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

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

Benefits

MIC pays out-of-network benefits for eligible health services received from non-network providers. Prior authorization may be required from MIC for certain out-of-network benefits. This Policy defines your benefits and describes procedures you must follow to obtain out-of-network benefits. In addition to the benefits described in this Policy, MIC may authorize more efficient methods of providing services.

Emergency services received from (and prior authorized referrals to) non-network providers are covered as in-network benefits and are *not* considered out-of-network benefits (provided you follow proper procedures).

Some benefits are provided only as in-network benefits. Read this Policy for a detailed

Before receiving services from a non-network provider, you should do the following:

- Confirm with the non-network provider what the services will be; and
- Verify with Customer Service the estimated non-network provider reimbursement amount for those services. Refer to *Your Out-Of-Pocket Expenses* for additional information.

explanation of in-network and out-of-network benefits.

Important: **Be aware that if you choose to use out-of-network benefits, you may have to pay more than if you use in-network benefits. The charges billed by your non-network provider may exceed the non-network provider reimbursement amount leaving a balance for you to pay in addition to any applicable copayment, coinsurance and deductible amount. The difference will not be applied to the out-of-pocket maximum amount described in *Your Out-Of-Pocket Expenses*. This means you may have substantial out-of-pocket expense when you use a non-network provider.**

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

Lifetime maximum amount

In-network and out-of-network benefits are subject to a combined lifetime maximum amount payable by MIC. See *Your Out-Of-Pocket Expenses* for a detailed explanation of the lifetime maximum amount.

Exclusions

Some health services, such as transplant services, hospice services and home infusion therapy, are not covered when received from or under the direction of non-network providers. Read this Policy for a detailed explanation of exclusions.

Claims

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

3. Cancellation

Your coverage may be canceled only under certain conditions. This Policy describes all reasons for

cancellation of coverage. See *Ending Coverage* for additional information.

4. Prescription drugs and medical equipment

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

There is an annual prescription drugs and pharmacy services maximum amount payable for benefits for prescription drugs and pharmacy services. This amount is described in the Out-of-Pocket Expenses table in the Your Out-Of-Pocket Expenses section.

5. Continuity of Care

If MIC terminates its contract with your current primary care *provider*, specialist or *hospital* without cause, you may be eligible to continue care with that *provider* at the in-network *benefit* level.

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

i. Upon request, MIC will authorize continuity of care as described above for up to 120 days for the following conditions:
   - an acute condition;
   - a life-threatening mental or physical illness;
   - pregnancy beyond the first trimester of pregnancy;
   - a physical or mental disability defined as an inability to engage in one or more major life activities, provided that the disability has lasted or can be expected to last for at least one year, or can be expected to result in death; or

- a disabling or chronic condition that is in an acute phase.

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

ii. Upon request, MIC will authorize continuity of care as described above for up to 120 days in the following situations:
   - if you are receiving culturally appropriate services and MIC does not have a *network provider* who has special expertise in the delivery of those culturally appropriate services within MIC's time and distance requirements; or
   - if you do not speak English and MIC does not have a *network provider* who can communicate with you, either directly or through an interpreter, within MIC's time and distance requirements.

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

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

If MIC terminates your current *provider's* contract for cause, MIC will inform you of the change and how your care will be transferred to another *network provider*.

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

6. Prior authorization

Prior authorization from MIC may be required before you receive certain services or supplies in order to determine whether a particular service or supply is medically necessary and a benefit.

MIC uses written procedures and criteria when reviewing your request for prior authorization.

Your attending provider, you or someone on your behalf may contact MIC to request prior authorization. Your network provider will contact MIC to request prior authorization for a service or supply. You must contact MIC to request prior authorization for services or supplies received from a non-network provider.

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

- Reconstructive or restorative surgery;
- Treatment of a diagnosed temporomandibular joint disorder or craniomandibular disorder;
- Organ and bone marrow transplant;
- Home health care;
- Medical supplies and durable medical equipment;
- Outpatient surgical procedures;
- Skilled nursing facility services; and
- In-network benefits for services from non-network providers.

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

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

MIC will review your request and provide a response to you and your attending provider within

To determine whether a certain service or supply requires prior authorization, please call Customer Service at one of the telephone numbers listed inside the front cover.

This is not an all-inclusive list of all services and supplies that may require prior authorization. Please call Customer Service at one of the telephone numbers listed inside the front cover to obtain the current list of services which require prior authorization.

If a network provider fails to obtain prior authorization *after* you have consulted with them about services requiring prior authorization, you are not subject to a penalty for failure to obtain prior authorization.

Under certain circumstances, MIC may perform concurrent review to determine whether services continue to be medically necessary. If MIC determines that services are no longer medically necessary, MIC will inform both you and your attending provider in writing of its decision. If MIC does not approve continued coverage, you or your attending provider may appeal MIC's initial decision (see the *Complaints* section).

ten business days after the date your request was received, provided all information reasonably necessary to make a decision has been made available to MIC.

MIC will inform both you and your provider of MIC's decision within 72 hours from the time of the initial request if your attending provider believes that an expedited review is warranted, or MIC concludes that a delay could seriously jeopardize your life, health, or ability to regain maximum function.

If MIC does not approve your request for prior authorization, you have the right to appeal MIC's decision as described in the Section titled Complaints.

7. Pre-existing condition limitations

For in-network and out-of-network benefits, you must pay for services you receive to treat a pre-existing condition.

Prescription drugs from a pharmacy will be considered in determining whether you have a pre-existing condition limitation; however, such prescription drugs (used in this determination) may be a benefit. See *Specialty Prescription Drug Program* for information.

Length of pre-existing condition limitation

The pre-existing condition limitation applies during the first 18 months following your enrollment date.

However, the length of time that a pre-existing condition limitation may be imposed on a member is reduced by the aggregate of certain periods of qualifying coverage applicable to you as of the enrollment date.

A period of qualifying coverage will not be counted if, after such period and before the enrollment date, there was a 63-day period during all of which you were not covered under any qualifying coverage. Time spent in a waiting period will not be considered a break in coverage.

MIC may modify your pre-existing condition limitation period if it ascertains that the initial determination of your prior qualifying coverage was inaccurate. If this occurs, MIC will notify you of the correct pre-existing condition limitation period.

When a pre-existing condition limitation does not apply

No pre-existing condition limitation may be applied to an individual who maintains qualifying coverage (without a break of 63 or more days) for 12 months.

a. A pre-existing condition limitation will *not* apply to the condition of pregnancy.

C. *How Providers Are Paid By MIC*

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

Network providers

See *Definitions*. These words have specific meanings:

- Coinsurance
- Copayment
- Deductible
- Hospital
- Member
- Network
- Non-network
- Physician
- Provider

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

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

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

Fee-for-service payment means that MIC pays the network provider a fee for each service provided. If the payment is per service, the network provider's payment is determined according to a set fee schedule. The amount the network provider receives is the lesser of the fee schedule or what the network provider would have otherwise billed. If the payment is percentage of charges, the network provider's payment is a set percentage of the provider's charge. The amount paid to the network provider, less any applicable copayment or coinsurance or deductible, is considered to be payment in full.

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

Risk-sharing payment means that MIC pays the network provider a specific amount for a particular unit of service, such as an amount per day, an amount per stay, an amount per episode, an amount per case, an amount per period of illness, an amount per member, or an amount per service with targeted outcome. If the amount paid is less than the cost of providing or arranging for a member's health services, the network provider may bear some of the shortfall. If the amount paid to the network provider is more than the cost of

providing or arranging a member's health services, the network provider may keep some of the excess.

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 is based on the non-network provider reimbursement amount and 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 and deductible amount.**

D. *Your Out-Of-Pocket Expenses*

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

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

1. A provider performs, prescribes or recommends the service; or
2. The service is the only treatment available; or
3. You request and receive the service even though your provider does not recommend it. (Your network provider is required to inform you or, in some instances, provide a waiver for you to sign.)

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

- Most in-network benefits are covered at 100% after you pay a deductible amount.
- Most out-of-network benefits are covered at 100% of the non-network provider reimbursement amount after you pay a deductible amount.

See *Definitions.* These words have specific meanings:

- Benefits
- Claim
- Coinsurance
- Copayment
- Deductible
- Medically necessary
- Member
- Network
- Non-network
- Non-network provider reimbursement amount
- Prescription drug
- Provider
- Subscriber

If you miss or cancel an office visit less than 24 hours before your appointment, your provider may bill you for the service.

If you use out-of-network benefits, you may incur costs in addition to your deductible amount. If the amount that your non-network provider bills you is more than the non-network provider reimbursement amount, *you are responsible for paying the difference.* In addition, the difference will not be applied toward the out-of-pocket maximum (described in this section).

Expenses you must pay

For both in-network and out-of-network benefits, you must pay the following:

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

   *You must pay an annual deductible. (See the Out-of-Pocket Expenses table in this section.) However, the deductible does not apply to outpatient prescription drugs (*see Prescription Drugs And Pharmacy Services *and* Specialty Prescription Drug Program*).*
2. Any charge that is not covered under this Policy.

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

1. Any charge that exceeds the non-network provider reimbursement amount. ***This means you are required to pay the difference between what MIC***

pays to the provider and what the provider bills. As a result, you may have substantial out-of-pocket expense when you use a non-network provider.

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

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

Customer Service will provide you with an *estimate* of the non-network provider reimbursement amount based on the information provided at the time of your inquiry. The *actual amount paid* will be based on the information received at the time the claim is submitted and subject to all applicable benefit provisions, exclusions and limitations, including but not limited to your deductible.

2. Any charge that is not covered under this Policy.

Out-of-pocket maximum

The out-of-pocket maximum is an accumulation of in-network and out-of-network copayments, coinsurance and your deductible only. Unless otherwise specified, you will *not* be required to pay more than the out-of-pocket maximum of copayments, coinsurance and/or your deductible, as described in the Out-of-Pocket Expenses table in this section, for benefits received during any calendar year.

Any amount or charge *not* covered, including charges for services not eligible for coverage and any charge in excess of the non-network provider reimbursement amount, is *not* applicable toward the out-of-pocket maximum.

After you satisfy the out-of-pocket maximum, all other *eligible* in-network and out-of-network services received during the rest of the calendar year will be covered at 100%, except for any charge not covered by MIC or charge in excess of the non-network provider reimbursement amount.

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

Annual prescription drugs and pharmacy services maximum amount

The annual prescription drugs and pharmacy services maximum amount payable for benefits under this Policy is described in the Out-of-Pocket Expenses table in this section, and in the Prescription Drugs And Pharmacy Services and Specialty Prescription Drug Program sections.

Lifetime maximum amount

The lifetime maximum amount payable per member for in-network and out-of-network benefits (combined) under this Policy is described in the Out-of-Pocket Expenses table in this section. You should monitor the amount paid for in-network and out-of-network benefits and contact MIC when you are close to reaching your lifetime maximum amount.

Out-of-Pocket Expenses

Copayment or Coinsurance	See specific benefit for applicable copayment or coinsurance
Calendar Year Deductible	**Deductible is subject to a "cost of living" increase on a yearly basis. This "cost of living" increase is tied to the Consumer Price Index (CPI) and may be up to, but no greater than, the CPI. You will receive a notice of change 30 days in advance.** $9,300 Applies to your combined in-network and out-of-network benefits.
Calendar year out-of-pocket maximum (for copayments, coinsurance and deductible combined)	
Out-of-pocket maximum except for benefits described in *Prescription Drugs And Pharmacy Services* and *Specialty Prescription Drug Program* :	Out-of-pocket maximum is the deductible.
Prescription Drugs And Pharmacy Services and *Specialty Prescription Drug Program* Out-of-pocket maximum:	Does **not** apply.
Annual prescription drugs and pharmacy services maximum amount payable	$2,000
Lifetime maximum amount payable per member	$5,000,000 Applies to your combined in-network and out-of-network benefits.

E. *Professional Services*

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

Covered

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

- *In-network benefits* apply to:
  1. Professional services received from a network provider;
  2. Professional services for testing and treatment of a sexually transmitted disease and testing for AIDS and other HIV-related conditions received from a network provider or a non-network provider;
  3. Family planning services, for the voluntary planning of the conception and bearing of children, received from a network provider or a non-network provider.
- *Out-of-network benefits* apply to professional services received from a non-network provider. In addition to the deductible, you will be responsible for any charges in excess of the non-network provider reimbursement amount.

The most specific and appropriate section of this Policy will apply for professional services related to the treatment of a specific condition. For example, benefits for reconstructive surgery services are described in *Reconstructive And Restorative Surgery*.

Prior authorization. Prior authorization from MIC may be required *before* you receive services or supplies. Call Customer Service at one of the telephone numbers listed inside the front cover. See *How To Access Your Benefits* for more information about the prior authorization process.

See ***Definitions***. These words have specific meanings:

- Benefits
- Convenient/urgent care center
- Deductible
- Emergency
- Hospital
- Inpatient
- Member
- Network
- Non-network
- Non-network provider reimbursement amount
- Physician
- Prenatal care
- Provider

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

Not covered

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

1. Mental health or substance abuse services, except as described in *Mental Health* and *Substance Abuse*.
2. Maternity care services, other than prenatal care.

Your Benefits and the Amounts You Pay

Benefits (after $9,300 deductible)	**In-network benefits You pay**	**Out-of-network benefits You pay**
1. Office visits	$50 copayment per visit for the first 3 visits per calendar year.* The deductible does not apply for the first 3 visits. Thereafter, you pay nothing after deductible.	Nothing
2. Convenient/urgent care center visits	$100 copayment for the first visit per calendar year. The deductible does not apply for the first visit. Thereafter, you pay nothing after deductible.	For emergency services from non-network providers, refer to *Emergency Services From Non-Network Providers*. Nothing for non-emergency services received from non-network providers
3. Maternity care		
a. Prenatal care services, including services for prenatal complications without delivery, received from a physician during an office visit, an outpatient hospital visit, or an inpatient stay	Nothing. The deductible does not apply.	Nothing
b. Services received for labor and delivery	No coverage	No coverage
c. Post-partum office visit	No coverage	No coverage

Your Benefits and the Amounts You Pay

Benefits (after $9,300 deductible)	**In-network benefits You pay**	**Out-of-network benefits You pay**
4. Preventive health care (**Please note:** This only applies when there is no existing condition or no complaint about your health, regardless of the reasons that you scheduled your office visit.)		
a. Health education and health supervision services provided during an office visit (including evaluation and follow-up)	Nothing The deductible does not apply for the first $200 in benefits paid per person for services 4a, 4d, 5, and 7 per calendar year.	Nothing
b. For subscribers who are between the ages of birth and 72 months old, child health supervision services (i.e. pediatric preventive services, developmental assessments and laboratory services) appropriate to the age of a child from birth to age 6. Coverage is limited to: • 5 visits from birth through 11 months • 3 visits from 12 months through 23 months • 1 visit per calendar year from 24 months through 72 months	Nothing. The deductible does not apply.	Nothing
c. Immunizations for subscribers who are between the ages of birth and age 18	Nothing. The deductible does not apply.	Nothing
d. Early disease detection services including physicals.	Nothing The deductible does not apply for the first $200 in benefits paid per person for services 4a, 4d, 5, and 7 per calendar year.	Nothing

Your Benefits and the Amounts You Pay		
Benefits (after $9,300 deductible)	**In-network benefits You pay**	**Out-of-network benefits You pay**
5. Routine screening procedures for cancer	Nothing The deductible does not apply for the first $200 in benefits paid per person for services 4a, 4d, 5, and 7 per calendar year.	Nothing
6. Allergy shots	Nothing	Nothing
7. Refractive eye exams Coverage is limited to one visit per calendar year for in-network and out-of-network benefits combined.	Nothing The deductible does not apply for the first $200 in benefits paid per person for services 4a, 4d, 5, and 7 per calendar year.	Nothing
8. Chiropractic services to diagnose and to treat, by manual manipulation or certain therapies, neuromusculoskeletal conditions related to the spine or joint	$50 copayment per visit for the first 3 visits per calendar year.* The deductible does not apply for the first 3 visits. Thereafter, you pay nothing after deductible.	Nothing
9. Professional sign language interpreter services in a physician's office (Call Customer Service to arrange such services.)	$50 copayment per visit for the first 3 visits per calendar year.* The deductible does not apply for the first 3 visits. Thereafter, you pay nothing after deductible.	Nothing
10. Surgical services (as defined in the Physicians' Current Procedural Terminology code book) received from a physician during an office visit or an outpatient hospital or ambulatory surgical center visit	Nothing	Nothing
11. Anesthesia services received from a provider during an office visit or an outpatient hospital ambulatory surgical center visit	Nothing	Nothing

Your Benefits and the Amounts You Pay		
Benefits (after $9,300 deductible)	**In-network benefits You pay**	**Out-of-network benefits You pay**
12. Services received from a physician during an emergency room visit	Nothing	For emergency services from non-network providers, see *Emergency Services From Non-Network Providers*. Nothing for non-emergency services provided in a non-network hospital emergency room.
13. Services received from a physician during an inpatient stay	Nothing	Nothing
14. Anesthesia services received from a provider during an inpatient stay.	Nothing	Nothing
15. Outpatient and inpatient lab and pathology	Nothing	Nothing
16. Outpatient and inpatient x-rays and other imaging services	Nothing	Nothing
17. Other outpatient hospital or ambulatory surgical center services received from a physician	Nothing	Nothing
18. Treatment to lighten or remove the coloration of a port wine stain	Nothing	Nothing
19. Diabetes self-management training and education, including medical nutrition therapy, received from a provider in a program consistent with national educational standards (as established by the American Diabetes Association)	Nothing	Nothing

Your Benefits and the Amounts You Pay		
Benefits (after $9,300 deductible)	**In-network benefits You pay**	**Out-of-network benefits You pay**
20. NeuropSYFhological evaluations/cognitive testing, limited to services necessary for the diagnosis or treatment of a medical illness or injury	Nothing	Nothing
21. 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	Nothing Coverage is limited to a combined in-network and out-of-network total of 5 training visits and 2 follow-up eye exams per calendar year.	Nothing Coverage is limited to a combined in-network and out-of-network total of 5 training visits and 2 follow-up eye exams per calendar year.
22. Eyewear, including eyeglass lenses, frames or contact lenses received from an optical *provider*.	Medica pays up to $50 per calendar year for in-network and out-of-network benefits combined. You are responsible for any costs in excess of $50.	Medica pays up to $50 per calendar year for in-network and out-of-network benefits combined. You are responsible for any costs in excess of $50.

*** The copayment and visit limit are combined on an annual basis for all eligible services identified throughout this Policy.**

F. *Prescription Drugs And Pharmacy Services*

This section describes coverage for prescription drugs, some over-the-counter (OTC), and supplies received from a pharmacy. For purposes of this section, the word supplies means eligible diabetic equipment and supplies. For coverage of specialty prescription drugs, see *Specialty Prescription Drug Program*.

The MIC drug formulary (formulary) identifies prescription drugs, some OTC drugs, and supplies that are preferred by MIC for dispensing to a member. Where appropriate, the formulary includes generic equivalents of brand name drugs and supplies. The formulary also identifies whether a drug is classified by MIC as a formulary generic or formulary brand name drug. You will have your lowest copayment or coinsurance when you use formulary generic products.

The terms "generic" and "brand name" are used in the health care industry in different ways. To be sure that you know whether a drug is classified by MIC as formulary generic or formulary brand name, please review the following definitions:

Generic – A drug: (1) that is chemically equivalent to a brand name drug; or (2) that MIC identifies as a generic product. Classification of a drug as a generic is determined by MIC and not by the manufacturer or pharmacy. A drug is classified as a generic based on available data resources, such as First DataBank, that classify drugs as either brand name or generic based on a number of factors. Not all products identified as a "generic" by the manufacturer, pharmacy or your physician are classified by MIC as generic.

Brand name – A drug: (1) that is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that MIC identifies as a brand name product. A drug is classified as a brand name based on available data resources, such as First DataBank, that classify drugs as either brand name or generic based on a number of factors. Not all products identified as a "brand name" by the manufacturer, pharmacy, or your physician are classified by MIC as brand name.

If you have questions about the current classification of a drug on the formulary, call Customer Service at one of the telephone numbers listed inside the front cover.

See *Definitions*. These words have specific meanings:

- Benefits
- Claim
- Convenient/urgent care center
- Copayment
- Emergency
- Hospital
- Medically necessary
- Member
- Network
- Non-network
- Non-network provider reimbursement amount
- Physician
- Prescription drug
- Provider

You will have your lowest copayment or coinsurance when you use formulary generic products.

Diagnosed Lyme disease is covered the same as any other illness under this certificate.

The formulary and appropriate use guidelines are periodically reviewed and modified by MIC. This may mean that a formulary drug or supply may become non-formulary when a more appropriate equivalent becomes available. Your pharmacist will dispense the generic equivalent of drugs or supplies according to the formulary. Network providers, network pharmacies and members have access to MIC's drug formulary.

If you have questions about MIC's formularies or whether a specific specialty prescription drug, prescription drug, OTC drug, or supply is covered, or would like to request a copy of the formularies at no charge, call Customer Service at one of the telephone numbers listed inside the front cover. The formularies are also available on www.medica.com.

MIC occasionally adds OTC drugs to the formulary. However, these formulary OTC drugs must be prescribed by a provider and dispensed at a pharmacy.

MIC's appropriate use guidelines are based on United States Food and Drug Administration (FDA) approval, manufacturer's packaging guidelines and clinical publications.

Non-formulary products

Non-formulary products are prescription drugs and supplies that are not on the formulary. These may be brand name prescription drugs or supplies that have a therapeutically equivalent brand name or generically equivalent product on the formulary. If you use non-formulary products, you will have a higher copayment or coinsurance.

Product selection

When you receive a formulary generic prescription drug or supply under your in-network benefit, you will pay the formulary generic copayment or coinsurance described in the table in this section. MIC pays any remaining amount according to the written agreement between MIC and the pharmacy. For example, if the agreement states that generic prescription drug "A" costs $50, and your formulary generic copayment is $10: you will pay $10 and MIC will pay $40.

Receiving formulary brand name or non-formulary drugs or supplies when chemical equivalent formulary generics exist may result in significantly higher out of pocket costs.

When a chemically equivalent generic drug or equivalent generic supply is on the formulary, and you or your provider still choose (for any reason) to utilize a formulary brand name or non-formulary prescription drug or supply under your in-network benefit, MIC will pay the amount MIC would have paid had you received the formulary generic drug or supply, as described in the immediately preceding paragraph. You will pay, in addition to the applicable copayment or coinsurance described in the table, any remaining charges due the

pharmacy in excess of MIC's payment to the pharmacy. These additional charges will not be applied toward the out-of-pocket maximum.

Please note that receiving formulary brand name or non-formulary drugs or supplies when equivalent formulary generics exist may result in significantly more out-of-pocket costs.

For example, you receive non-formulary prescription drug "B," although chemically equivalent formulary generic prescription drug "A" exists. MIC's agreement with the pharmacy states that non-formulary drug "B" costs $200 and chemically equivalent generic drug "A" costs $50 (as in the example above). The formulary generic copayment is $10 and the non-formulary copayment is $50. As described in the example above, MIC will pay $40. This is the amount MIC would have paid if you had received formulary generic drug "A." You will pay $160, an amount that includes the non-formulary copayment and the amount remaining due to the pharmacy after you paid your copayment and MIC paid the amount it owed.

Formulary exceptions

Exceptions to the formulary can include antipSYFhotic drugs prescribed to treat emotional disturbance or mental illness, and certain drugs for diagnosed mental illness or emotional disturbance if removed from the formulary or you change health plans.

Prior authorization

You are responsible for paying the cost of prescription drugs, formulary OTC drugs, or supplies you receive if you do not meet MIC's authorization criteria for the prescription drug or supply.

Certain prescription drugs, formulary OTC drugs and supplies require prior authorization. The provider who prescribes the drug or supply initiates prior authorization. Network providers, including network pharmacies, are given a list of formulary drugs and supplies that require prior authorization.

If prior authorization is not obtained, you are required to pay the cost of the products and submit a paper claim with supporting documentation.

Prescription drugs, formulary OTC drugs, and supplies are not subject to the deductible.

Covered

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

- *Benefits* apply to:
  1. Prescription drugs or formulary OTC drugs, including smoking cessation products, prescribed by a provider authorized to prescribe the drug and received at a network pharmacy; or
  2. Prescription drugs or formulary OTC drugs for family planning services or the treatment of sexually transmitted diseases when prescribed by or received from either a network or a non-network provider; or
  3. Diabetic equipment and supplies, including blood glucose meters, (described in this section) when received from a network pharmacy (You must provide the name of your prescribing provider to the network pharmacist).

See *Miscellaneous Medical Services And Supplies* for coverage of supplies such as dietary medical treatment of phenylketonuria (PKU).

See *Specialty Prescription Drug Program* for coverage of specialty prescription drugs.

There is an annual prescription drugs and pharmacy services maximum amount payable for benefits for the prescription drugs and pharmacy services described in this section and in the Specialty Prescription Drug Program section. This amount is described in the Out-of-Pocket Expenses table in the Your Out-Of-Pocket Expenses section.

Prescription unit

Prescription drugs, formulary OTC drugs, and supplies will not be dispensed in excess of one prescription unit except as described below. Three prescription units may be dispensed for drugs and supplies prescribed to treat chronic conditions that are received at a network pharmacy that MIC has specifically designated to dispense multiple prescription units. For the current list of such designated pharmacies, call Customer Service at one of the telephone numbers listed inside the front cover. This list is also available on www.medica.com. When you have used 75 percent of your prescription, you may refill your prescription before your refill date.

Copayments or coinsurance will apply separately to each prescription unit dispensed.

1. For prescription drugs and formulary OTC drugs, including smoking cessation products, one prescription unit is equal to:
   a. Up to a 31-consecutive-day supply, unless limited by the drug manufacturer's packaging or MIC's appropriate use guidelines;
   b. Up to a 31-day supply per type of insulin ; or
   c. A one-cycle supply of oral contraceptives.
2. For diabetic supplies, one prescription unit is equal to the greater of:

Smoking cessation products may be limited by the drug manufacturer's dosing instructions or MIC's appropriate use guidelines.

a. Up to a 31-consecutive-day supply, unless limited by the drug manufacturer's packaging or MIC's appropriate use guidelines; or

b. 100 units.

Not covered

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

The following are not covered:

1. Any amount above what MIC would have paid when you fail to identify yourself to the pharmacy as a member. (MIC will notify you before enforcement of this provision.)
2. OTC drugs that by federal or state law do not require a prescription order or refill and any medication that is equivalent to an OTC drug, (except OTC drugs that are on the formulary and that are received as described in this section).
3. Replacement of a drug or supply due to loss, damage or theft.
4. Appetite suppressants.
5. Erectile dysfunction medications.
6. Weight loss medications.
7. Homeopathic medicine.
8. Growth hormone.
9. Drugs and supplies prescribed by a provider who is not acting within their scope of licensure.
10. Specialty prescription drugs, except as described in *Specialty Prescription Drug Program*.
11. Prescription drugs or formulary OTC drugs, including smoking cessation products, received at a non-network pharmacy.

Your Benefits and the Amounts You Pay		
Benefits	**In-network benefits** **You pay**	**Out-of network benefits** **You pay**
1. Outpatient prescription drugs and formulary OTC drugs, including smoking cessation products, other than those described below or in *Specialty Prescription Drug Program*	**Formulary generic:** $5 per prescription unit or refill for formulary generic drugs; or **Formulary brand name:** $50 per prescription unit or refill for formulary brand name drugs; or **Non-formulary:** $90 per prescription unit or refill for non-formulary prescription drugs	No Coverage
2. Up to a 24-hour supply of emergency prescription drugs received from a hospital or convenient/urgent care center	**Formulary generic:** $5 per prescription unit or refill for formulary generic drugs; or **Formulary brand name:** $50 per prescription unit or refill for formulary brand name drugs; or **Non-formulary:** $90 per prescription unit or refill for non-formulary prescription drugs	No Coverage
3. Diabetic equipment and supplies, including blood glucose meters	**Formulary generic:** $5 per prescription unit or refill for formulary generic drugs; or **Formulary brand name:** $50 per prescription unit or refill for formulary brand name drugs; or **Non-formulary:** $90 per prescription unit or refill for non-formulary prescription drugs	No Coverage

G. *Specialty Prescription Drug Program*

This section describes coverage for specialty prescription drugs received from a designated specialty prescription drug pharmacy. Specialty prescription drugs include but are not limited to high technology prescription drug products for individuals with diseases that require complex therapies. Such specialty prescription drugs are identified on the MIC specialty prescription drug formulary, as described below. Many of these prescription drugs require special handling and close patient monitoring.

Designated Specialty Prescription Drug Pharmacies

A designated specialty prescription drug pharmacy means a specialty prescription drug pharmacy that has entered into a separate contract with MIC to provide specialty prescription drug services to members.

For the current list of designated specialty prescription drug pharmacies, call Customer Service at one of the telephone numbers listed inside the front cover, or access www.medica.com.

Formulary Specialty Prescription Drugs

See *Definitions*. These words have specific meanings:

- Benefits
- Claim
- Coinsurance
- Medically necessary
- Member
- Network
- Physician
- Prescription drug
- Provider

The MIC specialty prescription drug formulary identifies specialty prescription drugs that are preferred by MIC for dispensing to members. Where appropriate, the specialty prescription drug formulary includes generic equivalents of brand name specialty prescription drugs. You will have your lowest coinsurance when you use formulary specialty prescription drugs.

The specialty prescription drug formulary also identifies whether a drug is classified by MIC as a formulary generic or formulary brand name specialty prescription drug. You will have your lowest copayment or coinsurance when you use formulary products.

The terms “generic” and “brand name” are used in the health care industry in different ways. To be sure that you know whether a drug is classified by MIC as generic or brand name, please review the following definitions:

Generic – A drug: (1) that is chemically equivalent to a brand name drug; or (2) that MIC identifies as a generic product. Classification of a drug as a generic is determined by MIC and not by the manufacturer or pharmacy. A drug is classified as a generic based on available data resources, such as First DataBank, that classify drugs as either brand name or generic based on a number of factors. Not all products identified as a

"generic" by the manufacturer, pharmacy or your physician are classified by MIC as generic.

Diagnosed Lyme disease is covered the same as any other illness under this certificate.

Brand name – A drug: (1) that is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that MIC identifies as a brand name product. A drug is classified as a brand name based on available data resources, such as First DataBank, that classify drugs as either brand name or generic based on a number of factors. Not all products identified as a "brand name" by the manufacturer, pharmacy, or your physician are classified by MIC as brand name.

If you have questions about the current classification of a drug on the specialty prescription drug formulary, call Customer Service at one of the telephone numbers listed inside the front cover.

The specialty prescription drug formulary and appropriate use guidelines are periodically reviewed and modified by MIC. Designated specialty prescription drug pharmacies will dispense the generic equivalent of specialty prescription drugs according to the specialty prescription drug formulary. Network providers, designated specialty pharmacies, and members have access to MIC's specialty prescription drug formulary.

If you have questions about MIC's formularies or whether a specific specialty prescription drug, prescription drug, OTC drug, or supply is covered, or would like to request a copy of the formularies at no charge, call Customer Service at one of the telephone numbers listed inside the front cover. The formularies are also available on www.medica.com.

MIC's appropriate use guidelines are based on United States Food and Drug Administration (FDA) approval, manufacturer's packaging guidelines and clinical publications.

Non-Formulary Specialty Prescription Drugs

Non-formulary specialty prescription drugs are specialty prescription drugs that are not on the specialty prescription drug formulary. These are generally specialty prescription drugs that have a therapeutically equivalent product on the specialty prescription drug formulary. If you use non-formulary specialty prescription drugs, you will have a higher coinsurance.

You will have your lowest coinsurance when you use formulary specialty prescription drugs.

Formulary exceptions

If you would like to request a copy of MIC's specialty prescription drug formulary exception process, call Customer Service at one of the telephone numbers listed inside the front cover.

Exceptions to the formulary can include antipSYFhotic drugs prescribed to treat emotional disturbance or mental illness, and certain prescription drugs for

diagnosed mental illness or emotional disturbance if removed from the formulary or you change health plans.

Prior authorization

Specialty prescription drugs may require prior authorization. The provider who prescribes the specialty prescription drug initiates prior authorization. Network providers, including designated specialty prescription drug pharmacies, are given a list of specialty prescription drugs that require prior authorization.

If prior authorization is not obtained, you are required to pay the cost of the specialty prescription drug and submit a paper claim with supporting documentation.

You are responsible for paying the cost of specialty prescription drugs you receive if you do not meet MIC's authorization criteria for the specialty prescription drug.

Covered

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

- *Benefits* apply to:

  Specialty prescription drugs prescribed by a provider authorized to prescribe the specialty prescription drug and received from a designated specialty prescription drug pharmacy.

Specialty prescription drugs are not subject to the deductible.

There is an annual prescription drugs and pharmacy services maximum amount payable for benefits for the prescription drugs and pharmacy services described in this section and in the Prescription Drugs And Pharmacy Service section. This amount is described in the Out-of-Pocket Expenses table in the Your Out-Of-Pocket Expenses section.

Prescription unit

Specialty prescription drugs will not be dispensed in excess of one prescription unit. However, when you have used 70 percent of your prescription, you may refill your prescription before your refill date.

For specialty prescription drugs, one prescription unit is equal to up to a 31-consecutive-day supply (unless limited by the specialty prescription drug manufacturer's packaging or MIC's appropriate use guidelines).

Not covered

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

The following are not covered:

1. Any amount above what MIC would have paid when you fail to identify yourself to the designated specialty prescription drug pharmacy as a member. (MIC will notify you before enforcement of this provision.)
2. Replacement of a specialty prescription drug due to loss, damage or theft.
3. Specialty prescription drugs prescribed by a provider who is not acting within their scope of licensure.
4. Prescription drugs, OTC drugs, and specialty prescription drugs not on MIC's specialty prescription drug formulary.
5. Specialty prescription drugs received from a pharmacy that is not a designated specialty prescription drug pharmacy.
6. Erectile dysfunction medications.
7. Growth hormone.
8. Weight loss medications.

Your Benefits and the Amounts You Pay

Benefits	You pay
1. Specialty prescription drugs received from a designated specialty prescription drug pharmacy.	**Formulary Specialty Prescription Drugs:** 20% coinsurance up to a maximum of $200 per prescription unit or refill for formulary specialty prescription drugs received from a designated specialty prescription drug pharmacy; or **Non-Formulary Specialty Prescription Drugs:** 40% coinsurance up to a maximum of $400 per prescription unit or refill for non-formulary specialty prescription drugs received from a designated specialty prescription drug pharmacy. The deductible does not apply.

H. *Hospital Services*

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

Covered

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

- *In-network benefits* apply to hospital services received from a network hospital or ambulatory surgical center.
- *Out-of-network benefits* apply to hospital services received from a non-network hospital or ambulatory surgical center. In addition to the deductible described for out-of-network benefits, you will be responsible for any charges in excess of the non-network provider reimbursement amount.

Prior authorization. Prior authorization from MIC may be required *before* you receive services or supplies. Call Customer Service at one of the telephone numbers listed inside the front cover. See *How To Access Your Benefits* for more information about the prior authorization process.

See Definitions. These words have specific meanings:

- Benefits
- Deductible
- Emergency
- Hospital
- Inpatient
- Member
- Network
- Non-network
- Non-network provider reimbursement amount
- Physician
- Prenatal care
- Provider

Not covered

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

1. Admission to another hospital is not covered when care for your condition is available at the network hospital where you were first admitted.
2. Maternity care services, including all maternity labor and delivery services, other than prenatal care.

Your Benefits and the Amount You Pay		
Benefits (after $9,300 deductible)	**In-network benefits You Pay**	**Out-of-network benefits You pay**
1. Outpatient services		
a. Services provided in a hospital emergency room	$200 copayment for the first visit per calendar year. The deductible does not apply for the first visit. Thereafter, you pay nothing after deductible.	For emergency services from non-network providers, see ***Emergency Services From Non-Network Providers***. Nothing for non-emergency services provided in a non-network hospital emergency room
b. Outpatient lab and pathology	Nothing	Nothing
c. Outpatient x-rays and other imaging services	Nothing	Nothing
d. Maternity labor and delivery services	No coverage	No coverage
e. Prenatal care services, including services for prenatal complications without delivery	Nothing. The deductible does not apply.	Nothing
f. Other outpatient services	Nothing	Nothing
g. Other outpatient hospital and ambulatory surgical center services received from a physician	Nothing	Nothing
h. Anesthesia services received from a provider during an office visit or an outpatient hospital or ambulatory surgical center visit	Nothing	Nothing
2. Services provided in a hospital observation room	Nothing	Nothing

Your Benefits and the Amount You Pay		
Benefits (after $9,300 deductible)	**In-network benefits You Pay**	**Out-of-network benefits You pay**
3. Inpatient services, including semi-private room and board in a hospital and services received from a physician during an inpatient stay: A private room is covered only for conditions of preeclampsia, radium implants, contagion or immunosuppression that require isolation		
a. Inpatient services other than for maternity care	Nothing	Nothing
b. Inpatient service for maternity care:		
i. For inpatient services related to prenatal care services, including prenatal complications, that do not result in a delivery	Nothing. The deductible does not apply.	Nothing
ii. For all other inpatient maternity labor and delivery services	No coverage	No coverage
iii. Anesthesia services received from a provider during an inpatient stay	Nothing	Nothing

I. *Ambulance Services*

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

Prior authorization. Prior authorization from MIC may be required *before* you receive services or supplies. Call Customer Service at one of the telephone numbers listed inside the front cover. See *How To Access Your Benefits* for more information about the prior authorization process.

Covered

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

- *In-network benefits* apply to ambulance services arranged through a physician and received from a network provider.
- *Out-of-network benefits* apply to ambulance services arranged through a physician and received from a non-network provider (except as described in number 1 in the table in this section). In addition to the deductible described for out-of-network benefits, you will be responsible for any charges in excess of the non-network provider reimbursement amount.

See *Definitions*. These words have specific meanings:

- Benefits
- Deductible
- Emergency
- Hospital
- Network
- Non-network
- Non-network provider reimbursement amount
- Physician
- Provider
- Skilled nursing facility

Not covered

These services, supplies and associated expenses are not covered:

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

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

Your Benefits and the Amounts You Pay		
Benefits (after $9,300 deductible)	**In-network benefits You pay**	**Out-of-network benefits You pay**
1. Ambulance services or ambulance transportation to the nearest hospital for an emergency	Nothing	See *Emergency Services From Non-Network Providers*.
2. Non-emergency licensed ambulance service that is arranged through an attending physician, as follows:		
a. Transportation from hospital to hospital when:	Nothing	Nothing
i. Care for your condition is not available at the hospital where you were first admitted; or		
ii. Required by MIC		
b. Transportation from hospital to skilled nursing facility	Nothing	Nothing

J. *Home Health Care*

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

Covered

For benefits and the amounts you pay, see the table in this section. As described under numbers 1 and 2 in the table in this section, MIC (in accordance with Medicare guidelines) considers you *homebound* when it is medically contraindicated for you to leave your home (i.e., when leaving your home would directly and negatively affect your physical health). A child may still be considered "confined to home" when attending school where life support specialized equipment and help are available.

Benefits covered under numbers 1, 2 and 4 in the table in this section are limited to a combined annual benefit maximum each calendar year.

- *In-network benefits* apply to home health care services ordered or prescribed by a physician and received from a network home health care agency.
- *Out-of-network benefits* apply to home health care services that are ordered or prescribed by a physician and received from a non-network home health care agency. In addition to the deductible described for out-of-network benefits, you will be responsible for any charges in excess of the non-network provider reimbursement amount.

Important: Out-of-network benefits are not provided for home infusion therapy. Home infusion therapy is covered only if provided by a network provider.

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

Prior authorization. Prior authorization from MIC may be required *before* you receive services or supplies. Call Customer Service at one of the telephone numbers listed inside the front cover. See *How To Access Your Benefits* for more information about the prior authorization process.

See Definitions. These words have specific meanings:

- Benefits
- Custodial care
- Deductible
- Hospital
- Network
- Non-network
- Non-network provider reimbursement amount
- Physician
- Prenatal care
- Provider
- Skilled care
- Skilled nursing facility

Not covered

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

These services, supplies and associated expenses are not covered:

1. Companion, homemaker and personal care services.
2. Services provided by a member of your family.
3. Custodial care and other nonskilled services.
4. Physical, speech or occupational therapy provided in your home for convenience.
5. Services provided in your home when you are not homebound.
6. Services primarily educational in nature.
7. Vocational and job rehabilitation.
8. Recreational therapy.
9. Self-care and self-help training (non-medical).
10. Health clubs.
11. Disposable supplies and appliances, except as described in this Policy.
12. Home infusion therapy provided by a non-network provider.
13. IV therapy.
14. Correction of speech impediments (stuttering and lisps) and assistance in the development of verbal clarity.
15. Voice training and voice therapy.
16. Outpatient rehabilitation services when no medical diagnosis is present.

Your Benefits and the Amounts You Pay		
Benefits (after $9,300 deductible)	**In-network benefits You pay**	**Out-of-network benefits You pay**
1. Intermittent skilled care when you are homebound, provided by or supervised by a registered nurse. Coverage is limited to an annual benefit maximum of $25,000 per calendar year for numbers 1., 2. and 4. of this Section combined.	Nothing For high-risk prenatal care services, the deductible does not apply.	Nothing
2. Skilled physical or speech or occupational therapy when you are homebound. Coverage is limited to an annual benefit maximum of $25,000 per calendar year for numbers 1, 2. and 4. of this Section combined.	Nothing	Nothing
3. Home infusion therapy	Nothing	No coverage
4. Services received in your home from a physician. Coverage is limited to an annual benefit maximum of $25,000 per calendar year for numbers 1., 2. and 4. of this Section combined.	Nothing	Nothing

K. *Outpatient Rehabilitation*

This section describes coverage for both professional and outpatient health care facility services. A physician must direct your care.

Covered

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

- *In-network benefits* apply to outpatient rehabilitation services arranged through a physician and received from a network physical therapist, a network occupational therapist, a network speech therapist or a network physician.
- *Out-of-network benefits* apply to outpatient rehabilitation services arranged through a physician and received from a non-network physical therapist, a non-network occupational therapist, a non-network speech therapist or a non-network physician. In addition to the deductible described for out-of-network benefits, you are responsible for any charges in excess of the non-network provider reimbursement amount.

Not covered

These services, supplies and associated expenses are not covered:

1. Services primarily educational in nature.
2. Vocational and job rehabilitation.
3. Recreational therapy.
4. Self-care and self-help training (non-medical).
5. Health clubs.
6. Correction of speech impediments (stuttering or lisps) and assistance in the development of verbal clarity when there is no reasonable expectation that the condition will improve over a predictable period of time according to generally accepted standards in the medical community.
7. Voice training and voice therapy.
8. Outpatient rehabilitation services when no medical diagnosis is present.

Prior authorization. Prior authorization from MIC may be required *before* you receive services or supplies. Call Customer Service at one of the telephone numbers listed inside the front cover. See *How To Access Your Benefits* for more information about the prior authorization process.

See Definitions. These words have specific meanings:

- Benefits
- Deductible
- Network
- Non-network
- Non-network provider reimbursement amount
- Physician

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

Your Benefits and the Amounts You Pay		
Benefits (after $9,300 deductible)	**In-network benefits You pay**	**Out-of-network benefits You pay**
1. Physical therapy received outside of your home	Nothing	Nothing
2. Occupational therapy received outside of your home when physical function is impaired due to a medical illness or injury or congenital or developmental conditions that have delayed motor development	Nothing	Nothing
3. Speech therapy received outside of your home when speech is impaired due to a medical illness or injury, or congenital or developmental conditions that have delayed speech development	Nothing	Nothing

L. *Mental Health*

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

For purposes of this section:

1. Outpatient services include:
   a. Diagnostic evaluations and pSYFhological testing.
   b. PSYFhotherapy and pSYFhiatric services.
   c. Relationship and family counseling services.
   d. Intensive outpatient programs, including day treatment, meaning time limited comprehensive treatment plans, which may include multiple services and modalities, delivered in an outpatient setting (up to 19 hours per week).
   e. Treatment for a minor, including family therapy.
   f. Treatment of serious or persistent disorders.
   g. Diagnostic evaluation for attention deficit hyperactivity disorder (ADHD) or pervasive development disorders (PDD).
   h. Services, care or treatment ordered by a court on the basis of a behavioral health care evaluation performed by a physician or licensed pSYFhologist and that includes an individual treatment plan.
   i. Treatment of pathological gambling.
2. Inpatient services include:
   a. Semi-private room and board.
   b. Attending pSYFhiatric services.
   c. Hospital or facility-based professional services.
   d. Partial program. This may be in a freestanding facility or hospital based. Active treatment is provided through specialized programming with medical/pSYFhological intervention and supervision during program hours. Partial program means a treatment program of 20 hours or more per week and may include lodging. (Refer to 2.a., b., c. and d. in the table in this section to determine your benefits.)

Prior authorization.
For prior authorization of *in-network benefits*, call MIC's designated mental health and substance abuse provider at:

- 1-800-848-8327
- TTY: 1-800-543-7162

For prior authorization of *out-of-network benefits*, call Customer Service at one of the telephone numbers listed inside the front cover.

See Definitions. These words have specific meanings:

- Benefits
- Claim
- Custodial care
- Deductible
- Emergency
- Hospital
- Inpatient
- Medically necessary
- Member
- Mental disorder
- Network
- Non-network
- Physician
- Provider

e. Services, care or treatment ordered by a court on the basis of a behavioral health care evaluation performed by a physician or licensed pSYFhologist and that includes an individual treatment plan. (Refer to 2.a., b., c. and d. in the table in this section to determine your benefits.)

f. Residential treatment services. These services include either:

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

   ii. A licensed or certified mental health treatment program providing intensive therapeutic services. In addition to room and board, at least 30 hours a week per individual of mental health services must be provided, including group and individual counseling, client education, and other services specific to mental health treatment. Also, the program must provide an on-site medical/pSYFhiatric assessment within 48 hours of admission, pSYFhiatric follow-up visits at least once per week, and 24 hour nursing coverage.

   (Refer to 2.a., b., c. and d. in the table in this section to determine your benefits.)

Covered

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

For claims questions regarding *in-network benefits*, call MIC's designated mental health and substance abuse provider Customer Service at 1-866-214-6829.

- For *in-network benefits*:

  1. MIC's designated mental health and substance abuse provider arranges in-network mental health benefits. MIC's designated mental health and substance abuse provider will refer you to other mental health providers only if network providers cannot provide the services you require. If you require hospitalization, MIC's designated mental health and substance abuse provider will refer you to one of its hospital providers (MIC and MIC's designated mental health and substance abuse provider hospital networks are different).

2. Notify MIC's designated mental health and substance abuse provider as soon as reasonably possible after receiving any emergency mental health inpatient services. Call MIC's designated mental health and substance abuse provider at: 1-800-848-8327 or TTY: 1-800-543-7162.
3. Second opinions from a qualified provider are covered under in-network benefits only if MIC's designated mental health and substance abuse provider determines that no treatment is necessary. You must receive your second opinion within 30 calendar days of MIC's designated mental health and substance abuse provider's first evaluation. MIC's designated mental health and substance abuse provider will consider the second opinion but is not required to accept it.

- For *out-of-network benefits*:

1. Mental health services from a non-network provider listed below will be eligible for coverage under out-of-network benefits. Emergency mental health services are eligible for coverage under in-network benefits.
2. You must receive services directly from or at any of the following non-network providers to obtain out-of-network benefits:
   a. Licensed pSYFhiatrist
   b. Licensed pSYFhologist
   c. Licensed registered nurse certified as a clinical specialist or as a nurse practitioner in pSYFhiatric and mental health nursing
   d. Licensed mental health clinic.
   e. Licensed residential treatment center
   f. Licensed independent clinical social worker
   g. Licensed marriage and family therapists
   h. A hospital that provides mental health services

In addition to the deductible described for out-of-network benefits, you are responsible for any charges in excess of the non-network provider reimbursement amount.

Not covered

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

These services, supplies and associated expenses are not covered:

1. Services for mental disorders not listed in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders.*
2. Services from a network provider for a condition that cannot be improved with treatment.
3. Services, care or treatment that is not medically necessary, unless ordered by a court as specifically described in this section.
4. Relationship counseling beyond initial evaluation and brief intervention services.
5. Services beyond the initial evaluation to diagnose developmental disability or learning disabilities.
6. Services, including room and board charges, provided by mental health providers who are not licensed to practice independently or substance abuse providers who are not certified, such as services received at a halfway house, housing with support, a Rule 36 facility or therapeutic group home, except for outpatient mental health services that are specifically described in this section.
7. Services to assist in activities of daily living that do not seek to cure and are performed regularly as a part of a routine or schedule.
8. Room and board charges associated with mental health residential treatment services providing less than 30 hours a week per individual of mental health services, or lacking an on-site medical/pSYFhiatric assessment within 48 hours of admission, pSYFhiatric follow-up visits at least once per week, and 24 hour nursing coverage, except as described in 2.f.i. in this section.

Your Benefits and the Amounts You Pay		
Benefits (after $9,300 deductible)	**In-network benefits You pay**	**Out-of-network benefits You pay**
1. Outpatient services	$50 copayment per visit for the first 3 visits per calendar year.* The deductible does not apply for the first 3 visits. Thereafter, you pay nothing after deductible.	Nothing
2. Inpatient services		
a. Semi-private room and board	Nothing	Nothing
b. Hospital or facility-based professional services	Nothing	Nothing
c. Attending pSYFhiatrist services	Nothing	Nothing
d. Partial program	Nothing	Nothing

*** The copayment and visit limit are combined on an annual basis for all eligible services identified throughout this Policy.**

M. *Substance Abuse*

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

For purposes of this section:

1. Outpatient services include:
   a. Diagnostic evaluations.
   b. Outpatient treatment (structured outpatient services for less than nine hours per week delivered in an outpatient setting).
   c. Intensive outpatient programs, including day treatment, meaning time limited comprehensive treatment plans, which may include multiple services and modalities, delivered in an outpatient setting (between 9 and 19 hours per week).
   d. Services, care or treatment for a member that has been placed in the Minnesota Department of Corrections' custody following a conviction for a first-degree driving while impaired offense; to be eligible, such services, care or treatment must be required and provided by the Minnesota Department of Corrections. (Refer to 1.a. and b. in the table in this section to determine your benefits.)
   e. Services, care or treatment ordered by a court on the basis of a behavioral health care evaluation performed by a physician, licensed pSYFhologist, licensed alcohol and drug dependency counselor or a certified chemical dependency assessor and that includes an individual treatment plan. (Refer to 1.a. and b. in the table in this section to determine your benefits.)
   f. Treatment of pathological gambling.
2. Inpatient services include:
   a. Semi-private room and board.
   b. Attending physician services.
   c. Hospital or facility-based professional services.

Prior authorization.
For prior authorization of *in-network benefits*, call MIC's designated mental health and substance abuse provider at:

- 1-800-848-8327
- TTY: 1-800-543-7162

For prior authorization of *out-of-network benefits*, call Customer Service at one of the telephone numbers listed inside the front cover.

See ***Definitions***. These words have specific meanings:
- Benefits
- Claim
- Custodial care
- Deductible
- Emergency
- Hospital
- Inpatient
- Medically necessary
- Member
- Mental disorder
- Network
- Non-network
- Physician
- Provider

d. Services, care or treatment for a member that has been placed in the Minnesota Department of Corrections' custody following a conviction for a first-degree driving while impaired offense; to be eligible, such services, care or treatment must be required and provided by the Minnesota Department of Corrections. (Refer to 2.a., b. and c. in the table in this section to determine your benefits.)

e. Partial program. This may be in a freestanding facility or hospital based. Active treatment is provided through specialized programming with medical/pSYFhological intervention and supervision during program hours. Partial program means a treatment program of 20 hours or more per week and may include lodging. (Refer to 2.a., b., c., d. and e. in the table in this section to determine your benefits.)

f. Substance abuse residential treatment services. These are services from a licensed chemical dependency rehabilitation program that provides intensive therapeutic services following detoxification. In addition to room and board, at least 30 hours per week per individual of chemical dependency services must be provided, including group and individual counseling, client education, and other services specific to chemical dependency rehabilitation. (Refer to 2.a., b. c., d. and e. in the table in this section to determine your benefits.)

g. Services, care or treatment ordered by a court on the basis of a behavioral health care evaluation performed by a physician, licensed pSYFhologist, licensed alcohol and drug dependency counselor or a certified chemical dependency assessor and that includes an individual treatment plan. (Refer to numbers 2.a., b. and c. in the table in this section to determine your benefits.)

Covered

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

- For *in-network benefits*:

1. MIC's designated mental health and substance abuse provider arranges in-network substance abuse benefits. MIC's designated mental health and substance abuse provider will refer you to other substance abuse providers only if network providers

For claims questions regarding *in-network benefits*, call MIC's designated mental health and substance abuse provider Customer Service at 1-866-214-6829.

cannot provide the services you require. If you require hospitalization, MIC's designated mental health and substance abuse provider will refer you to one of its hospital providers (MIC and MIC's designated mental health and substance abuse provider hospital networks are different).

2. In-network benefits will apply to services, care or treatment for a member that has been placed in the Minnesota Department of Corrections' custody following a conviction for a first-degree driving while impaired offense. To be eligible, such services, care or treatment must be required and provided by the Minnesota Department of Corrections.
3. Notify MIC's designated mental health and substance abuse provider as soon as reasonably possible after receiving any emergency substance abuse inpatient services. Call MIC's designated mental health and substance abuse provider at 1-800-848-8327 or TTY: 1-800-543-7162.
4. Second opinions from a qualified provider are covered under in-network benefits only if MIC's designated mental health and substance abuse provider determines that no treatment is necessary. You must receive your second opinion within 30 calendar days of MIC's designated mental health and substance abuse provider's first evaluation. MIC's designated mental health and substance abuse provider will consider the second opinion but is not required to accept it.

- For *out-of-network benefits*:

1. Substance abuse services from a non-network provider listed below will be eligible for coverage under out-of-network benefits. Emergency substance abuse services are eligible for coverage under in-network benefits.
2. You must receive services directly from or at any of the following non-network providers to obtain out-of-network benefits:
   a. Licensed pSYFhiatrist
   b. Licensed pSYFhologist
   c. Licensed registered nurse certified clinical specialist or as a nurse practitioner in pSYFhiatric and mental health nursing
   d. Licensed chemical dependency clinic
   e. Licensed residential treatment center

In addition to the deductible described for out-of-network benefits, you will be responsible for any charges in excess of the non-network provider reimbursement amount.

f. A hospital that provides substance abuse services

g. Licensed independent clinical social worker

h. Licensed marriage and family therapist

Not covered

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

These services, supplies and associated expenses are not covered:

1. Services for substance abuse disorders not listed in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders*.
2. Services from a network provider for a condition that cannot be improved with treatment.
3. Services, care or treatment that is not medically necessary, unless ordered by a court as specifically described in this section.
4. Services to hold or confine a person under chemical influence when no medical services are required, regardless of where the services are received.
5. Services beyond the primary treatment of substance abuse.
6. Services, including room and board charges, provided by mental health providers who are not licensed to practice independently or substance abuse providers who are not certified, such as services received at a halfway house or therapeutic group home, except for outpatient substance abuse services that are specifically described in this section.
7. Room and board charges associated with substance abuse treatment services providing less than 30 hours a week per individual of chemical dependency services, including group and individual counseling, client education, and other services specific to chemical dependency rehabilitation.
8. Services to assist in activities of daily living that do not seek to cure and are performed regularly as a part of a routine or schedule.

Your Benefits and the Amounts You Pay		
Benefits (after $9,300 deductible)	**In-network benefits You pay**	**Out-of-network benefits You pay**
1. Outpatient services	$50 copayment per visit for the first 3 visits per calendar year.* The deductible does not apply for the first 3 visits. Thereafter, you pay nothing after deductible.	Nothing
a. Evaluations, diagnostic and primary treatment services	$50 copayment per visit for the first 3 visits per calendar year.* The deductible does not apply for the first 3 visits. Thereafter, you pay nothing after deductible.	Nothing
b. Intensive outpatient programs	$50 copayment per visit for the first 3 visits per calendar year.* The deductible does not apply for the first 3 visits. Thereafter, you pay nothing after deductible.	Nothing
c. Methadone maintenance therapy	$50 copayment per visit for the first 3 visits per calendar year.* The deductible does not apply for the first 3 visits. Thereafter, you pay nothing after deductible.	Nothing
2. Inpatient services:		
a. Semi-private room and board	Nothing	Nothing
b. Hospital or facility-based professional services	Nothing	Nothing
c. Attending physician services	Nothing	Nothing
d. Partial program	Nothing	Nothing
3. Residential treatment services	Nothing	Nothing

*** The copayment and visit limit are combined on an annual basis for all eligible services identified throughout this Policy.**

N. *Durable Medical Equipment And Prosthetics*

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

Covered

For benefits and the amounts you pay, see the table in this section. MIC covers only a limited selection of durable medical equipment and certain related supplies, and hearing aids that meet the criteria established by MIC. Some items ordered by your physician, even if medically necessary, may not be covered. To request a list of MIC's eligible durable medical equipment and certain related supplies, call Customer Service at one of the telephone numbers listed inside the front cover.

MIC determines if durable medical equipment will be purchased or rented. MIC's approval of rental of durable medical equipment is limited to a specific period of time. To request approval for an extension of the rental period, call Customer Service at one of the telephone numbers listed inside the front cover.

- *In-network benefits* apply to durable medical equipment and certain related supplies and prosthetic services prescribed by a physician and received from a network durable medical equipment provider, and hearing aids as described in 4. in the table in this section when prescribed by a network provider. To request a list of network durable medical equipment providers, call Customer Service at one of the telephone numbers listed inside the front cover.
- *Out-of-network benefits* apply to durable medical equipment and certain related supplies and prosthetic services prescribed by a physician and received from a non-network provider. *Out-of-network benefits* also apply to hearing aids as described in 4. in the table in this section. In addition to the deductible described for out-of-network benefits, you are responsible for charges in excess of the non-network provider reimbursement amount.

Prior authorization. Prior authorization from MIC may be required *before* you receive services or supplies. Call Customer Service at one of the telephone numbers listed inside the front cover. See *How To Access Your Benefits* for more information about the prior authorization process.

See *Definitions*. These words have specific meanings:

- Benefits
- Deductible
- Medically necessary
- Network
- Non-network
- Non-network provider reimbursement amount
- Physician
- Provider

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

Not covered

These services, supplies and associated expenses are not covered:

1. Durable medical equipment and supplies, prosthetics, appliances and hearing aids not on the MIC eligible list.
2. Charges in excess of the MIC standard model of durable medical equipment or prosthetics or hearing aids.
3. Repair, replacement or revision of durable medical equipment, prosthetics and hearing aids, except when made necessary by normal wear and use.
4. Duplicate durable medical equipment, prosthetics and hearing aids.

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

Your Benefits and the Amounts You Pay

Benefits (after $9,300 deductible)	**In-network benefits You pay**	**Out-of-network benefits You pay**
1. Durable medical equipment and certain related supplies	Nothing	Nothing
2. Repair, replacement or revision of durable medical equipment made necessary by normal wear and use	Nothing	Nothing
3. Prosthetics:		
a. Initial purchase of breast prostheses	Nothing	Nothing
b. Initial purchase of artificial limbs and eyes	Nothing	Nothing
c. Scalp hair prostheses due to alopecia areata	Nothing MIC pays up to $350. This is calculated each calendar year.	Nothing MIC pays up to $350. This is calculated each calendar year.

Your Benefits and the Amounts You Pay		
Benefits (after $9,300 deductible)	**In-network benefits You pay**	**Out-of-network benefits You pay**
d. Repair, replacement or revision of artificial limbs, eyes and breast prostheses made necessary by normal wear and use	Nothing	Nothing
4. Hearing aids for members under age 19 for hearing loss that is not correctable by other covered procedures. Coverage is limited to one hearing aid every three years.	Nothing	Nothing
5. Eligible ostomy supplies **Please note:** Eligible ostomy supplies may be received from a pharmacy or a durable medical equipment provider	Nothing	Nothing

O. *Miscellaneous Medical Services And Supplies*

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

Covered

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

- *In-network benefits* apply to miscellaneous medical services and supplies received from a network provider.
- *Out-of-network benefits* apply to miscellaneous medical services and supplies received from a non-network provider. In addition to the deductible described for out-of-network benefits, you are responsible for any charges in excess of the non-network provider reimbursement amount.

Not covered

Other disposable supplies and appliances, except as described in this Policy.

Prior authorization. Prior authorization from MIC may be required *before* you receive services or supplies. Call Customer Service at one of the telephone numbers listed inside the front cover. See *How To Access Your Benefits* for more information about the prior authorization process.

See ***Definitions***. These words have specific meanings:

- Benefits
- Deductible
- Medically necessary
- Network
- Non-network
- Non-network provider reimbursement amount
- Physician
- Provider

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

Your Benefits and the Amounts You Pay		
Benefits (after $9,300 deductible)	**In-network benefits** **You pay**	**Out-of-network benefits** **You pay**
1. Blood clotting factors	Nothing	Nothing
2. Dietary medical treatment of phenylketonuria (PKU)	Nothing	Nothing
3. Amino acid-based elemental oral formulas for the following diagnoses: a. Cystic fibrosis; b. amino acid, organic acid, and fatty acid metabolic and malabsorbtion disorders; c. IgE mediated allergies to food proteins; d. food protein-induced enterocolitis syndrome; e. eosinophilic esophagitis; f. eosinophilic gastroenteritis; and g. eosinophilic colitis. Coverage for the diagnoses in 3.c.-3.g. above is limited to members five years of age and younger.	Nothing	Nothing
4. Total parenteral nutrition	Nothing	Nothing

P. *Organ And Bone Marrow Transplant Services*

This section describes coverage for certain organ and bone marrow transplant services. Services must be provided under the direction of a physician and received at a transplant facility. This section also describes benefits for professional, hospital and ambulatory surgical center services.

Coverage is provided for certain types of organ transplants and related services (including organ acquisition and procurement) and for certain bone marrow transplant services that are medically necessary, appropriate for the diagnosis, without contraindications and non-investigative.

Prior authorization. Prior authorization from MIC may be required *before* you receive services or supplies. Call Customer Service at one of the telephone numbers listed inside the front cover. See How To Access Your Benefits for more information about the prior authorization process.

Covered

MIC uses specific medical criteria to determine benefits for organ and bone marrow transplant services. Because medical technology is constantly changing, MIC reserves the right to review and update these medical criteria. Benefits for each individual member will be determined based on the clinical circumstances of the member according to MIC's medical criteria.

Coverage is provided for the following human organ transplants, if appropriate, under MIC's medical criteria and not otherwise excluded from coverage (see *Not covered* below): cornea, kidney, lung, heart, heart/lung, pancreas, liver, allogeneic, autologous and syngeneic bone marrow.

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

- *In-network benefits* apply to transplant services provided by a network provider and received at a designated facility for transplant services. MIC has entered into separate contracts to provide certain transplant-related health services to members receiving transplants.

  Once evaluated and listed as a potential recipient at a designated facility for transplant services, you must remain with that facility, unless it is medically necessary for your transplant to be rendered elsewhere. You cannot be listed at more than one facility. If you independently choose to be listed at additional facilities, any charges for services they provide will not be covered under this Policy.

See *Definitions*. These words have specific meanings:

- Benefits
- Deductible
- Designated facility
- Hospital
- Inpatient
- Investigative
- Medically necessary
- Member
- Network
- Non-network
- Non-network provider reimbursement amount
- Physician
- Provider

Bone marrow transplants include the transplant of stem cells from bone marrow, peripheral blood and umbilical cord blood.

For in-network benefits, MIC 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 transplant facility (that you select from among the list of transplant facilities MIC provides). Based on the type of transplant you receive, MIC will determine the specific time period medically necessary for these services.

- **Important:** *Out-of-network benefits* are not provided for transplant services. Transplant services are covered only if provided by a network provider and designated facility for transplant services.

Not covered

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

These services, supplies and associated expenses are not covered:

1. Organ and bone marrow transplant services except as described in this section.
2. Supplies and services related to transplants that would not be authorized by MIC under the medical criteria referenced in this section.
3. Chemotherapy, radiation therapy drugs or any therapy used to damage the bone marrow and related to transplants that would not be authorized by MIC under the medical criteria referenced in this section.
4. Living donor transplants that would not be authorized by MIC under the medical criteria referenced in this section.
5. Islet cell transplants except for autologous islet cell transplants associated with pancreatectomy.
6. Services required to meet the patient selection criteria for the authorized transplant procedure. This includes treatment of nicotine or caffeine addiction, services and related expenses for weight loss programs, nutritional supplements, appetite suppressants and supplies of a similar nature otherwise not covered under this Policy.
7. Mechanical, artificial or non-human organ implants or transplants and related services that would not be authorized by MIC under the medical criteria referenced in this section.

8. Transplants and related services that are investigative.
9. Private collection and storage of umbilical cord blood for directed use.
10. Transplant services provided by a non-network provider or non-designated transplant facility.

Your Benefits and the Amounts You Pay

Benefits (after $9,300 deductible)	In-network benefits You pay	Out-of-network benefits You pay
1. Office visits	Nothing	No coverage
2. Outpatient services		
a. Professional services		
i. Surgical services (as defined in the *Physicians' Current Procedural Terminology* code book) received from a physician during an office visit or an outpatient hospital visit	Nothing	No coverage
ii. Outpatient lab, pathology and x-rays	Nothing	No coverage
iii. Other outpatient hospital services received from a physician	Nothing	No coverage
b. Hospital and ambulatory surgical center services		
i. Outpatient lab, pathology and x-rays	Nothing	No coverage
ii. Other outpatient hospital services	Nothing	No coverage
3. Inpatient services	Nothing	No coverage
4. Services received from a physician during an inpatient stay	Nothing	No coverage

Your Benefits and the Amounts You Pay		
Benefits (after $9,300 deductible)	**In-network benefits You pay**	**Out-of-network benefits You pay**
5. Anesthesia services received from a provider during an inpatient stay	Nothing	No coverage

Q. *Surgery For Weight Loss*

This section describes coverage for surgery for morbid obesity. Services must be provided under the direction of a designated physician and received at a designated facility. This section also describes benefits for professional and hospital services.

Prior authorization. Prior authorization from MIC is required *before* you receive services or supplies. Call Customer Service at one of the telephone numbers listed inside the front cover. See *How to Access Your Benefits* for more information about the prior authorization process.

Covered

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

- *Benefits* apply to surgery for morbid obesity provided by a designated physician and received at a designated facility. A designated physician or facility is a physician or hospital that has been designated by the American Society of Bariatric Surgeons or MIC to provide surgery for morbid obesity. To request a list of designated physicians and facilities to provide surgery for morbid obesity, call Customer Service at one of the telephone numbers listed inside the front cover.

See ***Definitions***. These words have specific meanings:

- Benefits
- Copayment
- Deductible
- Designated facility
- Designated physician
- Hospital
- Inpatient
- Investigative
- Medically necessary
- Member
- Network
- Non-network
- Physician
- Provider

Not covered

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

These services, supplies and associated expenses are not covered:

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

2. Surgery for morbid obesity when performed by a non-network physician or received at a non-network hospital.
3. Surgery for morbid obesity except as described in this section.
4. Services and procedures primarily for cosmetic purposes.
5. Supplies and services for surgery for morbid obesity that would not be authorized by MIC.
6. Services required to meet the patient selection criteria for an authorized surgery for morbid obesity. This includes services and related expenses for weight loss programs, nutritional supplements, appetite suppressants and supplies of a similar nature not otherwise covered under the Policy.

Your Benefits and the Amounts You Pay

Benefits (after $9,300 deductible)	**In-network benefits You pay**	**Out-of-network benefits You pay**
1. Office visits	$50 copayment per visit for the first 3 visits per calendar year.* The deductible does not apply for the first 3 visits. nothing after deductible.	No coverage
2. Outpatient hospital services	Nothing	No coverage
3. Outpatient services received from a physician in a hospital	Nothing	No coverage
4. Inpatient services	Nothing	No coverage
5. Services received from a physician during an inpatient stay	Nothing	No coverage

*** The copayment and visit limit are combined on an annual basis for all eligible office visit services identified throughout this Policy.**

R. *Reconstructive And Restorative Surgery*

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

Covered

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

- *In-network benefits* apply to reconstructive and restorative surgery services received from a network provider.
- *Out-of-network benefits* apply to reconstructive and restorative surgery services received from a non-network provider. In addition to the deductible described for out-of-network benefits, you will be responsible for any charges in excess of the non-network provider reimbursement amount.

Prior authorization. Prior authorization from MIC may be required *before* you receive services or supplies. Call Customer Service at one of the telephone numbers listed inside the front cover. See How To Access Your Benefits for more information about the prior authorization process.

See Definitions*.* These words have specific meanings:

- Benefits
- Cosmetic
- Deductible
- Hospital
- Inpatient
- Medically necessary
- Member
- Network
- Non-network
- Non-network provider reimbursement amount
- Physician
- Provider
- Reconstructive
- Restorative

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

Not covered

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

These services, supplies and associated expenses are not covered:

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

Your Benefits and the Amounts You Pay

Benefits (after $9,300 deductible)	**In-network benefits You pay**	**Out-of-network benefits You pay**
1. Office visits	$50 copayment per visit for the first 3 visits per calendar year.* The deductible does not apply for the first 3 visits. Thereafter, you pay nothing after deductible.	Nothing
2. Outpatient services		
a. Professional services		
i. Surgical services (as defined in the *Physicians' Current Procedural Terminology* code book) received from a physician during an office visit or an outpatient hospital or ambulatory surgical center visit	Nothing	Nothing

Your Benefits and the Amounts You Pay		
Benefits (after $9,300 deductible)	**In-network benefits You pay**	**Out-of-network benefits You pay**
ii. Anesthesia services received from a provider during an office visit or an outpatient hospital or ambulatory surgical center visit	Nothing	Nothing
iii. Outpatient lab and pathology	Nothing	Nothing
iv. Outpatient x-rays and other imaging services	Nothing	Nothing
v. Other outpatient hospital or ambulatory surgical center services received from a physician	Nothing	Nothing
b. Hospital and ambulatory surgical center services		
i. Outpatient lab and pathology	Nothing	Nothing
ii. Outpatient x-rays and other imaging services	Nothing	Nothing
iii. Other outpatient hospital and ambulatory surgical center services	Nothing	Nothing
3. Inpatient services	Nothing	Nothing
4. Services received from a physician during an inpatient stay	Nothing	Nothing
5. Anesthesia services received from a provider during an inpatient stay	Nothing	Nothing

*** The copayment and visit limit are combined on an annual basis for all eligible services identified throughout this Policy.**

S. *Skilled Nursing Facility Services*

This section describes coverage for use of skilled nursing facility services. Care must be provided under the direction of a physician. Skilled nursing facility services are eligible for coverage only if they qualify as reimbursable under Medicare.

Covered

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

- *In-network benefits* apply to skilled nursing facility services arranged through a physician and received from a network skilled nursing facility.
- *Out-of-network benefits* apply to skilled nursing facility services arranged through a physician and received from a non-network skilled nursing facility. In addition to the deductible described for out-of-network benefits, you will be responsible for any charges in excess of the non-network provider reimbursement amount.

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

Prior authorization. Prior authorization from MIC may be required *before* you receive services or supplies. Call Customer Service at one of the telephone numbers listed inside the front cover. See *How To Access Your Benefits* for more information about the prior authorization process.

See ***Definitions***. These words have specific meanings:

- Benefits
- Custodial care
- Deductible
- Hospital
- Inpatient
- Network
- Non-network
- Non-network provider reimbursement amount
- Physician
- Skilled care
- Skilled nursing facility

Not covered

These services, supplies and associated expenses are not covered:

1. Custodial care and other non-skilled services.
2. Self-care or self-help training (non-medical).

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

3. Private room, except for conditions of preeclampsia, radium implants, contagion or immunosuppression that require isolation.
4. Services primarily educational in nature.
5. Vocational and job rehabilitation.
6. Recreational therapy.
7. Health clubs.
8. Correction of speech impediments (stuttering or lisps) and assistance in the development of verbal clarity.
9. Voice training and voice therapy.
10. Outpatient rehabilitation services when no medical diagnosis is present.

Your Benefits and the Amounts You Pay

Benefits (after $9,300 deductible)	**In-network benefits You Pay**	**Out-of-network benefits You Pay**
1. Daily skilled care or daily skilled rehabilitation services, including room and board Benefits are limited to 120 days per calendar year for in-network and out-of-network combined. This day limitation applies whether or not your deductible has been met.	Nothing Services are covered only after transfer to a skilled nursing facility within 30 days of discharge from a hospital in which you were confined for not less than three consecutive calendar days. Services must begin within 14 days of an inpatient stay of at least three days in a hospital.	Nothing Services are covered only after transfer to a skilled nursing facility within 30 days of discharge from a hospital in which you were confined for not less than three consecutive calendar days. Services must begin within 14 days of an inpatient stay of at least three days in a hospital.
2. Skilled physical or occupational therapy when room and board is not eligible to be covered	Nothing	Nothing

Your Benefits and the Amounts You Pay		
Benefits (after $9,300 deductible)	**In-network benefits You Pay**	**Out-of-network benefits You Pay**
3. Services received from a physician during an inpatient stay in a skilled nursing facility Benefits are limited to services received during 120 days of inpatient stay per calendar year for in-network and out-of-network combined. This day limitation applies whether or not your deductible has been met.	Nothing	Nothing

T. *Hospice Services*

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

Covered

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

Hospice services are comprehensive palliative medical care and supportive social, emotional and spiritual services. These services are provided to terminally ill persons and their families, primarily in the patients' homes. A hospice interdisciplinary team, composed of professionals and volunteers, coordinates an individualized plan of care for each patient and family.

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 at a time.

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

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

See *Definitions*. These words have specific meanings:

- Benefits
- Deductible
- Member
- Network
- Physician
- Skilled nursing facility

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

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.

not later than two days after the hospice care is initiated.

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

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.

Not covered

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

These services, supplies and associated expenses are not covered:

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

Your Benefits and the Amounts You Pay		
Benefits (after $9,300 deductible)	**In-network benefits You Pay**	**Out-of-network benefits You Pay**
1. Hospice services	Nothing	No coverage

U. *Temporomandibular Joint (TMJ) Disorder*

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

This section also describes benefits for professional, hospital and ambulatory surgical center services.

Covered

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

- *In-network benefits* apply to TMJ services received from a network provider.
- *Out-of-network benefits* apply to TMJ services received from a non-network provider. In addition to the deductible described for out-of-network benefits, you will be responsible for any charges in excess of the non-network provider reimbursement amount.

Prior authorization. Prior authorization from MIC may be required *before* you receive services or supplies. Call Customer Service at one of the telephone numbers listed inside the front cover. See *How To Access Your Benefits* for more information about the prior authorization process.

See Definitions. These words have specific meanings:

- Benefits
- Deductible
- Hospital
- Inpatient
- Member
- Network
- Non-network
- Non-network provider reimbursement amount
- Physician
- Provider

TMJ disorder is covered the same as any other joint disorder under this Policy.

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

Not covered

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

1. Diagnostic casts and diagnostic study models.
2. Bite adjustment.

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

Your Expenses and the Amounts You Pay

Benefits (after $9,300 deductible)	**In-network benefits You Pay**	**Out-of-network benefits You Pay**
1. Initial office visit for evaluation	$50 copayment per visit for the first 3 visits per calendar year.* The deductible does not apply for the first 3 visits. Thereafter, you pay nothing after deductible.	Nothing
2. Office visits (including further evaluations)	$50 copayment per visit for the first 3 visits per calendar year.* The deductible does not apply for the first 3 visits. Thereafter, you pay nothing after deductible.	Nothing
3. Outpatient services		
a. Professional services		
i. Surgical services (as defined in the *Physicians' Current Procedural Terminology* code book) received from a physician or dentist during an office visit or an outpatient hospital or ambulatory surgical center visit	Nothing	Nothing
ii. Anesthesia services received from a provider during an office visit or an outpatient hospital or ambulatory surgical center visit	Nothing	Nothing

Your Expenses and the Amounts You Pay		
Benefits (after $9,300 deductible)	**In-network benefits You Pay**	**Out-of-network benefits You Pay**
iii. Outpatient lab and pathology	Nothing	Nothing
iv. Outpatient x-rays and other imaging services	Nothing	Nothing
v. Other outpatient hospital and ambulatory surgical center services received from a physician or dentist	Nothing	Nothing
b. Hospital and ambulatory surgical center services		
i. Outpatient lab and pathology	Nothing	Nothing
ii. Outpatient x-rays and other imaging services	Nothing	Nothing
ii. Other outpatient hospital and ambulatory surgical center services	Nothing	Nothing
4. Physical therapy received outside of your home	Nothing	Nothing
5. Inpatient services	Nothing	Nothing
6. Services received from a physician or dentist during an inpatient stay	Nothing	Nothing
7. Anesthesia services received from a provider during an inpatient stay	Nothing	Nothing
8. TMJ splints and adjustments if your primary diagnosis is joint disorder	Nothing	Nothing

*** The copayment and visit limit are combined on an annual basis for all eligible services identified throughout this Policy.**

V. *Medical-Related Dental Services*

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

Covered

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

- *In-network benefits* apply to medical-related dental services received from a network provider.
- *Out-of-network benefits* apply to medical-related dental services received from a non-network provider. In addition to the deductible described for out-of-network benefits, you will be responsible for any charges in excess of the non-network provider reimbursement amount.

Prior authorization. Prior authorization from MIC may be required *before* you receive services or supplies. Call Customer Service at one of the telephone numbers listed inside the front cover. See *How To Access Your Benefits* for more information about the prior authorization process.

See ***Definitions.*** These words have specific meanings:

- Benefits
- Deductible
- Dependent
- Hospital
- Member
- Network
- Non-network
- Non-network provider reimbursement amount
- Physician
- Provider

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

Not covered

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

These services, supplies and associated expenses are not covered:

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

Your Benefits and the Amounts You Pay

Benefits (after $9,300 deductible)	**In-network benefits You pay**	**Out-of- network benefits You pay**
1. Charges for medical facilities and general anesthesia services that are: a. Recommended by a network physician; and b. Received during a dental procedure; and c. Provided to a member who: i. Is a child under age five (prior authorization is *not* required); or ii. Is severely disabled; or	Nothing	Nothing

Your Benefits and the Amounts You Pay		
Benefits (after $9,300 deductible)	**In-network benefits You pay**	**Out-of- network benefits You pay**
iii. Has a medical condition and requires hospitalization or general anesthesia for dental care treatment. **Please note**. Age, anxiety and behavioral conditions are not considered medical conditions.		

W. Emergency Services From Non-Network Providers

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

Covered

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

- If there was a delay associated with getting to a network provider, your health would be endangered; or
- Because of your health condition you are unable to request treatment from a network provider.

You must notify MIC of emergency inpatient services as soon as reasonably possible after receiving inpatient services: Call Customer Service at one of the telephone numbers listed inside the front cover.

For emergency mental health or substance abuse inpatient services, you must notify MIC's designated mental health and substance abuse provider as soon as reasonably possible. MIC's designated mental health and substance abuse provider can be reached at:

- 1-800-848-8327
- TTY: 1-800-543-7162

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

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

See *Definitions*. These words have specific meanings:

- Benefits
- Claim
- Deductible
- Emergency
- Hospital
- Inpatient
- Member
- Network
- Non-network
- Physician
- Provider

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

Not covered

These services, supplies and associated expenses are not covered:

1. Non-emergency care from non-network providers except as described in this Policy.
2. Unauthorized continued inpatient services in a non-network facility once the attending physician agrees it is safe to transfer you to a network facility.

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

3. Follow-up care or scheduled care from a non-network provider except as described in this Policy.
4. Transfers and admissions to network hospitals solely at the convenience of the member.

Your Benefits and the Amounts You Pay

Benefits **(after $9,300 deductible)**	**In-network benefits** **You pay**
1. Emergency services that are: a. Administered under the direction of a physician; *and* b. Otherwise eligible for coverage in this Policy.	Nothing
2. Ambulance service or ambulance transportation to the nearest hospital for an emergency	Nothing

X. Referrals To Non-Network Providers

This section describes coverage for referrals from network providers to non-network providers. In-network benefits will apply to referrals from network providers to non-network providers as described in this section. It is to your advantage to seek MIC's authorization for referrals to non-network providers *before* you receive services. MIC can then tell you what your benefits will be for the services you may receive.

What you must do

1. Request a referral or standing referral from a *network provider* to receive *medically necessary* services from a *non-network provider*. The referral will be in writing and will:
   a. Indicate the time period during which services must be received; and
   b. Specify the service(s) to be provided; and
   c. Direct you to the *non-network provider* selected by your *network provider*.
2. Seek prior authorization from MIC by calling one of the telephone numbers listed inside the front cover. MIC does not guarantee coverage of services that are received before you obtain prior authorization from MIC.
3. If prior authorization has been obtained from MIC, pay the same amount you would have paid if the services had been received from a network provider.
4. Pay any charges not authorized for coverage by MIC.

What MIC will do

1. May require that you see another network provider selected by MIC before a determination by MIC that a referral to a non-network provider is medically necessary.
2. May require that you obtain a referral or standing referral (as described in this section) from a network provider to a non-network provider practicing in the same or similar specialty.
3. Provide coverage for health services that are:

See *Definitions.* These words have specific meanings:
- Benefits
- Medically necessary
- Network
- Non-network
- Physician
- Provider

If you want to apply for a standing referral to a non-network provider, contact MIC for more information. If determined by MIC to be medically necessary, a standing referral may be granted by MIC.

A standing referral is a referral issued by a network provider and authorized by MIC for conditions that require ongoing services from a non-network specialist provider. Standing referrals will only be authorized for the period of time appropriate to your medical condition.

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

a. Otherwise eligible for coverage under this Policy; and

b. Recommended by a network physician.

4. Notify you of authorization or denial of coverage within ten days of receipt of your request. MIC will inform both you and your provider of MIC's decision within 72 hours from the time of the initial request if your attending provider believes that an expedited appeal is warranted, or MIC concludes that a delay could seriously jeopardize your life, health, or ability to regain maximum function.

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

Y. Harmful Use Of Medical Services

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

When this section applies

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

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

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

MIC will send you specific information about:

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

See ***Definitions***. These words have specific meanings:

- Benefits
- Emergency
- Hospital
- Network
- Physician
- Prescription drug
- Provider

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

Z. Exclusions

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

1. Services that are not medically necessary. This includes but is not limited to services inconsistent with the medical standards and accepted practice parameters of the community and services inappropriate—in terms of type, frequency, level, setting and duration—to the diagnosis or condition.
2. Services or drugs used to treat conditions that are cosmetic in nature, unless otherwise determined to be reconstructive.
3. Refractive eye surgery.
4. The purchase, replacement or repair of eyeglasses, eyeglass frames, or contact lenses when prescribed solely for vision correction, and their related fittings and except as stated in *Professional Services.*
5. Services provided by an audiologist when not under the direction of a physician, hearing aids (including internal, external or implantable hearing aids or devices) and other devices to improve hearing, and their related fittings, except cochlear implants and related fittings and except as stated in *Durable Medical Equipment And Prosthetics*.
6. A drug, device or medical treatment or procedure that is investigative.
7. Services for genetic screening and testing except when:
   a. Recommended by a genetic counselor as predictive of a disease process, and treatment standards of care exist for the disease process; or
   b. Reproductive choices would be made based on the test findings.
8. Services or supplies not directly related to care.
9. Autopsies, except as stated in *General Provisions*.

See *Definitions*. These words have specific meanings:

- Claim
- Cosmetic
- Custodial care
- Emergency
- Investigative
- Medically necessary
- Member
- Non-network
- Physician
- Pre-existing condition
- Provider
- Reconstructive

MIC 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.

10. Enteral feedings (unless they are the sole source of nutrition) except for the dietary medical treatment of PKU.
11. Nutritional and electrolyte substances except as specifically described in Miscellaneous Medical Services And Supplies.
12. Physical or occupational or speech therapy when there is no reasonable expectation that the condition will improve over a predictable period of time.
13. Reversal of voluntary sterilization.
14. NeuropSYFhological evaluations/cognitive testing, except as stated in *Professional Services*.
15. Personal comfort or convenience items or services, including but not limited to breast pumps except when the pump is medically necessary.
16. Custodial care, unskilled nursing or unskilled rehabilitation services.
17. Respite or rest care except as otherwise covered in *Hospice Services*.
18. Travel, transportation or living expenses.
19. Household equipment, fixtures, home modifications and vehicle modifications.
20. Services to treat nicotine addiction except as stated in *Prescription Drugs And Pharmacy Services*.
21. Massage therapy, provided in any setting, even when it is part of a comprehensive treatment plan.
22. Routine foot care, except for members with diabetes, peripheral vascular disease, peripheral neuropathies or blindness.
23. Services by persons who are family members or who share your legal residence.
24. Services for which coverage is available under worker's compensation, employer liability or any similar law.
25. Services received before coverage under this Policy becomes effective.
26. Services received after coverage under this Policy ends.
27. Unless requested by MIC, charges for duplicating and obtaining medical records from non-network providers and non-network dentists.

28. Photographs, except for the condition of multiple dysplastic syndrome.
29. Occlusal adjustment or occlusal equilibration.
30. Dental implants (tooth replacement).
31. Dental prostheses.
32. Orthodontic treatment, except as stated in *Medical-Related Dental Services.*
33. Treatment for bruxism.
34. Services prohibited by law or regulation, or illegal under Minnesota law.
35. 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).
36. Exams, other evaluations or other services for employment, insurance or licensure.
37. Exams, other evaluations or other services for judicial or administrative proceedings or research, except emergency examination of a child ordered by judicial authorities, or which MIC determines is medically necessary, or as otherwise covered under this Policy.
38. Non-medical self-care or self-help training.
39. Educational classes, programs or seminars, including but not limited to childbirth classes.
40. Coverage for costs associated with translation of medical records and claims to English.
41. Treatment for spider veins.
42. Services not received from or under the direction of a physician, except as described in this Policy.
43. Preventive dental services.
44. Elective, induced abortions, except as *medically necessary* to protect the life or health of the mother.
45. Implants for the purpose of contraception.
46. Therapeutic acupuncture.
47. Services billed by an acupuncturist.
48. Services for or related to vision therapy and orthoptic and/or pleoptic training, except as stated in *Professional Services*.
49. Services for or related to intensive behavior therapy treatment programs for the treatment of autism spectrum disorders. Examples of such services

include, but are not limited to, Intensive Early Intervention Behavior Therapy Services (IEITBS), Intensive Behavior Intervention (IBI), and Lovaas therapy.

51. Sensory Integration including Auditory Integration Training.
52. Orthognathic surgery.
53. Health care professional services for maternity labor and delivery in the home.
54. Telephone consultations.
55. Surgery for morbid obesity, except as stated in *Surgery For Weight Loss*.
56. Growth hormone
57. Infertility services and services and drugs for or related to assisted reproductive technology (ART).
58. Services to treat a pre-existing condition as described in *How To Access Your Benefits*.
59. Maternity care services, other than prenatal care.
60. Charges that are eligible, paid, or payable under any medical payment, personal injury protection, automobile or other coverage that is payable without regard to fault, including charges that are applied toward any deductible, copayment or coinsurance requirement of such coverage.
61. Services for private-duty nursing.
62. Services for sex transformation surgery, sex hormones related to surgery, related preparation and follow-up treatment, and care and counseling, unless medically necessary and prior authorization is obtained from MIC before you receive services.
63. Functional capacity evaluations and related services for vocational purposes or for determination of disability or pension benefits.
64. Services for chemotherapy, supplies, drugs and aftercare in connection with a human organ transplant that is not covered (see *Organ And Bone Marrow Transplant Services*).
65. Services for systemic candidiasis, omeopathy and immunoaumentive therapy.
66. Services for or in connection with fetal tissue transplantation.

67. Services which are not within the scope of licensure or certification of the provider.
68. Charges for services by a non-network provider in excess of the non-network provider reimbursement amount.
69. Non-emergency transportation.
70. Non-emergency services received outside the United States.
71. Preventive health care, except as stated in *Professional Services*.

AA. How To Submit A Claim

This section describes the process for submitting a claim.

See *Definitions*. These words have specific meanings:

- Benefits
- Claim
- Dependent
- Member
- Network
- Non-network
- Non-network provider reimbursement amount
- Provider

Claims for benefits from network providers

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

Network providers are required to submit claims within 180 days from when you receive a service. If your provider asks for your health care identification card and you do not identify yourself as a MIC 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 your enrollment materials. You may request additional claim forms by calling Customer Service at one of the telephone numbers listed inside the front cover. If the claim forms are not sent to you within 15 days, you may submit an itemized statement without the claim form to MIC. You should retain copies of all claim forms and correspondence for your records.

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

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

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

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

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

Claims for emergency services provided outside the United States

Claims for emergency services rendered in a foreign country will require the following additional documentation:

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

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

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

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

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

Time limits

If you have a complaint or disagree with a decision by MIC, you may follow the complaint procedure outlined in *Complaints* or you may initiate legal action at any point.

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

BB. Coordination Of Benefits

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

1. *Applicability*

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

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

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

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

See *Definitions*. These words have specific meanings:

- Benefits
- Claim
- Deductible
- Hospital
- Emergency
- Medically necessary
- Member
- Non-network
- Non-network provider reimbursement amount
- Provider
- Subscriber

2. *Definitions that apply to this section*

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

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

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

Security Act, as amended from time to time).

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

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

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

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

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

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

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

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

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

When a plan provides benefits in the form of services, the reasonable cash value of each

service rendered will be considered both an allowable expense and a benefit paid.

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

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

3. *Order of benefit determination rules*

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

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

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

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

iv. *Group plan/individual plan.* The benefits of a group plan are determined before those of an individual plan.

v. *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.

vi. *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.

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

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

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

4. ***Effect on the benefits of this plan***

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

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

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

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

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

When this plan is a secondary plan, this plan will pay the balance of any remaining expenses determined to be eligible under this Policy, according to the out-of-network benefits described in this Policy. Most out-of-network benefits are covered at 100% of the non-network provider reimbursement amount, after you pay the applicable deductible amount. In no event will this plan provide duplicate coverage.

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

5. ***Right to receive and release needed information***

Certain facts are needed to apply these COB rules. MIC has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. MIC 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 MIC any facts it needs to pay the claim.

6. ***Facility of payment***

A payment made under another plan may include an amount, which should have been paid under this plan. If it does, MIC 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. MIC will not have to pay that amount again. The term *payment made* includes providing benefits in the form of services, in which case *payment made* means reasonable cash value of the benefits provided in the form of services.

7. *Right of recovery*

> **Please note.** See ***Right Of Recovery*** for additional information.

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

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

b. Insurance companies; or

c. Other organizations.

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

CC. Right Of Recovery

This section describes MIC's right of recovery. MIC's rights are subject to Minnesota and federal law.

See Definitions. These words have specific meanings:
- Benefits
- Claim

1. MIC 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. MIC's right of subrogation shall be governed according to this section. MIC's right to recover its subrogation interest applies only after you have received a full recovery for your illness or injury from another source of compensation for your illness or injury.
2. MIC's subrogation interest is the reasonable cash value of any benefits received by you.
3. MIC's right to recover its subrogation interest may be subject to an obligation by MIC to pay a pro rata share of your disbursements, attorney fees and costs, and other expenses incurred in obtaining a recovery from another source unless MIC is separately represented by an attorney. If MIC is represented by an attorney, an agreement regarding allocation may be reached. If an agreement cannot be reached, the matter must be submitted to binding arbitration.
4. By accepting coverage under this Policy, you agree:
   a. To cooperate with MIC or its designee to help protect MIC's legal rights under this subrogation provision and to provide all information MIC may reasonably request to determine its rights under this provision.
   b. To provide prompt written notice to MIC when you make a claim against a party for injuries.
   c. To provide prompt written notice of MIC's subrogation rights to any party against whom you assert a claim for injuries.
   d. To do nothing to decrease MIC's rights under this provision, either before or after receiving benefits, or under this Policy.
   e. MIC may take action to preserve its legal rights. This includes bringing suit in your name.

For information about the effect of Minnesota and federal law on MIC's subrogation rights, contact an attorney.

f. MIC may collect its subrogation interest from the proceeds of any settlement or judgment recovered by you, your legal representative or the legal representative(s) of your estate or next-of-kin.

g. To hold in trust the proceeds of any settlement or judgment for MIC's benefit under this provision.

DD. Eligibility And Enrollment

This section describes who can enroll and how to enroll.

Who can enroll

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

Subscriber eligibility.

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

1. be a Minnesota resident; and
2. be at least 18 years of age; and
3. complete an application form provided by MIC; and
4. provide MIC certain information regarding his or her health status; and
5. be accepted by MIC for enrollment.

See Definitions. These words have specific meanings:

- Continuous coverage
- Member
- Mental disorder
- Physician
- Placed for adoption
- Pre-existing condition
- Premium
- Qualifying coverage
- Subscriber

Notification

The subscriber must notify MIC in writing within 30 days of the effective date of any changes to address or name, or other facts identifying you.

The date your coverage begins

Coverage will begin after the application for coverage has been approved by MIC. MIC will notify the subscriber of the approval and the effective date of coverage.

- Premium must be paid from the date coverage starts.

Coverage begins at 12:01 a.m. on the effective date of enrollment.

EE. Ending Coverage

This section describes when coverage ends under this Policy.

When coverage ends

See *Definitions*. These words have specific meanings:

- Certification of qualifying coverage
- Claim
- Member
- Premium
- Subscriber

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

1. The date MIC notifies you that MIC will cease doing business. Coverage will end on the last day of a month. (To cease doing business means to discontinue issuing new individual health plans and to refuse to renew all of MIC's existing individual health plans.)
2. The end of the month for which the subscriber last paid the premium due.
3. The end of the month following the date the subscriber requests that coverage end. Written request for termination of the subscriber's coverage must be received by MIC at least 31 days before the date of termination. However, the effective date of such termination must be the end of the month. Any refund of premium shall be mailed to the subscriber upon receipt of this notice by MIC.
4. If you terminate this Policy within the first ten days of receiving it, coverage shall terminate retroactive to the effective date of this Policy.
5. The end of the month following the date you enter active military duty for more than 31 days. Upon completion of active military duty, your coverage will be reinstated if you notify MIC within 90 days after removal from active military duty. Preexisting condition limitations or exclusions will not apply.
6. The date of the death of the member.
7. The end of the month following the date 31 days after MIC notifies you that coverage will end because you did not pay a copayment or coinsurance for in-network benefits.
8. The date specified by MIC in written notice to you that coverage ended due to fraud. Fraud includes but is not limited to:

If coverage ends due to fraud, coverage will be retroactively terminated at MIC's discretion to the original date of coverage or the date on which the fraudulent act took place.

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

You have the right to a certification of qualifying coverage when coverage ends. You will receive a certification of qualifying coverage when coverage ends. You may also request a certification of qualifying coverage within the 24 months following the date your coverage ends.

FF. Complaints

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

You may call Customer Service at one of the telephone numbers listed inside the front cover or by writing to the address below in *First level of review*, number 2. You also may contact the Commissioner of Commerce, Minnesota Department of Commerce, at (651) 296-2488 or 1-800-657-3602.

See Definitions. These words have specific meanings:

- Claim
- Inpatient
- Network
- Provider

First level of review

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

You may have another person make a complaint on your behalf by telephone or in writing. Before releasing confidential information to a person filing a complaint on your behalf, MIC will require you to sign an authorization form.

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

You may direct any question or complaint to Customer Service by calling one of the telephone numbers listed inside the front cover or by writing to the address listed below.

1. If your complaint is regarding an initial decision made by MIC, and your complaint requires a medical determination in its resolution, your complaint must be made within one year following MIC's initial decision.
2. For an oral complaint that does not require a medical determination in its outcome, if MIC does not communicate a decision within ten business days from MIC's receipt of the complaint, or if you determine that MIC's decision is partially or wholly adverse to you, MIC will provide you with a complaint form to submit your complaint in writing. Mail the completed form to:

   Customer Service
   Route CP320
   PO Box 9310
   Minneapolis, MN 55440-9310

3. MIC will provide written notice of its first level review decision to you and your attending provider, when applicable, within 30 calendar days from receipt of your complaint or request.
4. When an initial decision by MIC not to grant a prior authorization request is made before or during an ongoing service requiring MIC's authorization, and your attending *provider* believes that MIC's decision warrants an expedited appeal, you or your

attending *provider* will have the opportunity to request an expedited review by telephone. Alternatively, if MIC concludes that a delay could seriously jeopardize your life, health, or ability to regain maximum function, MIC will process your *claim* as an expedited review. In such cases, MIC will notify you and your attending *provider* by telephone of its decision no later than 72 hours after receiving the request.

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

NOTE: 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. MIC will inform you in writing whether the second level of review is optional or required.

Second level of review

If you are not satisfied with MIC's first level 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 MIC within one year following the date of MIC'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*, number 2.
2. Regardless of the method chosen for review (hearing or a written reconsideration), testimony, explanation or other information provided by you, MIC staff, providers and others is reviewed.
3. MIC will provide written notice of its second level review decision to you within:
    a. 30 calendar days from receipt of written notice of your appeal for required second level reviews; or
    b. 45 calendar days from receipt of written notice of your appeal for optional second level reviews.

External review

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

Minnesota Department of Commerce
85 7th Place East, Suite 500
St. Paul, MN 55101-2198

A filing fee of $25 must accompany your written request, unless waived by the Commissioner. An independent entity contracted with the State Commissioner of Administration will review your request. The external review decision will not be binding on you but will be binding on MIC. Contact the Commissioner of Commerce for more information about the external review process.

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

In addition to directing complaints to Customer Service 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.

GG. General Provisions

This section describes the general provisions of this Policy.

See Definitions. These words have specific meanings:

- Benefits
- Claim
- Member
- Network
- Premium
- Provider
- Subscriber

Examination of a member

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

Clerical error

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

Relationship between parties

The relationships between MIC and network providers are contractual relationships between independent contractors. Network providers are not agents or employees of MIC. 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

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

Notice

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

However, notice of termination for nonpayment of premium shall be given by MIC to each subscriber.

Entire agreement

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

Amendment

This Policy may be amended in accordance with this Policy. When this happens, you will receive a new policy or amendment. No other person or entity has authority to make any changes or amendments to this Policy. All amendments must be in writing.

Discretionary authority

MIC has discretion to interpret and construe all of the terms and conditions of this Policy and make determinations regarding benefits and coverage under this Policy.

HH. Definitions

In this Policy (and in any amendments), some words have specific meanings.

Term	Definition Within each definition, you may note bold words. These words also are defined in this section.
Benefits	The health services or supplies (described in this Policy and any subsequent amendments) approved by MIC as eligible for coverage.
Certification of qualifying coverage	A written certification that group health plans and health insurance issuers must provide to an individual to confirm the **qualifying coverage** provided to the individual under the group health plan or health insurance.
Claim	An invoice, bill or itemized statement for **benefits** provided to you.
Coinsurance	The percentage amount you must pay to the **provider** for **benefits** received. Full **coinsurance** payments may apply to scheduled appointments canceled less than 24 hours before the appointment time or to missed appointments. For in-**network benefits**, the **coinsurance** amount typically is based on the lesser of the: 1. Charge billed by the **provider** (i.e., retail), or 2. Negotiated amount that the **provider** has agreed to accept as full payment for the **benefit** (i.e., wholesale). When the wholesale amount is not known nor readily calculated at the time the **benefit** is provided, MIC uses an amount to approximate the wholesale amount. For services from some **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 MIC **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**.

Term	Definition Within each definition, you may note bold words. These words also are defined in this section.
	For out-of-**network benefits**, in addition to any **copayment**, **coinsurance** and **deductible** amounts, you are 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 *Specialty Prescription Drug Program*, the calculation of **coinsurance** amounts as described above do not include possible reductions for any volume purchase discounts or price adjustments that MIC 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**.
Continuous coverage	The maintenance of continuous and uninterrupted **qualifying coverage** by an individual. An individual is considered to have maintained **continuous coverage** if enrollment is requested under this Policy within 63 days of termination of the previous **qualifying coverage**.
Convenient/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.
Copayment	The fixed dollar amount you must pay to the **provider** for **benefits** received. Full **copayments** may apply to scheduled appointments canceled less than 24 hours before the appointment time or to missed appointments. 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**. MIC pays any remaining amount according to the written agreement between MIC and the **provider.** The **copayment** may not exceed the retail charge billed by the **provider** for the **benefit**. For out-of-**network benefits**, in addition to any **copayment**, **coinsurance** and **deductible** amounts, you are responsible for any charges in excess of the **non-network provider reimbursement amount**.

Term	Definition Within each definition, you may note bold words. These words also are defined in this section.
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 before **claims** for health services or supplies received from **network** or **non-network providers** are reimbursable as **benefits** under this Policy.
Designated facility	A **designated facility** means a **network hospital** that MIC has authorized to provide certain **benefits** to **members**, as described in this certificate.
Designated physician	A **designated physician** means a **network physician** that MIC has authorized to provide certain **benefits** to **members**, as described in this certificate.
Designated provider	A **designated provider** means a **network provider** that MIC has authorized to provide certain **benefits** to **members**, as described in this certificate.
Emergency	A condition or symptom that 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 in serious jeopardy.
Enrollment date	The date of the **member's** first day of coverage under this Policy.

Term	Definition Within each definition, you may note bold words. These words also are defined in this section.
Hospital	A licensed facility that provides diagnostic, medical, therapeutic, rehabilitative and surgical services by, or under the direction of, a **physician** and with 24-hour R.N. nursing services. The **hospital** is not mainly a place for rest or **custodial care**, and is not a nursing home or similar facility.
Inpatient	An uninterrupted stay , following formal admission to a **hospital**, **skilled nursing facility** or licensed acute care facility. **Inpatient** services in a licensed residential treatment facility for treatment of emotionally disabled children will be covered as any other health condition.
Investigative	As determined by MIC, 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. MIC 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**.

Term	Definition Within each definition, you may note bold words. These words also are defined in this section.
	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 MIC to be **investigative.** MIC will determine if a use is an accepted off-label use based on published reports in authoritative peer-reviewed medical literature, clinical practice guidelines or parameters approved by national health professional boards or associations and entries in the following drug compendia: *The American Hospital Formulary Service Drug Information* and the *United States Pharmacopoeia Dispensing Information*.
Medically necessary	Diagnostic testing and medical treatment, consistent with the diagnosis of and prescribed course of treatment for your condition, and preventive services. **Medically necessary** care must meet the following criteria: 1. Be consistent with the medical standards and accepted practice parameters of the community as determined by health care **providers** in the same or similar general specialty as typically manages the condition, procedure or treatment at issue; and 2. Be an appropriate service, in terms of type, frequency, level, setting, and duration, to your diagnosis or condition; and 3. Help to restore or maintain your health; or 4. Prevent deterioration of your condition; or 5. Prevent the reasonably likely onset of a health problem or detect an incipient problem.
Member	A person who is enrolled under this Policy and on whose behalf the premium is being paid. In this Policy, the words you, your or yourself refer to the member.
Mental disorder	A physical or mental condition having an emotional or pSYFhological origin, as defined in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM).
Network	A term used to describe a **provider** (such as a **hospital**, **physician**, home health agency, **skilled nursing facility** or pharmacy) that has entered into a written agreement with MIC or has made other arrangements with MIC to provide **benefits** to you. The participation status of **providers** will change from time to time.

Term	Definition Within each definition, you may note bold words. These words also are defined in this section.
	The MIC **network provider** directory will be furnished automatically, without charge.
Non-network	A term used to describe a **provider** not under contract as a **network provider**.
Non-network provider reimbursement amount	The amount of a **non-network provider's** charge that is eligible for benefits under the Policy. The **non-network provider reimbursement amount** is determined as follows: 1. For **emergency** services and services provided upon referral from a **network provider** (see the sections ***Emergency Services From Non-Network Providers*** and *Referrals To Non-Network* Providers): The **non-network provider's** charge. 2. For family planning services for the voluntary planning of the conception and bearing of children, services for testing and treatment of a sexually transmitted disease, and testing for AIDs and other HIV-related conditions: The **non-network provider's** charge. 3. For prescription drugs and pharmacy services: 85% of the **non-network provider's** charge. 4. For all other services: The lesser of: a. the **non-network provider's** charge; or b. the fee maximum amount for the service as determined pursuant to MIC's fee schedule then in effect for the Medica Solo product. If the amount billed by the **non-network provider** is greater than the **non-network provider reimbursement amount**, *you must pay the difference*. Such difference is in addition to any **copayment, coinsurance** or **deductible** amount you may be responsible for according to the terms described in this Policy. In addition, such difference will not be applied to the out-of-pocket maximum described in *Your Out-of-Pocket Expenses*.
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.

Term	Definition Within each definition, you may note bold words. These words also are defined in this section.
Pre-existing condition	A physical or mental condition other than a pregnancy, present before your **enrollment date** under the Policy, for which medical advice, diagnosis, care or treatment (including treatment with **prescription drugs**) was recommended by or received from a **physician** or other **provider** within the six months immediately preceding your **enrollment date**. Refer to *How To Access Your Benefits* for additional information regarding **pre-existing conditions** and the application of a **pre-existing condition** limitation.
Premium	The monthly payment required to be paid by you for coverage under this Policy.
Prenatal care	The comprehensive package of medical and pSYFhosocial 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.
Provider	A health care professional or facility licensed, certified or otherwise qualified under state law to provide health services.
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 policy 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;

Term	Definition Within each definition, you may note bold words. These words also are defined in this section.

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. A plan similar to any of the above plans provided in the State of Minnesota or in another state, as determined by the Commissioner of Health or the Commissioner of Commerce.
16. Any plan established or maintained by a state, the United States government, or a foreign country, or any political subdivision of a state, the United States government, or a foreign country that provides health coverage to individuals who are enrolled in the plan.
17. The State Children's Health Insurance Program (SCHIP).

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;

Term	Definition Within each definition, you may note bold words. These words also are defined in this section.
	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. Any **pre-existing condition** limitation may be affected by your prior **qualifying coverage**. You have the right to prove your prior **qualifying coverage** to MIC. You have the right to obtain a **certification of qualifying coverage** from a prior plan. MIC can assist you in obtaining the **certification of qualifying coverage** from the prior plan.
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**.

Term	Definition Within each definition, you may note bold words. These words also are defined in this section.
	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**.
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**.
Skilled care	Nursing or rehabilitation services requiring the skills of technical or professional medical personnel to develop provide and evaluate your care and assess your changing condition. Long-term dependence on respiratory support equipment and/or the fact that services are received from technical or professional medical personnel do not by themselves define the need for **skilled care**.
Skilled nursing facility	A licensed bed or facility (including an extended care facility, **hospital** swing-bed and transitional care unit) that provides skilled nursing care, skilled transitional care, or other related health services including rehabilitative services.
Subscriber	The person to whom this Policy is issued.

MN-SOLO-PC07-100-01