Minnesota Policy of Coverage

for Individuals and Families

Altru Prime by Medica[SM]

MN-PC-25-01

Bronze H Plan Zero

Plan Identifier 2025-IFBAPBHMNZ

Cancellation Within First Ten Days

The subscriber may cancel this Policy by delivering or mailing a written notice to **Medica Insurance Company, 401 Carlson Parkway, Attn: Member Services, Route CP595, Minnetonka, MN 55305** or to an agent of the company. This Policy must be returned before midnight the tenth day after the date you receive this Policy and then this Policy is considered void from the beginning. Notice given by mail and return of this Policy are effective when postmarked, properly addressed, and postage prepaid. Medica 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.

Discrimination is Against the Law

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

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

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

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

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

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

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

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

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

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

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

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

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

ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປຂໍ້ມູນນີ້ຟຣີ, ໃຫ້ໂທຫາເລກໝາຍທີ່ມີຢູ່ໃນເອກະສານນີ້ ຫຼື ຢູ່ດ້ານຫຼັງຂອງບັດ Medica ຂອງທ່ານ.

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

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

နမ့်ဆဲဉီးတ၊်ကွိးထံစ၊းကလီနှ်နၤတ၊်ဂ့၊်တ၊်ကွိုးဆံၤလ၊းအကလီနှ်, ကိးလီတဲစိနှိဉ်ဂ်၊်လ၊းအပဉ်ယှာ်လ၊းလ်ာ်တီလ်ာ်မီအပူၤဒၣ်းမ့တမ့်ဖဲနနှနိုင်လော်အုဉ်သးဒးကှအလိၢ်ခံတကပၤအဖိခိဉ်နှဉ်တက့၊်.

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

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

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

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

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

COMIFB-0119-M

Helpful Resources

Medica Member Services

Call the Medica Member Services phone number on the back of your Medica ID card (TTY: **711)** if you have any questions. Health Plan Specialists are available 8 a.m. – 6 p.m. CT Monday – Friday (Closed 8 – 9 a.m. Thursdays). You can also send a secure message at **Medica.com/Contact**.

MNsure Contact Center

Call **1 (855) 366-7873** (TTY: **711**) if you purchased your coverage through MNsure, and you need assistance with your financial help (like advance premium tax credits) or need to make changes to the demographic information on this Policy. Or visit **MNsure.org/Help**.

Nurse Line

Call **1 (866) 668-6548** (TTY: **711**) to talk with a nurse for advice on where and when to get care, or how to provide care safely at home. Available 24/7. In a medical emergency, please call **911.**

Secure Member Site

You can view much of the information you may need by signing in to your secure member site at **Medica.com/SignIn**. The website allows you to view information specific to you and your plan:

- View your ID card
- See what's covered by your plan, including important plan documents
- Track your plan balances, such as your deductible and out-of-pocket maximum
- View your claims and explanations of benefits (EOBs)
- Look up prices for prescription drugs and how they're covered by your plan
- Look up providers and pharmacies in your network
- Access wellness tools and support
- Pay your premium

Important Notice: This plan is an Exclusive Provider Organization (EPO) plan. EPO plans cover health care services only when provided by a provider who participates in the network. If you receive services from a non-network provider, you will have to pay all of the costs for the services, except that emergency services must be covered regardless of whether they are delivered by a network provider.

Table Of Contents

Terms and Conditions

Term of this Policy

This Policy is a legal contract between the subscriber and Medica Insurance Company (Medica) and describes the benefits covered under this Policy.

All coverage under this Policy begins at 12:01 a.m. Central Time on the date the coverage becomes effective. Unless the Policy is terminated earlier (due to your non-payment of premium or for fraud or intentional misrepresentation of a material fact, or as otherwise described in *Ending Coverage*), this Policy ends at the end of the applicable calendar year.

Entire agreement

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

1. This Policy of Coverage, the *Benefit Chart* section of this Policy of Coverage, any amendments; and
2. Your application for coverage.

Guaranteed renewal

This Policy will not be canceled or non-renewed merely because your health deteriorates. Renewal is subject to Medica's right to terminate this Policy due to your non-payment of premium or for fraud or intentional misrepresentation of a material fact, or as otherwise described in *Ending Coverage*. Medica has the right to change the premium as allowed under Minnesota law.

Nondiscrimination policy

Medica's policy is to treat all persons alike, without distinction based on:

- race
- color
- creed
- religion
- national origin
- sex
- pregnancy
- gender
- gender identity
- marital status
- status with regard to public assistance
- disability
- sexual orientation
- age
- genetic information; or
- any other classification protected by law.

For more information, see the non-discrimination notice at the beginning of this Policy. If you have questions, call Member Services at the number on the back of your Medica ID card.

Assignment

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

Acceptance of coverage

By accepting the health care coverage described in this Policy you, on behalf of yourself if covered under this Policy, and/or on behalf of the dependents enrolled under this Policy, authorize the use of a social security number for purpose of identification and declare that the information supplied to Medica for purposes of enrollment is accurate and complete.

You understand and agree that any omissions or incorrect statements that you knowingly made in connection with your enrollment under this Policy may invalidate your coverage.

Amendment

This Policy or the *Benefit Chart* section of this Policy may be amended as described in this Policy. When this happens, you will receive a new policy or amendment approved and signed by an executive officer of Medica. No other person or entity has authority to make any changes or amendments to this Policy. All amendments must be in writing.

Discretionary authority

Medica 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.

Certain terms are specifically defined in this Policy and Medica will interpret and construe the terms and conditions consistent with those definitions. It is important that you read and understand the defined terms.

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

Notice

Except as otherwise provided in this Policy, written notice given by Medica to the subscriber will be deemed notice to all individuals covered under this Policy in the event of termination or nonrenewal of this Policy for any reason.

Cancellation

Your coverage may be canceled only under certain conditions. See *Ending Coverage* for additional information.

Reinstatement

If any renewal premium is not paid within the time granted the subscriber for payment, a subsequent acceptance of premium by Medica shall reinstate this Policy. In all other respects the subscriber and Medica will have the same rights under this Policy as they had immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with a reinstatement.

Examination of a member

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

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 Member Services at the number on the back of your Medica ID card.

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 need alternative formats, such as large print or an audio format, please call Member Services at the number on the back of your Medica ID card to request these materials.

Disclosure required by Minnesota law

This Policy is expected to return on average 85.3% of your premium dollar for health care coverage. The lowest percentage permitted by state law for this Policy is 72%.

Policy

This Policy is a legal contract between the subscriber and Medica and describes the benefits covered under this Policy.

By:

Alicia Reuter

Secretary

By:

Elizabeth F. Erickson

President and CEO

Member Bill of Rights and Member Responsibilities

Member Bill of Rights

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

1. Available and accessible services, including emergency services 24 hours a day, seven days a week; and
2. Information about your health condition, appropriate or medically necessary treatment options and risks, regardless of cost or benefit coverage, so you can make an informed choice about your health care; and
3. Participate with providers in decision-making regarding your health care, including the right to refuse treatment recommended to you by Medica or any provider; and
4. Be treated with respect and recognition of your dignity and privacy, including privacy of your Medical and financial records maintained by Medica or any network provider in accordance with existing law; and
5. Contact Medica and Minnesota's Commissioner of Commerce to file a complaint about issues related to benefits (see *Complaints*). To file a complaint with the Minnesota Department of Commerce call **1 (800) 657-3602** and request insurance information. You may begin a legal proceeding if you have a problem with Medica or any provider; and
6. Receive information about Medica, its services, its providers, and member rights and responsibilities; and
7. Appeal a decision regarding your health care coverage by calling Member Services at the number on the back of your Medica ID card. See *Complaints* for more information on your appeal rights; and
8. Make recommendations regarding Medica's member rights and responsibilities statement.

Member responsibilities

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

1. Establishing a relationship with a network provider before becoming ill, as this allows for continuity of care; and
2. Providing the necessary information to providers or Medica needed to determine the appropriate care. This objective is best obtained when you share:
    a. Information about lifestyle practices; and
    b. Personal health history; and
3. Understanding your health problems and agreeing to, and following, the plans and instructions for care given by those providing health care; and
4. Practicing self-care by knowing:
    a. How to recognize common health problems and what to do when they occur; and
    b. When and where to seek appropriate help; and
    c. How to prevent health problems from recurring; and

5. Practicing preventive health care by:

    a. Having the appropriate tests, exams and immunizations recommended for your gender and age as described in this Policy; and

    b. Engaging in healthy lifestyle choices (such as exercise, proper diet and rest).

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

I. Introduction

A. About this Policy

This Medica 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. The most specific and appropriate section will apply for those benefits related to the treatment of a specific condition.

For subscribers purchasing coverage through MNsure, MNsure will determine whether the subscriber is qualified to purchase coverage through MNsure and will notify Medica. Members are subject to all terms and conditions of this Policy.

Medica 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.

Benefits apply when you receive health services from network providers. Such services must be prescribed by and received from a network provider, unless otherwise indicated in this Policy. Benefits also apply to coverage for emergency services from non-network providers, including when you are traveling out of the service area or network access area.

Non-emergency care outside of your service area or network access area is generally not covered. Follow-up care or scheduled care following an emergency must be received from a network provider to be covered as a benefit. Benefits also apply to most non-emergency services from non-network health care professionals at a network facility.

If a network provider refers you to a non-network provider, you must call Medica to determine if the services to be performed by the non-network provider are covered as benefits. Such requests must be prior approved by Medica to be eligible for coverage as benefits. Medica approves requests to non-network providers only if care is not available from network providers.

Some terms used have specific meanings. In this Policy, the words *you*, *your* and *yourself* refer to the member. The term *subscriber* refers to the person who is applying for or is issued this Policy. See *Definitions* for more terms with specific meanings.

B. Eligibility

To be eligible to enroll for coverage under this Policy, you must be a *subscriber* or *dependent* 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 reside in the plan's service area as defined in this Policy; and
2. if you are enrolling in a Catastrophic Plan, be under the age of 30 at the start of the policy year or qualify for a hardship exemption, as determined by MNsure; and
3. complete an application form.

Child only eligibility

Individuals under the age of 21 are eligible to enroll as a subscriber without an adult under this Policy. Siblings of the child subscriber may be added to the child subscriber's Child Only policy. Any newborn infant or child newly placed for adoption of a subscriber under the age of 21 may be covered through a separate child-only policy or this child only policy.

Dependent eligibility

To be eligible to enroll for coverage, the *dependent spouse or domestic partner* must be:

1. a Minnesota resident; and
2. if enrolling in a Catastrophic Plan, be under the age of 30 or qualify for a hardship exemption, as determined by MNsure, when added as a dependent.

To be eligible to enroll for coverage, a dependent child must be under the age of 26.

Extending a child's eligibility

A dependent child is no longer eligible for coverage under this Policy at the end of the year in which he or she reaches the dependent limiting age of 26. The dependent child may be eligible for a special enrollment period at the end of the month in which the dependent child reaches the dependent limiting age of 26**.** See the section on *Special enrollment periods and effective date of coverage* for more information. However, the child's eligibility continues if the child is incapable of self-sustaining employment by reason of developmental disability, mental illness, mental disorder or physical disability and is chiefly dependent upon the subscriber for support and maintenance. To continue coverage for a disabled dependent, you must provide Medica with proof of such disability and dependency within 31 days of the child reaching the dependent limiting age of 26. Beginning two years after the child reaches the dependent limiting age of 26, Medica may require annual proof of disability and dependency. Your disabled dependent is covered under this Policy regardless of age and without application of health screening.

C. Enrollment

Open enrollment and effective date of coverage

For subscribers and dependents, the period of time identified each year by Medica or by MNsure, as applicable, for open enrollment, is the period during which subscribers and dependents may elect to enroll in coverage. An application for yourself and any dependents must be submitted to MNsure for coverage offered through MNsure, or to Medica for coverage offered directly through Medica. You must pay any applicable initial premium for your Policy to become effective.

Unless otherwise stated by MNsure or Medica, during open enrollment your coverage under this Policy:

- For plan selections made between November 1 and December 15, will be effective January 1; and
- For plan selections made between December 16 and January 15, will be effective February 1.

Services received before the effective date of this Policy are not covered.

Special enrollment periods and effective date of coverage

Special enrollment periods are provided to subscribers and dependents under certain circumstances.

Unless otherwise stated, you shall have 60 days following the date of the qualifying event to exercise your right for a special enrollment period. If you or your dependent did not receive timely notice of a qualifying event that makes you or your dependent eligible for a special enrollment period, and you or your dependent were otherwise unaware that the qualifying event occurred, you will have 60 days following the date you knew, or reasonably should have known, about the qualifying event to select a plan. If, however, you are losing Medicaid or CHIP coverage, you may have 90 days after the qualifying event to select a qualified health plan. Contact MNsure for more information.

Services received before the effective date of this Policy are not covered.

Qualifying events through MNsure

For coverage obtained through MNsure, eligibility for special enrollment periods will be as determined by MNsure.

Please note, if you purchased your coverage through MNsure, contact MNsure to notify them of the qualifying event and to exercise your right for a special enrollment period. Coverage is effective on the date established by MNsure. Contact MNsure for information about the limitations of each special enrollment period.

The following are the qualifying events for special enrollment periods available only if you enrolled through MNsure:

1. For an Indian enrolling through MNsure, or the dependent of an Indian that is enrolled or is enrolling through MNsure, on the same application as the Indian, on a monthly basis as determined by MNsure.
2. For subscribers or dependents enrolled through MNsure, the subscriber or dependent enrolled in the same qualified health plan is determined to be newly eligible for an advance premium tax credit or has a change in eligibility for cost-sharing reductions.
3. A subscriber, or his or her dependent, who is enrolled in an eligible employer-sponsored plan is determined newly eligible for the advance premium tax credit. The individual has 60 days before or after the life event to exercise his or her right for a special enrollment period.
4. For subscribers and dependents enrolling through MNsure, in the event of gaining status as a citizen, national, or lawfully present individual, or being released from incarceration, as determined by MNsure.
5. For subscribers and dependents enrolling through MNsure, the subscriber demonstrates to MNsure, and MNsure determines that exceptional circumstances apply.
6. The enrollment in a qualified health plan through MNsure, was influenced by a material error related to plan benefits, service area, or premium.
7. For a consumer who resolves a data matching issue following the end of an inconsistency period or has an annual household income under 100 percent of the

federal poverty level and did not enroll in coverage while waiting for MNsure to verify that he or she meets the citizenship, national, or immigration status.

8. For subscribers or dependents enrolled through MNsure who is enrolled in COBRA continuation coverage for which an employer is paying all or part of the premiums, or for which a government entity is providing subsidies, and the subsidies completely cease. The qualifying event is the last day of the period in which COBRA continuation coverage is paid for or subsidized. The individual has 60 days before and 60 days after the qualifying event to exercise his or her right for a special enrollment period.

9. For subscribers or dependents enrolled through MNsure, the subscriber or dependents is eligible for advance premium tax credits because their applicable percentage for purposes of calculating APTC is 0, and whose household income is expected to be no greater than 150 percent of the federal poverty line, and who are eligible to enroll in a silver-level qualified health plan with a monthly premium of $0 after advance premium tax credits.

10. For subscribers and dependents who receive an outreach letter from MNsure on the easy enrollment health insurance program and who are determined to be eligible to enroll in a qualified health plan, the individual has 65 days from the date the outreach letter was mailed to enroll in a qualified health plan through MNsure.

Qualifying events through MNsure or through Medica

If coverage was not obtained through MNsure, eligibility for a special enrollment period will be determined by Medica. Medica may ask you for information about your eligibility for the special enrollment period. By accepting coverage under this Policy, you agree to cooperate with our reasonable request for information.

Some of the information discussed in this section may be different if you enrolled through MNsure, including but not limited to the dates when your coverage begins and ends. Please contact MNsure directly or call our Member Services at the number on the back of your Medica ID card. If you enroll through MNsure, MNsure will determine your coverage effective date. Unless noted otherwise, if you enroll with Medica for any of the following qualifying events, your coverage will be effective on the first day of the month following the date you select your new plan.

The following are the qualifying events for special enrollment periods, whether you enrolled through MNsure or not:

1. The subscriber gains a dependent through marriage, birth, adoption, placement for adoption, or child support order or other court order.

    a. If coverage was obtained through MNsure, you must contact MNsure to enroll the dependent and determine what types of plan changes can be made due to this special enrollment.
    b. If you obtained coverage directly from Medica, for adding dependent children to this Policy, the notification period is not limited to 60 days for newborns or children newly adopted or newly placed for adoption, although you are encouraged to notify Medica within this time period. If you obtained coverage through MNsure, for adding dependent children to this Policy, the notification period may be limited to 60 days for newborn infants or children newly adopted or newly placed for adoption. In the case of marriage, at least one spouse must

demonstrate having minimum essential coverage for 1 or more days during the 60 days preceding the date of marriage unless:
(1) the spouse is moving from a foreign country or US territory,
(2) the spouse is an Indian as defined in the Indian Health Care Improvement Act, or
(3) the spouse lived for 1 or more days during the 60 days leading up to the event or during the most recent preceding open enrollment in a service area where no qualified health plans were offered through MNsure.

If not, then there is no special enrollment period for either spouse. The subscriber is permitted to either add the dependent to this Policy, or if the dependent is not eligible under this Policy, the subscriber and his or her dependents may enroll in another plan within the same metal level. If no plan is available in the same metal level, the subscriber and dependent may enroll in another plan one metal level higher or lower than the current plan. Or, at the option of the subscriber or dependent, the dependent may be enrolled separately in any available plan. In the case of birth, adoption or placement for adoption, child support or other court order, coverage begins on the date of birth, date of adoption or date of placement for adoption, respectively or the first of the month following plan selection if allowed by Medica or MNsure and elected by you, as applicable. In the case of marriage, coverage is generally effective on the first day of the month following plan selection through MNsure or enrollment with Medica, as applicable. See *How to add dependents* below for more information. In the case of a child support order or other court order, coverage is generally effective on the date specified in the order.

2. If the subscriber or enrolled dependent loses a dependent or is no longer considered a dependent through divorce or legal separation as defined by State law in the State in which the divorce or legal separation occurs, or if the member, or his or her dependent, dies. In these instances, if the result is a loss of minimum essential coverage for the subscriber or enrolled dependent, the person who lost coverage will have a special enrollment period.

3. For subscribers currently enrolled through MNsure, the subscriber or dependent enrolled in the same qualified health plan is determined to be newly ineligible for an advance premium tax credit or cost-sharing reductions.

4. A subscriber or dependent gains access to a new qualified health plan as a result of a permanent move. The subscriber or dependent must have had minimum essential coverage for at least one day in the 60 days prior to the permanent move unless (1) the spouse is moving from a foreign country or US territory, (2) the spouse is an Indian as defined in the Indian Health Care Improvement Act, or (3) the spouse lived for 1 or more days during the 60 days leading up to the move or during the most recent preceding open enrollment in a service area where no qualified health plans were offered through MNsure. The subscriber or dependent has 60 days after the qualifying event to exercise his or her right for a special enrollment. Moving solely for medical treatment or vacation does not qualify a subscriber or dependent for this special enrollment period.

5. The subscriber or dependent loses “minimum essential coverage,” as defined under federal law, is enrolled in a non-calendar year group or individual plan, or loses certain pregnancy-related coverage or coverage for an unborn child, or medically needy eligibility for Medicaid coverage as defined under the Social Security Act. Loss of

minimum essential coverage under this paragraph does not include voluntary termination of coverage or loss due to failure to pay premiums or rescission. The subscriber or dependent has 60 days before or after the qualifying event to exercise his or her right for a special enrollment period. The date of the loss of coverage for those enrolled in a non-calendar year plan is the last day of the plan or policy year. If the subscriber or dependent loses minimum essential coverage and selects a new plan on or before the last day of the month preceding the loss of minimum essential coverage, coverage may be effective on the first of the month in which the loss of minimum essential coverage occurs.

6. The subscriber demonstrates to Medica or MNsure, as applicable, that the health plan providing coverage to him or her substantially violated a material provision of its contract.
7. The subscriber demonstrates to Medica or MNsure, as applicable, that enrollment or non-enrollment in a health plan was unintentional, inadvertent or erroneous and the result of the error, misrepresentation or inaction of MNsure or the United States Department of Health and Human Services, or a non-MNsure entity providing enrollment assistance or conducting enrollment activities.
8. For subscribers and dependents, in the event of a qualifying event under section 603 of the Employee Retirement Income Security Act of 1974, as amended.
9. For subscribers or dependents, in the event the subscriber or dependent is a victim of domestic abuse or spousal abandonment, including a dependent or unmarried victim within a household, is enrolled in minimum essential coverage and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment. The dependent of a victim of domestic abuse or spousal abandonment applying for or covered on the same application as the victim, also may enroll in coverage at the same time as the victim.
10. This special enrollment period applies if a subscriber or dependent applies for coverage on MNsure during annual open enrollment or a special enrollment period, and is determined by MNsure as potentially eligible for Medicaid or CHIP, and is later determined ineligible for Medicaid or CHIP after open enrollment ended or more than 60 days after the qualifying event. It also applies if the subscriber or dependent applies for coverage at the State Medicaid or CHIP agency during annual open enrollment and is determined ineligible for Medicaid or CHIP after open enrollment has ended.
11. You or your dependent was enrolled in COBRA continuation coverage, or similar state program, for which an employer was paying all or part of the premiums, or for which a government entity was providing subsidies, and the employer completely ceases its contributions or the government subsidies completely cease.

How to add dependents

Except for policies issued to individuals under the age of 21, coverage for new dependents may be added after the subscriber's coverage begins as described in *Open enrollment and effective date of coverage* and *Special enrollment periods and effective date of coverage* above. Newborn infants are eligible for benefits from the moment of birth, including coverage for illness, injury, congenital malformation, or premature birth, including birth defects, as specifically described in this Policy.

Please note with regard to births and adoptions: Medica does not automatically know of a birth or adoption or whether the subscriber would like the newborn infant or newly adopted dependent to be added to the Policy.

Newborn infants and newly adopted dependents are eligible for coverage under this Policy from the moment of birth, adoption, or newly placed for adoption.

Medica requests notification in writing of the birth of the newborn infant, adoption or child newly placed for adoption and request that the newborn infant or newly adopted dependent be added to this Policy.

Medica may require additional premium to add the newborn infant or newly adopted dependent to your current Policy. Medica is entitled to all premiums due from the time of the newborn infant's birth, adoption or child newly placed for adoption until the time the covered subscriber notifies Medica of the birth or adoption.

Medica may withhold payment of any health benefits for the newborn or newly adopted dependent until the applicable premium has been paid. For that reason, it's very important that you request to Medica that the newborn or newly adopted dependent be added to the coverage.

If coverage was obtained through MNsure, you must contact MNsure to enroll the dependent and determine what types of plan changes can be made due to this special enrollment period.

Medica may reduce payment by the amount of premium that is past due for any health benefits for the child until any premium you owe is paid.

Notification

As a member, it is your responsibility to notify Medica of any changes that might affect your coverage. You should report these changes to Medica immediately. These changes include, but are not limited to:

1. Eligibility for Medicare or Medicaid.
2. Coverage under other health insurance.
3. Loss of eligibility for coverage due to divorce or death of the subscriber.
4. You have moved.
5. The addition of newly acquired dependents.
6. Changes in qualified dependent status.

Unless a longer period is provided in this Policy, the subscriber must notify Medica in writing within 30 days of the effective date of any changes to home address or name, addition or deletion of dependents, or other facts identifying you or your dependents. (The notification period is not limited to 30 days for newborn infants or children newly placed for adoption; however, we encourage the covered subscriber to enroll a newborn infant or dependent under this Policy within 30 days from the date of birth, date of placement for adoption, or date of adoption.)

D. Premiums

Your premiums must be prepaid by the subscriber or other acceptable third party from the date coverage starts. If a subscriber or dependent has enrolled through a special enrollment period retroactively, your premiums must be paid by the date established by Medica.

If you are receiving an advance premium tax credit, you will need to pay your share of the first month's premium by the date established by Medica.

Your premium may change each year as permitted by state and federal law. You will be provided at least 30 days written notice before a change in the premium.

Medica does not accept premium payment directly or indirectly from any third party including, but not limited to, any provider, manufacturer of prescription drugs, health care professional, or any third-party organization contracted with a provider to provide administrative or financial services, except as stated in this section. Medica will accept premium payments from the following third parties, to the extent required by law:

- Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act;
- Indian tribes, tribal organizations or urban Indian organizations;
- State and federal government programs that provide premium and cost-sharing support for specific individuals;
- Small employers that qualify as a Qualified Small Employer Health Reimbursement Arrangement under the 21st Century Cures Act; and
- Employers using an Individual Coverage Health Reimbursement Arrangement (ICHRA) are permitted, to the extent such payments are lawfully funded through an HRA that constitutes a group health plan under applicable federal regulation.

Medica may, in its sole discretion and in accordance with applicable law or regulatory guidance, decline to accept premium payments made directly or indirectly by any other person or entity from which Medica is not required by law to accept third party-premium payments.

Premiums paid by you, the subscriber, or the third-parties listed in the prior sentence, will not be reimbursed or contributed to by or on behalf of any other third party including, but not limited to, any provider directly or indirectly.

E. Grace period

If you are not receiving advance premium tax credits, the grace period for the subscriber's payment of premiums will be 31 days from the date a premium payment is due. If you pay the premium at any time during this grace period, this Policy shall not be terminated.

If you are receiving an advance premium tax credit, the grace period for the subscriber's payment of premiums will be 3 consecutive months from the date a premium payment is due.

- If you pay your full share of the premium at any time during this grace period, which includes any additional missed premium payments during the grace period, this Policy shall not be terminated.

- If your share of the full premium is not paid by the end of the grace period, coverage will end as stated in *Ending Coverage*. Medica will pay benefits only for the first month of the grace period.
- For example, if you fail to make the premium payment for March, April and May, Medica will pay benefits ***only*** for services you receive in March, unless you pay your full share of all the premiums for March, April and May by the end of May. **Be aware that benefits will not be paid after the first month of the 3 month grace period.**

If premium is not paid by the end of the applicable grace period, coverage will end as stated in *Ending Coverage*, and Medica will not process any claims for services after the date of termination.

F. Changes to this Policy

The coverage provided under this Policy may change each year as permitted or required in compliance with federal or state regulatory requirements, or to ensure that this Policy maintains the actuarial value for the designated metal levels as defined in federal law. If we make a material modification to a term of this Policy that was also referenced on the most recent Summary of Benefits and Coverage (SBC) for this Policy, we will give you at least a 60 day advance notice prior to the effective date of the material modification. Any provision of this Policy which, on its effective date, is in conflict with the law of the federal government or this state is hereby amended to conform to the minimum requirements of such law.

G. Benefits

What you must do to receive benefits

Each time you receive health services, you must:

1. Confirm with Medica that your provider is a network provider with your Medica plan to be eligible for benefits;
2. Identify yourself as a Medica member; and
3. Present your Medica identification card. Having and using a Medica identification card does not guarantee coverage.

If your provider asks for your health care identification card and you do not identify yourself as a Medica member within 180 days of the date of service, you may be responsible for paying the cost of the service you received.

To see which providers are in your plan's network, check the online search tool on **Medica.com/SignIn** or call Member Services at the number on the back of your Medica ID card.

You may contact Member Services for estimates of the amount Medica has contracted to pay a particular network provider for a specific health care service and the amount you will pay as cost sharing for that service if received from that network provider. Medica will provide you with requested estimates within ten business days from the date Medica receives a request containing all information needed to respond. Please note that the

estimates provided are not a final determination of eligibility for coverage or a guarantee of continuing provider network participation or final costs for services you receive.

It is your responsibility to alert Medica regarding any discounts, coupons, rebates, or financial arrangements between you and a provider or manufacturer for health care items or services, prescription drugs and/or devices. Call Member Services at the number on the back of your Medica ID card.

Benefits

Medica will cover health services and supplies as described in this Policy only when care is received from the following:

1. A network provider;
2. A non-network provider within the United States to whom you have been specifically directed by a network provider and are authorized by Medica;
3. A non-network provider within the United States when no in-network care is available within your service area or network access area and are authorized by Medica;
4. A non-network provider for emergency services within the United States, including when you are traveling out of the service area or network access area. To be eligible for coverage from non-network providers, services must be due to an emergency, as defined in *Definitions*; or
5. A non-network health care professional at a network facility for certain non-emergency services.

If there is no network provider and no non-network provider available within your service area or network access area, Medica may require you to see a provider that we have negotiated a reduced fee with if that provider is closer to your residence than a requested non-network provider.

Prior authorization may also be required from Medica for certain benefits even if a provider has directed or recommended that you receive the services or supplies. This Policy fully defines your benefits and describes procedures you must follow to obtain benefits.

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

Medica will cover:

- services for testing and treatment of sexually transmitted disease and testing for AIDS and other HIV-related conditions received from a network or a non-network provider.
- medical treatment or services provided by a licensed pharmacist acting within the scope of their license, including the following services:
    - collect specimens, interpret results, notify the patient of results, and refer the patient to other health care providers for follow-up care;
    - initiate, modify, or discontinue drug therapy only pursuant to a protocol or collaborative practice agreement;

        - protocol and collaborative practice agreement shall have the same meaning as set forth under the state pharmacy act;
    - initiate, order, and administer FDA-approved or authorized influenza and COVID-19 or SARS-CoV-2 vaccines to eligible individuals three years of age and older and all other FDA-approved vaccines to eligible individuals six years of age and older.
    - prescribing and administering drugs to prevent the acquisition of HIV provided the pharmacist has met all the conditions under state law to undertake such actions.

- family planning services, for the voluntary planning of conception and bearing of children, received from a network provider or a non-network provider. Family planning services do not include infertility treatment services.
- the management of chronic diseases including check-ups and coordinating treatment at the corresponding benefit level.
- routine patient costs in connection with a qualified individual's participation in an approved clinical trial at the applicable benefit level. Routine patient costs are items and services that would be covered benefits even when not provided in connection with a clinical trial. Routine patient costs do not include an investigative or experimental item, device or service; items or services provided solely to satisfy data collection and analysis needs and not used in clinical management; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- mental health and substance use disorder services in the same way it provides coverage for other health issues. The Mental Health Parity and Addiction Equity Act, as well as applicable state law, requires Medica, an insurer that offers mental health and substance use disorder benefits, to provide coverage of those benefits in a way that is comparable to coverage for general medical and surgical care. Cost-sharing requirements and limitations on mental health and substance use disorder benefits (such as copayments, visit limits and preauthorization requirements) must generally be comparable to, and no more restrictive than those for medical and surgical benefits.

Non-network providers

Under certain circumstances Medica will authorize your obtaining services from a non-network provider within the United States. Such authorizations are generally provided only in situations where the requested services are not available from network providers. Medica will authorize services received from non-network providers only if in-network care is not available in your service area or network access area and requires a request from an in-network provider. If there are no network providers and no non-network providers available within your service area or network access area, Medica may require you to see a provider that we have negotiated a reduced fee with if that provider is closer to your residence than a requested non-network provider. Please see *Requests to receive in-network benefits from non-network providers* in *Requests and Prior Authorization* for more information about request requirements and the process for receiving an authorized request.

Surprise billing protections

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

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

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

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

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

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

If you have questions about bills you receive from a non-network provider that provided services under the circumstances described under Minnesota Statute 62Q.556, please call Member Services at the number on the back of your Medica ID card. If you receive a bill that is larger than the applicable copayment, coinsurance, or deductible, you may submit the bill for processing to:

Member Services

Route CP595

PO Box 9310

Minneapolis, MN 55440-9310

When you access care from non-network providers, you will be responsible for filing claims in order to be reimbursed for covered benefits. For information on submitting claims, refer to *Submitting a claim*.

Exclusions

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

H. Providers

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

We recommend you verify that your provider is a network provider through our Find Care tool prior to receiving health services. You generally do not have access to non-network providers except in limited circumstances, which are detailed in this Policy.

Network providers

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

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

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

Fee-for-service payment means that Medica pays the network provider a fee for each service provided. If the payment is per episode, 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 billed charge. The amount paid to the network provider, less any applicable copayment, coinsurance or deductible, is considered to be payment in full.

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

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 based on the non-network provider reimbursement amount.

If the *Surprise billing protections* do not apply to a non-network benefit, the non-network provider reimbursement amount 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 coinsurance and deductible amount. Charges in excess of the non-network**

provider reimbursement amount do not accumulate to your deductible or out-of-pocket maximum.

When an emergency service from a non-network provider is covered under this Policy, the non-network provider is paid the in-network benefit level.

I. Submitting a claim

Claims for benefits from network providers

If you receive a bill for any benefit from a network provider, you may submit the claim following the procedures described below, under *Claims for benefits from non-network providers*, or call Member Services at the number on the back of your Medica ID card.

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

Claims for benefits from non-network providers

When you receive services from non-network providers, you will be responsible for filing claims in order to be reimbursed for covered benefits. Claim forms can be found in the Document Center at **Medica.com/SignIn** or you may request claim forms by calling Member Services at the number on the back of your Medica ID card. You should retain copies of all claim forms and correspondence for your records.

Generally, Medica does not accept assignment of benefits to non-network providers.

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

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

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

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

Claims for emergency services provided outside the United States

Claims for emergency services rendered in a foreign country are not covered.

Time limits

If you have a complaint or disagree with a decision by Medica, 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 three years after Medica has made a coverage determination regarding your claim.

J. Requests and Prior Authorization

Note: Prior authorization (approval in advance) is a clinical review that services are medically necessary. Receiving prior authorization is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, your eligibility and the terms and conditions of this Policy applicable on the date you receive services.

Prior authorization

Certain health services are covered only upon request. All requests to non-network providers and certain types of network providers require prior authorization by Medica. Prior authorization from Medica is required before you receive certain services or supplies even if a provider has directed or recommended that you receive the services or supplies in order to determine whether a particular service or supply is medically necessary and a benefit. Medica uses written procedures and criteria when reviewing your request for prior authorization. To determine whether a certain service or supply requires prior authorization, please call Member Services at the number on the back of your Medica ID card.

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

Emergency services do not require prior authorization.

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

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

1. Reconstructive or restorative surgery procedures;
2. Treatment of a diagnosed temporomandibular joint (TMJ) disorder or craniomandibular disorder;
3. Solid organ and bone marrow transplant services – this prior authorization must be obtained before the transplant workup is initiated;
4. Treatment at a designated facility for complex health conditions;
5. In-network benefits for services from non-network providers for a rare disease or condition, as defined in *Rare Diseases;*
6. Home health care services;
7. Durable medical equipment;
8. Outpatient surgical procedures;
9. Certain genetic tests;

10. Certain prescription drugs, biologics and biosimilars;
11. Inpatient care, including mental health and substance use disorders, skilled nursing facility services, long-term acute care hospital (LTACH) and acute inpatient rehabilitation (AIR);
12. Certain outpatient mental health and substance use disorder services;
13. Certain imaging services;
14. Certain professionally administered prescription drugs;
15. Non-emergency licensed air ambulance transportation; and
16. Benefits for services from non-network providers, with the exception of emergency services.

Certain biologics, biosimilars and professionally administered prescription drugs may be subject to step therapy. In certain cases, it is possible to get an exception to step therapy requirements, please see *Exceptions to Step Therapy* in *Prescription Drugs* or *Prescription Specialty Drugs*.

Pregnancy/maternity care services received from a network provider do not require prior authorization or a request.

Please note: This is not an all-inclusive list of all services and supplies that may require prior authorization.

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

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

Medica will review your request for prior authorization and provide a response to you and your attending provider within five business days of the date your request was received, provided all information reasonably necessary to make a decision has been given to Medica.

Medica will respond within a time period not exceeding 48 hours (including at least one business day) from the time of the initial request if 1) your attending provider believes that an expedited review is warranted, or 2) Medica concludes that a delay could seriously jeopardize your life, health or ability to regain maximum function, or 3) you could be subject to severe pain that cannot be adequately managed without the care or treatment you are requesting.

If Medica does not approve the request for prior authorization, you have the right to appeal Medica's decision as described in *Complaints*. If you are a new Medica member and have a prior authorization for services from your former health plan, Medica will accept that prior authorization for at least the first 60 days of coverage under this plan. In order to obtain

coverage for this 60-day period, you or your provider must send Medica documentation of the previous prior authorization. For coverage to continue after the 60-day period, you, someone on your behalf or your attending provider should submit a request for prior authorization to Medica prior to the end of this 60-day period.

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

Requests to receive in-network benefits from non-network providers

To receive in-network benefits for services received from a non-network provider, your network provider must direct you to a non-network provider. Your network provider must also submit a prior authorization request to Medica prior to you receiving care from a non-network provider. Medica will only consider requests from an in-network provider. If Medica does not receive a prior authorization request or approve the prior authorization request from your network provider prior to you receiving services from the non-network provider, the services may be considered not covered by this Policy.

Medica will authorize requests for services from non-network providers only if in-network care is not available in your service area or network access area. If there are no network providers and no non-network providers available within your service area or network access area, Medica may require you to see a provider that we have negotiated a reduced fee with if that provider is closer to your residence than a requested non-network provider.

A standing request is a request issued by a network provider and authorized by Medica for conditions that require ongoing services from a non-network provider. For standing requests, a network provider will direct you to a non-network provider. If you would like to do so, contact Medica for more information. Standing requests will only be covered for the period of time appropriate to your medical condition. A standing request may be granted if Medica determines the standing request is appropriate. If you would like more information or to submit a standing request, call Member Services at the number on the back of your Medica ID card.

You must receive a standing request for the following: a chronic health condition; a life threatening mental or physical illness; pregnancy beyond the first trimester; a degenerative disease or disability; or any other condition or disease of sufficient seriousness and complexity to require treatment by a non-network provider. Please note, standing requests to non-network providers will only be authorized when the care you need is not available from network providers.

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

If your request to receive in-network benefits for services rendered by a non-network provider is denied, you have the right to appeal this decision as described in *Complaints*.

What you must do

1. Ask a network provider to submit a request or standing request for you to receive medically necessary services from a non-network provider. The request must be in writing and:
    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 Medica by calling the number on the back of your Medica ID card. Medica does not guarantee coverage of services that you receive from a non-network provider before you obtain prior authorization from Medica.
3. If prior authorization has been obtained from Medica, 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 Medica.

What Medica will do

1. May require that you see another network provider selected by Medica before Medica determines that a request to a non-network provider is medically necessary.
2. May require that you obtain a request or standing request from a network provider to a non-network provider practicing in the same or similar specialty.
3. Provide coverage for health services that are:
    a. Otherwise eligible for coverage under this Policy;
    b. Recommended by a network physician; and
    c. Determined by Medica that care is not available from a network provider. If there is no network provider and no non-network provider available within your service area or network access area, Medica may require you to see a provider that we have negotiated a reduced fee with if that provider is closer to your residence than a requested non-network provider.
4. Review your request for prior authorization and respond within five business days of receipt of your request provided that all information reasonably necessary to make a decision has been given to Medica. However, Medica will respond within a time period not exceeding 48 hours (including at least one business day) from the time of the initial request if 1) your attending provider believes that an expedited review is warranted, or 2) Medica concludes that a delay could seriously jeopardize your life, health or ability to regain maximum function, or 3) you could be subject to severe pain that cannot be adequately managed without the care or treatment you are seeking.

K. Continuity of care

Continuity of care is process by which Medica authorizes a member, for a limited period of time, to continue accessing covered services with a treating provider who is not in Medica's network while still receiving in-network benefits.

To request continuity of care, or if you have questions about whether you may be eligible, call Member Services at the number on the back of your Medica ID card.

Continuity of care is available if you are in an active course of treatment with a treating provider and the contract between Medica and the treating provider terminates without cause.

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

a. An ongoing course of treatment for an acute condition, such as chemotherapy for the treatment of cancer;

b. A life-threatening physical or mental illness;

c. Undergoing a course of institutional or inpatient care from the provider or facility;

d. Scheduled non-elective surgery, including postoperative care;

e. Pregnant and undergoing a course of treatment for pregnancy. Health services may continue to be provided through the postpartum period;

f. 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;

g. A disabling or chronic condition that is in an acute phase;

h. An ongoing course of treatment for a chronic condition; or

i. An ongoing course of treatment for a health condition for which a treating physician or provider attests that discontinuing care by that physician or provider would worsen the condition or interfere with anticipated outcomes.

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

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

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

1. If you are receiving culturally appropriate services and Medica does not have a network provider who has special expertise in the delivery of those culturally appropriate services within Medica's time and distance requirements; or

2. If you do not speak English and Medica does not have a network provider who can communicate with you, either directly or through an interpreter, within Medica's time and distance requirements.

Medica may require medical records or other supporting documentation from your treating provider to review your continuity of care request and will consider each continuity of care request on a case-by-case basis. If Medica authorizes your request to continue care with your current treating provider, Medica will explain how continuity of care will be provided. After the time period for which continuity of care is approved, your services or treatment will need to be transitioned to a network provider to continue to be eligible for benefits. If

your request is denied, Medica will explain the criteria used to make its decision. You may appeal this decision, as described in *Complaints*.

If your treating provider agrees to comply with Medica's prior authorization requirements, provides Medica with all necessary medical information related to your care, and accepts as payment in full the lesser of Medica's network provider reimbursement or the provider's customary charge for the service, then the treating provider will not be permitted to bill you for the amount in excess of your deductible and coinsurance or copayment described in the *Benefit Chart* section of this Policy.

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

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

L. Harmful use of medical services

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

If you have questions about how this provision applies to you, including the specific physician, pharmacy or hospital assigned for you, call Member Services at the number on the back of your Medica ID card. Additionally, you have the right to appeal Medica's decision concerning the application of this section. See *Complaints* for more information on your appeal rights.

M. Medica's Right to Subrogation and Reimbursement

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

1. Medica has a right of subrogation against any third party, individual, corporation, insurer or other entity or person who may be legally responsible for payment of medical expenses related to your illness or injury. Medica's right of subrogation shall be governed according to this section. Medica's right to recover its subrogation interest applies only after you have received a full recovery from another source of

compensation for your illness or injury. In this regard, full recovery does not include benefits paid by Medica or another health benefit plan to you or for your benefit.

2. Medica's subrogation interest is the reasonable cash value of any benefits received by you.

3. Medica's right to recover its subrogation interest may be subject to an obligation by Medica to pay from any recovery a pro rata share of your disbursements, attorney fees and costs, and other expenses incurred in obtaining a recovery from another source unless Medica is separately represented by an attorney. If Medica is represented by an attorney, an agreement regarding allocation may be reached. If an agreement cannot be reached, the matter must be submitted to binding arbitration.

4. By accepting coverage under this Policy, you agree:

    a. That if Medica pays benefits for medical expenses you incur as a result of any act by a third party for which the third party is or may be legally responsible, and you later obtain full recovery, you are obligated to reimburse Medica for the benefits paid in accordance to Minnesota law.

    b. To cooperate with Medica or its designee to help protect Medica's legal rights under this subrogation and reimbursement provision and to provide all information Medica may reasonably request to determine its rights under this provision.

    c. To provide prompt written notice to Medica when you make a claim against a party for injuries.

    d. To do nothing to decrease or limit Medica's rights under this provision, either before or after receiving benefits, or under this Policy.

    e. Medica may take action to preserve its legal rights. This includes bringing suit in your name.

    f. Subject to the full recovery requirement set forth in paragraph 1. above, Medica may collect its subrogation interest from the proceeds of any settlement or judgment that includes or otherwise relates to payment of medical expenses recovered by you, your legal representative or the legal representative(s) of your estate or next-of-kin.

N. Rewards and incentives

Medica may offer rewards or incentives to encourage you to access certain services, engage in healthy behaviors, and/or to participate in various optional programs, including but not limited to: access to free or low-cost mobile applications and/or, a health risk assessment tool, health risk assessment visits, obtaining preventive care, one annual wellness exam per adult member, discount cards. In some instances, these optional programs may be offered in combination with a non-Medica entity ("program vendor"). The optional programs are not benefits under this Policy, but are separate components which are not guaranteed and could be discontinued at any time. The optional programs are available as long as this Policy remains active, unless changed by Medica. Upon termination of coverage, the optional programs and the rewards or incentives for participating are no longer available.

Based on the terms of the optional programs being offered, you, and in some cases, your dependent(s) 18 years of age or older enrolled in this Policy, may be eligible to receive rewards or incentives. Rewards or incentives may include, but are not limited to gift cards, discount cards, and/or merchandise. Medica does not endorse any vendor, product or service associated with the optional programs or any rewards or incentives you may be eligible to receive. Program vendors are solely responsible for the products and services you receive. Certain rewards or incentives may be considered taxable income. You may wish to consult with your tax advisor or legal counsel for further guidance.

The decision about whether or not to take part in an optional program is yours alone. We recommend that you discuss such optional programs with your health care provider. Medica will notify you of the opportunity to participate in available optional programs and of any criteria for eligibility. Individuals in wellness programs who are unable to participate due to an adverse health factor shall not be penalized based upon an adverse health status and, unless otherwise prohibited by law, the Policy will allow a reasonable alternative to any individual for whom it is unreasonably difficult, due to a medical condition, to satisfy otherwise applicable wellness program standards.

Call Member Services at the number on the back of your Medica ID card if you have any questions.

O. Requests for Information

In the ordinary course of administering this Policy, Medica may ask you for information, for example:

- To confirm your eligibility for coverage;
- If we suspect fraud, waste, abuse, or harmful use of services;
- To assist Medica in administering the terms of this Policy; or
- To determine if -
    - You qualify for other insurance coverage;
    - A third-party may be responsible for payment of health care services; or
    - You qualify for our Medicare estimation program (if permissible under federal or state law).

By accepting coverage under this Policy, you agree to cooperate with our reasonable request for information.

II. Out-of-Pocket Expenses

You are responsible for paying the cost of a service that is not medically necessary or is not a covered 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.

You are responsible for paying the charges incurred when you miss or cancel an appointment.

Please see the *Benefit Chart* section of this Policy for specific information about your benefits and coverage levels. To verify coverage before receiving a particular service or supply, call Member Services at the number on the back of your Medica ID card.

A. Cost sharing: copayments, coinsurance and deductibles

For benefits, you must pay the following:

1. Any applicable copayment, coinsurance and deductible as described in the *Benefit Chart* section of this Policy. When you receive services that are benefits under this Policy from a network provider, you are not responsible for charges from that network provider other than your applicable copayment, coinsurance and deductible.

   You must pay an annual deductible. The time period used to determine how much of your deductible you have satisfied is a calendar year.

2. Any charge that exceeds the non-network provider reimbursement amount for certain services from a non-network provider. **If the amount billed by certain non-network providers is greater than the non-network provider reimbursement amount, *the non-network provider will likely bill you for the difference*. This should not happen if the protections described in *Your Rights and Protections Against Surprise Medical Bills* apply. However, you may be balance billed for services that are not described in *Your Rights and Protections Against Surprise Medical Bills.* This difference may be substantial, and it is in addition to any copayment, coinsurance or deductible amount you may be responsible for according to the terms described in this Policy. If you have any questions about surprise billing or balance billing, please call Member Services at the number on the back of your Medica ID card.**

   To inquire about the non-network provider reimbursement amount for a particular procedure, call Member Services at the number on the back of your Medica ID card. 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.

   Member Services 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 coinsurance and deductible.

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

Cost sharing reductions

Cost-sharing is a combination of coinsurance, copayments and your deductible.

If MNsure determines you are eligible for a cost-sharing reduction, you will be offered one of three silver cost-sharing variations based on your household income. This will lower your cost-sharing for benefits. If you move between different Medica cost-sharing variations because of a redetermination of your eligibility for a specific cost-sharing variation, the time period does not start again when you move to a new cost-sharing variation, including a standard silver plan. Because different variations may have different deductibles, if you move to a plan with a higher deductible because of a change in your income, you will have to meet the new higher deductible, but the amounts you paid already will be counted toward the new higher deductible. You might also move to a plan with a lower deductible based on a change in income, if you have already satisfied the high deductible, it will count toward your new deductible and out-of-pocket maximums, but you will not receive a rebate of the excess you have paid over your new deductible.

In the event a cost-sharing variation plan is no longer available through MNsure as outlined in the *Ending Coverage* section, and you move to the standard cost-sharing version of that same plan, the time period for determining your cost-sharing does not start again for that calendar year.

For example, if you satisfy a $500 deductible and pay $100 in copayments in one plan variation, then move to a different plan variation with a $750 deductible as a result of a change in eligibility, the $500 would apply towards the new deductible and you would need to satisfy the remaining $250 of the new deductible.

American Indians and Alaska Natives

If MNsure determines you are eligible for a zero cost-sharing variation, you will be offered a zero cost-sharing variation of the plan you have chosen. This will eliminate your cost-sharing for benefits. An individual that MNsure determines is an American Indian or Alaska Native will have no cost sharing required on benefits received from Indian Health Services, an Indian Tribe, Tribal Organization, or Urban Indian Organization (each as defined in 25 U.S.C. 1603), or through a referral under contract health services, as contract health services are defined and provided pursuant to 42 C.F. R. Subpart C and any other guidance issued pursuant to that section. If you intend this Policy to qualify as an HSA-compliant high deductible health plan allowing you to contribute to an HSA, you should carefully consider whether to accept a cost-sharing reduction for services from these providers. The cost-sharing reduction will disqualify this Policy from being an HSA-compliant high deductible health plan.

B. Out-of-pocket maximum

The out-of-pocket maximum is described in the out-of-pocket expenses table in the *Benefit Chart* section of this Policy.

Medica 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 Medica.

III. Covered Benefits

Eligible services are covered only when medically necessary for the proper treatment of a member, as defined in this Policy.

Prior authorization (approval in advance) is required before you receive certain services listed below. To determine if Medica requires prior authorization for a particular service or treatment, please call Member Services at the number on the back of your Medica ID card. Please see *Prior authorization* in *Requests and Prior Authorization* for more information about prior authorization requirements and processes.

A. Ambulance

Medica covers ambulance services as described in the *Benefit Chart* section of this Policy. Air ambulance services coverage includes protections from surprise billing, as described in *Surprise billing protections*.

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 the *Benefit Chart* section of this Policy).

B. Anesthesia

Medica covers anesthesia services as described in the *Benefit Chart* section of this Policy.

Not covered:

Anesthesia services provided by a non-network provider, except as described in *Emergency Room* and in *Surprise billing protections*.

C. Certain Cancer-Related Tests

Medica covers prostate cancer screening, including prostate-specific antigen blood tests and digital rectal examinations, for all men.

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

Not covered:

1. Prostate cancer screening provided by a non-network provider.
2. Diagnostic surveillance tests for ovarian cancer provided by a non-network provider.
3. Diagnostic services or testing after a mammogram provided by a non-network provider.

D. Chiropractic

Medica covers chiropractic services to diagnose and to treat conditions related to muscles, skeleton and nerves of the body. This includes spinal manipulations, manual muscle stimulations or other conjunctive or manipulative therapies.

Not covered:

1. Chiropractic services provided by a non-network provider.
2. Massage therapy which is performed in conjunction with other treatment by a chiropractor as part of a prescribed treatment plan that is billed separately.
3. Chiropractic services when there is no reasonable expectation of improvement.

E. Diabetes Management and Supplies (for Type I, Type II and Gestational)

Medica covers:

- 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);
- diabetic equipment and supplies, including blood glucose meters and continuous glucose monitoring equipment and related supplies when received from a network pharmacy;
- insulin pumps and their related supplies when received from a network durable medical equipment provider; and
- routine foot care if part of treatment for diabetes.

Member cost-sharing for medical supplies necessary to effectively and appropriately treat or administer a drug prescribed to treat diabetes, asthma, or allergies requiring the use of epinephrine auto-injectors and received at a network pharmacy or from a network durable medical equipment provider will be limited to $50 per month in total

Not covered:

Diabetes management and supplies received from or provided by a non-network provider.

F. Diagnostic Imaging

Medica covers diagnostic imaging services such x-rays and other imaging services when:

- ordered by a provider, and
- provided in a clinic or outpatient hospital facility.

Not covered:

Diagnostic imaging services provided by a non-network provider, except as described in *Emergency Room* and in *Surprise billing protections*.

G. Durable Medical Equipment, Orthotics, Prosthetics and Miscellaneous Medical Supplies

Medica covers only a limited selection of durable medical equipment, orthotics, prosthetics and certain supplies that meet the criteria established by Medica.

Medica covers orthotic and prosthetic devices or device systems, supplies, accessories, and services that are customized to the member's needs. Needs of the member include performing physical activities such as, but not limited to running, biking and swimming, as well as devices for showering and bathing.

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

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

Some items ordered by your physician, even if medically necessary, may not be covered. The list of eligible durable medical equipment and certain supplies is periodically reviewed and modified by Medica. To request a list of Medica's eligible durable medical equipment and certain supplies, call Member Services at the number on the back of your Medica ID card.

Medica determines if durable medical equipment will be purchased or rented. Medica'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 Member Services at the number on the back of your Medica ID card.

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

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

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

Member cost-sharing for medical supplies necessary to effectively and appropriately treat or administer a drug prescribed to treat diabetes, asthma, or allergies requiring the use of epinephrine auto-injectors and received at a network pharmacy or from a network durable medical equipment provider will be limited to $50 per month in total

Benefits apply to durable medical equipment and certain supplies prescribed by a physician and received from a network durable medical equipment provider as described in the *Benefit Chart* section of this Policy when prescribed by a network provider. Benefits apply when eligible orthotics and prosthetics are prescribed by a physician or licensed health care prescriber and received from a network provider.

To request a list of network durable medical equipment providers, call Member Services at the number on the back of your Medica ID card.

Not covered:

1. Durable medical equipment and supplies, orthotics, prosthetics and appliances provided by a non-network provider.
2. Durable medical equipment and supplies, orthotics, prosthetics and appliances not on the Medica eligible list.
3. Charges in excess of the Medica standard model of durable medical equipment, orthotics or prosthetics.
4. Repair, replacement or revision of properly functioning durable medical equipment, orthotics and prosthetics, including, but not limited to, due to loss, damage or theft.
5. Duplicate durable medical equipment, orthotics and prosthetics, including repair, replacement or revision of duplicate items.
6. Disposable supplies and appliances, except as described in this section and in the *Benefit Chart* section of this Policy under *Prescription Drugs*.

H. Emergency Room

Medica covers emergency room services within the United States, as described in the *Benefit Chart* section of this Policy, where a prudent layperson would believe that a condition or symptom 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.

Emergency services from non-network providers within the United States will be covered benefits. Cost sharing requirements that apply to emergency services received from non-network providers within the United States are the same as the cost-sharing requirements that apply to emergency service services received from network providers and count towards the in-network deductible. To be eligible for coverage from non-network providers, services must be due to an emergency, as defined in *Definition*s. All coverage and charges for emergency services comply with the No Surprises Act.

You must notify Medica of emergency inpatient services as soon as reasonably possible after receiving inpatient services. Call Member Services at the number on the back of your Medica ID card.

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

The decision to reimburse emergency care will not be made solely on the basis of the actual diagnosis. If the health services that you require do not meet the definition of emergency, you should refer to the most specific section of this Policy for a description of your benefits.

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

For information on submitting claims for emergency services received in a foreign country, refer to *Submitting a claim*.

Not covered:

1. Non-emergency care from non-network providers.
2. Unauthorized continued inpatient services after an emergency in a non-network facility if you have validly consented to those services as described in *Surprise billing protections*.
3. Follow-up care or scheduled care from a non-network provider, except as described in *Benefits*. Follow-up care or scheduled care under this exclusion does not include emergency services and post-stabilization emergency services you have not consented to as described in *Surprise billing protections*.
4. Transfers and admissions to network hospitals solely at the convenience of the member.
5. Services received outside the United States.

I. Gender Affirmation Care

Medica covers medically necessary gender affirming health care services for gender dysphoria, as defined in the *Diagnostic and Statistical Manual of Mental Disorders*. Treatment includes surgical and non-surgical services and mental health services.

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

Medical necessity review is based on Medica's policy, which references multiple resources, including but not limited to the World Professional Association for Transgender Health (WPATH) Standards of Care for the Health of Transsexual, Transgender and Gender Nonconforming People.

Please note: Coverage for prescription drugs that are medically necessary for the treatment of gender dysphoria is as described in *Prescription Drugs* and *Prescription Specialty Drugs* in this section.

Not covered:

1. Services, care or treatment that are not medically necessary.
2. Services received from a non-network provider.

J. Genetic Counseling and Testing

Medica covers genetic counseling, whether pre-test or post-test, and whether occurring in an office, clinic or through telehealth. Medica also covers genetic testing when the test will directly affect treatment decisions or frequency of screening for a disease, or when results of the test will affect reproductive choices. Medica covers rapid whole genome sequencing for members who: are age 21 or younger; have a complex or acute illness of unknown etiology; and are receiving inpatient hospital services in an intensive care unit or neonatal or high acuity pediatric care unit. Medica covers biomarker testing to diagnose, treat, manage, and monitor illness or disease if the test provides clinical utility. Please see the *Benefit Chart* section of this Policy for more information.

Not covered:

1. Genetic counseling and testing services provided by a non-network provider.
2. Genetic testing when performed in the absence of symptoms or high risk factors for a heritable disease.
3. Genetic testing when knowledge of genetic status will not affect treatment decisions, frequency of screening for the disease or reproductive choices.
4. Genetic testing that has been performed in response to direct to consumer marketing and not under the direction of your physician.

K. Hearing Aids and Services

Medica covers hearing exams. Medica also covers hearing aids for members for hearing loss that is not correctable by other covered procedures as described in the *Benefit Chart* section of this Policy.

Medica covers only a limited selection of hearing aids that meet the criteria established by Medica. Some items ordered by your provider, even if medically necessary, may not be covered. The list of hearing aids is periodically reviewed and modified by Medica. To request a list of Medica's hearing aids, call Member Services at the number on the back of your Medica ID card.

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

To request a list of hearing aid vendors, call Member Services at the number on the back of your Medica ID card.

Not covered:

1. Hearing exams, hearing aids and related services provided by a non-network provider.
2. Hearing aids not on the Medica eligible list.
3. Charges in excess of the Medica standard model of hearing aids.
4. Repair, replacement or revision of properly functioning hearing aids, including, but not limited to, due to loss, damage or theft.
5. Duplicate hearing aids, including repair, replacement or revision of duplicate items.
6. Hearing aids that are available over-the-counter.

L. Home Health Care

Medica covers skilled care in your place of residence for members that are homebound. Skilled services must be ordered by a physician who has conducted a face-to-face assessment per Medicare guidelines. (Exception: You are not required to be homebound to be eligible for home infusion therapy or services received in your home from a physician.)

Covered home health aide services must be ordered by a physician and related to the active and specific treatment of the covered member. Services and care must be provided by a home health aide that is supervised by a skilled service provider in accordance with Medicare guidelines.

To be considered homebound, a physician must certify that you are homebound. To be homebound means the following:

- Leaving your home is not recommended because of your condition.
- Your condition keeps you from leaving your home without help (such as using a wheelchair or walker, needing special transportation or getting help from another person).
- Leaving home takes a considerable and taxing effort.

A person may leave home for a medical treatment or short, infrequent absences for non-medical reasons, such as attending religious services. You can still get home health care if you attend adult day care, but you would get the home care services in your home. A dependent child may still be considered homebound when attending school where life support specialized equipment and help are available.

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

Benefits in the *Benefit Chart* section of this Policy apply to covered home health care services received from a network home health care agency. Please see the *Benefit Chart* for more information. You may be eligible for additional hours of private duty nursing care per week if you have Medica coverage and are also enrolled in the Medical Assistance program.

Not covered:

1. Home health care provided by a non-network provider.
2. Extended hours home care.
3. Companion, homemaker and personal care services.
4. Services provided by a member of your family.
5. Custodial care and other non-skilled services.
6. Physical, occupational or speech therapy provided in your home for convenience.
7. Intermittent skilled nursing care or skilled physical or occupational therapy provided in your home when you are not homebound.
8. Speech therapy provided in your home when you are not homebound.
9. Services primarily educational in nature.
10. Vocational and job rehabilitation.
11. Recreational therapy.
12. Self-care or self-help training (non-medical), including, but not limited to, educational therapy, aerobic conditioning, therapeutic exercises, work hardening programs, etc., and all related material and products for these programs.
13. Health clubs.
14. Disposable supplies and appliances, except as described in *Durable Medical Equipment, Prosthetics and Miscellaneous Medical Supplies* and in the *Benefit Chart* section of this Policy under *Prescription Drugs*.
15. Physical, occupational or speech therapy services when there is no reasonable expectation of improvement.
16. Voice training.
17. Outpatient rehabilitation services when no medical diagnosis is present.
18. Prescription drugs provided or administered by a physician or other provider, except those prescription drugs that meet the definition of "professionally administered prescription drugs." Coverage for "professionally administered prescription drugs" is as described under *Professionally Administered Prescription Drugs*. Coverage for prescription drugs is as described in *Prescription Drugs*, *Prescription Specialty Drugs* or otherwise described as a specific benefit elsewhere in this section.

M. Hospice

Medica covers hospice services including respite care. Care must be ordered, provided or arranged under the direction of a physician and received from a hospice program.

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

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

Continuous hospice care is from two to twelve hours of service per day provided by a registered nurse, licensed practical nurse, or home health aide, during a period of crisis in order to maintain a terminally ill member at home.

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

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

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

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

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

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

Not covered:

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

8. Bereavement counseling, except when recommended and provided by the hospice program.

N. Hospital

Medica covers physician directed hospital and ambulatory surgical center services as described in the *Benefit Chart* section of 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.

Important: The most specific and appropriate section of this Policy will apply for benefits related to the treatment of a specific condition.

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

Medica will cover up to 120 hours of communicator or interpreter services provided by a home care nurse or personal care assistant to the ventilator-dependent person during the time the ventilator-dependent person is in a hospital licensed under Minn. Stat. Chapter 144. The coverage of communicator or interpreter services for the ventilator-dependent person is limited to those communicator or interpreter services required to assure adequate training of the hospital staff to communicate with the patient and to understand the unique comfort, safety, and personal care needs of the patient.

When an inpatient stay spans an old and new policy year, the benefit for charges billed on the hospital claim will be based on the old policy year provisions. Certain covered services received, such as a physician visit or lab and pathology services, performed during the inpatient stay but billed separately from the hospital, will apply to the benefits in effect on the date the covered service was provided.

If your coverage under this Policy ends during your inpatient stay, Medica will not cover the portion of your inpatient stay or other services received after this Policy terminates.

Not covered:

1. Services received from a non-network hospital or non-network ambulatory surgical center.
2. Prescription drugs received at a hospital on an outpatient basis, except prescription drugs that meet the definition of "professionally administered prescription drugs" or prescription drugs received in an emergency room or a hospital observation room. Coverage for "professionally administered prescription drugs" is as described under

Professionally Administered Prescription Drugs. Coverage for prescription drugs is as described in *Prescription Drugs* and *Prescription Specialty Drugs*.

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

O. Infertility Services

Medica's coverage is limited to the diagnosis of infertility as described in the *Benefit Chart* section of this Policy. Coverage includes benefits for professional, hospital and ambulatory surgical services. All services, supplies and associated expenses for the treatment of infertility are not covered.

Not covered:

1. Services received for the diagnosis of infertility provided by a non-network provider.
2. Procedures, tests or other services that are exclusively provided to monitor the effectiveness of non-covered fertilization procedures.
3. Physician, hospital and ambulatory surgical center services for the treatment of infertility.
4. Infertility prescription drugs.
5. Consultation and treatment for assisted reproductive technology (ART).
6. Services related to adoption.
7. Collection, retrieval, purchase, freezing and/or storage of sperm or eggs.

P. Lab and Pathology

Medica covers services provided in a clinic or outpatient hospital facility as described in the *Benefit Chart* section of this Policy. Medica covers lab and pathology services when ordered by providers who are operating within the provider's scope of licensure. Inpatient lab and pathology services are covered at the *Hospital* or *Skilled Nursing Facility* benefit level as described in the *Benefit Chart* section of this Policy.

Please note: Lab and pathology for preventive health care services are covered at the *Preventive Health Care* benefit level as described in the *Benefit Chart* section of this Policy.

Not covered:

Lab and pathology services provided by a non-network provider, except as described in *Emergency Room* or to the extent the lab and pathology services are provided under Minnesota Statute 62Q.556, or as described in *Surprise billing protections*.

Q. Lyme Disease

Medica covers services for the treatment of Lyme disease as described in the *Benefit Chart* section of this Policy.

R. Maternity

Medica covers medical services for prenatal care, labor and delivery, postpartum care and related complications as described in the *Benefit Chart* section of this Policy. Medica covers abortions and abortion-related services, including pre-abortion services and follow-up services.

Under the **Newborns' and Mothers' Health Protection Act of 1996** Medica may not restrict benefits for any hospital stay in connection with childbirth for the mother or newborn child member to less than 48 hours following a vaginal delivery (or less than 96 hours following a cesarean section). However, federal law generally does not prohibit the mother or newborn child member's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, Medica may not require a provider to obtain prior authorization from Medica for a length of stay of 48 hours or less (or 96 hours, as applicable).

More than one copayment or coinsurance may be required if you receive more than one service or see more than one provider per visit. Medica encourages you to enroll your newborn dependent under this Policy within 30 days from the date of birth, date of placement for adoption or date of adoption.

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

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

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

Services that are not considered prenatal care may be eligible for coverage under the most specific and appropriate section of this Policy. Please refer to the *Benefit Chart* section of this Policy for coverage information.

Postnatal care includes routine follow-up care from your provider after delivery. Services eligible for coverage include but are not limited to, parent education, assistance and training in breast and bottle feeding and conducting any necessary and appropriate clinical tests.

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

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

1. A comprehensive postnatal visit with a provider not more than three weeks from the date of delivery;

2. Any postnatal visits recommended by a provider between three and 11 weeks from the date of delivery; and

3. A comprehensive postnatal visit with a provider 12 weeks from the date of delivery.

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

When an inpatient stay spans an old and new policy year, the benefit for charges billed on the hospital claim will be based on the old policy year provisions. Certain covered services received, such as a physician visit or lab and pathology services, performed during the inpatient stay but billed separately from the hospital, will apply to the benefits in effect on the date the covered service was provided.

If your coverage under this Policy ends during your inpatient stay, Medica will not cover the portion of your inpatient stay or other services received after this Policy terminates.

Not covered:

1. Maternity care provided by a non-network provider, except as described in *Surprise billing protections*.

2. Health care professional services for maternity labor delivery in the home.

3. Services from a doula.

4. Childbirth and other educational classes.

S. Medical Related Dental

Medica covers certain dental services received from a physician or dentist as described in the *Benefit Chart* section of this Policy.

Medica covers the evaluation(s) to determine whether you have temporomandibular joint (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. TMJ disorder is covered the same as any other joint disorder as described in the *Benefit Chart* section of this Policy.

For dependents up to the limiting age, Medica covers inpatient and outpatient expenses arising from medical and dental treatment of cleft lip and cleft palate, including orthodontic and oral surgery treatment. Benefits for dependents age 19 and older are limited to inpatient or outpatient expenses arising from medical and dental treatment that was scheduled or initiated prior to the dependent turning age 19. See *Extending a child's eligibility* in *Eligibility* for details regarding dependent limiting ages. If the dependent is enrolled in a dental plan and orthodontic services are eligible for coverage under the dental plan, the dental plan shall be primary.

Not covered:

1. Medical-related dental services provided by a non-network provider.
2. General dentistry including, but not limited to, diagnostic and preventive services, restorative services, endodontic services, periodontal services, indirect fabrications, dentures and bridges, and orthodontic services unrelated to cleft lip and palate for a dependent child.
3. Dental services to treat an injury from biting or chewing.
4. Treatment for bruxism.
5. Tooth extractions, except for emergency accident-related dental services.
6. Osteotomies and other procedures associated with the fitting of dentures or dental implants.
7. Dental prostheses.
8. Occlusal adjustment or occlusal equilibrium, except related to the surgical and non-surgical treatment of temporomandibular joint (TMJ) disorder.
9. Dental implants (tooth replacement), except dental implants related to cleft lip and palate for a dependent child as described in the *Benefit Chart* section of this Policy.
10. Orthognathic surgery for cosmetic purposes. However, emergency treatment of complications from cosmetic surgery is covered as described in the *Emergency Room* section of this Policy.
11. Diagnostic casts, diagnostic study models and bite adjustments unless related to the treatment of TMJ disorder and craniomandibular disorder.
12. Dental services, including but not limited to, preventive, major, minor and restorative services, except as described in this section.

T. Mental Health and Substance Use

Medica covers services to diagnose and treat mental or substance use disorders listed in the current edition of the *International Classification of Diseases* or the *Diagnostic and Statistical Manual of Mental Disorders* as described in the *Benefit Chart* section of this Policy.

Mental health and substance use benefits

Medica requires prior authorization (approval in advance) before you receive certain mental health or substance use services or treatment. To determine if Medica requires prior authorization for a particular service or treatment, please call your plan's designated mental health and substance use disorder provider at the number on the back of your Medica ID card. Please see *Requests and Prior Authorization* in the *Introduction* for more information about prior authorization requirements and processes.

Your plan's designated mental health and substance use disorder provider will coordinate your network mental health and substance use services. If you require hospitalization, your plan's designated mental health and substance use disorder provider will refer you to one of its hospital providers. **Please note:** The hospital network for medical services and mental health

and substance use disorder services may not be the same. Call your plan's designated mental health and substance use disorder provider at the number on the back of your Medica ID card.

Emergency mental health and substance use services are covered benefits. After receiving emergency mental health or substance use inpatient services please notify your plan's designated mental health and substance use disorder provider at the number on the back of your Medica ID card as soon as reasonably possible.

Outpatient services include:

1. Diagnostic evaluations, assessment and treatment planning.
2. Treatment and procedures.
3. Medication management, including medication-assisted treatment.
4. Intensive outpatient programs.
    - For mental health services, the program may be freestanding or hospital-based and provides services for at least three hours per day, two or more days per week.
    - For substance use-related and addictive disorders services, the program provides structured programming for adults and adolescents, consisting primarily of counseling and education about addiction related and mental health problems.
5. Intensive behavioral and developmental therapy for the treatment of autism spectrum disorder, including applied behavioral analysis. The therapy must be:
    - Focused on the treatment of core deficits of autism spectrum disorder.
    - Provided by a Board-Certified Behavior Analyst (BCBA) or other qualified provider under the appropriate supervision.
    - Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.

    This section describes only the behavioral component of treatment for autism spectrum disorder.
6. Individual, family and group therapy, if there is a clinical diagnosis.
7. Treatment of serious or persistent disorders.
8. Services, care or treatment described as benefits in this Policy and ordered by a court of competent jurisdiction to be provided by a network provider or another provider as required by law. The court order must be based on a behavioral care evaluation performed by a licensed psychiatrist or a doctoral level licensed psychologist. This evaluation must include a diagnosis and an individual treatment plan for care in the most appropriate, least restrictive environment. Medica is entitled to receive a copy of the court order and the behavioral care evaluation. This court-ordered coverage is not subject to a separate medical necessity determination. The evaluation performed by a network provider is also a covered service.
9. Treatment of pathological gambling.
10. Services, care or treatment provided by the Minnesota Department of Corrections to a member while the member is committed to the Minnesota Department of Corrections' custody following a conviction for a first-degree driving while impaired offense if:

a. A court of competent jurisdiction makes a preliminary determination based on a chemical use assessment conducted under Minnesota Statutes section 169A.70 that treatment may be appropriate and includes this determination as part of the sentencing order; and

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

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

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

11. Partial hospitalization/day treatment/high intensity outpatient program. This may be in a freestanding facility or hospital based. Active treatment is provided through specialized programming with medical/psychological intervention and supervision during program hours. Partial program means a treatment program of 20 hours or more per week.

Inpatient services include:

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

Corrections' custody following a conviction for a first-degree driving while impaired offense if:

a. A court of competent jurisdiction makes a preliminary determination based on a chemical use assessment conducted under Minnesota Statutes section 169A.70 that treatment may be appropriate and includes this determination as part of the sentencing order; and

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

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

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

Not covered:

1. Mental health and substance use services provided by a non-network provider, except as described in *Surprise billing protections*.
2. Services performed in connection with conditions not classified in the current edition of the *International Classification of Diseases* or the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
3. Individual, family and group therapy, in the absence of a clinical diagnosis.
4. Services beyond the initial assessment to diagnose intellectual or learning disabilities.
5. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.
6. Services, including room and board charges, provided by providers or facilities that are not appropriately licensed, certified, or otherwise qualified under state law to provide mental health and substance use services or which provide a primary treatment modality that is experimental or investigational as determined by Medica.
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. Mental health residential treatment services that do not provide all of the following: room and board; group, family and individual counseling; client education; other services specific to mental health treatment; on-site medical/psychiatric assessment within 48 hours of admission, medical/psychiatric follow-up visits at least once per week; and nursing coverage.
9. Substance use disorder residential treatment services that do not provide all of the following: room and board; group, family and individual counseling; client education; other services specific to substance use disorder treatment; on-site medical/psychiatric assessment within 48 hours of admission, medical/psychiatric follow-up visits at least once per week; and nursing coverage.

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

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

U. Office Visits

Medica covers office visits as described in the *Benefit Chart* section of this Policy.

Important: The most specific and appropriate section of this Policy will apply for benefits related to the treatment of a specific condition. For some services, there may be a facility charge resulting in copayment or coinsurance in addition to the provider services copayment or coinsurance. More than one copayment or coinsurance may also be required if you receive more than one service, or see more than one provider per visit. Call Member Services at the number on the back of your Medica ID card to determine in advance whether a specific procedure is a benefit and the applicable coverage level for each service that you receive.

Please note: This benefit does not include services received from locations using "hospital-based outpatient billing" practices. The most specific and appropriate benefit in this Policy will apply for each service received at that type of provider. If you are unsure if your provider uses these billing practices, please contact them.

Not covered:

1. Office visit services provided by a non-network provider.

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

V. Organ and Bone Marrow Transplants and Other Complex Health Conditions

Medica covers certain organ and bone marrow transplant services and services for other complex health conditions. Not all network hospitals are designated facilities for organ and bone marrow transplants and other complex health conditions. Services covered under this section must be provided under the direction of a physician and received at a designated facility. Coverage under this section is provided for certain complex health conditions and certain types of organ or bone marrow transplants and related services (including organ acquisition and procurement) that are:

- medically necessary,
- appropriate for the diagnosis,
- without contraindications, and
- non-investigative.

Organ and Bone Marrow Transplants: Medica uses specific medical criteria to determine benefits for organ and bone marrow transplant services. Because medical technology is constantly changing, Medica 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 Medica's medical criteria.

Coverage is provided for the following human organ transplants, if appropriate, under Medica's medical criteria and not otherwise excluded from coverage:

- kidney,
- lung,
- heart,
- heart/lung,
- pancreas,
- pancreas/kidney,
- intestinal,
- liver,
- allogeneic, autologous and syngeneic bone marrow. Bone marrow transplants include the transplant of stem cells from bone marrow, peripheral blood and umbilical cord blood.

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

Benefits apply to transplant services provided by a network provider and received at a designated facility for transplant services. Medica has entered into separate contracts to provide certain transplant-related health services to members receiving transplants. You may be evaluated and listed as a potential recipient at multiple designated facilities for transplant services.

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

Other Complex Health Conditions: Defined services from the designated specialty complex care provider are covered when:

1. You have received an undifferentiated diagnosis or diagnosis of a complex condition;
2. You have been referred to the designated facility by your network provider;

3. The designated facility has agreed to provide to you complex care health services; and
4. You or your network referring provider have received an authorization number from Medica.

Complex care health services are services provided for the exclusive purpose of treating a complex health condition that involves one or more of the following elements: (i) is life threatening; (ii) may cause serious disability or other severe consequences, including risk of morbidity or mortality; (iii) affects multiple organ systems; (iv) the required treatments are technically challenging and carry a risk of serious complications;(v) is medically complex or rare; or (vi) previous treatments have failed or there is no known diagnosis for the condition. A condition may meet one or more of the above criteria but still not require complex care health services. Whether treatment of a condition requires the provision of complex care health services will be determined by your network provider and the designated facility, in consultation with Medica.

Important: An approved request is required before you receive complex care health services. Please see *Requests to receive in-network benefits from non-network providers* in *Requests and Prior Authorization* for more information about request requirements and the process for receiving an authorized request.

Services covered under this section must be provided under the direction of a specialty complex care provider and received at a designated facility. Coverage under this section is provided for complex care medical services and that are:

- medically necessary,
- appropriate for the condition,
- without contraindications, and
- non-investigative.

Benefits for complex health conditions under this section apply to complex care health services provided at the designated facility by a specialty complex care provider.

Not covered:

1. Services provided by a non-network provider or non-designated facility.
2. Supplies and services related to transplants that would not be authorized by Medica under the medical criteria referenced in this section.
3. Living donor transplants that would not be authorized by Medica under the medical criteria referenced in this section.
4. Islet cell transplants except for autologous islet cell transplants associated with pancreatectomy.
5. Services required to meet the patient selection criteria for the authorized procedure. This includes:
    - services and related expenses for weight loss programs,
    - nutritional supplements,
    - appetite suppressants, and

- supplies of a similar nature not otherwise covered under this Policy.

6. Mechanical, artificial or non-human organ implants or transplants and related services that would not be authorized by Medica under the medical criteria referenced in this section.
7. Services that are investigative.
8. Private collection and storage of umbilical cord blood for directed use.
9. Prescription drugs provided or administered by a physician or other provider on an outpatient basis, except those prescription drugs that meet the definition of "professionally administered prescription drugs." Coverage for "professionally administered prescription drugs" is as described under *Professionally Administered Prescription Drugs.* Coverage for prescription drugs is as described in *Prescription Drugs* and *Prescription Specialty Drugs* or otherwise described as a specific benefit in this Policy.

W. PANS/PANDAS

Medica covers medically necessary services recommended by your provider for the treatment of diagnosed pediatric acute-onset neuropsychiatric syndrome (PANS) and pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and include but are not limited to antibiotics, prescription drugs and behavioral therapies to manage neuropsychiatric symptoms, plasma exchange, and immunoglobulin, as described in the *Benefit Chart* section of this Policy.

X. Port Wine Stain Removal

Medica covers port wine stain removal services as described in the *Benefit Chart* section of this Policy.

Y. Prescription Drugs

Prescription drugs and supplies are covered if they are:

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

The *Benefit Chart* section of this Policy describes your copayment or coinsurance for prescription drugs themselves. An additional copayment or coinsurance applies for the provider's services if you require that a provider administer self-administered prescription drugs, as described in other applicable sections of this Policy. For these purposes, "self-administered prescription drugs" are prescription drugs that do not meet the definition of "professionally administered prescription drugs."

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

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

Member cost sharing for prescription drugs prescribed to treat diabetes, asthma, or allergies requiring the use of epinephrine auto-injectors and received at a network pharmacy will be limited to $25 per prescription unit

Member cost-sharing for medical supplies necessary to effectively and appropriately treat or administer a drug prescribed to treat diabetes, asthma, or allergies requiring the use of epinephrine auto-injectors and received at a network pharmacy or from a network durable medical equipment provider will be limited to $50 per month in total

Medica's Prescription Drug List

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

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

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

The Drug List includes preferred generic and non-preferred generic prescription drugs. These prescription drugs are your lower copayment or coinsurance options.

- **Preferred generic** drugs are your lowest copayment or coinsurance option. For your lowest share of the cost, consider a preferred generic covered drug if you and your provider decide it is appropriate for your treatment.
- **Non-preferred generic** drugs have a higher copayment or coinsurance than preferred generic drugs. Non-preferred generic drugs are covered at two benefit levels. If you have questions about which benefit level a specific non-preferred generic drug is covered at, see the Drug List at **Medica.com/SignIn** or call Member Services at the number on the back of your Medica ID card.

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

- **Preferred brand** prescription drugs on the Drug List have a higher copayment or coinsurance. You may consider a preferred brand covered prescription drug to treat your condition if you and your provider decide it is appropriate.
- **Non-preferred brand** prescription drugs have the highest copayment or coinsurance. The covered non-preferred brand prescription drugs are usually more costly.

If you have questions about the Drug List or whether a specific prescription drug is covered (and/or whether the prescription drug is preferred generic; preferred brand, non-preferred generic; or non-preferred brand, non-preferred generic), or if you would like to request a copy of the Drug List at no charge, call Member Services at the number on the back of your Medica ID card. It is also available on **Medica.com/SignIn**.

Prescription unit

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

One prescription unit from a pharmacy is a 31-consecutive-day supply, except for prescription contraceptives. One prescription unit for a prescription contraceptive is as prescribed by the prescribing provider and up to a 12-month supply.

Medica has specifically designated certain network pharmacies to dispense multiple prescription units. These pharmacies may dispense three prescription units for covered prescription drugs prescribed to treat chronic conditions. For the list of these designated pharmacies, visit **Medica.com/SignIn** or call Member Services.

Special requirements

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

Prior authorization (PA)

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

Step therapy (ST)

Certain prescription drugs require completion of step therapy in order to be covered. The prescription drugs subject to step therapy are shown on the Drug List with the abbreviation

"ST." You must meet applicable step therapy requirements before Medica will cover these preferred brand or non-preferred brand prescription drugs. When the treatment of stage four advanced metastatic cancer or associated conditions is covered, Medica will not limit or exclude from coverage an FDA approved drug by mandating that a member with stage four advanced metastatic cancer or associated conditions follow a step therapy protocol if the use of the approved drug is consistent with:

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

Quantity limits (QL)

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

Pharmacy requirement

Certain self-administered cancer treatment prescription drugs must be obtained from a Medica-designated specialty pharmacy in order to be covered.

Generic requirement

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

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

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

Investigative

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

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

to be marketed for its proposed use by the 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 providers in the applicable specialty or subspecialty that typically manages the condition as determined by a survey or poll of a representative sampling of these providers.

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

Exceptions to the Drug List

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

If you have a condition that may seriously jeopardize your life, health or ability to regain maximum function or if you are undergoing a current course of treatment with a prescription drug not included on the Drug List, an expedited review may be requested. Medica will make a determination and provide notification on an expedited review request within 24 hours of receiving the request. For all other exception requests (standard requests), Medica will make a determination and provide notification within 72 hours of receiving the request.

If Medica denies your request for an exception, you, your provider or other designee may request an independent review of Medica's decision by an external review organization. To make a request, you may call Member Services at the number on the back of your Medica ID card or contact Medica by writing to Member Services, Route CP595, PO Box 9310, Minneapolis, MN 55440-9310. You will be notified of the external review organization's decision within 72 hours of receipt of the request for external review, unless you are requesting review of a denial that was completed as an expedited review. In that case, you will be notified of the external review organization's decision within 24 hours of receipt of the request for external review.

If you would like to request a copy of the Drug List exception process or for more information regarding the expedited review process, call Member Services at the number on the back of your Medica ID card.

Antipsychotic prescription drugs

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

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

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

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

Exceptions to step therapy

In certain cases it is possible to get an exception to step therapy requirements. To obtain more information about the step therapy exception process, please go to **Medica.com/StepTherapy** or call Member Services at the number on the back of your Medica ID card. Medica will respond to a request for an exception to step therapy requirements within five days of receipt of a complete request. If you have a condition that may seriously jeopardize your life, health or ability to regain maximum function, Medica will respond within 72 hours of receipt of a complete request. If we do not approve your request for an exception to step therapy requirements, you have the right to appeal Medica's decision. Medica will respond to a request for such an appeal within five days of receipt of a complete request. If you have a condition that may seriously jeopardize your life, health or ability to regain maximum function, Medica will respond within 72 hours of receipt of a complete request. See *Complaints* for more information on your appeal rights. If Medica's decision on appeal upholds the initial denial of your request for an exception to step therapy requirements, you have a right to request an external review as described in *Complaints*.

Not covered:

1. Prescription drugs, including diabetic equipment and supplies and preventive prescription drugs and other supplies, received at a non-network pharmacy.
2. Prescription drugs prescribed for investigative uses.
3. Over the counter (OTC) drugs that by federal or state law do not require a prescription order or refill and any prescription drug that is therapeutically equivalent to an OTC drug.
4. Replacement of a prescription drug due to loss, damage or theft.
5. Appetite suppressants.

6. Weight loss prescription drugs.
7. Sexual dysfunction prescription drugs.
8. Non-sedating antihistamines and non-sedating antihistamine/decongestant combinations.
9. Proton pump inhibitors, except for members twelve (12) years of age and younger, and those members who have a feeding tube.
10. Prescription drugs prescribed by a provider who is not acting within their scope of licensure.
11. Homeopathic medicine.
12. Infertility prescription drugs.
13. Prescription drugs, equipment and supplies not listed on the Drug List, unless covered through the exception process described in *Exceptions to the Drug List* and *Drug List exceptions for antipsychotic prescription drugs*. Such exclusions are in addition to prescription drugs or classes of prescription drugs excluded under other provisions of this Policy.
14. Bulk powders, chemicals and products used in prescription drug compounding.
15. Products that are duplicative to, or are in the same class and category as, products on the Drug List, unless covered through the exception process described under *Exceptions to the Drug List* in this section.
16. New to market prescription drugs: Products recently approved by the FDA and introduced into the market will not be covered until they are reviewed and considered for placement on the Drug List.

Z. Prescription Specialty Drugs

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

Specialty prescription drugs are covered if they are:

- Prescribed by an authorized provider,
- Included on the Drug List (unless identified as not covered), and
- Received from a designated specialty pharmacy.

A current list of designated specialty pharmacies is available on **Medica.com/SignIn**. You can also call Member Services at the number on the back of your Medica ID card.

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

Member cost sharing for specialty drugs prescribed to treat diabetes, asthma, or allergies requiring the use of epinephrine auto-injectors will be limited to $25 per prescription unit

Medica's Specialty Prescription Drug Program

The Drug List is comprised of prescription drugs that meet the medical needs of our members and have been selected based on their safety, effectiveness, uniqueness and cost. These prescription drugs have been approved by the FDA. A team of physicians and pharmacists meets regularly to review and update the Drug List. The *Benefit Chart* section of this Policy describes your copayment or coinsurance for the specialty prescription drug.

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

If you have questions about the Drug List or whether a specific specialty prescription drug is covered (and/or the benefit level at which the prescription drug may be covered), or if you would like to request a copy of the Drug List, at no charge, call Member Services at the number on the back of your Medica ID card. It is also available on **Medica.com/SignIn**.

Prescription unit

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

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

Special requirements

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

Prior authorization

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

Step therapy (ST)

Certain specialty prescription drugs require completion of step therapy. The prescription drugs subject to step therapy are shown on the Drug List with the abbreviation "ST." You must meet applicable step therapy requirements before Medica will cover the requested prescription drug. When the treatment of stage four advanced metastatic cancer or associated conditions is covered, Medica will not limit or exclude from coverage an FDA approved drug by mandating that a member with stage four advanced metastatic cancer or

associated conditions follow a step therapy protocol if the use of the approved drug is consistent with:

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

Quantity limits (QL)

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

Investigative

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

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

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

Exceptions to the Drug List

In certain cases, it is possible to get an exception that will cover a specialty prescription drug that is generally not covered. **Please note that exceptions will only be allowed when specific clinical criteria are satisfied.**

If you have a condition that may seriously jeopardize your life, health or ability to regain maximum function or if you are undergoing a current course of treatment with a prescription drug not included on the Drug List, an expedited review may be requested. Medica will make a determination and provide notification on an expedited review request within 24 hours of receiving the request. For all other exception requests (standard requests), Medica will make a determination and provide notification within 72 hours of receiving the request.

If Medica denies your request for an exception, you, your provider or other designee may request an independent review of Medica's decision by an external review organization. To make a request, you may call Member Services at the number on the back of your Medica ID card or contact Medica by writing to Member Services, Route CP595, PO Box 9310, Minneapolis, MN 55440-9310. You will be notified of the external review organization's decision within 72 hours of receipt of the request for external review, unless you are requesting review of a denial that was completed as an expedited review. In that case, you will be notified of the external review organization's decision within 24 hours of receipt of the request for external review.

If you would like to request a copy of the Drug List exception process or for more information regarding the expedited review process, call Member Services at the number on the back of your Medica ID card.

Antipsychotic prescription drugs

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

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

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

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

Exceptions to Step Therapy

In certain cases it is possible to get an exception to step therapy requirements. To obtain more information about the step therapy exception process, please go to **Medica.com/StepTherapy** or call Member Services at the number on the back of your Medica ID card. Medica will respond to a request for an exception to step therapy requirements within five days of receipt of a complete request. If you have a condition that may seriously jeopardize your life, health or ability to regain maximum function, Medica will respond within 72 hours of receipt of a complete request. If we do not approve your request for an exception to step therapy requirements, you have the right to appeal Medica's decision. Medica will respond to a request for such an appeal within five days of receipt of a complete request. If you have a condition that may seriously jeopardize your life, health or ability to regain maximum function, Medica will respond within 72 hours of receipt of a complete request. See *Complaint*s for more information on your appeal rights. If Medica's

decision on appeal upholds the initial denial of your request for an exception to step therapy requirements, you have a right to request an external review as described in *Complaints*.

Not covered:

1. Specialty prescription drugs noted on the Drug List with a 'SP' indicator and received from a pharmacy that is not a designated specialty pharmacy.
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 prescribed for investigative uses.
5. Weight loss prescription drugs.
6. Specialty prescription drugs not listed on the Drug List, unless covered through the exception process described in *Exceptions to the Drug List*.
7. Infertility prescription drugs.
8. New to market prescription drugs: Products recently approved by the FDA and introduced into the market will not be covered until they are reviewed and considered for placement on the Drug List.

AA. Preventive Health Care

Routine preventive services are as defined by state and federal law. Medica covers the following eligible preventive health services as described in the *Benefit Chart* section of this Policy:

1. Child health supervision services, including well-baby care, pediatric preventive services, appropriate immunizations up to age 18, developmental assessments, and appropriate laboratory services.
2. Adult immunizations.
3. Early disease detection services including physicals.
4. Routine screening procedures for cancer including, but not limited to, screening for prostate cancer, ovarian cancer and colorectal cancer. See *Certain Cancer-Related Tests* for more information about surveillance testing for ovarian cancer for at-risk women and screening for prostate cancer.
5. Women's preventive health services including mammograms (including digital breast tomosynthesis), screenings for cervical cancer (including pap smears), human papillomavirus (HPV) testing, counseling for sexually transmitted infections, counseling for immunodeficiency virus (HIV), BRCA genetic testing and related genetic counseling (when appropriate) and contraceptive methods and contraceptive services. **Note**: Preventive mammogram screenings include, but are not limited to, coverage for women at risk for breast cancer. "At risk for breast cancer" means 1) having a family history with one or more first- or second-degree relatives with breast cancer; 2) testing positive for BRCA1 or BRCA2 mutations; 3) having heterogeneously dense breasts or extremely dense breasts based on the Breast Imaging Reporting and Data System

established by the American College of Radiology; or 4) having a previous diagnosis of breast cancer.

6. All pre-exposure prophylaxis and post-exposure prophylaxis when used for the prevention or treatment of human immunodeficiency virus.

7. Other preventive health services, including screening for tobacco use and tobacco cessation counseling.

Please see the definition of Preventive Health Services for more information.

Please note: If you receive preventive and non-preventive health services during the same visit, the non-preventive health services may be subject to a copayment, coinsurance or deductible, as described in other applicable sections in the *Benefit Chart* section of this Policy. The most specific and appropriate benefit will apply for each service received during a visit.

For example, laboratory and diagnostic imaging may be subject to other plan benefits if determined not to be part of a preventive visit. See *Diagnostic Imaging* and *Lab and Pathology* for more information. When you have symptoms or a history of an illness or injury, laboratory and diagnostic services relating to that illness or injury are no longer considered preventive health services.

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

Not covered:

Preventive health services provided by a non-network provider.

BB. Professionally Administered Prescription Drugs

Medica covers medically necessary professionally administered prescription drugs that are administered, in conjunction with a covered benefit such as an office visit or home health care visit, by a provider acting within the scope of the provider's license, on an outpatient basis in a hospital, provider's office or in your home.

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

If you require certain professionally administered prescription drugs, we may direct you to a designated facility with whom we have an arrangement to provide those certain professionally administered prescription drugs. Such designated facilities may include an outpatient pharmacy, specialty pharmacy, home health care agency, home infusion provider, hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy. If you or your provider administering the professionally administered prescription drugs are directed to a designated facility and you or your provider choose not to obtain your professionally administered prescription drug from that designated facility, benefits are not available under this Policy for that professionally administered prescription drug.

Not covered:

Professionally administered prescription drugs provided by a non-network provider.

CC. Rare Diseases

Medica covers medically necessary services from a licensed health care provider related to the diagnosis, monitoring, and treatment of a rare disease or condition. Prescription drugs, procedures or treatment, or laboratory or clinical testing for the diagnosis, treatment or monitoring of a rare disease will be covered in the same manner as any other diseases or conditions covered under this Policy except as otherwise set forth in this Rare Diseases section. Prescription specialty drugs for rare diseases and condition are covered as described in Prescription Specialty Drugs. Services will be covered as described in the *Rare Diseases* section of the *Benefit Chart*.

Definition of Rare Disease or Condition

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

1. That affects fewer than 200,000 persons in the United States and is chronic, serious, life-altering, or life-threatening;
2. That affects more than 200,000 persons in the United States and a drug for treatment has been designated as a drug for a rare disease or condition pursuant to United States Code, title 21, section 360bb;
3. That is labeled as a rare disease or condition on the Genetic and Rare Diseases Information Center list created by the National Institutes of Health; or
4. For which a member:
    a. has received two or more clinical consultations from a primary care provider or specialty provider that are specific to the presenting complaint;
    b. has documentation in the member's medical record of a developmental delay through standardized assessment, developmental regression, failure to thrive, or progressive multisystemic involvement; and
    c. had laboratory or clinical testing that failed to provide a definitive diagnosis or resulted in conflicting diagnoses.

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

Medica will use prior authorization (approval in advance) to confirm that your disease or condition is a rare disease or condition as defined above before you can receive coverage as described in the *Rare Diseases* section of the *Benefit Chart*. You may also need to obtain prior authorization for coverage of certain services or supplies if those services or supplies are subject to Medica's prior authorization requirements for non-rare diseases or conditions. Please see *Requests to receive in-network benefits from non-network providers* in *Requests and Prior Authorization* for more information about request requirements and the process for receiving an authorized request.

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

Transition of Care to a Network Provider

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

Not covered:

1. Prescription drugs for rare diseases and conditions received from a retail pharmacy. Coverage for prescription drugs received from a retail pharmacy is as described in *Prescription Drugs*.
2. A prescription drug, device or medical treatment or procedure that is investigative.
3. Services received outside the United States.

DD. Reconstructive and Restorative Surgery (Including Mastectomy Reconstruction)

Medica covers medically necessary reconstructive and restorative surgery services. To be eligible, reconstructive and restorative surgery services must be medically necessary and not cosmetic.

Medica will cover all stages of reconstruction of the breast on which the mastectomy was performed and surgery and reconstruction of the other breast to produce a symmetrical appearance if the mastectomy was medically necessary (as determined by the attending physician and patient). Medica will also cover prostheses and physical complications, including lymphedemas, at all stages of mastectomy.

Not covered:

1. Reconstructive and restorative surgery services provided by a non-network provider.
2. Revision of blemishes on skin surfaces and scars (including scar excisions) primarily for cosmetic purposes, except as described in in the *Benefit Chart* section of this Policy under *Port Wine Stain Removal*.
3. Repair of a pierced body part and surgical repair of bald spots or loss of hair.
4. Dental services, including but not limited to, preventive, major, minor and restorative services, except as described in *Medical Related Dental.*
5. Services and procedures primarily for cosmetic purposes. However, emergency treatment of complications from cosmetic surgery is covered as described in the *Emergency Room* section of this Policy.
6. Surgical correction of male breast enlargement primarily for cosmetic purposes.
7. Hair transplants.

8. Prescription drugs provided or administered by a physician or other provider on an outpatient basis, except those prescription drugs that meet the definition of "professionally administered prescription drugs." Coverage for "professionally administered prescription drugs" is as described under *Professionally Administered Prescription Drugs*. Coverage for prescription drugs is as described in *Prescription Drugs* and *Prescription Specialty Drugs,* or otherwise described as a specific benefit in this Policy.
9. Orthognathic surgery for cosmetic purposes. However, emergency treatment of complications from cosmetic surgery is covered as described in the *Emergency Room* section of this Policy.

EE. Rehabilitative and Habilitative Therapies

Medica covers the following rehabilitative and habilitative care provided on an outpatient basis:

- physical therapy,
- speech therapy, and
- occupational therapy

as described in the *Benefit Chart* section of this Policy. A physician must direct your care.

Coverage for services provided on an inpatient basis is as described under *Hospital*.

Not covered:

1. Rehabilitative and habilitative therapies provided by a non-network provider.
2. Services primarily educational in nature.
3. Vocational and job rehabilitation.
4. Recreational therapy.
5. Self-care or self-help training (non-medical), including, but not limited to, educational therapy, aerobic conditioning, therapeutic exercises, work hardening programs, etc., and all related material and products for these programs.
6. Health clubs.
7. Physical, occupational or speech therapy services when there is no reasonable expectation of improvement.
8. Voice training.
9. Group physical, speech and occupational therapy.

FF. Skilled Nursing Facility

Medica covers skilled nursing facility services as described in the *Benefit Chart* section of this Policy. Care must be provided under the direction of a physician.

Not covered:

1. Services received from a non-network skilled nursing facility, except as described in *Surprise billing protections*.
2. Custodial care and other non-skilled services.
3. Self-care or self-help training (non-medical), including, but not limited to, educational therapy, aerobic conditioning, therapeutic exercises, work hardening programs, etc., and all related material and products for these programs.
4. Services primarily educational in nature.
5. Vocational and job rehabilitation.
6. Recreational therapy.
7. Health clubs.
8. Physical, occupational or speech therapy services when there is no reasonable expectation of improvement.
9. Voice training.
10. Outpatient rehabilitation services when no medical diagnosis is present.
11. Group physical, speech and occupational therapy.

GG. Sleep Studies

Medica covers sleep studies as described in the *Benefit Chart* section of this Policy.

Not covered:

Services received from a non-network provider.

HH. Telehealth Services

Medica covers telehealth services as described in the *Benefit Chart* section of this Policy.

Telehealth includes certain audio-only services as provided for in Medica's coverage policy.

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

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

Not covered:

Telehealth services provided by a non-network provider.

II. Urgent Care

Medica covers urgent care center visits as described in the *Benefit Chart* section of this Policy.

JJ. Vision

Medica covers an initial lens (eyeglass lens or contact lens) following surgical repair of the eye. For the purposes of this benefit, reasons for surgical repair include treatment for cataracts or diseases of the cornea surface.

Therapeutic contact lenses for the treatment of the following diseases of the ocular surface, when these contact lenses will result in significantly better visual and/or improved binocular function when compared to eyeglasses, such as the following conditions:

- keratoconus;
- pathological myopia;
- aphakia;
- anisometropia;
- aniseikonia;
- aniridia;
- corneal disorders;
- post-traumatic disorders;
- irregular astigmatism;
- high ametropia; and
- bullous keratopathy.

Medica covers vision services for members under age 19 including frames, lenses or contact lenses and certain low vision aids when prescribed solely for vision correction, and related fittings as described in the *Benefit Chart* section of this Policy. Lenses include single vision, bifocal, trifocal or lenticular with choice of glass or plastic lenses.

Not covered:

1. Vision services provided by a non-network provider.
2. The purchase, replacement or repair of low vision aids, eyeglasses, eyeglass frames or contact lenses when prescribed solely for vision correction, and their related fittings for members 19 years of age or older.
3. Routine vision exams for adults, unless otherwise stated in the *Benefit Chart* section of this Policy.
4. Refractive eye surgery.

KK. Exclusions

Medica will not provide coverage for any of the services, treatments, supplies or items described below even if it is recommended or prescribed by a provider or it is the only available treatment for your condition. **Important: The list below describes exclusions in addition to the services, supplies and associated expenses already listed as Not covered elsewhere 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 prescription drugs used to treat conditions that are cosmetic in nature, unless otherwise determined to be reconstructive. However, emergency treatment of complications from cosmetic surgery is covered as described in the *Emergency Room* section of this Policy.
3. Hearing aids (including internal, external or implantable hearing aids or devices) and other devices to improve hearing, and their related fittings, except as described in the *Benefit Chart* section of this Policy under *Hearing Aids and Services*. Additionally, hearing aids that are available over-the-counter will not be covered. Cochlear implants and their related fittings are covered as surgical services under *Office Visits* or *Hospital*.
4. A prescription drug, device or medical treatment or procedure that is investigative.
5. Autopsies, except as stated in this Policy.
6. Enteral feedings, unless they are the sole source of nutrition; however, enteral feedings of standard infant formulas, standard baby food and regular grocery products used in blenderized formulas are excluded regardless of whether they are the sole source of nutrition.
7. Nutritional and electrolyte substances except as described in the *Benefit Chart* section of this Policy under *Durable Medical Equipment, Prosthetics and Miscellaneous Medical Supplies*.
8. Physical, occupational or speech therapy or chiropractic services when there is no reasonable expectation of improvement.
9. Reversal of voluntary sterilization.
10. Personal comfort or convenience items or services.
11. Custodial care, unskilled nursing or unskilled rehabilitation services.
12. Respite or rest care except as otherwise covered in this Policy under *Hospice*.
13. Travel, transportation or living expenses. Certain travel or living expenses may be partially reimbursed when approved by Medica and related to services that have been authorized by Medica as described in *Organ and Bone Marrow Transplants and Other Complex Health Conditions*. For information about coverage of transportation via ambulance, please see *Ambulance* in *Covered Benefits*.

14. Household equipment which primarily has customary uses other than medical, such as, but not limited to, exercise cycles, air purifiers, central or unit air conditioners, water purifiers, non-allergenic pillows, mattresses or waterbeds.
15. Household fixtures, including, but not limited to, escalators or elevators, ramps, swimming pools and saunas.
16. Modifications to the structure of the home including, but not limited to, its wiring, plumbing or charges for installation of equipment.
17. Vehicle, car or van modifications including, but not limited to, hand brakes, hydraulic lifts and car carrier.
18. Massage therapy, provided in any setting, even when it is part of a comprehensive treatment plan.
19. Routine foot care, except as medically necessary for members who are at risk for developing foot disorders secondary to systemic disease or another medical condition. Such care must be performed by a licensed provider acting within the scope of their license to be eligible for coverage.
20. Services by persons who are family members or who share your legal residence.
21. Claims for benefits to the extent such claims have been paid under workers' compensation, employer liability or any similar law, auto insurance, or any other coverage or plan that is required to pay before this plan pays. In other words, Medica will not make duplicate payment on claims that have been paid previously by another payer.
22. Unless requested by Medica, charges for duplicating and obtaining medical records from non-network providers and non-network dentists.
23. Services to treat injuries that occur while on military duty and received as a result of war, or any act of war (whether declared or undeclared). This exclusion does not apply if you are a civilian.
24. Exams, other evaluations or other services received solely for the purpose of employment, insurance or licensure.
25. Exams, other evaluations or other services received solely for the purpose of judicial or administrative proceedings or research, except emergency examination of a child ordered by judicial authorities.
26. Non-routine vaccines.
27. Self-care or self-help training (non-medical), including, but not limited to, educational therapy, aerobic conditioning, therapeutic exercises, work hardening programs, etc., and all related material and products for these programs.
28. Educational classes, programs or seminars, including but not limited to childbirth classes, except as described in the *Benefit Chart* section of this Policy under *Diabetes Management and Supplies (for Type I, Type II and Gestational)*.
29. Coverage for costs associated with translation of medical records and claims to English.
30. Treatment for superficial veins, also referred to as telangiectasia, threat, reticular or spider veins.

31. Therapeutic acupuncture, dry needling or services billed by an acupuncturist.

32. Services for or related to vision therapy and orthoptic and/or pleoptic training, except as described in the *Benefit Chart* section of this Policy under *Vision*.

33. Orthognathic surgery for cosmetic purposes. However, emergency treatment of complications from cosmetic surgery is covered as described in the *Emergency Room* section of this Policy.

34. Bariatric surgery, including initial procedures, surgical revisions and subsequent procedures.

35. Services for private duty nursing, except as stated in *Home Health Care*.

36. Medical and hospital services that are directly related to a non-covered service will not be paid. If a particular type of service is denied, the bundle of services that accompanies that service, services that would not have been provided but for the provision of the non-covered service, are not covered. Medica does cover emergency services that are received to treat complications of a non-covered service.

37. Services which are not within the scope of licensure or certification of the provider.

38. Non-emergency transportation, except as described in the *Benefit Chart* section of this Policy under *Ambulance*.

39. Non-emergency services received outside the United States.

40. Services solely for or related to the treatment of snoring.

41. Services provided to treat injuries or illness as a result of committing a felony or attempting to commit a felony.

42. Interpreter services, however, Medica will cover up to 120 hours of communicator or interpreter services provided by a home care nurse or personal care assistant to the ventilator-dependent person during the time the ventilator-dependent person is in a hospital licensed under Minn. Stat. Chapter 144. The coverage of communicator or interpreter services for the ventilator-dependent person is limited to those communicator or interpreter services required to assure adequate training of the hospital staff to communicate with the patient and to understand the unique comfort, safety, and personal care needs of the patient.

43. Charges for interest, mailing and delivery.

44. Prescription drugs provided or administered by a physician or other provider on an outpatient basis, except those prescription drugs that meet the definition of "professionally administered prescription drugs." Coverage for "professionally administered prescription drugs" is as described under *Professionally Administered Prescription Drugs*. Coverage for prescription drugs is as described in *Prescription Drugs* and *Prescription Specialty Drugs* or otherwise described as a specific benefit in this Policy.

45. Any form, mixture or preparation of cannabis for medical or therapeutic use and any device or supplies related to its administration.

46. Non medical services (including but not limited to legal services, social rehabilitation, educational services except as described in this Policy, vocational rehabilitation, job placement services, animals and any service or treatment related to animals).

47. Consultation and treatment for assisted reproductive technology (ART).

48. Collection, retrieval, purchase, freezing and/or storage of sperm or eggs.

49. Services related to adoption.

50. Prescription drugs, supplies, biologics and biosimilars that have not been approved by the FDA.

51. Medical devices that have not been approved by the FDA, other than those granted a humanitarian device exemption.

52. New to market biologics, biosimilars and professionally administered prescription drugs. Biologics, biosimilars and professionally administered prescription drugs recently approved by the FDA (including approval for a new indication) will not be covered until they are reviewed and approved for coverage by Medica.

53. Professionally administered prescription drugs that do not meet both of the following requirements: (a) administered in conjunction with a covered benefit and (b) administered by a provider acting within the scope of the provider's license.

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

55. Services prohibited by applicable law or regulation in the jurisdiction in which the services are received. If you have questions regarding how this exclusion applies to your benefits, please call Member Services at the number on the back of your Medica ID card.

56. Health care services received outside of the United States. For purposes of this provision, United States means the 50 United States and the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

IV. Coordination of Benefits

A. Applicability

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

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:

1. Shall not be reduced when this plan determines its benefits before another plan; but
2. May be reduced when another plan determines its benefits first. The above reduction is described in *Effect on the benefits of this plan.*

B. Definitions that apply to this section

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

1. Group or non-group insurance or group-type coverage, whether insured or uninsured, or individual coverage. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
2. 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 (1) or (2) 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.

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

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.

Allowable expense means a necessary, reasonable and customary item of expense for health care, when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made. *Allowable expense* does not include the deductible for

members with a primary high deductible plan and who notify Medica of an intention to contribute to a health savings account.

The difference between the cost of a private hospital room and the cost of a 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 member does not comply with the plan provisions, the amount of such reduction will not be considered an allowable expense. Examples of such provisions are those related to second surgical opinions, and preferred provider arrangements.

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.

C. 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:

1. The other plan has rules coordinating its benefits with the rules of this plan; and
2. Both the other plan's rules and this plan's rules, in **Rules** below, require that this plan's benefits be determined before those of the other plan.

Rules

This plan determines its order of benefits using the first of the following rules which applies:

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.

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

1. The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but
2. If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

However, if the other plan does not have the rule described in (1) immediately above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

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

1. First, the plan of the parent with custody of the child;
2. Then, the plan of the spouse of the parent with the custody of the child; and
3. Finally, the plan of the parent not having custody of the child.

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

Joint custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering follow the *Order of benefit determination rules* outlined in ***Dependent child/parents not separated or divorced***.

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.

Workers' compensation. You should submit claims incurred as a result of a work-related sickness or injury to the employer for workers' compensation coverage, before submitting them to Medica.

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

***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.

D. Effect on the benefits of this plan

When this section applies

This section applies when, in accordance with the ***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 ***Reduction in this plan's benefits*** immediately below.

Reduction in this plan's benefits

The benefits of this plan will be reduced when the sum of:

1. The benefits that would be payable for the allowable expense under this plan in the absence of this COB provision; and
2. 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 the *Benefit Chart* section of this Policy. 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.

E. Right to receive and release needed information

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

F. Facility of payment

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

G. Right of recovery under Coordination of Benefits

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

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

3. Other organizations.

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

H. Coordination for Medicare-eligible individuals

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

Medicare is primary if you are enrolled in Medicare in the following circumstances:

- You are at least 65 years old;
- You are less than 65 years old, but are covered by Medicare because of disability or end stage renal disease.

Members eligible for enrollment in Medicare are strongly encouraged to enroll in both Medicare Part A and Medicare Part B as soon as they are eligible.

If you are eligible for Medicare, we will consider you covered by Medicare, whether or not you are actually enrolled in Medicare. For services that are covered by Medicare, we will reduce your benefits under this Policy by the amount you would have been eligible for under Medicare if you had actually enrolled in Medicare. We will not coordinate with Medicare for members over age 65 who are not eligible for Medicare Parts A and B.

If we believe you are eligible for Medicare, we will send you a communication. If you believe you are not eligible for Medicare, please notify us and provide information from the Social Security Administration as to the reason you are not eligible for Medicare. Failure to enroll in Medicare Part A and B will result in large out-of-pocket expenses for services that Medicare might have covered, because we will pay that member's claims as if the member is enrolled in Medicare.

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

V. Complaints

This section describes what to do if you have a complaint or would like to appeal a decision made by Medica. You may also have appeal rights under regulations implementing the Patient Protection and Affordable Care Act (PPACA).

You may call Member Services at the number on the back of your Medica ID card or by writing to the address below in *Internal review*, 1.a. You also may contact the Commissioner of Commerce, Minnesota Department of Commerce, at **(651) 539-1600** or **1 (800) 657-3602**.

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

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

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

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

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

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

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

Internal review

You may direct any question or complaint to Member Services by calling the number on the back of your Medica ID card or by writing to the address listed below.

1. Complaints that do not involve a review by Medica of whether an item or service was medically necessary:

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

Member Services

Route CP595

PO Box 9310

Minneapolis, MN 55440-9310

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

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

c. If Medica's internal review decision upholds the initial decision made by Medica, you have a right to submit a request for external review.

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

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

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

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

d. If Medica's internal review decision upholds the initial decision made by Medica, you have a right to submit a written request for external review as described in this section.

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

External review

NOTE: Information concerning how to request external review if Medica denies your request for an exception to the Drug List is found in the *Prescription Drugs* and *Prescription Specialty Drugs* sections of this Policy. Information concerning how to request external review for other decisions by Medica is described below.

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

Minnesota Department of Commerce
85 7th Place East, Suite 280
St. Paul, MN 55101-2198

You must submit your written request for external review within six months from the date of Medica's decision. An independent review organization contracted with the State Commissioner of Administration will review your request. You may submit additional information that you want the review organization to consider. You will be notified of the review organization's decision within 45 days. The external review decision will not be binding on you but will be binding on Medica. Medica may seek judicial review on grounds that the decision was arbitrary and capricious, involved an abuse of discretion or any other standard less favorable to the enrollee than a preponderance of the evidence. Contact the Commissioner of Commerce for more information about the external review process.

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

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

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

Civil action

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

VI. Ending Coverage

This section describes when coverage ends under this Policy.

When coverage ends

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

1. The date Medica notifies you that Medica will cease doing business or discontinue a particular product. 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 Medica's existing individual health plans.)
2. The end of the month for which the subscriber last paid the premium due, except as specifically described in item 3 below concerning subscribers receiving an advance premium tax credit.
3. If the subscriber is receiving an advance premium tax credit, the end of the first month for which the subscriber failed to pay the subscriber's share of all premiums due during the grace period. For example, if you fail to pay your share of the premium in March you have until the end of May (a 3 month grace period) to pay your premiums due during the grace period in full. If you do not pay all premiums for March, April and May, your coverage will be terminated as of the end of March.
4. For coverage purchased outside MNsure, the end of the month following the date the subscriber requests that coverage end. Written request for termination of the subscriber's and/or dependents' coverage must be received by Medica at least 31 days before the date of termination. However, the effective date of such termination must be the end of the month, except as provided in item 5 below. Any refund of premium shall be mailed to the subscriber upon receipt of this notice by Medica.
5. If the subscriber enrolled through MNsure, the date on which the subscriber requests termination if the subscriber has given MNsure at least 14 days' notice before a requested termination date. If the subscriber has not provided MNsure with at least 14 days' notice of a requested termination, termination will be effective 14 days after notice is received by MNsure. Any refund of premium shall be mailed to the subscriber upon receipt of the termination instructions by Medica.
6. If the subscriber terminates this Policy within the first ten days of receiving it, coverage shall terminate retroactive to the effective date of this Policy.
7. The end of the month following the date 31 days after we notify you that coverage will end because you do not reside in your plan's service area, provided the notification is made within one year following the date Medica was provided written notification of your address change. However, Medica may approve other arrangements.
8. 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 Medica within 90 days after removal from active military duty.
9. The date specified below in the event of divorce, death of the subscriber or when the subscriber's coverage ends UNLESS THE CONTINUATION RIGHTS STATED IN THIS POLICY ARE EXERCISED.

Your spouse and/or dependents have a right to continuation of coverage in the event of divorce, death of the subscriber or when the subscriber's coverage ends, provided they were covered under this Policy on the day before any of the stated events listed below and they exercise the right to continuation as set forth in this policy of coverage. If your spouse and/or dependents do not exercise the right to continuation as set forth in this Policy, their coverage will end as follows:

a. When the subscriber is enrolled under this Policy, coverage for enrolled dependents will end the date the subscriber's coverage ends; or
b. When the subscriber is enrolled under this Policy and in the event of the subscriber's death, coverage for the subscriber's enrolled dependents will terminate the end of the month in which the subscriber's death occurred; or
c. For a spouse, the end of the month following the member's notification to Medica of the divorce, unless as noted in *Continuation*.

10. For an enrolled dependent child, the end of the year in which the enrolled child is no longer eligible as a dependent as specified in this Policy.

11. The date specified by Medica in written notice to you that coverage ended due to fraud or intentional misrepresentation of a material fact. Medica shall send the written notice to you 30 days in advance of Medica's rescission action. If coverage ends due to fraud or intentional misrepresentation of a material fact, coverage will be retroactively terminated at Medica's discretion to the original date of coverage or the date on which the fraudulent act took place. After two years, coverage can only be retroactively terminated for fraud. Fraud includes but is not limited to:

    a. Knowingly providing Medica with false material information during the enrollment process such as information related to your eligibility or another person's eligibility or status as a dependent; 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.

Time Limits on the Effect of Misstatements

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

12. If you are enrolled in a Catastrophic Plan, the end of the policy year in which the subscriber covered under the plan is more than 30 years of age, or your hardship exemption issued by MNsure expires.

13. For coverage purchased through MNsure, on the date established by MNsure when MNsure makes a determination that you are no longer eligible for coverage under this Policy. If you are enrolled in a cost-sharing variation of a plan, your enrollment will be terminated and you will be enrolled in a standard plan at the same metal level. Your cost-sharing liability will be determined as set forth in Out-of-Pocket Expenses.

14. For coverage purchased through MNsure, on the date your plan is no longer certified or offered through MNsure. If you are enrolled in a cost-sharing variation of a plan, your enrollment will be terminated and you will be enrolled in a standard plan at the same metal level. Your cost-sharing liability will be determined as set forth in *Out-of-Pocket Expenses*.

15. The date immediately preceding the effective date of new coverage selected by a member during an applicable open or special enrollment period.

Continuation

In the following circumstances, Minnesota law requires that the subscriber and his or her dependents be allowed to maintain continuation coverage as follows:

1. For instances where the subscriber's spouse or dependent children lose coverage because of the subscriber's enrollment under Medicare, coverage may be continued until the earliest of:
    a. 36 months after continuation was elected;
    b. The date coverage is obtained under other health insurance coverage; or
    c. The date coverage would otherwise terminate under this Policy.
2. For instances where dependent children lose coverage as a result of loss of dependent eligibility, coverage may be continued until the earliest of:
    a. 36 months after continuation was elected;
    b. The date coverage is obtained under other health insurance coverage; or
    c. The date coverage would otherwise terminate under this Policy.
3. For instances of dissolution of marriage from the subscriber, coverage for the subscriber's spouse and dependent children may be continued until the earliest of:
    a. The date the former spouse becomes covered under other health insurance coverage; or
    b. The date coverage would otherwise terminate under this Policy.
4. For instances of the death of the subscriber, coverage for the subscriber's spouse and dependent children may be continued until the earliest of:
    a. The date the surviving spouse becomes covered under other health insurance coverage; or
    b. The date coverage would otherwise terminate under this Policy.

In no event shall the amount of premium or fee contributions charged exceed 102 percent of the cost to the plan for such period of coverage for other similarly situated spouses, former spouses and dependent children who are not the survivors of a deceased subscriber, without regard to whether such cost is paid by the employer or employee. Failure of the survivor to make premium payments within 90 days after notice of the requirement to pay the premiums shall be a basis for the termination of this Policy without written consent. In event of a termination by reason of the survivor's failure to make the required premium payment, written notice of cancellation must be mailed to the survivor's last known address at least 30 days before the cancellation.

The member may also be eligible for a special enrollment period. If the subscriber was enrolled through MNsure, please contact MNsure for more information on special enrollment periods. See *Special enrollment periods and effective date of coverage* for more information.

VII. Your Rights and Protections Against Surprise Medical Bills

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

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

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

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

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

You are protected from balance billing for:

Emergency services

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

Certain services at a network hospital or network health care facility

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

Ending surprise air ambulance bills

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

External review

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

Visit **cms.gov/NoSurprises/Consumers** for more information about your rights under federal law.

VIII. Definitions

In this Policy (and in any amendments), some words have specific meanings. Within each definition, you may note bold words. These words also are defined in this section.

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

Acute inpatient rehabilitation (AIR). An intensive form of medical rehabilitation in which patients receive three or more hours per day of core therapies (physical therapy, occupational therapy and speech therapy) overseen by a **physician** specialized in rehabilitation with around the clock nursing care.

Advance premium tax credit (APTC). The advance premium assistance credit available under Internal Revenue Code section 36B, as determined by **MNsure**, for individuals who meet certain income requirements, as determined by **MNsure**.

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

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

Assisted Reproductive Technology (ART). All treatments or procedures that include the handling of human eggs, sperm, and/or embryos to help a woman become pregnant. ART includes, but is not limited to, gamete intrafallopian transfer (GIFT), uterine embryo lavage, embryo transfer, artificial insemination (AI), intrauterine insemination (IUI), intracervical insemination (ICI), intravaginal insemination (IVI), in vitro fertilization (IVF), pronuclear state transfer (PROST), tubal embryo transfer (TET), zygote intrafallopian transfer (ZIFT), low tubal ovum transfer, intracytoplasmic sperm injection, (ICSI), cryopreservation (e.g., egg, embryo, sperm), and other third party-assisted ART methods (e.g., sperm donation, egg donation, Traditional Surrogates and Gestational Carriers, embryo donation).

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

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

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

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

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

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

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

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

The **coinsurance** amount is typically based on the lesser of the:

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

When the wholesale amount is not known nor readily calculated at the time the **benefit** is provided, Medica uses an amount to approximate the wholesale amount. For services from some **network providers**, however, the **coinsurance** is based on the **provider's** retail charge. The **provider's** retail charge is the amount that the **provider** would charge to any patient, whether or not that patient is a Medica **member**.

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

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

Combined day limit. Your total **benefit** is combined, for **inpatient hospital** services, **skilled nursing facility** services and **inpatient** mental health and substance use disorder services, and

limited to 365 days per **period of confinement**. Each day of such services provided counts toward this **combined day limit**, for the same **period of confinement**.

Contraceptive Method. A contraceptive method is a **prescription drug**, device, or other product approved by the FDA to prevent unintended pregnancy.

Contraceptive Service. A contraceptive services is a consultation, examination, procedure, and medical services related to the prevention of unintended pregnancy, including voluntary sterilization procedures, patient education, counseling on contraceptive methods, and follow-up services related to contraceptive methods or contraceptive services, management of side effects, counseling for continued adherence, and device insertion or removal. Contraceptive services do not include vasectomies.

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

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

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 **prescription drugs** that can usually be self-administered.

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

Dependent. Unless otherwise specified in this Policy:

1. The **subscriber's domestic partner** or spouse
2. A child of the **subscriber**, the **subscriber's domestic partner** or spouse who is a:
    a. Natural or adopted child
    b. Child **placed for adoption** with the **subscriber**, the **subscriber's domestic partner** or spouse
    c. Stepchild
3. A newborn grandchild who is financially dependent upon the **subscriber** or the **subscriber's** covered spouse, and who resides with that **subscriber** or the **subscriber's** covered spouse continuously from birth.
4. A child under legal guardianship of the **subscriber**, the **subscriber's domestic partner** or **subscriber's** spouse. However, Medica may request that the **subscriber** provide satisfactory proof of guardianship. See *Extending a child's eligibility* in *Eligibility* for details regarding **dependent** limiting ages.

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

Domestic partner. An adult who:

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

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

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

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

Enrollment date. The date of the **member's** first day of coverage under this Policy.

Extended hours home care. Extended hours home care (private duty nursing) is continuous and complex skilled nursing services greater than two consecutive hours per day provided in the **member's** home. The intent of **extended hours home care** is to assist the **member** with complex, direct, skilled nursing care, to develop caregiver competencies through training and education, and to optimize the **member's** health status and outcomes. The skilled nursing tasks must be required so frequently that the need is continuous. The duration of **extended hours home care** is temporary in nature and is not intended to be provided on a permanent ongoing basis. **Extended hours home care** is sometimes also called private duty nursing.

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

Genetic testing. The analysis of human DNA, RNA, and chromosomes and those proteins and metabolites used to detect heritable or somatic disease-related genotypes or karyotypes for clinical purposes. A genetic test must be generally accepted in the scientific and medical communities as being specifically determinative for the presence, absence or mutation of a gene or chromosome in order to qualify under this definition. Genetic test does not include a routine physical examination or a routine analysis, including a chemical analysis, of body fluids unless conducted specifically to determine the presence, absence or mutation of a gene or chromosome.

Habilitative care. Health care services are considered habilitative when they are provided to help a person who has not learned or acquired a particular skill or function for daily living to learn, improve or keep such skill or function, as long as measurable progress can be documented.

Health Insurance Marketplace. A governmental or non-profit entity established as an Exchange, also referred to in this Policy as the "**Marketplace**," pursuant to the Patient Protection and Affordable Care Act to make **qualified health plans** available to individuals and small employers.

Home health aide services. Part time or intermittent services to help you with activities of daily living.

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.

HSA-compliant high deductible health plan. A plan that complies with the requirements of Internal Revenue Code section 223 that allows an individual to contribute to a health savings account ("HSA").

Indian. Indians as defined in section 4 of the Indian Health Care Improvement Act.

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

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

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

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

Long-term acute care hospitals (LTACHs). Facilities that specialize in the treatment of patients with serious medical conditions that require care on an ongoing basis but no longer require intensive care or extensive diagnostic procedures. These patients are typically discharged from the intensive care units and require more care than they can receive in a rehabilitation center, **skilled nursing facility**, or at home.

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 psychological origin, as defined in the current edition of the *International Classification of Diseases* or the *Diagnostic and Statistical Manual of Mental Disorders* (DSM).

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

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

Please note: Individual, family and group counseling/therapy that is provided must be based on evidence-based modalities with proven efficacy. Therapy provided using modalities with unproven efficacy must occur in addition to the evidence based practices.

Minnesota resident. A person who lives in Minnesota, and intends to reside in Minnesota, or has entered Minnesota with a job commitment or is seeking employment in Minnesota.

MNsure. The Minnesota state **Health Insurance Marketplace** created under Minnesota Statutes chapter 62V.

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 Medica or has made other arrangements with Medica to provide **benefits** to you. The participation status of **providers** will change from time to time.

The Medica **network provider** directory is available without charge.

Network access area. Used to define areas where there are Medica contracted **providers** outside the **service area** for a specific product.

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

Non-network. A term used to describe a **provider** not under contract as a **network provider**.

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

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

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

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

Except when the protections described in *Surprise billing protections* apply, in addition, if the amount billed by the **non-network provider** is greater than the **non-network provider reimbursement amount**, *the **non-network provider** will likely bill you for the difference.* This difference may be substantial, and it is in addition to any **copayment**, **coinsurance** or **deductible** amount you may be responsible for according to the terms described in this Policy. As a result, the amount you will be required to pay for services received from a **non-network provider** will likely be much higher than if you had received services from a **network provider**.

The **non-network provider reimbursement amount** 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 **coinsurance** and **deductible** amount, except as described in *Surprise billing*

protections. Charges in excess of the **non-network provider reimbursement amount** do not accumulate to your **deductible** or **out-of-pocket maximum**.

Non-skilled care. Care that does not require skilled nursing or rehabilitation staff to manage, observe or evaluate your care. Any service that could be safely performed by a non-medical person (or yourself) without the supervision of a nurse is considered **non-skilled care**.

Out-of-pocket maximum. The total of the **copayments**, **coinsurance**, and **deductible** paid for **benefits** received under this Policy during a calendar year. Unless otherwise specified, you will not be required to pay more than the **out-of-pocket maximum** for **benefits** received under this Policy during a calendar year. Any amount or charge not covered, including charges for services not eligible for coverage, is not applicable toward the **out-of-pocket maximum**. After the **out-of-pocket maximum** has been met, all other covered **benefits** received during the rest of the calendar year will be covered at 100%, except for any charge not covered by Medica.

Period of confinement. This is (a) one continuous hospitalization, or (b) a series of hospitalizations or **skilled nursing facility** stays or periods of time when the **member** is receiving home health services for the same medical condition in which the end of one is separated from the beginning of the next by less than 90 days. For the purpose of this definition, "same condition" means illness or injury related to former illness or injury in that it is either within the same ascertainable diagnosis or set of diagnoses, or within the scope of complications or related conditions.

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

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

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

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

Premium. The monthly payment required to be paid by you for coverage under this Policy.

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

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

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

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

1. evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (USPSTF);
2. immunizations for routine use that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) with respect to the **members** involved (an ACIP recommendation is considered in effect after it has been adopted by the Director of the CDC, and a

recommendation is considered to be for routine use if it is listed on the CDC's Immunization Schedules);

3. with respect to **members** who are infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA);

4. with respect to **members** who are women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by HRSA (including FDA-approved contraceptive methods and contraceptive services).

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

Contact Member Services for information regarding specific **preventive health services** and services that are rated "A" or "B", and services that are included in guidelines supported by the HRSA. For a list of **preventive health services** please visit **Medica.com/SignIn.**

Primary care provider. A **provider** who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice, or general medicine or a **provider** providing services at a **retail health clinic**.

Professionally administered prescription drugs. **Professionally administered prescription drugs** must be, as determined by Medica, typically administered or directly supervised by a qualified **provider** or a licensed/certified health professional. Medica generally considers **prescription drugs** that require intravenous infusion or injection, intrathecal infusion or injection, intramuscular injection or intraocular injection, as well as **prescription drugs** that, according to the manufacturer's recommendations, must typically be administered by a health care **provider**, to be **professionally administered prescription drugs**.

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

Qualified health plan. A health plan that meets the requirements of federal law and is certified by **MNsure** as meeting the requirements.

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

Reasonable expectation of improvement. A reasonable expectation that the **member's** condition will improve over a predictable period of time according to generally accepted standards in the medical community.

Reconstructive. Surgery to rebuild or correct a:

1. Body part when such surgery is incidental to or following surgery resulting from injury, sickness or disease of the involved body part; or

2. Congenital disease or anomaly which has resulted in a functional defect as determined by your **physician**.

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

Rehabilitative. Physical, occupational and speech therapy services are considered **rehabilitative** when they are provided to restore physical function or speech that has been impaired due to illness or injury.

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

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

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

Service area. The geographic area where this health insurance plan accepts **members**.

Skilled care. A type of health care given when you need skilled nursing or rehabilitation staff to manage, observe and evaluate your care. Nursing, physical therapy and occupational therapy are considered **skilled care**. In addition to providing direct care, these professionals manage, observe and evaluate your care. Any service that could be safely done by a non-medical person (or by yourself) without the supervision of a nurse is not considered **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.

Special enrollment period. A time outside of the annual open enrollment period during which individuals and their qualified **dependents** are able to sign up for coverage. Individuals and/or qualified **dependents** are only eligible for a **special enrollment period** if they experience certain specified events. Please see *Enrollment*, for more information about **special enrollment periods**.

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

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

Subscriber. The person to whom this Policy is issued.

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

1. A 24-hour per day, structured setting, inclusive of room and board; and
2. The program administers at least the following basic services:
    - A combination of group, family and individual counseling provided by a clinically or appropriately licensed mental health professional and or graduate level professional

in process of obtaining licensure working under the oversight of a licensed mental health professional;

- Completion of a substance use disorder or chemical health assessment;
- Access to psychiatric services provided by a licensed psychiatric prescriber for mental health treatment as clinically indicated for substance use treatment;
- Individual and or family therapy a minimum of once weekly provided by a licensed mental health professional for substance use disorder or mental health treatment;
- Weekly client education (e.g. mindfulness, reflective journaling, sleep hygiene, anger management or safe sex practices);
- Other services specific to mental health treatment and or substance use treatment;
- Adequate nursing coverage for the specific level of care; and
- A written, specific, and person-centered treatment plan with viable discharge planning to support ongoing recovery efforts.

Please note: Individual, family and group counseling/therapy that is provided must be based on evidence-based modalities with proven efficacy. Therapy provided using modalities with unproven efficacy must occur in addition to the evidence-based practices.

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

Telehealth includes audio-only communication between a **provider** and a **member** if the communication is a scheduled appointment and the standard of care for that particular service can be met through the use of audio-only communication. However, substance use disorder treatment services and mental health care services delivered through **telehealth** by means of audio-only communication may be covered without a scheduled appointment if the communication was initiated by the **member** while in an **emergency** or crisis situation and a scheduled appointment was not possible due to the need of an immediate response.

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

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

Virtual care. Professional evaluation and medical management services provided to patients, in locations such as their home or office, through e-mail, telephone or webcam by a designated **virtual care provider**. **Virtual care** is used to address non-emergent medical symptoms for **members** for a subset of non-emergent infections and illnesses to which **providers** respond with substantive medical advice. **Virtual care** does not include telephone calls for reporting normal lab or test results or solely calling in a **prescription drug** to a pharmacy. The list of designated **virtual care providers** can be found online through Medica's "Find Care" tool, under "**Virtual Care**." Please note, not all medical conditions can be treated through **virtual care**. Your cost sharing may be different for services delivered via **telehealth** as compared to **virtual care** provided by a designated **virtual care provider**. Please refer to the *Benefit Chart* of this Policy to see the cost sharing associated with each of these **benefits**. If you have questions about whether a **virtual care** appointment with a **network provider** who is not a designated **virtual care provider** is eligible for coverage under the **virtual care benefit** in the *Benefit Chart* of this Policy, please call Member Services at the number on the back of your Medica ID card.

Altru Prime by Medica

MINNESOTA

Individual or Family

Bronze H Plan Zero

Benefit Chart

American Indians and Alaska Natives

An individual that MNsure determines is an American Indian or Alaska Native will have no cost sharing required on benefits received from Indian Health Services, an Indian Tribe, Tribal Organization, or Urban Indian Organization (each as defined in 25 U.S.C. 1603), or through a referral under contract health services, as contract health services are defined and provided pursuant to 42 C.F.R. Subpart C and any other guidance issued pursuant to that section.

Your Out-Of-Pocket Expenses

Important: The most specific and appropriate section of this Policy will apply for benefits related to the treatment of a specific condition.
We cover services only when medically necessary and consistent with the rules explained in your Policy. If a particular service, procedure or item is not specifically referenced in your Policy, coverage will be based on these rules. Generally, if not specifically referenced, the service, procedure or item will be subject to your deductible and Policy coinsurance amounts. Please contact Member Services if you have questions regarding whether and how a particular service, procedure or item is covered.

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Individual or Family

Bronze H Plan Zero

Benefit Chart

Please note: Services from non-network providers are not covered, except emergency services received in the United States and services authorized by Medica. For certain covered services from certain non-network providers, you are responsible for any charges in excess of the non-network provider reimbursement amount.	
Deductible	**Individual plan:** $0
	Family plan: Per member: $0 Shared family: $0
Out-of-pocket maximum	**Individual plan:** $0
	Family plan: Per member: $0 Shared family: $0
Lifetime maximum *(The maximum amount this Policy will pay for eligible services during your lifetime.)*	**Individual and family plan:** Per member: Unlimited

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Benefit Chart

Your Benefits and the Amount You Pay	
Please note: Services from non-network providers are not covered, except emergency services received in the United States and services authorized by Medica. For certain covered services from certain non-network providers, you are responsible for any charges in excess of the non-network provider reimbursement amount.	
A. *Ambulance*	
1. Ambulance services or ambulance transportation to the nearest hospital for an emergency	Nothing
2. Non-emergency licensed ambulance service that is arranged through an attending physician, as follows:	
a. Transportation from hospital to hospital when:	
i. Care for your condition is not available at the hospital where you were first admitted; or	Nothing
ii. The member is a mother whose baby requires transfer to a higher level of care, and the mother requires an inpatient level of post-partum care and has been accepted for admission at the receiving facility; or	Nothing
iii. Required by Medica	Nothing
b. Transportation from hospital, long term acute care hospital (LTACH), or an acute inpatient rehab (AIR) to skilled nursing facility	Nothing
B. *Anesthesia*	
1. Anesthesia services received from a provider during a covered office visit or an outpatient hospital or ambulatory surgical center visit	Nothing

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Your Benefits and the Amount You Pay	
Please note: Services from non-network providers are not covered, except emergency services received in the United States and services authorized by Medica. For certain covered services from certain non-network providers, you are responsible for any charges in excess of the non-network provider reimbursement amount.	
2. Anesthesia services received from a provider during a covered inpatient stay	Nothing
C. *Certain Cancer-Related Tests*	
1. Prostate cancer screening, including prostate-specific antigen blood tests and digital rectal examinations, for all men	Covered at the corresponding benefit level, depending on the type of services provided. For example, office visits are covered at the office visit benefit level, preventive services are covered at the preventive health care level, and laboratory services are covered at the laboratory benefit level.
2. Routine screening procedures for ovarian cancer	See *Preventive Health Care*
3. Diagnostic surveillance tests for ovarian cancer	Covered at the corresponding benefit level, depending on the type of services provided. For example, office visits are covered at the office visit benefit level and diagnostic imaging is covered at the diagnostic imaging benefit level.
4. Diagnostic services or testing after a mammogram if the network provider determines the member requires such additional services	Nothing
D. *Chiropractic*	
1. Chiropractic services to diagnose and to treat (by spinal manipulations, manual muscle stimulations or other conjunctive or manipulative therapies) conditions related to the muscles, skeleton and nerves of the body	Nothing

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Your Benefits and the Amount You Pay	
Please note: Services from non-network providers are not covered, except emergency services received in the United States and services authorized by Medica. For certain covered services from certain non-network providers, you are responsible for any charges in excess of the non-network provider reimbursement amount.	
E. *Diabetes Management and Supplies (for Type I, Type II and Gestational)*	
1. 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
2. Diabetic equipment and supplies, including blood glucose meters received from a pharmacy	See *Prescription Drugs*
3. Insulin pumps and their related supplies received from a durable medical equipment provider	See *Durable Medical Equipment, Prosthetics and Miscellaneous Medical Supplies*
F. *Diagnostic Imaging*	
1. Outpatient MRI, CT and PET CT scans in an office or hospital	Nothing
2. Professional services for an outpatient MRI, CT or PET CT scan in an office or hospital	Nothing
3. Outpatient x-rays and other imaging services in an office or hospital	Nothing
G. *Durable Medical Equipment, Prosthetics and Miscellaneous Medical Supplies*	
1. Durable medical equipment and certain supplies	Nothing

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Please note: Services from non-network providers are not covered, except emergency services received in the United States and services authorized by Medica. For certain covered services from certain non-network providers, you are responsible for any charges in excess of the non-network provider reimbursement amount.	
2. Repair, replacement or revision of durable medical equipment made necessary by normal wear and use	Nothing
3. Orthotic and prosthetic devices, supplies and services, including their repair and replacement	Nothing
a. Scalp hair prosthesis for hair loss due to a health condition including alopecia areata or treatment for cancer, including all equipment and accessories necessary for regular use, when prescribed by a provider, unless there is a clinical basis for limitation Coverage is limited to one prosthesis per calendar year for a diagnosis of alopecia areata. If the cost for the scalp hair prosthesis for this condition is less than $1,000, coverage will also be provided for any equipment or accessories necessary for regular use, when prescribed by a provider, up to a total dollar limit of $1,000. Coverage for any other scalp hair prosthesis for hair loss due to a health condition, other than alopecia areata, including treatment for cancer, will include all equipment and accessories necessary for regular use, when prescribed by a provider, unless there is a clinical basis for	Nothing

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Please note: Services from non-network providers are not covered, except emergency services received in the United States and services authorized by Medica. For certain covered services from certain non-network providers, you are responsible for any charges in excess of the non-network provider reimbursement amount.	
limitation, will be limited to $1,000.	
4. Injectable pharmaceutical treatments for hemophilia and bleeding disorders	Nothing
5. Dietary medical treatment of phenylketonuria (PKU)	Nothing
6. Amino acid-based elemental oral formulas when medically necessary. Conditions for which it is medically necessary include, but not limited to: a. cystic fibrosis; b. amino acid, organic acid, and fatty acid metabolic and malabsorption disorders; c. IgE mediated allergies to food proteins; d. food protein-induced enterocolitis syndrome; e. eosinophilic esophagitis; f. eosinophilic gastroenteritis; g. eosinophilic colitis; and h. mast cell activation syndrome	Nothing
7. Total parenteral nutrition	Nothing
8. Eligible ostomy supplies	Nothing
9. Insulin pumps and their related supplies **Please note:** Cost-sharing for medical supplies necessary to effectively and appropriately treat or administer a drug prescribed to treat diabetes from a	Nothing

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Your Benefits and the Amount You Pay	
Please note: Services from non-network providers are not covered, except emergency services received in the United States and services authorized by Medica. For certain covered services from certain non-network providers, you are responsible for any charges in excess of the non-network provider reimbursement amount.	
network durable medical equipment provider will be limited to $50 per month in total	
10. Eligible intermittent urinary catheters and insertion supplies	Nothing
H. *Emergency Room*	
Please note: Some services received during an emergency room visit may be covered under another benefit in this Policy. The most specific and appropriate benefit in this Policy will apply for each service received during an emergency room visit.	
1. Hospital emergency room in the United States	Nothing
2. Services received from a physician during a hospital emergency room visit in the United States	Nothing
I. *Gender Affirmation Care*	
1. Gender affirmation care	Covered at the corresponding benefit level, depending on type of services provided. For example, office visits are covered at the office visit benefit level and surgical services are covered at the surgical services benefit level.
J. *Genetic Counseling and Testing*	
1. Genetic counseling, whether pre- or post-test, and whether occurring in an office, clinic, or telephonically **Please note:** Genetic counseling for BRCA testing, if appropriate, is covered as a woman's preventive health service.	Nothing

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Please note: Services from non-network providers are not covered, except emergency services received in the United States and services authorized by Medica. For certain covered services from certain non-network providers, you are responsible for any charges in excess of the non-network provider reimbursement amount.	
2. Genetic testing services received in an office or outpatient hospital setting **Please note:** BRCA testing, if appropriate, is covered as a women's preventive health service.	Nothing
3. Rapid whole genome sequencing for members who: are age 21 or younger; have a complex or acute illness of unknown etiology; and are receiving inpatient hospital services in an intensive care unit or neonatal or high acuity pediatric care unit.	Covered at the corresponding benefit level, depending on type of services provided. For example, inpatient services are covered at the inpatient services benefit level and lab services are covered at the lab services benefit level.
4. Biomarker testing for the purpose of diagnosing, treating, managing, or monitoring illness or disease if the test provides clinical utility	Nothing
K. *Hearing Aids and Services*	
1. Routine hearing exams that are considered preventive health services as defined in this Policy	See *Preventive Health Care*
2. Routine hearing exams that are not considered preventive health services as defined in this Policy	Nothing
3. Hearing aids for members for hearing loss that is not correctable by other covered procedures Coverage is limited to one hearing aid per ear every three years. **Please note:** Cochlear implants are covered as a surgical service under *Office Visits* or *Hospital*.	Nothing

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L. *Home Health Care*	
1. Intermittent skilled nursing care when you are homebound, provided by or supervised by a registered nurse Coverage is limited to 120 visits per calendar year for numbers 1., 2. and 4. in this section combined. A visit is considered up to two continuous hours.	Nothing
2. Skilled physical therapy, skilled occupational therapy or speech therapy when you are homebound Coverage is limited to 120 visits per calendar year for numbers 1., 2. and 4. in this section combined.	Nothing
3. Home infusion therapy	Nothing
4. Services received in your home from a physician Coverage is limited to 120 visits per calendar year for numbers 1., 2. and 4. in this section combined.	Nothing
M. *Hospice*	
1. Hospice care	Nothing
2. Respite care Coverage for respite care is limited to five consecutive days per episode. Respite care and continuous care are limited to a combined maximum of 30 days.	Nothing

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N. *Hospital*	
1. Outpatient hospital or ambulatory surgical center services	
a. Surgical services (as defined in the *Physicians' Current Procedural Terminology* code book) received from a physician	Nothing
b. Other outpatient hospital and ambulatory surgical center services received from a physician	Nothing
c. Outpatient facility services, including services provided in a hospital observation room	Nothing
2. Inpatient hospital services	
a. Inpatient services, other than maternity care, including room and board in a hospital Coverage is limited to 365 day maximum per period of confinement, subject to the combined day limit.	Nothing
b. Inpatient services received from a physician during an inpatient stay	Nothing
c. Inpatient services provided through a home hospitalization program where available, as specifically described in this *Hospital* section.	
i. Services received from a home hospitalization program	Nothing

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Coverage is limited to 365 day maximum per period of confinement, subject to the combined day limit.	
ii. Physician services associated with a home hospitalization program stay	Nothing
O. *Infertility Services*	
1. Services to diagnose infertility	Covered at the corresponding benefit level, depending on type of services provided. For example, office visits are covered at the office visit benefit level and surgical services are covered at the surgical services benefit level.
P. *Lab and Pathology*	
1. Lab and pathology services received in an office or outpatient hospital	Nothing
2. CA-125 serum tumor marker testing when conducted as a surveillance test for ovarian cancer for at-risk women.	Covered at the corresponding benefit level, dependent on the type of services provided.
Q. *Lyme Disease*	
1. Lyme Disease	Covered at the corresponding benefit level, depending on type of services provided. For example, office visits are covered at the office visit benefit level and surgical services are covered at the surgical services benefit level.
R. *Maternity*	
Note: Items 1 and 2 describes coverage for prenatal care services only. Coverage of labor	

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and delivery services is as described elsewhere in this section.	
1. Prenatal care services that are considered preventive health services as defined in this Policy	See *Preventive Health Care*
2. Prenatal care services that are not considered preventive health services as defined in this Policy	
a. Hospital and ambulatory surgical center services for prenatal care in an inpatient setting	Nothing
b. Hospital and ambulatory surgical center services for prenatal care in an outpatient setting	Nothing
c. Professional services for prenatal care in an inpatient or outpatient setting	Nothing
d. Home health care	
i. Intermittent skilled nursing care when you are homebound due to a high risk pregnancy	See *Home Health Care*
ii. Home infusion therapy	See *Home Health Care*
3. Labor and delivery services **Please note:** Maternity labor and delivery services are considered inpatient services regardless of the length of hospital stay.	
a. Hospital services, including room and board charges Coverage is limited to 365 day maximum per period of	Nothing

Your Benefits and the Amount You Pay	
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confinement, subject to the combined day limit.	
b. Professional services while at a hospital	Nothing
c. Free-standing birth center services	Nothing
d. Professional services while at a free standing birth center	Nothing
4. Postnatal care in the first 12 weeks following delivery, including a home health care visit following delivery **Please note:** One home health visit is covered if it occurs within four days of discharge. If services are received after four days, please refer to *Home Health Care* for benefits.	Nothing
5. Licensed ambulance transportation arranged through an attending health care provider when the mother or newborn requires transfer to a different medical facility **Please note:** This coverage applies to the mother, dependent newborn and dependent newborn siblings who are covered under the plan.	Nothing
6. Abortions and abortion-related services	Covered at the corresponding benefit level, depending on type of services provided. For example, office visits are covered at the office visit benefit level and surgical services are covered at the surgical services benefit level.
S.*Medical-Related Dental*	
1. Oral surgery to treat medical conditions, such as cleft lip or palate,	See *Office Visits* and *Hospital*

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oral neoplasms, non-dental cysts, fracture of the jaws or trauma of the mouth and jaws	
2. Charges for medical facilities and general anesthesia services that are:	See *Anesthesia* and *Hospital*
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; or	
ii. Is severely disabled; or	
iii. Has a condition and requires hospitalization or general anesthesia for dental care treatment	
3. For a dependent child, orthodontia related to cleft lip and palate	Nothing
4. Accident-related dental services to treat an injury to sound, natural teeth and to repair (not replace) sound, natural teeth **Please note:** A sound natural tooth means a tooth (including supporting structures) that is free from disease that would prevent continual function of the tooth for at least one year. In case of primary baby teeth, the tooth must have a life expectancy of one year.	Nothing
5. Treatment of temporomandibular joint (TMJ) disorder and craniomandibular disorder	Covered at the corresponding benefit level, depending on type of services provided.

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	For example, office visits are covered at the office visit benefit level and surgical services are covered at the surgical services benefit level.
T.*Mental Health and Substance Use*	
1. Office visits, including evaluations, diagnostic and treatment services	Nothing
2. Intensive outpatient programs	Nothing
3. Partial hospitalization/day treatment/high intensity outpatient program	Nothing
4. Intensive behavioral and developmental therapy for the treatment of autism spectrum disorder, including applied behavioral analysis. Examples of such therapy include, but are not limited to, Early Intensive Developmental & Behavioral Intervention (EIDBI), Intensive Early Intervention Behavior Therapy (IEIBT), Intensive Behavioral Intervention (IBI) and Lovaas therapy.	Nothing
5. Medication-assisted treatment **Please note:** When the prescription drug component of this treatment is received at a pharmacy, your *Prescription Drugs* benefit will be applied.	Nothing
6. Inpatient services (including mental health residential treatment services and substance use disorder residential treatment services)	
a. Room and board	Nothing

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Coverage is limited to 365 day maximum per period of confinement, subject to the combined day limit.	
b. Hospital or facility-based professional services	Nothing
c. Attending psychiatrist and physician services	Nothing
U. *Office Visits*	
Please note: This benefit does not include services received from locations using "hospital-based outpatient billing" practices. The most specific and appropriate benefit in this Policy will apply for each service received at that type of provider. If you are unsure if your provider uses these billing practices, please contact them. Some services received during an office visit may be covered under another benefit in this Policy. The most specific and appropriate benefit in this Policy will apply for each service received during an office visit. Call Member Services at the number on the back of your Medica ID card to determine in advance whether a specific procedure is a benefit and the applicable coverage level for each service that you receive.	
1. Office visit services that are not considered preventive health services as defined in this Policy	Nothing
2. Professional services and procedures received during an office visit, including	Nothing

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diagnostic reading, testing, procedures, or evaluations	
3. Urgent care center visits	Nothing
4. Convenience care	
a. Retail health clinic	Nothing
b. Virtual care **Please note:** Your cost sharing may be different for services delivered via telehealth as compared to virtual care provided by a designated virtual care provider. Member cost share is based on place and type of service as defined in this Policy.	Nothing
5. Allergy Shots	Nothing
6. Neuropsychological evaluations/cognitive testing, limited to services necessary for the diagnosis or treatment of a medical illness or injury	Nothing
7. Surgical Services (as defined in the Physicians' Current Procedural Terminology code book) received from a physician	Nothing
V. *Organ and Bone Marrow Transplants and Other Complex Health Conditions*	
1. Organ and bone marrow transplant services and other complex health conditions	Covered at the corresponding benefit level, depending on type of services provided. For example, office visits are covered at the office visit benefit level and surgical services are covered at the surgical services benefit level.

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W. *PANS/PANDAS*	
1. Medically necessary treatment recommended by your provider for diagnosed pediatric acute-onset neuropsychiatric syndrome (PANS) and pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and include but are not limited to antibiotics, prescription drugs and behavioral therapies to manage neuropsychiatric symptoms, plasma exchange, and immunoglobulin	Covered at the corresponding benefit level, depending on type of services provided. For example, office visits are covered at the office visit benefit level and surgical services are covered at the surgical services benefit level.
X. *Port Wine Stain Removal*	
1. Elimination or maximum feasible treatment of port wine stains	Covered at the corresponding benefit level, depending on type of services provided. For example, office visits are covered at the office visit benefit level and surgical services are covered at the surgical services benefit level.
Y. *Prescription Drugs*	
1. Prescription drugs received at a retail pharmacy, other than those described below or in *Prescription Specialty Drugs*	**Preferred generic:** Nothing **Preferred brand, non-preferred generic:** Nothing **Non-preferred brand, non-preferred generic:** Nothing
2. Orally-administered cancer treatment prescription drugs, other than those described in *Prescription Specialty Drugs*	**Preferred generic:** Nothing **Preferred brand, non-preferred generic:** Nothing **Non-preferred brand, non-preferred generic:** Nothing

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3. Prescription insulin drugs	Nothing
4. Diabetic equipment and supplies, including blood glucose meters and continuous glucose monitoring equipment and related supplies **Please note:** Coverage for insulin pumps and their related supplies is described under *Durable Medical Equipment, Prosthetics and Miscellaneous Medical Supplies.*	Nothing **Please note:** The list of covered Preferred Diabetic Equipment and Supplies is specific and limited. For a current list, go to Medica.com/MNDrugList-2025 or call Member Services.
5. All FDA-approved prescription drugs (including women's contraceptives), tobacco cessation products and other supplies and services that are considered preventive health services **Please note:** The list of covered preventive prescription drugs and other services is specific and limited. For a current list, go to **Medica.com/SignIn** or call Member Services.	Nothing
Z. *Prescription Specialty Drugs*	
1. Specialty prescription drugs displayed with an 'SP' indicator on Medica's Drug List received from a designated specialty pharmacy other than those described below	**Specialty prescription drugs:** Nothing
2. Specialty prescription drugs displayed without an 'SP' indicator on Medica's Drug List filled at a network retail pharmacy	**Specialty prescription drugs:** Nothing

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3. Orally-administered cancer treatment prescription drugs received from a designated specialty pharmacy	**Specialty prescription drugs:** Nothing
AA. *Preventive Health Care*	
1. Child health supervision services, including well-baby care	Nothing
2. Immunizations	Nothing
3. Early disease detection services, including physicals Coverage is limited to one preventive physical exam per calendar year, unless additional visits are necessary to obtain all covered preventive health care.	Nothing
4. Routine screening procedures for cancer, including, but not limited to, screening for prostate cancer, ovarian cancer and colorectal cancer. See Certain Cancer-Related Tests for more information about surveillance testing for ovarian cancer for at-risk women and screening for prostate cancer.	Nothing
5. Women's preventive health services including mammograms (including digital breast tomosynthesis), screenings for cervical cancer, human papillomavirus (HPV) testing, counseling for sexually transmitted	Nothing

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infections, counseling for immunodeficiency virus (HIV), BRCA genetic testing and related genetic counseling (when appropriate), and contraceptive methods and contraceptive services	
6. All FDA-approved prescription drugs (including women's contraceptives), tobacco cessation products and other supplies and services that are considered preventive health services	See *Prescription Drugs*
7. Other preventive health services, including tobacco cessation counseling	Nothing
BB. *Professionally Administered Prescription Drugs*	
1. Professionally administered prescription drugs that are required to be administered at a designated facility	**If administered at a designated facility:** Covered at the corresponding benefit level, depending on whether it is administered during a home health care visit, office visit or outpatient hospital visit. For example, if the professionally administered prescription drug was administered during an office visit, then the professionally administered prescription drug is covered at the office visit benefit level. If the professionally administered prescription drug was administered during a home health care visit, then the professionally administered prescription drug is covered at the home health care visit benefit level. **If not administered at a designated facility:** No coverage

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2. Professionally administered prescription drugs that are not required to be administered at a designated facility	Covered at the corresponding benefit level, depending on whether it is administered during a home health care visit, office visit or outpatient hospital visit. For example, if the professionally administered prescription drug was administered during an office visit, then the professionally administered prescription drug is covered at the office visit benefit level. If the professionally administered prescription drug was administered during a home health care visit, then the professionally administered prescription drug is covered at the home health care visit benefit level.
CC. *Rare Diseases*	
1. Services from a licensed network health care provider related to the diagnosis, monitoring, and treatment of a rare disease or condition as defined in the Policy	Covered at the corresponding in-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit in-network benefit level and inpatient services are covered at the inpatient services in-network benefit level.
2. Services provided in the state of Minnesota by a licensed non-network health care provider related to the diagnosis, monitoring, and treatment of a rare disease or condition as defined in the Policy	Covered at the corresponding in-network benefit level, depending on type of services provided. For example, office visits are covered at the office visit in-network benefit level and inpatient services are covered at the inpatient services in-network benefit level.
3. Services provided outside the state of Minnesota by a licensed non-network health care provider related to the diagnosis, monitoring, and treatment of a rare disease or condition as defined in the Policy	The in-network copayment and coinsurance for the applicable service will apply. You will also likely need to pay your provider any billed amount above what Medica is required to pay the provider in accordance with Minnesota Statute Section 62Q.451, subd. 5. Such balance billed amounts are

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	not applied toward satisfaction of your out-of-pocket maximum.
DD. *Reconstructive and Restorative Surgery (Including Mastectomy Reconstruction)*	
1. Reconstructive and restorative surgery	Covered at the corresponding benefit level, depending on type of services provided. For example, office visits are covered at the office visit benefit level and surgical services are covered at the surgical services benefit level.
EE. *Rehabilitative and Habilitative Therapies*	
1. Rehabilitative and habilitative outpatient physical, occupational or speech therapy services	Nothing
2. Other outpatient rehabilitative or habilitative therapy services	Nothing
FF. *Skilled Nursing Facility*	
1. Daily skilled nursing care or daily skilled rehabilitation and habilitative services in a skilled nursing facility, acute inpatient rehabilitation (AIR) facility or long-term acute care hospital (LTACH), including room and board Coverage is limited to 120 day maximum per period of confinement, subject to the combined day limit.	Nothing

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2. Skilled physical therapy, skilled occupational therapy or speech therapy when room and board is not eligible to be covered	Nothing
3. Services received from a physician during an inpatient stay in a skilled nursing facility, acute inpatient rehabilitation (AIR) facility or long-term acute care hospital (LTACH) Coverage is limited to 120 day maximum per period of confinement, subject to the combined day limit.	Nothing
GG. *Sleep Studies*	
1. Sleep studies conducted in the home or in a facility	Nothing
HH. *Telehealth Services*	
1. Health services delivered by means of telehealth	Covered at the corresponding benefit level, depending on the type of services provided. For example, office visits are covered at the office visit benefit level, inpatient services are covered at the inpatient services benefit level and mental health services are covered at the corresponding mental health services benefit level.
II. *Urgent Care*	
1. Urgent care center visits	See *Office Visits*
JJ. *Vision*	
1. Routine vision exam – Children through age 18 (coverage continues	Nothing

Altru Prime by Medica

MINNESOTA

Individual or Family

Bronze H Plan Zero

Benefit Chart

Your Benefits and the Amount You Pay	
Please note: Services from non-network providers are not covered, except emergency services received in the United States and services authorized by Medica. For certain covered services from certain non-network providers, you are responsible for any charges in excess of the non-network provider reimbursement amount.	
through the end of the month in which the member turns 19)	
2. Routine vision exam – Adult	No coverage
3. Non-routine vision exam	Nothing
4. Vision Services	Nothing
5. Vision therapy and orthoptic and/or pleoptic training, to establish a home program, for the treatment of strabismus and other disorders of binocular eye movements Coverage is limited to five training visits and two follow-up eye exams per calendar year.	Nothing
6. Eyewear, including eyeglass lenses and frames or contact lenses, and low vision aids which are hand-held lenses, spectacle mounted lenses or telescopic lens systems for members 18 years of age and younger received from an optical provider (coverage continues through the end of the month in which the member turns 19) Coverage is limited to one pair of frames and lenses every calendar year. Contact lenses are limited to coverage once every calendar year. Low vision aids are limited to one device every calendar year.	Nothing